Making Old Age Meaningful

by Dr M D Husain

THE aged or the old population is steadily increasing in Bangladesh. This was indicated in a survey conducted by the Association of the Aged and the Institute of Geriatric Medicine at Dhaka, Bangladesh. In1951 the proportion of the aged population (60 years and above) was 4.4% and this increased to 5.2% in 1961, which gradually went up to 5.6% in 1981. It is speculated that by the end of the century, that is, by the end of the year 2000, the aged population would be 9.80 million, which is exactly equivalent to 7% of the total population. The gradual increase of longevity in Bangladesh is virtually responsible for this upward trend of the aged population in our society.

This increased trend of the aged population clearly indicates that sooner or later we would be confronted with a gigantic task for this group of people in our society. The overall increase of longevity in Bangladesh is perhaps due to our awareness of overall health-related activities and also of "self-help care." The Declaration of Alma-Ata conference in 1978 that set the goal of health for all by the year 2000 has inspired new hopes and aspirations for improvement of health at all levels, based on the philosophy of equity and a new approach, the primary health care approach.

Most countries therefore nowadays have given the priority to implement "Primary Health Care" in their national health care system. Although primary health care has well covered the essential elements of human care, still its elements have not yet included any kind of special care, like that of maternal and child health care, to the aged population of our country. According to reports of the society of the Aged (Geriatric Society) of Bangladesh, the most common diseases among the aged population in Bangladesh are aches and pains, rheumatism (vague rhe-umat-ism), anaemia, weakness (nutritional deficiencies) asth-ma, cough and cold. These disease were more prevalent in rural areas of the country. This is perhaps because of less opportunity for meeting basic needs in the rural communities. Besides, some of the other common diseases such as peptic ulcer, eye problem (cataract), blood pressure, diabetes mellitus and cardiac problems etc are found among the aged population too in our society.

Apart from organic diseases, the aged or the old suffer from loneliness, isolationism; at times despair, frustration, fear of death and depression. All these come in bouts of attacks in a series of waves with alteration of moods; at times elevated and at times depressed. Recently reports came that some old people suddenly died, virtually unattended. The simple fact was that there was nobody available near at hand at the time of death. Such incidents are not unusual in any societies. But it is more common in the Western society. Recently in USA a loyal dog was found to take care of his old master, when the master had suddenly collapsed in bed due to heart attack.

Old-age drudgery — Photo: Proshanto Karmaker Buddha

The growing population, rapid urbanization, steady break down of joint-family system, economic hardship, insufficient pension money and introduction of modern technologies within the society, etc; are factors that have attributed to increase the problems of the aged population. Therefore it is seriously affecting life of the aged in our society. The only way to minimise it is the co-operation of the Government and society along with the dedicated efforts of the old people themselves. Sooner, we realize this hard realities, the better for us. We must therefore get our old people well organized, well co-ordinated so as to help each other and to know whereabouts of others. For this, the old people should meet frequently at certain organized centre or place or day care centre or home (Old People's Home). Many developed countries nowadays have organized nursing homes or old-age homes or a paid home to look after the aged population of society.

In the day care centre, the elderly not only meet each other but they can also contribute to small-scale industrial works; such as sewing, handcrafts, weaving etc. Many such items can be marketed to support the expenses of such centres. By this way, the neglected elderly would feel better and proud being able to play a positive role in society. The organized elderly can easily arrange and participate in annual and half-yearly sports competition. Such sports are as playing cards, carom, chess, swimming, music, walkathon, discussion on literature and religions etc. All such activities will certainly keep them happy and fit as ever.

For prevention of anaemia and nutritional deficiencies within the old age group, the rich and capable elderly can voluntarily organize supply of supplement of cooked meals once or twice in a week in the area of their own locality. This would help a lot to maintain proper nutrition of the low-income poor elderly. In fact, this has been a regular practice in many Western European societies. We can also start similar sort of services for our old and needy people of society in the near future.

In our society, the poor-income pension-holders find it hard to mange their day to day expenses. In such circumstances, the rich elderly of the coming generation can organize among themselves to keep money in a bank, to be called The Bank for Financing the Elderly in limited projects and to meet up emergency financial crisis. Such projects could be the vegetable cultivation, tree plantation, fish cultivation, raising poultry, gardening and opening limited insurance schemes etc.

These are not difficult tasks and can easily be managed by the elderly or the old people themselves. The government on its part can play a positive role to lessen the hardship of the old age. The democratic government can issue "Senior Citizenship" card to every member of the old age group in society. The holder of such Card will be entitled to enjoy certain facilities at reduced rate, such as transport, essential food items, essential drugs, free hospital treatment and free entry to recreation centres. All these would be counted as a great help to the old people. Finally, old people have no reason to feel condemned or miserable and any amount of unwanted mercy is neither desirable nor a solution. That the old age is a normal process of life and therefore one has to accept it with courage and determination to find a way out for a meaningful life.

