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SOCIAL AND HEALTH STATUS OF THE AGED IN BANGLADESH

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It is now widely recognised that there is a need to take the scope of the population policy in Bangladesh beyond the confines of achieving population stabilisation through reduction of fertility. Although in recent years the approach to reduction of fertility has changed from narrow family planning to a broad based reproductive health approach, it is being increasingly felt that Bangladesh's population policy should encompass other equally important issues which have wide implications for the development process and the quality of life of people of Bangladesh. To address some of the related pertinent issues the Centre for Policy Dialogue has initiated a programme which aims at undertaking a series of studies covering the broad area of **Population and Sustainable Development.** The major objective of these studies is to enhance national capacity to formulate and implement population and development policies and programmes in Bangladesh, and through close interaction with the various stakeholder groups, to promote advocacy on critical related issues. The programme which is scheduled to be implemented by the CPD between 1999 and 2002 shall address, *inter alia,* such issues as population dynamics and population momentum and their implications for education and health services, the nexus between population correlates, poverty and environment, impacts of urbanisation and slummisation and migration, as well as human rights. The study has benefited from generous support provided by the United Nations Population Fund (UNFPA). The programme also envisages organisation of workshops and dialogues at divisional and national levels and also holding of international thematic conferences.

As part of the above mentioned CPD-UNFPA collaborative programme the CPD has planned to bring out a series of publications in order to facilitate wider dissemination of the findings of the various studies to be prepared under the aforementioned CPD-UNFPA programme. The present paper on the theme of ***Social and Health Status of the Aged in Bangladesh*** has been prepared by Professor Samad Abedin of the Department of Statistics, University of Rajshahi. The paper was presented at the seminar on *Aging in Bangladesh: Issues and Challenges* which was jointly organised by the Centre for Policy Dialogue and Department of Statistics, University of Rajshahi on December 22, 1999. The seminar was held at Rajshahi under the CPD-UNFPA programme on *Population and Sustainable Development*.

Assistant Editor: *Ms Ayesha Banu,* Coordinator (Dialogue & Communication), CPD.
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Introduction

Population ageing in Bangladesh is viewed as natural outcome of demographic transition from high fertility and mortality to low fertility and mortality. It represents the years of successful family planning and public health programs that have changed the population growth of the country (Strong, 1992). The demographic transition that has occurred, is envitably the outcome of socio-economic transformations through the process of development underway in the country. Development process not only has changed the demographic phenomena but also has changed (whatever it may be) inter-alia life style, values and outlook of the young population, and roles and functions of the family and community- thus society as a whole

There is considerable evidence that traditional systems of family structure, composition and functioning are undergoing a change under the impact of mass education, exposure to mass media, formalization and commercialization of economics, industrialization, urbanization, growing individualism and so on (Hugo, 1996). Increase participation of women in the workforce outside the home in cities may interfere with women being able to perform their traditional roles of providing continuous care of the elderly at home (Heisel, 1985). This changing situation is causing problems and unhappiness to the life of many elderly and endangered their well-being and survival.

The growth of the aged population is quite impressive in Bangladesh. Every year approximately 80,000 new elderly are entered into the group of the older persons. The estimates and projections show that the amount is certain to increase markedly with time. (Abedin, 1996). Such growing number of the aged population has laid down several issues related to their status and roles, care and living arrangements, health, social support and over all well-being of the elderly.

Traditionally, family remains the most fundamental social unit in which older persons belong. In providing all sorts of support to elderly, family members play vital role in the society. With development family roles and functions are shrinking. There is a strong movement towards nucleation families and family as a unit of production is declining. These changes will gather pace as economic development and social changes proceed and will impinge upon the availability of family support. Inevitably these changes will make an impact upon the well-being of the elderly.

In the light of phenomenal growth of the elderly population in the region, the International Conference on Population and Development (ICPD), held in Cairo in 1994, identified in its Program of Action the need to respond to the rapidly increasing proportion and absolute number of elderly persons in the total population. It emphasized that the economic and social impact of this Ageing of Population is both ‘an opportunity and a challenge to all societies’. The growth of the elderly population has become a focus in this process of population ageing and the Program of Action urges those countries enhance their awareness of the multi-faceted problems faced by the elderly and formulate early policies and programs necessary to dealing with the major issues of population ageing (UN, 1996).

Viewing the aged population as a significant and vulnerable group of the people in our national life and society there is a need to explore the situation of the elderly in order to have clear understanding of the problems and issues arising out of population ageing in the country. The aim of this paper is to provide a general overview on the social and health status of the aged population and try to identify social and health related issues that need to be addressed for the well-being of the elderly. The paper reviews the existing experience and in the light of that key issues of national interest will be identified and policy implications and strategies will be discussed.

The scope of the paper is (i) to investigate the status and roles of the elderly in the family and community in the context of household structure and composition; (ii) to explore the health status and health care issues; (iii) to understand the linkages between well being and time and economic development, in general (iv) to look at the living arrangements of the elderly and support exchanges of the aged with kins and others and the support system for the elderly currently exist in the country and (v) the policy implications and recommendations.

In Bangladesh, like many developing countries population ages 60 and over has been arbitrarily considered to be the aged or the elderly population (also older persons) in most of all studies made earlier, although there is no universally accepted specification of age span of years embraced by old age (Kabir, 1994). The present paper considers population of 60 years and over as the aged population or the older-persons or the elderly; also the senior citizens of the country. They are further categorized as Young-olds-those who are of age 60-69 years, Old-olds- who are of age 70-79 years and Extremely olds- aged 80 years and over. These divisions are arbitrary and *ceteris peribus*, demographic.

Forecast Ageing

In response to significant shift in fertility and mortality the pace of ageing transition in Bangladesh is certain to accelerate over the next few decades. The population of Bangladesh has already (in mid-1999) reached the mark of 127 million in which the share of the aged (population age 60 and over) is 6.35 million. As the age of total population will go up with time, the share of the elderly will also increase. A recent projection of population shows that the population of Bangladesh will be about 142.5 million in 2005 based on the estimated growth rate for the period 1991-2005 of 1.75 percent (Islam, 1999). All these estimates and projection show that the numbers and the proportion of the elderly are increasing. The projected changes for age structure involves a rise in the elderly share and decline in the youth share.

