World Health Organization

SPRC Social Protection Resource Centre

STATE OF OLD AGE WELL-BEING IN PAKISTAN

"Ageing must be Accepted, NOT IGNORED"

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STATE OF OLD AGE
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2020

Flagship report by SPRC

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ABBREVIATIONS

AAI	Active Ageing Index
ADB	Asian Development Bank
AJK	Azad Jammu & Kashmir
ANOVA	One-way Analysis of Variance
BHU	Basic Health Unit
BISP	Benazir Income Support Program
BOD	Burden of Disease
CFA	Confirmatory Factor Analysis
CFI	Comparative Fit Index
CHE	Central Health Establishments
COMSATS	Commission on Science and Technology for Sustainable Development in the South
COPD	Chronic Obstructive Pulmonary Disease
CSOs	Civil Society Organizations
DCP	Disease Control Priority
DHQ	District Headquarters
DHS	Demographic Health Survey
DM	Diabetes Mellitus
DOH	Department of Health
EMR	Eastern Mediterranean Region
EOBI	Employees' Old-age Benefits Institution
EPI	Expanded Program on Immunization
EQA	External Quality Assessment
EU	European Union
FATA	Federally Administered Tribal Areas
FBR	Federal Board of Revenue
FLHWs	Frontline Health Workers
GAWI	Global Age Watch Index
GB	Gilgit-Baltistan
GCU	Government College University
GDP	Gross Domestic Product
GFI	Goodness of Fit Index
GoP	Government of Pakistan
HAI	Healthy Ageing Index
HCFs	Health Care Facilities
HR	Human Resource
HSA	Health Services Academy
HTN	Hypertension
ICOPE	Integrated Care for Older People
ICT	Islamabad Capital Territory
ICUs	Intensive Care Units
IEC	Information, Education and Communication
IHD	Ischemic Heart Disease
IHME	Institute for Health Metrics and Evaluation
IHR	International Health Regulations
ILI	Influenza-Like-Illness
IP	Intellectual Property
IPC	Infection Prevention & Control
IPCAF	Infection Prevention and Control Assessment Framework
KP	Khyber Pakhtunkhwa
LAT	Laboratory Assessment Tool
LRTI	Lower Respiratory Tract Infection
LSD	Least Significant Differences
MDA	Mean Decrease Accuracy
MNCAAH	Maternal, Neonatal, Child, Adolescent and Older Person's Health
MNCH	Maternal, Newborn and Child Health

MONHSR&C	Ministry of National Health Services Regulations and Coordination
NADRA	National Database & Registration Authority
NAP	National Action Plan
NCD	Non communicable Disease
NDMA	National Disaster Management Authority
NDSP	National Diabetes Survey of Pakistan
NGOs	Non-governmental Organizations
NIH	National Institutes of Health
OECD	Organization for Economic Cooperation and Development
OOP	Out of Pocket
OPD	Out Patient Department
PAYG	Pay As You Go
PBM	Pakistan Bait-ul-Mal
PCA	Principal Component Analysis
PEI	Polio Eradication Initiatives
PESSIs	Provincial Employees Social Security Institutions
PCR	Polymerase Chain Reaction
PHC	Primary Health Care
PMC	Pakistan Medical Commission
PMT	Proxy Means Test
POC	Point of Care
POEs	Point of Entries
PPA	Pakistan Paediatrics' Association
PPE	Personal Protective Equipment
PPRP	Pakistan Preparedness & Response Plan
PSLM	Pakistan Social & Living Standard Measurement
R&D	Research & Development
RHC	Rural Health Clinics
RMSEA	Root Mean Square Error of Approximation
RMCNH	Reproductive, Maternal, Newborn, and Child health.
SARI	Severe Acute Respiratory Infections
SDGs	Sustainable Development Goals
SOGP	Obstetricians and Gynaecologists of Pakistan
SOPs	Standard Operating Procedures
SLIC	State Life Insurance Company
SPRC	Social Protection Resource Centre
SRMR	Standardized Root Mean Square Residual
SRH	Sexual and Reproductive Health
SRS	Simple Random Sampling
THQ	Tehsil Headquarters
TWG	Technical Working Group
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Care
UN	United Nations
UNDESA	United Nations Development of Economic & Social Affairs
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Population Fund
US	United States
VTM	Viral Transport Medium
WAPDA	Pakistan Water & Power Development Authority
WASH	Water, Sanitation and Hygiene
WDI	World Development Indicators
WHE	WHO Health Emergencies Program
WHO	World Health Organization
WHO EMRO	WHO Eastern Mediterranean Regional Office
WPP	World Population Projection
WWF	Workers Welfare Fund

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FOREWARD

Ageing is a natural phenomenon. A living organism one day dies; mostly by disease and infirmity. In some cases, the life could be cut short at an early stage by accidents, including, war, crimes, drugs, suicide, disease etc. Over the past decades, significant improvements in health and reduction in early life deaths have combined to result in better life expectancy both in the developed and developing countries. Disease being the weightiest factor resulting in the old age well-being loss, a better management of disease has pushed up the healthy expectancy of life in many countries. As the state of health is sensitive to financial and environmental factors, healthy life expectancy figures vary greatly across the countries. The Healthy Life Expectancy also depends on the 'subjective' elements as well as external determinants such as the individual emotional reaction to disease, reduced socio-economic relevance, neglect, violence and loneliness. The lived experience of the individuals, marking the personality, are quite varied as the lived experiences are shaped by the variables such as cultural frameworks, genetics and specificities of socio-economic conditions met by the individuals. Marked by disease and lower productivity, the older persons become more vulnerable to the shocks. The Old Age Well-being therefore depends upon a host of general and specific situations and circumstances. In Pakistan, the old age well-being is becoming a growing concern, but it is not yet become an important policy imperative.

It is the duty of the state to protect its citizens from any kind of vulnerability, whether it is physical, social or economic. The marginalized segments of the society, in principle, should get more attention of the government when it comes to protecting the citizens from these vulnerabilities. Old age population is considered as the vulnerable group of the society, which needs proactive response from the government. However, the population structure and dynamics vary significantly between the developed and developing countries with respect to the opportunities and priorities for old age population. Therefore, what old age brings in the developing economies is rather different from what it has to offer in the developed economies. Unlike developing nations, where, in most of the cases, the elderly do not have social health protection, in the developed countries, health insurance is a key component of social protection, especially for the elderly, as they are more susceptible to health problems. The similar kind of variation can be observed at social and economic level such as staying alone and having access to independent living even in an old age might be considered as a positive feature in the developed nations. On the contrary, being lonely is considered sad, in many societies of developing countries like Pakistan. Therefore, to ensure better well-being of older people, we need to identify the issues and challenges faced by the old age population with the socio-economic context of Pakistan. Older persons in Pakistan fall a victim to vulnerability on multiple accounts such as health, financial protection, food safety, and withdrawal from work force, dignity for older population etc.

Population of older persons is increasing worldwide due to increase in life expectancy and decrease in fertility rate and disease control interventions. Now, there are estimated one billion older people more than 60 years in the world, and it is projected that by 2050, 1/5th of the population will be more than 60 years. Pakistan is one of the 15 countries having more than 10 million older population, which will be doubled by 2030. Pakistan, being the 5th most populous country with population expected to rise to 243 million in 2025, has 6.2% of Pakistan's population above the age of 60 (GoP, 2020). In addition, a rising life expectancy means that the population of older people in Pakistan has been rising fast, and is expected to reach 16% or about 44 million persons of age 60 or more by 2050.

However, the conditions of older people in Pakistan, which is almost 13 million, are not commendable. Out of 13 million older people, only 1.8 million people get a pension or any allowance from social protection programs such as BISP and Pakistan Bait-ul-mal (PBM). Out of the remaining, 11.8 million elderly deprived of any social protection program; 1.8 million elderly belong to the lowest income percentile and need immediate assistance from the government and social protection institutions. Almost 0.415 million poor older people in Pakistan are sick, according to a recent Demographic Health Survey [DHS]. Therefore, these poor need a health protection program to meet their health expenditures.

Until date, the vulnerable older persons have not succeeded in getting the kind of attention from the government, community and the development sector, which could alleviate their situation. In Pakistan, the awareness about the rights of older people is poor. It is true that Pakistan has been facing many problems in managing its socio-economic balance but this could not be an excuse in giving little policy focus towards the welfare of elderly in Pakistan. It ranks extremely low in the Global Age Watch Index (GAWI), i.e., 92 out of 94 countries. GAWI ranks countries according to the circumstances of their older people, including health, income, employment and social connectedness. Pakistan ranks particularly low with respect to health of older persons, with a relatively low life expectancy and even lower healthy life expectancy within the region.

Pakistan does have a few programs in the country such as civil, military pension schemes, Employees Old Age Benefit Institution, Benazir Income Support Program, Pakistan Bait-ul-Mal (PBM) etc. but the initiative are too small and fragmented.

The old age brings with it structured and rampant vulnerabilities across all sections of society, all over the country and we need a proper, effective social protection framework to ensure the provision of a minimum social protection to the most vulnerable. The Social Protection Resource Centre (SPRC), Islamabad, a Think Tank dedicated to the universalization of social protection in Pakistan, being aware of the need to generate fresh authentic knowledge as a first step towards the establishment of such a framework has decided to bring out an annual State of Old Age Well-being Report from this year. The Reports aims at highlighting the demographic structure of the country related to old age and capture the trends and developments.

Being the first Report of its kind in Pakistan, the Report seeks to explicit the basic concepts of Healthy Ageing and initiates a discussion on the nature of old age wellbeing issues, as they exist in Pakistani society with the help of a survey done exclusively for this Report. The Report also puts the old age issues in a cultural perspective analysing the portrayal of older persons in the media. We, at SPRC however feel that the redressal of the ageing problems on sustainable basis requires the formulation of evidence-based strategies and interventions, which in turn depend on the existence of comprehensive and strong datasets showing the status and characteristics of older people in Pakistan. Our attitudes to the older persons are informed by our age-old norms and practices. Our Survey reveals that a large number of our older persons are living with unnecessary ill health, disability and loss of wellbeing. For a country with the average Life Expectancy at birth at 66 years, a healthy life expectancy of around 56 years is too short. In case of women, it is around 50. Why should our women live a big part of their lives in a poorer health than men? We feel, one of the key reasons of inaction to address the health and social protection issues, which are eating into our demographic dividend due to stunting in children and early onset of old age frailty is that our data systems have failed to capture the reality of our old age wellbeing. We need an integrated health and social protection responses on the basis of a nuanced but precise data on the complexities of health and declining functionality with the old age. Pakistan's national and local governments have not developed dedicated data sets on ageing population. We have been depending on the Indices developed elsewhere, even, if they might not be portraying our situation correctly as the subjective and cultural norms regarding the old age well-being could be different in different countries, the old age being primarily a social construct.

SPRC in its maiden report on the old age wellbeing is presenting an indigenously developed Health Ageing Index of Pakistan [HAIP] to provide concrete evidence of the gaps at national levels in the data available for planning for ageing and the health and wellbeing of older people. We feel that the SPRC Index should be able to measure systematically those SDG indicators that are relevant to older people.

With the prevalent challenge of COVID-19, older people are significantly more likely to be infected from the virus than younger people are. When older people are infected, they are much more likely to have a life-threatening condition, even amongst those whose general health is good. The mortality risk of those infected is also found to be particularly high for those with chronic conditions such as pulmonary hypertension and other cardiovascular disorders. Experts say that the higher risks are attributed to a weakening of the immune system with age. In order to address the impact of COVID-19 on the older people, this report has addressed the concerns and challenges to the older population through a rapid response survey in the metropolitan cities of Lahore, Karachi and Islamabad. The Report also includes a detailed Chapter on the interventions and work carried out by the country office of the World Health Organization in helping Pakistan combatting COVID-19.

In addition to HAIP, the Report has many other unique features. It provides regional comparisons in terms of the governmental responses to the old age problems, including the legal and institutional responses. The Report attempts at a quantification of the most pressing unmet social protection needs to help imagine the financing needs to meet the unmet social protection needs of the elderly in Pakistan. We strongly hope that this Report, which would be released every year on the UN Day of Older Persons on 1st October, would become a harbinger of a better life for the older persons in Pakistan.

Dr. Safdar A. Sohail
Executive Director
SPRC

SECTION 1

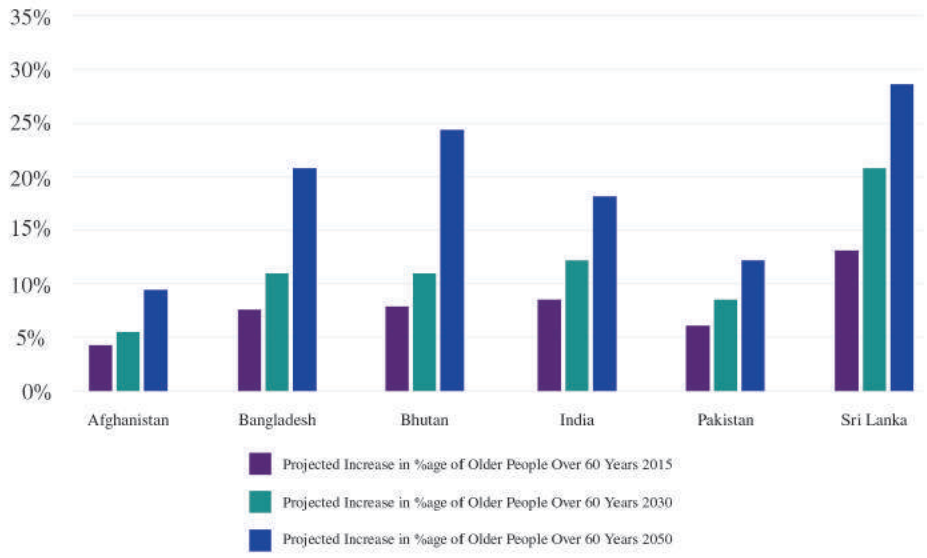
OLD AGE WELL-BEING IN PAKISTAN

DIMENSIONS & DETERMINANTS

1.1. OLDER POPULATION IN PAKISTAN

South Asian economies have been experiencing one of the highest population growth rates, with 64% of the population aged between 15 and 29 years[1]. In case of Pakistan, it is even higher and it is expected that the population of Pakistan will surpass 244 million by 2030. Moreover, the older population will increase by 3.3% annually between 2015 and 2030. Based on gender segregation, women have higher life expectancy rate than men in old age by 1.8 years[2]. It is estimated in the United Nations' World Population Projections (WPP) that the projected increase in the population of the older people in case of Pakistan will be 12.8% in 2050 as compared to 6.6% in 2015[3]. As shown in the Figure 1.1, in comparison to other South Asian countries, Pakistan will experience lesser proportional increases in the growth of older population due to the presence of higher levels of vulnerabilities for Pakistan's older persons in the region.

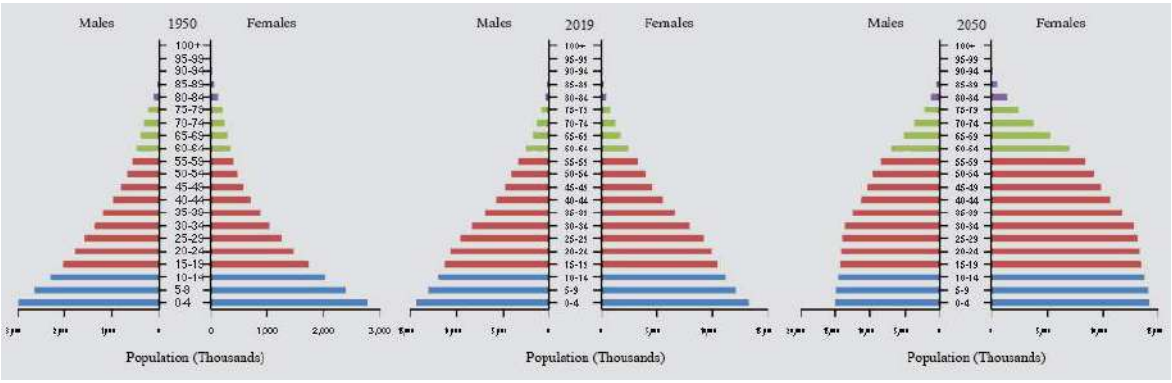
Figure 1.1 : Projections of Old Age Population in South Asian Countries



Source: UN World Population Projections (WPP), 2019

Pakistan is the fifth most populous country in the world with the total population of 207.7 million people[4]and it has now reached to 216.5 million[5]. Out of the total population, old age population in Pakistan is estimated to be around 12.5 million, which makes 7% of the country's total population, making the country among the group of top 15 countries globally having more than ten million older people. It is anticipated that by 2050, this population will increase to 44 million, which will make up 16% of the total population[6].

Figure 1.2: Population Pyramid for Older People in Pakistan



Source: World Population Ageing 2019: Highlights, UNDESA

[1]Ahmed, S. (2017). Pakistan National Human Development Report, Unleashing the Potential of a Young Pakistan. Islamabad: UNDP.

[2]http://www.globalagewatch.org/countries/country-profile/?country=Pakistan

[3]World Population Projections, 2019 https://www.un.org/development/desa/publications/world-population-prospects-2019-

[4]Pakistan Census 2017, Pakistan Bureau of Statistics

[5]World Development Indicators (WDI,2019) https://data.worldbank.org/indicator/SP.POP.TOTL?locations=PK

[6]United Nations, Department of Economic and Social Affairs, Population Division (2019). World Population Ageing 2019: Highlights (ST/ESA/SER.A/430).

It is clearly shown in the figure 1.2, that by 2050, not only the older population will increase, but also there will be gender disparity in terms of more expected increase in female older population in Pakistan. The trend analysis of the population growth rate for older people from year 1990s to 2000s showed that during 1950s to 1980s, the population growth rate for older people declined due to high fertility rate and increase in younger population. However, it started rising in 1990s and is still rising to more than 6.6% in case of rural areas and 5.1% in urban areas of the growth rate due to decreasing fertility rate and increased life expectancy rate[7].

Pakistan ranked 92 out of total 96 countries in Global Age Watch Index (GAWI, 2015)[8]. The ranking of Pakistan in four domains of GAWI is as follows also shown in figure 1.3; 95th in the income security domain with the lowest pension income coverages of 2.3%, 70th in the capability domain with only 15.8% of older people having a secondary or higher degree, 78th in the health domain with the lowest life expectancy at 60 years and 81st in the environment domain with the coverage of 60% of people having social connectedness, 46% enjoying civic freedom, and 55% with the facility of public transport.

Figure 1.3 : Pakistan's Ranking in GAWI (2015)

Source: Global Age Watch Index, GAWI, 2015

Though the Global Age Watch Index is afflicted with methodological limitations, yet in general, it anticipates increased dependency ratios in future, more pressure on existing resources to fulfil the needs of elderly such as the need for adequate healthcare systems, and voluntary & non-voluntary pensions. Pakistan's economy needs to be prepared to deal with this incoming change in the demographics, in order to maximize the nation's well-being. Unprotected by old age benefits, Pakistan has a significant number of very old people working to support for themselves and their families in precarious jobs such as daily wagers and security guards, whereas very old women could be found working as cleaners. Moreover, older people in Pakistan are highly vulnerable as compared to other developing countries to disease and health issues (Discussed in Detail in Section-IV and V) Considering these aspects, the importance of a well-established social security system and healthcare assistance to elderly in Pakistan can hardly be over-emphasized.

1.2. DIMENSIONS OF OLD AGE WELL-BEING

United Nations Universal Declaration of Human Rights states that older persons have a right to independence, participation, care, self-fulfilment and dignity. Old age, however, more often than not, is marked by age discrimination (stereotyping, neglect, social participation and loneliness), higher unmet financial and medical needs, and increased poverty. In the absence of robust data and indigenous old age well-being framework in Pakistan, this SPRC Report follows the Organisation for Economic Co-operation and Development (OECD) Well-being Framework of old age well-being indicators. Well-being is a comprehensive term that indicates how life is, and broadly includes material well-being, subjective well-being along with awareness and

[7]Mujahid, G and Siddhisena, KAP (2009) Demographic Prognosis for South Asia: Afuture of rapid ageing. Papers in Population Ageing No. 6.
[8]de Bruijn, J. G. M. (2015). Global Age Watch Index 2015, London, 2015, ch 8 Western Europe, North America and Australasia. Help Age International.

accessibility. From this framework, the SPRC Report establishes five dimensions i.e., socio-economic status, health, dignity & respect, independence and social protection. When it comes to ensuring well-being, basic necessities must be met and when it comes to fulfilling basic needs, social protection plays a key role especially for the well-being of marginalized groups of the society. Therefore, social protection is one of the additional, key dimension to be considered in case of old age well-being. Incontrovertible evidence at the global level has proved that the poverty in old age aggravates health issues. These two dimensions are also the prominent ones, as with the old age comes inability to work, creating economic vulnerabilities, leading to increased poverty. Furthermore, elders are at a higher risk of suffering from either a major or minor illness, because of low levels of immunity and deteriorated general health. Especially in case of developing countries, both these dimensions are further aggravated; hence, there is a need to address these issues in order to solve them through targeted policy interventions.

Ageing brings major changes in an individual's life, which calls for altered needs and requirements, hence altered ways to cope with life problems are required. In order to precisely aim at the well-being of older people, all dimensions of old age must therefore be identified and studied (See Figure 1.4).

1.2.1. AGEING DIMENSIONS

Based on extensive review of literature[9], this report identifies the following five dimensions of old age (See Figure 1.4):

1. Health: With age, health deteriorates, thus aged people are more likely to not only fall ill, but also to suffer from chronic diseases.

2.Socio-economic status: Due to lack of physical and psychological ability to work, older people are more likely to suffer from poverty.

3. Dignity and Respect: Ageing population increases dependency on the working population, their contribution to the economy declines and their needs increase (especially in financial and medical terms). As a result, elderly often face neglect and disrespect, where in fact they require support and to be treated with respect. It needs to be made sure that this segment of the society does not faces gender discrimination, age discrimination and is given the required extra support.

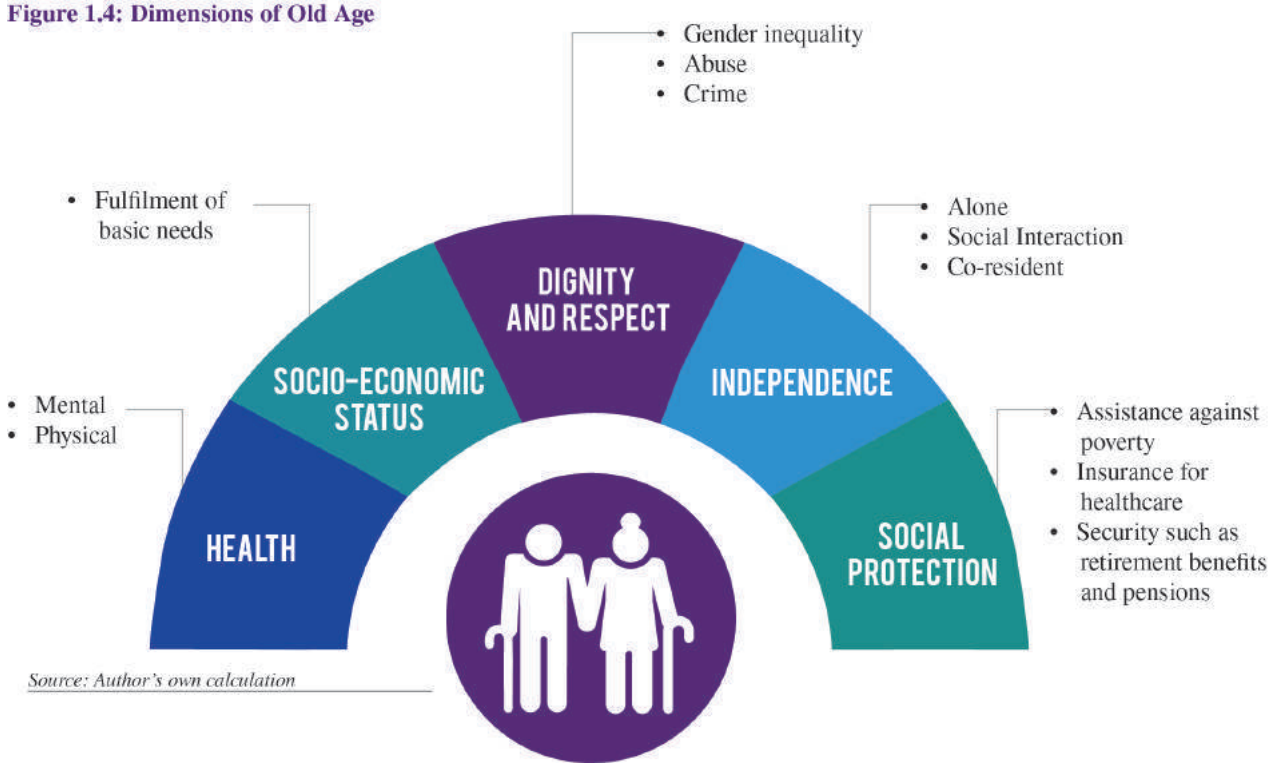
4. Independence: The older persons would be independent if they have access to the basic needs without being a burden and dependent on someone and access to work opportunities or have an alternative secure sources of income. With independence comes a sense of dignity, by being able to provide for yourself.

5. Social Protection: The elderly need protection:
- Assistance to deal with poverty
- Insurance for healthcare
- Security such as retirement schemes and pensions

The addition in the already set indicators of well-being was that of social protection. Thus, in order to assess the well-being of older people, the above-mentioned dimensions gave a comprehensive way forward for the SPRC Report.

[9]Measuring Well-being and Progress: Well-being Research - OECD. (n.d.). Retrieved September 28, 2020, from https://www.oecd.org/statistics/measuring-well-being-and-progress.htm

Figure 1.4: Dimensions of Old Age



Source: Author's own calculation

1.3. STATE OF OLD AGE WELL-BEING IN PAKISTAN

Based on the dimensions of old age identified above, this report established categories that individually contribute to "well-being", and further from those categories, identified indicators that had been studied to comment on the state of well-being of older people Pakistan. Table 1.1 enlisted these categories and the indicators used respectively for them.

