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# Improvement in Female Life Expectancy in India

DR. (SMT.) JAYASHREE

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## INTRODUCTION

As we enter the dawn of the 21st century we come across many global issues which need to be paid immediate attention. Population ageing is one such significant demographic development and it has become an integral part of our future. This vital factor has become a priority area of research. However, there is a dearth of studies on gender issues in ageing. Imbalance in gender ratio at older ages is one such aspect which is being experienced by the majority of countries.

The aim of the present paper is to analyse the gender ratios in population ageing and the implications on socio-economic and cultural life of the people. While analysing the situation some attempt has also been made to identify needs and demands and to ascertain the relevance and adequacy of existing provisions.

The paper has been divided into three parts:

1. Basic demographic parameters which facilitate the gender imbalance in society.
2. Implications of gender imbalance at later ages.
3. Suggestions and conclusions

Data for this study have been drawn from official census data, published statistics by individuals and institutions, United Nations reports on population, Population data sheets and other secondary reports on population.

Though there is abundant literature available on old age, we still know too little about what exactly is "old age" for women? We have too little detailed information about the internal situation of the elderly

women in family and society, because researchers have not ventured to study elderly women's hopes, fears, stresses and strains due to ageing. Thus, an elaborate and accurate picture of the position of elderly women is a primary requirement to frame a social policy relevant to the well-being of elderly women. For that we have to prepare a realistic appraisal of the current situation.

**The present distinctive feature of the elderly population throughout the world is preponderance of women over men.**

## **THE MAIN ATTRIBUTABLE FACTORS FOR THE PREPONDERANCE OF WOMEN OVER MEN:**

### **Declining Fertility and Mortality:**

Population ageing is the product of a dramatic decline in biological components of population, fertility and mortality. Since 1980, India has experienced a transition from high birth rate to low birth rate. There is no doubt that a steep decline in fertility and mortality is one of the great triumphs of human history. In earlier times Indian women were marrying at young ages and having an average of 5 to 6 births during their life time. Today Indian women are marrying at later ages and having an average of 2.93 births.

Table no.2 clearly shows that the earlier high birth rates and high mortality rates kept the elderly population at a low level. Now the low birth rates and low death rates have provided added years for elderly persons to live. Thus a clear paradigm shift can be observed.

Further, Table no. 2 shows that fertility and mortality

**Table No. 1: Total Fertility Rates, India**

Year	Children per woman
1950 - 55	5.97
1960 - 65	5.81
1970 - 75	5.43
1980 - 85	4.47
1990 - 95	3.56
2000 - 2005	2.93
2010 - 2015	2.50
2020 - 2025	2.10

rates are still dropping and by 2020 - 2025 The Child Birth Rate will be 14.80 and The Child Death Rate will be 7.70. As a result the ageing trend is gaining momentum. According to Global Ageing Report “more than half of the planet’s 65 plus population already lives in the developing world. By the year

2025, more than 2/3 of the world's older people will live in developing nations”.

Another alarming feature is that, people over 80 are the fastest growing segment of the population in many Asian and developing countries. Table no.3 discloses the global scenario of gender ratio at later ages. During 1995 the proportion of women aged 80+ was 13.3 percent and of men aged 80+ was 8.9 percent, and by 2050 the proportion of 80+ women will constitute 19 percent and 80+ men will be 14.2 percent.

Table no. 4 contains the data of percentage of men and women 60 years and over in Asia and India revealing that there has been preponderance-of women over men for both the whole of Asia as well as for India. Asia will have 22.5 percent women aged 60+ and 19.8 percent men and India will have 21.7 percent women and 19.7 percent men by 2050 A.D.

**Table No. 2: Percentage of CBR and CDR, India**

Year	CBR	CDR
1901	49.2	42.6
1911	48.1	47.2
1921	46.4	47.3
1931	45.2	31.3
1941	39.9	27.4
1951	41.7	22.8
1961	41.2	19.0
1971	37.2	15.0
1981	33.8	12.5
1991	29.3	9.8
1992	29.2	10.1
1993	30.0	10.0
1994	29.0	10.0
1995	28.0	9.0
1996	27.4	9.2
1997	25.4	9.1
1998	25.0	9.0
1999	24.6	8.7
2000 - 2005	20.30	8.1
2020 - 2025	14.80	7.70

**Source:** Women in India: A Statistical Profile, 1988.  
Population Data Sheet, 1993, 1994 and 1995  
Sample Registration Bulletin, 1986 - 1992

Because of this new trend, a new classification of aged persons has emerged in Gerontological literature such as 'Young-old' 'oldold' and 'oldest-old'. In all these age groups there has been a progressive increase in the number of women over number of men. Thus, the world of the “very old” will be the world of women.

### Changes in age Structure:

The age structure of a country helps us to understand the future prospects of the aged in general and elderly

women in particular. Regarding age composition of the population in the ESCAP region, the Economic and Social Survey of Asia and Pacific stated that "the share of younger population will fall from 29.1 percent in 2000 to 21.6 percent in 2025; the share of working age population will increase from 61.6 percent to 62.9 per cent and the share of old age population will rise from 9.3 percent to 15.5 percent in the region". The same trend has been observed in India which is depicted in table no.5. It is evident that as the proportion of the young cohorts has declined the size of the old cohorts has increased, resulting in population ageing.

**Table No. 3: Absolute (in '000) and relative frequencies of women and men, 80 years and over, world and its major regions: 1995 - 2000**

Region and subregion	1995		2025		2050	
	Women	Men	Women	Men	Women	Men
WORLD	40,006 (13.3)	21,519 (8.9)	84,896 (13.4)	51,027 (9.4)	200,535 (19.0)	129,736 (14.2)
AFRICA	1,481 (7.6)	1,019 (6.1)	4,453 (8.7)	3,142 (7.0)	13,876 (10.6)	10,220 (8.8)
ASIA	14,562 (9.8)	9,510 (7.2)	41,279 (11.3)	27,233 (8.3)	113,433 (17.7)	76,60 (13.4)
East Asia	8,497 (11.0)	4,547 (6.6)	21,383 (12.1)	12,588 (8.1)	53,690 (21.6)	31,759 (14.9)
South-Central Asia	3,824 (8.1)	3,539 (7.9)	13,369 (10.6)	10,525 (8.9)	40,081 (15.1)	31,643 (12.8)
South-East Asia	1,579 (9.0)	995 (6.8)	4,712 (10.0)	2,844 (7.3)	14,362 (15.5)	9,082 (11.4)
West Asia	662 (11.0)	429 (8.0)	1,815 (11.4)	1,276 (8.2)	5,300 (15.5)	3,876 (12.7)
EUROPE	15,358 (18.6)	6,308 (11.6)	21,337 (19.4)	10,221 (12.5)	33,053 (28.0)	18,008 (19.7)
LATIN AMERICA	2,350 (11.9)	1,679 (9.9)	7,531 (13.8)	5,052 (11.0)	20,941 (20.8)	13,850 (16.3)
NORTH AMERICA	5,906 (21.3)	2,823 (13.9)	9,577 (19.1)	4,966 (12.5)	17,717 (31.2)	10,351 (22.3)
OCEANIA	355 (17.6)	185 (11.1)	726 (17.3)	419 (11.8)	1,528 (25.7)	956 (18.9)
Australia and New Zealand	346 (18.8)	178 (11.9)	679 (18.5)	387 (12.6)	1,362 (29.2)	843 (21.6)
Melanesia	6 (4.0)	5 (3.5)	39 (9.0)	25 (6.3)	132 (12.5)	88 (9.3)
Micronesia	1 (9.1)	1 (9.1)	4 (9.5)	3 (7.3)	15 (15.6)	11 (12.6)
Polynesia	2 (12.5)	1 (7.1)	5 (11.1)	3 (7.1)	20 (15.9)	14 (12.4)

**Source:** Computed from medium variant projections in United Nations, 1994. The Sex and Age Distribution of the World Populations, the 1994 Revision. (United Nations Publication Sales No. E 95. XIII. 2)

**Table No. 4: Percentage of Men and Women 60+, Asia and India**

Year	Asia		India	
	Women	Men	Women	Men
1970	7.0	5.9	6.0	5.9
1995	8.8	9.5	7.6	6.8
2025	15.0	13.1	13.1	11.8
2050	22.5	19.8	21.7	19.7

**Source:** Computed from Medium Variant Projections in UN, 1994. The Sex and Age Distribution of the World Population. The 1994 Revision.