On the basis of medium variant projection made by Bangladesh Bureau of Statistics of the Government of Bangladesh (BBS, 1994; assuming NRR=1 by 2016) Abedin finds that the size of the population will continue to increase rapidly in coming years with varying sex differential in the size, aged dependency ratio will increase to nearly 27 in 2016 from 9 in 1996 per 100 working age population, ageing index will increase from 11.6 to 25.1 (during 1996 to 2016) because of decrease in the number of young population vis-à-vis increase in the number of the aged population and the sex ratio will still remain higher in favour of male elderly with a

declining tendency (from 116.8 to 107.4) indicating a tendency of outnumbering the male elderly by the female elderly (Abedin, 1996).

Quite a few studies have documented that interplay of trends in fertility and mortality has resulted in ageing of population in Bangladesh and reshaped the growth, structure and distribution of population (e.g. see Kabir, 1993; Sattar and Rahman 1993; Abedin 1995; Samad and Abedin 1998). Fertility decline seems to be the major determinant of the pace and scale of ageing in the population. The forecast ageing of population is mostly the result of reductions in birth rates and the reduced proportion of population in young age groups and is not primarily due to increase in life expectancy (Johnston, 1998) and this is both a cause and a consequence of shifts in the role and functioning of the family (Hugo, 1996). However, improvement in overall life expectancy improving the survival of the older age groups is causing the elderly as the fastest or near fastest growing age group in the population.

Status, Roles and Functions of the Aged Population in Family and Community

Status of the aged population in family/households largely depends on the type of households they live and the type of families they belong, interpersonal relationship with family/households members and between generations. The roles of the elders in decision-making depend on how much authority the elderly posses on the members of the households or on the family. However, the authority of the aged population in the family largely depends on the structure, composition and function of household and elderly status in the family and households.

A recent ESCAP report provides a better understanding of the typical household structures of elderly in Bangladesh (Samad and Abedin, 1998). It categorizes three main types of household structures (see Table 1). The first is a family of husband and wife only or of parents with unmarried children. This is defined as the nuclear family. Second, there is the joint family where related males belonging to two or three generations live together with their dependents or their wives, children of adult male members, their parents, and younger siblings. In this case, there is common residence, common property, common kitchen, and a system of mutual obligation among different members and exchange of ideas in decision making. Third, there is a system in which all paternally related members live separately in the same homestead, but are economically independent and the elders exercise authority and control over behaviors of its members. This is called an extended family and is characterized by co-residence.

As already mentioned with the pace of development and modernization in Bangladesh, close kin ties are breaking down, and there is a tendency to form nuclear families. Nonetheless, the majority of households in Bangladesh still live in a joint and extended family system with strong kinship ties.

Table 1. Percent Distribution of Households According to Type of Household, Household Structure and Household Head by Age, Sex and Residence

Household Type	Rural		Urban	
	Male	Female	Male	Female
All ages				
One Person	6.4	21.7	3.4	12.9
Nuclear	69.2	38.5	66.1	22.6
Extended	24.4	38.5	29.5	62.9
Less than age 60				
One Person	5.9	12.8	2.4	12.5
Nuclear	76.0	55.3	76.7	41.7
Extended	18.1	31.9	19.6	45.8
Age 60+				
One Person	8.8	33.3	6.3	13.2
Nuclear	35.3	16.7	37.5	10.5
Extended	55.9	47.2	56.2	73.7
Household Structure				
All ages				
One generation hh	6.3	20.5	3.9	14.5
Two generation hh	69.7	41.0	70.9	30.7
Three generation hh	24.0	38.5	25.2	54.8
Less than age 60				
One generation hh	6.0	12.8	3.0	12.5
Two generation hh	76.6	57.4	80.1	50.0
Three generation hh	17.4	29.7	17.0	35.5
Age 60+				
One generation hh	7.8	30.6	6.3	15.8
Two generation hh	35.3	19.4	46.4	18.4
Three generation hh	56.9	50.0	47.3	65.8
Household Head				
Self	81.3	47.3	87.2	52.3
Spouse	2.8	8.9	4.3	4.5
Son/ Son in-law	15.0	39.3	7.6	38.6

Source: Samad and Abedin, 1998; Tables 2.2, 2.2a, 3B.5

A moderate increase in nuclear households is also reported in a study by Amin and reflects the continuation of family formation patterns. The rise in landlessness, change in overall distribution of living arrangements, a simultaneous increase in child survival to adulthood, and a broadening availability of sons for support of elderly have counterbalanced the forces of changing lifestyles and household structure (Amin, 1998). However, she predicts that 'as fertility declines, and the dependency ratio of parents to sons increases, typical household structure will probably revert to one that is dominated by joint household' (Amin, 1998). Furthermore, Amin suggests that the family will continue to be the sole source of support for the elderly in Bangladesh even though intergenerational relationship will change. In fact, based on numerous readings, it seems that older persons can maintain their status and good relations by adjusting themselves with the changing environment.

A household strategy reported by Cain (1991) shows that 91 percent of persons aged 60 years or older live either with, or adjacent to, a mature son. The kinship network allows elderly to maintain their status in the household. This study shows that this traditional familial structure is still prevalent and serves as strong livelihood strategy. This confirms the Amin's study in which the livelihood and security of the elderly is still largely dependent on the family unit and household structure. Because, the livelihood of older persons is a function of their authority in the household, the older person depends on his contribution to the family to leverage his old age security.

