2 **Older Immigrants in France**
Philippe Pitaud

7 **Elderly persons and Ageing in South Africa**
Marina Clarke

12 **Shelter Homes for the Elderly in Malaysia**
A. Zaiton – S. G. Sazlina – V. Renuka

19 **Older Adults with Dementia**
Colette Berman

23 **Meeting the Challenges of Population Ageing**
S. Cilia – J. Cauchi

29 **Elderly Adults in Puerto Rico**
M.S. Avendez – A. L. Davila Romini

32 **INIA Activities 2009 –10**

CONTENTS

Y K Y K

OLDER IMMIGRANTS IN FRANCE
A medical and a social approach of exclusion

PHILIPPE PITAUD

Summary

The present paper is based on four years' data issued from health assessment, free of charge, intended for elderly immigrants in France and specie sally in Marseille.

The survey shows that elderly immigrants suffer from isolation (very few migrants have a family at their place of residence) butalso a collective isolation in certain distncts or homes for immigrants. In addition, we met specific -pathologies resulting from difficult working conditions, non access to services forolder persons, non access to social and health rights and from not being covered by social insurance.

To continue to live in theirown home, older immigrants need French society to develop for them a policy which allows: X suitable home, a coordinated range of services, the keeping up of social intercourse, and the mobilization and support of the informal assistance networks.

In modern societies, preventive action constitutes one of the tools used by those who try to reduce the cost of social security by taking appropriate steps to counteract the factors which can result in a loss of autonomy and in disability.

Thus, public authorities shoulder the cost of preventive action with regard to children and adolescents through school medical services and also throughout working life through occupational medicine.

Nevertheless and paradoxically, nothing, or very little, is done in the field of preventive medicine against the hazards of advancing age, notwithstanding the high proportion of health related expenditure in respect of persons over 60 years of age.

We therefore have to admit that today, whilst life expectancy has continued to increase since the end of the Second World War resulting in an average span of 20 years beyond retirement age, post-work life is completely neglected in so far as preventive medicine is concerned.

It is true that preventive action is not an easy thing. As Chauvenet has demonstrated with regard to what he terms Surveillance medicine", one consults a doctor only when one is sick. Thus, social security only intervenes with a contribution when a person presents symptoms against which there are medical expenses. The present culture does not (generally) accept medical surveillance if there are no symptoms.

This approach partially explains the weakness of preventive action in France, which remains the poor relation in the French health system. In the summer Ff 2003, there was a dramatic corroboration of this weakness with more than 14,000 deaths in two months.

Taking into account this problem, the Institute of Social Gerontology proposes an annual assessment free of charge which goes beyond medical treatment as a means of preventing disability. The assessments are relatively simple and are carried out by doctors qualified in geriatrics and therefore knowledgeable

about the conditions of elderly people. Once the assessment has been drawn up, the patients are referred back to their own doctor who will either carry out further investigations, or will decide on treatment. This is also in order to adhere to the ethics of the profession. This assessment offers the possibility of ascertaining the overall situation of the elderly person: it is not restricted to the medical aspect. The social condition of the people being examined, and any diffficulties relating to memory or of a psychological nature are also taken into account. Thus, it is possible for two psychologists to see those people in respect of whom the Institute doctor would have established the need for a memory test or for a consultation.

Interest in this activity which reaches about 800 people yearly in four sites, lies in the fact that the approach is based on health whilst the objective pertains to the psychosocial field. In this sense, the teams confirm their intention to develop preventive action particularly with regard to the groups exposed to greater risks as are the ageing populations coming from a disadvantaged socio-economic background or those who have been subjected to diffficult working conditions.

The uniqueness of this programme of action therefore resides in the fact that, besides assessment and the detection of health problems, it aims at the 'redynamisation' of the elderly person, who then becomes capable of fighting against:

- isolation and loneliness
- dependency and loss of autonomy
- the feeling of social rejection resulting from a combination of poverty and old age

In a larger approach to the problems of elderly people, I should like to recall that, since the 1 980's, social policies concerning elderly people have been aimed at the problems connected with disability (we live to an older and older age but not necessarily in good health). They evolve around two alternatives:

• Accommodation in collective structures (homes for the elderly comprising medical and non medical, public or private institutions, long-stay hospitals, etc.); the main issues here are the adaptation of the various types of accommodation to differing situations, their organisation as Living places until death", and the review of the scale of charges

• Continued living of the elderly in their own homes requires a range of services and support especially in the case of very disabled people who are confined to bed or to a wheelchair, the main issues relate to the development of care services on a daily basis, the coordination of and support to family, carers without whom it would often be difficult, if not impossible, for dependent people to go on living in their own homes.

Continued living of the elderly in their own home depends on three factors:

- a suitable home
- a coordinated range of services
- the maintenance of social intercourse and the mobilisation and support of the informal assistance networks

Brief reference to the present important elements of social policy on ageing will enable a better appreciation of the problems of elderly immigrants and particularly of those who, cut off from everybody, advance in age without the support of a family network.

Despite these concerns for elderly immigrants, and the present paper on their social exclusion due to poverty, isolation, specific pathologies resulting from difficultworking conditions, non access to services for older persons, non access to social and health rights and from not being covered by social insurance, few people in industrialized countries have actually acted in full consciousness of the reality of the situation.

The fact that immigrants grow old and remain in France when they retire from work is no longer a

secret even though many have dreamt of returning to their country of origin. The immigrant idealises the attraction of his county of origin; this attraction almost becomes a compulsion although he realises that it is an impossible dream and in turn he is torn between the fear of disintegration if he moves away from the realization of his dream and the fear of being suffocated if he moves closer to it.
The situation described in "Entre-deuxX (here and over there) leaves a strong mark on the immigrant caught as he is between a UhereX and a Uthere".
Advancing age, through the reduction of physical, sensory and psychological capabilities, especially if accompanied by difficult social and financial conditions, can give rise to various forms of suffering which could lead to disability.

We can thus only start to take stock of the risks of the ageing of immigrants and their eventual entry into the gold old" age bracket, keeping in mind the problems arising from physical and/or psychological disability within the context of an anaemic system of social security.

Data issued from our four years health and social assessment in poor areas of Marseille show that these populations are almost exclusively male. Income levels are low, the majority being workmen and labourers. Account also has to be taken of the fact that a number of them were out of work when they retired or did not have the necessary documentation to apply for a pension. Finally, there were some who despite a long stay in France did not know French well.

From the compounding of these facts which, with a few exceptions apply to practically all cases, emerges a marginalisation of the aged migrant; to this we must add the condibon of underprivileged "old person" whose advance in years only serves to increase the weakness.

This marginalisation is also, and above all, that of isolation - individual isolation (few migrants have a family at their place of residence), but also a collective isolation in certain districts or homes for immigrants. The question therefore arises as to whether it is possible for the elderly immigrants to go on living in their own houses supported by social-medical services.

The people seen by the Institute team are mainly pensioners, but also people in great difficulty such as recipients of Minimum Insertion Allowance, unemployed people, disabled people or people without any social coverage. More than two-thirds are married with children, but often the family is in the home country and they live alone. The average age is 65. From an ethnicity point of view, 96% were originally from North Africa, with a strong predominance of Algerians. The majority of their incomes are low, and below the minimum pension (i.e. 460 Euros).

More than half of them live in hotels, generally in bad conditions, (some of them had to vacate their rooms early in the moming, rented monthly, or even weekly). Living in a hotel entails difficulties in organising their life-style with real physical and emotional repercussions (especially in winter). In addition, this means that home-help allowances are inaccessible in the case of loss of autonomy.

Approximately 11% reside in homes for immigrants. The home permits the preparation of meals and partaking of meals together, and assures a higher standard of comfort and better hygiene. But paradoxically, (for the question has been considered) this type of lodging does not promote human relations or social life, it aggravates isolation and is sometimes the cause of physical and moral slovenliness.

All the others are tenants, sometimes living with their families; these enjoy social recognition and the possibility of a more regular life.

Finally, the majority of them (95%) are insured persons, even if a great number of them have not been able, have not wanted, or have not known how to vindicate their rights, for very often their cards are out-of-date, their files are not in order. All this means that they end up by losing access to their rights. In case of an emergency situation, it is thus difficult to intervene legally. Moreover, it should be noted that 90% of them do not belong to a mutual

benefit society, even amongst the recipients of the Minimum Insertion Allowance, in spite of the existence of a solidarity mutual benefit society run by the local authority (at the Department level).

From a medical point of view, and without going into details, 37% of the consultations have revealed an unknown pathology or have enabled the taking in hand of a known but neglected pathology.

During the conversation with a doctor, the first complaint is, Ul feel worn out", but the rest of the consultation shows that it is only one of the symptoms, more or less pronounced, of a depressive syndrome. It is a way of expressing the isolation, the solitude, the remoteness of the home country and the family, the bad living conditions and the bad social situation; in short, they are not without reason to be depressed.

Afterwards, complaints can be heard mainly concerning the rheumatology field or that of gastro-enterology, which are not unrelated to the psychosomatic sphere.

Our information coincides with that issued by our colleagues from Labour Medicine who have identified a certain number of pathological problems amongst these populations such as:

- first of all in the lumbar region; sciatic troubles, slipped discs; an indication of hard work

- broncho-respiratory infections; statistics show that immigrant workers, especially those coming from North Africa, have paid a heavy toll in so far as tuberculosis and silicoses are concerned, and cannot hope to live to an advanced age. A respiratory capacity reduced by 30 to 40% causes real breathing problems at 60 years and over

- cardiovascular problems; and

- metabolic dysfunctions, i.e., diabetes (due to heavy consumption of carbohydrates) recourse, in pertain cases, to dispensary services of ZMedicines sans Frontieres" or even to be taken in hand by other informal bodies

In the social sphere, we note that:

- more than 53% are pensioners
- 25% approximately are unemployed, compensated by parity bodies
- 7% receive the Minimum Insertion Allowance to complete their pension, and a few more receive a disability pension

The analysis of the files reveals that these pensioners mainly belong to the general system of the Social Security, and that 58% of them do not receive a complementary pension. The development of their career (duration of work declared, period of unemployment, of illness or of undedared work), the origin, and the nationality, are factors which can explain what has produced these situations, and how this precarious state has come about. Regarding the low level of retirement pensions, this is attributed to insufficient tax contributions. Indeed, most of them are unable to prove they have worked 150 temms of contributions with the general system in order to receive the full rate.

