

Double Burden of Disease

Double burden of communicable and non-communicable
disease in old age in South Asia



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Double burden of communicable and non-communicable disease in old age in South Asia

Learning from and improving HelpAge programmes on older people's health

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FOREWORD

Although the countries of South Asia are still young in terms of their demographic profile, their populations are also starting to age at an accelerating rate. As such, countries of the region face many challenges over the coming decades in providing adequate and appropriate health and care services to their older citizens, and the general population. While the control of communicable diseases remains a priority, in terms of older people we can expect to see increases in the prevalence of chronic and non-communicable diseases and disabilities which will place an unavoidable burden on health and social security systems, and straining the availability and affordability of long-term care.

This phenomenon has been termed the “double-burden” of disease, requiring societies in the region to adapt rapidly to the challenge of coping with a heavy and growing case-load of communicable and non-communicable disease simultaneously. And time is short to adapt. In the developed West, population ageing took much longer to develop than will be the case in South Asia. It has been said that the countries of Western Europe and North America became rich before they became old, having two to three generations to develop health, care and social security systems to meet the needs of the growing number of older citizens. In comparison, South Asia may have only one generation (25 years) to make the same adjustments.

This study, conducted by HelpAge International in collaboration with affiliates and partners in South Asia, attempts to capture and analyse the current situation in the region regarding the “double burden” challenge and provide some pointers on how some of the main issues identified can begin to be addressed by governments, the private and third sectors, donors and development institutions. I hope the study will be of interest to the broader health and care community and may help to stimulate further debate on this crucial issue.

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AUTHOR'S NOTE

The coexistence of communicable and non-communicable diseases (NCDs), also termed as the double burden of disease, has been impacting populations significantly across the world. The impact of this double burden on older population is naturally more severe. The prevalence of non-communicable diseases has been on the rise in older people with longer life spans and due to lifestyle and dietary factors as well as occupational and environmental hazards. On the same time, older people remain vulnerable to a number of communicable diseases due to poor nutrition, sanitation and hygiene.

The situation is more of a concern in South Asia where the numbers of older people are rapidly growing and while continuing to live in severe poverty and in difficult living conditions. While communicable diseases have been traditionally prevalent in the region, NCDs have also been on consistent rise making the double burden of disease very relevant in South Asia.

HelpAge and its partners' network have been seeking to understand the double burden situation by conducting a field based research to develop its capacities for future programming. This study has been a comprehensive exercise including literature research and data collection through interviews of older people and other key stakeholders. It is hoped that the outcomes guide health programmes and give a better understanding of the current situation.

The research has been led by GRAVIS, HelpAge affiliate from India, and has been supported by Help Age International - UK, Help Age International - Bangladesh, Help Age International - Nepal, Help Age International - Pakistan, Ageing Nepal, Nepal, Help Age Sri Lanka, Sri Lanka, Bangladesh Women's Health Coalition (BWHC), Bangladesh, and Bohubrihy, Bangladesh. I thank all the organizations for their sincere contributions to the research and most importantly the older people in Bangladesh, India, Nepal, Pakistan and Sri Lanka for their valuable feedback.

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1. THE BACKGROUND

Developing nations in South Asia – namely India, Pakistan, Bangladesh, Sri Lanka and Nepal have been seeing unprecedented economic growth in the past ten to fifteen years. They have also been struggling to fight the onslaught of communicable and lack of nutrition related diseases for a very long time. The double disease burden refers to the rise of communicable and non-communicable diseases (NCDs). Inefficient healthcare delivery systems and high rates of urbanization have contributed to periodic rises in communicable diseases such as tuberculosis, malaria and HIV. At the same time, as life expectancy increases in these nations, there has been a concomitant hike in the prevalence of NCDs such as cancer, diabetes and cardiovascular disease. This double disease burden is a common characteristic of such developing nations and the increasing morbidity and loss of economic activity has the risk of hampering economic growth.

NCDs such as heart disease, cancer, diabetes and lung diseases are no longer only a problem of the affluent and developed nations. These are now the leading causes of death in all the world's regions, except sub-Saharan Africa. The toll NCDs are taking (measured by years of life lost) on people aged 60 and older in low - and middle-income countries is much greater than for people in high-income countries¹.

The most common NCDs are cardiovascular diseases (including heart disease and stroke), diabetes, cancer, and chronic respiratory diseases (including chronic obstructive pulmonary disease

and asthma). The most important modifiable risk factors for NCDs are unhealthy diet, physical inactivity, tobacco use, and excessive alcohol consumption. These factors may all be affected

The World Health Organization's (WHO) World Health Report reports that:

- The number of people aged over 65 will rise from 390 million now to 800 million by 2025 - reaching 10% of the population.
- Today's global population is made up of 613 million children under 5; 1.7 billion children and adolescents aged 5-19, 3.1 billion adults aged 20-64; and 390 million over 65.
- The proportion of older people requiring support from adults of working age will increase from 10.5% in 1955 and 12.3% in 1995 to 17.2% in 2025.
- Infectious diseases still dominate in developing countries. As the economies of these countries grow, NCDs will become more prevalent.
- Diabetes cases in adults will more than double globally from 143 million in 1997 to 300 million by 2025.
- By 2025 the risk of cancer will continue to increase in developing countries.
- Worldwide, circulatory disease is the leading cause of death and disability in people over the age of 65 years.

Data sourced from:

http://www.who.int/whr/1998/media_centre/50facts/en/

¹Population Research Bureau, “**Noncommunicable Diseases Among Older Adults in Low- and Middle-Income Countries**”, Today's Research on Aging, No 26, August 2012; available on the website : <http://www.prb.org/Publications/Reports/2012/noncommunicable-diseases-older-adults.aspx>

by lifestyle choices that are often influenced by economic development and urban living. A number of interrelated trends have led to the growing burden of NCDs in low- and middle-income countries. These include a decline in the share of deaths from infectious disease due to improvements in nutrition, public health, and medicine; longer life expectancies as more children survive into adulthood; and population aging, as women have fewer children and older people represent a greater proportion of the total population. This shift in disease patterns is characterized by a decline in deaths from infectious diseases of childhood and an increase in NCDs of adulthood, known as the epidemiological transition.

These changes reflect advances in socio-economic development and progress in battling the most virulent infectious diseases. But the unprecedented pace of population aging is helping to fuel the growing burden of NCDs in low- and middle-income countries. While high-income countries have had many years to adjust as the proportion of older adults doubled, countries such as China, India and Thailand have experienced that shift in less than one quarter the time. The challenges facing low-resource countries confronting demographic and epidemiological transitions is great, and the data needed to make important decisions is only now becoming available.

Population Ageing² is an inevitable outcome of a positive demographic trend resulting from a continuous decline in fertility and rise in life expectancy leading to changes in the population age structure where the proportion of elderly increases. Population ageing and life expectancy continues to increase throughout most of the world as both death rates at older ages and fertility rates decline. The risk of early mortality has been reduced successively, through improvements in the occupational environment and advances in medicine. But the looming question remains about how countries will be looking after this ageing population. Questions about public expenditure on the increasing healthcare of the aged are pertinent to the financial stability of national budgets. As a higher number of persons fall into the age bracket of 60 and above, they also become relatively heavy users mainly of primary healthcare, and secondary and tertiary healthcare too.

WHERE DO THE OLDER PERSONS LIVE ?

According to the Department of Economic and Social Affairs of the United Nations (UNESA)³, the world's older population presently stands at around 760 million. Asia accounts for more

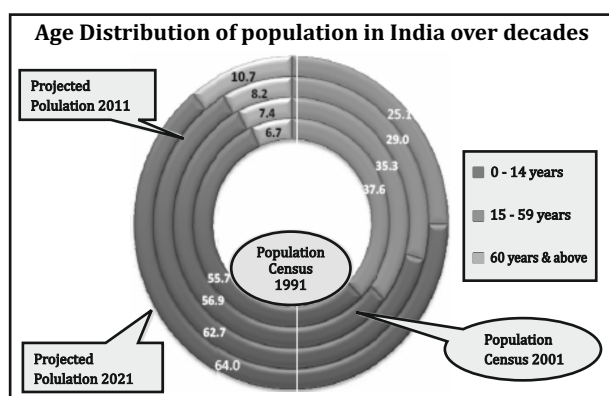
²Abeykoon, Dr A.T P.L., “**Population Aging in Sri Lanka: Challenges and Opportunities**”, Institute for Health Policy, available on website:

<http://www.cacci.org.tw/upload/13-ATPLAbeykoonPP167-174.pdf>

³Department of Economic and Social Affairs, United Nations, “**Current Status of the Social Situation, Well-Being, Participation in Development and Rights of Older Persons Worldwide**”, New York, 2011 – available on the website: <http://www.un.org/esa/socdev/ageing/documents/publications/current-status-older-persons.pdf>

than half of the total (414 million) including 166 million in China and 92 million in India). In 2005, 52% of the world's older population lived in urban areas with roughly equal proportions residing in less developed and more developed regions. However, the rural areas of the less developed regions were home to nearly 40% of the world's older population while only 10% lived in rural areas of the more developed regions. UNESA report further states that older men in the world are married, while older women are not, due to higher life expectancy of older women. Marital status affects the socio-economic wellbeing of older men and women. Further, around three quarters of those aged 60 years and above in the less developed regions live with children and/or grandchildren. In most of these households the older men are regarded as the head of the household.

Across Asia, the number of people aged 65 and above is expected to grow dramatically over the next 50 years. According to the Asia Society⁴, “for the region as a whole, the population in this age group will increase by 314% - from 207 million in 2000 to 857 million in 2050”.



The **Indian aged population** is currently the second largest in the world. Almost eight out of ten people in India live in rural areas. About 7.6% of India's population is over 60 years; this figure is expected to reach 18.84% in 2025. In India, the decadal growth rate for 1991-2001 in the age group 0-14 was only 6.7% while that of 60+ populations was 78.4%⁵. Half of the Indian elderly are dependents, often due to widowhood, divorce or separation, and a

majority of the elderly is women (70%). Of the minority (12.4%) of the elderly living alone, more are women (3.4%) than men (1.42%). The southern states in India are considered the biggest drivers of aging in India. However, other states such as Haryana, Himachal Pradesh, Maharashtra, Orissa and Punjab are also experiencing an elderly population boom, largely in rural areas⁶.

⁴sites.asiasociety.org/asia21summit/.../Asias-Aging-Population-East-West-Center1.pdf

⁵Desai, Nimesh G., Om Prakash and Vijender Singh, “Ageing and Mental Health in India: A Wakeup Call”, Helpage India Research & Development Journal, Volume 16- No.1, January 2010 – available on the website : http://www.helpageindia.org/helpageprd/index.php?option=com_publishing&view=articlesearch&Itemid=10

⁶Dev, Subhojit, Devaki Nambiar, J. K. Lakshmi, Kabir Sheikh, and K. Srinath Reddy, “Health of the Elderly in India: Challenges of Access and Affordability” in National Research Council. (2012). *Aging in Asia: Findings from New and Emerging Data Initiatives*. J.P. Smith and M. Majmundar, Eds. Panel on Policy Research and Data Needs to Meet the Challenge of Aging in Asia. Committee on Population, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press, 2012 – available on the website: <http://www.ncbi.nlm.nih.gov/books/NBK92618/>

In **Sri Lanka**, as in other developing countries, the rapidity of population ageing continues to outpace social and economic development. The current proportion of the elderly in the population (persons aged 60 years or above) is 9% and increasing⁷. Declining fertility rates and mortality rates and pronounced gains in longevity since the 1950s has led to an increase in the population (over 60 years of age) from 5.4% in 1946 to 10% in 2001, and projected to be 22% by 2033⁸. The Sri Lankan elderly have traditionally depended on the family as the main caregivers and support base. However, this feature can't be expected to continue. According to Department of Social Services records over the last two decades, the number of institutionalized elderly has increased considerably in Sri Lanka in urban areas and the number of old age homes nationwide has increased from 68 (1987) to 162 (2003).

Bangladesh is soon projected to experience a doubling of its elderly population (Biswas, *et al*, 2006)⁹. Bangladesh, with one of the highest population densities (985/km²) in the world, is projected to experience a dramatic growth in the absolute number of its population aged 60 years or older from the current level of approximately 7 million to 14 million by 2020 (WHO, 2005 in Biswas, *et al*).¹⁰

NCDs have already become the largest health burden in **Nepal**, accounting for 60% of lives lost due to ill health, disability and early death (World Bank report – '*Capitalising on Demographic Transition, Tracking Non-Communicable Disease in South Asia*'¹¹). The burden of NCDs will proportionately rise in the future, in particular due to further ageing of the population with 5.8% of the population expected to be over the age of 65 by 2025.