Heads of households are more likely to be male than female, even as they get older. They are reported to " retain ownership of (their) land and with it a degree of authority within the household until (their) death" (Cain, 1991). Older women are more likely to report their sons to be the heads of household in both rural and urban areas (Samad and Abedin, 1998). It is possible that women who report their sons over their spouses as heads of households are widows, however this can not be determined from the data given (Table 1). None the less, the data is consistent with the Bangladesh cultural norms in which women invest their livelihood in their husbands, and their old age security in their sons.

Studies repeatedly show that older men play a strong role as household heads while older women, including widows, tend to rely more so on their sons. There are however a small number of growing female-headed households found to be 6-7% even when women who are fully supported by a non-resident household are included. Amin reports that female -headed households have implications of weakening families as a source of welfare possibly the erosion of kinship support (Amin, 1998).

Household Decision and Authority

Household decision making is indicative of older person's status and authority. The ESCAP 1998 survey reveals that high proportions of young-olds compared with old-old have a say in a range of household decision making (about 70%), with more males than females being involved (see Table 2) (Samad and Abedin, 1998).

Table 2. Percent Distribution of Elderly who have a Say in Selected Household Decision Making by Age and Sex

HH Decision Making	Age group		Sex	
	60-69	70+	Male	Female
a. Daily expenditures	72.9	27.1	66.7	33.3
b. Type of daily food to buy	74.2	25.8	65.2	34.8
c. Education of young members	72.7	27.3	66.8	33.2
d. Marriage of young members	70.9	29.1	62.9	37.1
e. Investments	71.0	29.0	64.7	35.3
f. Buying major hh items	70.8	29.2	67.1	32.9
g. Where to go for treatment when member falling ill	71.6	28.4	65.2	34.8

Source: Samad and Abedin, 1998; Table 3B.2

Table 3. Percent Distribution of Elderly According to the Person who makes Major or Most Decision in the Household, by Sex and Residence

Main Decision maker	Rural		Urban	
	Male	Female	Male	Female
No one	31.8	37.5	63.2	76.1
Self	49.6	16.1	24.8	19.4
Spouse	5.6	5.4	9.4	3.4
son	12.1	34.7	1.7	1.1
Daughter	0.9	4.5	0.9	0.0

Source: Samad and Abedin, 1998; Table 3B.3

This pattern is consistent with the Bangladeshi traditional culture in which men have greater decision making power. The 1998 ESCAP survey reports 49.6% of older males in rural areas play a dominant role in making major or most household decision. Older females from rural areas report that 34.7% of the major decision are made by their sons, and 37.5% report that no one is the main decision-maker in the household (63.2% of urban males, and 76.1% of urban females). This demonstrates valued communal decision making that occurs in many extended households (Samad and Abedin 1998).

Through young olds and particularly male aged have a say in most of the household decision making but as the main decision makers the role of urban elderly are not clear. The

implications of male and female authority in decision making of the urban elderly are uncertain, but may suggest a break down of traditional male-female roles. It may also suggest that the authority of the older populations may be challenged by changes in household composition (Table 1). Maintaining traditional household structure of authority is thus significant to the status of elderly, particularly men.

Economic Activity and Household Chores

The older persons of Bangladesh contribute not only to household structure and functions but also to economic activity, household chores and decision making including material and non-material contributions to households. They continue their adult roles until they physically can not manage.

Men and women have separate work responsibilities and economic activities. Men are mainly the breadwinners while women maintain the household and perform the non-productive work. The ESCAP survey confirms this glaring disparity between men and women in which 44.5 percent of females versus 7.6 percent of males have no income (Samad and Abedin, 1998).

Consistent with patriarchal practices and the household decision making pattern, older men are more likely than older women to be involved in economic activities. The ESCAP study also reports that in rural areas 62.5 % of male and 26.8% female elderly are the main breadwinners whereas 31.8% and 52.5% of male and female elderly respectively report their children as the main breadwinner (Samad and Abedin, 1998). Similarly in urban areas 65.7% of male and 31.8% of female elderly are observed to be the main breadwinner, while 26.5% males and 62.5% females report their sons to be the main breadwinner. Once again older women are reliant on their sons for economic and old age security.

Financial security is difficult, not only for older persons, but also for younger generations. Living in joint or extended family is a part of Bangladeshi tradition and a means to survival for the elderly. Amin explains how elderly are thus motivated to live with their children and not on their own because of difficulties in maintaining their own household. She reports that the single person households, which are primarily those of older women with an average age of 60, are considerably worse off than the rest of the population. The highest average income levels are found in nuclear extended households demonstrating the material advantages of family networks (Amin, 1998).

The Bangladesh household is managed as an economic unit in which each member has a designated task. Cain describes how the complete household as one that is intergenerational. He states that ‘the division of labour and structure of authority generate a corporate product that is greater than the sum of the constituent individual contributions’ (Cain, 1991). The division of labour allocates maintenance of the household to women and the performance of productive labour for income and capital to men. Cain offers an important point regarding to the interpretation of work and labour in the household. “In Bangladesh, certain kinds of work or work settings are, indeed perceived as undesirable”. He continues to examine the status cost of work within a Bangladeshi community such as that women are said to do ‘no work’ -meaning no

outside, or 'directly productive work'. "The inside-outside division of labour separates men and women in Bangladesh and produces a social, or cultural, devaluation of women's work" (Cain 1991).

Older persons contribute to the livelihood of their families and communities as part of the economic unit of the household. The majority of activities done by older persons in Bangladesh are agricultural work and household chores. Household tasks, described as non-income generating work, are for the most part performed by females. For older females, the survey reports that majority of them doing cooking (85.7%), cleaning (69%), and laundry (70%) and reports that their children buy the food (76.1%), pay the bills (68.9%), and take care of the property (70.8%). Because the survey conducted was a general household survey, the situation of the female elderly widow is not reported. Similarly the situation of the amount of work carried out by the daughter-in-law is not reported because she is not included in the option for "person responsible for selected household chore" (see Table 4) (Samad and Abedin, 1998).

The gaps in the household survey are significant given the mother-in-law/daughter-in-law relationships in most Asian cultures. The elderly women are considered the domestic authority of chores and household tasks; it is possible that other female members often share the burden of household chores.

