Welcome


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Founded on 15\textsuperscript{th} January 1988.

Inspired by the spirit of service of Mahatma Gandhi, affection of Sane Guruji and compassion of Saint Mother Teresa.
What do we do for SC?

- Oldage homes- Day Care Centre, Century Club & Networking of NGOs working for SC, World SC Day celebrations
- Destitute Rehabilitation Centre
- Rural & Eye Hospital, Nursing School, Ward boy & Aaya Training
- Mobile Health Units, Health camps & education lectures & Physiotherapy, Yoga & Meditation centres, & Research.
- Meet the stalwarts. Collaboration with WHO, South East Asia Regional Office, on Promoting Active Healthy Aging and Elderly Health Care
Meet the Stalwart (ILC-I)
Indian Scenario

- India is a vast country - 3288000 Sq. Kms
- No. of villages in India – 6,38,387 villages
- Vast population > 1 billion
- 67% live in Rural areas
- 25% are BPL
- Elderly population = almost 10 crores
Problems in the villages

- Poverty
- Dependency
- Unorganized
- No Proper living arrangement
- No Employment
- Illiteracy
- Migration of youngsters to cities
- No Social Security - Pension - 14% SC, mostly urban
- Diversity & Diet
Rural Aging Project 2008-09
(Under guidance of Dr. Gururaj Mutalik, fmr Director WHO)

A Research & Action Project initiated by Janaseva Foundation in 38 villages in Taluka- Velha & Mulshi with Help from -

- Maharashtra Foundation, USA
- Share & Care Foundation, USA
- Mr Narendra Lakhani, USA
Pilot Study – conducted prior to Rural Aging Project for 600 Rural SC

<table>
<thead>
<tr>
<th>Sex</th>
<th>Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>306</td>
<td>51%</td>
</tr>
<tr>
<td>Male</td>
<td>294</td>
<td>49%</td>
</tr>
</tbody>
</table>

Various Factors / Issues studied under this survey & we decided to go for this research project.
Janseva Foundation during the last 2 years is conducting a Research study on aging in Rural areas, in 38 villages near Panseth. This study includes all aspects of aging including areas connected with the Human rights of the elderly.
Aims & Objectives of the Study

• To study the involvement of the community, rural elderly population (60 years and above) in 38 villages in Panseth area, Pune, Maharashtra for elucidating socio-economic, health and wellness, and other related issues and to formulate and apply intervention programs.

• To study policy requirements towards influencing the quality of life of the elderly
• To study the aging health profile in the community and diagnose and treat diseases, disabilities and promote wellness status of the community with appropriate intervention programs.

• To formulate a sustainable and self reliant package of services towards a healthy productive aging in the rural areas.
Methodology

• A complete survey of aging population using a questionnaire based on WHO guidelines. (1278 elders)
• A team of physicians undertook physical, and laboratory examination of all senior citizens to assess their health, fitness and disease status.
• Detailed psycho-social profile by special interviews.
• A Rural Hub served as the center of service and research activities used for multiple program activities.
• Many interconnected sub projects such as Nutrition and Rural aging, Model Village at Kuran, Education of the elderly, and Mental health assessment.
### Abnormalities found in 1278 SC

<table>
<thead>
<tr>
<th>BSL Fasting &gt; 120</th>
<th>Borderline</th>
<th>Diabetic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>110 pts</td>
<td>180 pts</td>
<td>290 pts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BUL</th>
<th>Females</th>
<th>Males</th>
<th>Total</th>
<th>Normal values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>52</td>
<td>95</td>
<td>147</td>
<td>15 – 35 mg %</td>
</tr>
<tr>
<td></td>
<td>4.5%</td>
<td>8.5%</td>
<td>13%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S. Creatinine</th>
<th>64</th>
<th>108</th>
<th>172</th>
<th>0.5 – 1.4 mg %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5.6 %</td>
<td>9.5 %</td>
<td>15.15 %</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt; 8</td>
<td>8 - 10</td>
<td>10 - 12.5</td>
<td>Total = 510</td>
</tr>
<tr>
<td>----------------</td>
<td>-----</td>
<td>--------</td>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Hb %</strong></td>
<td>83</td>
<td>180</td>
<td>247</td>
<td></td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Males</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Normal values</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S. Cholesterol</td>
<td>178</td>
<td>62</td>
<td>240</td>
<td>150 – 200</td>
</tr>
<tr>
<td></td>
<td>15.7 %</td>
<td>5.5 %</td>
<td>21.11%</td>
<td></td>
</tr>
<tr>
<td>S. Triglycerides</td>
<td>157</td>
<td>69</td>
<td>226</td>
<td>61 – 160</td>
</tr>
<tr>
<td></td>
<td>13.8 %</td>
<td>6.2 %</td>
<td>20 %</td>
<td></td>
</tr>
<tr>
<td>S. HDL</td>
<td>224</td>
<td>195</td>
<td>419</td>
<td>&lt; 45</td>
</tr>
<tr>
<td></td>
<td>17.5 %</td>
<td>15.2 %</td>
<td>32.7 %</td>
<td></td>
</tr>
<tr>
<td>Abnormalities</td>
<td>Females</td>
<td>Males</td>
<td>Total</td>
<td>Normal values</td>
</tr>
<tr>
<td>---------------</td>
<td>---------</td>
<td>-------</td>
<td>-------</td>
<td>---------------</td>
</tr>
<tr>
<td>B.P.</td>
<td>345</td>
<td>274</td>
<td>619</td>
<td>120/80 mm of Hg</td>
</tr>
<tr>
<td></td>
<td>30.4%</td>
<td>24.2%</td>
<td>54.6%</td>
<td></td>
</tr>
<tr>
<td>ECG</td>
<td>108</td>
<td>100</td>
<td>208</td>
<td>Out of 208 86 are Grossly Abnormal</td>
</tr>
<tr>
<td></td>
<td>9.5%</td>
<td>8.8%</td>
<td>18.3%</td>
<td></td>
</tr>
</tbody>
</table>
## Nutritional Status of Elderly in Detail in 139 SC