TABLE 1.1: CATEGORIES AND THEIR INDICATORS FOR OLD AGE WELL-BEING

DIMENSIONS	CATEGORIES	INDICATORS
Socio – Economic Status	Socio – Economic Status	Source of Income Asset/Property Ownership Dietary/Medicines Need Monthly Income
Health	Physical Health Mental Health	Disability Medically Identified Mental Health Issue Anxiety and/or Depression
Independence	Loneliness Social Participation	Feel Lonely Volunteer Activities Participation in Social Gatherings
Dignity & Respect	Stereotyping Discrimination Abuse and Neglect	Prevalence of Stereotyping Prevalence of Discrimination Participation in Decision Making Abuse Neglect
Life Satisfaction	Life Satisfaction	Level of Life Satisfaction
Social Protection	Social Assistance Social Security	Financial Assistance from Government Employment Security

SURVEY METHODOLOGY

In order to assess the well-being of older population in Pakistan, the Social Protection Resource Centre (SPRC) conducted a survey on Old Age Well-being in major cities of Pakistan. The sample universe was the old age population of Pakistan i.e., those aged 55 years and above. The sample size was 450 (80% men and 20% women), employing cluster sampling, within each city, respondents were profiled according to their economic class i.e., upper class, middle class and lower class, based on geographical divisions. Within each cluster, Simple Random Sampling (SRS) technique was used for respondent selection.

The questionnaire for the survey had 12 sections; demographics, socio-economic situation, physical health, mental health, alienation/loneliness, social participation/integration, social assistance, impact of COVID-19, stereotyping, discrimination and abuse, awareness and enabling environment and life satisfaction. These sections are inspired by the OECD Individual Well-being Framework.

1.3.1. SOCIO ECONOMIC STATUS

Socio-economic status is basically the social standing of an individual or group, often measured as combination of education, income and occupation. With regards to old age population, socioeconomic status showed a far-reaching perspective on their prosperity. It covered the aspects of income, asset/ property ownership, and provision of basic old age needs. These are essential components for the well-being of individual and societies, it provide them the resources to satisfy their needs.

The indicator provided a very good measure of income's contribution to well-being as the indicator is the measure of households' consumption possibilities available within the national accounts system[10].

Employment status of an older person plays a vital role in shaping his/her socio-economic status, income is derived from it which is essential to meet the basic needs of the life.

Figure 1.5: Employment Status of Older People

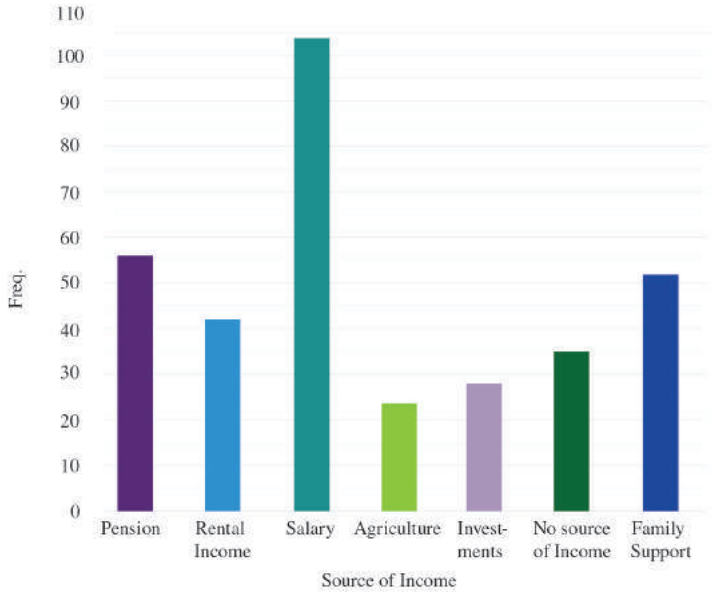
Source: SPRC Old Age Well-being Survey 2020

Figure 1.5 showed that 34% of the older people were still working even in this age, while 10% of the people were those who were working even after retirement, whereas 27% of the proportion were not working and 10% are those who were retired and decided to take rest in this phase of life. Moreover, out of total sample, 78% of the female were housewives.

Source of income as shown in the Figure 1.6 carried the thread of employment status of the older people further, which identified about the sources from which old ager population is receiving income.

[10]OECD Annual Repot (2007). Retrieved from https://www.oecd.org/newsroom/38528123.pdf

Figure 1.6: Source of Income of Older Population



Source: SPRC Old Age Well-being Survey 2020

It is evident from Figure 1.6 that salary turned out to be a prominent source of income for the older people followed by pension, family support and rental income. The least number of respondents reported agriculture as their source of income followed by investments and no source of income.

Given the cultural context of Pakistan, older people feel uneasy being financially dependent upon daughters, in most of the cases. Data showed that 22% of the older people received pocket money from daughters, while 66% received pocket money from sons. The results showed that 12% of the older people did not receive any pocket money at all and 5% said that they received it from other sources. Nonetheless, the percentage of older people receiving pocket money from daughters was significant.

Regarding the ownership of the property in old age, statistics in the Table 1.2 depict that 45% of the old age population never had any property on their name, while 66% still had possession of their property. On the other hand, 39% of elders were those who had transferred their property to their children. It is important to see how the socio-cultural dynamics of old age people vary from place to place and they live their lives according to that.

TABLE 1.2: GENDER ANALYSIS OF ASSET/PROPERTY OWNERSHIP

GENDER	ASSET/PROPERTY OWNERSHIP		
	Never Had Property	Transferred to Children	Still Have in possession
Female	52%	65%	43%
Male	31%	36%	68%

Source: SPRC Old Age Well-being Survey 2020

As shown in Table 1.2, there was greater percentage of females, who had either "never had any property" or had "transferred to children", contrary to which, there was a higher percentage of males who had property "still in possession".

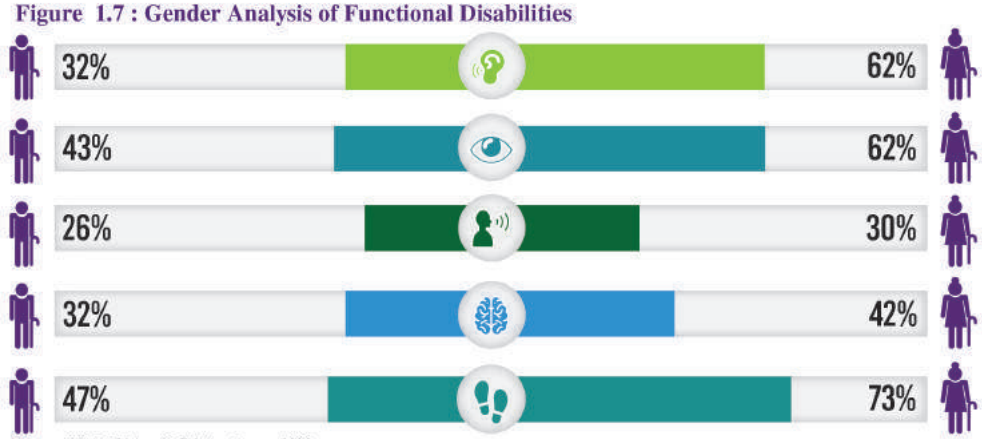
Food and medicines in old age play a vital role in continuing the journey of life more effectively and here, out of total sample, 86% of old age population said that their need of diet was properly being met. While an alarming figure of 30% of older population reported that their medicine needs were not being met properly, whereas in poor population whose income was below PKR 25,000, 60% of the older persons were those whose basic needs of the medicines were not being properly met and 32% were those whose food needs were also not being properly met.

1.3.2. HEALTH AND DISABILITY

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[11]. Health of the people is the most valued aspect of people's life. People's health status matters in itself, but also for achieving other dimensions of well-being, such as having good jobs and adequate income, being able to participate as full citizens to community life and to socialise with others.

Between 2015 and 2050, the proportion of the world's population over 60 years will nearly double from 12% to 22%. By 2020, the number of people aged 60 years and older will outnumber children younger than 5 years. In 2050, 80% of older people will be living in low and middle-income countries. The pace of population ageing is much faster than in the past. All countries face major challenges to ensure that their health and social systems are ready to make the most of this demographic shift[12].

Figure 1.7 : Gender Analysis of Functional Disabilities



Source: SPRC Old Age Well-being Survey 2020

A disability is any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions)[13].

Disability has three dimensions:

1. **Impairment** in a person's body structure or function, or mental functioning; examples of impairments include loss of a limb, loss of vision or memory loss.
2. **Activity limitation,** such as difficulty seeing, hearing, walking, or problem solving.
3. **Participation** restrictions in normal daily activities, such as working, engaging in social and recreational activities, and obtaining health care and preventive services[14].

Disability is a serious concern among the elderly where in gender analysis of functional disability data in Figure 1.7 guides us that nearly 32% of older men had hearing problems and 62% women had hearing problems. The proportion of the older men and women facing eyesight issues was 43% and 62% respectively. Moreover, 26% of older men lacked in communicating, while the proportion of the women were 30%. 32% of older men faced problems in remembering something and concentration while women in this domain was 42%. 47% of the old men faced serious problems in walking and taking stairs and stepping upward while women count was 73%.

This is startling that be it hearing, seeing, communicating, remembering or walking, women face much greater difficulty than men do. This means the older women in Pakistan, who otherwise live longer than men have a much more precarious and vulnerable old age.

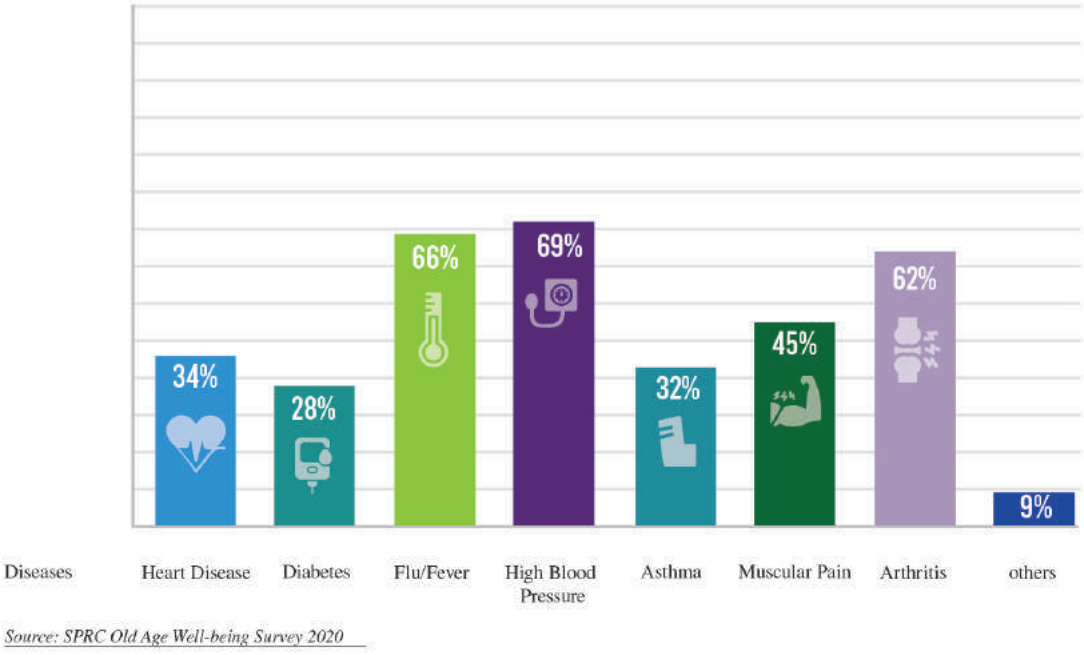
[11] Frequently asked questions. (n.d.). Retrieved September 28, 2020, from https://www.who.int/about/who-we-are/frequently-asked-questions

[12] Ageing and health. (n.d.). Retrieved September 28, 2020, from https://www.who.int/news-room/fact-sheets/detail/ageing-and-health

[13] Centre for Disease control and prevention, Disability and Health Overview, Impairments, Activity Limitations, and Participation Restrictions https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html

[14] Centre for Disease control and prevention, Disability and Health Overview, Impairments, Activity Limitations, and Participation Restrictions

Figure 1.8: Reasons for Visit to Hospital in the Last Six Months



Source: SPRC Old Age Well-being Survey 2020

In old age, people have multiple illnesses; many of these become chronic over time requiring continuous medical care. The results shown in Figure 1.8 show that high blood pressure was the major cause for older people visiting hospitals in the last six months while the least amount of people visited hospitals for diabetes and other diseases.

The physical and mental health plays a vital role in the overall satisfaction of life amongst the older persons. Physical health of the elderly, results showed that 70% of the older people went for walk even in this age, 74% of the people went to meet friends, and 94% of the people liked to meet relatives and 39% of the population in old age did physical exercise even in this age to keep themselves healthy.

The report also pointed out that 13% of the old age population was suffering from medically identified mental health issues, while 25% was suffering from anxiety and depression. It is evident that not every mental and psychological problem is medically identified but it can cause some effects as well. When we talked about enforced inabilities causing strain, 65% of the old age population told that paying rent and utility bills were causing serious strain. For 36% of the people, keeping the house adequately warm or cool appeared to them as enforced inability strain. For 53%, unexpected expenses was real reason for strain, while 3%, identified the inability to eat meat and protein regularly was a cause of strain. This brings out very clearly that these are the economic worries, which are the key stressors for the older persons in Pakistan.

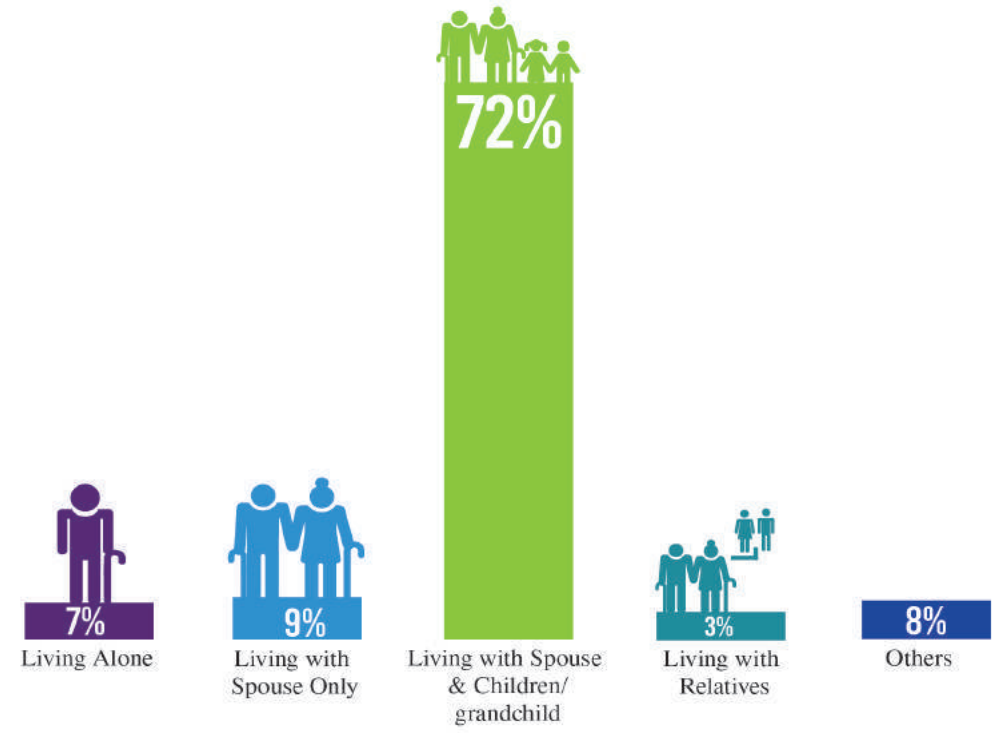
1.3.3. INDEPENDENCE

Independence for the older persons is defined as the ability to choose their living environment in old age. All the mentioned dimensions of old age and their respective categories are linked to each other; therefore, independence goes hand in hand with dignity and respect. However, the former is measured through loneliness, participation in volunteer activities and social gatherings.

Loneliness is a crucial factor linked to old age, as the time passes by, they feel themselves alienated and it is an important factor of causing anxiety and depression among elderly. It is interesting to see to what extent our old age population is independent and participating in social activities. Loss of independence can be discouraging to older adults[15].

[15]4 Reasons Independence Is Important for Seniors | VANTAGE Aging. (n.d.). Retrieved September 28, 2020, from https://vantageaging.org/blog/independence-is-important-for-seniors/

Figure 1.9: Residential Status



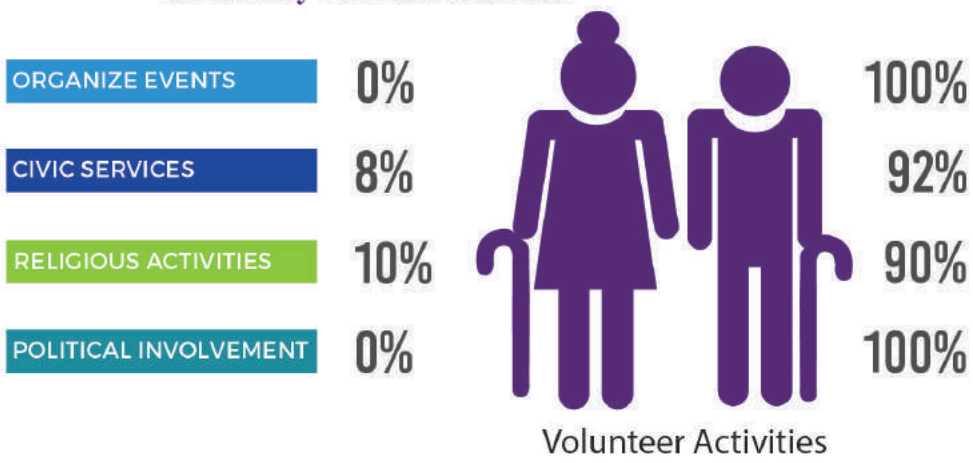
Source: SPRC Old Age Well-being Survey 2020

Nature of residence plays an important role in giving feel of loneliness. Statistics in Figure 1.9 showed that 72% of the old age population was living with spouse, children and grandchildren, while 16% were living alone or living with spouse only. This number in old age population carried pretty much weightage and 16% meant that a good number of older persons were under the umbrella of loneliness. Although the significant number of old age population was living in socially interactive residence but these numbers of living alone and living with spouse only are a matter of grave concern, particularly, if the trends continues. Statistics also showed that 67% of elderly said that they did not feel lonely at any time, while just 7% was living alone in this age, while 11% felt lonely most of the time. As we have very interactive culture as well, 72% of the people felt their neighbourhood and surroundings lively and safe and older people were often paying visits to their relatives and friends, but the point of concern here is that those older persons who felts that their neighbourhood was not safe and lively were 28% which is a big number. Though our Survey puts the neighbourhood safety at half of the GAWI Survey, but still, if more than a quarter of old age population felt that their neighbourhood was not safe and lively then this matter itself is in a need to be addressed.

We were keen to know about those factors, which can be termed as responsible for loneliness in old age. So, in view of 71% of the older people, living alone or living only with spouse was the cause of loneliness while 65% of the older people said that poor health facilities were the major cause and 30% of the older population felt that no interaction with the family members was the major factor for the loneliness.

Social participation and integration play an important role to safeguard people from loneliness by giving them opportunity to participate in social gathering and community events. Statistics of gender comparison of older population participation in community volunteer activities depicted that men are much more involved in social and volunteer activities as compared to women.

Figure 1.10 : Gender Comparison of Older Population Participation in Community Volunteer Activities

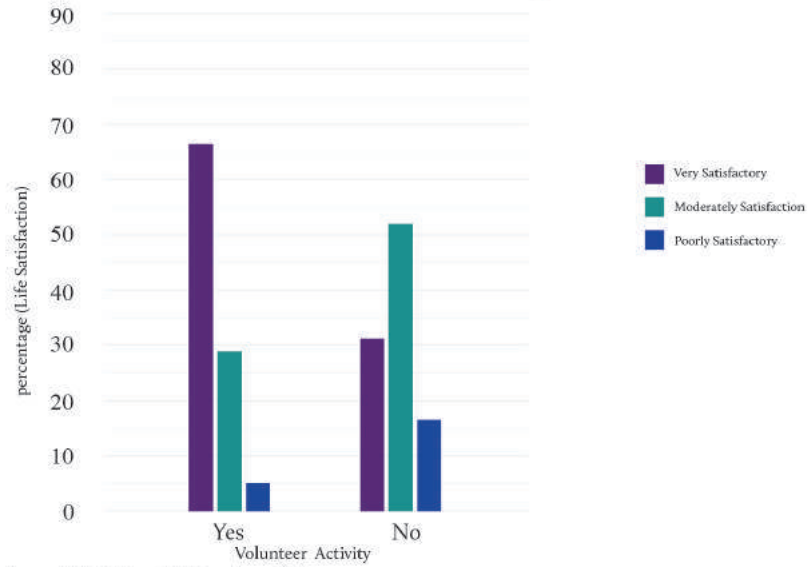


Source: SPRC Old Age Well-being Survey 2020

More data in this regard in the Figure 1.10 shows that those older people who were participating in community activities have 65% of population giving their volunteer services in organizing events while 63% were doing civic services and other developmental programs in community. 69% of the old age population was involved in some religious activities, as religion plays a vital role in keep people connected and bonded. Mosque plays key role in promoting social unity among the people and 34% of the older people were those, who were participating in political activities and doing volunteer for it as well. Therefore, these are some social participation dimensions where our older people are keeping themselves busy and even more productive.

Life Satisfaction combines multiple factors to depict how older people express their feeling and emotions for the life that they are spending to form an overall life satisfaction.

Figure 1.11 : Life Satisfaction of Older People who Participate in Volunteer Activities and who do not Participate in Volunteer Activities

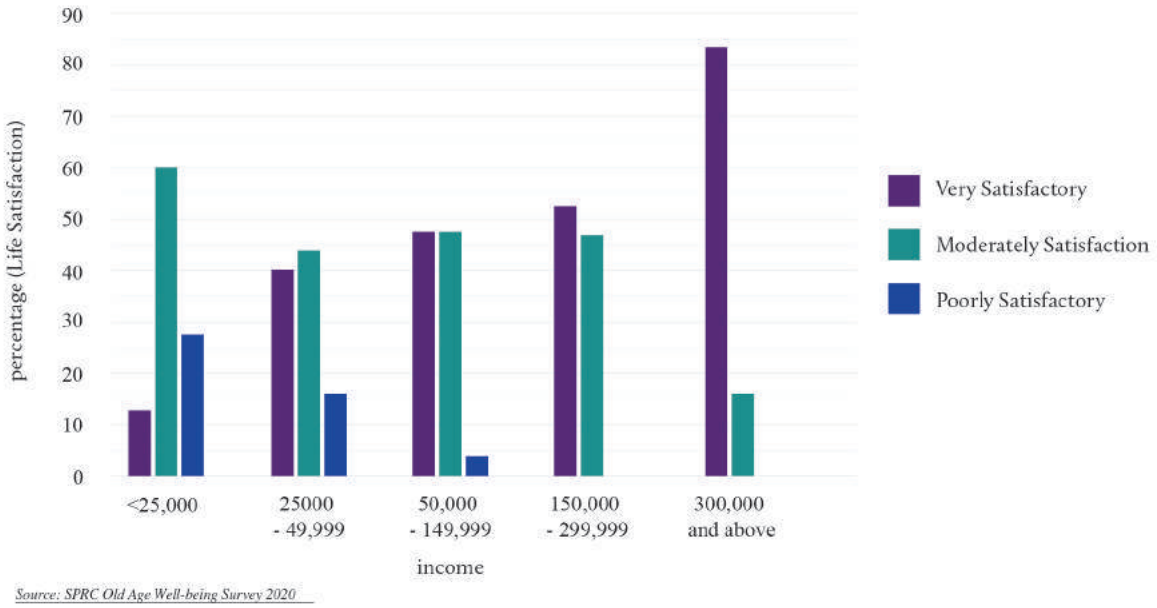


Source: SPRC Old Age Well-being Survey 2020

Figure 1.11 indicates that the levels of life satisfaction of those older people who participate in volunteer activities were higher in comparison than those who did not participate in these activities. These statistics eminently showed that among elderly population who participated in volunteer activities, 66% of them were those who were highly satisfied from their lives, whereas 29% of them were moderately satisfied. Hence, it is evident being in a socially interactive environment increases level of satisfaction from life as well for the older persons.

Moreover, economic condition plays a significant role in developing the overall life satisfaction for older person.

Figure 1.12 : Life Satisfaction of Older People based on their Economic Conditions



Source: SPRC Old Age Well-being Survey 2020

Figure 1.12 also indicated that economic condition of a person has a direct impact on his overall satisfaction with life. Level of satisfaction is directly proportional to the fulfilment of basic needs and smooth journey of life. Statistics are clearly depicting that among those having income less than PKR 25,000, 27% of them were poorly satisfied with their lives, which is a huge number, as the size of income increased the trend of being dis-satisfied started decreasing and while reaching to PKR 300,000 the poorly satisfactory trend touched zero. As the percentage of income increased from minimum to maximum, level of satisfaction increased along with it, that is why it is understood that economics plays vital role in shaping the overall satisfaction of life.

Statistics showed that more than 80% of the old age population felt satisfied from their life. This is also a point that when it comes to life satisfaction, older people do feel satisfied, in which the factors such as culture, family system and religion play an important role.

1.3.4. DIGNITY & RESPECT

Self-respect of any human being is an important aspect to be taken care of and its value gets higher, when it is for older persons. Stereotyping is basically "a fixed, over-generalized belief about a particular group or class of people" (Cardwell, 1996). The use of stereotype is a major way in which we simplify our social world, since it reduces the amount of processing (i.e. thinking). By stereotyping, we infer that a person has a whole range of characteristics and abilities that we assume all members of that group have. Stereotypes lead to social categorization, which is one of the reasons for prejudiced attitudes.[16]

Data showed nearly 63% of the old age population said most of the time or often their families and friends held them back from doing something just because of their age, which is really a major stereotype of our society, and it demotivates the elderly. Taking the discussion in to the arena of the discrimination and abuse, nearly 36% of the older people felt themselves discriminated at home. Data in Table 1.2 suggested that 92% of our old age population take part in the decision-making of the family. While talking about experiencing abuse at home, 95% of population said that they had not felt any abuse while 14% said that they experienced emotional or verbal abuse. Control over the expenses of older people is very important, as they are spending them by their own choice, or they are in any kind of pressure. Statistics showed that 69% of older people were spending their expenses on their own, while 76% were spending them on their children and that was with their consent. In addition, 12% said that family took it without their permission.