(Dr M D Husain is Vice-President, Public Health Association of Bangladesh and a life member of Bangladesh Association For the Aged and the Institute of Geriatric Medicine.)

Economic Impact of AIDS Accompanies Health Concerns

THE worldwide spread of AIDS is troubling primarily because of the suffering brought to its victims and the loss experienced by families, but the disease's economic implications are also raising concern.

The economic impact of, and private sector responses to the AIDS pandemic were discussed at the first Congressional Forum on the HIV/AIDS Pandemic, held June 23-25 with joint sponsorship of the bipartisan Congressional Task Force on International AIDS and the Human Rights Project.

Mead Over of the World Bank and S Bertozzi of the Zion Medical Center at The University of California pointed out the unusual characteristics of AIDS, or acquired immunodeficiency syndrome, which include 100 per cent fatality, death at prime years of productivity, lack of discrimination in victims, and expensive treatment. Bertozzi added that "clumping" in the distribution of AIDS in households and in different countries does not resemble other diseases and "overwhelms the social support structure to take care of the sick, and infected."

According to over, the best estimates suggest "AIDS will slow population growth, but will not reverse it" and its special features will counteract any resulting positive effect on GDP from slower population growth. Over recommended further micro level study of the pandemic's impact on the household to increase understanding of its overall economic consequences.

A representative of the Commercial Farmers Union in Zimbabwe, Peter, Frazer McKenzie, reinforced this need to examine micro level evidence. He described the enormous burden on widows in a subsistence farming economy. Oftentimes, there is no family member capable of performing the deceased's job in the fields. This labor deficiency results in increased financial insecurity for the family as farming is redirected away from "labor intensive cash crops" to crops which do not provide sufficient income for the family's survival.

Stasia Obremskey, a consultant for the Population and Community Development Association (PDA), remarked that a study of AIDS in Thailand found consequences such as loss of labor supply and an increase in health care costs made a "compelling case for early investment in an AIDS prevention programme." An investment in prevention leads to significant returns as both lives and resources are saved, she said.

Private sector representatives from Canada, Zimbabwe, Botswana, and Zambia described prevention programmes to help control the spread of AIDS, and their companies' attitude towards implementing AIDS related programmes.

Julie White of Levi Strauss in Canada outlined her company's four-part strategy for combating the AIDS pandemic. This includes steps to prevent employment and job application discrimination against infected workers, preventive education measures for all employees, equal medical insurance coverage for all employees, and "community strategy initiatives."

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The costs of taking no action are enormous, the company representatives agreed. Absenteeism will increase in the workplace and skill levels and experience will plummet, said Nick Brentnall, Managing Director of Barkley Bank Ltd, Zambia. "Business cannot hide from this disease," emphasized White.

Helen Tinker, public Relations Director for David Whitehead company in Zimbabwe noted that since the private sector has the resources and an attentive audience, it is the ideal group for creating AIDS awareness.

Many companies already implement some preventive measures. These include an AIDS peer education programme at Kgalagadi Breweries, Botswana, a live theatre group performing for employees on AIDS prevention measures and a comic strip about the disease at David Whitehead Company in Zimbabwe, and articles about AIDS in publications circulated to all employees and counseling services at Barkely Bank Ltd, Zambia.

In addition, Tinker stated that it is more effective "to involve people on the ground" rather than to have managers instructing employees on preventive measures.

Mamze Matome of Kgalagadi Breweries noted that a lot of companies are willing to have preventive AIDS programmes.

Preventive measures can be extremely effective. For example, David Whitehead Company's largest clinic noted a 75 per cent decrease in sexually transmitted disease rates following their programme implementation, All of the private sector representatives agreed that the private sector's immediate involvement in AIDS prevention programmes is important for a business's long run success.

— USIS News

Tobacco is Not All Cigarettes

India is trying to make its citizens kick the nicotine habit putting huge taxes on cigarettes. But while the measure has cut cigarette sales drastically, tobacco chewers are not affected. Mahesh Uniyal of IPS reports.

MORE and more Indians are extinguishing their last cigarette as the government's exorbitant tobacco taxes help the war against smoking, but millions of tobacco chewers in rural India continue to chomp away.

Every year, the Indian government slaps fresh levies on cigarettes that fetch over a billion dollars annually. And it seems to be the cost rather than the health warnings emblazoned across cigarette packs that has convinced Indians to go cold Turkey.

Taxes now make up nearly 75 per cent of the price of a cigarette in India. Cigarette production has fallen from 90 billion sticks to 70 billion over the last decade.

