Training to Provide for Healthy Rural Aging

Joseph Troisi, Ph.D., M.Phil., M.Th., M.A.(Soc), B.A.(Hons)

ABSTRACT: *More than 60 percent of the world's aged population is in developing countries, the majority living in rural and remote areas. Resources in these areas are scarce and there is a lack of services and programs, especially in the areas of health, housing and social welfare. The most serious deficiency faced by many countries in meeting the challenges of population aging is the pronounced scarcity of trained caregivers. Little attention has been given to developing effective training policies and programs. Most of the people providing a service to older people lack basic training and this is more so in rural and remote areas. The processes for extending healthy aging and postponing the onset of chronic diseases and disabling conditions exist already. Unfortunately, these processes are not disseminated in appropriate ways. It is therefore imperative to disseminate this information by training people at the grass roots level to reach the most vulnerable and isolated older people. Primary care workers should have the necessary skills, knowledge and techniques to facilitate good care of older people in their environment. This article reviews and analyzes attempts being made by a number of countries to meet this need. Though the basic issues dealt with are often the same, the approach used differs.*

The world of the 21st century is experiencing an extraordinary revolution in longevity. During the last five decades, we have on average gained almost 25 years in life expectancy (United Nations, 1999). In spite of this, however, one questions whether there has been a true democratization of longevity. Is it not a fact that while the world, especially the Western developed world, has succeeded in adding years to life, it has not yet succeeded in adding life to years? Do older people, especially those living in rural areas, really have an equal opportunity to a "healthy longevity" (Troisi, 1996b)? By "healthy longevity" we mean the totality of the individual person, not only an absence of disease. We should take into account every aspect of living, including the social, economic and the psychological as well as the health dimension (World Health Organisation, 1998). A person cannot feel healthy unless he is socially accepted by society.

By a healthy longevity we also mean a sustained longevity. It is an undeniable fact that poverty and disease are the main opponents of longevity. However, equally if not more destructive, are passivity and the feeling of oneself as a parasite (Townsend, 1997). Older people are often described in terms of "cost factors." They are portrayed as requiring more and more help and support which neither the family nor the state is able to afford. Many of the social policies and programs in various countries are based on the assumption that "society has a major responsibility to provide basic social welfare and support for all persons." The pressing needs and demands of the older population are often viewed from the country's economic point of view, and as a result older people are at best seen as a tolerated burden (Correll, 1993).

One of the paradoxes of the process of socioeconomic development of our century is that while, on the one hand, the remarkable advances in medical science and technology have made it possible to prolong life, although at exorbitant costs, on the other hand,

the provision of these very resources remains a major economic and social issue both for individual families caring for older members and also for every society at large. The significant increase in life expectancy unavoidably implies not only a heightened demand for existing services but also for new services and alternative approaches aimed at meeting these new challenges of population aging (Troisi, 1989b). Consequently, new approaches to medical care and the delivery of social and economic services are needed.

Aging in Rural and Remote Areas

More than 60 percent of the world's older population lives in developing countries. Population aging in these countries is occurring at a much faster rate than in the developed world. Besides, the majority of older people in these countries is found in rural and remote areas where resources are scarce. There is a lack of services and programs, especially in the areas of health, housing and social welfare. In South America, a large share of the older population is living at subsistence level. This reality is often coupled with the significant changes that the family is undergoing. The traditional role of the family in the care and support of the older members, especially those who are frail, is being subjected to various economic, social, and psychological difficulties and is obviously being threatened (Troisi, 1995). Moreover, there are no signs of viable alternatives to provide care for older people. This is a situation that will become increasingly manifest with all its implications in the first quarter of this century.

Training

Following upon the recommendations by the Vienna International Plan of Action on Aging, a number of countries throughout the world have developed innovative and concrete measures aimed at improving the situation of older people in their countries (United Nations, 1988). In spite of this, however, and notwithstanding the fact that 18 years have passed since the World Assembly on Aging, the results achieved so far have only been modest. How true is the Recommendation 57 of the Plan of Action, which highlighted the fact that the implementation of the same Plan fundamentally required trained personnel in the field of aging (United Nations, 1988 p. 48). The standard of care provided to any person, especially to older people, depends on the personal qualities of the caregivers as well as on their professional preparation.

The most serious deficiency being faced by many countries in economic, social and health planning to meet the challenges of population aging is the pronounced scarcity of trained caregivers. Although in many countries the need for training in the fields of geriatrics and gerontology has been recognized, this recognition has not yet been translated into action, as one would have expected (Troisi, 1989). Little attention has been given by national governments to the development of effective training policies and programs. It is worth pointing out that in the United States, geriatrics is taught as a compulsory subject in only a handful of medical schools. The growing needs far outweigh the efforts applied thus far. We are almost still in the same situation as 18 years ago, if not worse, given the rapid growth in the number and percentage of older people. Most of the people providing a service to older people still lack basic training on aging. This is the more so in rural and remote areas where the need is very pronounced.