⁷ Ministry of Social Services & Social Welfare and WHO Country Office Sri Lanka, "**Sri Lanka- Healthy Ageing**", Colombo, December 2009 available on the website :
http://www.whosrilanka.org/LinkFiles/WHO_Sri_Lanka_Home_Page_Healthy_Ageing.pdf

⁸ Siddhisena, K.A.P., "**Socio Economic Implications of Ageing in Sri Lanka: An Overview**", Working Paper No. WP105, Oxford Institute of Ageing, United Kingdom, October 2005 available on website:
http://www.ageing.ox.ac.uk/files/workingpaper_105.pdf

⁹ Biswas, Priti, Zarina Nahar Kabir, Jan Nilsson and Shahaduz Zaman, "Dynamics of Healthcare seeking behavior of Elderly People in Bangladesh", International Journal of Ageing and Later Life, 1(1): 69–89, 2006 available on website:
<http://www.ep.liu.se/ej/ijal/2006/v1/i1/a4/ijal06v1i1a4.pdf>

¹⁰ *ibid*

¹¹ Double Whammy for Nepal – World Bank report says heart disease cases rising", 9th February 2011, available on website:
<http://www.ekantipur.com/the-kathmandu-post/2011/02/09/top-story/double-health-whammy-for-nepal/218235.html>

Pakistan's demographic trends show that between 1990 and 2010, the 60+ population numbers increased by 75.1%¹². In 1998, Pakistan's older population was estimated at 5.6% of the population. It will probably double to 11% by the year 2025. Pakistan's life expectancy increased from 45.6 years in 1950 to 66.8 years in 2008. Driving this change is the decreasing under-five mortality rate, though not as rapidly as desired. Most of this decline is due to increased control of under-nutrition and infections. In today's Pakistan, fertility has started declining and life expectancy of older people has been increasing, and it is expected that in future both these processes will gain momentum, resulting into a many-fold increase in the population of elderly people (Jalaal and Younis, 2011)¹³.

PROVISION OF HEALTHCARE FOR THE ELDERLY

Among older people, NCD's already account for most deaths and the bulk of the disease burden, even in low income countries. In 2004, NCDs caused an estimated 86% of deaths among persons aged 60 years or above worldwide and accounted for 77% of deaths in low income countries, 89% in middle income countries and 91% in high income countries. Timely availability of healthcare services and a life of dignity are the most important requirements for elderly persons across the world – and more so in South Asia. A

Among older people, NCD's already account for most deaths and the bulk of the disease burden, even in low income countries. In 2004, NCDs caused an estimated 86% of deaths among persons aged 60 years or above worldwide and accounted for 77% of deaths in low income countries, 89% in middle income countries and 91% in high income countries.

healthy nation is the key and a key promoter of economic growth and social progress. Older individuals in good health enjoy a greater sense of personal well being and can participate more actively in the economic, social, cultural and political life of society. The Madrid International Plan of Action on Ageing (MIPAA)¹⁴ - adopted in 2002 - responded to opportunities and challenges of an ageing global population so as to promote the development of a society for all ages. It aimed to “ensure that persons everywhere are able to age with security and dignity and continue to participate in their societies as citizens with full rights”.¹⁵

¹² Gapminder. [Internet]. 2011 [Accessed Sept 30th 2011]. Available from: <http://www.gapminder.org/data/> in Jalaal, Sabeena and Mustafa Z. Younis, “Aging and Elderly in Pakistan”, Ageing International, DOI 10.1007/s12126-012-9153-4. Published online on 04 August 2012. Available on website: http://www.academia.edu/1854670/Aging_and_Elderly_in_Pakistan

¹³ Jalaal, Sabeena and Mustafa Z. Younis, “Aging and Elderly in Pakistan”, Ageing International, DOI 10.1007/s12126-012-9153-4. Published online on 04 August 2012. Available on website: http://www.academia.edu/1854670/Aging_and_Elderly_in_Pakistan

¹⁴ <http://www.unescap.org/sdd/issues/ageing/mipaa.asp>

¹⁵ Ibid

According to the UN – Department of Economic and Social Affairs (2011)¹⁶, *“the twentieth century witnessed an unprecedented decline in mortality. Between 1950 and 2005, the chances of surviving to old age improved substantially in all world regions”*. However, it is true that to a large extent most of these people don't have access to regular healthcare services and/or a life led with dignity. According to the WHO (2004), *“success in controlling communicable diseases has led both to lower mortality and to a shift in the major causes of death, as the share of deaths from NCDs such as cardiovascular diseases, stroke and cancer have come to account for a greater proportion of the total”*.

For the countries in South Asia, familial care of older persons is a deep rooted social norm. Caring for older people has been a moral obligation of children and as a result only a small proportion of older people in the region live alone. However, with changing family structure and composition, and in the face of urbanization, industrialization, migration and the increasing trend towards nuclear families coupled with declining fertility and increasing longevity, the ability of families to take care of older persons is gradually declining. The extent to which the family will remain the primary source of care for older persons will have important implications for formal arrangements for the care of older persons.

In India, according to Rajan (2006)¹⁷, a majority of the elderly suffer from diseases like cough (includes tuberculosis of the lungs, bronchitis, asthma, and whooping cough as per the International Classification of Diseases), poor eyesight, anaemia, dental problems, arthritis and loss of memory. He further goes on to say that functional disorders precede organic disorders which become frequent beyond seventy. To exacerbate the problem, there was found to be dissatisfaction among the elderly with respect to the provision of medical aid and that sick elderly lacked proper familial care, while public health services were insufficient to meet the health needs of the elderly.

Further, Dey, et al (2012)¹⁸, say that the elderly mostly suffer from cardiovascular illness, circulatory diseases, and cancers while the non-elderly face a higher risk of mortality from

¹⁶ Department of Economic and Social Affairs, United Nations, **“Current Status of the Social Situation, Well-Being, Participation in Development and Rights of Older Persons Worldwide”**, New York, 2011 – available on the website: <http://www.un.org/esa/socdev/ageing/documents/publications/current-status-older-persons.pdf>

¹⁷ Rajan, Irudaya S, **“Population Ageing and Health in India”**, Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai, July 2006 – available on website: <http://www.cehat.org/humanrights/rajan.pdf>

¹⁸ Dey, Subhojit, Devaki Nambiar, J. K. Lakshmi, Kabir Sheikh, and K. Srinath Reddy, **“Health of the Elderly in India: Challenges of Access and Affordability”** in National Research Council. (2012). ***Aging in Asia : Findings from New and Emerging Data Initiatives***. J.P. Smith and M. Majmundar, Eds. Panel on Policy Research and Data Needs to Meet the Challenge of Aging in Asia. Committee on Population, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press, 2012 – available on the website: <http://www.ncbi.nlm.nih.gov/books/NBK92618/>

infectious and parasitic diseases, thus displaying that India's accelerated demographic transition has not been accompanied by a corresponding epidemiological transition from communicable disease (CD) to NCDs. Dey, et al (2012)¹⁹, go on to say that *“the mixed disease burden among the Indian elderly places unique demands on the country's public healthcare system”*.

As is in the case of India, even in the rest of the South Asian countries, social determinants of health are critical. Recent studies show an increased feminization of the elderly population as more women report to be in poor health as compared to males, and yet a far greater proportion of men are hospitalized as compared to females. In addition to gender and marital status, religion, caste, education, economic independence, and sanitation have a bearing on elderly health. The stigma of aging as well as the health and social conditions the elderly commonly face (such as dementia, depression, incontinence, or widowhood) is another social barrier to access of health.

Table: Frequency (prevalence per 100 people) of 9 individual chronic health conditions used in defining multi morbidity by sex in Bangladesh²⁰

Chronic health condition	Total population		Men (n=204)		Women (n=248)		P value*
	No.	%	No.	%	No.	%	
Arthritis	260	57.5	113	55.4	147	59.3	0.231
Hypertension	175	38.7	74	36.3	101	40.7	0.192
Impaired vision	161	35.6	8	3.9	153	61.7	<0.0001
Signs of thyroid hypofunction	48	10.6	18	8.8	30	12.1	0.166
Obstructive pulmonary symptoms	31	6.9	27	13.2	4	1.6	<0.0001
Symptoms of heart failure	21	4.6	13	6.4	8	3.2	0.088
Hearing impairment	11	2.4	2	1.0	9	3.6	0.062
Obesity	11	2.4	3	1.5	8	3.2	0.186
Stroke	4	0.9	1	0.5	3	1.2	0.388

* p value is for the test of difference between men and women

In the study conducted by Khanam et al (2011), in Bangladesh, it was found that among individuals in urban areas, medical conditions, arthritis and hypertension were the most

¹⁹ Dey, Subhojit, Devaki Nambiar, J. K. Lakshmi, Kabir Sheikh, and K. Srinath Reddy, **“Health of the Elderly in India: Challenges of Access and Affordability”** in National Research Council. (2012). ***Aging in Asia : Findings from New and Emerging Data Initiatives***. J.P. Smith and M. Majmundar, Eds. Panel on Policy Research and Data Needs to Meet the Challenge of Aging in Asia. Committee on Population, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press, 2012 – available on the website: <http://www.ncbi.nlm.nih.gov/books/NBK92618/>

²⁰ Khanam, Masuma Akter, Peter Kim Streatfield, Zarina Nahar Kabir, Chengxuan Qiu, Christel Cornelius and Ake Wahlin, **“Prevalence and Patterns of Multimorbidity among Elderly People in Rural Bangladesh: A Cross-sectional Study”**, Journal of Health, Population and Nutrition, Aug;29(4):406-414, Centre for Control of Chronic Diseases in Bangladesh, August 2011 available on website: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3190372/>

common conditions. The prevalence of hypertension was higher in the non poorest quantities, but was only of borderline significance.

In a study conducted by Bisht, *et al* (2012)²¹ in Nepal, it was found that most elderly live with their children and/or grandchildren along with their spouses. Physical pain, respiratory problems, eye problems, gastric problems, blood pressure and dementia/Alzheimer's are the major health problems of the elderly, and most of them have had these problems for up to 5 years. The elderly are also found to be getting diagnosed by a doctor/health worker and most of them are doing/taking regular treatment/medicine. Some elderly were also observed with disabilities and the majority has hearing, visual and physical disabilities. Anxiety/stress, boredom and loneliness are the major mental health problems of the elderly. More elderly females than males have mental health problems.

In Pakistan, a newspaper article in Dawn (2011)²² stated that as per a report prepared by the provincial health department "the demographic changes in Pakistan were most prominent in urban areas and the urbanisation rate had grown steadily from 17.8% in 1951 to 37% in 2010". The burden of NCDs has overtaken maternal, newborn and child health and the communicable disease burden in Pakistan and is on the rise in Sindh. NCDs currently account for 59% of diseases in Pakistan, while the proportion for Sindh is expected to be even higher as it has the largest concentration of urban population among all the provinces.

The only population-based survey on NCDs was conducted in the mid-1990s showing unexpectedly high levels of NCDs - and the incidence had risen since then, said the report. In the same report it was stated that the incidence of chronic illnesses rises with age, requiring medical care. Fatigue, mobility impairment, dyspnoea, urinary incontinence and visual impairment had the worst impact on the life of the aging individual. Diabetes mellitus (28.1%), hypertension (42.5%), and arthritis (26.6%) were the most frequently reported chronic ailments. A large number of elderly people had religion (61.4%), reading (36.1%), socializing (53%) and watching television (49.5%) as a regular activity. Eighty-five (21.1%) of respondents reported having financial problems (Zafar et al. 2006).

²¹ Bisht, Dr. Prem Singh, Dr. Ram Sharan Pathak, Dr. Govind Subedi, Dhanendra Veer Shakya and Krishna Murari Gautam, **"Health and Social Care Needs Assessment of Elderly: The Context of Piloting Service Developments and Care of Elderly in Pharping, Kathmandu, Nepal"**, Central Department of Population Studies, Tribhuvan University and Ageing Nepal, United Nations Population Fund (UNFPA), Kathmandu, August 2012 - available on website:

<http://www.ifa-fiv.org/wp-content/uploads/2012/12/ReportElderlyNepal.pdf>

²² Dawn, **"Sindh yet to tackle non communicable diseases challenge"**, Karachi June 2013, available on website: <http://x.dawn.com/2013/06/12/sindh-yet-to-tackle-non-communicable-diseases-challenge/>

FINANCIAL AND ECONOMIC IMPLICATIONS OF AN AGEING POPULATION

Population ageing could have profound implications for the economies as well as societies experiencing a rapid increase in the share of older persons in the total population. While the rising demand for medical services in old age and high medical costs could impose pressure on governments and family budgets, an ageing population could lead to a drastic shift in the consumption and savings behavior of people²³. On the supply side, the share of the working age group is expected to drop; on the demand side there will be a growing demand for labour intensive services such as old age healthcare and institutional, social and home care services during the next 50 years. Ageing will have a negative impact on savings as retirement benefits are inadequate, hence greater consumption of savings and ultimately contraction of investment in these countries. Older persons are often afflicted by poverty owing to a host of factors including lack of skills or skill mismatch, lack of resources, ill health and social prejudices. This is particularly pronounced amongst the rural elderly, in particular older women.