The table also reveals that the proportion of the (0-14) children population dropped from 38.9 percent in 1950 to 23 percent by 2025 A.D. Thus, the percentage of elderly population has increased from 5.6 percent and it will reach 12.7 percent by 2050 A.D.

**Gender Differentials in Life Expectancy:**

Gender differentials in life expectancy are another significant and striking feature which facilitates the gender imbalance at later ages. Data from various sources show that life expectancy for women is generally higher than men. The main cause for “feminization” of later life is the steep drop in female mortality compared with male mortality. It is clearly evident from Table no.6 that, females heavily outnumber males among the elderly aged 60 years and over. The projected life expectancy which is depicted in table no.7, indicates that since 1955 life expectancy has been positively favourable to women in India and by 2025 A.D. they will be expected to live up to 73.6 years. From 1955 to 1995 female life expectancy rose from 38.7 to 60.7 years.

That the average length of life for women is greater as compared to males may be attributed to such factors as, lesser exposure to addiction, lower exposure to hazardous life styles, lower exposure to

**Table No. 5: Percentage Distribution of Child (0 - 14) Youth (15-24) and Elderly (60+) population for India.**

Year	0 - 14	15 - 24	60+
1950	38.9	19.4	5.6
1960	39.8	18.2	5.7
1970	40.4	18.1	6.0
1980	38.5	19.4	6.5
1990	36.0	19.5	7.1
2000	33.2	18.8	8.0
2010	29.7	18.2	9.0
2025	23.0	16.7	12.7

**Source:** The Sex and Age Distribution of the World Populations, 1992 Revision United Nations, New York, 1993.

pollution, lesser tension, healthier life style, healthy habits and constitutional factors. It is also evident that women with higher education, higher prestige occupations, higher income and those who benefit from women's improved opportunities, maintain a substantial longevity advantage over men.

Thus, ageing in India is disproportionately a female phenomenon and this gender dimension of ageing is a very significant aspect which needs to be given greater attention, concern and care.

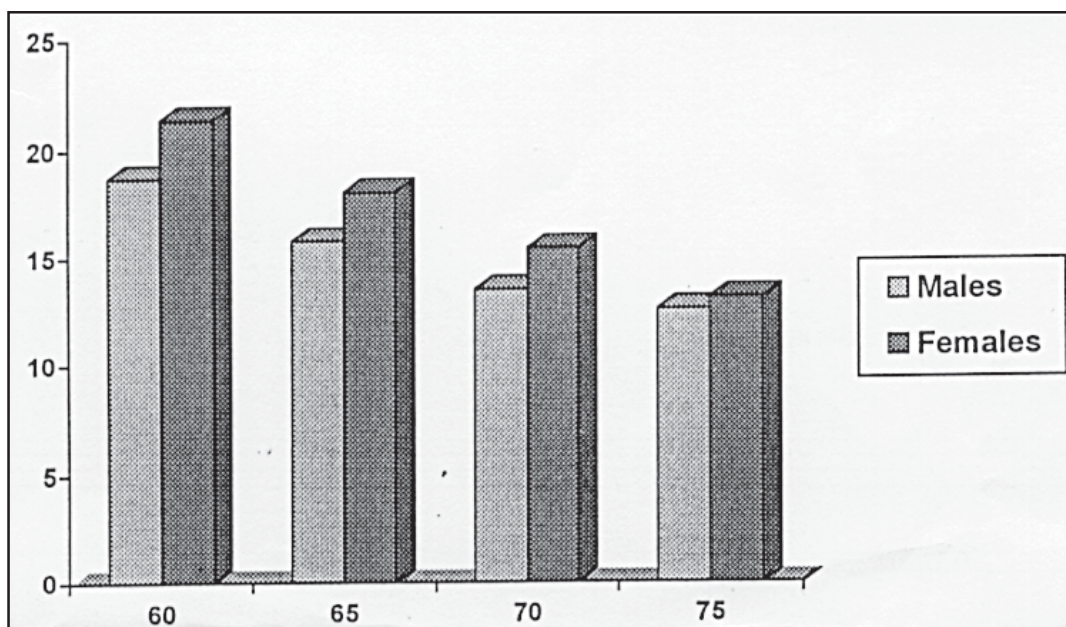
**Dependency Ratio:**

Dependency rates are defined as the ratio of persons under 15 and 60 years and older are related to those between the ages 15 to 60. Of late, the ageing population, with its corresponding increase in the ratio of elderly “beneficiaries” to young “contributors” has received considerable attention. With the increasing trend of longevity, the dependency load of elderly persons is gradually increasing. It is projected that the economically active age groups are not able to support the dependent age groups, especially the elderly (60+). Thus a longer period of support for the elderly poses an intolerable burden on the younger generation. In developing countries filial bondage still exists among the younger generation. However the

**Table No. 6: Life Expectancy at Older Age, India from 1901 to 2005 A. D.**

Year	Age							
	60		65		70		75	
	Males	Females	Males	Females	Males	Females	Males	Females
1901	9.00	9.30	7.30	7.60	5.80	6.00	NA	NA
1950	12.73	13.23	10.06	11.07	8.99	8.53	5.87	9.35
1990	16.91	18.54	14.21	15.55	12.16	13.26	11.37	12.21
2005	18.74	21.38	15.79	18.06	13.49	15.41	12.55	13.09

Source: Guha Roy, India & Mario Garret-Inter-Gerontological Aspects Demographic Change, Malta.



situation can be intolerable if filial care has to extend to half of a lifetime. Naturally it affects considerably the residential pattern.

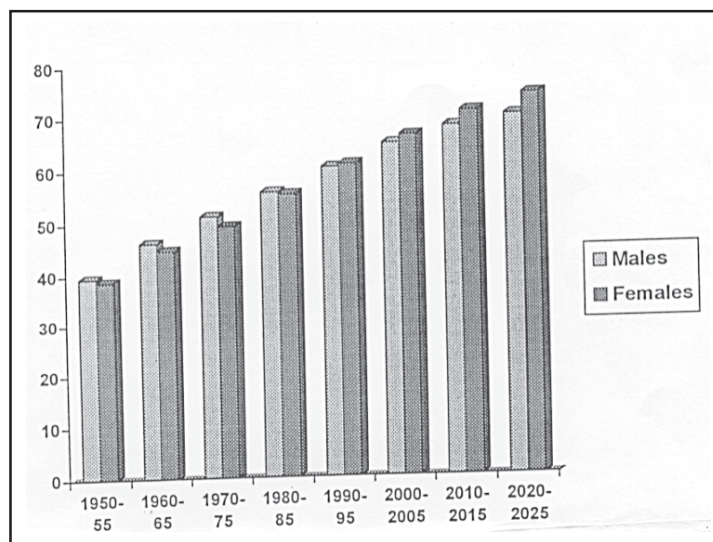
For as long as the patriarchal head of the family survives the women may not face acute problems, but once he expires difficulties arise among children. They either shirk the responsibility or they give care on the basis of tenure. Thus their high life expectancy can pose many problems for older women rather than men.

Table no. 8 shows that, both old dependency ratio and index of ageing are in an ascending order while young dependency ratio is in a descending order. The descending tendency of the young dependency ratio may probably be attributed to the present declining fertility rate. In the year 1950 the young dependency ratio was 70.17 and by 2025 it will decrease to 36.10, whereas the old dependency ratio which was very low (10.14 during 1950) is projected to reach 19.06 percent by 2025 A.D.