[16]McLeod, S. (2017). Stereotypes

Neglect in older people, statistics in Table 1.3 showed satisfactory results as just 10% of old age population said that they felt neglected in family and similar ratio was about neglect in community as well. Awareness and enabling environment play vital role regarding their rights and indulging them in various activities with the help of technology. Among those older people who use mobile phones, 80% did video calls with friends and family, while 45% took religious lectures and 30% spent time in entertainment and business. Therefore, overall, it becomes a good source of spending time in old age. Another good sign was that 89% had said that they had been given priority at public places like banks, chemists, stores, malls etc.

TABLE 1.3: STEREOTYPING, DISCRIMINATION, DIGNITY & RESPECT – OLDER PEOPLE

Monthly Income (PKR)	Stereotyped	Discrimination	Do not participate in decision making	Family neglect	Community neglect
less than 25,000	33%	25%	65%	56%	51%
25,000 – 49,999	45%	33%	27%	35%	35%
50,000 – 74,999	16%	20%	4%	4%	2%
75,000 – 99,999	4%	11%	2%	2%	4%
100,000 – 149,999	1%	5%	2%	0%	1%
150,000 – 199,999	1%	5%	0%	0%	1%
200,000 – 299,999	0%	0%	0%	0%	2%
300,000 & above	0%	2%	0%	4%	4%

Source: SPRC Old Age Well-being Survey 2020

Table 1.3 displayed that how income is related to older people feeling and/or facing negativity in the society. The table showed lower two income brackets unanimously faced the highest stereotyping, discrimination, family neglect, community neglect and had less participation in decision-making. As income increased, all percentages for these variables decreased, with the exception of highest income bracket. Among older people with income PKR 300,000 & above, there was an increased number of people facing discrimination, family and community neglect.

1.3.5. SOCIAL PROTECTION

Social protection, as defined by the United Nations Research Institute for Social Development, is concerned with preventing, managing, and overcoming situations that adversely affect people's well-being.

Social protection covers the areas of Social assistance, Social insurance and Social security. Income security is a major feature of social protection. The income security domain assesses people's access to a sufficient amount of income, and the capacity to use it independently, in order to meet basic needs in older age.[17] According to Global Age Watch Index (GAWI), the domain of income security comprises of four major indicators ;[18]

1. Pension Income Coverage
2. Poverty Rate in Old age
3. Relative Welfare of older people
4. GDP per capita

[17] About Global AgeWatch | About | Global AgeWatch Index 2015. (n.d.). Retrieved from https://www.helpage.org/global-agewatch/about/about-global-age watch/#domains
[18] About Global AgeWatch | About | Global AgeWatch Index 2015. (n.d.). Retrieved from https://www.helpage.org/global-agewatch/about/about-global-age watch/#domains

Social Protection is considered a pillar for giving older people a safe way of living their life. Statistics show that 27% of the old age population is receiving social assistance from the government. These numbers clearly depict that government need to increase or come up with bigger plan, where maximum number of older people can be covered. From those who were receiving social assistance, 71% of elder people were those who were receiving it from Benazir Income Support Program (BISP), while 29% were those who were receiving it from Zakat and Usher, while 14% were taking from Bait-ul-Mal. 33% of the population was receiving assistance from some other sources. Government should increase its capacity for this purpose, so that older population can be taken care of in a better way. Statistics showed 70% of older population did not receive any financial assistance from the government.

1.4. DETERMINANTS OF LIFE SATISFACTION

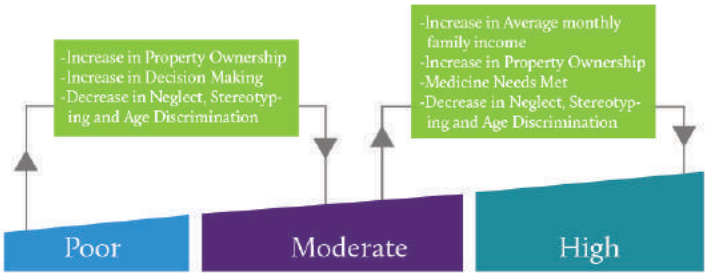
With the help of indicators developed for assessing the well-being of older people, earlier in this section, the report tried to evaluate the relationship of a few of these factors with life satisfaction of older people in Pakistan. The report was able to identify which of these factors determine different levels of life satisfaction among the older population. These factors included property ownership, dietary needs, medicine needs, average monthly family income, number or children, autonomous income, neglect, stereotyping and age-discrimination (See Table 1.4). To get a better insight of this relationship, three levels of life satisfaction were established i.e., poorly satisfied, moderately satisfied and highly satisfied.

TABLE 1.4: DESCRIPTION OF DEPENDENT AND INDEPENDENT VARIABLES – LIFE SATISFACTION OF THE OLD AGE

DEPENDENT VARIABLE	INDEPENDENT VARIABLES
Life Satisfaction	Property Ownership Diet Needs Medicine Needs Average Monthly Family Income Number of Children Neglect, Stereotyping & Discrimination Autonomous Income

Logistic Regression was employed in order to evaluate the relationship between life satisfaction of older people and the above-mentioned variables. Within logistic regression, the most relevant and suitable technique was the Generalized Ordered Logit Model, since considering this report's analysis, Ordered Logit Model had some limitations.

Figure 1.13 : Levels of Life Satisfaction



Levels of Life Satisfaction

The results suggested that for older people to be moderately satisfied, property ownership, household decision-making, neglect, stereotyping and age-discrimination had a significant impact. Additionally, for older people to be highly satisfied, fulfilment of medicine needs, average monthly family income and property ownership had a significant impact. The results as shown in the Figure 1.13 were very intuitive implying that for attaining moderate life satisfaction, social and cultural changes are required, while, for gaining a high level of life satisfaction economic needs being met are crucial.

SECTION 2

INSTITUTIONAL ARRANGEMENTS FOR ELDERLY IN PAKISTAN

2.1. INSTITUTIONAL ARRANGEMENTS FOR ELDERLY IN PAKISTAN

Pakistan is going through the process of demographic transition, marked by the presence of growing old age population. The changing demographic trend from the joint family to nuclear family has raised concerns about the dependency ratio of old age people and future family support in adequate terms. The Government of Pakistan has made efforts from time to time to protect the rights of older people and enhance well-being as well as to address their challenges. The Government has developed policies, laws and institutions for the older people at Federal and Provincial level.

The Constitution of Pakistan stated social security as a fundamental right. Article 38 (a), (d) and (e) of the Constitution of Pakistan (1973) stated that:

"The State shall provide for all persons employed in the service of Pakistan or otherwise, social security by compulsory social insurance or other means; provide basic necessities of life such as food, clothing, housing, education and medical relief, for all such citizens, irrespective of sex, creed, caste, or race, as are permanently or temporarily unable to earn their livelihood on account of infirmity, sickness or unemployment; reduce disparity in the income and earnings of individuals[19]."

This article includes the rights of all the individuals who are unable to work and earn their livelihood so it is also covering the rights of older persons.

The Government of Pakistan prepared Senior Citizens Bill in 2007 to enhance the welfare of the older people of the country. The bill included steps to improve the well-being of older people, which include concession in road transport, feasibility in provision of pensions, free entry in public places like parks, museums, zoo, book fairs, art galleries etc., provision of legal services and security, concession in income tax where income is not exceeded more than PKR 4,000, separate counters in banks, transport stations, post offices and other places[20].

After the 18th Amendment, Provincial Governments have made progress in this regard. The laws for the welfare of the older people have been enacted by three provinces i.e., Khyber Pakhtunkhwa (KP), Sindh and Baluchistan. In 2015, the Senior Citizen Bill approved by Khyber Pakhtunkhwa Assembly, the Sindh Assembly approved Senior Citizen Bill in 2016 and Baluchistan Assembly approved Senior Citizen Bill in 2017. These Bills covers wide range of instruments for the improvement of well-being of senior citizens with the focus on financial supports to older people, provision of Senior Citizens Cards, concession in medical charges and medicines, separate counters for the senior citizens in hospital, post offices etc., and establishment of homes for the homeless older people. These Bills also include the commitments of the state to formulate policies for the welfare of older people, promote research on different aspects of the older people, create facilities for the social interaction between older population, raise awareness through the media and educate older persons for their rights[21,22,23].

The three Provincial Bills have many aspects in common but the Bill of Senior Citizen, Sindh is more comprehensive and strong. It is not only raising the point of concession in transport and medicine charges for older people, but also the Government of Sindh has specified proportions and concessions. The Senior Citizen Bill of Sindh also highlighted establishment and management of old age homes including the various types of financial and medical services. Another unique feature of the Sindh Law is that it has made mistreatment with elderly a punishable act and has imposed fines and punished with the three months imprisonment.

The Province of Punjab has drafted a Bill for the Senior Citizens Welfare and Rehabilitation, 2013 to promote the health care, social security, support in case of disability and participation of senior citizens in all activities

[19]The Constitution of Islamic Republic Pakistan, 1973
[20]Senior Citizens Bill in 2007, Pakistan
[21]The Khyber Pakhtunkhwa senior citizens act, 2014.
[22]The Baluchistan Senior Citizens Act, No III of 2017
[23]The Sindh Senior Citizens Welfare act, 2014

of life without any age restriction. This is very comprehensive law, but it is still waiting for the approval.

The Islamabad Capital Territory (ICT) presented Senior Citizens Board Bill in 2017 to provide well-being, comfort and dignity to the senior citizens located in Islamabad. The Islamabad Capital Territory (ICT) Rights of Persons with Disability Act was finally passed by the National Assembly. This Act also focused on the rights of older people with disabilities. Under this act, the Government should take measures to ensure that full protection to older people with disabilities is provided under the law in enjoying their rights. The private sector as well as the government are expected to take necessary measures in prescribed manners to ensure development, advancement and empowerment of older people with disabilities[24].

The Government of Pakistan had developed National Policy for the promotion of better health of the elderly in 1999. This policy was comprehensive and it focused on the training of doctors and nurses for the primary care in geriatrics, provision of dental and domiciliary care, physiotherapy care with the multi-layered system of health care providers for the older people including social workers. Unfortunately, this policy has not been passed as a law by parliament yet[25]. The policies and plans of ministry of railway have also included the older people, which ensured that the senior citizen of age 65 and above will pay half fare at the time of booking. which ensured that the senior citizen of age 65 and above will pay half fare at the time of booking.

2.2. INSTITUTIONS FOR THE WELL-BEING OF OLDER PEOPLE

This section provides an overview of institutions contributing for the well-being of the older citizens. The institutions can be categorized into social security schemes and social assistance.

2.2.1. SOCIAL SECURITY SYSTEM

The social security system protects the vulnerable segment of the society from the social and economic risks. This system provides a ray of hope to those older people who have limited economic resources in their life. The aim of this system is to protect older people as well as adults from the social and economic crisis and to prevent them from the sale of their property during the situation of distress. These schemes or system usually covers three types of vulnerable groups: the disabled persons, retired employees, and families of the workers who died during the employment. The Government of Pakistan has established social security, health and welfare policies at the sector level which do cover a relatively small number of older persons who have served in formal employment. Following are the pensions and social security schemes being introduced to address the concerns and issues of the old age people shown in Table 2.1.

TABLE 2.1: SOCIAL SECURITY SCHEMES – PAKISTAN

Social Security Schemes	Functions
Government Servants' Pension-cum -Gratuity Scheme:	Under this system, the person is eligible for the pension after the retirement at the age of 60 or a government servant who has completed 25 years of pensionable service. Retired government servants are also entitled to medical treatment at the Government's expense and they are entitled to the reimbursement of medical charges.
Provincial Employees Social Security Scheme	The Scheme provides health benefits and cash benefits for the sickness, injury, disability, death grant and rehabilitation benefit.
Public Sector Benevolent Funds and Group Insurance	This Scheme provides benevolent grant, other benefits and Group Insurance to the employees of the Federal Government
Employee's Old-age Benefits Institution (EOBI)	The purpose of this institution is to provide subsistence pensions to Pakistani workers, employee or insured persons from the private sector who retires after completing a minimum number of 15 years of insurable employment.
Workers Welfare Fund (WWF)	It is established to provide low cost housing and other facilities to the industrial workers.

Source: Zia-ud-din.M (2017)

[24]The Islamabad Capital Territory Rights of Persons with Disability act, 2020
[25]Zaidi, et al. (2019). Moving from the margins: Promoting and protecting the rights of older persons in Pakistan. British Council Islamabad

2.2.2. SOCIAL ASSISTANCE PROGRAMS

There are social assistance programs, which provide unconditional cash transfer to the poor and needy people including older people. These programs targeted those who are poor and are unemployed more often than not. The Benazir Income Support Program (BISP) is the recent initiative of unconditional cash transfer to poor and deserving people. One of their Income Transfer Program covers older people with the age of 65 and above in all provinces. In Punjab, Sindh, KP and Baluchistan the 39%, 31%, 24% and 6% of old age population are getting unconditional cash transfer respectively, as per BISP data. The programs of social assistance introduced in Pakistan are discussed below in Table 2.2:

TABLE 2.2 : SOCIAL ASSISTANCE PROGRAMS – PAKISTAN

Social Assistance Programs	Functions
Zakat and Usher	It provides financial assistance to the poor, older persons, needy, orphans and disabled Muslim citizens of the Pakistan.
Bait-ul-mal	It is contributing to poverty alleviation by providing services and assistance to orphans, widows, invalid, infirm, destitute and other needy persons.
Benazir Income Support Program (BISP)	It provides unconditional cash transfers to the poor families.

Source: Zia-ud-din.M (2017)

2.2.3. INFORMAL INSTITUTIONS

In Pakistan, the older people are usually treated with courtesy and respect. It is the culture of Pakistan to provide protection to parents or grandparents. However, the requirements of the older population are changing with time. They face the issues of loss of income, lack of physical work, health issues and mental problems. Due to all these issues, the expectations of older parents increase that their children will look after them. The level of satisfaction was higher of those older people living in joint family. The major reason of satisfaction was the financial support and support in everyday life provided to older people. In Pakistan, almost 72% older people are still living with their children and grandchildren[26].

Older people not only live with their family members, but also, they make decisions for their children and other family members. Currently, almost 83% older people participate in the decision making of the family as the older people are considered as symbol of wisdom and piety. The older persons help in household chores and look after their grandchildren[27].

2.3. ROLE OF NGOS & OLD AGE HOMES

Non-governmental Organizations (NGO's) are playing important role in creation of healthy and secure communities through the provision of assistance and services. One important feature of NGOs is that they work closely with the people and during the occurrence of any issue, they can immediately access the location or area. In this regard, one of the pioneer organization was "Ladies Fellowship" established by working group of women for the welfare of aged persons. This organization conducts seminars to raise awareness about the problem of aged persons and highlights services required for them. Another organization known as "Pakistan Senior Citizens Association" was formed in 1985 in Karachi.

[26]Salahuddin, K., & Jalbani, A. A. (2006). Senior citizens: A case study of Pakistan. Journal of Independent Studies and Research (JISR), 4(2), 26.
[27]Itrat, A., Taqui, A. M., Qazi, F., & Qidwai, W. (2007). Family systems: perceptions of elderly patients and their attendents presenting at a university hospital in Karachi, Pakistan. Journal of pakistan medical association, 57(2), 106.

It is working for the group between both upper and middle classes to support the elderly and it has members from both genders. Another noteworthy organization established known as "Pakistan Association of Gerontology." The objective of this organization was to start program for the elderly and to make sufficient assessment of health facilities. In 1989, an organization was formed with the name of "Association for the Welfare of Retired Persons" in Islamabad[28]. In the same year, the old age home established with the name of "Nasheman" in Lahore to provide training, care and rehabilitative services to enhance the potential of special persons. The old age homes provide health services, clothing, food and also create family atmosphere for the older persons. Later on, different old age homes and social welfare organizations initiated for the provision of health, financial and other facilities to older persons of the society. The current government has also established many Shelters. The Punjab Government Department of Social Welfare has established Old Homes in different provinces. In most of these cases, these Old Homes and Shelters remain underutilized, the reasons for which need to be better understood.

2.4. REGIONAL COMPARISON AND EXPERIENCE OF OLD AGE CARE

The population of older people is increasing throughout the world. Different countries have introduced different laws and policies for the protection of senior citizens. It is instructive to look at the experience of other countries in the region.

2.4.1. INDIA

The population of older people has increased in India from twenty million in 1951 to one hundred four million according to the census of 2011 and is expected to rise up to 176 Million by 2026. It means approximately 10% of total population in India is aged 60 or above. Like elsewhere, in India too, the older people face different physical, economic and social issues. In India, any grievances regarding the provisions of older people are handled by the Ministry of Justice and Empowerment. The provisions have been made in the Constitution of India to preserve the rights of those aged above 60[29].

The Article 41 of the Constitution of India secures the right of senior citizens to employment, education and public assistance. It also ensures that the State must uphold these rights in cases of disability, old age, or sickness. At the same time, the Article 46 declares that educational and economic interest or rights of older person should be promoted by the State and it protected by from the social injustice and any exploitation.

In India, older people's rights have been protected through different policies and laws. According to the directions of the Ministry of Home Affairs of India, the Police Department is expected to give more attention to protect the rights and property of the senior citizens. It is also mandatory for the Police to visit older persons' home and review their cases. The Government of India along with other welfare organizations has specifically designed the facilities and services for the elderly. These services include reduction in income tax, high interest rate on savings, and concession in traveling (railway offers 50% discount for the elderly female and 40% for the male aged 60 and above and domestic airlines also offers 50% concession for the aged person 63 and above), special health treatment for the older and disabled person[30].

2.4.2. CHINA

[28]Akbar, A. (2020). NGOs working on Ageing in Pakistan Presentation project
[29]Singh.R.K. (n.d). Rights of Senior Citizen - The Maintenance and Welfare of Parents and Senior Citizens Bill, 2007
[30]Agewell Foundation status of social security and social protection floors in India, 2019

In China, with the improvement of social security system, the elderly policies are better covered now, which address the rights of urban elderly retirees and poor older people. In 1996, the Law on protection of the rights and interests of the elderly people of China was formulated. This law highlighted the rights and interests of the aged population according to various aspects. The Government has promised to increase the investment for the elderly services according to required services of aged population and economic development. The Local Governments are also mandated to take measures to develop services for the elderly care in rural as well as in urban areas.

The Government of China encourages and supports professional service organizations to provide daily care, emergency rescue, medical care, and psychological counseling for the elderly at home. The elderly support institutions funded by the Government give priority to the needs of the elderly, such as lonely older people and the disabled elderly that are in financial difficulties[31].

In 2000, the State Council and Central Committee of China took many decisions to strengthen the work on ageing. It focused on the improvement of social security system and established mechanism of the nation, society and family to ensure the basic needs and medical facilities for the older people. The National Ageing Office has also strengthened the work on the elderly in 2005 and issued a specific document to support the preferential treatment for the elderly, including a reduction in outpatient fee of elderly and provision of free medical examination.

2.4.3. BANGLADESH

Bangladesh is also experiencing the issue of ageing population. In order to address this issue, the Constitutional provisions, policies, laws and other instruments have been formulated for the well-being of older persons. The Constitution of Bangladesh has stated that it is the responsibility of the State to ensure basic necessities to older persons. In 2013, the National Policy on older persons was formulated for the first time for the well-being of the older people. One of the important aspects of this policy is the removal of discrimination and ignorance against older women and older persons with disabilities and to facilitate inter-generational communication and solidarity and also burial arrangement for needy/deprived older persons. This policy had also defined the calendar age of older person, which is 60 years and above.

The Parents Maintenance Act was formulated in 2013 in Bangladesh. Under this Law, the children are bound to look after their parents and grandparents. It focused on the provision of basic necessities, safety and other supportive opportunities to the parents. According to this Law, both sons and daughters are responsible for the maintenance of their parents and they cannot force the parents to go to any Institutional Rehabilitation Center. If children adopt nuclear family system then they are bound to maintain constant communication and visits the parents regularly. This law also includes the protection of grandparents by the grandson. If the child of parents violates these laws, then they will charge fine of TK.100 thousands and in case of not paying this amount of money, there is option of three months' imprisonment. In case of violation of parent's rights, the parents can complain in written format to the court of First Class Judicial Magistrate or Metropolitan Magistrate[32].

UNIQUE INTERVENTIONS BY NEIGHBOURING COUNTRIES

- **The Police Department has to visits the older people homes and reviews their cases.**
- **There is reduction in income tax, high interest rate on savings of the older people.**
- **The provision of concessions almost 50% in railway as well as domestic airlines.**
- **The reduction in outpatient fee and provision of free medical examination.**
- **The removal of discrimination and ignorance against older women and older persons with disabilities.**
- **The children are bound to protect their parents and grandparents.**
- **Imprisonment or fine will charged to children in case of ignorance of the protection of parents**

[31]Liu, Y. (2017). The elderly problems and policies in China: a comparison with Japan.
[32]Hussain.M (2018), Constitutional, Legal and Policy Framework of Human Rights for Older Persons in Bangladesh

SECTION 3

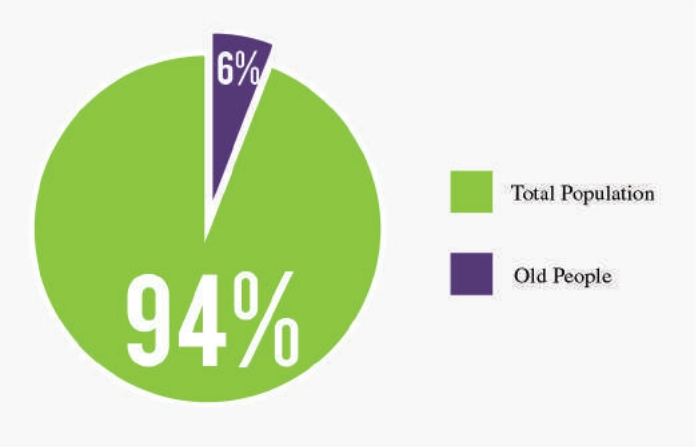
FINANCING THE NEEDS OF OLDER POPULATION

Pakistan, since its origin, has faced problems in managing its macroeconomic balance and very little focus is given towards the small time problems of the elderly in Pakistan. There very few effective policies on national or provincial levels in the country regarding this issue, which causes difficulty in implementing basic constitutional rights of the elderly[33]. However, there have been steps taken for the benefit this stratum through various policies and programs in the country such as pension schemes, Employees Old Age Benefit Programs, Bait-ul- Maal etc.

The current conditions of elderly people in Pakistan, which is almost 14 million is not very commendable. Out of 13.7 million elderly people, only 1.8 million people are getting pension or any allowance from social protection programs such as BISP and Bait-ul-Maal. Out of the remaining 11.8 million elderly who are deprived of any social protection program; 1.80 million elderly belong to lowest income percentile and need immediate assistance from Government and social protection institution. Almost .415 million elderly people living below poverty line in Pakistan are sick according to the recent Demographic Health Survey (DHS). Therefore, these poor need a health protection program in order to meet their health expenditures.

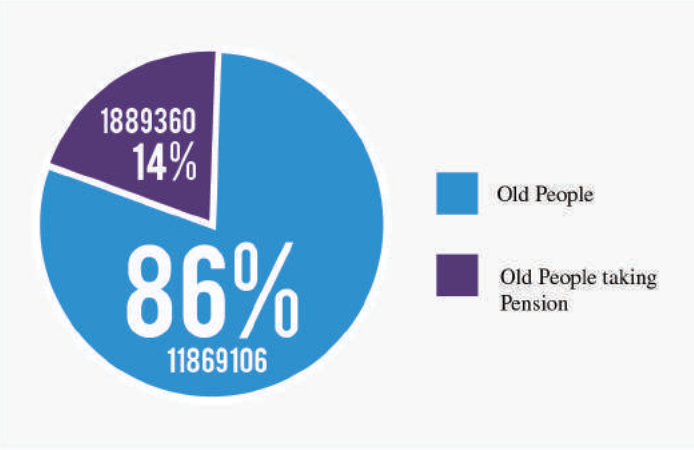
If the retirement age of Pakistan remains the same i.e., 60 years and the life expectancy of the people increases, there will be comparatively more people claiming pension benefits and fewer people working and paying income taxes[34]. This will increase burden on economy and slowdown the productivity growth. Therefore, Pakistan needs a robust social protection system in order to cope with the current and future needs of poor elderly of Pakistan. Due to poor management and weak system of public institutions, a large number of poor elderly are highly vulnerable and facing financial constraints to meet their basic needs. This is increasing the dependency ratio of elder people on their young ones and creating economic burden on the poor and unemployed workforce of Pakistan[35].

Figure 3.1: Old Age Population



Source: Authors' Own Calculation

Figure 3.2: Old Age Population Availing BISP & Pension



Source: Authors' Own Calculation

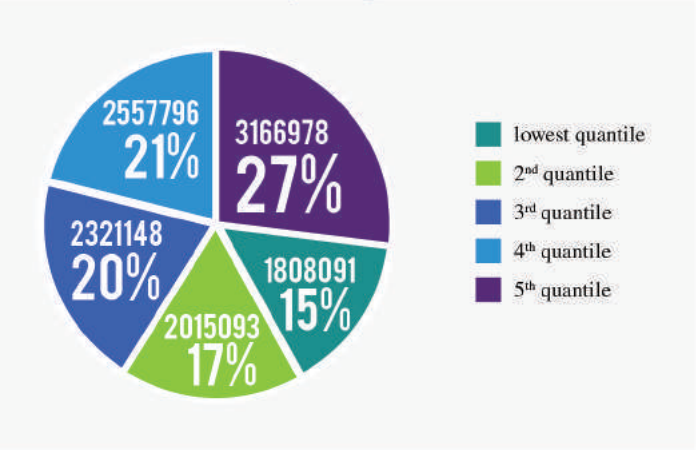
The current support programs include social security protection scheme, which gives pension and old age benefits to the elderly. The estimations results revealed that only1.32% people were taking pension and other security programs in Pakistan and out of that 1.32% population only .69 percent were old; which means that only 14% of elderly; which constituted up to 1.88 million out of 13.7 elderly million were taking pensions, while the remaining 11.8 million people were not being supported by the social protection scheme as shown in Figure 3.1 and Figure 3.2.

[33]Ul Haq, R. (2012). Life satisfaction and basic needs among elderly people in Pakistan: evidence from the PSES data. The Pakistan Development Review, 51(4), 519–540

[34]Raza, H., Ahmed, F., Mohiuddin, Z. A., & Osama, A. (2017). Mitigating Financial Burden of Elderly through Social Protection Schemes: Issues and Challenges for Pakistan. International Journal of Emerging Trends in Social Sciences, 1(2), 81–89.

