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OLDER PERSONS;

MEDICAL CARE, SOCIAL PROTECTION AND UNITED NATIONS PRINCIPLES: AN ANTHROPO-GERONTOLOGICAL APPROACH ON GERIATRIC HEALTH

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ABSTRACT… Background: The Older Persons (OPs) are the knowledge and experience banks who hand over their life experiences to run society to the youth to further take up the society for the continuity of life and its progressive upward mobility. **Objective:** The aim of study was to explore the interrelationship of older persons' health care and social protection in the light of United Nations Principles for Older Persons in Rawalpindi city. **Study Design:** Cross Sectional Study. **Materials and Methods:** Structured questionnaire was developed to collect information on Older Persons' health, economic and psychological status. In this regard, an extensive questionnaire was designed and pre-tested vigorously. **Place & Duration of Study:** The data collection was done in various union councils of Rawalpindi city. The study duration was three months and lasted from September 2013 to December 2013. **Results:** Family is concerned about the welfare of OPs but the financial liabilities. In 82.8% cases children were found to be caring whereas in 17.2% cases kids were totally forgetful. 46% OPs were primarily nursed by their spouses and 34% by sons or daughters. 44.3% OPs still managed their financial affairs. In 66% case no secondary financial facility was provided by the government. 28.9% cases were those where OPs requested help from other sources. **Conclusions:** The Islamic Jurisprudence, Constitution of Islamic Republic of Pakistan and UN Principles demand the governments and states to intervene in the situation and make sure that the OPs are enjoying equal access to independence, (social) participation, care, self-fulfillment and dignity.

Key words: Anthropology, Gerontology, Ageing, Older Persons (OPs), Health Issues, United Nations, UN Principles for Older Persons, Geriatric Health and Social Protection.

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INTRODUCTION

United Nations Principles for Older Persons were adopted by General Assembly resolution 46/91 of 16 December 1991[1]. The reasons behind this endeavor were to acknowledge the older persons' efforts and struggle that they made towards their society, community and families. The aim was to appreciate their effort for the first time at a global level. In addition, there were sources that perpetually revealed and uncovered that older persons during their retired life become a source of public satire for doing nothing and become a burden over the limited livelihood resources of their families, and also a public liability for the states. This state of affairs become more alarming and creates a mental dejection when the stories from the third world countries are given room at international level for pondering. The said documents not only appreciates the efforts of older persons but also 'recognizes that, in the Charter of the United Nations, the peoples of the United Nations declare, inter alia, their determination to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small and to promote social progress and better standards of life in larger freedom'.

The aim of the paper is advocate for the rights of the OPs as found during the course of a primary research conducted in Rawalpindi city in the northern Punjab province. The UN principles also refer that 'in a world characterized by an increasing number and proportion of older persons, opportunities must be provided for willing and capable older persons to participate in

and contribute to the ongoing activities of society'. The most part of the UN document for OPs states that the '(all member states') Governments need to incorporate the recommendations of UN principles into their national programs whenever possible'. The UN's stance is that qualitative work that aims for the welfare and development of the older persons be up to the standards already envisaged during the intellectual strives of International Plan of Action on Ageing and the conventions, recommendations and resolutions of the International Labor Organization, the World Health Organization and other United Nations entities'.

Chaudhry et al., (2014) referred to the vision of health held by Help Age International comments on Health states that 'the body gradually degenerates with age. Many diseases affect older people and the loss of mental acuity can impact older people's psychological well-being and lead to depression. There is a need for consistent medical care with good nutrition, exercise and mental stimulation to lessen the impact of ageing and support a healthy life in old age.' Help Age International further adds that 'the most common health problems with older people are sight impairments, dental problems, hearing impairments, foot problems, weakened immune systems, and mental disorders such as Alzheimer's'[2].

Chaudhry, Ahmed (2014) cited Ian Stuart-Hamilton (2011) that Gerontology is the study of old age and ageing. Although everyone has an intuitive sense of what 'old age' and 'ageing' are, providing a watertight objective definition is surprisingly difficult. Ageing could be said simply to be the process of growing older[3,4].

Health, although it is a factor of importance for both individuals and society as a whole, is a difficult entity to define. Culyer (1981) distinguishes between four main approaches to the definition of health: health as the absence of disease (a medical model approach); health as the absence of illness (a sociological perspective); health as an ideal state (the World Health Organization model); and health as a pragmatically defined entity[5].

There is a wide consensus that participation in social networks is highly beneficial and connected with ageing that is comfortable, secure and productive. Such participation, to the extent that it means feeling valued and appreciated, is regarded as a significant component of wellbeing[6].

Inadequate social support is associated not only with lower overall general health and wellbeing, but also with higher levels of emotional distress, more illness and higher mortality rates[7].