**Table No. 7: Life Expectancy at India  
(1950 - 55 to 2020 - 2025 A.D.)**

Year	0 - 14	15 - 24	60+
1950-55	38.6	38.7	39.4
1960-65	45.5	44.7	46.2
1970-75	50.3	49.3	51.2
1980-85	55.4	55.2	55.6
1990-95	60.4	60.7	60.1
2000-2005	65.2	65.9	64.4
2010-2015	69.0	70.5	67.6
2020-2025	71.6	73.6	69.6

**Source:** World Demographic Estimates and Projections 1950 - 2025, 1988. Department of International Economic and Social Affairs. United Nations.



**Implications:**

Generally, researchers treat elderly people as a homogeneous group overlooking the differentiation in the experience of ageing for men and women. There are significant differences in the way ageing affects men and women. Implications of ageing on the lives of elderly women are often taken as natural, to be expected and also trivial in nature. The needs and demands of the elderly women have not been given any priority in welfare policies.

The process of “feminization” of ageing has already been set in most of societies, which produces significant implications and also challenges to people who have elderly women at home and for elderly women themselves, because the prevailing socio-economic, demographic conditions are totally unusual for elderly women. Given this situation, naturally the question arises: how do they live in a fast changing society? What are their problems and preferences in life?

Will they lead a happy life? Are they really happy about the extension of life? These basic questions should be answered in our policy for elderly women.

Feminization of aging has its impact on various aspects of life such as economic, social, family,

**Table No. 8: Dependency ratios of India, 1905-2025**

Dependency Ratio	Year			
	1950	1990	2001	2025
Total Dependency Ratio	80.37	77.25	63.58	55.26
Old Dependency Ratio	10.14	12.56	12.59	19.06
Young Dependency Ratio	70.17	64.48	50.94	36.10
Index of Ageing	14.44	19.43	24.44	52.79

**Source:** Garret Mario, compiled from Data on International Gerontological Aspects of Demographic Change, Malta, 1990. Census of India, 1991.

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women's status, migration, living arrangements, social and economic security, and exchange patterns among the family members.

There is a common feeling that, elderly women of the coming decades will be quite well educated, more literate, better exposed to the outer world, have urban experience, financially independent, economically sound etc. etc. Hence, the implications of greater longevity for women may not cause any problems for these sections even if they are widows. This is purely an illusion, because these women who have all the above features belong to the middle class and they adopt small family norms. As a result they have few adult children to depend on. Hence, at the end of their life they are left alone by their limited care givers. Of course, they may not face acute financial problems. However, they have to suffer from loneliness, frustration, helplessness, emotional insecurity, along with common ageing ailments and disabilities.

When we turn our attention towards the non-middle class, non-urban, uneducated women folk who constitute majority of our population we get a bleak picture, and they are the most vulnerable segment and face many fold hurdles. Besides problems faced by her urban counterpart she has to face series of other problems like financial insecurity, dependency, discrimination, malnutrition, conflicts, abuse, intergenerational misunderstanding, diseases, disability, emotional insecurity, greater exposure to domestic violence so and so forth. Thus, it must be noted that implications of feminization of ageing do not differ substantially on the lives of elderly women in rural and urban areas.

### **Limited Care Givers:**

The elderly of the future society will have fewer living adult children than the current generation elderly due to the lower fertility rate which has been encouraged and supported by the government in all developing countries. This sustained lower fertility in any society will lead to fundamental changes in the nature of women's lives and this in turn affects the elderly persons' demands in terms of health, formal and informal support care, social security,

and emotional bondage between members of the household.

Because of the changing scenario, the life of the elderly will be quite different from their counterparts in the last few decades of the 20th century. Many men and women survive to become grandfathers and grandmothers without proper care givers.

### **Economy and Elderly Women:**

In Indian culture, paid work is always associated with men "Udyogam Purusha Laxanam". However a large percentage of women are predominately engaged either in unpaid household work or in care sector activities which are significantly underestimated, such as nurturing young children, providing care for older people, disabled and sick persons. These activities are considered as a fundamental duty. Besides these Indian women are largely employed in informal and unorganized private sectors where they get low wages. The following data substantiate the above facts.

Since two decades there has been a dramatic increase in women's share of agricultural employment due to the movement of men to non-farm employment (World Bank, 1991). The census report of India 1991 pointed out that 78 percent of women are actively engaged in agriculture as compared to 63 percent of men. FAO reports again aptly pointed out that "most farmers in India are women". Globally also women are not far behind in this respect. According to a UN report, women constitute half of the world's population and produce half of the agricultural products. However, the woman's role in production has not yielded anything for her personal development. This is clear in The World Action Plan announced at the middle of the United Nations Women's Decade (1976-1986). It says that women share a half of the world population, one-third of the official work and two-thirds of the total working hours. Nonetheless, they receive only 10 percent of the total income and own as little as one percent of world wealth. This kind of deplorable condition of women is due to prevalent illiteracy, lack of exposure to the outer world, low level of skills. Therefore they usually engage in jobs which neither fetch them solid

income nor financial security. The financial insecurity and lack of savings further amplify the other related problems of their lives when they are totally dependent upon care-givers.

Thus there is a need to recognise unpaid informal work done by women as productive, so that we can have some real changes in the lives of the elderly women, who numerically dominate in the population of the aged. These women are forced to realise all the disadvantages of having been a non-paid house keeper or caretaker, when they face a situation like husband's retirement, disability and death.

### **Co-residence or Living Arrangements:**

The imbalance in gender ratio which is favouring women in terms of greater life expectancy deeply affects the co-residence or living arrangements, exchange pattern and well-being of the elderly women. Because of imbalance in life expectancy more women will be living in their old age as widows. Men always get physical and emotional support from their wives. After the death of her husband, either she will be alone or she has to be under the control of children. She cares for all but no one cares for her. Men always get a multiple support system, whereas women do not get this kind of support. In bereavement, they may spend life with agony, loneliness and lack of security. Thus, the extension of life span for women especially at old age may be a real bane.

### **Widowhood:**

The marital status of the Indian woman is more of a cultural and social phenomenon and it determines her status in society. An excess of women over men at older ages is typically viewed as problematic since it reflects a high level of widowhood. Indian women who are widowed are known to be widely discriminated against and seldom receives respect and care from people in general and the family in particular.

A greater incidence of widowhood has been associated with differential life expectancy, age difference of partners and a lower rate of re-marriage

**Table No. 9: Widowhood among Elderly (60+) by Sex, India - 1991**

Status	Percentage
Widow	54.0
Widowers	15.5

**Source:** Census of India, 1991

among women and also the stigma associated with remarriage of women. According to the 1991 census a large majority of elderly males (80.7 percent) lived with a spouse. Only 44.2 percent of females lived with their spouse. Table no. 9 clearly indicates the incidence and extent of widowhood in India; it shows that a majority of the elderly women (54 percent) were widows. Due to this very status they are at greater disadvantage than elderly men. Thus, increasing life expectancy of women has given rise to a larger proportion of widows in the Indian social milieu.

### **Weakening of Filial Piety:**

Due to widowhood women become fully dependant upon young cohorts of the family. Since the majority of the 'old-old' will be women they need utmost care and concern from the family. In traditional Indian society the aged were regarded as a source of experience and as advisers of the family. Caring for the elderly parents was considered as an unwritten duty of the children; caring was not regarded as a burden nor were they treated as dependents. Now care givers (adult children) may consider elderly parents as pathological and an economic burden. The growing number of old age homes is an index of this scenario.

According to the National Ageing Survey carried out in 6 major states in India by Irudaya Rajan, Mishra and Sharma (1995), of the 329 old age homes in India, around 80 per cent accommodated both men and women; 14 percent were run only for

women and 6 percent were run only for men in 1989. Thus, elderly women have a greater chance of spending their last years in an institutional setting than men of the same age.