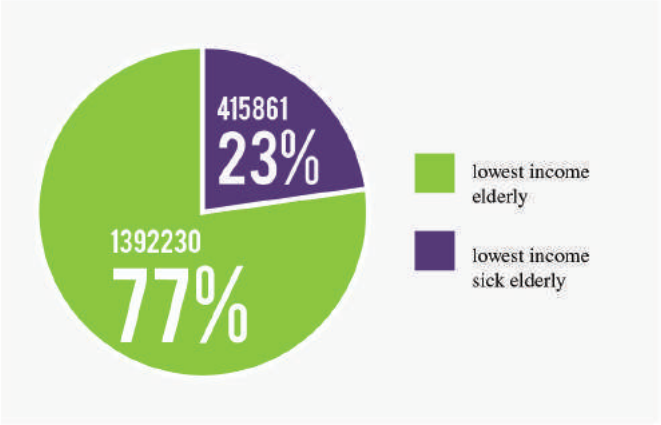
[35]Ashiq, U., & Asad, A. Z. (2017). The rising old age problem in Pakistan. Journal of the Research Society of Pakistan–Vol, 54(2).

Figure 3.3: Distribution of Income in Elderly Population



Source: Authors' Own Calculation

Figure 3.4: Elderly Population below Poverty Line with Health Problems



Source: Authors' Own Calculation

The BISP Program initiated by Government of Pakistan in 2008, which is currently distributing PKR 24,000 per year to 5.6 million families. This means that every family including old and young both are benefiting from this scheme by receiving PKR 2000 from the BISP every month. The estimations revealed that there were almost .415 million poor and old people who were sick but lack funding from BISP to finance their health and living expenditure.

In addition to the federal Health Insurance Scheme, the Sehat Sahulat Card medical health care program launched in KP, which allows its each family to get free access to medical services for up to one million per year. This scheme was initially operational for only a few districts in KPK serving only 40% of KP population but currently the program is expanded and all residents of KP (100%) can utilize this scheme to finance their healthcare needs. But KP holds only 19% of Pakistan population and the remaining 118 million people lack this service, therefore, the estimations showed that there are almost .257 million old and sick people who lack the Sehat Sahulat Health Service and are unable to meet their healthcare requirements, as the federal program does not reach a large number of households in Pakistan.

TABLE 3.1: GENDER BASED SEGREGATION LACKING ANY KIND OF SOCIAL PROTECTION SUPPORT

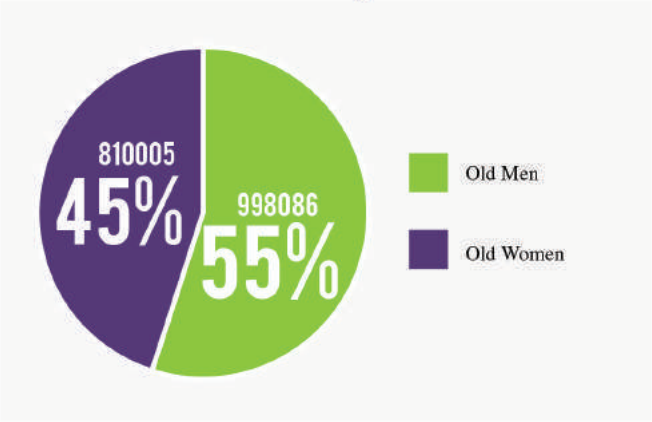
	Included Benefits (In Millions)	Without "Pension & BISP" (In Million)	Male Elderly (In Million)	Female Elderly (In Million)
Old Population	13.7	11.8	6.55	5.31
Poor Old Population	2.09	1.80	.99	.810
Sick Old Population	3.16	2.7	1.50	1.22
Old People who are Poor and Sick	.482	.415	.229	.186

Source: Authors' Own Calculation

The last two columns of Table 3.1 indicated the ratio of elderly male and female who lack any kind of social protection support (pension, BISP, Sehat Sahulat Card). There are almost 6.55 million elderly males in Pakistan who are not receiving any social protection or support programs. They lack basic health services provided by Sehat Sahulat Card, which suggest that there is an immense need to initiate protection program for them. Out of these 6.55 million elderly males, .299 million are living below poverty line.

Most of these elderly are sick and belong to the lowest income quintile but lack of income makes them vulnerable and leave them up to the grants and charity from the society.

Figure 3.5: Male and Female Ratio of Elderly Below Poverty Line



Source: Authors' Own Calculation

Figure 3.6: Sick Old Female below Poverty Line

Source: Authors' Own Calculation

Pakistan has elderly female population of 5.31 million. A large portion of these elderly women (.810 million) belong to lowest income percentile group and depend on their children and families to fulfil their needs. Out of these 5.31 million old women, .186 million are both living below poverty line and sick, which make them the most unprotected part of our elderly as shown in the Figure 3.5 and 3.6. The inclusion of these half million elderly into the social protection and support program will alleviate both financial poverty and health expenditure of old people.

3.1. CURRENT FINANCIAL NEEDS OF OLD AGE POPULATION

Currently, the population in Pakistan is around 220 million, out of which 13.7 million are elderly people. Out of these 13.7 elderly million, 1.80 million belong to the lowest income percentile group and need financial assistance for their living expenditure. These households do get the BISP Income Transfer but the transfer is already inadequate if we compare it with a generally agreed upon monthly expenditure of PKR 16216. As DHS suggests, most of the older persons in the lowest income group are sick, there is a need to enhance the Transfer amount by 1000 for each of the old parents and give separate Health Insurance Cards to the old persons, separately to the males and females. The upper limit of these Health Insurance Cards could be lower than the household card.

The other group, which needs an enhanced social and health protection is the group of older persons living out of the family. SPRC Old Age Well-being Survey puts the figure of such older persons at 28 %. As this is not a very well-studied phenomenon, we can presume that a good number of these older persons may be living out of the family by choice and would have the necessary means to live alone. There may be a certain percentage of such older persons which are out of the radar of NADRA and BISP and the local governments should try to document such older persons and take the financial support and health protection to them. The Government has launched many programs for the destitute people. With a better awareness of the presence of these schemes could enhance their utilization. The utilization of state facilities, incentives and concessions for older people is a major issue in Pakistan. The government does spend significant amounts of money but it does not produce optimum results due to very low utilization by the older persons. There may be cultural factors in play here. Instead of initiating high technology interventions, the local community based solutions combining both in-kind and cash solution should enhance the well-being of the older persons among the poor classes.

TABLE 3.2: CURRENT EXPENSES OF OLD AGE POPULATION 2020

Year 2020	Older People below Poverty Line	Male below Poverty Line	Female below Poverty Line	Poor & Sick Below Poverty
Old Population	1.80 million	.99 million	.810 million	.415 million
Health Cost Per year (In Rupees) if separate Health Insurance of Rs. 200,00s is provided, with a premium of Rs. 2000	20.21 billion	11.15 billion	9.05 billion	4.64 billion
Rs. 1000 additional to each parent from BISP	2.37 trillion	1.31 trillion	1.06 trillion	54.64 billion
Total Cost per year	3.51 trillion	1.94 trillion	1.57 trillion	80.92 billion

Source: Authors' Own Calculation

3.2. HOW OTHER COUNTRIES ARE FINANCING?

The Asian Development Bank (ADB) takes "social protection" to mean "policies and programs designed to reduce poverty and vulnerability by promoting efficient labour markets, diminishing people's exposure to risks, and enhancing their capacity to protect themselves against hazards and loss of income. Numerous developing countries have taken steps to provide healthcare, or health insurance, to the population as shown in the Table 3.3[36].

[36]Bloom, D. E., Jimenez, E., & Rosenberg, L. (2012). Social protection of older people. Global Population Ageing: Peril or Promise?, 83.

TABLE 3.3: FINANCIAL PROTECTION IN OTHER COUNTRIES

Country	Financial programs	Health Programs	Development programs
Europe	universal pension	Yes universal health	Yes
Scandinavia	universal pension	Yes universal health	Yes
Japan	universal pension	Yes universal health	Yes
Senegal	Yes	free health services	nutritional supplements support
Argentina	universal pension	free transport for older persons	Holds event to pass experiences and skills of older persons to young people
Indonesia	NA	provides free health care to older people	conducts workshops for younger and older people
Belize	non-contributory pension	health insurance	Yes
Bolivia	universal pension	free health care	NA
Brazil	universal pension	provide health care	NA
Belize	non-contributory pension	health insurance	Yes
Bolivia	universal pension	free health care	NA
Nepal	universal pension	Yes	health insurance schemes
South Africa	universal pension	provide health care through insurance	free travel when medically approved
Singapore	universal pension	Yes free healthcare	Yes
Lesotho	universal pension	NA	NA
Viet Nam	cash transfer to reduce poverty in old age	Free health insurance for people above 90	humanitarian aid and disaster relief programs
United States	Yes old age benefit allowance	Access to free health care by health insurance	training to older persons through the Emergency Preparedness Initiative.
China	Cash transfer	Free admission to hospital	free public transport, free entry in museums, parks etc.
Nigeria	retirement scheme for informal workers	NA	Ad hoc budget to provide short-term emergency relief
Serbia	$6 billion allocated for elderly Pensioners	free health care	free travel when medically approved
Lebanon	provides safety nets for poor older persons	NA	NA
Hungary	universal pension	provide health care	free public transport
Uruguay	a grant to elderly in poverty above 65	NA	pension for above 58, with 28 years of previous work
New Zealand	universal pension	provide health care	Holds older and younger people event to discuss intergenerational issues
Mozambique	NA	NA	free travel on public transport for older person
Finland	universal pension	Access to free healthcare	free travel when medically approved
Kenya	Cash transfers to elderly	social protection cash transfer scheme	Grants for elderly caring for sick kids or orphan
Thailand	Cash transfers programs	provides out-patient care	Green Channel or Fast Lane for older people

Source: Authors' Own Calculation

Several countries (including Bolivia, Botswana, Brazil, Mauritius, Namibia, and Nepal) have introduced universal non-contributory pensions. Targeted social pensions exist in many other countries, for example in all the more advanced Latin American welfare regimes, in several transition countries in Central and Eastern Europe and Central Asia, in South Africa, Bangladesh, India, Thailand, and Viet Nam and also in Egypt and the Russian Federation[37].

The US Social Security System is an example of a PAYG "Pay As You Go" system in which both workers and employers make mandatory contributions. In such a system, the availability of funds to pay retirement benefits to workers depends on a variety of factors, including prominently the long-term ability of the economy to generate enough employment so that accumulated contributions are sufficient (Gruber & Wise, 2010)[38].

Latin American Countries have an array of pension systems. Among those with publicly operated plans, coverage of employed individuals ranges from 52% in Brazil to 14% in Paraguay. In some Latin American Countries (Argentina, Brazil, Chile, and Uruguay), older people are less likely to be poor than the population as a whole, whereas the reverse holds in Bolivia, Colombia Costa Rica[39].

European countries due to abundance of resources have a universal social protection system in which every person who is unemployed, sick, old or disabled is eligible for a social allowance every month, which fulfil both their financial and health expenditure[40]. Scandinavia has tax-funded strategies to help older people age in place through community-based care[41].

Developed Asian countries have also a specific fund program for their elderly, which provides free health care and a basic income allowance, which is sufficient to meet their financial needs[42]. Sub Saharan African countries have a very limited pension system and only 2% of their elderly are getting pensions and social protection program while the rest of elderly rely on work or charities from other to meet their needs[43].

South Asian countries have a weak social security and pension system due to lack of resources, and political will. India, Pakistan and Sri Lanka have both defined-benefit and defined-contribution pension systems, both publicly managed, either by states or the national government. However, their reach is limited. Most workers in the formal sector are required to contribute to one or more of an array of pension programs. However, a large portion of poor older population of South Asian countries are unable to pay for healthcare out of their own resources, so government-financed healthcare is particularly important for them[44].

[39]Arza, C. (2017). The expansion of economic protection for older adults in Latin America: Key design features of non-contributory pensions. WIDER Working Paper.

[40]Gruziel, E. (n.d.). SOCIAL SECURITY OF ELDERLY PEOPLE IN THE SELECTED EUROPEAN UNION COUNTRY ON THE EXAMPLE OF POLAND. Wyższej Szkoły Gospodarki Krajowej w Kutnie, 237.

[41]Nygård, M., Härtull, C., Wentjärvi, A., & Jungerstam, S. (2017). Poverty and old age in Scandinavia: A problem of gendered injustice? Evidence from the 2010 GERDA Survey in Finland and Sweden. Social Indicators Research, 132(2), 681–698.

[42]Gough, I., Wood, G., Barrientos, A., Bevan, P., Room, G., & Davis, P. (2004). Insecurity and welfare regimes in Asia, Africa and Latin America: Social policy in development contexts. Cambridge University Press.

[43]Guven, M. U., & Leite, P. G. (2016). Benefits and costs of social pensions in Sub-Saharan Africa. World Bank.

[44] Matthews, N. R., Porter, G. J., Varghese, M., Sapkota, N., Khan, M. M., Lukose, A., Paddick, S.-M., Dissanayake, M., Khan, N. Z., & Walker, R. (2020). Health and socioeconomic resource provision for older people in South Asian countries: Bangladesh, India, Nepal, Pakistan and Sri Lanka.

3.3. FUTURE FINANCING FOR ELDERLY: RECOMMENDATIONS

Ageing is a natural process and older people are an inevitable part of our society. Despite many social protection programs operating in Pakistan, there is a dire need to improve and support the increasing number of poor elderly in our country who are unable to afford their financial and health expenditures. This situation, if left untreated, will increase the financial poverty and dependency ratio.

In order to improve and intensify the social protection programs in Pakistan, given the constraints of high poverty and unemployment, there are few policy measures, which can be taken to strengthen and enhance our existing system. First, to create awareness among both political bodies and public about the gravity of crisis, which is affecting the elderly of our society. This awareness will push the masses to demand and accept a better social welfare program for their elderly on the expense of their hard work that is "more taxes".

Second, the social protection program of our country has a very weak and poor database, which is disrupting the free flow of funds to the deserving poor elderly. The presence of corruption and biasedness in our current system have marshalled so many funds of right people into wrong hands that a large number of our vulnerable elderly are not getting any allowance. Therefore, there is a need to improve our database and keep a strict moral discipline among our public agents. Third, the financial situation of our country is not robust enough to protect our elderly and fulfil their health and financial expenditures. Given the current circumstances, 21% of our population is living below poverty line and 4.5% people of work age are unemployed. These problems demand that our solutions to help elderly should be cost effective.

Fourth and last, the Research and Development Sector (R&D) of our country is not given right attention and priority, which is essential for any country to learn from other countries and improve the mistakes, which occurred in the past. Therefore, there is an immediate need to build a robust national research and development institution dedicated to the social protection for elderly people, which will help policymakers to make efficient and effective policies within limited budget and adopt the right strategies to support the poor elderly of our country.

SECTION 4

HEALTH, PANDEMICS & OLD AGE

4.1. HEALTH & DISEASE BURDEN IN OLD AGE

Health of the older persons can be determined by physical, mental/cognitive and social factors. The major diseases effecting older people are heart disease, stroke, hypertension, diabetes (DM), chronic obstructive pulmonary disease (COPD), cancer, arthritis, mental health disorders, dementia/Alzheimer, injuries & accidents. All of the above-mentioned diseases are Non-communicable Diseases (NCDs). In 2017, Lancet published a multi-country study of Burden of Disease (BOD) and has predicted increasing burden of NCDs globally in coming years. This study has shown that there are now less deaths in all ages due to maternal & child health and communicable diseases in last decades as compared to non-communicable diseases now.

Globally more than 60% of mortality in old age (50 to 69 years) is attributed to NCDs, which has brought a lot of attention towards it.

TABLE 4.1 : MAJOR CAUSES OF MORTALITY IN 50 TO 69 YEARS - GLOBALLY AND IN PAKISTAN

Disease	Global	Pakistan
Ischemic Heart Disease	18%	25%
Stroke	12%	13%
Hypertension and other heart conditions	3%	3%
COPD & Asthma	6%	6%
Diabetes mellitus	4%	5%
All cancers	15%	26%
Cirrhosis	4%	4%

4.1.1. DISEASE BURDEN IN PAKISTAN: SITUATIONAL ANALYSIS

Pakistan is the 5th most populous country with 207 million population[45]. According to the Census 2017, 60.4% of the population lies within the age bracket of 15-65. In addition, 4.2% of population is 65 years plus. Pakistan's situation is not different from global estimates. Pakistan's Burden of Disease (BOD) has increased i.e., in communicable diseases, which was 60% in 2000, stood at 43.3% in 2017. As far as Non-communicable Diseases (NCDs) are concerned, these have increased from 31.7% to 47.5% and injuries from 7.3% to 9% in 2017.

[45]Pakistan Bureau of Statistics (2017), Population Census.

TABLE 4.2: TOP 10 BOD IN PAKISTAN ON RISKS, PREMATURE DEATHS, YLDS AND CAUSE OF DEATH

	Cause of death	Premature death	Years Lost with Disability	Risk Factors
1	Ischemic Heart Disease (IHD)	Neonatal disorders	Dietary Iron deficiency	Low birth weight
2	Neonatal disorders	IHD	Headache disorders	High blood pressure
3	Stroke	LRTI	Low Back pain	Child growth failure
4	Diarrheal disease	Diarrheal	Neonatal disorders	Air pollution
5	Lower respiratory infections (LRTI)	Road Injuries	Depressive disorders	High plasma glucose
6	Road injuries	Stroke	Diabetes	Smoking
7	Chronic Obstructive Disease	Congenital defects	Musculoskeletal	High body mass index
8	Cirrhosis	Tuberculosis	Anxiety disorders	Unsafe water
9	Tuberculosis	Cirrhosis	Hearing loss	High LDL cholesterol
10	Diabetes	Meningitis	Blindness	Diet low in whole grain

Source: Authors' Own Calculation

In 2017, approximately 1.4 million died in Pakistan, making 6.6 deaths per thousand population and 60.3 % of deaths were due to NCDs. Age related deaths in 50 to 69 years refer to Table 4.1. It makes more than 80% of deaths attributed to NCDs including malignancies. Highest is cancers of all types i.e., 26%, and then Ischemic Heart Disease (IHD) comprised of 25% proportion, Diabetes Mellitus (DM) contributing 4.5% and 3.7% is kidney disease.

Another study, STEP survey conducted in 2014-15 in the two provinces of Pakistan, Punjab and Sindh, has highlighted that 60% of surveyed population from 60-69 years is suffering from Stage I Hypertension. Diabetes Mellitus is a disease of life and, if not managed from early, could results in multi-organ complications and puts huge economic burden to the family. According to National Diabetes Survey of Pakistan (NDSP, 2016-17) conducted by Ministry of National Health Services Regulations and Coordination, MONHSR&C, Diabetes Prevalence in Pakistan is 26.3%, which implies that 27 million people of more than 20 years of age are suffering from diabetes.

With ageing population in older people of more than 70 years, Dementia/Alzheimer is more prevalent, which affects the quality of life of patient and needs assisted care and care of caregivers at home and institutional care. Alzheimer and other dementias cause 5.27 % total deaths in 2017 and Risk Attribution is 28%.

4.1.2. RESPONSE OF HEALTH SYSTEM TO NCDS IN PAKISTAN

International commitments of Government (including the Sustainable Development Goals, SDGs commitments) and National Health Vision (2016-2025) highlights the need to NCDs and their risk factors. In this regard, a huge treatment gaps are present in Pakistan, which contribute to an increased burden of disease in Pakistan including mental health issues. Poverty, lack of education and population explosion have further worsened health indicators, especially in vulnerable groups (older population). The National Health Vision (2016-2025), guiding document developed at national level, has highlighted the importance of financing, health services delivery, human resource for health, health information systems, governance, essential medical technologies, cross-sectoral linkages and global health responsibilities to tackle NCDs[46].

[46]Government of Pakistan (2016). National Health Vision Pakistan 2016 – 2025. https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/pakistan/national_health_vision_2016-25_30-08-2016.pdf

Another important intervention is including NCDs in National Health Insurance Program. Other NCDs like IHD, COPD, cancers and mental health disorders needs to be strategized to get tangible effects.

Health service delivery system in Pakistan is not geared towards the needs of older population especially in rural areas, resulting in increased number of old age-related illnesses, including mental health. In Pakistan, a large part of population is covered by private sector health facilities as commercial entities. Around 80% of outpatients are served by the private sector, which is not affordable by the majority of older persons and is of a suspect quality.

4.1.3. KEY BOTTLENECKS FOR OLDER POPULATION

1. NCDs are not prioritized at primary health care level
2. Lack of uniform implementation of proposed strategies in all provinces
3. No registry for cancer, Hypertension (HTN), Alzheimer's with age disaggregation
4. More focus on treatment than prevention.
5. Poor capacity of human resource to recognize and management of old age related non-communicable diseases in general and mental health issues and Alzheimer in particular.
6. Lack of inter-sectoral interventions covering social, financial, nutritional emotional and physical health needs of older people.
7. Governance gaps in policy guidelines and implementation.

4.1.4. RECOMMENDATIONS

1. Inclusion of older persons as a separate priority group in health packages, community interventions and social protection interventions.
2. Prioritization of NCDs in general and special attention to 60 plus population in upcoming Universal Health Coverage (UHC) strategy.
3. Mental health disorders of older persons should be addressed at community level with better awareness & counselling of care givers. Utilizing already Lady Health Workers (LHWs) who has a strong community presence should be helpful.
4. Development of a National Program for Dementia/Alzheimer in line with the WHO Integrated Care for Older People (WHO –ICOPE) Frameworks
5. Capacity building of healthcare workers in geriatrics
6. Inclusion of older persons in Sehat Sahulat Program as a separate group
7. Generation of evidence to make better policies and make evidence-based allocations

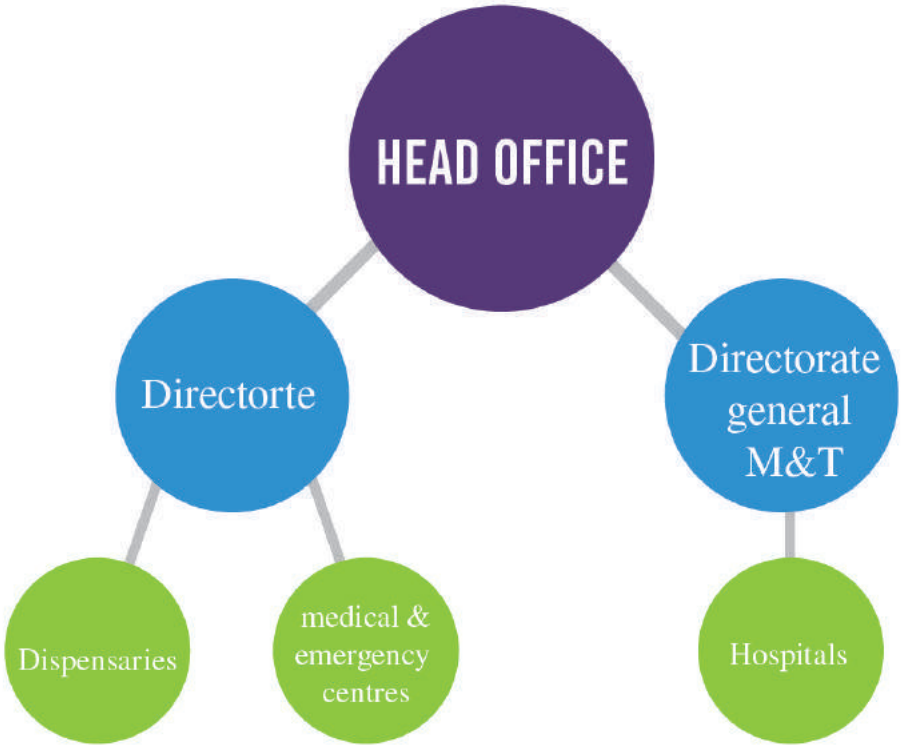
4.2. COMPARING THE EFFECTIVENESS OF SOCIAL HEALTH PROTECTION PROVIDED BY SOCIAL SECURITY INSTITUTIONS AND NATIONAL HEALTH INSURANCE SYSTEM

Health is a basic need of population and in Pakistan, though health indicators are improving over the years like maternal mortality ratio has decreased to 186/100,000 live births and life expectancy has increased (66.6 years) and under five mortality is better but still Pakistan is at the lowest level in the region. Pakistan is also a signatory of SDG Agenda with a commitment to leave no one behind. Pakistan spends 1% of its GDP in health sector, which is very low even in the region. An estimated amount of $45 per capita/year is spent on health, out of which, only $15 is spent by the public sector, and rest is Out of Pocket.

Pakistan's health system is divided into public sector and private sector and institutional health services providers such as Armed Forces, Employees Social Security Institutions' schemes, national health insurance scheme for poorest of the poor, NGOs and charity organizations covering only 29% of population. 65.2 % of health expenditure is Out of Pocket (OOP), which contributes to push people below poverty line. Poverty increases vulnerability to disease resulting in poverty trap.

There are two main social protection systems for health in Pakistan. Provincial Employees Social Security Institutions (PESSIs), which was established in 1967 under an Ordinance, to provide health coverage and compensations for injury to industrial workers and their dependent families including parents. PESSIs are provincial institutions, which operates under an administrative hierarchy consisting of Provincial Headquarters, headed by Commissioner Social Security and multiple Directorate as regional administrative units. Directorate is responsible for registration of workers and monitoring of service provision to the entitled. The hierarchy of PESSIs is shown in Figure 4.1 below.

Figure 4.1: PESSI Medical Wing Hierarchy



Health delivery system operates through network of dispensaries, medical centres and emergency centres, which provides primary health care including Maternal, New-born and Child Health (MNCH) services and immunization. Emergency medical centres take care of the injuries and usually relocated at workplace (factories). Secondary and tertiary health care is provided through network of hospitals and system of referral to public hospitals, where treatment is available (radiotherapy etc.).

PESSIs are actively providing services in all the provinces and in Islamabad Capital Territory and the Punjab Employees Social Security Institutions, with the largest network, according to available data has an approved budget of more than PKR 18 billion in 2020, with 12.3 billion estimated spending on medical care and capital medical expenditure. Total registered industrial organizations are 63,214 all over Punjab with 919,943 registered workers covered for complete health coverage and other benefits with 5.5 million dependents as shown in Table 4.3.

The main source of income (93.6%) of PESSIs is from the contributions by employers which is 6% of minimum wage (PKR 17,500) of secured worker.