Whilst community care has been adopted as the policy approach in developing services for the elderly in Hong Kong, it has been taken for granted that the Chinese community here would have an extended family or large kinship network to render such 'care in the community' possible. In a survey among 540 families in Hong Kong in 1989, it was found that eighty per cent of the respondents' families had a support network size of not more than four persons. The majority of the elderly respondents had, none, to very few, such family confidants. Furthermore, it was found that the more aged they were, the smaller was their support network. The smallness of these informal support networks among old people is a concern in social care for older people[8]. Community care providers in Australia have found that 41 to 62 per cent of new clients are depressed and 41 per cent are lonely[9].

As people age, their need for informal support and social care by their families and friends increases. This is especially so in older people who have just retired and the frail and oldest old (aged 80 and above). This is the result of a change in their social networks such as fewer contacts with former colleagues and reduced social contacts as a result of their increasing frailty (e.g. following a stroke or other decrease in their mobility levels). However, despite their stronger need for increasing social support, these problems may increase, adding to their social isolation

and loneliness in the community[10-11]. Research findings from the Growing Older Programme in the UK found that (1) older people who are living with a partner, companion or family members, are more likely to use positive strategies to promote personal optimism in old age. (2) Maintaining contact with other people is crucial in maintaining a reasonable quality of life (QOL). But it is the quality and 'density' of contact that matters, not the frequency. Older people with lots of friends and good-quality relationships, report the best QOL. For people from ethnic minorities, whose friendships are more likely to have been disrupted by migration, contact with family members is particularly important[12].

So in what ways can social care promotes the notion of ageing well for older people[13]? Adopting a life-course perspective that addresses role changes across the lifespan[14-16], this section addresses the following areas: dynamics of social care and informal support networks of older people; trends in community-based home-care services and social care needs of older people; promoting happiness in social care; a discussion of Litwak's theory of shared functions in informal care and critique; difficulties in looking after elders with dementia by their family members and coping methods; and a look at the prospect of effective social care.

It is argued that in formulating long-term care services, the small informal social support networks for older people cannot be neglected, and that a complementary partnership should be promoted in integrating formal and informal care sectors to bring about happiness and positive well-being among older people. Ngan and Kwok's study on disabled older Chinese people in Hong Kong found that 58.3 per cent of the respondents said that they had no faithful friends to share their emotional problems with, and a very high proportion (83.3 per cent) admitted that they wished to have more people for sharing their emotional and family problems[17-18]. This finding is supported by Lee's study (2008) in the city of Guangzhou in mainland China among frail elders who are clients of the 'home-based elderly service program'. She found that, although in urgent situations, frail elders can get immediate help from their grownup children, usually their sons who lived apart could not spend too much time with them nor provide long-term routine care. Despite their increasing hopes of seeing their sons more, the frail elders' expectations were not met, except during their sons' longer visits at times of accidents, falls, hospitalization and similar. Frail elders in Lee's study tended to suffer from loneliness – a problem the home-based elderly service program could not effectively deal with because it is largely a meals-on-wheels service plus limited nursing care. In addressing the merits and strengths of informal social care, constraints and limitations thus also need to be noted[11].

Researchers have found that positive social interactions between older people and their family members, relatives, friends and neighbors protect against developing difficulties with physical functions in later life[19-21]. Other studies have shown that being part of an extensive social network has a protective effect on elders' health[22-24].

The positive dynamics of social care are embedded in older people's social networks, which are typically composed of family members, friends and neighbors. It is thus natural for many governments to pursue a general policy of 'ageing in place', emphasizing keeping older and frail people in their home or family settings for as long as possible via the provision of home-based community support services. However, it could also be the case that increasing frailty results in older people having fewer contacts outside the home, and hence a reduction in their involvement with friends[25]. This particularly affects the oldest of elders (aged 80 and above) in Hong Kong and could affect their mental health and cause emotional states such as depression and loneliness[26-27]. Informal care is also particularistic in nature as some older people could have a very small informal support network[6,28]. In promoting 'ageing-in-place', strategies aimed at reducing social isolation are needed. These strategies can be planned by social workers, who mostly serve as 'care managers' in active consultation with

older people and their family cares.

At a conceptual level, it is necessary to delineate clearly the formal and informal sectors of care. According to Froland (1980), the formal sector of care encompasses government-mandated or sponsored services, whether state-administered or provided through chartered intermediaries such as private nonprofit organizations. As such, the formal sector also includes private market-based services (by reason of regulation or reimbursement) as well as services provided by voluntary organizations that receive governmental financial support through tax transfers[29].