Several factors can account for such a situation:

- insufficient duration of work periods (or undeclared periods of work)

- total or partial absence of relevant papers: work certificates, pay slips

- difficulties in establishing the reconstruction of the career (strong geographical mobility)

- periods of illness and unemployment (with low-rate salaries)

Bearing in mind these elements, not only the retirement pension by right will be at a minimum, but very often the request for retirement can be put to the authorities as soon as the age of sixty is reached (by using a practice of layingoff, one disguises the putting on one side of elderly workers, including non-foreigners); thus the pension is calculated at a reduced rate, due to an insufficient number of subscribed terms (except in special cases: for example, inability to work).

All these difficulties together with these brakes on the access to the health system are worsened by the illiteracy of the ageing immigrant workers. The analysis of the social files revealed that this concerns 95% of the clients.
One must also point out the difficulties met by elderly immigrants in relation to home-help services, or to obtain a place in an old person's home.

The problem of having access to services is a real one, and we should develop a programme aimed at public services, whose main lines will be:

- to make the public service aware of the difficulties encountered by the elderly migrant people

- to promote better co-ordination amongst the services involved

- to promote and develop the action of public services intervening,.on behalf of elderly people but directed at aged migrants

- to promote information about obtaining social rights and having access to preventative-health services amongst populations poorly or non-informed about these issues

Finally, we should like to say that, where elderly people are concerned, it is well known and recognised that there is a strong link between the medical and the social aspects. When an ageing population is also an underprivileged one, this link is even stronger. Thus, the most serious problem of these populations is the financial problem, because even though at least 95% of them are entitled to social security benefits, they are unable to shoulder the cost of a medical examination or the purchase of medicines.

Consequently, the result will be that many illnesses, which either remain undiagnosed or are neglected, will evolve towards a worsening situation, and will sometimes lead to invalidity with severe consequences for the individual himself and for the society in which he lives (cost of chronic illnesses and of institutionalisation).

There is a vast field of activities to be undertaken by the community for the prevention of disability in the case of old migrants.

Professor PHILIPPE PITAUD
Director, Institute of Social Gerontology
University of Provence
MARSEILLE, FRANCE
E-mail: (dessagis@univ-provence.fr)

ELDERLY PERSONS AND AGEING IN SOUTH AFRICA

MARINA CLARKE

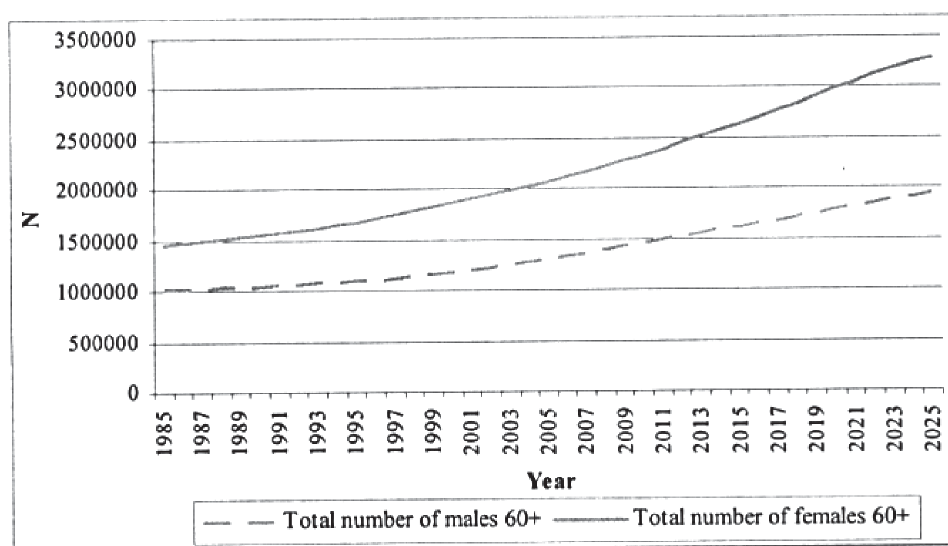
Introduction

Population ageing is a key demographic feature of the 20th century and is experienced by both developed and developing countries in the world.

In South Africa, a developing country with one of the most rapidly ageing populations in Africa and first that achieved democratic freedom in 1994 after more than 3 centuries of colonial and apartheid rule, the elderly are expected to make up about 10% of the total population within the next 15 years this (despite its severe disease profile HIV and AIDS, tuberculosis, malaria), and most of these will be female. It is essential to be cognisant of the political and socio-economic history of the majority of the elderly who were disenfranchised, marginalised, many chronically poor and rendered powerless pre-1994.

The South African Government, a signatory to the International Plan of Action on Ageing adopted by the United Nations in 2002, passed the Older Persons Act in June 2006 which heralded an era of hope for the elderly, particularly the poor and the disadvantaged. Prior to this, the majority of the elderly were seen as recipients of grants and objects of welfare. This Act emphasises the rights of older people, including access to community-based care and support services, the regulation of residential facilities for older people, and protection against abuse, ill treatment and neglect. One is unable to present a generic picture of older persons in South Africa because of the vastly divergent circumstances of large numbers of the elderly. A few, mainly from the ranks of those who prospered under the apartheid system are wealthy and financially able to provide for their physical needs although loneliness is widely reported amongst those people. These people are typically well educated and live in their own homes or in retirement villages that have frail care facilities, have accumulated assets, investments or receive pensions related to past employment. At the other end of this spectrum are those who have lived a

Figure 1: Population ageing in South Africa, 1985-2025 (numbers)



Source: ASSA2002, Joubert & Bradshaw, 2006

simple, subsistence lifestyle in rural areas and who have few if any accumulated assets. They usually have not had the benefit of formal education beyond 5 years of schooling and are functionally illiterate. They are dependent on employed children and family members for financial support. These extremely vulnerable members of society, access health care, social support with great difficulty as they live in remote areas without public transport, and where transport taxis and buses are available, they are expensive.

Demographics

In 2001, 7.3% of the population (2001 Census) were 60 years or older compared to 5.1% for the African continent as a whole (Joubert & Bradshaw, 2006). From the graph below (Figure 1), it can be seen that numbers are growing, with the number for females doubling in the 25 years (1987 and 2012) while the growth in the number of males is slower. If the decline in population growth due to HIV and AIDS is considered, it is evident that the elderly as a percentage of the total population will increase.

Care of the elderly

The State provides citizens or permanent residents whose income (combined income of both husband and wife if married) is below a certain level and are women 60 years or older and men 63 years or older, a monthly old age grant of R960 (2008) if they are not cared for in a State Institution or receive another social grant. Many do not have family on whom they can rely for support and must fend entirely for themselves and for any dependants (see section on HIV and AIDS below). The old age grant is at best able to provide for daily essentials and is not sufficient to keep a household out of poverty (Roberts, 2000). Thus unless family circumstances have changed, for instance a daughter or son has found a good job, or some kind of financial burden has been removed, they are likely to remain in chronic poverty. In 2000, when the grant was R520 p.m., there were approximately 1 635 000 persons receiving old age grants at a cost of R10 202 million to the national budget (Aliber, M. 2001).
As the wellbeing of the elderly especially in rural areas cannot be viewed in isolation from the poverty of the communities they live, an overview of typical poverty related activities for all ages is presented in Table 1.

The number of community based organisations (CBO), non-governmental organisations (NGO) and faith based organisations (FBO) has declined from an estimated 45000 - 80000 prior to 1994 dramatically as international funders moved from direct funding of CBOs and NGOs to channelling funds through the government. It is impossible to ascertain what funding impacts on the poor (and elderly) from this source. Dangor (1997) estimated that in 1994 that 54000 CBOs and NGOs received a staggering R10 billion (4.7% of GDP).

Table 1 Typical poverty-related activities of different sectors

	Government/ Parastatal	Private sector	NGOs and CBOs	FBOs
Social security	• Social grants (i.e. old age, disability, etc.) • Subsidised health care • School feeding programmes	• Occupational Insurance (unemployment insurance, medical aid, etc.) • Grants for charitable causes, e.g. child welfare	• Community-based home-care, e.g. for orphans • Charities, child welfare organisations, etc	• Soup kitchens • Health services • Shelters/ missions
Development and Job Creation	• Poverty Alleviation Fund • SMME support • Land redistribution • Community-Based Public Works	• SMME investment and support	• SMME support • Income generating community projects	• Income generating community projects

Source, Aliber, M. 2001.

Health care at local clinics, day hospitals and tertiary hospitals is available. The cost of these services is dependent on income. However the services carry a very heavy load with long queues being the norm. Access to health care is a major challenge for the poor, especially those living in rural areas where distances to clinics are great and public transport scarce. Currently, 35% of the medical practitioners serve 70% of the population. There are eight medical practitioners trained as gerontologists of whom only three continue to practice, two of whom are in the public service. Eleven nurses are registered as having gerontology training; this training is no longer offered because of a lack of student interest.

The government promotes the concept of volunteer community based home carers. In many communities are unfamiliar with the concept but studies show that informal untrained care givers function out of necessity. "In many cases older people are not only care givers but also care recipients. It is clear that informal care givers are already an indispensable family and community asset, but they need support from formal organisations and the state" (Marais and Eigelaar-Meets, 2007).

HIV and AIDS and the elderly

The high burden of HIV/AIDS in South Africa warrants special mention in any review of the elderly. Contrary to what one might expect because of the myth that older people are not sexually active, HIV does present itself in this age group and often goes undetected as certain symptoms of the infection (such as fatigue, memory loss, shortness of breath, sleeplessness, weight loss and digestive problems) are very similar to, and often mistaken for, signs of normal ageing, thus the benefit of early diagnosis and treatment is lost.

However the greatest impact of the pandemic on the elderly, particularly in the developing world, is the enormous burden and responsibility it places on older adults as it claims the health and lives of their adult children in their prime productive years who traditionally were expected to provide income and care for their parents. Many elderly people have little option but become caregivers for friends, ill adult children and grandchildren, a role for which they little knowledge or training. Added to caring for the ill, grandparents become surrogate parents to their grandchildren orphaned by Aids, or whose parents are too ill to work or provide care. As a result many of the elderly have no option but to seek work and become breadwinners once again as the old age grants are inadequate to provide for the needs of additional persons. The emotional and physical demands of working (whether in formal or informal employment or subsistence gardening) housekeeping, caring for the sick and looking after children are severe for the older person who in all likelihood will be facing a decline in their own health and abilities.