TABLE 4.3 : PESSI STATISTICS

Registered units	Registered workers	Dependents	Number of PHC facilities	Hospitals	Number of beds
63214	919943	5,508,708	229	17	2265

The publicly available data enables us to work out the financing requirement per person per year, as well as per household.

TABLE 4.4 : PESSI BUDGET 2020-21

Revenue Expenses	Approved Budget 2020-21 PKR	% of total income PKR	Per family /year (PKR	Per person /year (PKR)
Medical care expenses (hospitals)	7,952,563,000.00	43.95	8645/	1444/
Medical care expense (dispensaries)	2,825,178,000.00	15.61	3071/	513/
Capital expenses medical care wing	1,560,764,000	8.63		
Total medical care	10,777,741,000.00	59	11,715/	1919/

The cost of comprehensive Social Health Protection is very low, without any limitations as it includes out-door as well as in-door diagnostic tests as well as medicines.

4.2.1. SOCIAL HEALTH INSURANCE

Sehat Sahulat Program (SSP) is a targeted national program in Phase II and was started as 'Prime Minister National Health Program' in 2015. By launching this type of targeted social program, the Government hopes to extend the health coverage of inpatient services for the poorest of the poor. To identify beneficiaries, BISP data was used and National Database & Registration Authority (NADRA) and NGOs were involved for registration and issuance of Sehat Insaf Card. A National Poverty Score Card Survey enabled BISP to identify beneficiaries by application of Proxy Means Test (PMT) that is used to determine the welfare status of household on a score of 0 to 100 and households with scores less than or equal to 35 are considered eligible for SSP. Government pays premium per family to State Life Insurance Company and in-patient health services are provided through panel hospitals, (predominantly private) all over Pakistan.

So far, it is implemented in 71 districts in different provinces, with 100% coverage (whole population) in Federally Administered Tribal Area (FATA-as now merged with KP) and Tharparkar. Total targeted families are 9,527,598. In addition, enrolled families are 6,426,537.

Services provided are in-patient secondary health care including maternity care for which the Government pays PKR 60,000 per family/year. The second category is nine priority diseases, for PKR 300,000 per family per year, the total package increased to 720,000 per family/year in 2019.

Over the last five years, this program is increasing its coverage by area and has become more inclusive with the inclusion of Persons with Disabilities, registered with NADRA, and it will be covering Transgenders too.

A recent conducted actuarial study has reviewed financial aspects of this program and has worked on some projections for future guidance. According to exposure analysis of age bracket and calendar posed years, more population is exposed gradually from December 2015 to October 2018 but age bracket is years < 25 has maximal exposure (family). (Exposure refers to the total length of time (in years) that Program members have collectively been insured). Males have more exposure than females and trend is same from 2015 to 2018 i.e. 56% males & 44% females. By claim experience analysis, incidence rate or utilization rate 9.3 per 1000 members in 2016 and decreased to 6.3 per 1000 members, more female incidence in age group of 30 to 64 between 5 & 6 but more male incidence after 50 years of age. Cost per In Patient (IP) claim is more for males between 50 to 64 years as compared to other age groups. Urban rural utilization and IP claims are almost same.

Calculated average family size for analysis is 6.27 (census data, membership, stake holders discussions) analysis done on risk premium (paid to State Life Insurance Company, SLIC) and claim cost per family in 2016 & 2017 and combined. It implied that premium paid to SLIC per family combined in years 2016 & 17 was adequate to pay the claims.

TABLE 4.5: ADJUSTED RISK PREMIUM VS CLAIMS COST (RISK PREMIUM IS PREMIUM PAID/ FAMILY MINUS ADMINISTRATIVE COST)

Adjusted Risk Premium	Amount in PKR
Family premium (October 2018)	1,300
Family risk premium (October 2018)	1,092
Claims cost/family 2016	1,234
Claims cost/family 2017	1,005
Claims cost per family 2016/2017 (Combined)	1,044

Source: Actuarial analysis of Federal Sehat Sahulat Program for MNHSR&C, Government of Pakistan

According to the latest data produced by a study by MNHSR&C, in 2020, premium paid stood at PKR. 1998/ family per year. As this analysis is early, when membership was increasing so premium was adequate to pay claims but it is predicted that as membership will be stabilized then premium has to be increased to pay claims to the hospitals.

The cost claims are divided into six main headings, i.e., diagnostics and priority disease, maternity medical, maternity surgery, medical and surgery. Average cost per IP event in general is PKR 22,000 (simple calculation not actuarial), this study has projected costs for 2019 to 2021 based on base table and stress test has shown that if utilization is increased three times then the premium cost will increase to PKR 4316, which is 146% increase from base Table 4.6.

TABLE 4.6 : BASE TABLE OF STARTING COSTS AS AT 1ST JANUARY 2017

Categories	Utilization per 1000 members/annum	Average Cost per IP event
Diagnostics	0.17	24375
Maternity medical	0.37	14990
Maternity surgical	0.56	17290
Medical	2.17	12,153
Surgical	3.76	35,229

Source: Authors' Own Calculation

4.2.2. COMPARATIVE ANALYSIS OF PESSI AND SSP

There is still no comprehensive evaluation study of quality of services provided by private hospitals in case of SSP and there is no blanket coverage of all the conditions as the case in social security institutions. As we lack a proper evaluation to know about access, quality, patient satisfaction and impact on health indicators of targeted population and their loop spending, it is still early to declare SSP as a clear policy choice, as compared to the work-based social security, which could cover 90% of country's population, if properly implemented. SSPs , in principle covering 6.4 million families, making it 40 million population, which makes 19% of total population, but the utilisation of SSP is very low i.e., 2.3%.

According to Pakistan Social and Living Measurements (PSLM) Statistics (2018/19), Lowest Quantile Income in Pakistan, which gets SSP, is PKR 23192/month. Though, the amount per person per annum is not sufficient to give full coverage, yet the next two quantiles of income, which is between PKR 29000 and PKR 31000 are not covered. Any health event with OOPs/catastrophic health expenditure can push people from 3rd quantile to 1st quantile resulting in poverty trap, which will affect the health indicators viciously as shown in Table 4.7.

TABLE 4.7: AVERAGE MONTHLY INCOME BY QUINTILES, (1 IS THE LOWEST) PSLM 2018/19

PKR	Total	1	2	3	4	5
Pakistan	41,545	23,192	29,049	31,373	37,643	63,544

Social health protection is necessary in these circumstances and it has to be proactive rather than reactive which invests in people's social security and their ability to manage risks enabling them to plan and be more productive in their livelihoods.

At the moment, if the models of PESSIs and SSP are compared, both are targeted but work under different models. Social Security has its own service delivery system, which, over the time, has developed standards, and uniform pharmacopeia, as compared to SSP where 88% of health provision is through empanelled private hospitals, without uniform standards and pharmacopeia, which is bound to raise serious issues with time. These hospitals are not uniform in their services and quality, Human Resource (HR) and pharmacopeia. The remote area hospitals have inpatient facilities.

The range of coverage provided is limited for SSP and no outdoor consultations, which makes 80% of health seeking activity. Social security model is providing wide range of services including diagnostics and interventional, medical, surgery and maternity.

If the cost wise study is considered, though these are not direct estimates but calculating from budget allocations and targeted population, it is found that per annum spending on one family is (indoor and OPD) is PKR 11,715/ family and PKR 1919 per dependent (Budget allocations) with full utilization. Whereas, according to an actuarial study of Sehat Sahulat Program, a single in-patient incidence or admission claim ranges from PKR 12000 to PKR 35000. This is a very high cost with only hospitalization, which is hardly 20% of the total OOP. At the macro level, the premium paid to SLIC appears low because service utilization is 2.3%. The financing of SSP would become easy for the utilization, and coverage grow and the facilities like outdoor, lab tests and medicine are included in the scheme.

In conclusion, we contend that the Social Protection could continue with Social Security Programs as most of the people in the lowest quintile would be either unemployed or in precarious informal jobs. Our analysis, however, strongly suggests that the inclusion of the income two and three in social health protection on contribution based social security
institution is the way forward as an example of better policy, good governance and quality primary and secondary care. This contributory approach would be greatly helpful to get benefits at old age. With SSPs in its current form would under-serve the older persons, for all times to come.

4.3. IMPACT OF COVID-19 ON OLDER PEOPLE IN PAKISTAN

The health crisis, triggered by coronavirus, can isolate older people and the risk of this happening is far higher in the underdeveloped healthcare system of Pakistan. Primarily, in the drive towards containment, it is often difficult to isolate older persons from their families. With traditional family ties and extended family system, older people can only be isolated within the family home and even that may not be possible for low-income families. This is particularly challenging in urban low-income settings where large families live in small dwellings.

It is also customary for the older persons to embrace younger members, a tradition which carries a high risk of the spread of the virus. The best form of the social engagement for many of them is congregational daily prayers in the mosque and it is a religious taboo to restrict them from such gatherings. Their movement to separate quarantine facilities will also require extra diligence, as they are often illiterate and heavily dependent on their younger family members. They may face barriers to obtaining food and other essential supplies if quarantine conditions become scarce or more widespread.

Another problem is the ability of the health system to cope with surges in demand for those needing respiratory support and those with physical mobility constraints. Even at normal times, public health system in Pakistan faces severe capacity constraints in providing specialized geriatric care, such as availability of ventilators. Although extra efforts are currently being made to get new equipment, our medical services are unlikely to be able to offer the care needed in a speedy outbreak of the virus, as observed in China, Italy and Spain.

4.3.1. IMPACT OF COVID-19 ON OLDER PERSONS: QUANTITATIVE ANALYSIS

To measure the impact of COVID-19, a survey instrument was used, by using "Questionnaire for Assessing the Impact of the COVID-19 Pandemic on Older Adults", as developed by Asghar Zaidi and his colleagues at Government College University, GCU Lahore. Inferential statistics was applied on the data consisting of 71 older people to draw inferences about the impact of COVID-19 pandemic on older people. Inferential statistics consisting of Pearson Product Moment Correlation was used to determine the relationship among the main variables of the study.

Simple linear regression was used to determine the gender, education, family income as predictors of physical health, mental health, social and economic impact. The t-test for independent samples and One-way Analysis of Variance (ANOVA) was used to investigate the gender and family income differences in terms of physical health, mental health, social and economic impact. Cronbach-alpha reliability of the questionnaire was also determined. Reliability analysis of the "Questionnaire for Assessing the Impact of the COVID-19 Pandemic on Older Adults" indicated Cronbach alpha value falls in an acceptable range k= 19 (α=.68).

TABLE 4.8 : CORRELATION AMONG THE MAIN VARIABLES OF THE STUDY (N=71)

	Variables	Gender	Education	Family Income	Physical Health	Mental Health	Social Impact	Economic Impact
1	Gender	------	-.03	.84	-.07	-.08	**-.27***	-.03
2	Education		------	**.48****	-.06	.23*	-.21	**-.28***
3	Family Income				-.03	.130	**-.27***	**-.32****
4	Physical Health			------	------	.30**	.149	**.51****
5	Mental Health					------	.11	.07
6	Social Impact						------	.16
7	Economic Impact							------

*p< .05 **p < .01

Results in Table 4.8 indicated significant negative correlation between gender and social impact, i.e. older men experienced more adverse social impacts of COVID-19 than older women. Result also indicated significant positive correlation between education and family income, implying higher the education the higher the family income. Education is also positively correlated with mental health indicating that higher the educational qualification of the older people the more the mental health concerns. Moreover, education is significantly inversely related with economic impact implying that lesser the education the more was the economic impact.

Family income is negatively correlated with both social and economic impact indicating that higher the family income the lower social and economic impact experienced by the older people during COVID-19. Physical health is positively correlated with both mental health (psychological impacts) and economic impacts indicating that older people experiencing exacerbated impact on physical health also experienced poor mental health during COVID-19 and vice versa. Moreover, as for the manifestation of physical symptoms, the more the economic burden on older people and less the physical health concerns during COVID-19.

TABLE 4.9: GENDER DIFFERENCES (MEN = 42, WOMEN = 29) IN TERMS OF PHYSICAL HEALTH, MENTAL HEALTH, SOCIAL AND ECONOMIC IMPACT ON OLDER PEOPLE DURING COVID 19

Variables	Men Means	Women Means	t-statistic
Physical Health	13.1	12.7	.587^{ns}
Mental Health	7.4	7.4	.715^{ns}
Social Impact	**6.8**	**5.9**	**2.34***
Economic Impact	7.6	7.41	.328^{ns}

df=69,*p<.05

The t-test for independent samples analysis indicated that older men (M=6.8) and older women (M=5.9) differed significantly in terms of social impacts of COVID-19 (see Table 4.9). Based on this finding, it is inferred that older men experienced more adverse social impacts of COVID-19 in the form of practicing social distancing, not interacting with the family and avoiding going to the public places than the older women.

On the other hand, no significant differences were found in terms of physical health, mental health and economic impact between older men and women. In the light of these findings, it can be said that older men and older women both faced difficulty in getting routine medical care, avoided paying visits to general practitioners, hospitals and had sleep disturbances. Similarly, older men and women were equally affected psychologically by the COVID-19 and older men and women both were also equally subjected to economic impact of the COVID-19 and took measures to reduce the economic burden.

TABLE 4.10 : COMPARING FAMILY INCOME GROUPS IN TERMS OF PHYSICAL HEALTH, MENTAL HEALTH, SOCIAL AND ECONOMIC IMPACT ON OLDER PEOPLE DURING COVID 19 (N =71)

	Family Income Groups							
Dependent Variables	Below Poverty (1k-25k)	Low income (26k-50k)	Low middle income (51k-1lac)	Middle income (1.1k-2lac)	Upper middle income (2.1lac-2.5lac)	High income (Above 2.5 lac)		
	N=10 Mean	N=18 Mean	N=23 Mean	N=8 Mean	N=2 Mean	N=10 Mean	F	P
Physical Health	11.8	12.7	13.6	**14.5**	**15.0**	11.5	2.52*	.038*
Mental Health	6.1	6.9	**8.1**	7.1	**10.0**	7.0	4.02**	.003**
Social Impact	6.6	6.6	7.0	5.8	6.0	5.2	1.17	.131[ns]
Economic Impact	7.7	7.9	**8.0**	**8.3**	6.5	5.1	2.50*	.039*

df=5,*p<.05,P**p<.01

ANOVA results indicated that there are significant mean differences among different income groups in terms of physical, mental (psychological) and economic impacts of COVID-19. Table 4.10 indicated that physical health concerns were experienced during COVID-19 pandemic by older people belonging to upper middle- and middle-income group. Older people belonging to low-middle income and upper-middle income group were more affected psychologically by the COVID-19. Older people belonging to the middle-income and low middle-income group experienced more economic impact as compared to older people from other income groups.

Post Hoc analysis (Fisher Least Significant differences, LSD) further indicated that low-middle income group experienced significantly adverse physical impacts of COVID-19 (M=13.60, S.D=2.57) as compared to both high taxpayers (M=11.50, S.D=1.90) and below poverty income group (M=11.50, S.D=2.44).

Impacts of COVID-19 on mental health as experienced by different income groups followed the same trend as impacts on physical health. Upper middle-income group (M=10.0, S.D=1.41) experienced significantly adverse impacts on mental health as compared to below poverty group (M=6.1, S.D=1.10) and high taxpayers (M=7.0, S.D=0.81).

Post hoc analysis indicated that the social impact was more on the low income (M=6.6, SD=1.6) and middle income group (M=7.0, S.D=1.78) as compared to high tax payers (M=5.2, S.D=1.03).

Post Hoc analysis on economic impact of COVID-19 on different income groups indicated that high tax-payers (M=5.1, S.D=1.1) experienced significantly lower economic impact of COVID-19 as compared to all other income group that is below poverty (M=7.7, S.D=2.6), Low income (M=7.9, S.D=2.2) and Middle income (M=8.3, S.D=2.8).

TABLE 4.11: GENDER, FAMILY INCOME AND EDUCATION AS PREDICTORS OF PHYSICAL HEALTH, MENTAL HEALTH, SOCIAL IMPACT AND ECONOMIC IMPACT

Predictors	Dependent Variables	B	SE	*B*	R^2	t	F	P
Gender	Physical Health	-.360	.614	-.071	.005	-.715	.345	.559^{ns}
	Mental Health	-.291	.407	-.08	.007	----	.511	.477^{ns}
	Social Impact	-.971	.414	**-.272**	**.074**	-2.34	5.677	**.02***
	EconomicImpact	-.205	.627	-.039	.002	-.328	.107	.744^{ns}
Family Income	Physical Health	-.046	.167	-.033	.001	-.274	.075	.785^{ns}
	Mental Health	6.927	.405	.130	.017	1.08	1.17	.282^{ns}
	Social Impact	-.269	.113	**-.276**	**.076**	-2.83	5.677	**.02***
	EconomicImpact	8.994	.594	**.321**	**.103**	-2.82	7.953	**.006****
Education	Physical Health	.153	.289	-.064	.004	-.529	.280	.598^{ns}
	Mental Health	.376	.187	.235	.055	2.008	4.033	.049^{ns}
	Social Impact	-.354	.199	-.210	.044	-1.785	3.186	.079^{ns}
	Economic Impact	-.693	.284	**-.282**	**.08**	-2.443	5.96	**.01***

df=69,*p<.05,**p<.01

Simple linear regression analysis confirmed that gender is statistically significant predictor of social impact of COVID-19. R^2 indicated 7% variance in social impact accounted for by gender. Regression coefficient further indicated gender is likely to predict .27 standard deviation units change in social impact or in other words, negative Beta value shows that gender has 27% relative influence of social impacts on the older people during COVID-19 in Table 4.11.

It can be assumed that older men experienced more difficulty in maintaining the social distancing and staying in contact with their family through other sources such as phone calls, video calls etc. We can also assume that older men followed the precautionary measures such as wearing masks, sanitizing hands and avoided going to public places more strictly than older women. However, analysis also indicate that gender is not significant predictor of physical health, mental health and economic health.

Results indicated that family income is a significant predictor of social impact and economic impact. R^2 indicated 7% variance in social impact accounted for by family income. Regression coefficient further indicated family income is likely to predict .28 standard deviation units change in social impact or in other words, family income has 28% relative influence on social impacts among older people. In addition to social impact results indicated, that family income is also a statistically significant predictor of economic impact of COVID-19.

R^2 indicated 10% variance in economic impact accounted for by family income. Regression coefficient further indicates family income is likely to predict .32 standard deviation units change in economic impact or in other words, family income has 32% relative influence on economic impact. Based on this finding, it can be inferred that lower the family income more adverse the social and economic impact of COVID-19 on older people will be. Furthermore, results indicated that family income did not predict the physical and mental health of the older people.

Lastly, results indicated that education is statistically significant predictor of economic impact of COVID-19 for older people. R^2 indicated 8% variance in economic impact accounted for by education. Regression coefficient further indicated education is likely to predict .28 standard deviation units change in economic impact or in other words education has 28% relative influence on economic impact. In the light of the findings, we can say that less educated older people suffered from economic burden during the pandemic.

On the other hand, education is not a significant predictor of physical health, mental health and social impacts on older people during COVID-19.

In the light of the findings of the study, it is concluded that older men experienced more social impact of the COVID-19 than older women did. This means that older men faced difficulty in maintaining social distancing, staying at home, following the Standard Operating Procedures (SOPs), such as wearing masks, sanitizing hands etc. than older women. In our Pakistani culture, men socialize more as compared to women and socialization is an important source, which contributes to their contentment with life.

The study also indicated that the COVID-19 pandemic affected the physical health and mental health of older people belonging to middle and upper middle-income class. It can be assumed that due to lock down they were not able to visit the general health practitioners, did not pay visit to hospital for routine check-ups and had difficulty in getting the medical help, which in turn adversely affected their health.

The study further revealed that COVID-19 has been psychologically devastating for older people belonging to low and upper middle income. Similarly, the economic impact of COVID-19 was greater on low and middle-income group and they faced economic burden during COVID-19 took measures to combat this crisis by reducing expenditure and by holding back the financial support which they were providing to their family. Regression analysis has also supported the finding that lower the family income the greater the economic crisis experienced by the older people.

4.3.2. IMPACT OF COVID-19 ON OLDER PERSONS: QUALITATIVE ANALYSIS

This chapter complements the quantitative assessment of the impact of COVID-19 on older persons in Pakistan. For this purpose, the study analysed the information provided in the interviews with older persons (3 men and 3 women) with diverse educational, professional and socio-economic backgrounds, as conducted in Lahore during September 2020.

All the interviewees were aged 60 or above and they were prompted pertaining to the effects of pandemic of COVID-19 in Pakistan. The participants were contacted through community referral and they were interviewed in the comfort of their own homes at a time of their convenience.

TABLE 4.12 : CHARACTERISTICS OF INTERVIEWEES

Participant ID	Age	Profession	Marital Status	Family System	COVID-19
FP1	60	Housewife	Married	Joint	NO
FP2	60	Housewife	Married	Joint	NO
FP3	61	Housewife	Widow	Nuclear	NO
MP4	65	Business	Married	Joint	NO
MP5	67	Retired Professor	Married	Nuclear	NO
MP6	72	Retired Professor	Widower	Joint	NO

The Thematic Analysis Approach had been used as a method of analysis for analysing transcribed data i.e. interview data[47]. It has been widely used in sociology, psychology and business research[48,49].

The aim behind choosing thematic analysis as the analytic tool was, that it enabled to analyse data in a systematic and objective manner and allowed describing and interpreting responses from the data and condensing into fewer categories[50]. The categories are assumed to have contents, quotes, words that share meanings and contexts[51]. The data condensation resulted into broader themes, which portrayed the indigenous perspectives of how older persons in Pakistan responded and dealt with COVID-19. The themes are noted in the table 4.13 below.

TABLE 4.13: THEMATIC DISTRIBUTION FOR QUALITATIVE ANALYSIS

Sr No	Themes	Subthemes
1	Changes in Physical Health	• Physical Well Being • Use of Dietary/herbal Remedies • Self-hygiene and household cleanliness ✓ Heightened sense of Self-preservation
2	Restrictions on Social interaction	• Effect of COVID-19 on Social Connectedness
3	Psychological Impact of COVID-19	• Fearfulness
4	Religion as a Coping Mechanism/Religious Coping	--------
5	Role of Media	--------
6	Family Support & Elderly Care	--------
7	Perceived Economic Impact/Crisis	--------

4.3.3. THEMATIC ANALYSIS

4.3.3.1. CHANGES IN PHYSICAL HEALTH

In the perilous situation of COVID-19, the physical health and its maintenance became prime concern, particularly for older persons. Careful reviews of the transcripts and discussion lead to the conclusions that older persons interviewed report to be concerned about their physical health in general and physical well-being; dietary remedies and self-hygiene and household cleanliness to maintain health in particular.

[47]Two Decades of Developments in Qualitative Inquiry: A Personal, Experiential Perspective—Michael Quinn Patton, 2002. (n.d.). Retrieved October 21, 2020, from https://journals.sagepub.com/doi/10.1177/1473325002001003636
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4.3.3.2. PHYSICAL WELL-BEING

Respondents talked about their physical well-being. Most of them missed their regular exercise, walk and other physical activities and have not been able to get back in their routine after the long gap due to lock-down and closure of parks and gymnasiums

MP5 said, "I felt change in my physical health and well-being, I was going to gym regularly before the 18th March when the lock-down was imposed. I could not go to walking tracks, as I am not used to walk on the roads/streets… now the gyms are open but my body in not getting back into the routine. I have shoulder and knee pains due to exercise, its (body) not getting back into (exercise) routine"

Another woman participant (FP3) said, ***"I used to walk but due to social distance and the lock-down I limited my walk inside my house on the terrace, but it's not the same I cannot maintain my pace and space in not enough…"***

Hence, a sense of poor physical well-being was strongly observed among the older persons both men and women, and this is despite the fact that not all respondents suffered individually from COVID-19.

4.3.3.3. USE OF DIETARY/HERBAL REMEDIES

With the onset of the pandemic, many herbal remedies got popular since there were unknown medicinal remedies as such. The information about the dietary solutions and herbal remedies were available on social media, i.e. Facebook, WhatsApp and Instagram, as they became sources of information. Older persons were no exceptions in this case as they also used many such remedies

A male participant MP4 said, ***"…We discontinued using fizzy cold drinks and water instead we got ourselves mitti k gharry (earthen/clay pitchers) for naturally cold water. Herbal teas (Kehwa), lemon, black cumin (Kalonji) were used extensively"***

Another woman participant FP1 added, ***"We used to take steam almost daily to keep our throats healthy and used herbal tea (Kehwa) with lemon twice daily"***

Another participant MP5 said, ***"I suggested my family to increase the use of protein, eggs and fruits to boost their immunity"***

Therefore, it can be inferred that COVID-19 created a situation in which older persons used alternative diets and herbal remedies. In most cases, this points to improvements towards healthy and organic diets.

4.3.3.4. SELF-HYGIENE AND HOUSEHOLD CLEANLINESS

To contain the virus and prevent its attack, participants reported use of extensive cleanliness measures, self-hygiene and precautions. Interviewees explained in depth about their special arrangements to fight COVID-19

MP6 a male interviewee said, ***"We laid off our house maid, did all household ourselves for over three months, used separate shoes for going out and in-house use, changed clothes and took shower every time after coming back from market/shops."***

Another senior person MP5 quoted, ***"….Use of face mask and gloves had become a norm … it was a must…. I used to sanitise my car steering and door handles as well after coming from market… wash my hands many times a day ….. used disinfectant for ourselves and other coming in our house."***

Based on these accounts, it can be said that not just self-hygiene and household cleanliness increased but a heightened sense of Self-preservation was observed. Interview participants talked about using masks, sanitizers, disinfectants, repeated showers, different shoes for going out and in-house wear.

The most interesting observation was by one participant MP5 who said, ***"….. I did not touch the currency***

notes; I got them changed in the market….. I kept them in a paper envelop…. Disinfected them, ironed them and placed in the sun light".

Whereas, FP3 said, ***"…I avoided touching my face"…***

Many other such experiences and events were shared by the older persons, which indicated a heighted sense of self protection and survival. This is a positive development in many ways but it points to additional levels of anxiety in day-to-day interactions.

4.3.3.5. RESTRICTIONS ON SOCIAL INTERACTION

The accounts of older persons' interviews showed that the restrictions on the regular social interactions had a great impact on their social and psychological well-being. Their interview accounts revealed that they felt restricted, immobile, and even imprisoned in some instances. Women participants were observed to be more restricted, e.g., a participant did not go into social gatherings for 07 months, another avoided going out for 06 months and one reported to avoid social visits for 05 months. Men, however, were noted to be more mobile and less restricted, due to obvious reasons of trips for important errands; household provisions etc. Social interactions in their case were also restricted.