Froland (1980) refers to the informal sector of care as those sources of care and assistance provided by family members, kin, friends and neighbors, indigenous or natural helpers, and informal self-help or mutual aid activities found within networks or groups, usually on an unorganized or spontaneous basis[29]. In terms of its nature and origin, the informal care sector is referred to as the 'natural support systems' by Baker (1977) to include family and friendship groups, local informal caregivers and self-help groups not directed by care giving professionals in voluntary welfare organizations. Informal care is thus in the main based on informal social relationships, shared experiences, affective concern and altruism. Credibility is determined by norms of exchange within the social network whereas formal help is mostly associated with professional care in statutory, formal and voluntary welfare agencies and organizations[30].

According to Cobb (1982), informal support networks can usually perform the following four kinds of support: (1) Social support: this has three components: emotional support, esteem support and network support leading the recipient to believe that he or she has a defined position in a network of communication and mutual obligation. (2) Instrumental or informational support: this involves guiding persons to better coping or adaptation and to the maximization of their participation and autonomy[31]. This is what House (1981) has called informational support – the provision of advice, experience and knowledge[32]. (3) Active support or tending care: this is what mothers do for infants and nurses do for patients; it reflects the kind of tending care rendered by informal cares, as, for instance, in being spontaneous and attentive to the needs of the recipients[33]. (4) Material support: the provision of goods, financial and material aids, and tangible aids.

Cobb (1982) remarked that social support appeared to be the most important protective function for older people, who often experienced a reduction in their supportive social networks as a result of their retirement or increasing frailty[31]. However, among one's network of kin, friends, neighbors and co-workers, Hadley and Hatch (1978) found family members, notably spouse, sons and daughters, to be of over-riding importance in the provision of informal care to older people[34]. In the USA, Shanas (1979) has shown how the large majority of infirm older people rely almost entirely on their families, and to a lesser extent on their friends and neighbors, for help with the housework, in preparing meals, in shopping, in bathing themselves, and when they are bedridden[35]. Townsend (1965) in his classic study of family care of older people in London observed that those with families were far less likely to be admitted to institutions than those without, and those with very small families are more likely to be admitted than those with larger families[36].

MATERIALS AND METHODS

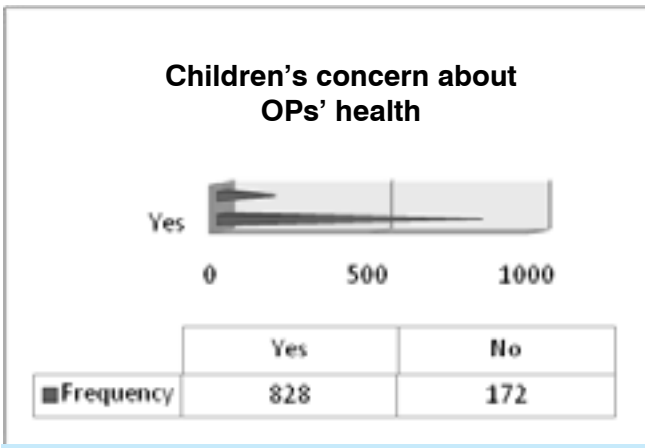
A structured questionnaire was constructed to gather the required information on selected topic. Questionnaire contained bio-informatics including demographic information of clients and the second part covered base-line information, Third part contained information on economic status, fourth part was about the medical histories of the older persons, fifth section comprised information on Social and Psychological profile of OPs, and the last and sixth part consisted information about legal and social protection issues of OPs. Questionnaires were administered with the help of a research team that comprised the graduates

of department of Anthropology of PMAS-Arid Agriculture University along with professionals of Regional Development Network (RDN) as well as field staff of Pakistan National Center on Ageing (PNCA).

RESULTS

Children's concern about Health

In a response to the question that whether the children were concerned about the health of their older parents, 82.8 percent said that 'yes' they were concerned but it were the financial hurdles due to which the kids did not afford to spend more on their health. On the contrary, 172 respondents (17.2%) said that kids were not concerned about the health of the older parents.



Graph: Children's' Concern about Health

Care-takers of OPs in Daily Chores

The sub-area explains the person that usually took care of the OPs in their daily lives. Results show that in 46% of the cases, OPs' spouses were the main persons handling the care issues. 34% cases witnessed 'sons or daughters' taking care of them. In 2.7% cases, either 'son-in-law' or 'daughter-in-law' assumed the responsibility of caring OPs in daily life. And, in remaining cases grand children, siblings, relatives, friends, and neighbors were reported to take care of OPs. 11.7 percent had no person to look after them in their daily lives.