This aspect of life for the elderly cannot be overstated and the consequences defy imagination. Although statistics are difficult to accurately determine, the Actuarial Society of South Africa has produced estimates that claim that in 2000 there were 124 989 AIDS orphans, by 2009 this had risen tenfold to 1 532 991 (more than 3% of total population) and is expected to grow to 1 938 000 by 2015 despite the increasing number of deaths. (Health Systems Trust website:*http:llwww.healthlink.orq.zalhealthstatsl891data*)

Daily life for the elderly

"Measures of healthy life expectancy often focus on the ability of persons to complete activities of daily living (ADLs) such as bathing, dressing, eating, getting in and out of bed, and toileting. More refined measures also consider instrumental activities of daily living (lADLs) which include preparing meals, shopping for personal items, managing money, using the telephone and doing light housework" (Crimmins, Hayward, and Saito, 1996).

Since 1994, great strides have been made in providing water, electricity and sewage systems to all in the country. As so many older persons live in remote areas, they have yet to benefit from these advances. Thus daily life for many includes fetching water and firewood, tilling vegetable patches and chickens, or other ways of supplementing income.

Many are also the caregivers to the young and the chronically or terminally ill.

Gathering at central points to collect government grants provides opportunity for socialization but only after long journeys on foot or by taxi or bus. These occasions are also times of fear as they become targets for criminals who attack them and steal their money or provisions that they have bought from their grant.

When in need of medical assistance for themselves or their dependants, a very early morning start to the local clinic is required (long before sunrise), which is inevitably means waiting in long queues without food, water or toilet facilities. The cold or rain only complicating the illness.

Involvement in church meetings, societies, choirs and prayer groups is an important part of daily life for most. According to the 2001 Census, 84.9% of South Africans classify themselves as religious. The church provides a vehicle for socialisation and mutual care and encouragement. Many continue the practice of burials in the birthplace of forefathers, so funerals occur often as the dead are brought from the city for internment. These funerals add to the financial burden of local residents as visiting family need food and accommodation, but bring the joy of seeing relatives and friends, thus playing an important role in maintaining family bonds.

"Unfortunately this vulnerable group has become the victim of crime which sometimes accompanied by violence and even rape. Social workers caring for the elderly say there are high levels of under-reporting of abuse, and that older people are subject to physical, financial, psychological, emotional, sexual and verbal abuse. Women are particularly vulnerable and those who are mentally and physically weak are seen as "easy targets". In cases involving rape, she said it was "very hard" for black elderly women who had been raped to report their attacks because of an inclination among the elderly not to talk about sex and a fear that their families would be disgusted" (Nkuna, 2008).

Globalisation has brought an unexpected difficulty to those elderly whose children and grandchildren have emigrated to other countries. Although some elderly have mastered the communication opportunities offered by computers and the interned the pain of separation is all too apparent; loneliness is exacerbated especially during illness and those culturally important events such as birthdays and graduations.

For the rural elderly, communication with family who live in the cities is difficult as mobile phones are costly and few have landline telephones. Letters are written which must be taken to the nearest village for posting and the reply will need to be similarly fetched. More usually, an oral message is sent via a friend from the area returning to the city. Thus many months can pass before any response is received to a message.

Involvement in society

A focus group in a recent study indicated that the main contribution to society by the elderly were their role as child-minders, the financial support of family members rendering them vulnerable to abuse by the selfsame family members. They also care for the sick and distribute food parcels amongst the poor, mainly as part of church outreach. Many create their own small businesses cooking, sewing and vending. Participation in community decision making processes is limited although a traditional role (Marais et al, 2007).

The same focus group respondents generally participate in social activities organised by the church and activities through the social clubs and Seniors' Centers, subsidised by Department of Social Development. They are involved in other initiatives of that Department such as the Golden Games, organised in 2006 as well as activities organised by other organisations such as trade unions. The group also indicated that they organised activities and outings on their own initiative (Marais et al, 2007).

Conclusion

The promulgation of the Older Persons Act in June 2006 by the South African Government provides an excellent framework for the restoration of the dignity of older persons, but the limited availability of finances and resources severely restricts the realisation of the spirit of the legislation as does the burden of illness (HIV/AIDS and others) and poverty. Living in fear of abuse and crime adds to

References

Aliber, M. 2001. Study of the incidence and nature of chronic poverty and development policy in South Africa: An overview. http://www.sarpn.orE/CountryPovertvPapers/SouthAfrica/policy/policy.pdf

Crimmins, Eileen M., Mark D. Hayward and Yasuhiko Saito, 1996, "Differentials in Active Life Expectancy in the Older Population of the United States," Journal of Gerontology: Social

Sciences, Vol. 51 B. No. 3, pp. S111 -120. In Kinsella K and Gist Y. Mortality and Health, U.S. Census Bureau, the Official Statistics™ September 28, 1998

Dangor, Z., 1997, The Non-Profit Sector in South Africa, Kent: Charities Aid Foundation.

Joubert, J & Bradshaw, D. Population ageing and health challenges in South Africa, Chapter 15, ln Steyn K & Fourie J (Eds), Chronic diseases of lifestyle in South Africa: 1995 - 2005,

Medical Research Council, Technical Report, May 2006.

Marais, S and Eigelaar-Meets, l. 2007. The social wellbeing of older persons in the Western

Cape: An overview. Medical Research Council. Cape Town

Nkuna, B. 2008. Elderly find themselves trapped in abuse. Cape Argus: February 17.

Roberts, B., 2000, Chronic and Transitory Poverty in Post-Apartheid South Africa: Evidence from KwaZulu-Natal, Working Paper No. 28, Centre for Social and Development Studies, University of Natal.

Dr. MARINA CLARKE R.N., Ph.D.,
Senior Lecturer
Cape Peninsula University of Technology
e-mail: clarkeM@cput.ac.za

SHELTER HOMES FOR THE ELDERLY IN MALAYSIA

A. ZAITON – S.G. SAZLINA – V. RENUKA

Abstract

This study describes for the first time the residents of public-t'unded shelter homes in Peninsular Malaysia. A cross sectional study of 1081 residents from all nine- shelter homes were interviewed from March to September 2003. The mean age of the residents was 71.8 + 0.23 [SEM1 years old. The majority of residents were males (58.6%), had no formal education (64.1%)* were from rural (81.1%) areas, had no family members (61.7%) and received no visits at all (85.5%) t'rom either friends or relatives. Two hundred and ninety five (27.3 %) had mild to severe disability, 226 (20.9%) had poor vision and 47 (4.3%) had reduced hearing. Only 447 (41.4%) older people were well nourished, 707 (78.9%) were at~risk of depression and 817 (75.6%) had probable cognitive impairment One hundred and forty three (14.1%) and 88 (8.1%) self reported to have hypertension and coronary heart disease respectively. It is clear that these residents have multiple co-morbidities and effective management strategies are required to ensure maintenance if not improved quality of life.

Keywords: elderly, public-i'unded shelter homes, profile, Peninsular Malaysia

INTRODUCTION

Population ageing is a global phenomenon. Malaysia's population is also rapidly greying. It was reported that the Malaysian population aged 60 years and over in 1960 was only 546,100, and by the year 2000 this population group had increased to almost 1.5 million l By 2030 the number of older persons (> 60 years) in Malaysia is expected to grow to about 6 million and this group will make up 17% of the total population 2 There is a need for planning to ensure that good management strategies are put in place so that older people can look forward to have good quality of life as they age.

It is clear that in the future, the living arrangements will be very different for older people. In the past, culturally, it was expected that the children would look after their older parents and provide them with shelter and emotional support. However with industrialisation, urbanisation and the need for more women to work, older people have to t'end for themselves more often. This has lead to an increase in the number of older people being institutionalised 3 4. For this reason, the authors of this paper felt that it is important that current residents of publicly funded shelter homes should be evaluated to enable better planning for the future.

There are currently nine public-handed shelter homes for older persons in Peninsular Malaysia. In total these homes provide 2650 beds and most often 90% of these beds are occupied. The main objectives of these residential care facilities are to provide shelter and medical and rehabilitative cars to people (mostly older persons) who lack financial and family support. In Malaysia, these shelter homes are viewed as a place of last resort, a home for the destitute and unwanted. They also receive far less financial support compared to other residential care or health care institutions.

The primary aim of this study was to determine the socio-demographic profile and cognitive, psychological, medical, nutritional and physical health of older residents of these public-funded shelter homes in Peninsular Malaysia.

METHODS

The study methodology has been previously described but is described briefly below 5. This study was conducted in all nine publicly funded shelter homes ('Rumah Seri Kenangan') in Peninsular

Malaysia between March and September 2003. 1126 residents were eligible for the study in that they were 60 years or older and had resided in the shelter homes for at least 3 months. Of these, 1081 residents participated in the study and were interviewed between March and September 2002. Forty-five residents did not participate due to poor health, dementia or intercurrent illnesses. Informed consent was obtained from all participants (or their proxy). The Department of Social Welfare, Malaysia, approved this study and ethics approval was obtained from the University Putra Malaysia.

Each resident's socio-demographic and baseline health characteristics were recorded using a standardized questionnaire. Two research assistants, trained by one of the authors (ZA) administered the structured questionnaires. Medical illnesses were recorded based on the responses of the residents and available records. Hearing was rated as reduced if the residents could not hear normal speech or hold normal conversation. Visual problem were noted if the residents needed glasses to read newsprint or perform their daily activities. Residents who were able to stand upright without support had their weight and height measured. Body weight measurement was made using a TANITA weighing scale. Height measurements were made using a SECA Bodymeter. The Body Mass Index (BMI) was then calculated in kg/m2.

Several well-known geriatric assessment scales were used in this study:

I) The 1 0-item Barthel index 6 was used to evaluate physical function. Subjects were categorized as independent if they scored the maximum score of 20. All other subjects were said to be dependent for at least one activity of daily living (ADL). Aspects of functional status studied were: ambulation, transfers, negotiation of stairs, feeding, grooming, dressing, toileting, bathing and bowel and bladder control.
2) To assess mood, the 12-item Geriatric Depression Scale for use in residential care (GDS) was used 7. Residents scoring 5 or more were said to be at-risk of depression (maximum score 12).