Table 4. Percent Distribution of Elderly According to Main Person Responsible for Selected Household Chores by Sex

Main person Responsible (for selected HH chores)	Household chores					
	Buying food	Cooking	Cleaning	Doing laundry	Paying bills	Taking care of property
Male						
Self	10.6	3.1	5.3	38.2	95.5	30.8
Spouse	3.3	86.6	84.5	51.0	0.0	1.2
Child	78.8	8.1	7.3	6.4	4.5	65.3
Sibling	2.8	1.2	0.9	3.2	0.0	2.3
Grandchild	1.7	1.0	1.2	1.2	0.0	0.4
Female						
Self	4.2	85.7	69.0	70.1	0.0	1.8
Spouse	12.5	0.0	0.0	12.5	22.6	23.0
Child	76.1	10.6	24.6	14.3	68.9	70.8
Sibling	3.1	2.3	3.2	1.2	4.3	2.4
Grandchild	3.2	0.5	1.3	0.8	3.2	1.8

Source: Samad and Abedin, 1998; Table 3B.1

Health Status and Care

Deterioration of one"s physical well being is a natural part of ageing and is a major concern of old age. In old age some of the most common health problems in Bangladesh are stomach ache and diarrhea, followed by asthma, peptic ulcer, blood pressure, diabetes, cardiac, dental and eye problems. They also suffer from gerito-urinary disease, mental disorder and malnutrition. Blood pressure, diabetes and cardiac disease are more common chronic health conditions among urban elderly where as pain, rheumatism, anemia, and respiratory problems are more common in rural elderly. Failing eyesight is prevalent overall and many suffer from insomnia (Kabir, 1994; Sattar 1996). A general survey reports that about 79% of older persons suffered from some of these health conditions if not others, because of the ageing process and the lack of available health care facilities (Rahman 1991).

The ESCAP survey data reveal that health of overwhelming majority elderly is fair, arthritis followed by back pain are, among others, the major chronic diseases among the elderly. Old-olds (age 70+) compared to young olds (age 60-70years), females compared to males, rural elderly compared to urban elderly have great problems with functional activities like crouching, lifting, walking etc. and also the problems of activities of daily living(ADL) like walking, clothing, taking to bath and/or going to toilet, preparing medicine and so on. With regard to selected emotional condition more elderly not co-residence with child and spouse have specific emotional problems of restlessness, worry and other strain than those co-residence with child and/or spouse. The overall health status of the elderly is good and/or somewhat poor and male elderly have more problems with ADL than female elderly (see Tables 5 & 6) (Samad & Abedin, 1998).

Table 5. Percent Distribution of Elderly According to the Main Chronic Disease by Age, Sex and Residence

Main chronic	Age		Sex		Residence	
disease	60-69	70+	Male	Female	Rural	Urban
Arthritis	25.3	28.4	21.8	31.5	26.9	25.9
Back pain	17.8	13.5	13.8	19.0	12.8	20.0
High blood pressure	7.8	7.1	8.0	6.0	4.6	10.7
Dyabetes	2.2	6.5	4.9	3.5	0.9	6.8
Heart problem	4.1	6.5	5.4	4.5	1.8	8.3
Ulcer	5.6	9.0	7.6	6.0	8.7	4.9
Asthma	4.5	5.2	6.3	3.0	5.5	3.9
Other	7.8	4.5	6.3	7.0	12.3	0.5
No chronic disease	24.9	19.3	25.9	19.5	26.5	19.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: Samad and Abedin, 1998; Table 3E.3

Table 6. Percent of Elderly having problems with Specific Functional Activities (SFA) and Activities of Daily Living (ADL) by Age, Sex and Residence

Specific activities						
a. Crouching	35.5	64.5	49.3	50.7	57.1	42.9
b. Lifting something as heavy as 5kg bag of rice	36.1	63.9	47.8	52.2	55.6	44.4
c. Walking about 500 meter	36.9	63.1	53.6	46.4	54.7	45.3
d. Going up and down stairs	34.3	65.7	54.3	45.7	61.1	38.9
e. Using fingers to grasp or handle	35.8	64.1	54.3	45.7	60.7	39.3
Specific activities						
a. Walking around the house	50.7	49.3	46.6	53.4	69.9	30.1
b. Eating	48.1	51.9	40.7	59.3	74.1	25.9
C. Putting on clothes	39.4	60.6	48.5	51.5	59.1	40.9
d. Taking a bath/ going to the toilet	47.3	52.7	43.6	56.4	74.5	25.5
e. Preparing medicine	25.9	74.2	58.3	41.7	86.2	13.8
f. Using transportation to go to places	42.1	57.9	58.5	41.5	49.1	50.9

Source: Samad and Abedin, 1998; Tables 3E.4 and 3E.5

The perception health problems in terms of main chronic disease and specific activities (see Tables 5 and 6) of the male and female elderly are more or less clear. Almost equal perception in health problems by male and female elderly contradicts the speculation of Ellickson that elder women are less like by to report poor health relative to older men (Ellickson, 1998).

Another survey however reported that a greater proportion of older females reported sickness, or having suffered from one or more diseases (79% females versus 67% males). Of these, 25% have been suffering for more than ten years, the greater proportion of being female (Ibrahim, 1988). So, there is no conclusive data that women suffer more than men, except perhaps when examining mortality data.

The major causes of death among older populations in Bangladesh are suggested to be dysentery, respiratory, fever and diarrhea (Sattar, 1996). The mortality data indicates that the health status of female elderly is reportedly worse than male elderly, which is consistent with their shorter life expectancy. Hence, having adjusted for gender-specific mortality selection, gender differences in health status are still prevalent and significant. Older women report having relatively poor health to older men in each old age group (Rahman, 1994).