### **Loneliness:**

Widespread loneliness among elderly women is yet another psychological implication of feminization of the elderly. Loneliness is primarily due to the communication gap between the members of the household. Now-a-days, due to decline in fertility, young cohorts have few children and they give utmost importance to their children's career and development. Their attention is totally devoted to children's upliftment. Naturally, elderly household get less attention, which creates a wide gap between old care-receivers and young care-givers. Grandchildren are also too busy in their own way and they do not keep healthy relation with grandparents. Hence old people feel that they are not wanted by both young tots and adult care-givers. Due to this old people suffer from a deep sense of loneliness. Thus increasing importance given to the desires and wishes of the living children and an increasingly materialistic life pattern, old widows will be neglected by their own children. In addition to this, due to lack of social security, insufficient care and lack of emotional support, they feel frustrated, which accelerates loneliness among elderly women.

The intensity of loneliness and frustration is more apparent in case of widows whose children have migrated to distant places. The incidence of loneliness also increases rather sharply as age increases.

### **Health**

Sound health is not a days product- In India women generally neglect their health, since the beginning, due to negligence and ignorance. Gender plays a significant part in determining physical well-being and access to health care. Indian women's health situation is quite different from that in the west, mostly due to their dietary habits, living standards, life-styles and environmental factors. Health of

Indian women is more or less related to their socio-economic status within the household. India being predominately a patriarchal society, women have a lesser share and access to health care. They are discriminated in terms of nutrition, care recognition, treatment and prevention. All these factors culminate when women attain their old age. Elderly women are commonly characterized as unhealthy because of the fact that older women suffer considerably worse health than older men. Since women live longer they have to face more health disabilities than men. Women are generally reluctant to avail health services until they become too sick. As women cross the 50+ line they suffer from heart diseases, osteoporosis, backbone disorders and various types of fractures simply because they do not know how to avoid these problems and how to care for themselves during and after any illness.

Elderly women have a higher risk of developing mental as well as physical morbidity. They are more susceptible to mental problems due to over pressure on their physical body, menopausal maladies, socio-economic factors, emotional attitude, family structure and ageing of the brain.

In most cases mental illness co-exists along with physical problems. The occurrence of mental illness is influenced by socioeconomic factors like lack of economic support, living arrangements, dissatisfaction with life, feeling of loneliness, self pity, fall in income and so on. Situational factors like widowed status, negligence of family members and menopause also contribute to fatigue that accelerates the mental instability.

Health care for elderly women has not been given considerable priority both in the family unit as well as in state planning. They consider it is wasteful to invest in a dying segment of the community.

### **Cultural Implications:**

The cultural implications of a differential gender ratio are more pronounced in developing and traditional societies like India. Here the family is the reference point for an individual. The sweeping changes which are taking place in the family unit

have altered the family's function, duties, obligations and attitude towards their elderly mentors in general and non-productive elderly women in particular. Some of the salient changing factors in the family unit which threaten the well being of elderly women are as follows.

- Decreasing trend of co-residence
- Migration of adult children
- Women working outside
- Excessive importance of children's education and career
- Growing consumerism in lifestyle
- Decreasing filial duties
- Weakening inter-personal relation in the households
- Movement towards conjugal families in the place of kinship oriented families

These factors push the elderly woman to the corner. She has to face the battle singly without having proper social support and economic security. This is the fate of normal elderly women in India.

If we look at the other segment which consists of destitute, divorced, unmarried, childless, homeless, separated old women, it is really disheartening. Though some of them are economically well-off and have financial security, they are not free from problems. Who cares for these people when they are in need of people? And who solaces them at times of crisis? remains a question. This requires a solution and needs a separate study.

### **SUGGESTIONS:**

It is clearly a fact that, compared with older men, older women are a more vulnerable and disadvantaged segment, both economically and socially. Hence, it is necessary to look into the implications of the feminization of ageing, and these

implications deserve the attention of researchers in India where patriarchal principles are working in the family and also in society. The prevailing informal as well as formal organisational and governmental modalities for the assistance of the elderly people should be modified to suit the needs and demands of the elderly women to lead a healthy and better life.

The changes which are taking place in our modern society will certainly pose multidimensional adjustments required from elderly women, their caretakers and also society. Some of the following mechanisms and strategies may be provided to elderly women in this regard.

Aged women should be given utmost priority in the household. Young cohorts who are supporting and caring for the elderly should be given some relaxation in income tax as well as concessions in health related issues.

Elderly women's skill, wisdom and experience may be used and utilised as potential human resources in all walks of life.

- Filial and emotional aspects of life should be given priority in the mass media.
- Sacredness of the mother, sacrifices of the mother and women's contribution in various fields should be lessons imparted in the educational curriculum.
- Poor showing of elderly women and abuses should be avoided in the media.
- The stereotyped model of elderly women should be changed.
- The (unpaid) work of women should be given equal respect by the society.
- The large increase in the number of 'oldest-old' is evident in both developed and developing regions, especially among women. Hence categorisation of the aged should be done on the basis of age and disability pattern, so that the

government can help the 'oldest-old' who really need help from society.

Women, both those who have not had any paid work and those who worked in the unorganized sector and housewives, should be given priority by the government in allocation of facilities. Care for elderly women should be considered as a family responsibility.

If the family is to remain the locus of care, government should give some benefits to the people who cares for their parents in old age, because in countries like India the welfare of the elderly receives low priority in resources allocation. The decline in Government provided social services and market oriented growth have pushed the elderly to the corner. Industrialisation, mechanisation and communication facilities and commercialisation of agriculture are great hurdles and reduce the opportunities of the elderly for self-support. Government can also encourage and strengthen filial duties of the children by promoting joint households.

Elderly women in rural areas are reluctant to move from their native places due to lack of education and dislike of exposure to the outer world. They are not ready to adjust to the changing situation and accept new roles in later life, especially in cities where their children migrate due to their job and career. Counselling centres should be opened to cater for the needs of these groups.

There is a need to build an emotional bridge between generations. Both young and old should arrive at some points where both should adjust and socialise themselves to a certain extent so that inter-relations in the household can be strengthened. Young ones should be taught to respect the aged and to understand the sentiments and emotions of the aged; this enhances healthy relations in the family and makes older persons more acceptable in the family. Besides this, encouraging intergenerational transfers within and across the households is one of the ways to retain emotional ties in the family, e.g. transfer of goods, remittances, childcare services and health services can flow across generations. By encouraging and practising these mechanisms one

can maintain the traditional flavour in the family.

Elderly women should be encouraged to keep some reserve amount for the rainy days, because most of the elderly women do not have savings and they are dependent on their children after the death of their husbands. Those who possess an income should have control of their income; their finance should not be controlled by their kin. To have an income of their own is the first and foremost requirement for elderly women.

For those who have property as the only source of income, they should keep part of the property under their ownership and control; it should be divided only after their death. One should not take for granted that the children will take care of them in old age. All deserving women should be brought under the pension scheme and it should specially benefit the needy women.

## CONCLUSION

Population ageing is a global issue which has become an integral part of our society. However, gender issues in ageing have not been seriously covered by many researchers. Imbalances in gender ratio at older ages is one such aspect which is experienced by the majority of the countries of the world. India is not an exception to this. The present distinctive feature of the elderly population throughout the world is preponderance in numbers of women over men.

While women can typically expect a longer life than men they can also expect a greater proportion of their old age will be spent with economic hurdles and health disabilities. In India women are predominantly engaged in "care sector" activities which do not fetch them a solid income, so they suffer more economic hardships in their old age.

The incidence of widowhood is another problem associated with differential life expectancy. Due to the very status they are at greater disadvantage than elderly men. In most of the families after the demise of the patriarchal head, adult care-givers consider elderly women as an economic burden. The

changing patterns of co-residence, weakening of filial piety and widening gap between generations are the other implications of gender imbalance.

Cultural implications of the differential gender ratio are more pronounced in developing and traditional societies like India where patriarchal principles are prevailing in family.

For generation after generation the developing nations were able to take care of their elderly people

under various contexts (concept of Rina, concept of Vasudeva Kutubhakam). This traditional pattern of long term care is undergoing a shift in most of the Asian countries. However, it is essential to focus more on the family based service and care for the well being of elderly women. In this direction government and non-government agencies should encourage and give special facilities for adult care givers to have joint households. Institutionalization is to be adopted as a last resort.