3) Cognition was assessed using the Elderly Cognitive Assessment Questionnaire (ECAQ) 8. Subjects were said to have cognitive impairment if they scored < 5 and no cognitive impairment if the scored > 6 (maximum score 10). Those scoring 5 or 6 were said to be borderline.

4) Nutritional status was assessed using the "DETERMINE Your Nutritional Health Checklist [NHC]' 9. Subjects scoring less than 3 were well nourished. Subjects scoring 6 or more were at high risk of under-nutrition and subjects scoring 3, 4 or 5 were said to be at moderate risk of under-nutrition.

The ECAQ, GDS-12R, Barthel Index and the NHC were translated by one author (ZA)~ and its accuracy was verified by a second author (VR).

RESULTS

This study had an excellent response rate of 96 % (1081 out of 1126 persons were included in this study). The baseline characteristic differences according to gender have previously been shown in tabulated form 5. However, we describe and discuss this for the first time in this paper.

Socio-demographic characteristic

Table 1 shows a tabulated summary of the socio demographic characteristic of the elderly residents. The mean age was 71.8 years + 0.23[SEM]. The ages of the residents were ranged from 60 to lO0 years old. Eight residents were not able to state their ages. The majority (67.2%) of residents were in the young old age group (60-74 years); however, almost a third of residents were 75 years and older. The male to female ratio was 1.4:1. 58.6% of the residents were men. The residents were of varying ethnicity with a large proportion of the residents being of Malay origin (44.4%). Almost one third of residents were of Chinese origin. 81.1% of the residents come from rural areas and most had no formal education (64.1%). Many also had no family (61.7%) and most reported no visits from people (85.5%).

Functional Status

The Barthel Index (table 1) revealed that most residents were independent. Two hundred and ninety

Table 1: Characateristic of the elderly people residing in the shelter homes in Peninsular Malaysia

Characteristic	n	%
Sex		
Male	633	58.6
Female	448	41.4
Ethnic		
Malay	480	44.4
Chinese	329	30.4
Indian	268	24.8
Others	4	0.4
Age		
60-69	187	17.5
65-74	533	49.7
75-84	287	26.7
>85	66	6.1
Origin		
Urban	204	18.9
Rural	877	81.1
Level of Education		
Primary School	353	32.3
Secondary School	35	3.2
No formal education	693	64.1
Family		
Family	414	38.3
No Family	667	61.7
Physical Function		
Dependent	786	72.7
Independent	295	27.3
– Feeding	31	2.9
– Bathing	96	8.9
– Grooming	79	7.3
– Dressing	87	8.1
– Bowel	107	9.9
– Bladder	100	9.3
– Toileting	98	9.0
– Transfer	144	13.4
– Ambulation	220	20.3
– Stairs	187	17.3

Table 2: Cognitive and Mental status of Elderly residents of the Rumah Seri Kenangan

Characteristic	n	%
Cognition		
Normal	157	14.5
Borderline impairment	107	9.9
Cognitively impaired/dementia	817	75.6
Mental Status		
At risk of depression	707	78.9

Table 3: Nutritional status and chronic illness among the elderly on the Rumah Seri Kenangan homes

Characteristic	n	%
Nutritional Status (N=1081)		
At risk of under nutrition (NHC>3)	634	58.6
Well nourished (NHC<3)	447	41.4
Chronic Illness		
Absent	**333**	**30.8%**
Present	**748**	**69.2%**
– Diabetes		**8.8%**
– Coronary heart disease		**8.1**
– Hypertension		**14.1**
– Asthma		**5.8**
– Osteoarthritis		**4.3**

five (27.3%) residents were dependent in at least one ADL. The most common type of functional dependence was for ambulation (20.3 %), negotiating stairs (17.3%) and transferring (13.4%).

Cognitive and Mental status

Many residents appeared to be at-risk of depression (65.3%) (Table 2). Many were also cognitively impaired (75.6%) (Table 2).

Nutritional (including Body Mass Index)

The nutritional status (assessed by NHC and BMI) of these residents have been described in detail in other papers by this group (Refs 5, 10). 32.1% of residents were at moderate risk of undernutrition and a further 26.6% were at high risk of under-nutrition (Table 3). 14.3% ol the respondents were underweight with very low body mass index (BMI) <18.5 kg/m2. 18.2 % recorded a BMI between 18.5 and 20 kg/m2 . The majority (61.1%) of residents had a healthy weight with a BMI between 18.5 and 23 kg/m2 whilst 24.6% were overweight with a BMI > 23 kg/m2. It should be noted that the BMI was not determined in 102 residents as 101 were too physically dependent and one resident declined.

Health Profile

As shown in Table 3, 747 (69.2%) respondents had at least one chronic illness. 20.9% of residents had visual problems. Of these, 13 were blind and three reported having cataracts. The rest used glasses. Fitty-eight residents were found to have difficulty with hearing and of these 11 were deaf.

DISCUSSION

This study is novel in that it provides for the first time a detailed description of older people residing in publicly funded shelter homes in Malaysia. A large proportion of these residents is between the ages of 60 and 74 years and is physically independent. Experience from developed countries would suggest that many of these people could sustain an independent lifestyle in the community with adequate financial and community support (e.g. publicly funded domiciliary services). Not surprisingly, this study also shows that older people from rural areas with no family support and low educational background are at high risk of becoming destitute and being institutionalized prematurely. Preventative strategies need to be put in place in the community to ensure that older people remain independent in the community for as long as possible. This study also reveals that a large number of older people in institutions are at risk of depression, malnutrition cognitive impairment, physical disability (hearing and visual impairment) and chronic illnesses (such as diabetes).

Interestingly, the majority of residents in this study were men and were younger than 75 years. This is in contrast to studies done overseas which shows that nursing home residents were more likely to be older (75+) and female (Refs 11 , 1 2). It would appear that people are prematurely being institutionalized and this is most likely because there is a lack of community and financial support (e.g. domiciliary care and pension schemes). This needs to be explored further. Although we have no way of proving this, it may be that women are more able to cope on their own. For this reason! more men require institutionalization. Culturally it is normal for women to be in charge ol household chores whilst men lack these skills and may require institutional care as a result. Also? it is possible that widowed women may be able to stay with children because they help with domestic chores whilst widowed men are more likely to be institutionalized because they are viewed more as a burden. This too needs further evaluation.

Functional status may decline with increasing age and physical disability becomes more common. This decline in part is related to a decline in muscle strength (Refs 13, 14). In this study elderly residents who were dependent had dilficulties in ambulation (30.3%), negotiating stairs (17.3%) and transferring (13.4%). Many residents were also underweight and at-risk of undernutrition (Refs 5, 10) and as a result very likely had sarcopenia. In this study, less than 10% of residents complained of bowel and bladder troubles. This is very different from that noted overseas whereby urinary incontinence is often stated to be one of the most common complaints in residential homes (Refs 15, 16, and 17). It may be that these complaints were under-reported because there is a stigma associated with this and also many people were too embarrassed to report it.

Early recognition of cognitive impairment is important as cholinesterase inhibitors may be of benefit in some (Ref 18) and early planning is important (e.g. end of life care and institutionalization) (Ref 19). In this study, a large number of residents were found to be cognitively impaired or at-risk of cognitive impairment. We are uncertain of the significance of this result given that the majority of residents were independent. Firstly, a large number of people in this study were found to

be atrisk of depression and so may have 'pseudo-dementia'. Also, a large number of residents had not received a high level of education and this too can affect cognitive assessment scores (i.e. lowering them). Thirdly, this cognitive tool has not been previously validated in Malaysia and so its validity is uncertain. Fourthly, many people had hearing impairment and this may have affected the scores somewhat. Nevertheless, these results are of concern and this requires further evaluation.

In this study the majority of residents had some form of chronic illness. Lawlor et al found nearly three quarters of British women studied had at least one chronic disease (Ref 20). Hypertension, diabetes, coronary heart diseases, asthma and arthritis are common in older people and this is further supported by the Malaysian National Health Survey (Ref 21). Good management of hypertension and diabetes has been shown to reduce the risk of cardiac disease (Ref 22, 23). Management of asthma and arthritis has also been shown to improve quality of life (Ref 24, 25). In this study many people reported visual and hearing impairment and this needs to be managed as these handicaps may aflect quality of life and increase the risk of experiencing adverse health outcomes such as falls (Ref 26).

This study had an excellent response rate of 96% and also was comprehensive in that residents of all shelter homes in Peninsular Malaysia were evaluated. This study also has several limitations but still provides new insight into areas that require further evaluation and management. Many of the geriatric assessment tools used in the study were validated overseas. The researchers only performed brief visual and hearing assessments and so it is very likely that we have underestimated the true prevalence of these impairments. Also, we used subjective reports of health status. Given the large proportion of people with depression and cognitive impairment, the reliability of their response is uncertain. Nevertheless, it is more likely that we have underestimated the true prevalence of these illnesses.

To summarise, this study clearly describes the health and socio-demographic characteristics of elderly shelter home residents in Malaysia and this information can be used for future planning. The most important observation is that people are being institutionalized at a very young age (compared to developed countries) and this is likely because currently there are no pension schemes ('safety net') and community support services. This is a possible area for further evaluation and development. Also, it would appear that men and older people with poor education and from rural areas are at high risk of institutionalization. Chronic illnesses, visual and hearing impairment and cognitive and mood disorders appear to be common and therefore residents in these home require medical evaluation and management. As these shelter homes are 90% occupied at any one time, there needs to be planning to meet the demands of an ageing population. More shelter homes may be required but perhaps the institution of financial assistance and community support services may be beneficial in stemming the shortfall in residential care places that is bound to occur.

Acknowledgements

This study was supported by a grant from Universiti Putra Malaysia no. 04-08-02-0050F. We are grateful to the Department of Social Welfare and the staff of all nine the ‘Rumah Seri Kenangan’ for their assistance.

References:

1. Tengku-Aizan, H., Jariah, M. & Chai, S.T. Socioeconomic Status of Older Malaysians: A Gender Comparison. Malaysian Journal of Family Studies 2004; l(pt 1):54-69

2. United Nations. 2005. World Population Prospects. The 2004 Revision. New York: United Nations. Available at: http://esa.wn.org/unpp/ . Accessed June 26, 2006.