In addition, household structure, daily living can influence the health status of the elderly. Studies indicate that the elderly suffer from tension and anxiety for a variety of socio-psychological causes including the death of spouse, presence of an unmarried daughter of marriageable age, and increasing tendency of indifference and disobedience towards them by younger generations (Kabir, 1994). Many of the psychological ailments are also the result of changing times and cultural practices in which the elderly may have difficulty in adjusting the psychological problems that may reflect adjustment difficulties.

Loneliness and worry are serious emotional problems facing the older population, mostly young-olds and elderly women that live apart from their children and/or spouse (Samad & Abedin, 1998). Again the prevailing preference reflects for sons and tradition of children as old-age security in the Bangladeshi tradition.

Older persons living in two/three generational households and with prevailing status and roles in the families are expected to get greater care of their health problems whether physical, mental or emotional from the family members viz. spouses, children and kins in particular. The ESCAP study reveals that care and assistance provided to those elderly for the aforesaid problems are mostly by their spouses and children and also by other relatives. Male elderly themselves and/or their sons bear the medical expenses. Care are also provided for preparing meals/cooking, cleaning, reading/talking/listening daily, preparing medicine, taking to see doctor and washing/laundry occasionally. It is observed that whatever care and whenever care are needed are provided by the kins of the elderly. Mostly females are the caregivers who provide care to both male and female elderly.

Medical services are limited in Bangladesh and thus lead to greater health problems for the elderly. As a part of a vulnerable group, the older population has a greater need for, but less access to health care. The medical facilities are not adequate to meet the health care requirements of 120 million people, let alone the 7 million elderly. There is thus differential care received by those who have greater mobility, meaning men versus women, and those who are socio-economically advantaged. 75% of those that have reported having consulted a physician at one time or another report difficulty in getting proper treatment due to lack of money to pay for medicines and related expenses (Ibrahim, 1988)

Living Arrangements and Supports Exchanges

Living arrangements are the important components of the overall well-being of the elderly. While provide some indication of the amount of potential care and support available to the elderly and the degree to which these may experience loneliness, social isolation. In the absence of well-developed systems for providing social services to the elderly, the elderly must rely those with whom they live in close proximity for economic, social and physical support as their economic productivity and health decline (Domingo and Casterline, 1992)

The likelihood of living of the older persons with spouses and children are very strong in Bangladesh. Though the structure and composition of households reveal a clear indication of forming nuclear families yet the older persons seem to live mostly in three generational extended households. Most of the elderly live not only with kins of affinal and consanguinnial relations but

also with kins of fictive relation. Living arrangements with spouses and children are very strong. Co-residence of young olds with young children and old-olds and extremely olds with adult and married children is pronounced in the ESCAP survey. Kins who do not live with elderly are likely to live in the nearby location or in the same community. Thus to live with children and rotated among children's house could be the best living arrangements of the aged in Bangladesh.

The responsibility of care taking for the older population is predominately taken on by children or spouse (in the case of men). Women are burdened with increased responsibility because they, for their spouses are the primary care takers. Their children generally care for older women, particularly by their daughters. They will however still rely on their sons for financial support in the cost of care and decision making authority.

The ESCAP survey on elderly shows that negligible fractions of the aged population live alone and a large proportion live with kin, a spouse and/or children. Most of the elderly not living with a child/children are by no means isolated from their children, rather most of them have children living nearly and/or have frequent contact with children (Samad and Abedin, 1998). This reflects the continued interaction between the generations and favourable for well-being of the elderly since co-resident and nearly kin are assured to be dependable sources of assistance and support.

With regard to support exchange, the flow of support is from the elderly parents to their children since younger elderly are more likely to co-reside with children. Many elderly continue to play a parental role of providing economic and other support to dependent children thus puts pressure on the elderly to maintain economic productivity. Also, because married children will often have other kin to support (spouse, children, in-laws), they too may not be an optimum source of support for their elderly parents. Economically productive unmarried children would seem to be the best source of support.

The older persons not only receive support and from their children and kins but also provide support to their kins and sibling. Elderly also make contributions to their families in care giving, household tasks and other daily activities. The ESCAP survey shows that sweeping majority of the aged population receive physical care from their children and the elderly also provide physical care to their grand children. They help to take care of children of other relatives, help financially to their children, and give material support in the form of food, clothes and other materials to their children and siblings.

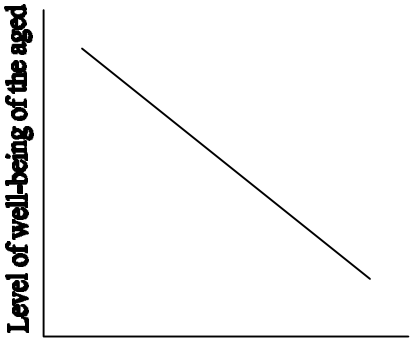
Social support should be conceptualized as a multidimensional entity and as a function of socio-economic characteristics of the elderly. Numerous investigation have suggested that social support has a major impact on the health and well being of the elderly but it is not clear how it operates. In general, those who are more privileged socio-economically such as young olds, male and urban residents tend to have more supportive social relation and exchanges. However, those who are less advantaged, such as old-old and extremely old, female and rural residents, are more dependent on the family for support. The aged populations are observed to actively engaged in exchanges of social support with their families (Samad and Abedin, 1998).

Understanding Well-being & development Interrelationship:
Three Schools of Thought

There is no consensus in the literature regarding the impact of development, economic and/or social, on the well-being of the elderly. Hugo (1991) suggests that it is possible to recognize three broad schools of thought with respect to the impact of development upon the well-being of the elderly. Hugo's viewpoint is based on the works of Cowgil and Holmes (1972), Evandrou et. al. (1986), Hunt(1978) and some others. The model as suggested by Hugo is depicted graphically here.