Graph: Caregivers of Respondents in Daily Chores

Financial Care-taker

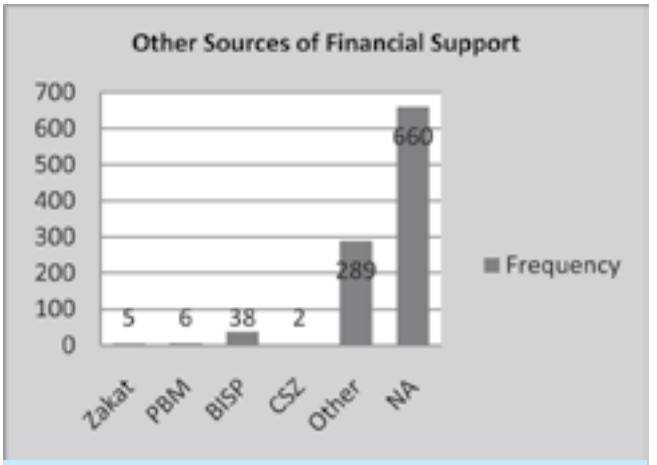
This domain provides an insight about OPs' life especially when they were not economically active. 44.3% OPs still managed to look after their financial needs. In 30.2% cases the siblings and their own kids helped them directly. 11.8 percent cases were the ones where relatives supported the OPs. Friends made up for 1.1% of the total cases. It is however important to note that most of the financial help was not long lasting as added by the respondents. It could be a timely-bound help like in case of getting ill or had some other financial crisis faced by the OPs. But in case of kids supporting their older parents, the frequency was somewhat satisfactory though it was not as per the mark.

Graph: Financial Care takers of Respondents

Secondary Financial Support to OPs

In 66% cases, the OPs did not avail any secondary source of income support. The second highest fraction that was 28.9% stated that they were seeking help from other sources that included

their families, relatives, friends, by either the informal sources of Zakat or somebody helping them in monetary terms. 3.8% pronounced that they were getting help from Benazir Income Support Program (BISP). The percentiles of Zakat department or the Pakistan Bait-ul-Mal departments were only 0.5 and 0.6 percent respectively.



Graph: Other Sources of Financial Support

DISCUSSION

Pakistani society is a Muslim society and Islam lays moral responsibility over the off springs to take care of the older parents as they took care of their children since they were kids and helpless. Islam also educates about the rights and moral duties towards humanity and older persons score on the top. The Holy Prophet (PBUH) also commanded the Muslims to behave responsibly in respect of care, respect and obedience of the OPs, failing to which the OPs become the direct responsibility of the state and government for their welfare and all human necessities. The overall observations during the study were interesting and eye opening as the large families' size, pressing economic conditions and poor housing in the Rawalpindi city brought the OPs on the brinks of poor and unhealthy life standards. The family set up of the indigenous Rawalpindi population is joint or joint extended due to which the grandparents, married siblings along with their wives and kids used to live in houses that had accommodation of two to three room on an average but in severer case it was observed to be only one room. The initial response from the OPs was a state of denial due to the fear of bringing bad name for the family's respect but as the course of the study passed and with better interviewer-respondent rapport it was found that kids were not taking of the Older Parents as they were supposed to be. The OPs and their children both in separate interview situation revealed that there is firstly some lack of care due to incompatibility between the spouses of children, and secondly the lack of care was due to the economic burdens. It was found that OPs were mostly taken care by their spouses or their kids. Similarly still a large majority (44.3%) managed their own financial affairs as it was found that become economically dormant might increase the plight of the OPs. Whereas, the state level financial and social support mechanism were not effective to reach out to the OPs in times of need. The sample responded that in 66% cases the OPs were away from availing any such financial facility. The reasons were the lack of information, demands of bribery on behalf of the staff of such supports organization or the red tape in their mechanism and fear of shame for the family. 28.9% benefited from alternate source other than the primary support organizations run by the government. On the other hand, the UN Principles expect the respective governments and the state to come up with the framework and institutional set up to implement the UN Principles in letter and spirit in order to ensure the independence, participation, care, self-fulfillment and dignity of the OPs. The research findings and case studies obtained confirmed that there is a need of honest commitment on behalf of the government to prioritize the welfare and development of the OPs in Pakistan.

CONCLUSIONS

The rights of OPs as recognized by the UN Principles are independence, participation, care, self-fulfillment and dignity. These rights are not to something at the free will of the society or the government rather it is the moral obligation of the society and state to look into providing these rights to its OPs as their basic human rights that are further protected under the Islamic provision in the Islamic Jurisprudence (Shariah). The chapter two of the Constitution of Islamic Republic of

Pakistan also recommends that basic rights to life as the constitutional rights of all citizens of Pakistan without any discrimination. The social institutions of immediate and extended family, the protective role of society and the incubation of government cannot be ruled out at any level of policy, plans of action, legislation and practical interventions aimed at welfare of the OPs. These institution are direct stakeholders to work, devise and build a social environment worth of living healthy and mentally satisfactory for the Older Persons in Pakistan.

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