3. Cheung P. Ageing population In: Chan KM et al (eds). Geriatrics Medicine for Singapore. Singapore Gerontological Society 1996.

4. Kane RL. Changing the image of long term care. Age Ageing 2000; 29:481 -3.

5. Visvanathan R. Zaiton A, Sherina MS, Muhamad YA. The nutritional status of 1081 elderly people residing in publicly funded shelter homes in Peninsular Malaysia. Eur J Clin Nutr 2005 March; 59(pt 3): 318-324.

6. Collin C, Wade D.T, Davies S. Horne V. The Barthel ADL Index: a reliability study. Int. Disabil. Studies 1988; 10: 61-63.

7. Sutcliffe C, Cordingley L, Burns A, et al. A new version of geriatric depression scale for nursing and residential home populations: the geriatric depression scale (residential) (GDS12R). Int Psychogeriatr 2000; 12(pt 2):173-81.

8. Kua EH, Ko SM. A questionnaire to screen for cognitive impairment among elderly people in developing countries. Acta Psychiatr Scand 1992; 85 (pt 2): 119-22.

9. Posner BM, Jettee AM, Smith KW, Miller DR. Nutrition and health risks in the elderly: the nutrition screening initiative. Am J Public Health 1993; 83(pt 7):972-8.

10. isvanathan R & Zaiton A. Good Oral Health, Adequate Nutrient Consumption And Family Support Are Associated With A Reduced Risk Of Being Underweight Amongst Older Malaysian Residents Of Publicly Funded Shelter Homes. *Asia Pacific Journal Clinical Nutrition 2006*; 15(3): 400-405

11. Tomiak M, Berthelot JM, Guimond E, Mustard CA, Factors associated with nursing homes entry for elders in Manitoba Canada. *J Gerontol A Biol Sci Med Sci* 2000; 55A:M279-287.

12. Klein T. Salaske I. Determinants of nursing home admission and chances for prevention. A longitudinal study in Germany. *Gerontology* 1994; 27:442-55.

13. MaGee MA, Anthony LJ, David WK. The description of activities of daily living in five centres in England and Wales. *Age and Ageing* 1998; 27:605-613.

14. Seeman TE, Charpentier PA, Berkam LF, Tinetti ME, Guralnik JMn Albert M et al. Predicting changes in physical performance in high functioning elderly cohort: McArthur studies of successful ageing. *J. Gerontol* 1994; 49:M97-M 108.

15. Peet SM, Casteleden CM, Mcgrother CW. Prevalence of urinary and faecal incontinence in hospital and residential and nursing homes for older people. *BMJ* 1995; 311: 1063- 1064.

16. Mohide EA. The prevalence and scope of urinary incontinence. *Clin Geriatr Med* 1986; 2:639-55.

17. Ouslander JG, Kane RL, Abrass IB. Urinary incontinence in Elderly nursing home patients. *JAMA* 1982; 248:1194-8.

18. Wilcock GK, Lilienfiled S. Gaens E. Efficacy and safety of galantamine in patient with mild to moderate Alzheimer's disease. A multicentre randomized controlled trial. *BMJ* 2000; 321:1 -7.

19. Richie K. The screening of cognitive impairment in the elderly: a critical review of current methods. *J ClinEpidemiol* 1988; 41:635-43.

20. Lawlor DA, Patel R. Ebrahim S. Association between falls in the Elderly women and chronic diseases and drug use: cross sectional study. *BMJ* 2003; 327:712-717.

21. Report of Second National Health and Morbidity Survey Conference. Hospital Kuala Lumpur 20 -22 November 1997.

22. Hansson L, Zanchett A, Carruthers SG,. Effects of intensive blood pressure lowering and low dose aspirin in patient with hypertension: Principle results of Hypertension Optimal Treatment. Randomised trial. *Lancet* 1998; 351 :1755-1762.

23. Diabetes control and complications trial research group (DCCT). The effect of intensive treatment of diabetes on development and progression of long term complication in insulin dependent diabetes mellitus. *N Eng J Med* 1993; 329:977-986.

24. Huss K, Neumann PL, Mason PJ, Nanda JP, Huss RW et al. Asthma severity, atopic status, allergen exposure and quality of life in elderly person. *Annals of Allergy, Asthma & Immunology* 2001; 86(pt 5): 524-530.

25. Geba GP, Polis AB, Kong SX, Dixen ME, Dobbins TW et al. Quality of life in the treatment of osteoarthritis: comparison of rofecoxib to nabumetone and placebo. *J of Am Geriart* Soc 2001; 49(pt 4): S87.

26. Legood R. Schuffman P. Cryer C. Are we blind to injuries in the visually impaired? A review of literature. *Inj Prev* 2002; 8:155-160.

DR A. ZAITON M.D., M.Med.
DR S. G. SAZLINA MB., BS., M.Med.
Department of Community Health
Faculty of Medicine
Universita Putra Malaysia
SERDANG, MALAYSIA

DR V. RENUKA FRACP., Ph.D.
Queen Elizabeth Hospital
SOUTH AUSTRALIA

MERCK INSTITUTE FELLOWSHIPS

The International Institute on Ageing, United Nations – Malta has received a grant from the Merck Institute of Ageing and Health, Washington D. C. for Training Programmes, which are held in Malta. for 2 participants in the 9-month Postgraduate Diploma Course in Gerontology and Geriatrics at the European Centre for Gerontology, University of Malta.

Applications for the above Fellowships will be received by Professor Joseph Troisi, Director of the International Institute on Ageing,United Nations – Malta, 117, St. Paul Street, Valletta VLT 1216, Malta.

The closing date of applications can be obtained from the Institute's website, **www.inia.org.mt.**

OLDER ADULTS WITH DEMENTIA:
The value of Life-story work

COLETTE BERMAN

INTRODUCTION

Life-spans have been extended, but, like taxes, ageing unless preceded by death is inevitable. This reality is never more stark than in older age, when parents have passed away and friends and siblings are also passing. When facing end of life tasks, the greatest comfort can be gained from reflecting on a life well lived.

Erikson, in his Stages of Psychosocial Development, describes the final developmental stage (Stage 8) which generally occurs past the age of 65 as a time of "Ego integrity versus Despair". Successfully completing this stage enables individuals to confront death with few regrets, whilst being unable to meet the challenge results in feelings of bitterness and despair. What constitutes a life well lived is entirely subjective, depending on the individual, personality, interests, aptitudes, and place in history: "the social and historical meaning of the individual in the society and in the period (C. Wright Mills, 1959)

In acknowledging that the individuals have played the hand dealt to them by life to the best of their ability, it is also important to distinguish between ordinary lives and "lives ordinarily lived" (Clark, 1999). That is, the maze of "private troubles" that they have negotiated amongst the "public issues" of their place and time in history. As an example, the memory of childhood hunger is always painful; but if the hunger was due to poor family management or to a state of war holds a different significance.

Advanced age brings with it a number of age related changes (Cavanaugh & Krauss Whitbourne, 1999) which affect individuals to different degrees according to their past lifestyles and innate reserves. Although dementias can and do occur in younger persons, dementia is predominantly a disease of ageing, and ultimately results in death. The Malta Dementia Society estimates that there are some 4,000 persons with dementia in Malta, and that this is due to double over the next twenty years. Worldwide, it is estimated that one person is diagnosed every seven seconds.

According to Cavanaugh and Whitbourne “SDAT [senile dementia of the Alzheimer's type] is always characterised by impairment of both short and long-term memory. Memory losses eventually become so severe that the individual may fail to recognize even very close loved ones. ... visuospatial disturbances resulting in an inability to find one's way around the neighbourhood and house, and rapid personality change, often increases in aggression and socially inappropriate behaviour. Eventually, SDAT results in loss of the self …”

IDENTITY

Role Theory describes how identities are formed through the various roles that we attain for ourselves and are ascribed to us by others and that make up our role-set. (Compton and Galaway, 1999, p. 40). Through the interaction between our roles and our environment we establish a sense of who we are in the scheme of things. In the terms of structural functionalism described by Talcott Parsons (Macionis and Plummer, 2002), we assess the function of the various elements we perform in relation to the whole.

Bond and Coleman comment on the difficultiess faced through ageing and dementia to maintain an identity intact "when so many of these contacts, roles and activities are lost" (Bond and Coleman, 1990). These incremental losses take with them the elements that make up individual identities.

There are approximately 81,400 persons over the age of 60 currently living in Malta, 56% of whom are women. By 2025 it is estimated that there will be over 109,000 persons over the age of 60, of whom 58% will be women. Woods develops a similar argument to that made by Bond and Coleman (1990) with particular respect to the tenuous identities held by many women. He notes that women in particular take a passive approach to their lives, "describe their lives in relation to significant others, and see events through eyes not their own." (Woods, 1999). Thus the loss of significant others also results in the loss of self. Loss of identity, and of self, can make the achieving of Ego Integrity an impossible task; and this is the challenge faced by a growing number of older adults, and older women in particular.

The self is particularly threatened by dementia because, unlike other memory disorders, it attacks long past as well as recent memories. Even early memories are not spared (Fromholt & Larsen, 1991). However, it is also typically a gradual process and much can be done to preserve a more coherent sense of self by sensitive counselling and repeated encouragement of individuals to recall their story (Mills & Coleman, 1994). (Cited in Woods, 1999, p.63)

The importance of Life Story Work lies in retaining or regaining, a sense of individuality and identity, to "establish an identity in the present" by making reference to the past.

“The body is an object in which we are all privileged, or doomed, to dwell, the source of feelings of well-being and pleasure, but also the site of illnesses and strains. (...) [I]t is an action-system, a mode of praxis, and its practical immersion in the interactions of day-to-day life is an essential part of the / sustaining of a coherent sense of self-identity. (Giddens, 1991, p. 99).”

LIFE-STORY WORK

"The role that reminiscence can have in older people's lives has only recently been affirmed. Although recognised by Aristotle as an important feature of old age, its treatment has often been unsympathetic." (Bond & Coleman, 19,90, p.96). Life Story Work is more than reminiscence, and does not set out to resolve past problems, as Life Review Therapy does (NHS Trust, Z006), although this may result. "Encouraging people to talk about the past can be a way of helping them to manage change in their lives and establish an identity in the present" (Open University, 2008, p.7).