"…we did not attend funeral of our first cousin who died due to COVID-19…. I advised all my family to NOT to go to a wedding ceremony in Gujranwala …….. It's the same where our cousin went and picked the virus and died…" He further added that "we did not meet our family, sisters and brothers on the two Eids ….. did not go to check on our ailing relatives… it felt so bad but we were helpless" said MP4

FP1 said, ***"I could not visit hospital for my regular check-ups, the scare to catch the virus was so much, my son asked me to not to get sick and eat healthy food and stay in home"***

The aftereffects of such a long restricted social life are noteworthy as well.

FP1 interviewee said, ***"I feel strange when I go out, the fear is still there and people are shopping on carts and elsewhere as if nothing is wrong***"

FP3 sharing her apprehension said, ***"everything is opening up, business, schools and colleges but people need to be careful…. the virus is still there"***

The restrictions on going out for simple errands, seeing relatives and meeting ailing relatives, attending funerals or wedding ceremonies, has been felt deeply by all the participants. Since, these simple gestures and social etiquettes are part of our socio-religious morals and have importance in our culture.

The restriction on social interactions has had great impact on overall social and psychological well-being of older adults. The feeling of socially connected to one's family and close relatives, as a support mechanism in the Pakistani context, is very important and a hallmark feature of our cultural setup. The feelings of social connectedness were also affected as a result of restrictions imposed on social interaction in the form of lock-down.

4.3.3.6. EFFECT OF COVID-19 ON SOCIAL CONNECTEDNESS

Since Pakistani culture happens to be traditional and collectivistic, the familial bonds are strong and people are well connected with each other. The well-knit family ties are strengthened with constant and close connections and knowledge of where about of family members.

MP5 said, ***"Phone calls, WhatsApp calls have been the only source for us to stay in touch with our sisters and brothers; I used to talk to them almost every day just to check how they were doing".***

Considering the fact that people were under lock-down and not allowed to move freely and meet their families, the social media and online calling apps proved to be very useful and their usage increased many folds.

"I think that my use was doubled since I had been worried and wanted to be aware of safety of my sister she lives in Norway and daughter who lives in Germany. I used to talk to them once or twice a week but since there was COVID-19 so I called almost every day," said FP1.

Similarly, referring to the impacts of lock-down, participants also shared their perceptions of the lockdown…. FP3 said, ***"There were no gatherings, it had become so quiet, everyone was in their houses".***

Another interviewee FP1 said, ***"Eid was not same as every year, we did not go to any relative's house, there were no Eid get-to-gathers, I did not like the distance and disconnect with my family".***

Similarly, a male senior person MP4 said, ***"It seems that the world had become colourless"***, while explaining his discontent with the lock down.

Considering these opinions, it can be summarised that lock-down and poor social connectedness of Pakistani people has had its effects on social and psychological lives of older persons.

4.3.3.7. PSYCHOLOGICAL IMPACT OF COVID-19

Women interviewees in general shared more psychologically laden concerns in their accounts as compared to men. They were more fearful not just for themselves but for their children being mothers and grandmothers.

FP1 shared with despair that, ***"What have these kids seen in their life…!? !.... their work and education are suffering, they are stuck in homes, all they have is TV and mobile which are no good…. We have lived our lives but I feel for them…."***

A mother of five children, FP3 said, ***"I do not allow my son to go out for grocery, I go myself, it's difficult to go out in summers but I take the pain, I can't let my children suffer, but what will happen if I get sick…."***

4.3.3.8. FEARFULNESS

One of significant sub-themes under psychological effects of COVID-19 was its fear from multiple dimensions. All female participants shared their fear of COVID-19 in their interviews; they talked about fear of getting unwell due to COVID-19, they were fearful that their children or families might be affected by COVID-19; now they are concerned about reopening of schools and colleges.

"I wake up in the middle of night, feeling worried about my children…" she further added showing her worry that ***"I do not allow them to go out and if they go I keep calling them to get back home early"*** (FP3)

The women participants also shared fear of death, after-life, fear of isolation and exhibited an existential crisis. There was a sense of purposelessness and uncertainty about the future; women participants were more mindful of the problems due to COVID-19 and questioned themselves that;

"I fear if I die due to COVID-19, I have a daughter and 2 sons who are unmarried, what will be their future ….. and what have done for myself and my after-life" (FP3)

Being a religiously mindful and traditional population, most people in Pakistan are observed to be sensitive towards issues of good/bad deeds; and fate and afterlife. During COVID-19, all such fears have been observed to be accentuated by the uncertainty. The above and many other quotes vividly show that people had become very apprehensive and fearful due to the spread of COVID-19.

4.3.3.9. RELIGION AS A COPING MECHANISM/RELIGIOUS COPING

Due to the depression, anxiety, fearfulness and other symptoms of worry reported by the participants they were asked about their most preferred coping mechanism to deal with all such aspects of one's psychological health. The most preferred coping mechanism mentioned by all the participants was diverting towards divine guidance, religiousness, prayer, recitation of Quran and repentance.

In this regard, MP5 said, ***"People have become more religious and religiously active; I used to offer namaz, now I have become even more regular".*** The findings of the quantitative study also augment these observations.

Another male participant MP4 explaining the significance of religiousness in our culture and brought-up quoted, ***"I miss going to Jumma Prayer, it has been my routine from young age to go to Masjid to offer Namaz, I have made my drawing room as Musallah, me and my family offer namaz here, recite Quran and say our prayer here".***

The fear of COVID-19 has been so great that people sought solace and peace by offering their religious rituals; FP2 said, ***"I repent and seek forgiveness from ALLAH …. I'm afraid what have we done that such a disease has been sent by HIM upon us; it's a result of our ill-doings".***

However, after the lockdown is over and life is getting back to regular routine in Pakistan, a male interviewee MP4 said, ***"I'm excited about opening up of Masjids, I have started going to Jumma Prayer it feels good to be back in HIS house".***

4.3.3.10. ROLE OF MEDIA

At this juncture, the role of media is very important to be discussed as it was the only source of information and entertainment both at the same time, during the COVID-19.

Most of the senior interviewees did not feel satisfied with the way COVID-19 news were covered by almost all the media houses in Pakistan.

"My son did not let me watch news, it was all about the numbers of COVID-19 positive cases and deaths, it was so depressing to see the news" said FP1

Another participant MP5 said, ***"News channels aired news updates in so festive and loud manner, with background music and like a running commentary of cricket match that death toll has increased and COVOD-19 cases have increased… I discontinued watching news… I used to watch other channels"***

A male participant MP4 said, ***"The self-proclaimed news agencies have caused much problem on Facebook and WhatsApp, I know a lady she is not a doctor but she would share forwarded messages so frequently without authentication and verification that it was disturbing"***

The interviewee account shows that transmission of news need regulation and better media management by all stakeholders i.e. media houses, NGOs and Government.

4.3.3.11. FAMILY SUPPORT AND ELDERLY CARE

However, on the other side, it is also observed that in the absence of an active social life, regular business and errands; people were left with no choice but to stay home and spent time with immediate family. With COVID-19 in backdrop, the lockdown and closure of all business, families had a chance to catch up with long lost relationships and make up for the busy times.

An elderly mother FP2 said, ***"My children took extra special care of me during these days, it was due to the fact that they were home all day"***

Moreover, a senior adult male participant MP5 said, ***"my children took care of us old couple and were very cautious about our health during COVID-19"***

Similarly, FP3 also added, ***"Two of my daughters are doctors they took care of me really well"***

However, it was also observed that mothers were more aware and concerned about their children and grandchildren.

A senior participant FP2 said, ***"I wait for my son to get back home when he used to go to market for grocery, I would ask him to change clothes and bathe and sanitise himself".***

It was observed that elderly cares improved, and young were also looked after by their parents. The findings are also corroborated by the fact that the need for social connectedness also increased during COVID-19 in the collectivistic society of Pakistan.

2.3.3.12. PERCEIVED ECONOMIC IMPACT/CRISIS

During COVID-19, when the entire world economy was in doldrums, Pakistan was no exception. The markets were closed, businesses were shut down, and people were uncertain about the continuously emerging situation. The uncertainty was so rampant that people had to change the usual ways of their lives.

Women had perceived the economic impact differently than men participants …FP2 said, ***"I controlled my home expense, we did not shop this summer for clothes neither me nor my daughter-in-law"***. Another female participant FP3 shared her opinion that ***"I had stocked three months grocery due to the uncertainty; it disturbed my monthly budget since I live on pension."***

Meanwhile the male participants saw the economic crisis in terms of closure of their businesses, clinical practices etc. MP4 stated, ***"Our factory is closed, we had to shut it down, the construction sector is closed my son is architect he is free from last 5 month, I knew it was coming….. I believe in Almighty it too shall pass".***

Another senior adult male participant MP5 said, ***"I had some top-up income from my clinic, I used to sit there for counselling and due to lock down the clinic is closed, so I feel it has affected my income".***

Hence, the COVID-19 has had its impact on the economic situation of people and elderly if not directly but indirectly also felt the pressure.

4.4. CONCLUSIONS

The brief qualitative study brought up the effects of COVID-19, which encompassed the physical and mental health, social and economic aspects of older people. It is observed that no single aspect of senior citizens' life remained unaffected. This qualitative study indicated that older people had become health conscious to the extent of being absorbed by the thought of COVID-19 and how to stay safe from it; similarly the high risk and susceptibility of contracting the virus made older people anxious, fearful and depressed. The prolonged lockdown and resultant social disconnectedness further created a social crisis, which hit most if not all older people.

Since the virus has been contained for now; the results suggest to look into providing counseling facility; a 24/7 hotline where older people can call and seek guidance and help. Educational institutions, media houses, NGOs can arrange seminars and awareness sessions for parents, grandparents of the students to deal with the aftereffects of COVID-19 on older persons, as its impacts might be felt and to stay here for a while. Older people need to know about their increased risk to make informed decisions about how to protect themselves. The local administration needs to bear in mind that a large number of older people in Pakistan are illiterate. Thus, awareness campaigns may not be equally effective to target older people unless designed exclusively for them. An older age perspective should be included explicitly in all efforts to contain spread of coronavirus.

Finally, there is a considerable risk that the effect such contagious virus may cause a collapse in older people's social positioning and enhance age-based discrimination. This epidemic should make us realize even more that there is no place in the society for those who stigmatize against older people.

SECTION 5

HEALTHY AGEING

5.1. HEALTHY AGEING IN PAKISTAN

5.1.1. DEFINING HEALTHY AGEING

Ageing population is a relatively new issue from historical point of view as statistical evidence of ageing population (aged 65 and over) in 1950 was not greater than 11% for any country. In 2000, the highest in the world was 18% but the projections indicated a dramatic increase by the year 2050, when the old age population is expected to reach 38%[52]. These projections point towards the rising needs of old age well-being in near future.

The term *Healthy Ageing* is used broadly in policy circles and academics. It is basically used to recognize disease Free-State that differentiates between healthy and unhealthy older persons. It can be defined as a lifelong process enhancing opportunities for improving health and social, physical and mental well-being, quality of life, independence and improving effective life changes. The World Health Organization (WHO) based healthy ageing on functional perspective and life course changes. The WHO defines healthy ageing as *"the process of developing and maintaining the functional ability that enables well-being in older age".*

Where, functional ability is related to health attributes that facilitate persons to be and to do what they have reason to value. Functional ability included relevant environmental characteristics, intrinsic capacity of individuals and interaction between them. These characteristics include person's ability to think, work, remember and grow, meet basic needs, build and maintain relationships and contribute to society[53].

The active and healthy ageing is defined as *"the situation where older people can live their independent, healthy and secure life and they can participate in formal labour market as well as in unpaid productive activities".*

5.1.2. MEASURING HEALTHY AGEING: LITERATURE REVIEW

The ageing process is not only about the population structure, it is inter-sectoral process too. Our national and local governments have not developed dedicated data sets on ageing population. Therefore, we have to depend on the Indices developed elsewhere, even, if they might not be portraying our situation correctly as the subjective and cultural norms regarding the old age well-being could be different in different countries, the old age being primarily a social construct. SPRC has benefitted from the insights provided by the international experience in terms of measurement of old age well-being. The United Nations Population Fund (UNFPA) and Help Age International published a report on ageing in the 21st century in 2012. The GAWI Index has four domains, which include 13 indicators. The index is calculated by taking the geometric means of normalized values of all the four domains. The all four domains carry equal weight. The value of each domain is also a geometric mean of all the indicator of all domains with the equal weights. The first domain of index is the Income Security, which is described through the access of sufficient amount of income and its use independently. The indicators of income security are the pension income coverage, poverty rate in old age and relative welfare of older people. The second domain is Health Status and its indicators are life expectancy at age of 60, healthy life expectancy at age of 60 and psychological wellness. The third domain is Employment and its indicators are employment and educational status of older people. Older people want to live independently and feel safe and secure in the environment. Due to which forth domain is selected as Enabling Environment and the indicators of this domain are social connections, physical safety, civic freedom and access to public transport.

[52] World population Aging 1950-2050, United Nations Population Division
[53] WHO (2015) report on Health and ageing

The 91 countries are ranked globally with the GAWI index, which is best to live in for the older people[54]. In the case of UNECE's Active Ageing Index (AAI), four domains were selected. These domains are employment, participation in society, independent, healthy and secure life and capacity enabling environment for active ageing. Each domain has different indicators with their relative weights and these indicators were selected with the advice of AAI Expert Group, which included statisticians, academics and representatives of national and international organizations. All the indicators were measured on the same scale ranging from 0 to 100 where, 0 is for the least positive result in terms of active and healthy ageing and 100 is for the best possible result. The AAI was calculated by taking the weighted sum of four domains and each domain is itself a weighted sum of the indicators included in each domain. This indicator calculated for the 28 European Union (EU) countries with the focus on older people. The finding showed that the Sweden, Denmark and Finland are on the top of the ranking in 28 EU countries. The Central and eastern European countries and Greece are at the bottom of the ranking[55].

A study had been conducted on the behavioural determinants of healthy ageing by Peel et al. (2005). For this study, the concept and definition of healthy ageing was adopted, which was given by WHO and it extended to physical, mental and social well-being. The determinants of healthy ageing have been categorized into different factors including demographic, medical, psychosocial and behavioural. This study has shown that behavioural determinants are significantly associated with the healthy ageing. The determinants of healthy ageing are smoking status, consumption of alcohol, obesity, dietary intake and physical activity. The evidence of an association of healthy ageing showed not smoking, being physically active, and maintaining weight with in normal range and moderate alcohol consumption[56].

The people aged 60 in Latin American countries are expected to double by 2050. The Risk of disability and non-communicable chronic diseases increases with age as well. A group of experts decided to create Healthy Ageing Index (HAI) in subset of six low and middle-income countries. The study has used indicators of functional ability and intrinsic capacity. The mean and variance of adjusted weighted least square estimators used for the analysis of categorical data. An HAI with excellent psychometric properties was created by using items of functional ability and intrinsic capacity and it is recommended that further research is required to explore sub population differences and to validate this index to other cultural settings[57].

The reports of European Union also stimulated healthy ageing as priority policy. The EU described the healthy ageing, as "it is the process to enhance the opportunities for the mental, physical and social life of older people so that they can participate actively is society without any discrimination and also enjoy healthy and independent life". The Heuvel and Olaroiu (2019) had identified determinants of healthy ageing at national level. The indicators under the three aspects including vulnerability, social cohesion and resilience of healthy ageing have assessed. The indicators of vulnerability at national level indicated the proportion of people at the risk of poverty. Social cohesion at national level described the extent to which people are willing to accept each other. Resilience at national level represented the provision of health care services and social security for the people. This study had used data from 2013 to 2014 from the Eurostat and European Social Survey. The Principal Component Analysis (PCA) is used to explore the coherence between the indicators. In order to analyse the significant contribution of these three aspects into healthy ageing the linear regression analysis has used. The results depicted that healthy ageing vary from 64.7 years to 80.3 years between the 31 European countries. The results also showed that resilience and vulnerability has significant contribution in healthy ageing[58].WHO is undertaking a longitudinal study called Study of Global Ageing and Adult Health [SAGE]. WHO's SAGE is collecting data on adults aged 50 years and older, plus a smaller comparison sample of adults aged 18–49 years, from nationally representative samples in China, Ghana, India, Mexico, Russian Federation and South Africa. Pakistan does not have any such representative samples data.

[54]Taipale, V. T. (2014). The Global Age Watch Index, GAWI 2013. Gerontechnology, 13(1), 16-20.
[55]Zaidi, A., Gasior, K., Zolyomi, E., Schmidt, A., Rodrigues, R., & Marin, B. (2017). Measuring active and healthy ageing in Europe. Journal of European Social Policy, 27(2), 138-157.
[56]Peel, N. M., McClure, R. J., & Bartlett, H. P. (2005). Behavioral determinants of healthy aging. American journal of preventive medicine, 28(3), 298-304.
[57] Daskalopoulou, C., Chua, K. C., Koukounari, A., Caballero, F. F., Prince, M., & Prina, A. M. (2019). Development of a healthy ageing index in Latin American countries-a 10/66 dementia research group population-based study. BMC medical research methodology, 19(1), 226.
[58]Van den Heuvel, W. J., & Olaroiu, M. (2019). Determinants of Healthy Ageing in European countries, Journal of Gerontology & Geriatric Medicine, 4(5).

5.1.3. DETERMINANTS OF HEALTHY AGEING IN PAKISTAN

Based on the literature in previous section, SPRC has devised Healthy Ageing Index for Pakistan [HAIP]. Previously, it has never been constructed using micro-data in Pakistan. SPRC's intent of the index was to have a metric based on self-reported questions of healthy ageing in five domains. SPRC conducted a survey of sample consisting 450 observations from three major cities of Pakistan. Literature suggests that various factors could be potential determinants of healthy ageing in Pakistan. Figure 5.1 shows the domains and variables selected in each domain in order to construct Healthy Ageing Index of Pakistan (HAIP).

Statistical methodology adopted for construction of Healthy Ageing Index Pakistan (HAIP) was factor analysis, in particular Confirmatory Factor Analysis (CFA). Factor analysis identifies the common variance amongst a set of observed variables (i.e., indicators), and creates a factor (i.e., index) comprised of that common variance. Traditional guide for factors with Eigen value greater than 1 suggests two factors, a two-factor solution was chosen for the analysis.

To build a CFA model we have three latent factors related to healthy ageing, each latent factor is not directly measured. Model was then estimated using maximum likelihood estimates.

Fit indices of the model are given in Table 5.1; the final model is absolute fit in terms of The Root Mean Square Error of Approximation (RMSEA) and Standardized Root Mean Square Residual (SRMR) and Goodness of Fit Index (GFI) values, whereas the Comparative Fit Index (CFI) is quite lower to the cut-off point of 0.9.

Figure 5.1: Healthy Ageing Domains and variables

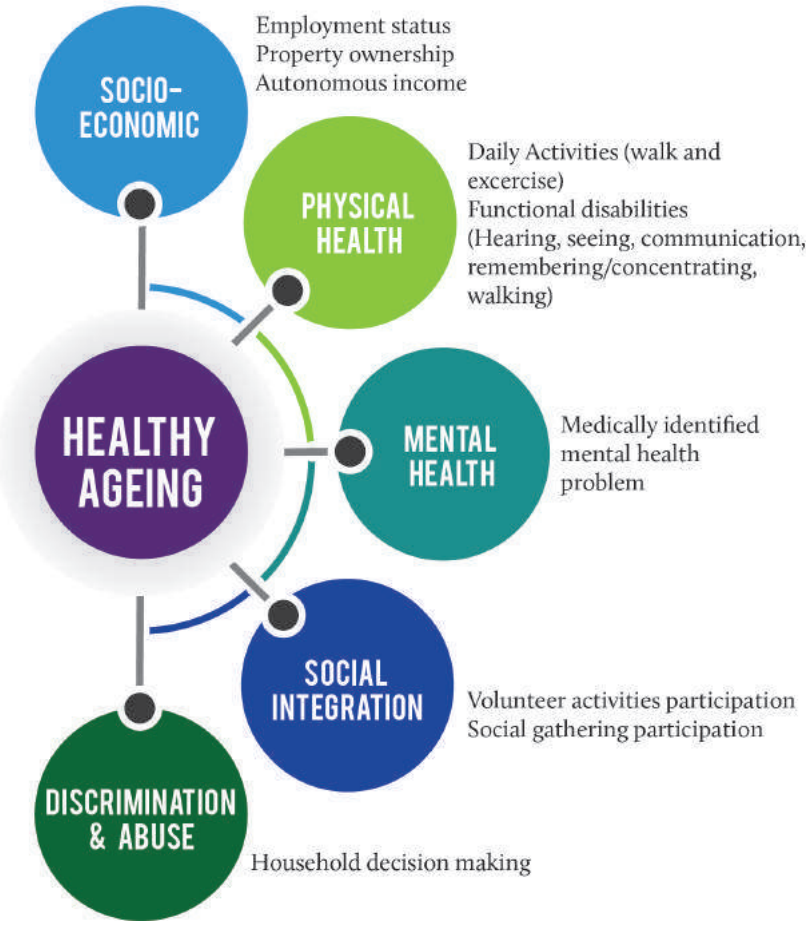


TABLE 5.1 : ESTIMATIONS

	Chi sq (df)	p-value	CFI	RMSEA	SRMR	GFI
18 item-2 factor Model	305.9(125)	<0.001	0.66	0.08	0.07	0.87

To get Healthy Ageing Index Pakistan, predicted values of CFA model were extracted where factor loadings were treated as regression estimates as shown in Table 5.2.

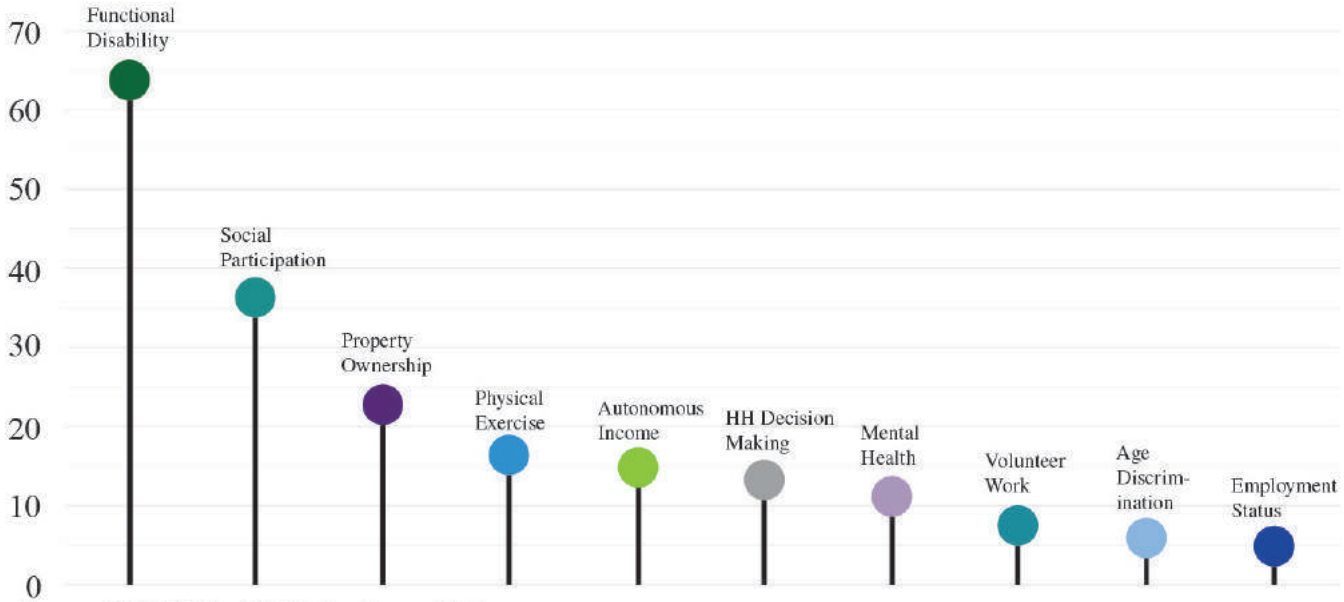
TABLE 5.2 : TWO-FACTOR SOLUTION CORRESPONDING TO CFA CONDUCTED ON THE SAMPLE OF PEOPLE AGED 55 AND ABOVE (N = 450): FACTOR LOADING ESTIMATES AFTER VARIMAX ROTATION.

Variables	Factor 1	Factor 2
Employment Status	0.355	------
Physical Health: Going for Walk	0.541	------
Physical Health: Meeting Neighbours/Friends	0.329	0.157
Physical Health: Meeting Relative	------	0.116
Physical Health: Physical Exercise	0.357	0.172
Functional Disability: Hearing	0.567	0.111
Functional Disability: Seeing	0.530	0.132
Functional Disability: Communication	0.164	0.701
Functional Disability: Remembering/ Concentrating	0.555	0.282
Functional Disability: Walking/Climbing Steps	0.723	-0.111
Medically identified mental heal issue	-------	-0.232
Residential Status	0.155	-------
Participation in volunteer activities	0.191	-------
Looking after grand children	0.371	-0.413
Household Decision Making	0.101	0.210
Property Ownership	-0.109	-0.278
Autonomous Income	0.103	0.200
Age Discrimination	0.203	-------

To quantify the importance of variables in predicting healthy ageing in old age, Mean Decrease Accuracy (MDA) was estimated through Random Forests. Random Forests is a machine learning technique that can handle non-linear numeric and categorical predictors and outcomes.

Results showed that functional difficulties (seeing, hearing, communication, remembering/concentrating, walking/climbing stairs) affect healthy ageing the most. As old age is associated with functional decline, it should be identified at an early stage. This will help to bring proper interventions to ensure healthy ageing.

Figure 5.2: Determinants of Healthy Ageing



Source: SPRC Old Age Well-being Survey 2020

Social Participation refers to meeting friends/family/relative and participating in social gatherings. Older adults are at higher risk of undesirable health effects combined with social isolation and loneliness. Social participation has been found to be related to better functional skills and well-being. Third important determinant of healthy ageing is property ownership. This is correlated to older people participating in household's decision making. Results suggest that those older people who keep the ownership of their property feel less discriminated and take their decisions on their own. On the other hand, age discrimination is positively correlated to those who either do not have any property or transferred their property to children. Activities such as walk/exercise works as medicine for older people. These daily life activities play a very important role in prevention of diseases and promote healthy ageing.