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# WILL LEGISLATION HELP THE CARE OF OLDER PERSONS?

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For a long time now, tradition and culture in India have held the care of aged parents as the duty of their children. This is true not only of India but of many countries especially of Asia and Africa. Demographic transition, socio-technological transformation, modernization, urbanization, migration changes in family structure and several other factors have affected the continued care of older persons by their children resulting in shifts in the degree of such commitment (Ramamurti & Jamuna, 2004). A survey (Jamuna, 2003) of the views of younger people (age 25-40 years) on the caring obligation at three points of time viz., 1984, (91%) 1994 (67%) and 2001 (51%) showed a gradual reduction of the proportion of persons considering it as a duty owed to ageing parents by their children.

The age structure of the Indian population is showing signs of change over the last decades. The older segment of the population is growing faster than the younger segments of the population and also as a proportion of the total population. The total fertility rate (TFR) is on the decline with states like Kerala, Punjab, Goa and Tamil Nadu recording a figure less than two (Rajan et al., 2003) foreboding a reduction in the care providing younger population, a situation that obtains in many European countries.

It is in the context of the foregoing scenario that the Indian Government's plan to bring out legislation mandating the care of the ageing parents by their children, is to be viewed. Already, the state of Haryana has such a legislation in effect. Also, section 125 of the Criminal Procedure Code (India), 1973, provides for the maintenance of needy aged parents by viable children on a complaint lodged by the parent. Yet, there are critical issues that need to be

considered with regard to the enactment of legislative provisions for the care of the older persons. Some of the issues are discussed here.

In a semi-federal structure such as that of India, subjects of governance are grouped under three heads viz., central (federal) subjects, state (provincial) subjects and concurrent (or common) subjects. Elderly persons' welfare falls in the concurrent and common list necessitating concurrence between the state and centre with regard to the legislation and its implementation. As a bulk of the funding for old age pensions has to come from state resources, states may be disinclined to bear the huge expenditure. Also, different states may run the programme in different ways with varying efficiency, making coordination a difficult exercise.

An issue of significance is with regard to the extent to which a legislation could actually help in ensuring elder care by children. Despite the fact that the legal provision for care by children under section 125 Cr P.C. already exists, few have utilized it. Parents feel inhibited to seek legal assistance from a court to secure maintenance from their children and would seem to opt to suffer silently. Also, parents would hesitate to complain for fear of repercussions of such an act. It could result in emotional severance of a tender bond with their children.

An aspect that pertains to a technical difficulty is in determining the level of adequacy of resources for the parents to be declared as needy. Similar difficulty exists in assessing the financial viability of children (sons and daughters) and the quantum of support they are to extend to their parents. Adequacy is a difficult term to assess.

In caring for aged parents do married daughters and sons have to share the responsibility? Because the daughter (though married) has been made eligible to parental property, it is argued that she should be made liable to care for her parents. Being married, she is already saddled with the care of her husband's aged parents and therefore would it be fair to add to her a further burden of the care of her own parents? In cases where she happens to be the only child the care obligation for her own parents could additionally fall on her shoulders.

The government while legislating for care of older persons by their children has also an obligation to facilitate such care. Cases are not wanting where even willing children are unable to extend care adequately due to other pressing obligations. In dual career families where husband and wife go out to work, they have found it difficult to care for the frail elderly at home. Moreover, their attention will have to be divided between caring for the older persons in the family on the one hand and also taking care of their own young children, attending to one's own spouse and other professional / civic obligations. In all such cases there is a great need for assistance in caring tasks. If only supportive services such as respite care / home care / bedside care services, meals services, nursing services were available at reasonable cost or through volunteer agencies (eg. senior volunteers) providing services at nominal cost, such supportive services would go a long way in relieving the care overload of care givers. The government has to encourage the establishment of such supportive care services in the community. They would not only provide assistance but also enhance the quality of caregiving to the older parents by their own children and the caring burden would be considerably lightened. If these services are available, many children would not feel disinclined to keep their parents under their own care.

Another inhibiting factor for grown up (especially married) children to keep at home their aged and frail parents is the poor interpersonal relationships between the primary caregiver (e.g., daughter-in-law) and the care receiving older people (mother-in-law and father-in-law). This is typical of Indian families where the daughter-in-law is married into

the aged person's family (marrying the aged persons' son). Traditional inter-perceptions between mother-in-law and daughter-in-law have generally been poor, stigmatized and stereotyped. Positive family counselling to improve the relations and interactions would be of great help. Such counselling would need to encourage the older people to reinforce positively and recognize the caring service rendered by the daughter in law rather than demand such services. Obligations and duties are to be transformed into loving and caring acts. After all, care is termed as a loving and noble act that deserves social recognition and praise.

It has to be stressed that comprehensive elder care legislation or enactment needs to have punitive (for those who transgress) as well as promoting components. The law needs to first provide for the building of caring traits in individuals and then having provided for building such traits and behaviour, can have care enforcing punitive components. Caring, especially caring for older people has to be widely encouraged as a laudable value in life in all individuals as part of rearing and early socialization. Eldercare as a value is to be inculcated in schools as part of the educational curriculum. Sensitivity for social service as a valued activity can be promoted in schools by providing children with regular hands-on experience and prizes / merit certificates awarded to those who regularly participate in such activities. Helping, as a desirable personality trait, has to be built into the individual. Any legislation on eldercare by children has to be comprehensive to include inculcation of care giving as a worthy trait. The development of human resource in the area of extending caring service to those in need is as invaluable as the development of the three Rs and professional skills.

National policies of many countries ( including NFOP the National Policy for older persons, of India) have envisaged the strengthening of the family as caregiver to the older person. Does the concept of the family include, in addition to the husband and wife, the married sons and daughters? Do married daughters share the same responsibility as married sons in the care of older parents? Does it apply when man and women "stay together" and have children

but are not legally married? These aspects need to be clarified before an act is introduced.

In many developing countries a majority of the older population are indigent and are finding independent living rather difficult. In many cases the children of these indigent parents themselves live in conditions of poverty making the application of the law ineffective. The state may be hard pressed to subsidise such maintenance. At best the state may be able to subsidise partially the maintenance of destitute old people, still at a huge cost to the exchequer. The Government will have to think of raising the revenue needed by additional taxation.

Under these restraining conditions of elder care and maintenance, as a supplemental and long term measure, the government could provide for a contributory pension scheme, through out the working years of an individual's life. A huge proportion of the working age group in many developing countries are either unemployed, partially employed or self employed in the unorganized sector with no guarantee of a regular income. Under such circumstances, where daily subsistence is itself not ensured, a contributory long term pension scheme becomes inoperative. Therefore, on the economic front, employment potential has to be enhanced substantially to create some employment for every person, at least through the working years, creating capability in individuals to contribute regularly to one's own pension fund.

Another possibility is to amend the government's retirement law, so as to provide retirees a facility to work, if they choose on a part time basis in a suitable position, in return for a nominal payment. This may be useful where there is no provision for retirement pension and the individual has not saved for a personal pension fund. This means that in place of a government pension, a retiree can be "re employed" part time for a consolidated payment. The creation

of part time work opportunities for retired people would be a step towards the productive utilization of the trained manpower of retirees. It also promotes the concept of utilization of "Skill Banks" of able seniors and optimum usage of manpower available in a country.

The earnings of an older person, however small the amount of earning be, will still have a salutary effect on the caring by his children. The older person would not be felt as a complete "burden" if the older person could contribute at least a portion of his earning to the family towards family maintenance. In many families such contributions are in vogue and go a long way in alleviating the financial stringency of the caregiving family. Apart from monetary help, the care receiving parents can do a lot of other things to assist the family in its daily chores (caring for grand children, home making etc.) as long as they are able to do these.