Affordability is another question that needs to be addressed in an urgent manner. Most of the South Asian countries do not have a promising mechanism of ensuring social security for the elderly or persons post-retirement. In all the countries listed in this report, a high proportion of the population will have to work as long as possible so as to support themselves. In India, employer insurance and pension schemes are available only to as low as 9% of rural males and 41.9% to urban males who are in the formal sector; among females, the figures are lower still – 3.9% of rural women and 38.5% of urban women (Dey, et al, 2012)²⁴. Medical insurance is not enough as it does not cover most persons, as well entire range of medical needs. The National Family Health Survey 2004-05 indicates that only 10% of households in India had at least one member of the family covered by any form of health insurance. For those who have it, it does not cover out-patient treatments and drug purchases. Last but not the least; insurance companies often explicitly exclude the elderly due to age limits or eligibility restrictions for those with pre-existing conditions.

²³ United Nations – Economic and Social Commission for Asia and The Pacific, '**Economic and Social Survey of Asia and The Pacific – 2005: Dealing with Shocks**' – Chapter 3: '**Dynamics of population ageing: how can Asia and the Pacific respond?**' Thailand, 2005 – available on the website: http://www.unescap.org/pdd/publications/survey2005/9_Survey05_Ch-III.pdf

²⁴ Dey, Subhojit, Devaki Nambiar, J. K. Lakshmi, Kabir Sheikh, and K. Srinath Reddy, "**Health of the Elderly in India: Challenges of Access and Affordability**" in National Research Council. (2012). ***Aging in Asia: Findings from New and Emerging Data Initiatives***. J.P. Smith and M. Majmundar, Eds. Panel on Policy Research and Data Needs to Meet the Challenge of Aging in Asia. Committee on Population, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press, 2012 – available on the website: <http://www.ncbi.nlm.nih.gov/books/NBK92618/>

According to Siddhisena (2005)²⁵, in Sri Lanka it is difficult to separate health expenditure for the elderly from general health expenditure budgets since the government provides free medical treatment for all who need it irrespective of age. However, more and more Sri Lankans are becoming conscious of ill health over time and more ready to use medical services when ill. Age-sex specific rates of utilisation of medical services have increased substantially in Sri Lanka since the 1920s, even whilst the population's health status has been improving (Rannan, 2007)²⁶.

Table : Calculation of personal medical service expenditures by age for 2005²⁷

Age group (years)	Share of population	Public outpatient costs (Rs. M)	Public admission costs (Rs. M)	Private outpatient expenditures (Rs. M)	Private admission expenditures (Rs. M)	Total expenditures (Rs. M)
0-14	25%	4,896	5,541	9,376	2,209	22,022
15-59	65%	9,920	17,810	18,995	7,099	53,824
60-74	8%	2,199	3,920	4,211	1,562	11,892
75+	2%	644	1,056	1,234	421	3,355
All	100%	17,659	28,327	33,816	11,291	91,093

Siddhisena (2005)²⁸, states that as per current distribution, most expenditure in Sri Lanka are no longer for CDs but for NCDs, including injuries. With an ageing population, the spending on NCDs is likely to increase substantially. Spending on cardiovascular diseases will increase from 7.6% to 11.4%; for diabetes from 2.5% to 3.4% and on chronic respiratory diseases from 8.7% to 9.5% by 2050. On the other hand, these projections also show that the share of spending on cancer may actually not increase that much.

Projections in the same study state that there are three different scenarios concerning the future trend in the public/private share of medical care provision. All the scenarios assume that the health system will evolve to reach its final state by 2040, when the final public/private share of provision will be realized. After 2040, it is then assumed that these shares will not change. The choice of a 40 year end point is based on the assumption that when Sri Lanka reaches a level of economic development comparable to an upper middle income economy today, it will have largely decided upon the type of health care system that it wants. Each scenario therefore represents different assumptions about the long term strategy for public sector provision.

²⁵ Siddhisena, K.A.P., "Socio Economic Implications of Ageing in Sri Lanka: An Overview", Working Paper No. WP105, Oxford Institute of Ageing, United Kingdom, October 2005 available on website : http://www.ageing.ox.ac.uk/files/workingpaper_105.pdf

²⁶ Ravi P. Rannan-Eliya and Associates, "Population Ageing and health Expenditure: Sri Lanka 2001-2101", Institute for Health Policy, Colombo, March 2007 available on the website : http://www.un.org/en/development/desa/policy/wess/wess_bg_papers/bp_wess2007_srilanka.pdf

²⁷ Ibid

²⁸ Ibid

Bangladesh (too) has a tradition where financial support is extended for the elderly. In 1997 the Government of Bangladesh started a programme for the poor elderly – the Old Age Allowance Programme (OAAP). In addition to this OAAP, the government has another assistance programme for widows and destitute women. The government has also built old age homes in each of the six administrative areas of the country called “homes of peace” – to accommodate 500 older persons. Changing work and living habits have forced many elders to be neglected – emotionally and physically, leading to abandonment in some cases.

A major deterrent factor hindering access to health care is financial constraints, as shown, for example, in Pakistan, where 76% of personal expenditure goes on out of pocket expenses.

POLICY INITIATIVES

The **Indian government** has taken significant steps since the endorsement of the MIPAA. It has instituted a National Policy on Older Persons (1999) and a few States have a State Policy on Older Persons too. Other acts such as the Maintenance and Welfare of Parents and Senior Persons, 2007, and Grant-in-Aid Schemes, National Old Age Pension Schemes, concessions on facilities to senior citizens, free legal aid, setting up of geriatric centres, special rebates under the Income Tax Act, higher rates of interest for savings in bank accounts and investment schemes and the like, have been put in force.

In **Sri Lanka**, the government has set up the Protection of the Rights of Elders Act (Number 9 of 2000), which is a breakthrough in the history of services for elders in Sri Lanka. The Act made provision for the establishment of a National Council for Elders, a National Secretariat for Elders, a National Fund for Elders and a Maintenance Board for Elders. The National Charter and National Policy on Elders were adopted by the Cabinet in 2006. The National Secretariat, in collaboration with the WHO, formulated the National Plan of Ageing in 2010. The plan was developed in line with the priority areas and strategies of the National Policy. Activities, timeframes and responsible partners were identified in line with the priority areas and strategies. Elder's Committees have been established all over the island at different administrative levels, including provincial, district, and division and Grama Niladari levels. Apart from this, Day Care Centres, home care services and legal aid provisions for the elderly have been put in place.

In **Bangladesh**, the National Committee on Aging was constituted for the first time after the Vienna International Plan of Action on Aging in 1982 (Khan, 2009)²⁹. The Committee allocated fund to the Bangladesh Association for the Aged and Institute for Geriatric Medicine (BAAIGM). The state otherwise has paid attention towards welfare of the elderly in the country through the National Health Policy, Health Nutrition and Population Sector

²⁹ Khan, Mehedi Hasan, “Policy Responses to the Emerging Population Ageing in Bangladesh: A Developing Country's Experience”, available on the website : <http://iussp2009.princeton.edu/papers/91324>

Programme adopted in 2003. The National Policy on Ageing was adopted in line with the MIPAA and received ministerial approval in 2007³⁰. The National Social Welfare Policy formulated in 2004 has laid emphasis on elderly issues too.

Bangladesh's Ministry of Social Welfare has finalized the National Policy for Elderly People. This policy includes the provision of social security, health care services, financial security, a national awareness programme, coordination between older persons and the new generation, but there is not enough emphasis on developing care support for the elderly in the future. The Revised Programme Implementation Plan (July 2003 – June 2010) of the Health, Nutrition & Population Sector Programme of the Government of Bangladesh mentions the possibility of developing a strategy for meeting the health care needs of senior citizens.

In **Nepal**, the Directive Principles of the Interim Constitution of Nepal 2006 (2063 Nepali fiscal year) outline that the State shall pursue the policy of making a special provision for education, health and social security and for the protection and progress of children, the helpless, women and the old, disabled and weak. Moreover, the Civil Code has provisions for elderly people in its section on property rights. The Local-Self Governance Act - 1999, carries the provision for the protection and development of orphans, the helpless, women, older people and the disabled (Dhakal, 2012)³¹.

A separate sectoral policy for the elderly was first developed in the ninth five-year plan. Various programmes have been launched for the welfare of the elderly. Recently, the Ministry of Health and Population (MoHP) conceptualized an ageing survey to explore the various issues for evidence-based planning for the elderly. Moreover, the MoHP has also conceptualized specialized geriatric programmes and home visits for the welfare of the elderly and expanded the advocacy programme all over the country through local-level population management programmes.

Pakistan's National Policy - In 1999, the government designed a National Policy for the Promotion of Better Health of the Elderly. This policy incorporated training of primary care doctors in geriatrics, availability of dental care, domiciliary care, and a multi-tiered system of health care providers for the elderly including physical therapists and social workers.

³⁰ Country Report of Bangladesh in the '**High-Level Meeting on the Regional Review of the Madrid International Plan of Action on Ageing (MIPAA)**' during 9-11 October 2007 in China. Available from: <http://www.unescap.org/esid/psis/meetings/AgeingMipaa2007/Bangladesh.pdf>; quoted in Khan, Mehedi Hasan, "**Policy Responses to the Emerging Population Ageing in Bangladesh: A Developing Country's Experience**", available on the website: <http://iussp2009.princeton.edu/papers/91324>

³¹ Dhakal, Megha Raj, "**Ageing and Health in Nepal**", Regional Health Forum – Volume 16, Number 1, 2012 available on the website: http://www.searo.who.int/publications/journals/regional_health_forum/media/2012/rhf2012v16n1p12.pdf

2. THE STUDY

A. BACKGROUND AND OBJECTIVES OF THE STUDY

The need to undertake community-based research on older people's health needs and the impact of the double burden of disease has been felt for a long time within the Help Age network. Other research may have focused on the double burden in South Asia, but with a greater focus on country level data, a lack of attention on remotely located communities and with little cognisance of ground work that is going on. Given this information gap, Help Age International planned this study in 5 South Asian countries in the SAARC region, namely Bangladesh, India, Nepal, Pakistan and Sri Lanka.

It was envisaged that the research findings will provide evidence to support the development of regional health advocacy work. It will be of great use as the Help Age network progresses further with its health work, especially baring in mind the growing prevalence of NCDs in the developing world, in addition to the historical existence of infectious diseases. For the South Asia region where the research is proposed, the number of older people is rising and is set to increase significantly over the next decade. The “double burden” is clearly a major health and socio-economic challenge. Ageing and development within communities will have a greater link in future with the growing double burden of disease and, therefore, the research will connect itself to other parts of older people's lives and interventions focusing on their needs.

The research assessed the social impact of the “double burden” of communicable and non-communicable disease for older people in 5 countries in South Asia, with the following objectives:

- To collate, review and analyse all available secondary data on the double burden of communicable and non-communicable diseases
- To develop a profile of existing programmes of work and experience from HelpAge and partners addressing or facing issues of the double burden and the impact it is having on older people in South Asia
- To identify key areas for future work/research and collate good approaches and lessons learned to develop new and inform existing programmes of work

The overall expected outcome of the study would be that:

The South Asia HelpAge network will have an understanding of the context of the double burden in the communities we work with in the region, the impact it is having and to be able to develop better-informed health programming and advocacy work.

The three main areas where the research will be used are:

- To build capacity and awareness of agencies working for the improvement in the health of older people

- To use the findings to influence policy makers and donors to increase resources available for health care of the elderly
- The findings will also be a good resource for global-level advocacy work on NCDs being driven by HelpAge International.

The study report will be shared with the following audience groups:

- Health practitioners, para-medics and medics
- NGOs working on ageing and health
- Government stakeholders
- Donors/policy makers

B. STEPS IN THE RESEARCH AND IMPLEMENTATION ARRANGEMENTS

The preliminary plans were made in consultation with GRAVIS (HAI affiliate from India and proposed lead organization for the research), HAI Head Office health team, HAI South Asia Regional Office and Country leads from all five countries to be researched.

It was planned to conduct the research through the following steps :

- Desk review of secondary data and literature relevant to the five countries involved.
- Data collection in the five countries including: (i) programme review of work around NCDs and CDs and lessons learnt to date in relation to the double burden and (ii) community level survey/interviews/focus group discussions with partners and local health authorities/older people and their families in the five countries. A total of 1,000 older people (200 per country) were to be interviewed
- Data collation and analysis
- Write-up, review and edits
- Final report to be produced and disseminated

C. RESEARCH PARTNERS

The following organisations supported the research in the different countries :

- Bangladesh - Help Age International Bangladesh, Bangladesh Women's Health Coalition, and Bohubrihy.
- India - GRAVIS (lead organization)
- Nepal - Help Age International Nepal and Ageing Nepal
- Pakistan - Help Age International Pakistan
- Sri Lanka – Help Age Sri Lanka

In addition, HAI Head Office health team guided the research study and the HAI South Asia Regional Office coordinated progress of the work.

3. THE LEARNING

The data collection process was discussed with all research partners. The desk review of county level data and literature was organized by the GRAVIS team. Valuable support in the country level data research was obtained from all partners in the different countries.