Governments in developing countries are thus being faced with a two-edged sword. On the one hand is a rapidly growing aged population, especially in the rural and remote areas. On the other hand, very often these areas lack the basic resources and trained personnel to provide these services.

Who needs to be trained? The Plan of Action, in Recommendation 7, stated that "Practitioners and students in the human care professions . . . should be trained in principles and skills in the relevant areas of gerontology, geriatrics, psychogeriatrics and geriatric nursing" (United Nations, 1988, p. 31). In Recommendation 54 it is clearly laid down that "education and training in the various aspects of aging and the aging of the population should not be restricted to high levels of specialisation, but should be made available at all levels" (United Nations, 1988, p. 47). This includes all those who work with older people at home or in institutions, be they volunteers or family members, as well as the older people themselves. Societies are often encouraged to look at older people as a resource, but governments often tend to consider older people as receivers rather than as contributors. Older people themselves should be educated in self-care. HelpAge, the international organization dedicated to disadvantaged older people, has been very successful, especially in the rural and remote areas of South America and Africa, in training the young old who in turn would be able to teach others (HelpAge, 1999). Moreover, the

population at large should be informed in regard to dealing with the elderly. Thus, for example, Caritas Malta, the Catholic Church secretariat for social and charitable action, had in 1987 started a "Schools' Programme" aimed at raising school children's awareness about the phenomenon of aging and the needs and potential of older people, while at the same time creating a positive image of older people (Troisi, 1989b).

The past decade has seen the emergence of a number of community-based programs and services for older people. This has, in turn, increased the variety of skills needed and the level of training. In a number of countries, an effective network of primary health workers at the community level is the focus of health care policy. This includes deployment of locally recruited community health workers aimed at reaching the most vulnerable and isolated older people.

What should be the content of the training programs? Recommendation 54 places particular emphasis on the need "to regulate the training skills and educational requirements for different functions in the field of aging" (United Nations, 1988, p. 47). Training programs have to be tailored to the nature of the participants, the work they are doing and the needs entailed. Though the basic issues dealt with might often be the same, the approach differs. The processes extending healthy aging and postponing the onset of chronic diseases and disabling conditions exist already. Unfortunately, these processes are not disseminated in appropriate ways. This is the more so at the primary care level and at the village level. It is, therefore, imperative to disseminate this information by training people at the grass roots level so as to reach the most vulnerable and most isolated older people (Troisi, 1996b). Para-professionals and primary care workers should have the necessary knowledge, skills, and attitudes to facilitate good care, namely concern, maintenance, and treatment of older people in their localities. They should be knowledgeable in problems of older people and risk factors of aging, as well as in health in old age and its common ailments, their prevention, management and rehabilitation.

As pointed out earlier, healthy aging should not be considered only from the medical point of view but must be fully integrated into an overall holistic approach. Moreover, because of the multifaceted nature of aging, the Plan of Action emphasizes the need of developing multidisciplinary and interdisciplinary education and training programs. These should include a basic understanding of aging from the biological, social, and psychological perspectives. Furthermore, one has to bear in mind the fact that, especially in the case of the caring disciplines, these cannot function competently when isolated.

In line with the dual approach recommended by the Plan of Action, namely "an international programme for training concomitant with national and regional training programmes that are particularly relevant to the conditions in the countries and regions concerned," the International Institute on Aging, United Nations—Malta (INIA), was set up in Malta in April 1988 in collaboration with the Government of Malta (United Nations Economic and Social Council, 1987). Similarly, HelpAge runs the Asia Training Centre on Aging (ATCOA) in Chiang Mai, Thailand. These two organizations through their training programs and courses are each succeeding, in their own way, to meet the acute shortage of trained personnel.

INIA provides multidisciplinary education and training in gerontology and geriatrics at various levels to personnel mainly from developing countries. In order to maximize the efficiency and effectiveness of practical training, INIA has designed and implemented innovative training strategies and techniques oriented toward people who are working in the field of aging. These, in turn, promote the multiplier effect in their respective countries through the dissemination of the information, knowledge and skills acquired. During the past 13 years, more than 1,700 people from 123 countries have benefited from the short training programs held in Malta. In addition, around 790 people have participated in 23 "in situ" training programs carried out in Barbados, Brazil, China, Egypt, Ghana, India, Kuwait, Mexico, Morocco, Panama, the Philippines, South Africa, Thailand and Tunisia.

The short training programs held in Malta as well as the "in situ" programs have their own pros and cons. Thus the participants of the programs held in Malta do benefit from the very internationality and varied experience of the same participants. This is of great importance since a candidate is able, within the short span of two weeks, to understand better what is happening in other countries in a particular area of aging. On the other hand, the participants in the "in situ" programs tend to be more homogenous in nature and thus are more familiar with the national or local situation. In this manner, within a shorter span of time they are better able to access the needs and situation of older people in their own country.