In conclusion, it is necessary that in implementing legislation in a developing country such as India where a majority live near or below the poverty line, several technical points need to be considered and worked out e.g., establishing the inadequacy of means of living of the older persons and the viability of children to extend care. The legislation has to be comprehensive in that in addition to punitive clauses, it should facilitate the establishment of care supportive infrastructure to encourage care giving by children. Over and above this, economic measures have to be introduced that would provide fair opportunities for individuals to secure gainful employment during their working years as well as in the later years. This would enable efficient use of productive manpower, maximize care giving capability in children and promote self dependency and financial viability for the elderly. In short, it has to be a total, well rounded package that addresses most, if not all issues involved in caregiving and makes caregiving an attractive duty!

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## 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 the years 2003, 2004 and 2005 for Training Programmes, which are held in Malta. These funds support the educational activities of 8 Fellows from developing countries participating in the Short Training Programmes in Social Gerontology, Economic and Financial Aspects of Ageing, Geriatrics and Demographic Aspects of Ageing as well as 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 Frederick F. Fenech, Director of the International Institute on Ageing, United Nations – Malta, 117, St. Paul Street, Valletta VLT 07, Malta, e-mail [ffen@inia.org.mt](mailto:ffen@inia.org.mt).

The closing date of applications can be obtained from the Institute's website, [www.inia.org.mt](http://www.inia.org.mt).

# A FALLS INJURY PREVENTION PROGRAMME: TAI CHI

FREDERICK EHRlich – HENRY ZHENG

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## **Falls and Fall-related Injury - A Most Costly and Traumatic Health Threat Facing the Elderly**

Falls and fall-related injury pose one of the most costly and traumatic health threats to the elderly. In the United States, more than one-third of adults aged 65 years and older fall each year (Hornbrook 1994). Older adults are hospitalized for fall-related injuries five times more often than they are for injuries from other causes (Alexander, 1992). In 2001, more than 1.6 million seniors were treated in emergency department for fall-related injuries and nearly 388,000 were hospitalised (CDC 2003). Among older adults, falls are the leading cause of injury deaths (Murphy 2000). In 1997, about 9,000 seniors died of fall-related injuries. The total cost of fall-related injuries in 1994 among people aged sixtyfive and older was US\$27.3 billion (Englander 1996). By 2020, the cost of fall-related injuries is expected to reach US\$43.8 billion (Englander 1996)

The most serious health consequence of falls is fractures. 87% of all fractures among older adults are due to falls (CDC 2003). Of all fall-related fractures, hip fractures are the most serious and lead to the greatest number of health problems and deaths. Approximately 250,000 hip fractures occur each year among people over age 65 (CDC 2003). Assuming 5% inflation and growing number of hip fractures, the total annual cost of these injuries is projected to reach US \$240 billion by the year 2040 (Cumming 1990).

In Australia, falls and fall-related injury are such a serious public health issue that falls prevention is identified as a national health priority (National Falls Prevention for Older People Initiative, 2004). Falls are by far the most common cause of injury among elderly Australians (Pointer et al., 2003).

Approximately one in every three of Australians aged sixty-five or older suffers one or more falls each year (Dolinis, 1997; Lord, 1993). The cost of falls to the health system is staggering. In 1995-96 alone, the lifetime cost from falls stood at AU\$3.1 billion. The annual lifetime cost of injuries from falls exceeds that of motor vehicle crashes and all other causes (CSIRO, 2000).

In terms of hip fractures, based on current trends, it is projected that the number of hip fractures from falls each year will double by 2026 and increase four-fold by 2051 (Sanders, 1999). It is also estimated that if the falls rates continue at the 2001 rate, an additional 886,000 hospital bed days will be required in Australia per year, specifically allocated to manage fall-related injuries (Moller, 2003).

Statistics from World Bank (1993) show that falls in developing countries accounted for similar burden of injury by type to that of developed countries for 1990.

As the world population becomes increasingly sedentary and ages rapidly, the situation for falls and fall-related injury is expected to worsen and calls for comprehensive and effective intervention strategies.

## **Exercise Intervention Strategy**

One of the key objectives in falls prevention is to identify, develop and implement safe, effective, cost-efficient and evidence-based intervention strategies to manage falls risk factors and prevent falls. Falls risk factors are multifactorial, ranging from physical, psychological, social to environmental. Reduced muscle strength, poor balance, mobility and flexibility, limited motion range or low Body Mass

Index due to physical inactivity and aging are among the most significant physical risk factors for falls and fall-related injury (Nevitt et al, 1989; Lord et al 1993, 2001; Campbell, et al, 1989; Tinetti, et al, 1995, etc). However, these risk factors are not only identifiable, but also modifiable. Research shows that physical exercises incorporating strength, balance, endurance, flexibility and mobility training can improve the performance of these falls risk indicators (Hill et al., 1999; Johansson & Jarnlo, 1991; Judge et al., 1994; Skelton et al., 1995). Multi-component group exercises targeting balance and strength training can reduce falls risk among older people (Lord et al., 1995 & 2003; Means et al., 1996; Barnett et al., 2003; Rubenstein et al., 2000; Day et al., 2002).

One type of exercise identified by a number of studies as particularly effective in reducing falls risk and preventing falls is Tai Chi (Wolf et al, 1996; Jacobson et al., 1997; Hong et al 2000; Tse and Bailey, 1992; Li et al, 2004, et al). Tai Chi is a system of low impact, cognitive and aerobic exercise for health and fitness. It contains weight-bearing and weight-transferring movements. It is characterized by circular and fluid movements flowing in a natural, smooth and ceaseless sequence. Tai Chi emphasizes the importance of dynamic balance, postural control, movement coordination and mental focus. This low-tech and moderate exercise regimen is demonstrated to be effective in counteracting the major amendable physical risk factors and preventing falls.

### **The Tai Chi for Health & Falls Injury Prevention Programme**

However, one major barrier to the public access to Tai Chi as a safe and effective exercise intervention strategy for falls prevention is the significant variability in the content of Tai Chi. Tai Chi is a general term. There exists a great variety of Tai Chi - traditional Tai Chi versus modern Tai Chi and spiritual Tai Chi versus martial art Tai Chi, etc. Within traditional Tai Chi, there are many different styles such as Chen style Tai Chi, Sun style Tai Chi, Yang style Tai Chi, Wu style Tai Chi, Tai Chi Chih, etc. As far as modern Tai Chi is concerned, there are 8-Form Tai Chi, 16-Form Tai Chi, 24-Form Tai

Chi, 42-Form Tai Chi and other competition forms. Spiritual Tai Chi such as Taoist Tai Chi emphasizes spiritual dimension whereas martial art Tai Chi stresses self-defense techniques. Tai Chi varies significantly from style to style and from form to form in terms of exercise principles, techniques, intensity and duration, etc. Studies relied on grossly different content of Tai Chi. In most cases, only a few movements extracted from different styles or forms were used in Tai Chi trials and the results were scattered. Therefore, it is imperative and of vital importance to develop a modified and targeted Tai Chi intervention model that incorporates essential Tai Chi exercise techniques effective for counteracting falls risk factors and eliminates dangerous, ineffective or irrelevant movements in the existing Tai Chi forms.

The Tai Chi for Health & Falls Injury Prevention Program, jointly developed by Exercise Medicine Australia and Professor Ehrlich from the School of Public Health & Community Medicine, the University of New South Wales, offers precisely such a modified Tai Chi model in time. It is a targeted and comprehensive Tai Chi intervention program newly developed in Australia. The key exercise techniques developed in the special Tai Chi intervention program include *weight bearing & weight transfer; isometric and isotonic contractions; lowering body gravity centre; directional change; symmetrical movements; dynamic balance and postural control; toe clearance and visualisation*, which are designed to effectively tackle the major physical, psychological and social risk factors of falls and fall-related injury. Based on exercise science and falls risk management principles with incorporation of essential Tai Chi techniques, the Tai Chi for Health & Falls Injury Prevention Program aims at achieving the following objectives:

- To overcome lower body weakness and improve core stability by building strength on the legs, waist and back
- To improve the body's mobility, flexibility, coordination and balance by increasing strength and flexibility of working muscles and joints and expanding motion range.
- To prevent bone demineralisation and build bone

mass, thus minimising risks of bone fractures should a fall occur.