Field visits by the GRAVIS researcher were made to 3 countries - Bangladesh, Nepal and Sri Lanka. A total of 1,000 older people were interviewed through a survey questionnaire. A total of 22 Focus Group Discussions (FGDs) were organized in all 5 countries involving 327 older people. Visits to hospitals, healthcare centres, research institutes and government ministries and department were made in Bangladesh, India, Nepal and Sri Lanka. 17 interviews with medical personnel, government representatives and policy makers were conducted to consult expert opinion. The data collection process in Pakistan was organized in communication with the local HAI team.

A. COUNTRY PROFILES

Bangladesh

Bangladesh is a fertile alluvial plain on the delta of three main rivers, the Ganges, the Brahmaputra and the Meghna which covers 144,000 square kilometres. The country is the most densely populated in the world with a population of approximately 163.5 million people, 31.5% of whom are living under the poverty line. The tropical monsoons with heavy summer rains experienced in Bangladesh are generally accompanied by cyclones and floods, often with catastrophic consequences.



Currently, Bangladesh is experiencing a demographic transition, rapidly increasing the proportion of the population of 60 years and above. In terms of numbers, the older population of Bangladesh constitutes one of the largest groups in the world. Presently, older people account for around 7% of the country's total population, amounting roughly 11 million people. By 2050, the 60+ population will account for 20% of the total population, a three-fold increase from the present time. The increase in the older population in Bangladesh during the period 1990-2025 is projected to happen much faster (219%) than that of developed European countries such as Sweden (33%), UK (45%) or Germany (66%). Changing lifestyles, urbanisation and the decline of the traditional family support system have increased the plight of the elderly people, especially the poor and the women.

High prevalence of morbidity is a common feature in old age and expenditure on the health care of older persons is much higher compared to younger adults. There is also disregard for the nutritional needs of older people as nutritional assessments tend to focus exclusively on the under five age group without taking representative samples of the nutritional status of other age groups. Older women experience proportionately higher rates of chronic illness and disability than older men. Older women live with frequent chronic conditions, many of which are irreversible, but not life threatening.

Bangladesh has made significant progress in health outcomes and the government has been pursuing a policy of health development that ensures provision of basic services to the entire population, particularly to the under-privileged population in the rural areas. Within the overall development policy framework of the government the goal of the health, nutrition and population sector is to achieve sustainable improvement in health, nutrition and reproductive health, including the family planning status of the population - particularly of vulnerable groups, including women, children and the poor, with the ultimate aim of their economic emancipation and physical, social, mental and spiritual well-being. Health services are being provided in government run hospitals and clinics according to the specified system. No particular emphasis is given to older people's treatment or facilities, i.e. special/extra care, priority services, concessions/free services/health card, etc. Even older people's health services are not a highlighted issue in the health policy unlike that for children and women.

India

Estimates suggest that there are currently some 100 million people aged 60 or over in the country. The figure is likely to reach a whopping 177 million by the year 2025. One out of every 10 older people living in the world lives in India. 40% of the older people of the country are living below poverty level and 80% of them live in rural areas. Whereas life expectancy has increased from around 36 years in 1951 to 65 years in 2006, it is still less than 60 years in the rural areas. The feminization of ageing is also noteworthy and the trends suggest by 2015, 51% of the older people living in the county will be women.



The miseries of older people in India are often compounded by poverty, geographic displacement, environmental disasters or destruction of social structures. The socio-economic situation of the elderly population is, undoubtedly, weak and poor. A survey conducted in a part of the country revealed that 32% older people felt they are not “treated well” within their families and communities. During a survey of older people in the state of Rajasthan, only 6% reported having a regular source of income. Abuse of older people is also becoming common in many communities. Rapid industrialization and fast-track urbanisation has disrupted intergenerational bonds leaving older people vulnerable, suffering and isolated.

There is an unquestionable lack of adequate healthcare services for older people in the country. Provision is in a very poor state in the rural areas and remote parts of the country. The vast majority of older people in these underserved areas is malnourished, lives with a weak immunity and is prone to a wide range of infectious and chronic diseases. For example, there are an estimated 12 million blind people in the country. A majority of them are older people living in rural areas. High prevalence rate of diseases such as Tuberculosis and Malaria among the elderly is another fact that illustrates the complexity of the situation. Concerned with the gravity of the situation, the Government of India came up with the National Policy for Older People (NPOP) in 1999 which strongly stresses the need for age-friendly healthcare interventions. In the following years, efforts have been made by the government to mobilize resources and partner with various stakeholders. Nevertheless, not much progress has been taken in this regard. Furthermore, due to a number of reasons, geriatric healthcare remains an area of “lack-of-interest” among healthcare professionals and in the medical schools.

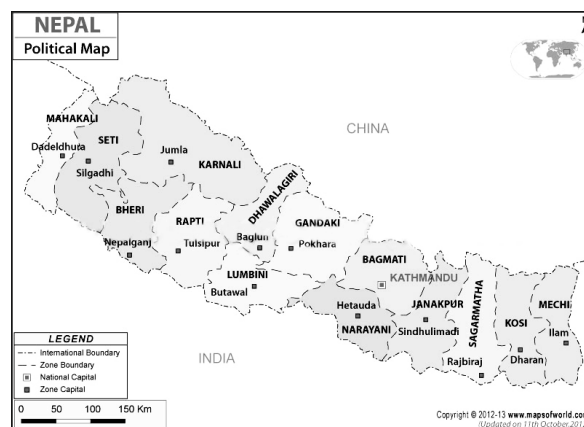
India is also a unique country in terms of its diversity. Every region of India is diverse with regard to ethnicities, languages, food habits, and religious practices, social, cultural and economic status. Hence, planning at a national level becomes a difficult task. The characteristics of each region and associated disparities play a prominent role in developing

effective, national level policies. As India lurches forward to become the most populous nation on the earth by the middle of the 21st century, it will have significant demographic challenges to address.

Nepal

Nepal is a Himalayan country situated between the cultures of the two major Asiatic civilizations : India to the south and China to the north. Nepal is known as one of the important hot spot of the world for its rich bio-diversity. Its wide ranging terrain consists of high mountains, hills, elevated plains (locally called tars), river valleys and flat plains. The topography varies greatly from the low *Terai* plain in the south, which has an average height of 300 meters above sea level, to the Himalayas in the north, which peak at more than 8,000 meters above sea level. The topography of Nepal can be divided conveniently into three main ecological zones: mountain, hill, and *Terai*. Nepal is administratively divided into the five development regions along its length from east to west.

Beyond the five development regions the country is divided into 14 Zones, 75 Districts, 58 Municipalities, 3,915 Village Development Committees (VDC) and nearly 36,000 wards. The *Ilaka* is an administrative service level between the district and the VDC; there are 9 *Ilakas* per district. At the district level, each of the departmental or ministry offices oversees the plans and programmes for the sector of their concern. The role of the Chief District Officer is to maintain law and order; whereas the Local Development Officer co-ordinates the development activities in the district through the District Development Committee (DDC), an elected body of people's representatives. The District Health Officer is responsible for all health activities in the district including the organization and management of district hospital, Primary Health Centers (PHCs), Health Posts (HPs) and Sub Health Posts (SHPs).



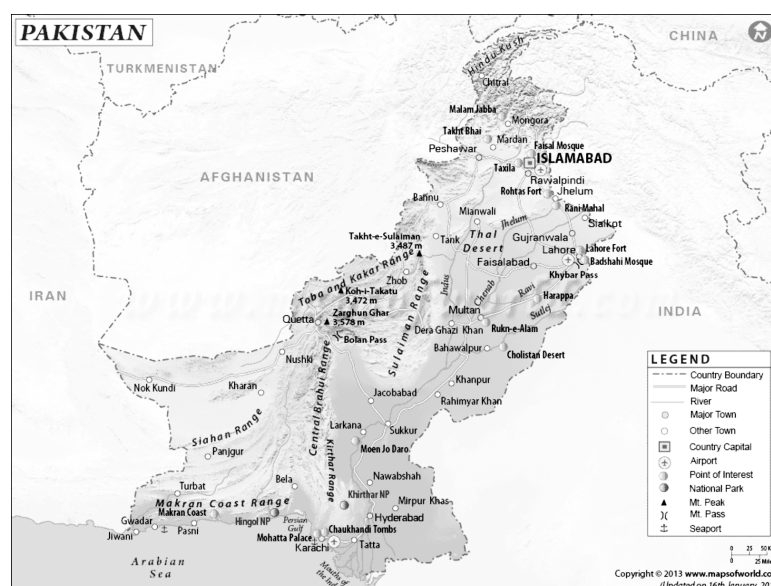
The health needs of elderly people (60 years and above) are the most sensitive. Among the elderly, women are the worse sufferers with 39.6% reporting chronic illness such as asthma, rheumatism-related conditions, gastrointestinal disease and high blood pressure, compared to 36.4% for men.

The proportion of the 60+ population is already increasing from 6.8% per cent in 1995/96 to 7.6% in 2003/04 and 9.1% in 2010/11, thanks to the success achieved in extending health services in the past. But the nature of the health service needs of the future population is going to be more demanding owing to the higher proportion of older persons in the population. It is worth noting that the proportions of people suffering from chronic illness or non-communicable diseases like cancer, rheumatism, asthma, heart diseases, diabetes, kidney problems, high/low blood pressure and occupational illness have shown an increasing trend from 6.5% in 1995/96 to 11.7% in 2010/11.

The Nepal Government's National Health Policy (1991), Second Long - Term Plan (1997-2017), and the current Three Year Interim Plan (2010/11 - 2012/13) all give the highest priority to extending the health care system to the poor, rural, marginalized and most vulnerable in the population. Special attention is to be focused on maternal child health, elderly health, infectious diseases and outpatient care. In approaching these problems, the Health Sector Reform Strategy 2004 also emphasized the concepts of “decentralization” and “public- private partnerships”.

Nepal has come up with various plan and policy documents focused on ageing in the past two decades. These include, the Second Long-Term Health Plan (SLHP, 1997- 2017), the Senior Citizens Policy and Working Policy (2002), the Health Care Implementation Guidelines for Older People (2005), the National Action Plan for Senior Citizens (2006), and the Senior Citizens Act (2007). The Universal Old Age Allowance was introduced in 1994 – 95, which made Nepal one of the few countries of the world to adopt such a cash transfer provision. The programme has gone through many changes since it began. The initial allowance of NRs. 100 per month has now increased to NRs. 500 per month. The qualifying age has been reduced from 75 in the beginning to 70 years now and changes have also been made in the distribution system to improve coverage.

Pakistan



Ranking 135th on the United Nation's Human Development Index, Pakistan has a population of approximately 148 million of whom half are children under 15 years of age. This makes Pakistan the 7th most populous country in the world. Infant mortality stands at 90 per 1,000 live births with maternal mortality at 340 per 100,000 live births (median estimates). In terms of health status, Pakistan faces a double burden: a rapidly increasing incidence of NCDs and injuries, superimposed on endemic CDs. The most persistent health burdens in Pakistan affect women and children. Forty percent of children under-five-years of age are malnourished. One out of every tenth child born does not live to see his/her first birthday. Twenty-five percent of all children born are of low birth weight, i.e., less than 2.5 kg. These children are usually born to mothers who are malnourished. Almost 50% women of child bearing age suffer from nutritional anemia. In contrast to Western women, all Pakistani women are at increased risk of dying due to pregnancy related causes. One pregnant woman dies every twenty minutes, due mostly to avoidable causes.

Pakistan's demographic trends show that between 1990 and 2010 the population aged 60+ years increased by 75.1%. It is projected that life expectancy will increase to 72 years by 2023. A WHO report (1998) projected that 5.6% of Pakistan's population was over 60 years of age, with a probability of doubling to 11% by the year 2025. Elderly people in Pakistan lead a mainly sedentary lifestyle which may play a significant role in immobility disorders, loss of muscle mass (sarcopenia) and falls, which are common geriatric syndromes. Old aged sedentary lifestyle and obesity are also associated with high prevalence of hypertension (17.9%), diabetes (10%) and hypercholesterolemia (3.7%) which are precursors of chronic disease. The prevalence of obesity in Pakistan for the age group 25 to 64 is 13% for males and 23% for females.

Healthcare in Pakistan is administered mainly in the private sector which accounts for approximately 80% of all outpatient visits. The public sector was until recently led by the Ministry of Health, however, the Ministry was abolished in June 2011 and all health responsibilities (mainly planning and fund allocation) were devolved to provincial Health Departments which had until now been the main implementers of public sector health programmes. Like other South Asian countries, health and sanitation infrastructure is adequate in urban areas but is generally poor in rural areas. About 19% of the population and 30% of children under age of five are malnourished. The geriatric population is growing at an alarming rate. The present global elderly population aged 65+ stands at 380 million, and by the year 2020, it is projected to increase to more than 690 million. Elderly population growth has been observed in developed as well as developing countries, with the Asia region exhibiting the fastest aging population as a consequence of recent the epidemiological transition. The majority of the elderly has one or more chronic illness like diabetes, hypertension and heart disease and is vulnerable to various disabilities, nutritional challenges, loss of independent functioning and depression as a consequence of complications arising from chronic diseases.