Life Story Work is being frequently used with looked after children, in order to give them a tangible past and a sense of identity that they would otherwise not have had. Its benefits to enable terminally ill patients to positively face their final task and leave a legacy of their lives have also been recognised. Increasingly a more rigorous approach is being taken to examining its applicability for preserving memories and a sense of identity for persons with mild to moderate dementia and the findings have indicated "less negative change than control participants" (Cohen, 2007, p. 129) and "significant improvement in psychosocial well-being for the intervention group". (Lai, Kayser-Jones, 2004).

Life Story Work is a process, and it is within this process that individuals can validate their identity and the lives they have lived. (Kolva, 2004). It need not necessarily take the form of a book, but could include a scrap book, a memory poster or a time-line. Two great-aunts of mine had a "memory box" that contained many photographs along their lifespan, but also other mementos such as locks of hair, scraps of lace, letters, postcards, tickets and programs from plays and operas they had attended and voyages they had made. Being allowed to go through the box and being told stories attached to the items it contained was a special treat.

DISCUSSION

The value and purpose of Life Story Work lies in reminding the clients of who they are and what they have achieved. The therapeutic benefits come out of the process of being able to reminisce, and to build upon this reminiscence. A time-line may turn into a scrap-book or be supplemented by a series of written memories. Through the process, as well as sharing the memory of their achievements, even if this is

only with themselves or the person assisting them, they may also confront disappointments and losses they have incurred in their lives, and acknowledge why certain things happened the way they did "combing] to terms with their lives as they have lived them" (Bond & Coleman, 1990).

For the process to be legitimate, it is important for any other person involved to take on the role of a **validating witness**. One of the most important tasks is for the helper to be emotionally present for the individual and receptive, open and non-judgemental of the story they are telling, cognisant that whatever may be being told is of consequence to the teller and has been shared at an emotional cost. Therefore description of household chores undertaken as a child which may on face value appear mundane are valuable, because apart from locating the individual within a place in culture and history, they have contributed to the unique identity of the individual telling their life story.

As the life story unfolds there may be triumphs and losses that have never before been shared, and some which without express permission may never be appropriately shared.

On the other hand, details of routine life which were considered mundane might be gladly shared, and in the sharing not only validate the lived life but also enhance anthropological knowledge of times not so long past. This also enables interpretation of meaning of current circumstances in the light of past history. Envisage the situation of attempting to persuade an older adult that brown bread is a healthier option, without recognising that in their past brown bread was eaten furtively as to be seen eating it was an admission that one could not afford white bread.

Another role of the validating witness is that of curator of the individual's identity. Especially working on behalf of a frail older adult:

‘curation' combines telling 'about', 'for', and 'with' the person living with dementia in interactions that reproduce and reconfirm her self-identity. It is argued that curation enables the person with dementia to be acknowledged in interaction as an individual with a coherent, evolving identity that spans past, present, and future." (Crichton and Koch, 2007).

This places the witness in the role of safe-keeper of the client's identity with their family, within the institution, and with the individual themselves. "There comes a point when a person's story must be sustained by others if it is to be kept alive, but this is more likely to occur if efforts have already been made to encourage and keep active the person's own account of his/her story." (Woods, 1999).

The reinforcing of the person's identity is valuable not only on an emotional level, but also on a functional level. "The findings suggest that familiarity of the social and physical environment promotes involvement in activities. This provides a sense of continuity for the participant, with implications for his or her quality of life and personhood." (Phinney et. al., 2007). Exercising the mind through recalling past events and maintaining current competencies enhances neuroplastic changes in the brain, maintaining capacity for as loY as is possible.

Maintaining a person's individuality, and through this their humanity as far as possible through their own agency, and beyond this through the agency of others (such as through Duration) prevents or at least postpones "shunting [the person with] dementia into a residual social category, a kind of antechamber where social death precedes biological death." (Gilleard and Higgs, 2000. P.188).

Respect and validation for a persons life story is essential for preserving their identity with themselves and others and can make the difference in the way advanced old age is faced. For the individual this could be the difference between facing a life well lived, or despair and depression. For Family members and staff within the caring institution keeping the sense of personhood alive enables a more positive attitude to be maintained in regard to that person than would otherwise be held through regarding the increasingly "uncivilized body" that replaces the loss of self.

References:

Bond, J. & Coleman, P.,(Eds.) (1990). Ageing in Society. UK: Sage Publications.

Cavanaugh J., Kwang Whitbourne S. (1999). Gerentology, An Interdisciplinary Perceptive.

Clark, C. (1999). Social Work Ethics: Politics, Principles and Practice. Palgrave/ Macmillan. ~/

Cohen, G. (2007). "Joint reminiscence groups for people with dementia and their family caregiver: a randomized controlled trial platform". Paper first presented at: International Reminiscence and Life Review Conference 2007, Selected Conference Papers and Proceedings, November 15-16, 2007, San Francisco, CA

Compton, B., & Galaway, B. (1999) Social Work Processes, 6th Ed. USA: Brooks/Cole Publishing Company.

Crichton, J. & Koch, T. Dementia. Living with Dementia: curating self-identity. Vol. 6. No. 3. (AUG 2007) 365-381. Sage Publications.

Giddens, Anthony (1991), Modernity and self-identity. Self and society in the late modern age. Cambridge: Polity Press.

Gilleard, C., & Higgs, P., (2000). Cultures of Ageing: Self, Citizen and the Body. UK: Prentice Hall. - ,

Kolva, J. (2004). Life story telling by older adults to elucidate the meaning of their lives. Published PhD Thesis, Saybrook Graduate School and Research Centre. Accessed through Ageline Database.

Lai, C. & Kayser-Jones, J. International Psychogeriatrics: Randomised controlled trial of a specific reminiscence approach to promote the well-being of nursing home residents with demential. Vol. 16. No. 1. (Mar 2004). Cambridge University Press.

Macionis, J. & Plummer, K. (2002). Sociology: A Global Introduction. (2nd Ed.).
Harlow: Pearson Education Limited.

Malta Dementia Society, http://www. maltadementiasociety.org. mt/

NHS Trust. (2006). Pennine Care: Powerpoint presentation by the Life Story Steering Group. http://www.efflnninecare.nhs.uk/abouSboard/meetings/20060627/55.06%20LIFESTO RY%20PRESENTATION%20FOR%20TRUST%203.Pot.

Open University, 2008 http://oDen learn .open.ac.uk/file. php/1572/formats/print. htm Retrieved www 7th Nov. 2008.

Phinney, A., Chaudhury, H. & O'Connor, D., Aging and Mental Health: Doing as much as I can do: the meaning of activityfor people with dementia. Vol II. No. 4. (Ju1 2007). 348393. Taylor & Francis.

Xuereb, M. (2008). Dementia Seminar 3, PGD Gerontology & Geriatrics, LecturS
Notes, Slide 96. .<

Sparks, N. (1996). The Notebook. USA: Warner Books Inc.

Woods, R. (Ed.). (1999). Psychology of Ageing: Assessment, Treatment and Care. Chichester: John Wiley & Sons, Ltd.

Wright-Mills, C., (1959). The Sociological Imagination. Publisher: Oxford University Press.

COLETTE BERMAN BA(Hons.), Dip. Ger.
Senior Technical Officer, INIA, Malta
E-mail: colette berman@inia.org.mt

Country Report

MEETING THE CHALLENGES OF POPULATON AGEING –

Who are the role players?

S. CILIA – J. CAUCHI

Population ageing occurs when the median age of a country or region rises and is constituted by a shift in the distribution of a country's population towards greater ages. Thus an increase in the population's mean age may be described as a decline in the fraction of the population composed of children and a rise in the fraction of the population that is elderly.

In Malta, the fraction of the population aged sixty and over make up 18% of the island's population. This fraction is increasing with statistics showing that in the year 2015 the number of elderly people over 65 will be 77,000 and by the year 2050 the number will exceed 101,000. People are living longer with a life expectancy of 77 years for males and 81 years for females, (Galea M 16/02/09).

This increase in the elderly population is of concern to the Governmental Bodies that manage the ministries that tackle the challenges raised by the growing elderly population. The family unit is also a target in this social reality.

The Elderly Person

Images of elderly people are usually such that portrait them as weak and in need of help due to the inevitable psychological and physical decline as well as their predestined dependence and need of institutionalization. They may also seem as a burden on society since they do not contribute usefully and productively to society. Moreover elderly people may be thought of as a homogenous group, forgetting that there are males and females with different needs and interests and desires, also sexual ones.

A more realistic portrait is that as people age, they find themselves slowing down in their activities with some of their facilities declining and at the same time, developing certain disabilities. Although old age is not synonymous with ill health, ailments especially chronic diseases are more common among the elderly who in turn would require frequent medication or specialized treatment. This ill health diminishes one's independence and ability to perform the normal tasks of daily living. Mobility might also be heavily impaired, (Lungaro Mifsud S 1995).

When ill health arises causing decreased mobility, maintaining social contacts might be difficult thus giving rise to loneliness and isolation. Ageing unfortunately is a time of losses that incorporates health, one's own possessions, friends, neighbours and maybe also relatives. An elderly person's emotional needs must not be forgotten as it is important for them to feel secure, respected and loved. The elderly person enjoys feeling part of the family network. Being a social being, social contacts are also important such as visiting relatives and friends.

The more active they keep themselves and the more they maintain their identities and continue with their own usual daily activities the more likely it is that they will remain independent. 80% of Maltese

elderly prefer to continue living at home (Delia 1993 as cited in Miljanic Brinkworth et al, 2001). By 2020, 60 year olds will be more active and therefore will continue to live at home while those in a residence for the elderly will be of an older age, (Micallef Sue 2008).

Roles and Functions of the Elderly People

With improved health standards people are living longer and healthier. However, people get old not when the state decides to label them as elderly persons but when they can no longer be independent in their daily activities of living and this most often than not is not at the age of 60 or 65 but much later on in life. In Malta the retirement age is gradually being raised to age 65. Also a person reaching retirement age can continue to work and derive any earnings from such work and at the same time still receive his or her social security pension.