- To improve the body's balance control mechanism by increasing the body's ability to sense, adjust and orient to changes of motion direction and floor conditions.
- To improve the blood-pumping capacity of the muscle, thereby reducing high blood pressure and minimising falls risk.
- To improve the body's ability to stabilise and balance itself through halfsquat movement techniques with lowered gravity centre.
- To improve toe clearance during walking.
- To manage stress, increase self-confidence and overcome anxiety and fear of falling.

The Tai Chi for Health & Falls Injury Prevention Program is developed for wide public access for the purpose of improving public health and preventing falls. It is easy to learn and safe to deliver in community, residential care and hospital settings. It

contains complete warm-up and cool-down exercises as an integral part of the program. There is a complete and detailed manual and instructional DVD available for this program, which provides comprehensive information on falls risk factors and management, key exercise techniques, teaching and practice guidelines, detailed description and analysis of the physiological functions of each movement. There is a step-by-step teaching and demonstration of the program on the DVD.

The success of the campaign in falls prevention lies in a coordinated and sustained approach towards implementing safe, effective, evidence-based and cost-efficient intervention practices. In order to facilitate effective implementation of the Tai Chi for Health & Falls Injury Prevention Program, Exercise Medicine Australia conducts international training workshops in collaboration with falls injury prevention bodies, research institutions, health promotion units, hospitals and community service centers of both developed and developing countries to train exercise instructors, nurses and physiotherapists for safe and effective delivery of the programme.

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# The Implementation of WHO's Programme in ASEAN Countries

T. SETIABADHI

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## Introduction

Much of the population of the Asian and Pacific Region has become inevitably and rapidly older, along with the rest of the world. What is popularly known as the "greying" or ageing of populations is changing the face of the region and challenging traditional thinking.

By the year 2025, the number of older persons (people aged 60 and over) in Asia will be about 705 million, more than double that in 2000 when it was around 322 million. While the total population of Asia is projected to grow by 1 per cent per year during that period, the population aged 60+ will be growing by 3.1 per cent. As a consequence, the proportion of older persons in the population will increase from less than 9 per cent to nearly 15 per cent.

During the first World Assembly on Ageing which was held in Vienna in 1982, our attention was drawn to the potential problems of population ageing. The years since have witnessed a growing realization of many of those concerns, emphasizing to governments the need to take both more focused and yet more diversified action in the implementation process. Some of the UN-ESCAP activities are:

- The Macao Declaration and Plan of Action on Ageing for Asia and the Pacific was adopted in Macao in 1998 and was endorsed by the members and associate governments of ESCAP in 1999 - noting that unprecedented ageing of societies in the twentieth century poses a serious and complex challenge to all nations. It states that a basic change is needed in social attitude towards ageing and older persons and the way in which societies are organized. It provides guidance to governments, NGOs and other organizations in their endeavor to improve the well being of older persons. Under the plan of the Macao Declaration, four immediate tasks are to be

taken up by governments in view of the importance of population ageing for national social and economic development. These tasks are:

1. Understanding of the issues and implications of population ageing
  2. Preparation of an Ageing Process that is productive and fulfilling,
  3. Development of a national infrastructure for ageing, along with an enabling environment; and
  4. Delivery of essential services. This plan of action addresses seven major areas of concern relating to ageing and older persons:
    - a. The social position of older persons,
    - b. Older persons and the family,
    - c. Health and nutrition,
    - d. Housing, transport and the built environment,
    - e. Older persons and the market
    - f. Income security, maintenance and employment; and
    - g. Social services and the community.
- By 2001, many countries and areas in the Asia Pacific regions had established national policies on ageing, e.g., China, Indonesia, Malaysia, Philippines, Republic of Korea, Singapore, and Thailand.
  - The International Year of Older Persons in 1999 and its follow up witnessed the implementation and/or various enhancements of national policies and programmes for older persons in many countries in the region. The Year has brought about positive changes regarding attitudes and behaviours as well as understanding and action for the benefit of older persons along the four dimensions of its theme: "Towards a society of all ages".

These four dimensions are:

1. The situation of older persons
2. Lifelong individual development

3. Multigenerational relationships, and
4. The development and the ageing of populations.

- During the second World Assembly on Ageing, The International Plan of Action on Ageing 2002 was amended. Accordingly, there were calls for changes in attitudes, policies, and practices in all sectors to realize the enormous potential of ageing in the twenty-first century. According to the text, all older persons should be able to age with security and dignity, and continue to take part in society as citizens with full rights. Governments are primarily responsible for implementing the Plan of Action, but partnerships between government, civil society, the private sector and older persons themselves are also stressed. Concrete actions to put the Plan into effect were laid down, according to three priorities:

1. Older persons and development,
2. Advancing health and well-being into old age, and
3. Enabling and supportive environments.

The first priority -- older persons and development -- focuses on eight issues which call for urgent action to ensure the continuing integration and empowerment of older persons, thus enabling them to participate actively in society, development and the labour force. Governments should focus on involving older persons in decision-making, creating employment opportunities for those who wish to work, and improving living conditions and infrastructure in rural areas. Governments should also alleviate poverty in rural areas and among older persons in general, integrate older migrants within new communities and create equal opportunities for education and training.

Under the second priority -- advancing health and well-being into old age governments should reduce the effects of factors increasing disease and dependence in older age, develop policies to prevent ill-health and provide access to food and adequate nutrition. The needs and perceptions of older persons should be integrated into the shaping of health policy. They should also work to eliminate social and economic inequalities based on age, gender or

other grounds, develop and strengthen primary health-care services, and strengthen primary and longterm care services. The health priority also urges governments to provide a continuum of care, ranging from health promotion and disease prevention to the provision of primary care and acute care treatment for older persons. It also urges support for improvement in long-term health-care and social services, including the provision of palliative care for older persons suffering painful or incurable disease. They should work to ensure the integration of palliative care into comprehensive health care and develop standards of training in palliative care and encourage multi-disciplinary approaches for all service providers of such care. Other recommendations under health priority include improving assessment of the impact of HIV/AIDS on older people's health, particularly in the developing world, and providing adequate information and training to older persons living with HIV/AIDS and their caregivers. Comprehensive mental health-care services should be developed, treatment services provided and older persons with disabilities should be allowed to participate fully in society.

The third priority -- ensuring enabling and supportive environments - urges recommendations for improving housing and living environments of older persons, promoting a positive view of ageing, and enhancing public awareness of the important contributions of older persons. It also addresses the availability of accessible and affordable transport for older persons, providing a variety of care and services for older persons, supporting the care-giving role of older persons and creating support services to address elder abuse.

### **Problems faced in Asia-Pacific Area**

As a result of decreases in fertility and increases in life expectancy, the Asia Pacific regions will become home to the majority of the world's older persons within the next 25 to 30 years. This study discusses some of the general, social and economic implications of rapid population ageing in Asia Pacific, using examples from the region. This region is also home to many diverse cultures, each of which

having its own interpretation of the ageing process and what it means to grow old. As such, policy makers need to be sensitive to the cultural context when developing policies for older persons. The ageing process also differs significantly for males and females, and policies for older persons should be attuned to these differences. Although many countries in the region have established national programmes on ageing, much remains to be done. At present, the majority of Governments in the Asia Pacific area continue to expect the family to shoulder the primary responsibility for older family members. Most formal programmes to support older persons are still in their infancy. The difficulty lies in balancing the need for resources for socioeconomic development against that for support for older persons. The region has seen tremendous economic growth in the last several decades and this growth is expected to continue. What does this development mean for older persons who will constitute an increasingly large portion of Asia's population over time? The rapidity with which these demographic and social changes are occurring constitutes an important concern. Governments in Asia Pacific have much less time to react to these changes as compared to their Western Counterparts that adapted to these changes over a longer period of time. In summary, Asia Pacific countries are faced with a demographic and socio-economic environment that is historically unique but which also requires unique solutions.