Sri Lanka

Sri Lanka has a geographical extent of 65,610 Km², which is divided into 25 Districts for administrative convenience. These 25 Districts are again clubbed together into 9 Provinces. According to the 2012 Census and Statistics, the total population of Sri Lanka is 20.26 million and the population above 60 years is 2.46 million (12.2% of the total). Females constitute 51.5% of the total population.



In comparison with the census in 1981, the population below 15 years has decreased by 9.4% points, from 35.2% to 25.8%. In contrast, the population above 60 years has increased by 5.6% points, from 6.6% to 12.2%. Accordingly, the population of Sri Lanka seems to be gradually changing to an ageing population. The decrease of births, further increase of life expectancy, and increased net migration of the 15 – 59 years age group for education and employment abroad may have been the causal factors for the increase of the aged population.

The Ministry of Health runs a network of hospitals across the Island. The main hospitals are located in the major cities with rural hospitals and dispensaries established in rural areas. In addition, a substantial number of privately owned hospitals are also catering to the needs of the population, but are mainly based in the capital Colombo.

Improving the capacities of medical officers on palliative care has been identified as an important intervention in expanding the provision of these services throughout the country. The certificate course in palliative care for medical officers was offered by the Institute of Palliative Medicine, Calicut, India (WHO Collaborating Centre in Community- Based Palliative

Care and Long-Term Care) in association with the College of General Practitioners of Sri Lanka (CGPSL), together with the National Cancer Control Programme, Ministry of Health and the WHO Country Office Sri Lanka.

Having understood the importance of the ageing population, the Ministry of Health is taking strong steps to provide special care for senior citizens in Sri Lanka. In addition to the certificate course, the Ministry of Health has identified 11 government hospitals across the Island to establish special wards for senior citizens. In addition, a sub-hospital close to Colombo will be converted to a geriatric hospital in the near future as a pilot project.

World Health Day, which is celebrated on 7th April each year, is held to mark the anniversary of the founding of the WHO in 1948. In addition to the main themes, the local theme in Sri Lanka for 2013 is high blood pressure. This was seen as a very good opportunity for the country to highlight progress made on tackling NCDs and disseminate facts of a Medical Research Institute (MRI) study that was done on assessing salt consumption and high blood pressure. There were numerous activities organised both at central and peripheral for the day.

It was indeed a milestone in the journey of prevention and control of NCDs that the year 2013 was declared “The Year for Prevention & Control of NCDs”. This decision was taken by the Minister of Health after consultation with the President of Sri Lanka and after obtaining approval from the Cabinet of Ministers. The national event to launch the programme was held in the North Western Province.

The launch of the guideline for the management of NCDs in primary health care using the total risk assessment approach has been a significant development in Sri Lanka. The guidelines have been developed by the Ministry of Health for use by medical officers involved in primary health care.

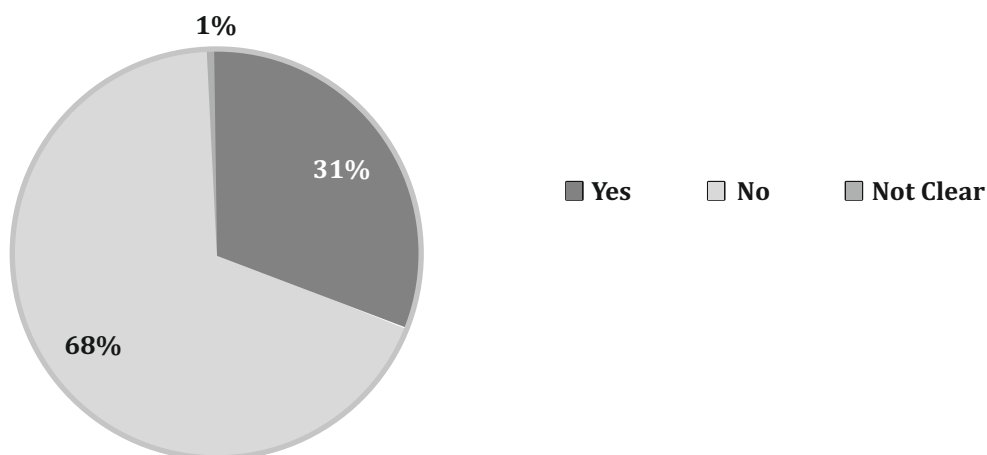
B. SURVEY, FGDS AND EXPERT LEVEL DISCUSSIONS FINDINGS

The above three exercises looked at a wide range of issues including older people's perceptions of their health status, prevalent diseases in the communities, availability and accessibility of health services for older people, effectiveness of ongoing health interventions and policy level provisions. Older people, caregivers, country teams of Help Age and partners, and experts from the government and healthcare sphere responded to the topics. To understand the findings, the same have been categorized in following sections:

Socio-economic aspects

It was essential to understand how older people contribute to families' income and how productive they are. A set of questions in the survey and FGDS tried to understand what older people have to say about their productivity.

Older people who have to work to earn an income



A significant part of the population does not work to earn an income. Belonging to the age group of 60 years and above, coupled with the fact that they live in a joint family, indicates that they are dependent on the rest of the earning members in the household. 68% of the persons interviewed do not work to earn incomes as compared to the 31% who still have to work for a living at this age.

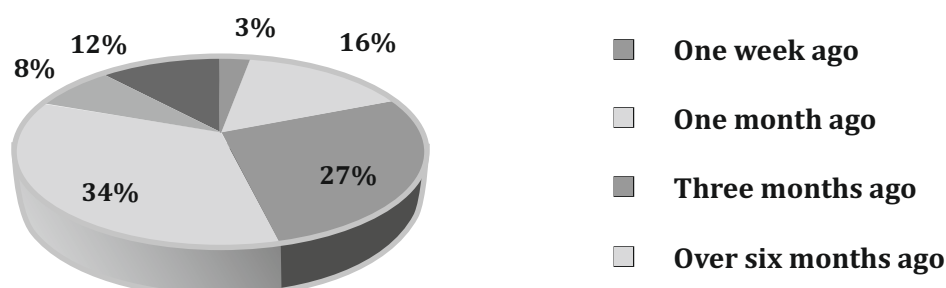
The fact that majority of older people do not have to work and have support is good news. However, on the productivity point, FGD's reveal that older people support occupations like farming and animal husbandry that does not bring a direct income. In the FGD's, more than 75% older people desired that they want to be engaged in some type of livelihood generation activity.

Access to healthcare

Most of the areas where the data collection took place were quite rural and remote. The availability and accessibility of healthcare services for older people was a major topic in the exercise.

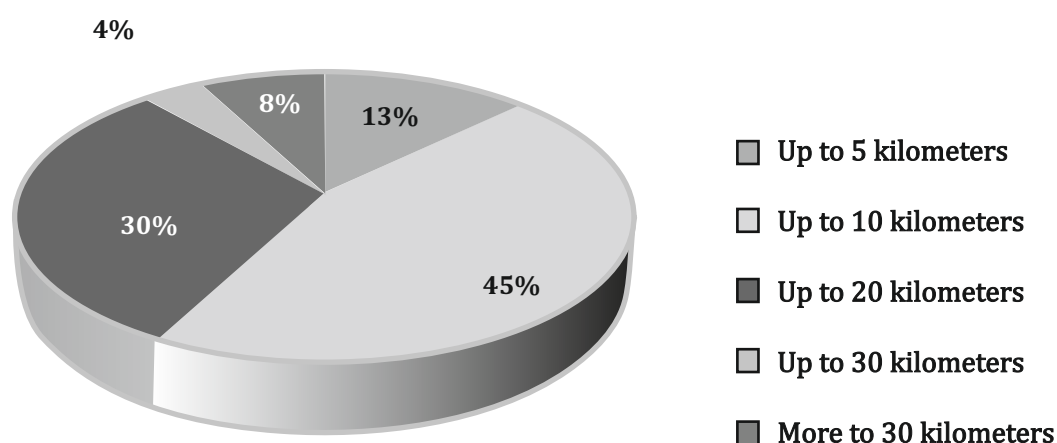
In response to the question on when did the older people see the doctor last (see the chart below) – A mere 3% said they saw a doctor last week and about 16% said recently which is a month ago. Some 27% said it was close to three months back while a large 34% said it was over six months ago. An 8% said that it was either over a year or they cannot remember.

When was the last time you had seen a doctor

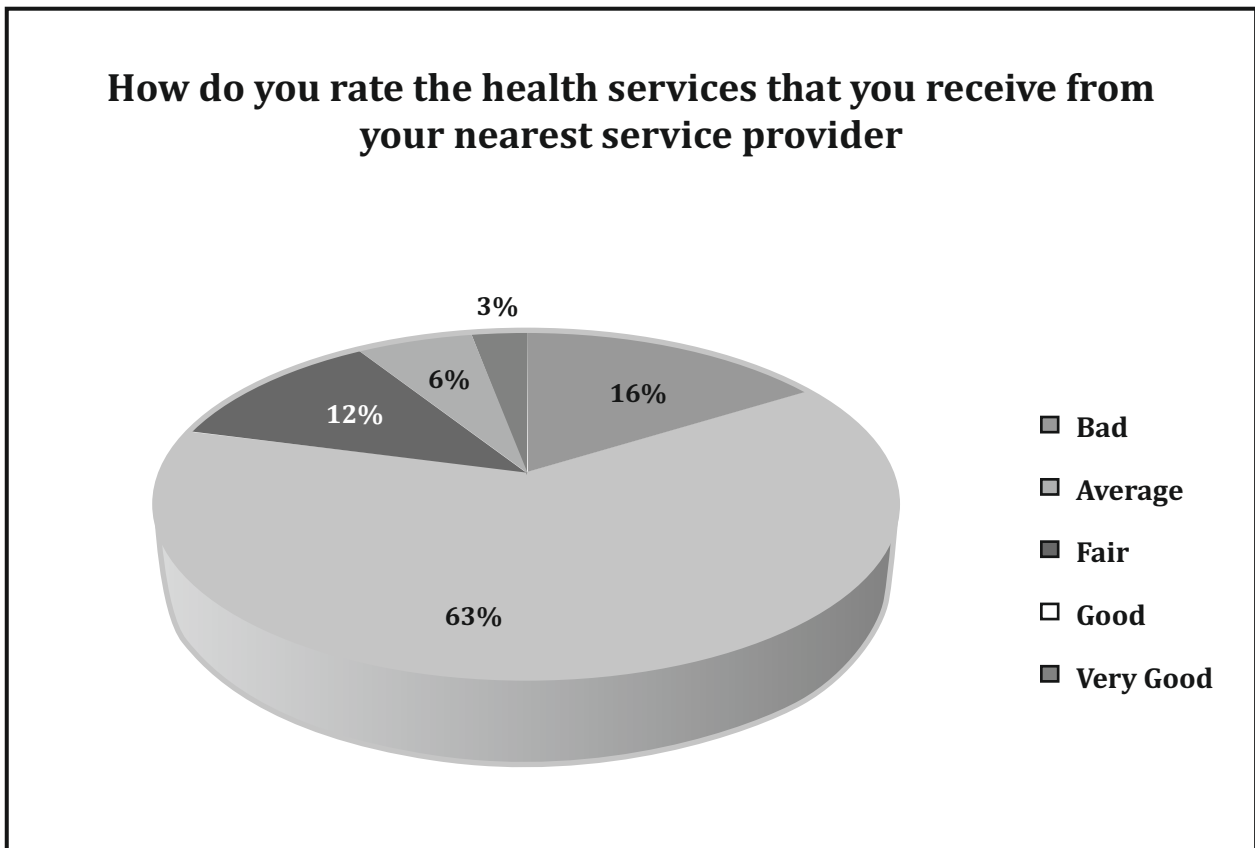


On the distances traveled to reach a health facility or see a doctor – the answers ranged in distances between up to 5 km to over 30 kms. In India, in the Desert of Thar, the distances were found to be quite long. In Sri Lanka, the health facilities are nearer. About 13% travelled close to 5 kms to see a doctor while a huge 45% travelled up to 10 kms. Also 30% went as far as 20 kms to see a doctor and a small 4% travelled up to 30 kms. But there were close to 8% of the persons who travelled more than 30 kms to see a doctor.

How far do you have to travel to see a doctor



The satisfaction levels with the nearest available health facilities views was canvassed. The responses are summarized in the chart below:



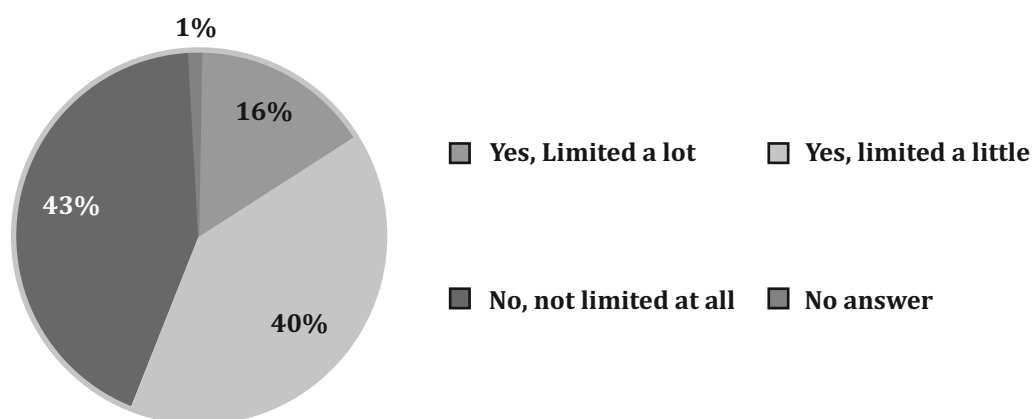
More than half of the people i.e. 63% rated their health service provider as Average, which shows the condition of these health care services is mediocre. 16% rated it as Bad while 12% said it was Fair. A mere 6% and 3% rated them as Good and Very Good respectively.