Through the SPRC Annual State of Social Protection 2020, SPRC presents its original Healthy Ageing Index of Pakistan for scientific scrutiny. SPRC believes that a robust indigenous index would go a long way in providing robust, cost-effective solutions to the actually unmet social protection needs of the older persons in Pakistan. The emergence of more robust local data sets would also be helpful in projecting the old age situation in Pakistan in global indices more correctly.

SECTION 6

ROLE OF MASS MEDIA IN PAKISTAN IN PROMOTING HEALTH AGEING

Instead of promoting Health Ageing as a public good, the media is negatively affecting the perceptions of old people via negative stereotypes, stories, misery porn and general disingenuous attitude about the value of old age folk. These perceptions negatively reinforce some of the traditional social behaviours, which need to change in the wake of new socio-economic realities and in the light of a better scientific understanding of the ageing process. A caricatural dramatization of some particularly vicious stereotypes discourages a large number of older persons, already fighting disease and naturally occurring marginalization from the individual efforts at Healthy Ageing and discourage them from reaching out the older persons to form a positive social force.

6.1. THE POWER OF MASS MEDIA

Mass media is not only consumed by the masses, but also watched by the shapers of the public opinion, by legislators, judiciary, and bureaucracy. In the studies on media psychology, the mass media influence is defined as an effect on actions, manner and en-masse individual and audience opinion making. Negative mass media influence can have dire consequences, leading people to crime, violence, mental and physical illness and (in some cases) disorders etc. Mobs have been formed on mere rumours, which has led to lynching and property destruction. Children have killed by using guns due to negative influence if mass media or due to some occult stuff (like the case of the Slender man girl murder) propagated by the mass media.

Mass media is not inherently bad either; it is the manner in which it is used. Positive perceptions are key to mass movements in this day and age. Positive media influence does exist, such as the way people come together during disasters and general community efforts for good outcomes (e.g. food distribution in Vietnam during the COVID-19 lockdown). Quiz based games, educational programs, travel blogs, food competitions, sports etc. all engender positivity and happy reactions from people. Mass media can produce positive effects by increasing literacy, awareness, news and information about important events, sicknesses and warnings. The COVID-19 lockdown has successfully demonstrated that the Advertisement captured the need for public service messages, warnings and instructions for life during this pandemic. The nature of mass media is such that it spreads direct and indirect sources, and everyone comes across a different array of these information bites within media sources. These all can overall be negative and positive; such is the importance of this aspect of the social media that during sensitive events, notwithstanding its potential of positive impacts, mass media is banned to prevent confusion and rash decision due to incomplete/lack of information.

Mass media uses archetypes, stereotypes, events, personalities, criminal activities, heroic acts and other features of human lives to create perceptions and feelings about certain groups of people. For negative use, the negative events are overdone to the point of sensationalism in order to put off the viewer, causing them to view that group negatively. A constant negative messaging and forcing viewer to create negative associations can result in the vilification of a group, resulting in anti-group policies and attitudes.

6.2. SPRC STUDY ON OLD PERSONS' PORTRAYAL IN PAKISTANI MEDIA

The study shows that, in Pakistan, old people in media are often the victims of the 'media negativity spin'. The most worrisome stereotype in this regard is the general conception of old people as both a burden and a parasite, to the point that policies in place for them are, at best, inadequate, and at worst, missing entirely, leading to misery and in the case of health, death due to lack of medical coverage. Instead of promoting/spreading the idea of healthy ageing as a good thing, the failures of old age are often shown via harmful caricatures, tropes and stereotypes in society. This is also a direct failure for media policymakers too, as most of these anti-social

stereotypes ae caricatured manifestations of ageing and could be seen as concretizing the failure of Heath Ageing.

Some of these character types may exist in the society but reinforcing these stereotypes through media as naturally occurring can occlude the process, which leads to these caricatured personifications of the older persons. In reality, a large number of the older persons can age well, if the media shows that the processes, which result in heathy or unhealthy ageing are man-made and the individuals, families and communities can improve these processes, if they were better aware of these processes. If the question of Old Age Neglect and Old Age Violence and older persons job dynamics are given more air space and are treated with sensitivity, the care gap of the older persons created by the poor support of the government (financial protection, health protection and rights protection) and dwindling solidarity/social network support (family, associative life, mosque) would significantly reduce, increasing the old age well-being in Pakistan. We have seen the TV Serials successfully promoting the emancipation of women. A lot of thought goes behind the characters which are related in such a way that they continue managing better the process of becoming confident, independent women towards the end of the serial. Healthy Ageing is not taken up in the same vein as if it was not that important.

6.3. KEY STEREOTYPES

This study examined editorials, TV dramas and movies to observe the perceptions that media has of old people (60+ years of age). Additionally, this study checked for the frequency of coverage of old age-related problems (gerontological) covered in the said media. In the first glance, one gets the impression that the presence of elderly is respected in our culture. It was found that the elderly were primarily being used as a prop to push the plot forward, rather than as their own people. In usual TV Drama Serials, several harmful tropes are used e.g., burdens, powerless sources of unsolicited wisdom, 'parent' role, particularly for women, sacrificing all the time, using and elderly-as-a-plot point, as a butt of jokes etc. These kinds of harmful stereotypes have proliferated media for the past few decades and do not seem to be going away anytime soon.

The findings did come across a recent tilt in TV serials for older people but in such a way that they are almost always considered to be the 'invisible' problem, which exists in small but significant populations, but they are attended so poorly that it seems they'd much rather be forgotten. For example, a popular adage for old people in terms of economic help is that they are 'not asking for much'. While on the surface this appears to be a sentiment of humility and even frugality, in truth, it is used to justify minimal health and monetary compensations dealt out to the elderly folk. For us the popular Economics of the Ageism Stereotype portends in a very bad direction. A very common trope and role of the elderly is to be stand-ins for money, with sometimes a little bit of ableism and if they could not 'perform' on this account, the "elderly are burdens" bigotry is brought in and usually the older persons perish in their own unresolved sentimentalism in the face of ungrateful children.

This one dimensional and cynical use of old people is on par with the perceived notion that they are burdens, or at least unwelcome but begrudging ones. The 'burden' perception comes from the fact that their economic capability is accentuated. If such perception is juxtaposed with the fact that Pakistan has been a country of historically poor coverage of employment and unemployment benefits, with a very limited pension coverage and low asset base in case of 70% of the population, the lack of value of the older people makes them socially worthless; always in need of money for their health problems. This exposes the older people to double whammy as their daughters marry their tormentors for the treatment of fathers/mothers.

Hypothetically, the elderly enjoy a great and revered place in the structure of the present society, as guides in terms of wisdom, knowledge, tradition and religion; provided they have assets and pension, the media blurts. Many TV Serials though indirectly hint at the unfulfilled responsibility of the State towards the elderly, in terms of health and minimum financial protection, by showing the troubling trend of economic destitution and neglect among older persons.

nomically irrelevant.

The answer is that the media is spreading such primarily economic stereotypes that do not value old people at the basic filial and human level.

With the review of media, TV, Press, the following pattern of stereotypes with 'space occupancy'/Weightage emerges:

TABLE 6.1: STEREOTYPES, THEIR WEIGHTAGE AND DOMINANCE IN MEDIA

S.No	Stereotype	Weightage	Dominant Media
1	Burden/family parasites	90%	TV Drama Serials
2	Receding Role as Parents	60%	TV Drama and Commercials
3	Desperate Old people	50%	TV Drama Serials, Morning Shows
4	Con grandpa/ma	45%	TV Drama Serials
5	Funny Oldies	25%	TV Drama, Comedy Shows

Source: Authors' Own Calculation

6.4. AGEISM RESULTING IN UNINTENTIONAL MALICIOUS POLICYMAKING

Ageism lends to the idea that those that are older are, simply put, inferior to the younger people. There are several varieties of the phenomenon of Ageism.

Personal ageism involves ideas, attitudes, beliefs and practices on the part of individuals that are biased against persons or groups based on their age.

Institutional ageism involves ideas, attitudes, rules or practices that are carried out with the knowledge that they are biased against persons or groups based on their older age. This category includes practices that take advantage of the vulnerabilities of older persons.

Unintentional (or inadvertent) ageism involves ideas, attitudes, rules or practices that are carried out without the perpetrator's awareness that they are biased against persons or groups based on their older age.

All the three types of ageism mingle into each other and can be found in the media, marketing and Op-Eds of major newspapers today. In the survey conducted by SPRC of 200 Opinion pages of major newspapers, the Older Persons attracted the attention of only seven Opinion pieces and that also indirectly in the discussion on pensions. Such Ageism has led to such policies or the lack thereof, which adversely affect the populations that are negatively perceived. These social trends are making the prospect of Health Ageing in Pakistan even

that are negatively perceived. These social trends are making the prospect of Health Ageing in Pakistan even more difficult more and more individuals, local governments and state start viewing old people as burdens and waste of resources that could be spent elsewhere. Looking on the Older Persons only through the prism of dependence belies the solid knowledge and evidence, which has been produced to demonstrate that the gap between the Life Expectancy and Healthy Life Expectancy could be significantly reduced by practicing Health Ageing, which would make the older persons active contributors to the socio-economic life of the family and community. The fact however remains that a large number of households in today's Pakistan could not afford the treatment of their parents and could not make even a small financial provision for their routine up-keep. If the State does not effectively help the family in the social health protection of the older persons, one is bound to conclude that the State is complicit in spreading these stereotypes. Moreover, the decision makers are forgetting that the expenditure in prolonging the Healthy Life Expectancy would be far smaller as compared to the anticipated socio-economic contribution of the older persons with longer Healthy Life Expectancy.

6.5. RECOMMENDATIONS

1. First and foremost, we need to do more research to inform the media policy and Writer's messaging choices. In Pakistan, one often feels like the media has created, perhaps inadvertently, stereotypes and tropes so harmful that they have produced a new reality giving life to absurd assumptions about old age. This lack of focus on what actually means to age healthily, to age gracefully where all the needs are met, means that the idea of ageing itself is up for debate. Right now, it is shown negatively, as if ageing itself is a loser's prize.

2. In our popular imagination, shaped largely by the mass media, our society is now caring less of others, as compared to the fast. This perception, as a self-fulfilling prophecy hits the Older Persons disproportionately. A related assertion is that this phenomenon is more prevalent in cities than in rural areas. Mass media provides its own answers to these questions, which could be influenced by the hunches/biases or half-baked ideas of the authors. This is directly impacting the Health Ageing negatively. Has the mass media become a part of the problem when it comes to the care of Older Persons in Pakistan? There is a need to engage the Writers of TV Serials, copywriters of Commercials and Op-ed authors in this debate.

3. A better overall understanding of healthy ageing is still weak in Pakistan. The Older Persons do not have a constituency. A better understanding of healthy ageing should also help us better understand the economics of old age on the issues such as the links between GDP and Social Protection, health life expectancy and old age benefits and pensions etc.

4. Health is a pivot in any social protection system. There is a need to mobilize much more intellectual resources to make this understood widely. The bad health is one of the prime reasons why ageing is perceived so difficult is general. The lack of treatment or interrupted treatment often leads to more serious morbidities and psychological disorders. The role of external determinants in healthy ageing should get equal coverage along with the internal drivers of Health Ageing.

5. There is a need to nuance the messaging in the media. In many cases, despite the poverty, the results/impacts mentioned above are not strongly present if the individual concerned has stronger social networks, including the bonding and belief structures. Therefore, while talking about the Old Age Well-Being, both the subjective feelings of well- being and objective conditions which lower the well-being should be highlighted. In other words, 'worry' and poverty do not automatically decrease the well-being. In this regard, another issue, which our media presents in a very crude way, is the linkage of poverty with community solidarity. More often than not, an increase in poverty is shown in an almost automatic way in decrease is social support. In-kind social support in the case of Older Persons plays a very important part and a better interplay between the state responsibility, social support and philanthropy do produce better results. The Media, projecting the social reality, can become that evidence, which demonstrates that it is the absence of the social support, which is emerging a key factor in lowering down the Old Age Well-being.

SECTION 7

WHO COUNTRY OFFICE PAKISTAN'S CONTRIBUTION TO COVID-19

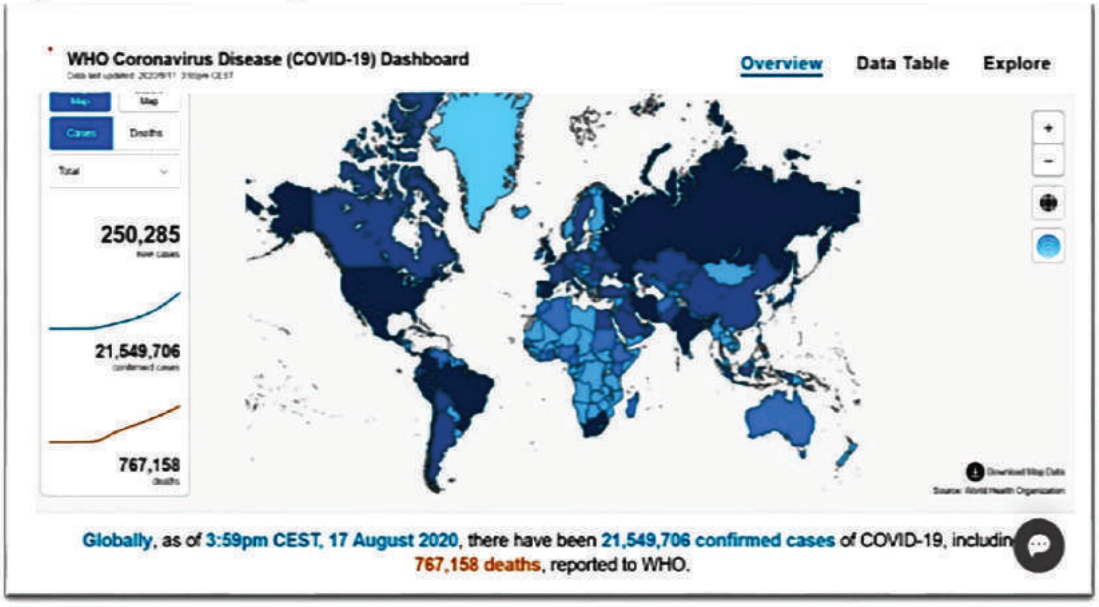
RESPONSE IN THE COUNTRY

Dr Palitha Mahipala,
WHO Representative/ Head of WHO Mission in Pakistan

7.1. BACKGROUND

The pandemic of COVID-19 was first notified on 31st December 2019 in Wuhan City, Hubei Province of China. As of 31st August 2020, the disease had infected over 25,143,696 people globally with 844,341 deaths (CFR 3.36%). The most affected region is America with 13,268,684 cases. Eastern Mediterranean Region (EMR) had registered 1,915,275 cases. See Figure 7.1 below showing details of the spread of the disease globally as of 17th August 2020.

Figure 7.1 : Global Spread of COVID-19



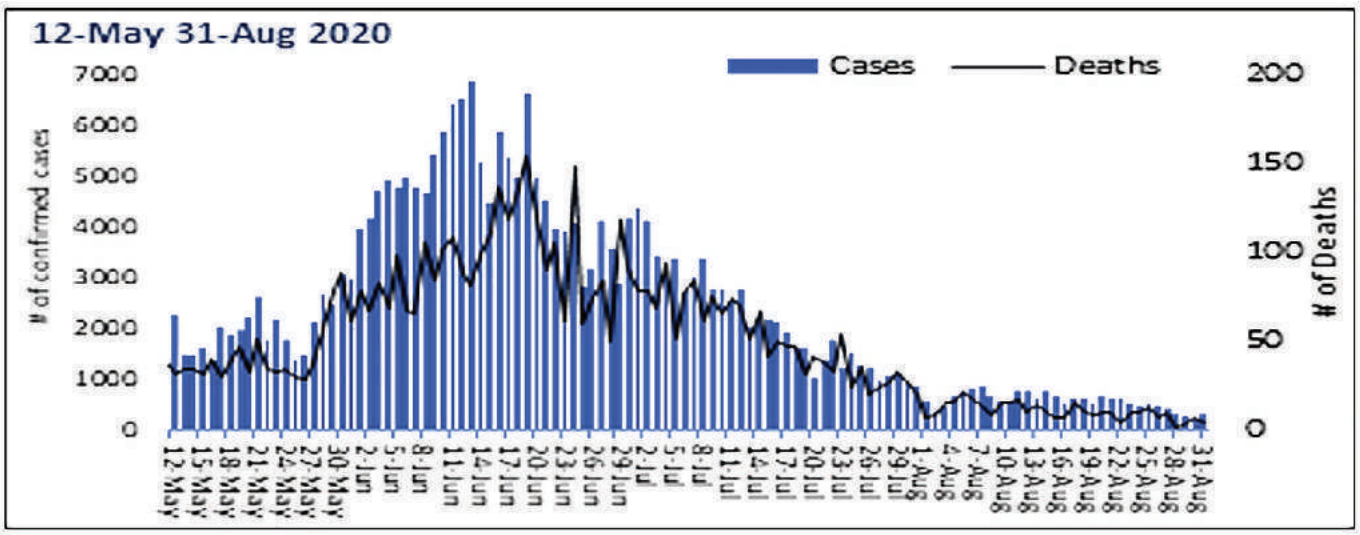
In Pakistan, the first COVID-19 case was reported on 26 February 2020 from Karachi. On the same day, another case was confirmed in Islamabad. As of 31st August 2020, Pakistan registered 289,832 cases of COVID-19 with 6,190 deaths (CFR: 2.13%). The number of cases reported on daily basis increased steadily by day from March onwards, until the middle of June 2020 where 6,825 cases were registered in a day.

Figure 7.2: WHO Country Office Established a SHOC Room By 15th January to Strategically Respond to COVID-19 Outbreak in Pakistan

COVID-19 offers a stark reminder to why there is need to invest in stronger health and data systems, rooted in primary healthcare, to achieve universal health coverage and to meet the health-related targets of the SDGs. Responding to serious challenges posed by this pandemic, countries have made difficult decisions in determining how best to respond to COVID-19 while maintaining the delivery of essential health services, especially for their vulnerable populations.

Following the identification of the first case of COVID-19 in 26th February 2020, the Government of Pakistan took strong steps based on epidemiological data to deal with the emergency. The World Health Organization (WHO) provided technical assistance to the Government of Pakistan (GoP) for the response. The daily case incidence for COVID-19 in Pakistan increased gradually from February until Eid-ul-Ftr (22-27th May 2020), following which the rise in the daily incidence rate was steep and sudden. The steps taken and the public health interventions employed by the GoP with the support of the WHO helped the health system to handle the crisis and not become overwhelmed. As a result of the interventions and initiatives, the disease curve was successfully kept relatively flat in spite of the sudden rise in the cases following Eid. The daily incidence began to decline around the end of June, continuing with the same declining trend through July and August, despite having another big social event i.e. Eid-ul Azha. (Refer to the figure below for the trend of COVID-19 infection as shown in Figure 7.3 in Pakistan over last 6 months.)

Figure 7.3: Trend of COVID-19 Infection in Pakistan



WHO stood at the forefront with the government and local authorities, who were working with commitment and dedication, to build up immediate and rapid response mechanism? To help prevent and limit the spread of COVID-19 in the country, and reduce the related morbidity and mortality, WHO Pakistan provided technical support in the development of Pakistan Preparedness and Response Plan (PPRP) which outlined the international assistance required by the Government of Pakistan to stop the transmission of the pandemic and respond to the emerging public health needs. WHO Pakistan contributed in various areas such as coordination and planning, case management, disease surveillance, laboratory, community mobilization and sensitization to curtail the spread of the deadly coronavirus. Prone to after its emergence, WHO initiated multi-sectoral, multi-partner coordination mechanisms, conducted an initial capacity assessment and risk analysis and established metrics, monitoring and evaluation systems to support preparedness and response activities at the national and provincial level. It engaged with local donors and existing programs to mobilize and allocate resources to respond to COVID-19 according to areas outlined by the PPRP. It implemented a risk-communication and community engagement plan for COVID-19. The proactive leadership of WHO lent its support to policymakers, local authorities and other organizations at every tier to control the spread of deadly Coronavirus.

Figure 7.4: WHO Country Representative, Dr Palitha Mahipala at Official Launching Ceremony of Pakistan's Preparedness and Response Plan (PPRP) for COVID-19 along with Honorable Government Officials of the Ministries.

Together with other partners, WHO has helped the Ministry of National Health Services, Regulations and Coordination (MNHSR&C), GoP to define core services and adapt guidance as well as review strategies to ensure the functioning of the core services to mitigate the direct and indirect effects of the pandemic on the vulnerable population groups. It is essential that actions to ensure the maintenance of Essential Maternal, Neonatal, Child, Adolescent and Older Adults (MNCAAH) services are a clearly defined part of the response to the COVID-19 pandemic.

Based on the Health System building blocks WHO assisted the government in developing the Pakistan preparedness and response plan (PPRP) to handle the COVID-19 pandemic. The goal of the plan is to reduce the risk of COVID-19 pandemic to the population of Pakistan by preventing, detecting and responding to the pandemic at all levels. WHO supported the government of Pakistan to respond to the outbreak of COVID-19. This report provides a brief summary of WHO support to the response and will be presented under the key pillars as highlighted below.

Pillar 1: Country-Level Coordination, Planning, and Monitoring
Pillar 2: Risk Communication and Community Engagement
Pillar 3: Surveillance, Rapid Response Teams, and Case Investigation
Pillar 4: Points of Entry
Pillar 5: National Laboratories
Pillar 6: Infection Prevention and Control
Pillar 7: Case Management
Pillar 8: Continuation of Essential Services

7.2. COORDINATION, PLANNING AND MONITORING

Besides supporting development of the PPRP under Pillar 1, WHO also supported the development of a National Action Plan (NAP), Global Humanitarian Response Plan GHRP and social-economic plan for COVID-19. Ministry of NHSRC is the driving institution for the response of the pandemic. WHO Technical staff joined and provided technical support to Technical Working Group (TWG) on coordination, surveillance, infection prevention & control, laboratory, case management and risk communication and

also supported the establishment of National Operational Cell at MoNHSR&C.

Figure 7.5: WHO Representative in Pakistan, Dr Palitha Mahipala Addressed a Media Briefing in Islamabad and Provided Information to Journalists Regarding the COVID-19 Situation in Pakistan

To facilitate planning on the response to the pandemic, there was a need to have figures on possible cases at a given time. Modelling is one of the ways to get some projections of figures to facilitate planning. WHO therefore, supported the MNHSR&C in modelling and projection of figures for the pandemic through the Health Services Academy.

In March 2020, the WHO Country Office Pakistan constituted a Think Tank of experts to provide inputs regarding the changing situation of the COVID-19 pandemic in the country, and to provide technical advice on the preparedness and response to COVID-19 and other public health issues to the country office and other stakeholders. The Think Tank comprised of people from esteemed national and foreign educational institutes, government offices, and ministries. They were responsible for focusing on the areas of Health System and Coordination, Surveillance, Epidemiology, Infectious Diseases, Case Management, Infection Prevention and Control (IPC), Risk Communication, and Medical supplies. The Think Tank has been very useful in analysing the COVID-19 situation in Pakistan, and in advising the WHO Representative for efficient and effective management of the pandemic.

WHO conducted an initial capacity assessment and risk analysis, including mapping of vulnerable populations by adapting human rights approach and intersectional analysis that would form the basis of the socio-economic impact analysis. WHO established metrics and monitoring and evaluation systems to assess the effectiveness and impact of planned measure.

WHO Country Office supported a high-level technical expert mission from the WHO Regional Office for the Eastern Mediterranean. The objective of the mission was to provide support on key areas including surveillance, International Health Regulations (IHR), Point of Entries (POEs) and Infection, Prevention & Control (IPC). The mission recommendations were shared with the national counterparts and follow up remote support from Head Quarters and Regional Office.

WHO also coordinated donor and partner meetings on COVID-19 giving updates on the pandemic.

WHO Pakistan developed a composite template for partner resource mapping to document commitment by partners/donors. WHO engaged with local donors and existing programs to mobilize/allocate resources and capacities to implement an operational plan. WHO reviewed regulatory requirements and legal basis of all potential public health measures and monitored the implementation of PPRP based on key performance indicators in PPRP.

Figure 7.6: A Partner Meeting in Process in WHO Conference Room

7.3. RISK COMMUNICATION & COMMUNITY ENGAGEMENT

Under this pillar WHO supported formulation of messages to the public about social distancing, mask usage, safe Ramadan, burial practices, and others based on the global guidance. WHO provided support to scale-up the Government's helpline "1166" from 55 to 250 agents and 21 WHO-supported technical advisors (medical doctors) addressed millions of calls. These advisors were responsible for answering on average 400 calls a day. WHO supported compilation and analysis of social data, which helped to develop targeted messages. A new "Oversight Management Team" was set up for the management of the helpline, of which WHO contributed two additional staff members. WHO developed and disseminated to health facilities "tool kit" with essential IEC materials. Community engagement was supported at the points of entry by placing and running three information booths at major airports.

Figure 7.7: Virtual Meeting with Religious Leaders on RCCs

WHO and Health Services Academy (HSA) signed an MoU on the "We Care" program. Under this program, WHO undertook three initiatives to support HSA which include developing of donning and doffing of Personal Protective Equipment (PPE) video, translation of the PPE video in Sindh and Pashto to be used in a training session for the training of health care workers, newspaper advertisement for raising awareness on adopting protective measures i.e. Social distancing, wearing of masks and practising hand hygiene to protect themselves from the COVID-19 virus and radio messages developed and disseminated through national radio channels in Urdu for raising awareness on COVID-19.

Figure 7.8: WR-Pakistan, Dr Palitha Mahipala Met with Dr Yasmin Rashid Health Minister Punjab and Discussed about Corona Response Activities in Punjab

WHO engaged with 15 key-influencers to share over 50 testimonials on key topics through own communication channels and/or media for the general public. Social media engagement plan was implemented, identifying key health influencers. Media professionals were engaged to address specific myths and misconceptions.

WHO engaged with religious scholars through Virtual meetings with Heads of Islamic Advisory Group (EMRO-led) and National Islamic Advisory Group for high-level advocacy. IEC materials were produced and disseminated (14 social media messages/graphics and posters in mosques on measures to take) for Ramadan and engaged with various partners (Facebook, Google, WhatsApp) on dissemination of COVID-19 related messages. WHO established partnerships with Facebook, WhatsApp and Google to design and disseminate messages; specifically, use of US$ 500,000 Facebook ad-credits and translation of "WHO Health Check" WhatsApp bot into Urdu and US$ 1million Ad-credit campaign with Google ad-words and YouTube.