Most of the formal programmes for older persons in the Asia Pacific are modelled after programmes that have been instituted in developed countries. The main concern for Asian Governments is to ensure that family support for older persons does not decline once formal programmes, such as social security packages and nursing homes, become available. There is also a pervasive concern that socio-economic development is eroding the strength of family support for older persons. As mentioned earlier, there is mixed evidence regarding this concern. Many countries continue to show high levels of family support for older persons in the face of the rapid socio-economic development. Other countries show a decline in certain types of support for older persons. In this regard, the definition of

older persons' well-being needs to be carefully assessed.

The well-being of older persons is a composite of numerous factors, some of which are discussed in UN-ESCAP's study, such as work, health, and social integration. The labour force participation of older persons is likely to change in the future, particularly with the move among several Asian countries to increase retirement ages. In countries that are ageing rapidly such as Japan and Singapore, the labour force participation of older persons may become more important as dependency ratios increase. Labour shortages may require countries with low fertility levels to provide better incentives for older persons to continue working. Whether older persons will choose to work remains an empirical question. Whether an older person can work, in part, an outcome of his/her health status. The need for health care services and sound health care financing is paramount in the region countries in Asia Pacific.

The social integration of older persons is also a top priority. The successful integration of older persons into families and communities at large will benefit all age groups and national socio-economic development. As older females are projected to make up the bulk of older populations, their needs should be addressed to ensure success of the programmes for older persons.

### **The 2005 WHO Guidance on Health Programme**

During the plenary session of the 18th Congress of the International Association Of Gerontology (held in Brazil/ Rio de Janeiro, June 26 - 3, 2005) - Alexandre Kalache (the Coordinator of the WHO Ageing and Life Course) presented an interesting report.

Some topics which were discussed include:

- The Definition of Active Ageing
- Gender and Cultural issues. While having important effects on health programme, those issues were not included with the other determinants. Mr. Kalache proposed to discuss intensively, such as:

1. Access on Health and Social Care Services;
2. Personal Determinants,
3. Behaviour Determinants,
4. Psychological Determinants,
5. Social Determinants, and
6. Economic Determinants.

- The promotion of the approach called '**AGE FRIENDLY PRIMARY HEALTH CARE**' to developing countries. Once the approach is implemented in developing countries it will reap the positive result: **Towards an ACE-FRIENDLY SOCIETY**.

- WHO - INTRA project which is conducted in three stages with the development of a '**South to**

**South Exchange**' network. The network will facilitate exchanges of Knowledge, Experiences, and Models of Good Practices amongst the developing countries in the Southern part of the world.

- Considering the ASEAN-ROK program is not yet included in the **INTRA** project **<Integrated Health Systems response to rapid population ageing in developing countries>**- it is worthwhile to arrange an immediate discussion between UN-ESCAP, HelpAge International, and WHO in order to propose the implementation of the ASEAN-ROK programme into their next programme.

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# INTERNATIONAL DIARY 2005 / 2006

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**November 10th- 12th Manila, Philippines**

6th Annual Convention 2005 - Thinking Globally  
Acting Locally: Geriatric Medicine in the  
Philippines

E-mail: [driJeovsta@yahoo.co.uk](mailto:driJeovsta@yahoo.co.uk)

**November 16th- 18th Madrid, Spain**

International Meeting on the "Contribution of Older  
Persons to the Social and Economical Development"

E-Mail: [mbravot@mtas.es](mailto:mbravot@mtas.es)

**November 17th –20th - Thessalonica, Greece.**

2nd International Congress on Brain and Behaviour  
Website: [www.psvchiatry.ar](http://www.psvchiatry.ar)

**December 5th - 7th Singapore**

International Conference- Female Deficit in Asia:  
Trends and Perspective

Organized by CEPED - CICRED - INED

Website: [www.cicred.orq/Enq/Seminars/  
Femaledeficit.htm](http://www.cicred.orq/Enq/Seminars/Femaledeficit.htm)

**2006****February 8th - 17th – New York**

UN Commission for Social Development 44th  
Session

**February 9th - 11th – India**

Asian Regional Conference on "Aging with Health  
and Dignity: Strategies and Best Practices

E-mail: [indira313@hotmail.com](mailto:indira313@hotmail.com)

**February 20th - 24th - Buenos Aires, Argentina**

International Forum on the Social Science-Policy  
Nexus

Website: [www.unesco.org/shs/ifsp](http://www.unesco.org/shs/ifsp)

E-Mail: [ifsp@unesco.org](mailto:ifsp@unesco.org)

**March 15th - 19th –Turkey**

Middle East Congress on Aging

Website: [www.meca2006.org](http://www.meca2006.org)

E-mail: [erfem@erfem.org](mailto:erfem@erfem.org) / [info@meca2006.org](mailto:info@meca2006.org)

**April 2nd - 6th April, Istanbul, Turkey**

International Congress of Elderly Health

Website: [www.geriatrics2006.org](http://www.geriatrics2006.org)

E-mail: [info@interium.com.tr](mailto:info@interium.com.tr)

**May - Serbia and Montenegro**

Seventh National Gerontological Congress

Quality of Life in Old Age - The challenge of the  
21th Century

Website: [www.gds.org.yu](http://www.gds.org.yu)

E-mail: [gdsdragana@yubc.net](mailto:gdsdragana@yubc.net)



# INIA'S ACTIVITIES 2005/6



## 2005

- 7th - 18th November International Short Training Programme in **DEMOGRAPHIC ASPECTS OF POPULATION AGEING, POLICIES AND ITS IMPLICATIONS FOR SOCIO-ECONOMIC, POLICIES AND PLANS**, (MALTA)
- 25th - 27th November Commonwealth Heads of Government Meeting (CHOGM), **Valletta** (MALTA)
- 5th - 16th December In-Situ Training Programme in **GERONTOLOGY AND GERIATRICS** in collaboration with Caisse Nationale de Securite Sociale (CNSS). **Tunis**, (TUNISIA)

## 2006

- 23rd - 31st January In-Situ Training Programme in **Gerontology**, (TURKEY)
- 8th - 17th February 44th Session of the Commission for Social Development, **New York** (UNITED STATES OF AMERICA)
- 20th February - 3rd March International Short Training Programme in **SOCIAL GERONTOLOGY**, (MALTA)
- 20th - 31st March International Short Training Programme in **ECONOMIC AND FINANCIAL ASPECTS OF AGEING**, (MALTA)
- 2nd - 6th April Geriatrics 2006 **INTERNATIONAL CONGRESS OF ELDERLY HEALTH** organised by the Geriatrics Society - Turkey, with the scientific support and co-operation of the European Union Geriatric Medicine Society (EUGMS), the International Institute on Ageing (INIA), and the International Association of Gerontology (IAG), **Istanbul** (TURKEY)
- 15th - 26th May International Short Training Programme in **MEDICAL GERONTOLOGY (GERIATRICS)**, (MALTA)
- August In-Situ Training Programme in **Gerontology** in collaboration with the Singapore Action Group of Elders (SAGE), (SINGAPORE)



# INIA'S ACTIVITIES 2005/6



September	In-Situ Training Programme in <b>Gerontology</b> , (SOUTH AFRICA)
October	In-Situ Training Programme in <b>Gerontology</b> in collaboration with the Beijing Civil Affairs Bureau (BCAB), (CHINA)
October 2006 - June 2007	International <b>POST GRADUATE DIPLOMA IN GERONTOLOGY AND GERIATRICS (Dip.Ger.)</b> European Centre in Gerontology and Geriatrics, (University of Malta), (MALTA)
13th - 24th November	International Short Training Programme in <b>DEMOGRAPHIC ASPECTS OF POPULATION AGEING, POLICIES AND ITS IMPLICATIONS FOR SOCIO-ECONOMIC, POLICIES AND PLANS</b> , (MALTA)

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