The majority of older people (over 55%) in Bangladesh, India and Pakistan seemed to be dissatisfied with the quality of health services available. Satisfaction levels are higher in Nepal and Sri Lanka.

Mobility and activeness status

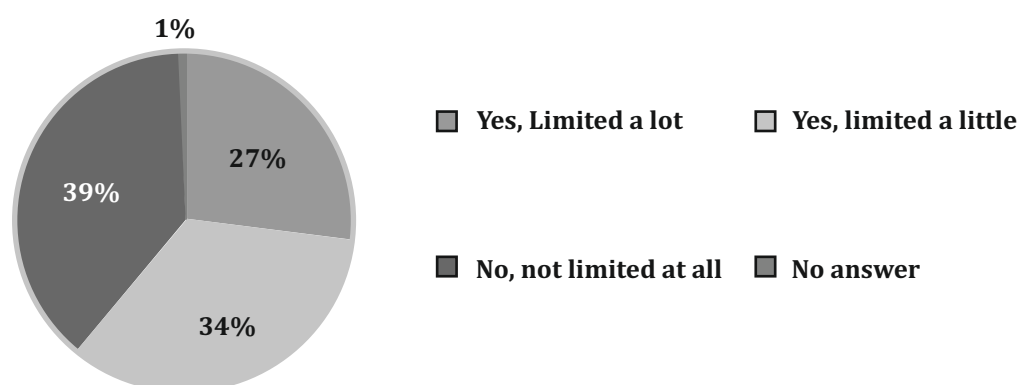
In this part, the questions focused on understanding what older people's mobility limitations are and how this affects their daily activities of life.

Limitations in walking short distances



More than half the persons had some sort of limitation in walking short distances even. Though about 43% responded by saying that their current state of health did not limit them from walking short distances (up to 0.5 kilometers). However, about 40% of the persons stated that they were slightly limited in their ability to walk short distances. It was 16% of the respondents who said that walking short distances did incumbent on them limitations while 1% had no answer.

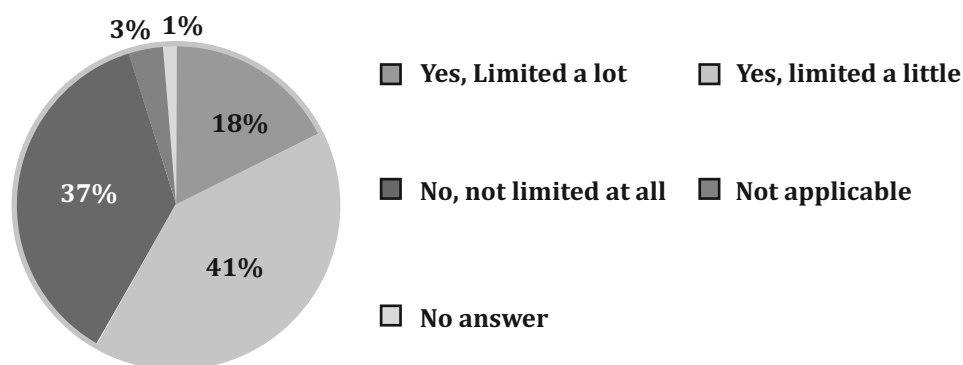
Limitations in walking long distances



The percentage of persons who are inconvenienced by walking long distances due to their age and related disabilities are close in comparison. About 39% of the respondents stated that they were not limited by walking long distances, whereas 27% of the persons stated that they were severely limited in their ability to walk long distances. A close 34% of the respondents were slightly limited in their ability to walk long distances.

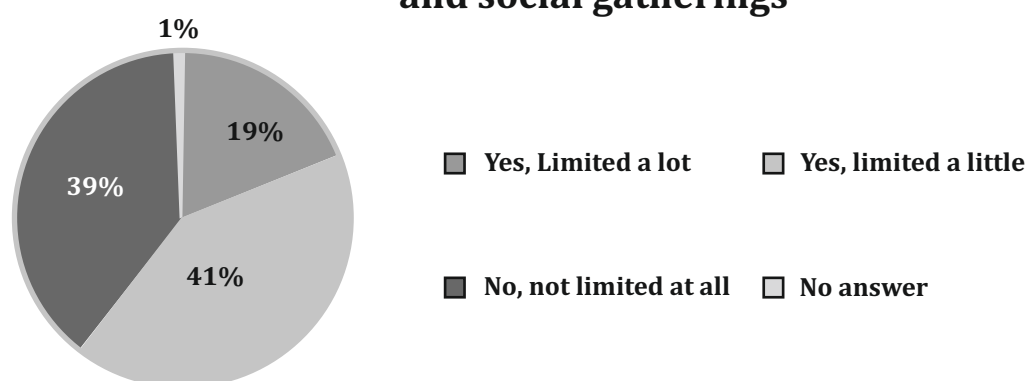
In Sri Lanka, 78% of older people said that pain in their bones and joints is a major mobility limitation for them. In Nepal, 60% older people said that pain limits their mobility.

Limitations in completing household chores



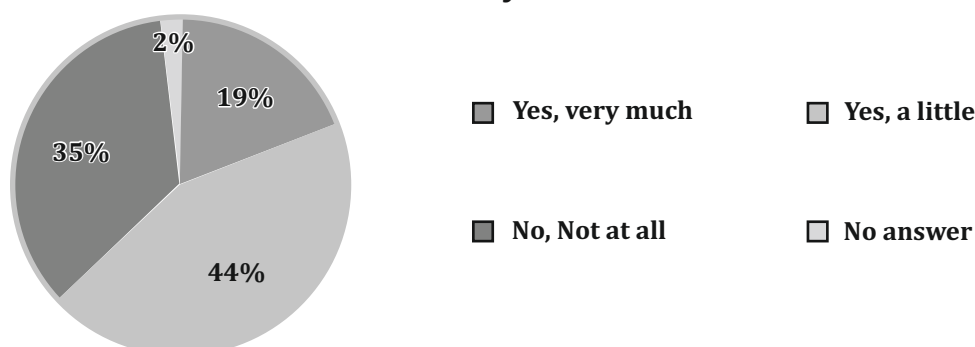
A large 41% of the respondents are said they were limited slightly and about 18% said it hey were limited a lot by their age to be able to complete their household chores. However, a significant 37% of the persons also stated that they were not limited in any way and were able to do all their household chores, while for 3% this was not applicable.

Limitations in participating in family events and social gatherings



Persons of older age found it slightly difficult to participate in family events and social gatherings. About 41% of the respondents stated that they found it slightly difficult to attend social functions and about 19% said it had limited them a lot. However, a comparable 39% of the respondents stated that they were in no way limited and were able to attend most social events or gatherings if they took place.

Does your physical health prevent you from accomplishing as much as you would want ?

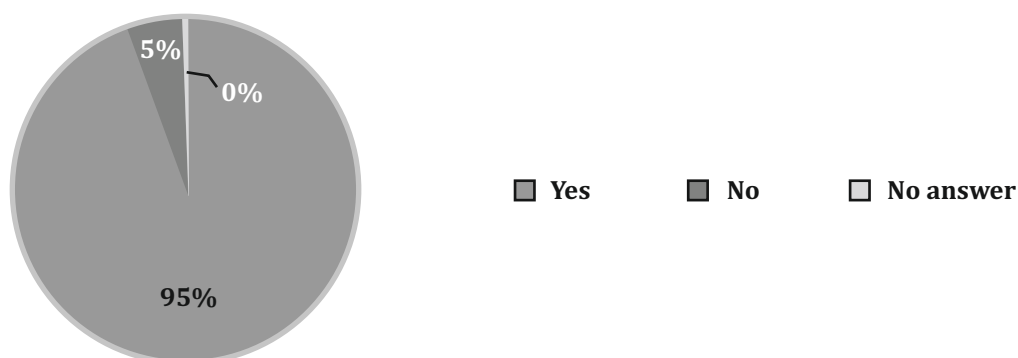


Most of the persons interviewed agreed that overall deterioration in physical health has led them to accomplish less than they used to earlier. 19% said it affected them very much while 44% respondents stated that they found it a little difficult to carry out tasks and activities as they would do so earlier. For 35% of the respondents, being aged has not made any difference at all and 2% had no answer.

Mental Health Status

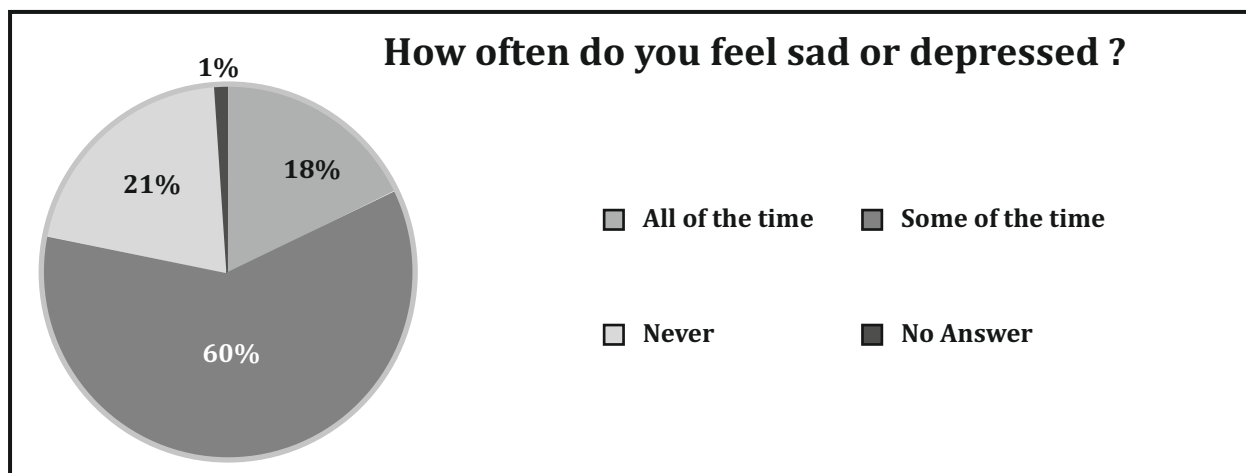
It was important to understand the mental health status of older people in the region. A series of questions in the survey as well as in the FGDs tried to understand older people's mental health issues and behavioral practices.

Do you have relationships with other people of your age ?



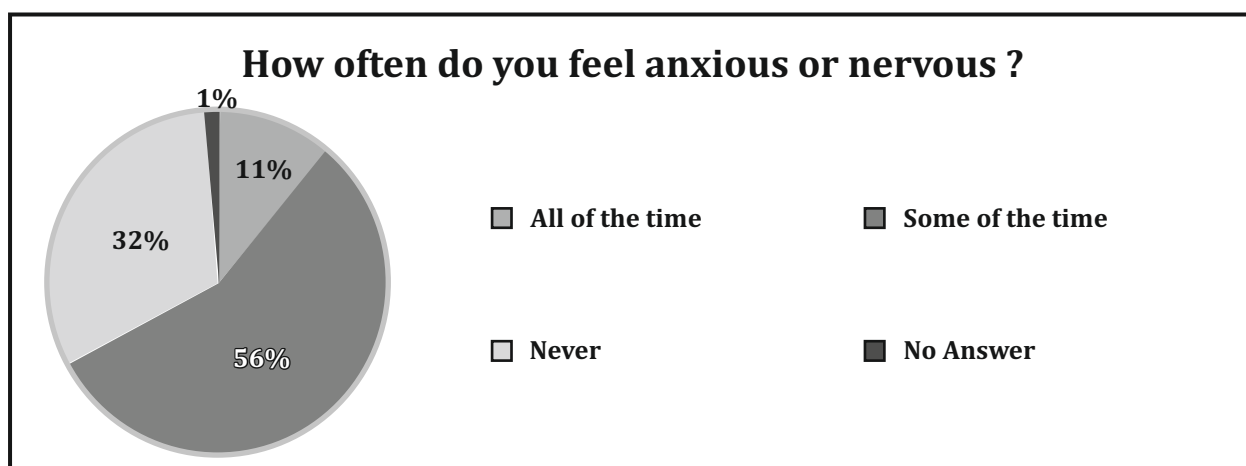
Most of the respondents 95% stated that they did have relationships with their peers. Only a small 5% of the respondents stated that they were unable to maintain a relationship with persons of the same age. Older persons do find companionship with persons of their own age. This is very clearly reflected in the graph above.