But Indian health officials are not celebrating yet. Cigarette smoking is a predominantly urban habit, and makes up a mere five pre cent of tobacco use in this country of 840 million.

The real battle is against smokeless tobacco and the non-Cigarette smoker, say health officials. India tobacco is more often chewed or rolled up in leaves for a quick and inexpensive nicotine hit.

They say the worldwide campaign against cigarette smoking launched by the UN World Health Organisation (WHO) should also include smokeless tobacco and non-cigarette smoking.

The WHO says construction workers, uranium miners and those in the aluminium, copper smelting, chemical and textile industries are especially vulnerable as the tobacco smoke there mixes with other hazardous workplace-generated compounds.

But Indian blue collar workers are more likely to chew tobacco or smoke bidi, a popular indigenous cigarette made from tobacco wrapped in a tree leaf.

Half of all Indian tobacco consumption is either chewed or taken as snuff. Tobacco is often added to pan — areca nuts, lime paste and spices rolled up in a betel leaf — and sold at innumerable street corner kiosks.

Small aluminium foil sachets of pan masala, a dry spicy mixture of tobacco, lime and arecanuts, are also highly popular with rich and middle class Indians.

The rest is smoked, 40 per cent of it as bidis. More and more people are switching from expensive cigarettes to the cheap bidis, of which at least 900 billion sticks are produced annually.

But a *bidi* is more harmful than a cigarette. It has higher levels of carbon monoxide, tar and nicotine, exposing the smoker to an increased risk of cancer, say experts.

Health agencies have estimated that tobacco kills at least three million persons annually. In India alone, nearly a million people are estimated to die every year from tobacco-related diseases.

Of the 1.5 million registered cancer patients in this country, one-third are smokers. But nine out of ten oral cancer patients — over half of all cancer cases — are tobacco chewers. Medical experts say tobacco is also responsible for severe morbidity among Indian workers by producing a variety of respiratory and heart ailments.

The tobacco habit is picked up early in this country. Almost 80 per cent of males and 40 per cent of females over the age of ten in are estimated to be tobacco addicts.

In the countryside, tobacco is an inseparable part of life. Children watch their elders sharing the indigenous pipe called hukka and chewing a mixture of tobacco and lime.

Health officials are also concerned by the widespread use — especially in villages — of tobacco-based toothpowders that indigenous medicine system recommend for heal thy teeth and gums.

The government plans to ban its manufacture. Warnings on cigarette packets was made mandatory in 1975. Since then, tobacco advertising has also been banned from state-run radio and television. Airlines, trains, buses and government offices are slowly becoming off bounds for the smoker.

But *bidis* and packets of chewing tobacco still do not carry warnings. In India's federal administration, New Delhi cannot make laws regulating their sales and promotion, which is the responsibility of state governments.

"Government action and laws alone cannot solve the problem," says TK Das, a senior health ministry official in New Delhi. "Non-governmental organisations (NGOs) have a very big role to play in educating the people against tobacco, specially in rural areas."

The government is also planing to phase out tobacco cultivation now that studies by the farm ministry show alternate crops can be equally profitable, say officials.

Zambian Doctors Look to Computers for Medical Information

HAKIKA Mopima was sick and in hospital in Lusaka two months ago. Today, he has returned to the University Teaching Hospital on appointment to see a doctor, but it is hard to find his file in the huge statistic department and he has lost his previous discharge slip.

Alice Adine was rushed back to the hospital and the doctor recommended emergency re-admission. Her file also is hard to find because the record clerks are off-duty.

And no one can find Alex Soba's laboratory results, one week after the doctor prescribed a specimen examination. They could be misfiled or in another department, or they could be lost altogether.

While some of these problems with Zambia's medical services are just frustrating, others, like delayed or lost laboratory or X-ray results, can be life-threatening.

Dr John Omara is worried about these problems at his own University Teaching Hospital — the biggest referral hospital in Lusaka — and more serious problems in the rural areas of Zambia. Doctors and paramedics in the north cannot keep abreast with new developments in drugs, diseases, equipment or treatment.

In an effort to overcome some of theses problems, Omara and a team of doctors have completed a project called Data Network for Hospitals and Education (DNHE),

Medical care is one of the most neglected areas in the developing world. Many hospitals do not have access to the most basic information about their patients. In Zambia doctors have completed a project aimed at developing a data network for managing patients' data and training doctors.

which is to be launched this month and eventually extended to rural hospitals by satellite.

Omara says he thought of the idea in 1980, when he was a student at the medical school in Lusaka. The rather "jumbled method of teaching" lacked practical self-learning, he says.