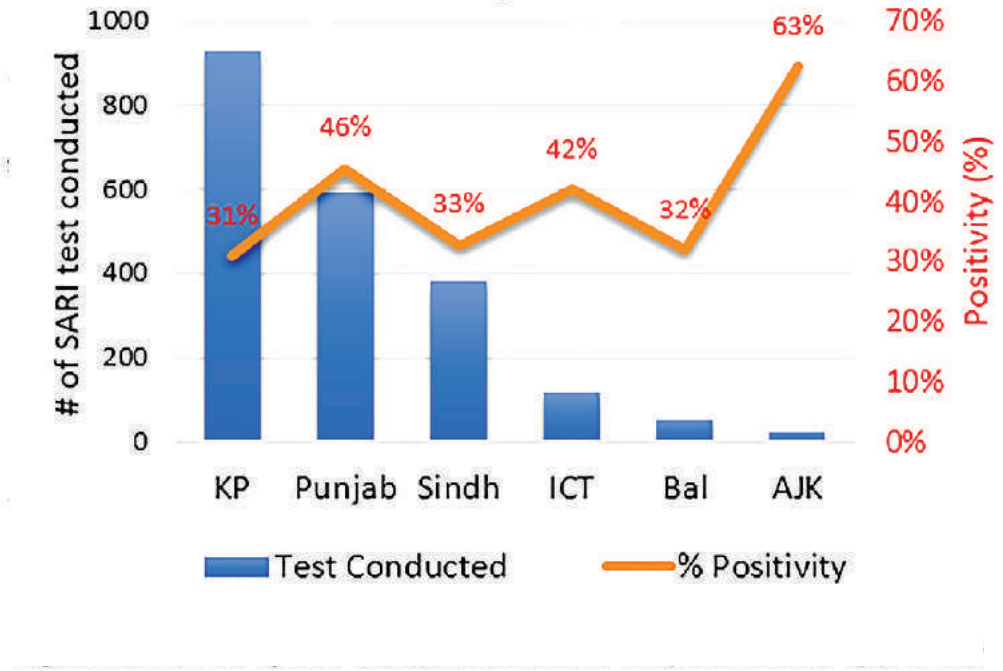
WHO provided technical support in vetting developing and printing of IEC materials on basic preventative behaviors, hand washing, social distancing, IPC. WHO supported the strategy for community engagement and activities of the partners. Media briefings for electronic & Print media were organized to take media on board on the latest situation and role of WHO in COVID-19 response and how WHO was supporting the MoNHSR&C. Capacity building activities were conducted to train of over 2,100 health staff on risk communication. The latest information regarding WHO response to COVID-19 pandemic is available on the following given link

http://www.emro.who.int/pak/programmes/emergency-preparedness-a-humanitarian-action.html

7.4. SURVEILLANCE AND CASE INVESTIGATION

WHO supported the Federal and Provincial Ministries of health in baseline assessment of the surveillance systems and it was identified that there is q a strong surveillance system for reporting on infectious disease throughout the country. Engagement of the Polio Eradication Initiative (PEI) surveillance platform for the surveillance of COVID-19 was done to facilitate early case detection and reporting for COVID-19 cases. The PEI teams initiated the COVID-19 Surveillance activities in February 2020 with the training of health care workers. COVID-19 surveillance data collection and reporting were initiated by involving the polio surveillance structure of 3,563 active surveillance sites. WHE teams trained a total of 15,965 health care workers from different cadres including 4,238 medical staff and 466 informal health care providers & courier service providers.

Figure 7.9: Number of SARI Cases, Test Conducted and Positive Cases by Province



WHO expanded its capacity by hiring surveillance officers/epidemiologist and data managers to support the government to enhance its capacity for surveillance, case detection, investigation, contact tracing and data analysis at the national and provincial level. Fourteen additional surveillance technical consultants (5 epidemiologists/surveillance officers and 9 data analysts) were hired and deployed at National and Provincial level to support the health departments.

The WHO PEI surveillance teams were involved at all levels of surveillance data from health facilities reporting to the district level and further submission to the provincial and federal level. The team was working as an integral part of COVID-19 surveillance system because of no other active surveillance system for infectious disease available.

The WHO surveillance teams conducted basic epidemiological analysis of the COVID-19 data on daily basis, producing daily situation reports at national and provincial level and share with stakeholders for advocating the evidence-based decision making to COVID-19 response. WHO advocated and supported the health department for establishing the Severe Acute Respiratory Infections (SARI) and Influenza-Like-Illness (ILI) active case finding and testing for COVID-19 through the WHO Health Emergencies Program (WHE) and PEI surveillance teams. SARI / ILI surveillance including case identification and testing for COVID-19 initiated in all the provinces.

As a way of measuring the extent of COVID-19 in the community and ensuring ongoing surveillance, WHO supported SARI/ILI surveillance. WHO supported in the training of the Rapid Response Teams through its PEI teams, which were involved in contact tracing in some districts. WHO trained 91 Rapid Response Teams at provincial and district level in all the provinces (more trainings in progress) with a total of 587 persons trained in all the provinces of Pakistan.

TABLE 7.1: NUMBER OF TRAININGS FOR RAPID RESPONSE TEAMS IN PROVINCES

S#	Province	No of RRTs trained	No of persons trained
1	**Punjab**	36	346
2	**KP**	36	139
3	**Baluchistan**	12	42
4	**Sindh**	7	60
Total		**91**	**587**

WHO supported in conducting preparedness and assessment at Point of Entries for Surveillance gaps and needs. The WHE surveillance Teams conducted capacity building training in surveillance, case investigation (including sample collection and transportation), contact tracing, quarantine and isolation and home care. WHE teams trained a total of 15,964 health care workers from different cadres including 4,238 medical staff and 466 informal health care providers & courier service providers. These teams worked in close coordination with the department of health, Rapid Response Teams and PEI surveillance teams to provide support in strengthening the COVID-19 surveillance.

TABLE 7.2: NUMBER OF HEALTH CARE WORKERS TRAINED FROM DIFFERENT CADRES BY WHO

S#	Cadre	No of Health care workers trained
1	Medical Staff	4,238
2	Paramedical Staff	4,751
3	Front Line & Community Worker	4,432
4	Facility Support & Janitorial Staff	2,077
5	Informal Health Care Providers & Couriers	466
Total		**15,964**

7.5. POINT OF ENTRY (POE)

There are 19 PoEs in Pakistan (10 Airport, 6 ground crossings, 3 seaports), all federally managed. In response to the COVID-19 pandemic, the land crossings with Iran and Afghanistan were closed and initially the airports were kept functional. The focus was on the management of infected travellers at PoE for detection, interview, reporting, isolation/case management/referral.

The WHO country office in collaboration with Central Health Establishments (CHE) carried out a comprehensive assessment of capacities at Point of Entries for COVID-19 preparedness and response. Based on the assessment findings, technical support was provided for developing SOPs & protocols and established passenger screening at major airports, land crossings and the Karachi seaport. Logistic and HR support was extended by WHO through the establishment of Health Information desks at 4 major airports (Islamabad, Karachi, Lahore & Quetta).WHO provided logistic support for screening by the provision of equipment & supplies (200 thermo-guns, 1500 PPE sets, 1 million Information, Education and Communication (IEC) material). National Institute of Health (NIH) & WHO jointly conducted simulation exercises at airports staff including the use of PPE and handling of suspected cases.

WHO conducted rapid assessments at the PoE and provided assorted medical equipment (thermal guns and scanners) and supplies especially PPEs for the PoEs. Capacity building of staff at PoEs was done and an information desk was established at the Islamabad airport.

Figure 7.10: Site visit to Islamabad International Airport with the Minister Health and Directorate of Central Health

7.6. NATIONAL LABORATORIES

At the initial stage of the pandemic when most of the confirmed cases were in China, WHO Pakistan facilitated international collaboration with WHO Collaborating Centres for provision of reagents and control materials as well as shipment of samples of suspected COVID-19 cases to reference laboratories for confirmation. As the disease spread and more countries started reporting cases, WHO Pakistan supported the development of comprehensive laboratory guidance & protocols in the national context in light of the global technical recommendations including national lab testing strategy, gguidance for the collection, storage, transport of suspected specimens for laboratory diagnosis of (COVID-19) infection and quality assurance for COVID-19 Laboratory Diagnostics.

WHO donated 8 Real time PCR machines and 15 Point of Care (POC) automated Polymerase Chain Reaction (PCR) machines to National Disaster Management Authority (NDMA) and federal and provincial health ministries. The POC machines are functional in key health facilities in Punjab, KP, Baluchistan and ICT.

WHO has donated sample collection supplies including Viral Transport Medium (VTM), RNA extraction and SARS-CoV2 testing kits for over 70,000 tests to enhance the lab testing capacities at key health and laboratory facilities and support sentinel SARI surveillance for COVID-19.

Figure 7.11: WHO Representative, Dr Palitha Mahipala Handed over 3 PCR Machines to Dr Yasmin Rashid, Minister Health Punjab for Enhancing Testing-capacity of Punjab

In order to effectively support the Government of Pakistan to respond to COVID-19, WHO recruited and deployed skilled laboratory human resource on short-term contract at national and provincial labs. WHO has conducted training provincial training in which over 400 laboratory staff and rapid responders have been trained on sample collection, packaging and transport of COVID-19 samples, and the appropriate use of PPE. In addition, technical trainings on Real time PCR, development of SOPs, laboratory quality and bio risk management have been provided in Sindh, Punjab, KP, Baluchistan, ICT, Azad Jammu & Kashmir (AJK) and Gilgit-Baltistan (GB).

WHO has been engaged in comprehensive laboratory assessments to gauge the testing capacity in the country. On-site laboratory visits have been conducted in major testing facilities in Islamabad, Punjab, Sindh Baluchistan and all labs In Khyber Pakhtunkhwa. Technical HR support is being provided in ICT, Baluchistan and AJK. WHO has engaged with the provincial regulatory bodies including the Punjab Health Care Commission to assess and authorize new COVID-19 PCR labs using the WHO Laboratory Assessment Tool (LAT) for COVID-19.

To ensure quality of test results, WHO technically supported NIH to implement external quality assurance program for COVID-19 labs and development of first indigenous External Quality Assessment (EQA) panel completed. The first EQA panel was dispatched from NIH to 10 laboratories on 15 July 2020 and the results are awaited from the participating labs. WHO Regional Office for the Eastern Mediterranean (WHO EMRO) provided EQA panel to the NIH national reference public health lab, and additional panels were requested from the Regional Office for 8-10 provincial Public health labs.

7.7. INFECTION PREVENTION AND CONTROL (IPC)

WHO supported the government to adapt/develop technical guidelines and SOPs on IPC, which were launched by the Special Advisor to the Prime Ministry for Health – Dr Zafarullah Mirza. Printing and distribution of over 10,000 guidelines & SOPs on IPC was also supported by WHO. In addition, WHO supported printing and distribution of over 80,000 copies of IEC material covering over 35 IPC topics including case management and general awareness. Some of the materials have been translated into local languages and distributed to all four provinces, ICT & AJK as posters, pan flex and standees for displaying IPC practices in isolation hospitals. The purpose was to serve as reminders for HCWs and communities to prevent infection and reduce harm by avoiding unsafe infection prevention & control practices.

Five IPC experts were hired for ICT and four major provinces for dedicated support to improve IPC in isolation HCFs whereas Forty WHO Expanded Program on Immunization (EPI) and PEI staff were assigned to IPC implementation for COVID-19 response.

In order to guide and monitor the IPC component of the response, WHO conducted IPC assessment in 204 health facilities located throughout the country using custom made tool with 15 IPC & 13 Water, Sanitation and Hygiene (WASH) indicators. Five (5) IPC experts hired for Islamabad Capital Territory (ICT) and four major provinces for dedicated support to improve IPC in isolation healthcare facilities. Follow up assessments were conducted in 91 health facilities in April 2020. IPC component was included in the hospital readiness tool, which was implemented in 96 Health Care Facilities (HCFs) in June 2020. WHO also supported procurement and distribution of PPE/IPC supplies worth USD 112k to provincial Department of Health (DOH), POEs, designated hospitals/isolation, ICUs and quarantine facilities.

Figure 7.12: Training on Infection Prevention & Control Supported by WHO

Findings from the assessment guided WHO support to the government. This support includes establishment of IPC Committees in Sindh, KP, Punjab, Balochistan & ICT at provincial and district level. A total of 120 hospital IPC committees are notified (42 in Sindh; 3 in ICT, 52 in Punjab, 7 in AJK, 8 in Balochistan & 8 in KP) whereas thirty-nine (39 HCFs) official designated as IPC demonstration sites; 49 HCFs (ICT & Sindh) are categorized on WHO Infection Prevention and Control Assessment Framework (IPCAF) tool. Technical support was also provided to develop SOPs for Isolation & quarantine facilities on the following topics; hand hygiene, responsible & rational use of PPEs, donning & doffing, droplet & contact precautions, respiratory etiquettes, social distancing, IPC measures in quarantine facility, safe household waste management, safe & respectful burial practices and WHO guiding statement on spraying.

Capacity building activities were conducted with over 12,600 Healthcare Workers (HCWs). Online training of 65 IPC focal points on IPC and case management were done. Trainings of master trainers in KP and Sindh and training of ICT District IPC Committee was done.

A WhatsApp group of IPC teams throughout the country was established to facilitate sharing information and discussions. Capacity was built for over 10,000 health workers in IPC and PPEs were supplied. WHO supported development and launch of the IPC strategy and formation of UN IPC working group involving United Nations International Children's Emergency Fund (UNICEF), WHO, UN-HABITAT and UN-WOMEN.

WHO in collaboration with Health Services Academy/ MoNHSR&C initiated a number of activities for protection of Frontline Health Workers (FLHWs) for development of PPE guidelines and training modules, training of 100,000 FLHWs on the responsible use of PPE, development of PPE instructional video along with Radio and print advertisements.

7.8. CASE MANAGEMENT

WHO supported the government in strengthening the case management capacity, with baseline preparedness and readiness assessment at national, provincial and hospital level. WHO in collaboration with the Federal and Provincial health department conducted a quick case management preparedness assessment at national, provincial and facility level at the beginning of 2019-nCoV Pandemic in January, February 2020. The preparedness gaps identified were considered during development of the National Action Plan for COVID-19 Response. Subsequently, a detailed hospital readiness assessment for the COVID-19 response cross-sectional study was conducted across all the provinces and regions of Pakistan. This study was conducted in 96 major hospitals which are providing care to the COVID-19 patients across all parts of Pakistan comprising 60 teaching hospitals, 29 districts headquarter hospitals and 7 tehsils headquarter hospitals. Among these 36 hospitals were assessed in Sindh, 26 in Punjab, 15 in KP, 13 in Balochistan, 4 in Azad Jammu Kashmir and 2 in Gilgit Baltistan. The hospital readiness assessment report identified the gaps in the cases management.

WHO extended technical support for the case management capacity building of clinicians and health care workers on basic life support and ICU through a collaborative initiative with the Health Services Academy Islamabad and critical case management in the provinces.

Through this partnership, 1000 health care workers (Doctors and Paramedical staff) were trained on conducting basic life support, use of PPE, the critical management and handling of admitted COVID-19 patients. 4 consultants (2 KP, 1 Punjab and 1 Baluchistan) were hired to conduct trainings on COVID-19 case management using the adapted WHO case management guidelines. Assorted medical supplies and equipment were also provided to government to support case management.

Working closely with the MoNHSR&C and other partners, WHO technical teams coordinated with Society of Obstetricians and Gynaecologists of Pakistan (SOGP) and Pakistan Paediatrics Association (PPA) to develop clinical guidelines on management of COVID-19 in pregnancy and in children respectively

These clinical guidelines were translated into training packages which were implemented through the platforms of these professional associations (SOGP & PPA) to reach out to their respective chapters at provincial and district levels. Specific focus was on the identification of Multisystem Inflammatory Syndrome in Children (MIS-C) and adolescents for which technical discussions were organized between PPA and WHO EMRO and Headquarter (HQ) teams to review the suspected cases and also build consensus on the management protocols for such cases. Pakistan was the first country in WHO EMRO to report suspected cases of MIS-C and the case reports have been also published by the clinicians.

Figure 7.13: Visit to PIMS Isolation Centre

WHO facilitated technical deliberations on the global case reporting form for COVID-19 in pregnancy to be contextualized and approved by the MoNHSR&C. The form was also developed into a mobile application for ease of reporting and data management. The SOGP platform was engaged for dissemination of the form and its application to ensure all cases are recorded.

7.9. CONTINUATION OF ESSENTIAL SERVICES

WHO, in collaboration with the Government of Pakistan prepared an action plan to support the government to strategically plan for maintaining essential health services as an additional pillar to the Pakistan Preparedness and Response Plan (PRP). The purpose of this plan is to "Ensure the continuity of essential diagnostic, treatment and prevention services during the current COVID-19 response while ensuring the protection, safety and well-being of health care workforce as well as of the clients and patients". The plan draws upon the latest WHO interim guidance; "COVID-19: Operational guidance for maintaining essential health services during an outbreak". The guidance advocated for a balance between the demands of responding directly to COVID-19, while simultaneously maintaining essential health service delivery and mitigating the risk of health system downfall through simplified purpose-designed governance and coordination mechanisms complement response protocols, identification of context-relevant essential services, optimization of service delivery settings and platforms establishment of effective patient flow (screening, triage, and targeted referral) at all levels, rapidly re-distributing health workforce capacity, including by re-assignment and task sharing and Identifying mechanisms to maintain availability of essential medications, equipment and supplies.

A set of targeted immediate actions to reorganize and maintain access to essential quality health services for all in Pakistan were organized including: Immunization, RMNCAH, Communicable Diseases (HIV, TB, Malaria, NTDs), Non-Communicable Diseases, Nutrition Services, Gender and Human Rights and Health Systems Strengthening. The following criteria was applied: priority of the activity and intervention to be delivered, the current and expected capacity to deliver, feasibility of the intervention, innovation of the approach, partnership with other entities including donors / Civil Society Organizations (CSOs) / private sector, platform of delivery if applicable, complementation of the activity to other interventions and continuation and maintaining the previous level of services if possible.

The pandemic of COVID-19 disrupted almost all essential health services including emergency services, OPD services, routine immunization and others. To ensure delivery of essential services, it is important to establish outreach mechanisms as needed. WHO spearheaded necessary mechanisms to disseminate information to prepare the public and guide safe care-seeking behaviour. WHO supported establishment of screening for all patients on arrival at all sites & isolation centres using the most up to date COVID-19 guidelines. WHO provided support to ensure equity-based triage at all sites providing emergency care. WHO supported the establishment of clear criteria and protocols for targeted referral.

WHO worked closely with the MoNHSR&C to define interim guidance on continuation of essential sexual, reproductive and maternal healthcare services. These guidelines were finalized in consultation with broad range of stakeholders and approved by the Ministry as well as published on official website of the Ministry for wider dissemination. WHO being member of the H-5 platform, also contributed the preparation of "framework for maintaining essential health and nutrition services during COVID-19 outbreak in Pakistan". The framework was jointly prepared by WHO, UNICEF, UNFPA, UNAIDS and the World Bank (WB). It was presented to the Ministry in a virtual meeting of the partners for their review and feedback. The framework identifies pathways for sexual, reproductive maternal health; new-born, child and adolescent health, and HIV interventions to meet the needs of women, children and adolescents in this context. This document includes a minimum set of intervention to be considered in setting priorities in the areas of new-born and child healthcare, immunization, family planning, tuberculosis, nutrition and HIV to sustain current gains, while emphasizing the protection of health workers with regard to infection prevention and control training, access to personal protective equipment, sanitation and a safe and respectful working environment.

A critical need was highlighted by the MoNHSR&C to provide necessary capacity building support to the healthcare providers engaged in telemedicine services to ensure provision of essential sexual and reproductive health services. WHO developed a 5-day virtual training package on sexual and reproductive health for telemedicine providers at PHC levels. The package was pilot tested for doctors working with Commission on Science and Technology for Sustainable Development in the South (COMSATS), Human Development Foundation and Sehat Kahani – all three organizations having long standing experience and networks of telemedicine services in the country. Two virtual workshops were also conducted for midwives/lady health visitors from the same organizations thereby virtually training a total of 50 telemedicine providers on Sexual and Reproductive Health (SRH) working across the country. The same virtual training package on SRH has been rolled-out in all four provinces for further capacity building interventions involving healthcare providers from provincial and district levels.

Figure 7.14: Closing Session of Virtual SRH Training for Telemedicine Providers

Figure 7.15: Virtual SRH Training for Telemedicine Providers

7.10. WHO'S CONTINUED COMMITMENT

The World Health Organization at global, regional and country level stands fully committed to the Government of Pakistan as its Member State to provide all necessary technical support to ensure fullest attainment of health for all people.

WHO being perceived as "the custodian of healthcare'' was at the forefront of coordinating and planning concerted efforts to provide a collaborative platform for research and knowledge-sharing activities. WHO Pakistan would continue to strengthen Pakistan Response to COVID-19 until the pandemic is over in the country.

CONCLUSION & POLICY RECOMMENDATIONS

The report provided a comprehensive yet dynamic analysis of the key components of the old age well-being in Pakistan considering the multi-dimensional aspects. It has covered upon a wider scope revolving around the physical, mental, social, cultural, economic, legal and regional perspectives. The report was divided in to four sections. The first section had covered the concept of old age well-being based on the existing demographic trends globally and nationally; it is inferred that the proportion of the old age population would be higher in the near future in Pakistan and could become a great challenge in terms of fulfilling their unmet needs in social, economic, legal and psychological aspects. Therefore, the report laid out a framework covering the five key dimensions of old age well-being along with the major determinants of healthy ageing. Along with this framework, the report highlighted the supply side of the old age well-being by focusing on the existing institutional framework and identification of the unmet needs of the older people in 2025 in Pakistan. Then, second section covered the relationship of pandemics and healthy ageing with special reference to the impact of the burden of diseases and COVID-19 on well-being of the older persons in Pakistan through primary and secondary data analysis. The report is followed by the third section on healthy ageing, which highlighted the concept, measurements and determinants of the healthy ageing in Pakistan. It highlighted the fact that if the selected determinants of the healthy ageing is focused upon in policy making, only then the healthy ageing and old age well-being can be ensured effectively and inclusively. The report is concluded with the section four covering the international interventions by WHO in Pakistan for the old age well-being prior to and during the COVID-19 pandemic and the way forward in post-pandemic period. Following are the key policy recommendations based on the findings extracted from the study done for the old age well-being in Pakistan;

1. SPRC has identified five ageing dimensions such as health; socio-economic status; independence; dignity and respect; and social protection. Each of these dimensions requires specific policy interventions from all the stakeholders to enhance old age well-being.

2. SPRC Survey results suggest that property ownership; involvement in decision-making, monthly family income and age discrimination (neglect, stereotyping, age shaming) are key determinants of the level of life satisfaction among older people. The chances of higher life satisfaction increases if we improve these key determinants. This requires interventions at both formal and informal levels (households and governments) to pay attention to improve the mechanism of property ownership, poverty reduction strategies and social awareness for the rights of older people.

3. Pakistan can implement a few good interventions, already being implemented by the neighbouring countries, to enhance the old age well-being. This includes personal police visits, removal of discriminations and legal protection against abuse and neglect.

4. Estimates suggest that Pakistan has 6% older population in the country, which is roughly 13.7 million. Out of these 13.7 million, 23% of the older people are living below the poverty line with the health problems. There are 11.8 million elderly, who do not have any kind of social protection including 1.80 million poor old people; 2.7 sick old people; and .415 million poor and sick old people. These numbers should not be taken lightly and needs an immediate attention to initiate protection program specifically for them.

5. Based on the gender segregation of older people, 45% and 55% of the old men and female are living below the poverty line respectively, which means such social protection policy interventions are needed, which targets the gender discrimination in specific.

6. The estimates of the current and future financial needs point out the unmet financial needs of the older people. The total current cost of old age population below poverty line is 3.51 trillion million out of which the food cost is the highest among health, food and rent costs. However, the future expense of the 2.15 million old population below poverty line would be 5.14 trillion of the total expense by 2025, which would include an immense increase in food and health cost. The unmet needs of the old people is quite significant by these statistics as in 2025, old people would be in much need of 1.63 trillion additional costs of expenses. Hence, there is a dire and an immediate need of rigorous planning for fulfilling these needs and expenses of the older people through minimum social protection programs in the near future.

7. It is evident from the report findings that major causes of the mortality in older people are the non-communicable diseases, which comprised of the 47.5% of the deaths caused by HT and Diabetes. The deaths caused from hypertension and diabetes are avoidable if treated with necessary preventive measures in the early stage. Hence, NCDs and mental health disorders should be prioritized in general in the National UHC strategy with the special focus on capacity building of the healthcare sector.

8. Considering the old age well-being w.r.t COVID-19 aftereffects, the older people had faced significant immobility restraints in terms of their freedom to socio-economic living. Thus, an inclusive framework of social protection system must be formulated as post-COVID-19 strategy, which should address on the old age well-being w.r.t to their economic and social restraints.

9. Research shows that functional ability (disability) is the top determinant of health ageing of older people, followed by social participation, property ownership and household decision-making. Special focus of the State is required to ensure the necessary services required to improve the functional ability of the older people.

10. The national and provincial policy interventions to address the unmet social, psychological and economics needs of the old age people must be aligned with the international interventions as introduced by WHO-ICOPE for the old age well-being and healthy ageing to prevail sustainable development.

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PAKISTAN ALLIANCE FOR SOCIAL PROTECTION (PASP)

Pakistan Alliance for Social Protection (PASP) is a multi-stakeholder partnership under the umbrella of the think tank; Social Protecting Resource Centre (SPRC) to develop a Framework with active collaboration of Alliance Partners. It was established to help the Government of Pakistan and the Private sector for strengthening the Universal Social Protection System (USPS) in Pakistan. PASP is based on the voluntary collective effort of concerned organizations and leading professionals with no financial or political obligations to its partners. It is comprised of Academics, Civil Society Representatives, businessmen, professionals, Public Servants, Worker's Representatives and professionals from all walks of life. The minimum we request from the Individual or institutional Alliance Members is to provide us the moral support and provide critical ideas to take the Cause forward. PASP has its own Secretariat and dedicated human resources to expedite the adoption of a Universal Social Protection System in Pakistan.

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