To go further, these relationships are able to act as a safety valve when pressures from other family members come to press on them - emotionally and physically. The next set of questions reflects the above position since it was noticed that a significant number of persons do not feel sad or depressed, nor do they lonely and isolated by the younger generation.



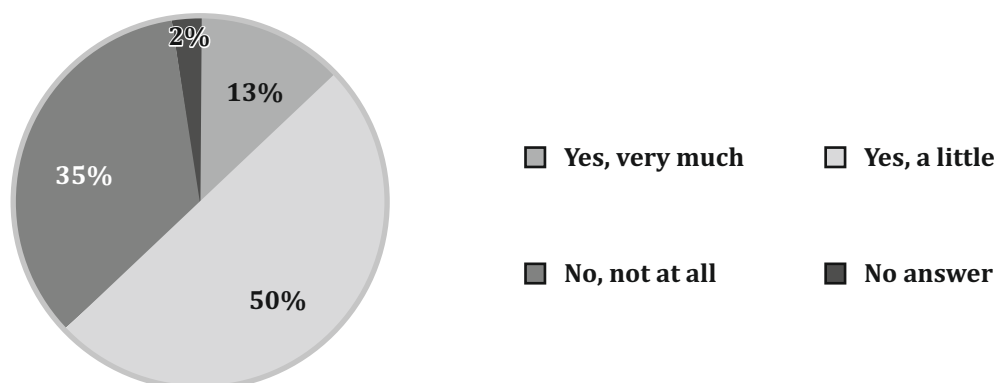
Many of the respondents stated that they felt sad or depressed most of the time. 60% of the persons said that they felt depressed 'at some time' and another 18% respondents said they felt depressed 'all the time'. However, about 1% had no answer while close 21% of the respondents also said that they did not feel depressed at all.

More than 65% of older women in Pakistan, Bangladesh and Nepal suggested that sadness or depression affect them at times. The percentage of sadness in older women was found to be lower in India and Sri Lanka.



Reflective of the age of the persons interviewed, 56% of the respondents felt nervous or anxious 'sometimes'. Another 11% of the respondents felt anxious 'at all times'. Despite the above responses, 32% of the respondents did not feel anxious or nervous at all and a mere 1% had no answer. This is notable given the age of these respondents and the situations that some of them could be placed in by their families.

Mental or emotional problems affecting one's role in the family



More than half the percentage of respondents stated that their emotional problems affect their role in the family. 50% of the respondents state that they did feel that their emotional status got a 'little' in their way of playing a significant role in their family matters. Another 13% respondents said it affected them 'very much'. However, another 35% said it did not affect them at all and about 2% had no answer at all.

Prevalence of diseases

Discussions with older people, caregivers and experts tried to extract which NCDs and CDs are most prevalent in the region. The most prevalent NCDs were found to be:

- Hypertension
- Arthritis
- Diabetes
- Low vision
- Cancer
- Gastro-intestinal diseases
- Genito-urinary diseases

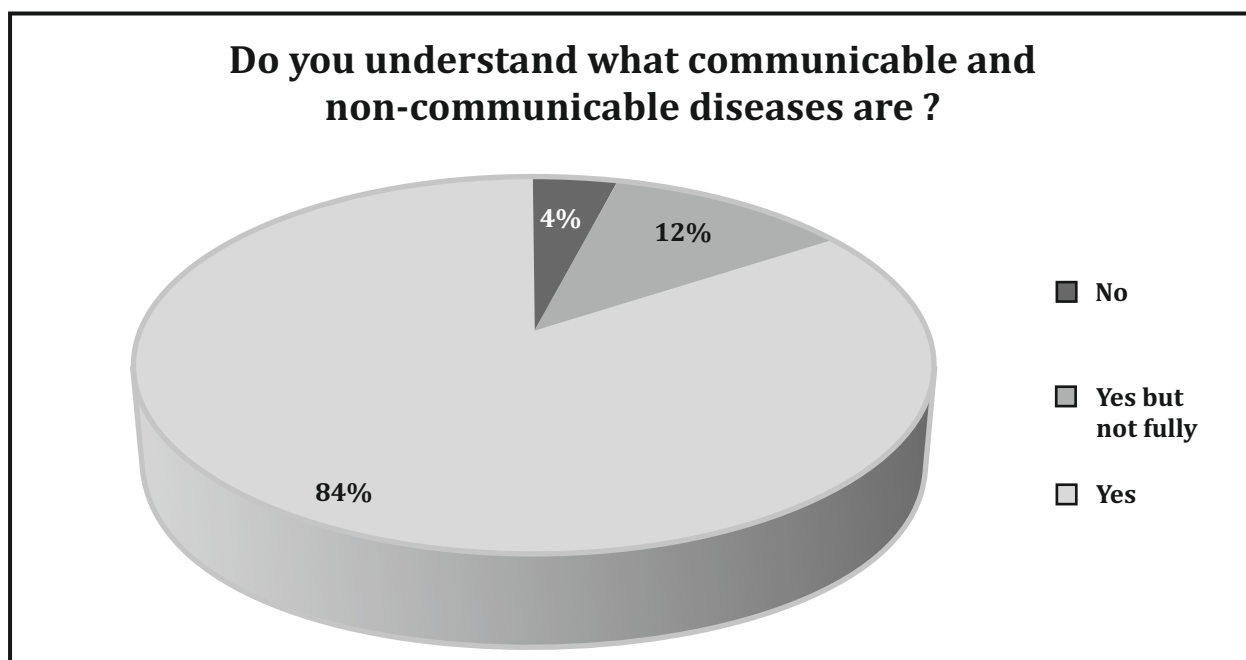
In all countries, hypertension remains one of the leading NCDs. This could be extracted from the discussions with experts and country level disease prevalence data. The vast majority of older people live with an undiagnosed hypertension. Across the region, diabetes is a growing epidemic. In India, more than 50 million people are living with diabetes, a large number of whom are people above 50 years of age. The survey and FGDs reveal that arthritis and low vision are very common health problems among the elderly affecting their mobility and daily lives.

Most common CDs found to be the following:

- Malaria
- Tuberculosis (TB)
- Pneumonia
- Gastro-intestinal infections leading to diarrhea
- Dengue fever

In the region, Sri Lanka shows the lowest incidence of communicable diseases due to effective infection control. In other countries, including India, Nepal, Pakistan and Bangladesh the incidence of above communicable diseases are quite high. India has the highest number of people living with TB, a large number of which are people above 50 years of age.

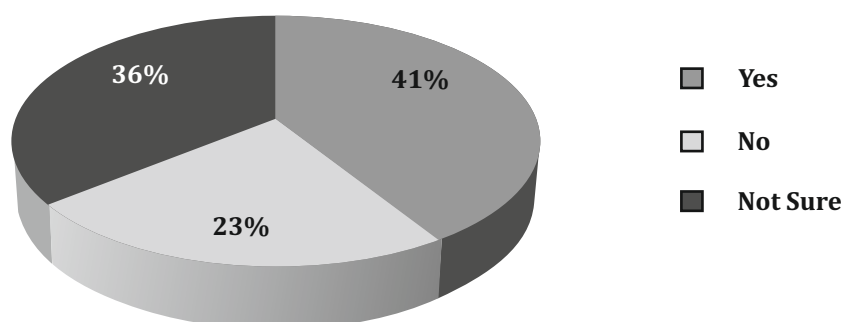
The field research interviewed older people to understand whether they are familiar with communicable and non-communicable diseases. Not surprisingly, the majority of respondents did not know a great deal about the two types of diseases.



To get more information on the double burden of disease, older people were explained the main symptoms of CDs (such as fever, vomiting, diarrhea) and NCDs (such as chronic pain, fatigue, loss of organ function). They were then inquired whether they think that they have been impacted by at least one CD and one NCD condition in the past six months.

In the FGDs, very few older people said they were aware of HIV infection. Experts in their interviews revealed that there are no HIV positive older people in their communities although no data was available of testing.

Do you think you have been affected by at least one NCD and CD in the last six months ?

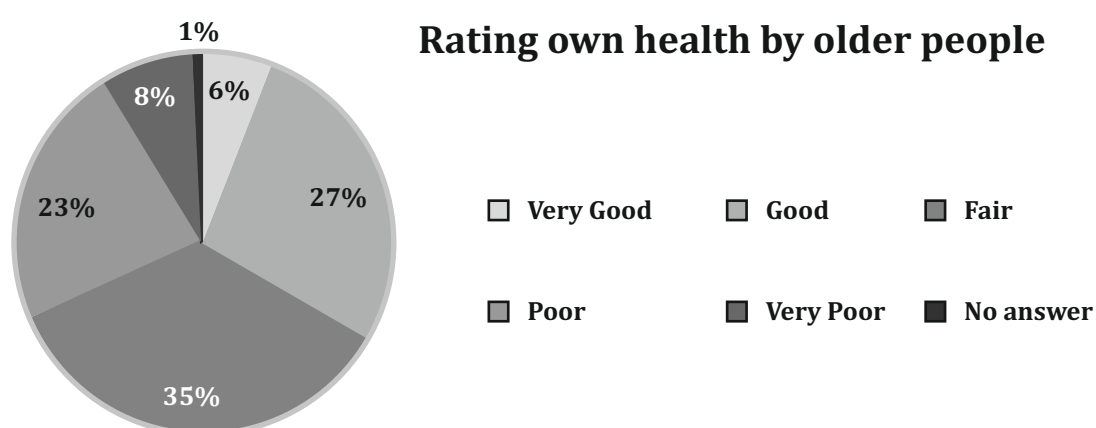


In India, around 54% older people thought that they have been affected by a CD and an NCD in last six months. In Sri Lanka and Nepal this ratio was 22% and 29% respectively

The survey and FGDs also revealed that most older people (over 85%) have the support of care-givers in their families and communities. However, over 80% of care-givers have not received any formal self-care or health training. Their support to older people remains limited to providing mobility support and in buying and giving them medicines based on prescriptions.

Overall health perceptions and future priorities

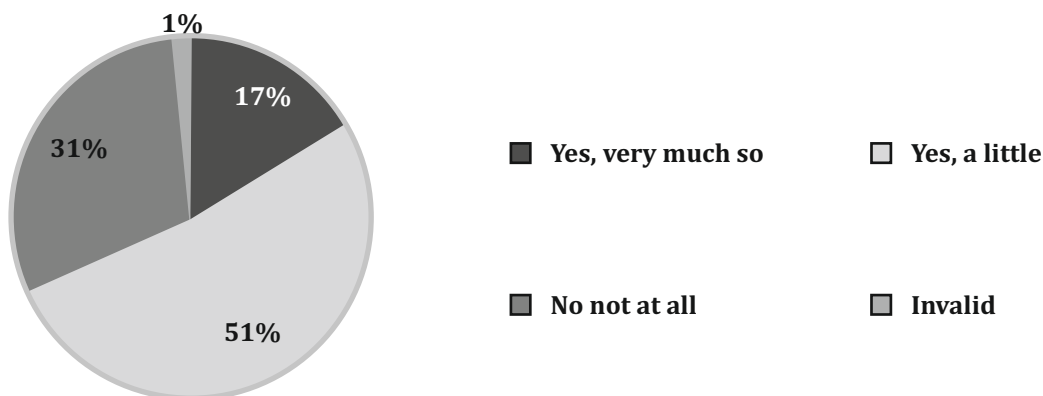
Rating own health by older people



A majority of the respondents agreed that they did not feel that their health was in a very bad or severe condition. 27% felt Good about their health while 35% felt their health was Fair and

some 6% felt it was Very good. However, a total of 31% of the respondents answered in the negative and stated that they did not feel like they were in very good health.

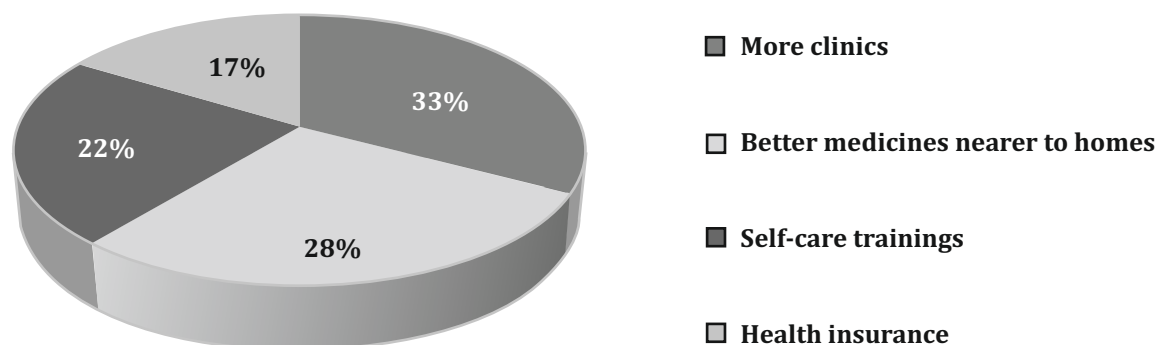
Health prevents one from living a more active and engaging life



A majority of the respondents stated that they did feel that their ill health or mental conditions prevented them from living a more active and engaging life. As high as 68% of the respondents (17% said 'very much so' and 51% said 'Yes, a little') stated that their life was not as active and engaging as it should be or had been in the past. 31% of the persons stated that they did not feel like their health prevents them from leading an active life. They continue to be as actively engaged in social and familial activities as much as possible.