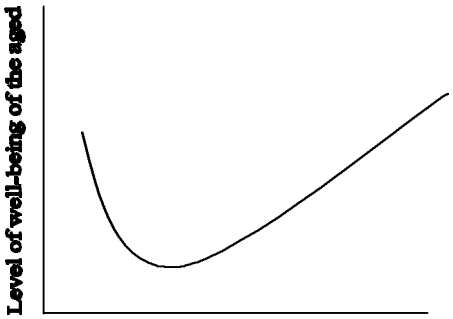
Figure 1. Model showing the Relationship between Development and Well-being of the Aged

I. DECLINE IN WELL-BEING



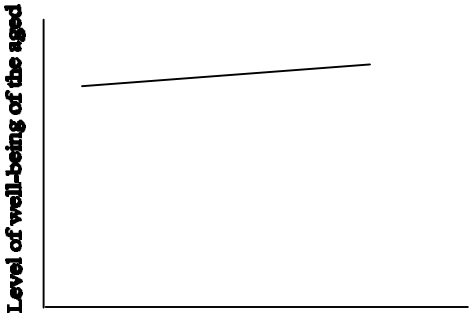
(Time and Economic Development)

II. INITIAL DECLINE FOLLOWED BY IMPROVEMENT



(Time and Economic Development)

III. LITTLE CHANGE OR STEADY IMPROVEMENT



(Time and Economic Development)

Model-I indicates the decline in the level of well-being of the elderly with time and economic development. Following the work of Cowgill and Holmes (1972), this model suggests that the status of the elderly declines with the pace of economic development. Cowgill argues that processes associated with development (e.g. industrialization, urbanization, modern health technology and mass education) results in a deterioration in the well-being of the elderly through trapping them in traditional and less well-paid jobs, separating them from families, depriving them from meaningful roles and in general lowering their status in relation to younger groups(Hermalin,1995). The relationship more or less seems to be linear.

Based on observations of Palmore and Mauton (1974) and some other researchers Heisel (1985) suggests that 'the relationship between the status and well-being of the aged and modernization may be U-shaped rather than linear'. This leads to develop Model-II which shows the U-shape relationship between the pace of economic development and the level of well-being indicating declination of the level of well-being of the elderly followed by improvement as economic development proceeds. The model represents a transition from high levels of well-being based on family support to high levels of well-being in which institutional supports are a major components. Accordingly to model, there is an intervening period of low average levels of well-being in which emerging governmental support is not sufficient to counterbalance the reduction in family based support. Essentially then this model is one in which it is assumed that formal institutional support systems gradually are developed to substitute for informal system which are weakened as social and economic change occurs (Hugo,1996).

The third model, Model-III, which is based on the European experience of intergenerational relations within families and the well-being of the older people suggests that the decline in family support with development has been exaggerated and that family support of the aged has been maintained (Evandrou et. al., 1986; Hunt,1978). The model indicates a little change and steady improvement in the level of well-being of the elderly with the pace of development reflecting the desire of the elderly for greater autonomy and freedom and their improved average economic situation which allows maintenance of an independent as long as possible (Wall, 1984;Michael et. al., 1980).

Regarding the three models Hugo (1996) points out that these are too simplified but do indicate the wide range of views which are currently held on the implications of development on the well-being of the aged and it is likely that the older generation is many countries (like Bangladesh) will not be able to count upon the degree of support from their families that has been the case. However, the model(s) is yet to test empirically in case of Bangladesh.

Support Activities

The issue of ageing population in Bangladesh is a recent phenomenon and the problems of the elderly have only began attracting attention. Very few elderly welfare programmes are available in Bangladesh. To the knowledge the support activities for the elderly that are available in the country are accounted below.

Government Programmes

1. **Formal Pension Scheme:** All males and females who retire from the government jobs after the age of 57 years get pension. There is also a formal programme available to the elite retired military personal. Only a negligible fraction of the total elderly are accounted for such pension scheme.

2. Old Age Pension Scheme: Initiated from the year 1998 the welfare project involving old people in which a pension will be awarded to the 'most aged and vulnerable ten persons from each ward under the unions of the country will be given 100 taka each per month for one year'. Of these ten, at least five to be women. About four hundred thousand elder people in the country will be benefited from this program (Khan, 1998).

3. Under the Annual Development Programme (ADP) government has planned to establish Six centers for the elderly in 6 division of the country. The main purpose of the scheme is to provide life long facility for care, protection and leading a normal life of the elders. The important part of this programme is to create environment of the Divisional Shishu Paribar's inmates with the elders of such centers with care, affection and love. The elders in turn will get opportunity to forget their loneliness by caring the children with love and affection. These centres will be called Shanti Nivas (Home for Peace)

4. The fifth five-year plan envisages alleviation of rural poverty and sets fifteen objectives to attain. The plan recognizes the need for government intervention in the area of human resources development and economic development of the poor. It also stresses institutional development at local level for implementation of pro-poor projects. The plan makes assessments of essential needs in different cycles of life and states basic support/services required. The last cycle obviously cover old age. The proposed services are creating centres for old people with facilities for light economic/ income generating activities, geriatrics medical and social welfare services for the poor and the aged (Khan, 1999).

5. A National Committee on Ageing was formed to identify the problems of the older population, but includes a government or retired government member without NGO representation. This could indicate a lack of representation of persons knowledgeable about the situation of poor older people.

Non-Government Initiatives

1 Probin Hitoishi Sangha (PHS):

Bangladesh Association for the Aged & the Institute of Geriatic Medicine (BAAIGM). PHS/BAAIGM is the prime non-government organization at national level working for the welfare of the elderly persons in Bangladesh.

The Sangha was established in 1960. It is a voluntary, non-profit, non-political, non-governmental organization registered with the Department of Social Services and Social Welfare. It is devoted to the welfare of aged persons above 55 years of age.

The services provided by this Association are:

Health Care Services: i) Free medical examination and advice, ii) All pathological services: general and biochemistry, iii) Physiotherapy treatment, iv) Eye, Ear, Nose, Throat, Dental, Cardiology and Neurology.