The increasing number of elderly people should be seen as a valuable resource as they have the expertise, the knowledge and the experience which makes them an excellent source of reference in different fields, (Galea M 2009).

There are associations and self help groups from which the elderly can benefit such as a number of pensioner's associations. University of the third age, founded in Malta 1992, focuses on the developmental aspect as a means for the elderly to learn new things. Some of the areas covered include languages, history, philosophy, political science and psychology. It is not job oriented therefore it does not offer a degree however on completion of the courses the elderly students receive a certificate of participation to encourage them to attend. It serves as a means of combating loneliness and a proof that they are not a waste in society.

Elderly people entering the third age, are not allowed or able to do many of the things they used to and so can fmd themselves becoming bored. Al'ter retirement one has to adapt to a completely different life style. Older people must engage in active ageing where they must take on an active participation in society and leave institutionalization as a very last resort.

Many Maltese elderly live alone. However they are deeply embedded in the family support networks of interdependence, of giving and receiving. Very often the elderly are an asset to their working children. There arises a means of *intergenerational solidarity,* where both generations benefit from each other. This is manifested in various ways including, baby sitting, conflict resolution and advice. In turn the elderly person receives, company, help in household chores and financial assistance.

The Familv

In Malta, the central role played by the family as the principal provider of care is still maintained and the exchange of obligations are still the basis of family relations. The family plays an important role in providing financial, practical, emotional and social support. An elderly person still needs to feel security, recognition, respect and love thus the elderly value contacts with the family (Micallef T. 1994, 2000, Triosi J. 1995, 1991, 1984).

Changes in Family Structure

Maltese families had an extended family format in the pre and early post war eras. This format comprised of a network of relatives all living in one residence or in very close proximity to one another, acting as a close knit community. The females in this type of family were the primary care givers. The patriarch of the family, often the oldest male member, layed down the rules, worked (if not retired) and arbitrated disputes. Other senior members of the household babysat for the infants.

Recently the trend has shifted to a nuclear family structure. This consists of a married couple with an average of two children. Some families will have one grandparent living with them. Other emerging family types are single parent families, couples with no children, blended families and geographically removed families. Still Maltese society has always been characterized by strong family bonds and most help for the members continues to come from blood relations. In fact less than 5% of the country's elderly which at the end of 2002 constituted 17% of the total population, live in government or private run

homes. The rest are living in their own homes or with their adult children, relatives or friends.

Difficulties in caring for Elderly Persons

Those elderly people who tend to become more dependent on their adult children and close relatives would require added support and care from their part. This is an increasing problem due to the nuclear family type structure. The family unit has become smaller and is subjected to considerable strain as there are fewer members to shoulder responsibilities involved with caring for the older persons: Daughters and sons of the ageing parents, once married do not necessarily live close by their parents. Siblings are less numerous per family therefore the 'load' or rather time factor per sibling for caring for their parents is increased.

- Those people who decide not to get married, do not necessarily remain living in the same household as their parents, therefore being a bachelor or a spinster does not mean that one is available to take on the role as a main carer for one's elderly relative or parent.

- The increased cost of living and the reduction of the family size, increased the tendency for women to enter the workforce, to contribute to the economic effort of the family. The idea of a 24 hour house wife does not exist in many households as both parents usually need to work to maintain their family. This definitely offers less time and resources for the younger parents to take care of their ageing parents.

- Due to elderly persons living longer, their sons and daughters who would be their caregivers would be elderly themselves too, sometimes making them unfit to provide for the increasing needs of their parents. Although no statistical data were found, an increasing percentage of young Maltese couples are tending to live abroad due to better work opportunities; therefore caring for an elderly parent becomes even more difficult.

Caring for an elderly person requires time, money and skill and this is directly proportionate to the level of dependence of the elderly person. Caring for a very frail and dependant elderly person is demanding, complex and frequently associated with negative health effects on the care giver. This has been termed care giver burden, sometimes including; depression, psychological distress, lowered life satisfaction, interpersonal conflict, social isolation and stress related physical complaints. All this is further compounded if there is only one caregiver or if there is no support from other kin.

Help in Caring for Elderly Persons

The needs of the frail elderly can no longer be met by the family alone without the support of specialized programmes and services sponsored by the State. In fact the government must work in partnership with families in the care for the elderly, as families and communities may never be substituted, (Galea M. 2009).

The Maltese government through the ministry of social policy offers more than 30 services to try to provide the elderly with the necessary needs in order to improve their quality of life whilst remaining in their own homes, community and environment. Currently such services include:

- Day centres, of which there are 16 where currently 157 men and 1323 women attend

- Domiciliary nurses

- 2,592 elderly people using the home care help service

- Handyman services amounting to around 2000 jobs done in a year

- Incontinence services

- Meals on wheels where 60 000 meals were given to the elderly in a year

- Telecare service which is used by 9447elderly persons (Galea M. 2009)

The government also offers the rehabilitation centre for the elderly at Zammit Clapp hospital and Karen

Grech Hospital where health care professionals see to the physical and medical needs of elderly persons in order to allow them to return back to their own homes and live independently or with the necessary services required for a more independent life. Residential homes which are found in various parts of Malta offer lodging to those elderly people who do not wish to live in their own home. These also offer respite care in order to alleviate the care given by family members for a short period of time.

St. Vincent de Paul residence is the largest government run residential home which offers direct medical care services to its residents. SVPR provides the facility for couples, especially those who are mobile or semi-mobile, to share a flat-let accommodation. It also provides respite care service to provide some temporary relief for carers. A person can be admitted for respite care more than once a year. Each time, the period of stay will be approximately 3 weeks. During 2002, 81 persons, 65 females and 16 males, benefited from the respite service. The staff of the Rehabilitation Department also offers community services going to homes of elderly persons for physiotherapy, speech therapy and occupational treatment (Muscat A. 2000, Zammit). This residence is also offering a four month course for carers who will be able to learn under the supervision of the nurses there, (Galea M. 2009).

Long term healthcare facilities are also to be found in the two geriatric wards attached to the Gozo General hospital, in one of the government run residential homes. Similarly, the 18 Church-run homes and a number of private homes also offer long term health facilities.

Services and organizations that offer support for carers of the elderly persons include MMDNA, Hospice movement, Caritas Malta where the Church Secretariat for Social and Charitable Action co-ordinates and develops work among the sick, the elderly, persons with special needs, drug users and other people in difficulty, and the CANA Movement.

Role of the State

The Maltese government, in May 1987 appointed a parliamentary secretary exclusively for the care of the elderly. The issues concerning the elderly and our ageing population could be dealt with holistically. The parliamentary secretary was placed under the Ministry of Social Policy. To increase the opportunities of continued involvement and participation of the elderly in all facets of life, a national council of the elderly was set up in 1992. This Council is also responsible for protecting the rights of the elderly ensuring their social and economic security and planning a national response to the challenges of population ageing.

The Welfare State: A model in which the state assumes primary responsibility for the welfare of its citizens. This responsibility in theory ought to be comprehensive, because all aspects of welfare are considered and universally applied to citizens as a right. “Welfare state” can also mean the creation of a safety net of minimum standards of varying forms of welfare. In many welfare states, especially continental Europe, welfare is not provided by the state but by a combination of independent, voluntary mutualistic and government services. The functional provider of benefits and services may be a central or state government, a state sponsored company or agency, a private corporation, a charity or another form of non-profit organization.

Reliable knowledge on the real needs of citizens, the extent to which people in need make use of self-help resources in the family and community, and the kind of help they demand from specialized institutions is indispensable. The crucial question is whether citizens are willing, and if so how, to transfer demands for social benefits and welfare services from direct provision by the state to other institutions, self-help groups, producers and consumers in a civil society. The development of civil society is concerned with citizens' actual participation in a combination of self-help groups, exchange of services with family members, relatives, neighbours or friends, voluntary organizations, social institutions in the community and the corresponding demands for state subsidiary help or

intervention. The success or otherwise of the welfare mix in a civil society depends on an adequate appraisal of citizens' strategies for welfare, their demands for help from the various agents of society, and the subsequent development of policies by the state and its social partners, (Abela A. M.).

Action Taken by the Government

The Maltese government, with this welfare system, has been able to provide services for the elderly that offer support, care, in terms of health issues and the ability of prolonging the elderly persons stay in the community, by targeting their main requirements and needs. This was done with the help of non-governmental organizations, private voluntary organizations as well as improved government health care services and policies.

There were also tax benefits given to the elderly and /or their carers, such as Energy Benefits, subsidaries by government for carers, where the Social Assistance to carers of elderly relatives which was previously payable only to female applicants was extended to male relatives too, (Camilleri J. 2008).

The government has government run residences for the elderly as mentioned previously. However now the private sector has also entered this field which was previously reserved for State and Church. This intervention provides more places and more rooms. In total, with government run homes, church homes and residences in the private sector, the number of beds totals 4000. The private homes for the elderly are quite pricey and the government had introduced a measure of help in the form of tax credits. Another positive initiative was the introduction of a number of private-public partnerships. Government owned homes are run by private enterprise or the government subsidises a number of places in some private homes, (Fr J. Borg 2009). To be able to provide better care and services in these homes subsidised by the government, the elderly persons pension is deducted when they reside in long stay homes.

Another recent proposal by the government was the planning for Night shelters in the locality of Zejtun at the Jesus of Nazareth Convent which will provide a place for the elderly to sleep at night to prevent them being alone at home. However during the day they can carry on with their normal daily routines in their own homes.

The government also issues a special identity card given to all elderly people residing in Malta, once they have reached 60 years of age. This card entitles them to various benefits such as free transport to hospital and back, priority of service and free entrance in various establishments etc.

Conclusion

Therefore the role players are mainly;
- the **Family** who are the first main carers of their elderly relatives only made possible and manageable with the necessary services and benefits required.

- the **Government** through various services and policies that make it possible for the continuing care of the elderly people in society through the main carers or by providing alternative residences with the appropriate medical care and attention for the elderly.

- **Society** as a whole, by being more tolerant and vigilant through knowledge and awareness of living in an ageing community, thus being able to identify possible needs for the elderly that are being overlooked.