On the point of what changes older people would like to see in the health services provided to them, majority responded in health centers/clinics nearer to their homes and neighborhoods. Better medicines and self-care trainings came next in the list. 33% wanted more Health Clinics while 28% wanted Better medicines available nearer to their homes. Self-care Training was the preference of 22% while 17% looked for Health Insurance due to expensive medical treatments.

What changes would you like to see in health services for you ?



C. GOOD PRACTICES

Advocacy and research

GRAVIS, the HelpAge affiliate from India, is actively engaged in advocacy and research on older people's health status to generate evidence aimed at the overall improvement of the service delivery for the elderly. GRAVIS's Promoting Older people led Community Action (POC) project delivered a number of such interventions over the last five years.

An important initiative was taken by GRAVIS to understand older people's health needs, which gave shape to a comprehensive needs assessment document in 2008. The document built the foundation to plan and implement SCOPE (Self Care for Older People) interventions in the Thar Desert, supported by Help Age International and the Tsao Foundation, Singapore. SCOPE revolves around training older people and their caregivers, research on changes brought by self-care, and advocacy to replicate the model.

Another advocacy initiative was to organize health talks and campaigns on ageing on days such as World Health Day (WHD) and the International Day for Older Persons (IDOP), and organising regular advocacy dialogues including older people, service providers and government functionaries.

In this regard, a national level entitled “Ageing and Development: Health Care Aspects”, was organized by GRAVIS and HAI in December 2012. The event had more than 100 participants with a strong representation of older people followed by service providers, researchers, civil society and the government. The discussions touched upon the current status of health care for older persons and on ways forward.

Advocacy and research interventions by GRAVIS over the last few years have generated greater awareness on ageing and health in the Thar Desert, have generated good evidence and made practical recommendations for the future. It is envisaged that these outputs will lead to an improved service delivery system for older people and will contribute to realizing the vision of age-friendly healthcare.

Homecare volunteers trainings by Help Age Sri Lanka (HASL)

Training Department of HASL undertakes training of home care volunteers (25 in each batch). These home care volunteers (between 55 to 65 years) are selected from senior citizens committees (SCCs) in rural areas subject to a criteria. They undergo an intensive in-house training program for 05 days. Both external and internal resource persons take various training modules. Training program consists of modules such as ageing process, needs & habits of elders, basic nursing, age related diseases, first aid, basic counseling and active ageing. After the training these volunteers start visiting houses of most vulnerable elders in their locality to provide care. Records of their visits are maintained by these volunteers and necessary feedback is given to their respective SCCs during monthly meetings.

In addition, a carefully selected young unemployed (both male and female) people are also provided with the same training and placed in houses where there are requests for home carers. HASL receives such requests from wealthy houses, mainly from Colombo, where there

are feeble older people. Carers are paid a fixed monthly allowance by the client and also provide accommodation, food etc.

D. SUMMARY OF FINDINGS

The tools used for the research study – a survey of 1,000 older people, FGDs with older people and discussions with HelpAge and partners teams and experts - presented a good picture of older people's health status and their perceptions. The exercise also brought insights on how accessible health services are for older people and what the service gaps are. The findings can be summarized in the following main points:

- The majority of older people the HelpAge network are reaching in South Asia live in rural settings and in impoverished conditions. The main occupations of households include agriculture, animal husbandry and wage labour. While a good number of older people responded that they do not have to work directly to meet their needs and have their families' support, they also said they were willing to do productive work to earn some income. Therefore, there is a need to exploring opportunities and means to utilize the productive potential of older people. But their expression they are well supported and do not need to work comes from the fact that most old people live in a joint family system.
- Caretakers in the community are mostly available. In most cases they are family members, the children of older people. The caretakers, largely, are untrained and provide basic aid to older people without much knowledge on their health status and diseases.
- In terms of access to health facilities and quality of the same, mixed responses were recorded. Distances to the nearest health facilities in various countries varied, Sri Lanka reporting the shortest and India reporting the longest. In terms of quality of health services, the larger percentage of older people responded that they were not happy with this.
- On mobility and activeness status, most older people expressed difficulties and limitations. In certain settings like the Thar Desert of India and in Pakistan, walking long distances for various daily chores is quite common and older people expressed their concern on the same. Physical pain due to various conditions including arthritis and muscle diseases was a very common observation in older people. Low vision also emerged as a very common complaint limiting daily life activities for older people. Mobility and activeness limitations can be directly associated to the growing prevalence of NCDs in the region.
- Mental health issues were also observed to be a key health challenge. Due to traditional practices and values, most older people live in joint families and are somewhat supported. Yet, the majority of older people believed that they suffer from depression, anxiety and nervousness. This could be due to other persisting diseases of a non-

communicable and communicable nature, lack of productivity in their own life and lack of psychosocial support.

- The prevalence rates of various diseases in older people were determined through a number of sources including discussions with older people and experts as well as studying country level data. Of the NCDs, the following were noted to be the most common :
 - Hypertension
 - Arthritis
 - Diabetes
 - Low vision
 - Cancer
 - Gastro-intestinal diseases
 - Genito-urinary diseases

Of the CDs, the following were found to be the most prevalent:

- Malaria
- Tuberculosis (TB)
- Pneumonia
- Gastro-intestinal infections leading to diarrhea
- Dengue fever
- Older people's understanding on communicable diseases and non-communicable diseases, not surprisingly, is quite poor. Most older people were unable to differentiate between the two categories. The prevalence of the double burden could be considered higher with varying differences across the countries, with India reporting the highest prevalence.
- HIV awareness among older people is alarmingly low in all countries of the region. In addition, expert opinion seems to suggest that HIV is not a relevant issue be looked at in elderly populations.
- The percentage of older people feeling very negative about their overall health status was lower than those who seemed to feel fair, good or without major complaints. Nonetheless, around 31% of older people felt their health was not in a good state and they needed more help. A majority of respondents stated that they felt their ill health or mental condition prevented them from living a more active and engaging life. As many as 68% of respondents said their life was not as active and engaging as it should be or had been in the past.
- For the future priorities in health services for older people, older people demanded more easily accessible health facilities, better and easily available medicines and emphasised the importance of self-care education.

4. THE WAY FORWARD

The study findings presented the gaps and opportunities in the context of healthcare services for older people, particularly keeping the double burden in view. While there were some variations in different countries on perceptions and in the state of healthcare services, by and large, the overall situation had many similarities and common trends. The way forward and the recommendations are applicable for all countries of the region and provide great scope for internal learning and exchange.

SELF CARE MODEL

Self-care is a cost-effective approach with long-term benefits leading to a better health status of older people and reduced expenses on the management of chronic health conditions such as hypertension and diabetes. While the research study in itself does not draw any positive lessons in this regard, the research takes an encouraging note from self-care models promoted by several organizations, including GRAVIS in India through the Self Care for Older People (SCOPE) project, and health training sessions in Sri Lanka and Pakistan focusing on home care and mobility aids, etc. Self-care training models must be developed and promoted for older people and their caregivers in the region. National plans and health policy will play an important role in active partnerships with NGOs, and focused efforts on self-care must be advocated for.

A greater focus in the self-training models should be put on raising the awareness of older people and their care-givers on CDs and NCDs, preventive measures and management of NCDs. A regional level guiding document on self-care trainings should be developed in consultation with all stakeholders.

VILLAGE HEALTH WORKERS (VHWS)

VHWs have been used effectively in several healthcare spheres including maternal and child health, community eye care and nutrition in all countries of the region. In the HAI network, GRAVIS and HelpAge Sri Lanka have been using the VHW model effectively.

There is great potential in furthering the model in remote communities where these VHWs can be effective health educators and make referral linkages for older people. However, the training and capacity building processes must take a national approach in countries as per their relevance, keeping local characteristics in view. National Health Plans and Policies on ageing must have adequate space and resources for taking this up. The role of civil society/NGOs in training and coordinating VHWs must be taken into account and appropriate partnerships must be developed in this context.

CARE-GIVERS TRAININGS

Lack of training at the caregivers' level emerged as a key challenge and gap in the study findings. While the caregivers in the communities seem to be quite motivated to provide help

and support to older people, their capacities and understanding need to be enhanced. Self-care trainings are one way of addressing this. Stronger connections between VHWs and caregivers will be the other effective means of an ongoing capacity building process.

OUTREACH MEDICAL SERVICES

Lack of healthcare in remote areas is clearly a major issue in the region, and is more severe for older people whose mobility is compromised. Outreach medical camps run by several partners in the HAI network in South Asia have been quite effective. However, the focus of these camps should be equally on providing medical aid as well as raising health awareness levels among the elderly and their care-givers. National programmes on older people's health must take cognisance of the importance of outreach medical care for older people and should allocate expertise and resources for it. Best practices on outreach medical camps should be disseminated.

HIV AWARENESS

The awareness on HIV infection in elderly is alarmingly low and there is a serious negligence of the HIV threats to the elderly by service providers. This aspect must be taken up strongly in training and capacity building interventions. Training contents on HIV for the elderly should be developed regionally taking into account older people's sensitivity and perceptions on sexual health. Advocacy within the national health plans should be taken up to prioritize HIV education in older people's health programmes. A study at the regional level to understand HIV and ageing further will be helpful. The HAI regional network should also develop a regional level strategic document on HIV and ageing, followed by the research.

NETWORKING

A major gap in the context of age friendly healthcare is that there are several players working in isolation without partnership platforms in countries as well as regionally. For example, in India the National Programme for Healthcare of Elderly (NPHCE) and field level implementers, including NGOs and private practitioners, do not enjoy adequate coordination. Networking between the government, old age health programmes, NGOs, private practitioners and the community of older people must be developed and sustained at national level. Networking tools such as gatherings, meetings and consultations must be resourced and organised. This will not only improve implementation and impact as a result of better coordination, but will also include a wider range of voices in the planning and monitoring of interventions.

Regional level partnerships and information-exchange mechanisms should be developed and sustained by the HAI network. A good advocacy target in the context would be South Asia Association for Regional Cooperation (SAARC) to be approached by network partners.

A great opportunity exists to liaise with geriatric education departments in medical schools, an initiative which is taking birth and shape in all South Asian countries at the moment. For

example, In India 10 medical schools are about to set up new departments for geriatrics education. Collaboration with this part of academia will result into bringing older people's needs and concerns to the training of geriatricians and in ensuring effective geriatrics education.

ADVOCACY AND RESEARCH

The sustainability of developmental interventions and in particular community health programmes depends a great deal on continuing advocacy and research interventions. Advocacy and research on ageing and health have been given lesser attention to date regionally, and in many other parts of the world. This applies even more so to the double burden of disease which has not been researched much in the past. This component must be strengthened with more resources allocated and, more importantly, through skills building of people/organisations working at the field level so that they can themselves engage effectively in research and advocacy.

CONCLUDING NOTE

The South Asia region is going through a rapid demographic transition, with the older population steadily increasing in number. The double burden of disease is very relevant in the region and presents complex socio-economic and medical challenges for communities and governments. A multi-dimensional approach needs to be taken to make major inroads in the situation. There is a need to work on regional level guidelines and directions through active advocacy and research, followed by active implementation strategies at national level in participation with NGOs, civil society and older people's groups.

The HAI network has a strong presence in some parts of the region with effective ongoing work with the communities. The knowledge and expertise within the network need to be enhanced and shared through mutual exchange. Partnerships must be strengthened, mainly with government health services both at national and regional levels. A periodic review of the double burden situation in order to assess progress made as well as to identify further steps must also be considered.

5. ABBREVIATIONS

BAAIG	Bangladesh Association for the Aged & Institute for Geriatric Medicine
BWHC.....	Bangladesh Women's Health Coalition
CDs.....	Communicable Diseases
CGPSL.....	College of General Practitioner of Sri Lanka
DDC	District Development Committee
FGDs.....	Focus Group Discussions
FY.....	Financial Year
HAI	Help Age International
HIV	Human Immunodeficiency Virus
HPs.....	Health Posts
IDOP.....	International Day for Older Persons
MIPAA	Madrid International Plan of Action on Ageing
MoHP.....	Ministry of Health & Population
MRI	Medical Research Institute
NCDs	Non- Communicable Diseases
NGOs	Non-Government Organization
NPHCE.....	National Programme for the Healthcare of Elderly
NPOP.....	National Policy for Older People
OAAP.....	Old Age Allowance Programme
PHCs	Primary Health Centers
SAARC	South Asian Association for Regional Cooperation
SCOPE	Self Care for Older People
SHPs	Sub Health Posts
SLPHP	Second Long Term Health Plan
UK.....	United Kingdom
UN	United Nations
UNESCAP	United National Economic and Social Commission for the Asia Pacific
UNFPA	United Nations Population Fund
VDC	Village Development Committee
VHW.....	Village Health Worker
WHD	World Health Day
WHO.....	World Health Organization