Recreational Socio-economic Activities: Include Indoor games, Library, Picnics, Sports, Milad, Open house, Group discussion, Eid reunion etc. to encourage exchange of ideas and increase awareness of the problems of old age, income generation activities of destitute old persons, Relief and rehabilitation during natural calamities like cyclone, tidal bore, flood, etc., specially for the affected elderly poor people.

The Shangha has already constructed a dormitory building having 52 seats under a development project with a grant from GOB for providing shelter to distressed elderly people free of cost and also to rich elderly people for a payment who have none to look after.

The organization is presently running the following programmes:

i) 50 Bed Geriatric Hospital, out-door programmes and pathological services.

ii) 50 capacity Dormitory for the elderly.

iii) Recreation and reading programmes.

iv) Vocational training and management of revolving funds.

v) Research and publication centre.

2 Elders Rehabilitation Centre, Gazipur, Bangladesh:

This organization is registered under the Department of Social Service. The organization has a land of 60 Bighas where there is an arrangement of accommodation for 500 old people. At present 50 elders (25 male & 25 female) of age 60+ are residing in this centre. They are given free accommodation, food, clothing and medi-care facilities. They are being imparted religious & general education. The elders are involved in gardening, farming, pisicultural & other recreational activities. The agency is run by a strong committee of 21 members. A private person who is holding the post of Managing Director (A.Z. Mukul) of a group of industries is giving financial assistance. The sponsor of this organization seeks no government grant.

3. RIC (Resource Integration Center)

The goal of RIC is to minimize the number of destitute, disabled, and vulnerable elders. They provide ‘community based habitation for elderly people,’ credit and medical services. Some new programs include housing grants, an elder’s club, a day care centre, monthly pension and funeral

support. Credit program helps older populations to become financially independent and to play a more prominent role in the community. Credit strengthens their role of women particularly because they have a greater need for economic sustenance. They also provide preventative and curative services with the support of Help Age International (HAI). Physicians make follow up visits at patients' homes, indicates their outreach community; and they have a strong referral system.

4 Service Centre for Elderly People (SCEP)

SCEP, a non-government organization in Rajshahi starts working for the elderly in 1994 with a slogan "A Care for the Generation'. It provides health service and recreational facilities to the older persons of age 60 and more for their social and emotional peace. Persons of age 18 and above of Rajshahi city are eligible for membership, however, elderly are the registered member. Present activities of the SCEP for the registered elderly include listening to the radio, watching television, reading newspapers, magazines, playing indoor games. Every Friday health investigation of the registered elderly is made. SCEP is a project of 'Rajhahi –Christiansand Friendship Committee' and is run by the executive body of SCEP.

5 Elderly Development Initiatives (EDI)

EDI situated in Manikgonj near Dhaka. It is a community based self-help organization has some programmes for the development of elderly in Manikgonj.

6 Bangladesh Retired Government Employees Welfare Association, Dhaka

This organization also offer medical services to members and provides welfare services to retired employees and their families.

7 Bangladesh Retired Officers Welfare Association, Dhaka

Similarly, this organization offers socioeconomic services to retired police officials and their families

8 Defense Personal Welfare Trust, Dhaka

This trust provides socioeconomic and medical services for employees of the defense.

Role of Religious Teaching & Practices:

The traditional support system for the aged now prevails in Bangladesh is:

i) Islamic Teaching, foremost among them, the Institutions of Zakat(Obligatory alone) and FITRA (a core of the Islamic Social Justice)

ii) Traditional Practices of alms giving, The Holy Quaran enjoins various principles on support to the elderly. In many verses there are explicitly commitments to show respect to the elderly, treat them kindly & give them elevated status in both family & community levels. These principles have had a far-reaching impact on traditional values and practices.

Policy Implications

From the foregoing analysis it appears that the structure and composition of families and households are undergoing a change from joint and extended multigenerational type to nuclear one. The elderly people are in problems with the changing situation of our traditional joint family system. They are becoming isolated or alienated from their kindred and as a result the aged population are left to live alone and to face socio-economic, health and emotional problems on

their own. However, still family being the basic unit of society where an individual from birth to death gets care, affection and respect and provides status and security, the traditional joint family system should be strengthened in order to keep the elderly people within their kinship network relations for providing economic and psycho-social support by their family members.

The older persons hold a special position in the family, giving and receiving support from the other family members. The Asian countries have a high regard for the unique role that the family plays in supporting older persons. The emotional, social, physical and economic supports provided by the family are indispensable and can not be replaced by other institutions. Family institution still remains strong inspite of cultural change and migratory movement. It is anticipated that the family will continue to play the critical support role in future. Policy makers and planners, community leaders as well as government should look on those forces that have adverse effect on the capacity of the family to support and care for older persons. Declining family size, the increasing number of women joining the work force, the diminishing extended family arrangements and the geographic mobility of family members are contributing factors. They reduce the number of potential caregivers within the family and the options of burden sharing. Given these changes, it becomes necessary for government to take necessary step to enhance the care-giving capability of family through appropriate programs. The programs should, as suggested in the Macau Plan of Action (held in Macau in 1998) include the following elements-(i) promotion of co-residence through housing policies and financial incentives, (ii) provision of home nursing services for the older persons, (iii) provision of facilities for care, (iv) provision of programs on counseling, professional guidance and emotional support and (v) strengthening the inter-generational relationships.

There are quite a good number of vulnerable older persons whose families are no longer able to offer support or who have not family. These groups of older persons include the destitute, the low or no income, the minorities, the displaced and disabled and person with long term medical conditions. They require direct humanitarian assistance. These groups should receive special attention and be adequately covered by the social safety net. The government should identify and assess the size of these groups and the extent to which assistance is required. The widows should get special attention to meet their special needs.

The older persons not only receive support and care from the family members-children and their kins, but also render care and support to the family members such as financial help and care to grandchildren. They are ‘only the receiver and not giver’-this notion should be dispelled. Their contribution should be recognized and should pay special tribute to their contributions. The intergenerational exchange is two-way, with all members benefiting from this process. The assistance rendered by the older person range from intangibles such as helping with childcare providing financial support for the family. These contributions, taken together, strengthen the family unit and bind the generations over the life course.