References

Demography Changes and Crime - Rising Elderly Population Sue Micallef 2008. *http://ezinearticles.com/?id= 1 i94671*

Ageism: The Unrecognized Oppression Marvin Formosa *www. um. edu. mt/pub/formosam4. htm*

Lungaro Mifsud S. 1995, as cited in Supporting Family Carers of Older People in Europe - The National Background Report for Malta, J. Troisi and M. Formosa

Galea M. Parlimentary Secretery 2009 *http://www.msp.gov.mt/documents/family/opm_elderly_leaflet.pdf*

First Experience. Second Home. Third Age, Fr. Borg J. 2009 *http://www.timesofmalta.com/blogs/view/20090416/frHoe-borg/*.

Annual Departmental Report for 2007, Social Security Division Camilleri J.2008 *http://www.msp.gov.mt/documents/dss/dss_2007.pdf*

Demands for Welfare: The State and Civil Society in Malta Abela Anthony M. *http://staff.um.edu.mt/aabe2/Welfare.htm*

Muscat A. 2000, Zammit, as cited in Supporting Family Carers of Older People in Europe - The National Background Report for Malta, J. Troisi and M. Formosa

Micallef T. 1994, 2000, Triosi J. 1995, 1991, 1984, as cited in Supporting Family Carers of Older People in Europe - The National Background Report for Malta, J. Troisi and M. Formosa

---

SIMON CILIA
Physiotherapist
Mater Dei Hospital, MALTA
e-mail: simcil123@yahoo.co.uk

JEANINE CAUCHI
Physiotherapist
Mater Dei Hospital, MALTA
e-mail: jeanine.cauchi@gmail.com

Country Report

ELDERLY ADULTS IN PUERTO RICO

M. SANCHEZ AYENDER - A.L.DAVILA ROMINI

Puerto Rico is one of the three Antilles with a Hispamic tradition. The culture of these Antilles - Puerto Rico, Cuba and the Dominican Republic - is traditionally culture understood as developing from the interaction between the Spanish conquerors, Arawak Indians, and Black African slavers with the Hispanic trails predominationg. In the case od Puerto Rico, the United States possession of the island from 1898 has also left its mark on cultural values and norms, on social, political and economic institutions, and on the characteristics inherent to social change in the last half century. The language spoken on this Caribbean island is Spanish.

The ageing of the population of Puerto Rico is a trend of the last three decades. In a short span of time, the country has undergone a dramatic numerical and proportional increase of the population 65 years of age and older. In 1950, the proportion of persons 65 and over was four per cent and for 1990 it had increased by more than twofold (97%). The median age in 1990 was 28.4 in comparison to 18.4 in 1950.

The rapid aging of the population in a few decades has been the result of a reduction in birth rates, the migration of young adults (20-34 years of age) to the United States, and the return migration of adults 55 and over from the States to their country of origin. It is expected that these trends will continue in the years to come and the proportion of older adults will by 2020, when the post war baby-boom generation reaches this age, this proportion is expected to augment to almost 18%.

Birth rates decreased from 36 per 1000 in 1952 to 18 per 1000 in 1991. The average number of children per woman declined from 5.4 in 1950 to 2.2 in 1991.

Forty seven per cent of the population 16 years of age and older is in the labour force (1.180.162). eighty per cent of these are employed (934736). Around 3 % (2.8) ofthise in the labour force are employed in agriculture; 31 % are in the industry sector and 66.2% are in the service sector.

Eighty five per cent of the households are comprised by two or more persons. Of these, 98.5% are family households. Twenty three per cent of all family households are female headed households and in 73% of all family households both husband and wife are present. Single headed households comprise 14.7% of all households and 53.6% of these are women.

The principal causes of death in 1991 were: heart diseases (22%), cancer (16%), dibetes (6%), AIDS (5%), and cerebro-vascular diseases (5%). Infant mortality has decreased from 68.3 per 1000 in 1950 to 13 per 1000 in 1991. Neonatal mortality in 1991 was near 9 per 1000 live births and postneonatal was 4 per 1000. The leading causes of infant mortality are: low birth weight (22%), congenital anomalies (18%), and respiratory distress syndrome (17%).

Women in Puerto Rico outnumber men. For 1990, females comprised 51.6% of the population. The median age for women in 1990 was 29.6 and for men 27.2. female life expectancy in 1993 was 79 years in comparison to 70 for males.

Twenty seven per cent of the population live below the poverty level. Poverty is more common in rural than urban areas. Per capita income for 1990 was US$4200. Seventy one per cent of the population live in urban areas.

Eighty seven percent of those ten years of age and older know how to read and write. In 1990 females comprised 54% of the older population. Female life expectancy is 79 years in comparison to 70 for males. Almost half of the women in this age category are widows (48%). The proportion of widows to widowers is 3 to 1.

Sixty three per cent of the elderly live below the poverty level. Poverty is more common among rural elderly (79%) than among their urban counterparts (56%) and among women than men. The median of completed school years for the aged is 3 to 4 years of elementary school. Most elderly persons live in family households. Eighteen per cent live alone. Women are twice more likely than men to live in the house of another person, generally an offspring (24% vs 11%). Less than two per cent of the aged live in homes for the elderly. More women (25%) than men (18%) live alone in their own home.

There is a progressive decrease in the proportion of persons 65% who reside in their own household as age increases. This proportion diminishes from 89% for the age category 65 - 69 to 54% for those 85 years of age and older. On the other hand, the proportion of those who reside in the homes of other persons increases from 9 to 44% for the same age categories. The proportion of those who reside in homes for the aged or other institutions rises from 0.1 per cent for those 65 - 69 to 2.6% for those 85 and over.

The principal causes of death for this age subgroup in 1989 were: heart diseases (30%), cancer (16.3%), diabetes (7.7%), cerebro-vascular diseases (5.9%), pneumonia (5.8%), and hypertension (4%). During 1988, 83% suffered from at least one chronic illness or condition while less than one per cent suffered from an acute one. The rate for those 65 and older who suffered from at least one chronic condition during 1988 was 319 per 100 in comparison to 101.9 per 100 for those under 65. Elderly women had a higher rate (356 per 100) than their male counterparts (277 per 100). The five chronic diseases which afflicted more the aged in the aforementioned year are: arthritis and rheumatism (48.6 per 100), hypertension (33.9 per 100), heart diseases (20.9 per 100), diabetes (20.6 per 100) and depression (13.1 per 100). Three fifths of the older woman suffering from some type of chronic disease are afflicted by rheumatism or arthritis. Men exhibit lower rates; 32 per cent lower. The elderly are twice as likely as those 45 to 64 years of age to suffer from impediments or defects (53 per 100 vs 31.9 per 100); defects of sight rank first.

Eighty three per cent of the older persons in Puerto Rico have a health care plan, including Medicare for those who receive Social Security. Fewer women than men enjoy these benefits. The average number of visits is 55 for every 100 women and 48 for every 100 men. More elderly persons visit a physician than those in the other age groups combined, including children. They average six visits per year. Eighty five per cent visit a physician more than once a year. Two thirds go to private services and one third to public services. The aged are more than twice as likely as the rest of the population to be hospitalised (158 per 100 vs 64 per 100). Men register higher rates (180 per 100) than women (134 per 100). Their average stay for all elderly is 9.4 days in comparison to 7.1 days for the rest of the population.

The rapid industrialization and urbanization which Puerto Rico has undergone in the last thirty years have affected not only family structure but also patterns of family interaction. However current research indicates that the family continues to provide a vital source of support to its aged members despite changes related to decrease in size and incorporation of women into the formal labour force. The family continues to provide most of the care the aged need. The aged spouse and children, particularly middle-aged daughters, are the main providers of care. The elderly are an important resource for their families and are very involved in childcare.

Professor MELBA SANCHEZ-AYENDEZ Ph.D.
School of Public Health – University of Puerto Rico
E-mail: sanc369att.global.net

Professor ANA LUISA DAVILA Ph.D.
School of Public Health – University of Puerto Rico
E-mail: adavila@yem.upv.edu

The Editor invites:
All readers and users of BOLD to send him critical comments and suggestions.

The Editor appeals:
We need regular inflow of your best, most colourful and significant photographs relevant to our Ageing themes to feature on the front covers of BOLD.

Copy Deadline:
The next issue of BOLD will be published
in
Proposals for articles or letters, information, news bulletins and conference details may be addressed to:

The Editor,
International Institute on Ageing,
United Nations - Malta
117, St. Paul's Street, Valletta VLT 07 - Malta

INIA'S ACTIVITIES 2009 - 10

1st - 7th November 2009	Training Programme in Guangzhou, China in collaboration with the Guong Dong Research Centre on Public Affairs for the Elderly (GRCPAE)
8th - 14th November 2009	Training Programme in Beijing, China in collaboration with the Beijing Civil Affairs Bureau(BCAB)
15th - 21st November 2009	Training Programme in Beijing,China in collaboration with the Social Welfare Centre, Ministry of Civil Affairs, People's Republic of China (SWC) and the Support and Nursing Committee for the Elderly, China, (NCE)
23rd Nov - 4th Dec 2009	International Training Programme in **DEMOGRAPHIC ASPECTS OF POPULATION AGEING, POLICIES AND ITS IMPLICATIONS FOR SOCIO-ECONOMIC, POLICIES & PLANS.**
5th - 11th December 2009	Training Programme in St. Petersburg in collaboration with City Geriatric Centre, St. Petersburg.
9th - 18th January 2010	Short Training Programme in SOCIAL, **ECONOMIC AND HEALTH ASPECTS OF AGEING** in collaboration with the Beijing Civil Affairs Bureau (BCAB), MALTA
15th - 26th February 2010	International Programme in **Social Gerontology**.
8th - 19th March 2010	International Training Programme in **Economics and Financial Aspect on Ageing.**
19th - 30th April 2010	International Programme in **Medical Gerontology (Geriatrics)**.
1st Oct 2010 - 1st June 2011	International **Post Graduate Diploma** in Gerontology and Geriatrics (European Centre for Gerontology, University of Malta)
11th - 22nd October 2010	International Training Programme in **Policy FORMULATION, PLANNING, IMPLEMENTATION AND MONITORING OF THE MADRID INTERNATIONAL PLAN LOF ACTION ON AGEING.**
29th Nov - 10th Dec 2010	International Training Programme in **DEMOGRAPHIC ASPECTS OF POPULATION AGEING, POLICIES AND ITS IMPLICATIONS FOR SOCIO-ECONOMIC**, Policies and Plans.