During 12 years as a student, senior doctor and administrator in rural and urban hospitals, he examined the distressing conditions of patients and staff, inadequacies in junior doctors and their desire for further education in order to produce an alternative curriculum.

He recommends a more practical training that can help a student "to integrate both theory learning and bedside learning in one session at the patient's bedside" so that he can cope with whatever responsibilities he may get in rural hospitals.

The project is based on an extensive use of audio-visual computer facilities, aimed at developing four aspects of the medical services : a data communications network for managing patients' data; the guidance for the staff on duty; the training of medical manpower and a system for them to continue their education.

Video,audio equipment, closed-circuit television and computer networks will form a system of information flow between the Central Data Room and user terminals in all departments at the University Teaching Hospital and even students' hostels at the medical school.

The user terminals can be used by basic and clinical science students for self-instruction; by paramedics to solve problems or by consultants and lecturers for learning, editing, altering and preparing better teaching materials.

Medical students will spend four months of their first 11 months at the University of Zambia Medical School learning how to use the electronic equipment. This will make them less dependent on the presence of teachers and text-book theory, and will enable students to "marry theory to practical situations. That is integrated learning," says Omara.

Omara thinks more rural people should be recruited as doctors to serve their own communities.

Omara's project is stirring up interest outside Zambia. Professor C F Kiire of the University of Zimbawe's Department of Medicine describes DNHE as "an excellent project which if implemented should be a great contribution to medical education in Africa".

More importantly, Zambia will be linked to Healthnet, a satellite system aimed at exchanging health information between developed and developing countries.

The project launch is scheduled for June if all the $400,000 needed for the first phase can be mobilised in time. Omara is confident that the project will provide better trained doctors to Zambia in the future. — Gemini News

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Central Data Room of Lusaka's University Teaching Hospital

New Surgery for Slipped Disc

by T V Padma

A new from of surgery that is simpler, has fewer post-operative complications and needs lesser time for hospitalisation is being introduced in India to treat patients suffering from slipped disc.

Slipped disc, medically known as lumbar disc prolapse or herniated disc, is especially common among young people. It is a painful disorder in which an invertebral disc present between two bones in the spinal column ruptures, and part of its pulpy core protrudes, exerting painful and sometimes disabling pressure on a nerve.

About 95 per cent disc prolapses occur in the lower back, but they can affect any part of the back or neck.

They usually develop gradually as a result of degeneration of discs with age, although sometimes a prolapsed disc may be caused by a sudden strain action such as lifting a heavy weight or twisting violently.

People between the ages of 30 and 40 are the most likely to suffer from a slipped disc and its incidence is greater in men than in women. Also people who spend long periods sitting without a break are prone to it.

Normally the disc comprising fibro-cartilgenous tissue acts as some sort of shock absorber.

The spinal column is built of a series of bones called vertebrae placed one on the top of the other, explained Dr V S Mehta, a neurosurgeon at the All India Institute of Medical Sciences (AIIMS), New Delhi.

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Between these vertebrae is a disc with an outer ring of fibrous tissue and an inner cartilege core known as the nucleus pulpsous. The disc makes the spinal column more flexible and resilient and acts as a buffer against jarring.

With age, the outer fibrous ring degenerates in places and the inner nucleus pulpsous protrudes out, Dr Mehta said.

It presses on the neighbouring spinal nerve, causing pain in the legs and the buttocks, and in rare cases, it exerts pressure on the spinal cord itself, leading to paralysis of legs and loss of bladder and bowel control.

This happens most often in the disc between the fourth and fifth vertebrae, Dr Mehta said.

The conventional treatment for this painful condition includes bed rest, physiotherapy and pain killers or local anaesthetic injections, but in those cases that do not respond to this protocol, surgery is required to remove the protruding mass.

About one-fifth of the slipped disc cases need surgery, doctors say.

In India, doctors resort to open or micro surgery for which a patient has to be hospitalised and off work for between four and eight weeks after the operation.

A new method — percutaneous endoscopic lumbar discectomy — is now becoming popular in most European countries in place of the conventional microsurgery for slipped discs.

The technique was recently demonstrated by a leading international expert in the field, Prof H M Mayer, from the University of Berlin, at a national workshop held at AIIMS.

In the new method, the prolapsed disc is removed through a thin tube, called an endoscope, which is introduced into the disc under local anaesthesia and without any skin incision.

The patient needs to be hospitalised for only two or three days and can be back at work in about 10 years.

The very fine tube with a diameter of 4.5 mm carries within it a small wire that guides the forceps and cutters in removing the bulging tissue.

The new method is more flexible and can be further improved by using a laser beam to guide the endoscope.

Even if it does not succeed, doctors can perform microsurgery again to remove the tissue, Prof Mayer said.

— (PTI Science Service)