The overall level of health of older persons is not good. They are prone to age related disease. They need proper medi-care to maintain their good health. Maintenance of good health can be achieved through proper nutrition, early diagnosis, preventive care, healthy life style, including harmonious family life, health and physical education and social participation. The

promotion and implementation of these low costs, prevention-based initiatives could significantly enhance maintaining good health of the elderly.

Health needs of the older persons are multidimensional. Not only physical health but also mental and emotional health of the older persons is equally important for their well-being. A system of coordinated care need to be provided instead of person oriented intervention. Within the system measures should be taken to detect the presence of psychological emotional problems in addition to physical health and provide suitable solution. Health education program should be introduce for healthy ageing that will help understanding and create awareness about the health problems among the elderly and help adoption of a healthy life style. The elderly should be given nutritional advice to minimize dietary deficiencies and imbalances.

In Bangladesh society older persons are enormously respected and valued. The remain active in a variety of activities that have significant bearing on the cultural, social and economic life of a country and society. They have a significant presence in both formal and informal sectors. The contributions of older persons have proved to be valuable resources for the social and economic development of the country. The preparation for a productive and meaningful role at older ages should be undertaken at both the individual and the society level. At the individual level the satisfaction must be associated with personal satisfaction and fulfillment achieved through involvement in family, community and work place activities. This involvement is a life long process starts from an early age and continue to older ages. The life long preparation should include life long education and provision of equal opportunity to allow older persons to remain engaged as many social, economic and community activities as possible.

The 1994 ICPD adopted a 20 years Programme of Action in a range of population and development activities bearing in mind the crucial role that early stabilization of global population growth could play in achieving sustainable development. The programmes set forth 15 principles to guide the policies and programmes set up to achieve these objects. Almost all of these principles have direct relevance for the formulation of policies and programmes with respect to the aged. Some of these principles may be relevant for the development of appropriate programmes and policies for the aged population in our country. For principles and its relevance to aged population see Hugo (1996).

Research Needs

The situation of the elderly in Bangladesh is yet to fully understand. The research in this area is meager. Many aspects of elderly's life style, their needs and demands remain unfold. Paucity of nationally representative data makes it impossible to have a clear understanding on their livelihood and well-being. Research on these aspects is scanty. There is a need to conduct research on questions related to demographic, social, health and economic characteristic of the aged population and implications of findings for formulating public policy. There is very little information available on the well-being of the elderly population and specially whether or not the situation is improving, being maintained or deteriorating with the pace of development and modernization. Establishing the contemporary levels of well-being among the elderly and the extent and the direction of change which is occurring in it should be an important research

priority. To understand clearly the issues and challenges of the ageing of population research should be undertaken on

-- the demographic implications of population ageing
-- Social, economic and health consequences of population ageing
-- Support network for the elderly and
-- Productive ageing.

. Of all the aspects immediate research needs for the elderly people are on

-- Forecasting ageing through projections and estimates
-- Growth and structure of family pattern and status, roles and functions of the older persons
-- Care and living arrangements of the elderly
-- Co-residency and support exchanges
-- Health status and health care
-- Support system currently available and future demand
-- Violence against elderly
-- Status of elderly women who are not in marital union, distressed and deserted
-- Poverty and Ageing
-- Livelihood and well-being stratagy.

The Macau Plan of Action addresses seven major areas of concern relating to ageing and older persons in the Asia–Pacific region. These are

(a) Social position of elder persons, (b) older persons and the family (c) health and nutrition (d) housing transportation and the build environment (e) older persons and the market, (f) income security maintenance and employment; and (g) social services and the community. Specific action is recommended for each of the seven major areas of concern.

To provide factual basis for addressing issues related to changing age structures reliable data on the family and the household kinship structures and social security systems are needed. It is therefore suggested to collect demographic, social, economic and health data on all age groups through defined data collection system. Bangladesh has a long tradition of collecting data through census. Besides so many national surveys like Bangladesh Fertility Survey, Bangladesh Demographic and Health Survey, Bangladesh Agricultural Survey and the like are conducted specific to the problems. In order to understand the situation of the elderly covering the aspects stated above Bangladesh Elderly Survey is recommended.

Concluding Remarks

Population ageing is emerging as a serious issue in Bangladesh and is becoming a serious concern for the development agendas. But the country seems to be less aware of the consequences of ageing of population- might be, due to reasons that the country is now facing with more pressing issues related to population growth, poverty, malnutrition, unemployment,

illiteracy and so on. Public concern with population ageing is even more recent. Government as policy makers, and society at large, as advocators probably are not prepared right now, to respond to the newly emerging issues involving in the process of growing old, or to anticipate the different and much more complex problems with which the elderly have to cope.

The rapid ageing of population and the growing cohorts of older persons have particular implications for the development of the country indicating increasing economic dependency and rising incidence of care giving to the aged by the traditional social unit-the family. Moreover, it has endangered the societal strains in the process of determining the allocation of resources to serve the elderly in terms of social and fiscal support, health services, and income support.

The challenges posed by ageing of population are not only in the development field but also in humanitarian areas. The problems faced by the elderly are concerned with well-being and the social adjustment as well. For them the challenge lies in discovering new and innovative ways of providing necessary support for the well-being of the elderly, develop ways of exploiting their potentials and providing services to improve their quality of life(Chaklader,1997). Perhaps the greatest challenge to the ageing of population as has mentioned by Johnston(1998), is to ensure that those alive today who have made the greatest contribute to the society-the older people-are not left behind in the thrush of to a new, more individualistic set of values.

Continued comprehensive research is needed to expand our knowledge on the ageing process and on the circumstances in which ageing is taking place. Carefully conducted representative survey will provide us with a scope to understand the full range of determinants of the consequences of ageing which in turn, help formulating appropriate policies and programmes for the aged of Bangladesh.

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