<table>
<thead>
<tr>
<th>Risk of malnutrition</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malnourished</td>
<td>16</td>
<td>34</td>
</tr>
<tr>
<td>Normal</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>87</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Body Mass Index</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 19</td>
<td>19</td>
<td>55</td>
</tr>
<tr>
<td>19 to less than 21</td>
<td>19</td>
<td>24</td>
</tr>
<tr>
<td>21 to less than 23</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>23 or greater</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>
Bone Mass Density in Rural Elderly

BMD done in 903 SC out of 1236 SC

- Normal = 571
- -2.5 to -4.5 = 290
- -4.5 to -6.5 = 37
- > -6.5 = 5
Activities of Daily Living is a good measure of Functional Competence

- In general, 83% of the rural elderly have more than 3 Morbidities as against 73% of the urban elderly.
- 58% of the urban elderly seek medical advice as against 19% of the rural elderly who come for health advice on their own when disease is in advanced stage.
Prevalence of diseases / disorders

88% of the elderly in this study had at least one of the following disease / disability:

- Anemia: 40%
- Arthritis: 68%
- Hypertension: 43%
- Visual problems – cataract: 43%
- Diabetes: 29%
- Hearing problems: 54%
- Gastrointestinal disorders: 44%
- Acid peptic disease: 70%
- Caries teeth and poor hygiene: 80%
- Hemorrhoids - 21%
- Varicose veins - 08%
- Urinary diseases - 32%
- COPD, bronchitis & BA - 36%
- Tuberculosis - 05%
- Skin diseases - 30%
- Psychological Problems – anxiety, depression and Dementia - 10%
- Alzheimer - 01%

8% of all elderly had 5 disorders
16% had 4 disorders
22% had 3 disorders and
34% had 2 disorders
Causes of mortality in these villages in last 2 ½ years

Large no. of cases go unregistered, out of which only 10% of deaths are medically certified. Unfortunately in the death certificates ‘senility’ is given as cause of death in all the cases in all the villages.

In the project period 50 deaths occurred due to cardiovascular diseases, complications of diabetes, accidental injuries and infections. Occasionally we see patients of malignancy.
Rural Hub at AMBI, Janaseva Foundation

A multicenter facility services to the elderly from the surrounding rural areas e.g. Yoga, and meditation, health education, counseling in legal disputes, employment potential, vocational training, talks on rights and privileges of the elderly, motivational sessions etc.
Rural Sanitation Programme – Construction of Toilets
Strength of our Study

- Participation of SC was quite high
- Good follow up
- Effective programme in disease prevention
- Improvement record is maintained
- Medical Officers of PHC are involved
- Construction of Rural Hub – SC Activities
- Physiotherapy Centre at Ambi – Physiotherapy Equipments in Mobile Vans
Limitations of the study

- Exact age is not known
- Chances of misrepresenting of information by the respondents
- Proxy’s rating on disability was less accurate than the patients own rating
- Superstitions
- Addiction e.g. tobacco, alcohol – don’t cooperation
- Mediclaim – Health Insurance is not available in rural areas
Conclusion

- Poverty, poor hygiene and unhealthy environmental conditions are still predominant in Rural India e.g. unclean drinking water, dirty food, climatic conditions e.g. respiratory diseases in rainy season
- Poor ventilation in rooms where wood is used as fuel for cooking and bad housing conditions
- Lack of early detection, awareness, stigma about disease and to pursue medical advise.
- Increase in tobacco use, Pan Masala, Alcohol consumption, Air – Water pollution, Excessive use of pesticides should be controlled.
- Changing dietary factors e.g. diet, stress.
- Comprehensive health policy on Rural Ageing should be materialized.
IFA Executives visit
Life for the elderly in villages, especially women, is a long hard journey and often a bitter struggle.
The woods are lovely
Dark and deep
And we have promises to keep
And miles to go
Before we sleep,
And miles to go,
Before we sleep.

- Robert Frost

Thank YOU