One of the most difficult aspects of providing training in care of older people for rural primary care workers is the geographical location and environmental situation of the educational institutions. Practically all the existing institutions are to be found in urban

areas. This produces a geographic challenge in delivering training programs to the front-line staff in the rural and remote areas of the country. In addition, in a number of areas in Canada and the United States for a number of months in the year, these areas become inaccessible. Moreover, in the past, the focus was on bringing students to these urban training centers (Havens, 2000).

To overcome these difficulties, certain Canadian universities (e.g., the University of Manitoba, and Simon Fraser University, Vancouver) are using distance education programs delivered via teleconferences, videoconferences, correspondence courses and itinerant instructors. In addition, project-based courses are being used. In these courses instructors and students meet as a group face-to-face at the beginning of the course and at least once more during the course. Following the first meeting, the students send their projects in to the instructors, step-by-step throughout the course, and the instructor returns them with comments and further instructions (Gutman, 2000).

A program of video education modules that are transmitted using satellite relay and reception dishes that can be located in remote centers is being utilized in Australia. The present coverage of this program is across Australia and to certain Asian and Pacific countries (Andrews, 2000).

A number of universities in Argentina, Brazil, Chile, Cuba and Uruguay have postgraduate courses in geriatric medicine and geriatric nursing. But once again these universities are to be found in the major cities. Moreover, trained professionals are not ready to go to work in rural and remote areas. To overcome this, efforts are being made to train primary care workers providing basic and necessary skills to assist older people with everyday situations and pathologies. Particular emphasis is being made on active aging and enhancement of the quality of life as effective means to delay the onset of chronic diseases and disabling conditions. Older people are encouraged to be part of this education process. The identification of leaders at the community level to contribute to the training process is being encouraged. Special emphasis is being made on recognizing the early signs of dysfunction, associated with protocols for safe, cheap and effective interventions (Acanfora, 2000).

Another difficulty often encountered by governments and private organizations in training rural primary care workers in the care of older people is the lack of appropriate training materials. To meet this need certain WHO regional directorates have published manuals for training and program development in health care of older people. These manuals combine the theoretical and the practical aspects of caring for older people. They provide a comprehensive background to the key principles involved in health care for older people. At the same time, information is also given describing practical ways of meeting the needs of older people as well as best practices, evidence-based approaches, and assessments and management of specific conditions (Troisi, 1996b).

In light of these needs, a consultation meeting was convened in February 1996 by the WHO Collaborating Centre for Healthy Aging, Institute of Gerontology, University of Malta, and co-sponsored by the WHO Regional Office for Europe. The aim of this meeting was to develop a training program for primary care workers in the care of older people. The training program is aimed at giving the intermediate range primary health care workers engaged in the field of aging a better understanding of the various aspects of aging and of the needs of older people as well as the basic skills, knowledge and techniques necessary to meet these needs adequately, thus improving older people's quality of life and well-being.

The program is oriented more toward skills than theoretical knowledge. A mixture of the four basic training techniques is suggested: a) participatory lectures using handouts and visual aids followed by participatory discussions; b) workshops and guided group discussions; c) role playing; and d) using the individuals' working experience as a learning experience. The degree of emphasis and importance given to each technique depends on the background of the participants. The trainers, besides being involved in the caring professions, should be experienced in participatory, interactive techniques at the grass roots level and also in team-teaching techniques.

The program content is to be adapted to the conditions and diversity of situations of the particular country. It should have a threefold structure including: a) an orienation session; b) core and comprehensive topics; c) an assessment/evaluation session. The core topics are the ones that contain the basic concepts to be known by all the participants. These include: the process of aging; the behavioral and social aspects; health promotion; medical and related problems; and functional and environmental assessment. The comprehensive topics are important for a more complete understanding of specific aspects relating to older people. These include, among others: local support services; ethical and legal issues; medications; and basic communication skills. Particular emphasis in each training program is to be given to the interdisciplin-

ary approach, the team approach and the sharing of responsibilities.

Conclusion

The gap between the projected increases of the older population and the consequently required services, combined with the parallel development of the personnel needed to carry out these services, creates a pressing and urgent need to train appropriate staff. In order to meet the special needs of the rapidly expanding older population adequately, training of personnel has become a major issue that needs to be tackled with urgency, lest events overtake.

Although in certain cases it might become necessary to refer patients to specialist facilities and to geriatric expertise, the main priority in geriatric training should be in devising and deploying programs and training materials for use by primary health caregivers. These need to emphasize that most older people are not ill, that most ill older people are not in hospitals, and that most care is given by people who are not medical doctors.

It will be important in the not-too-distant future to explore innovative ways of providing education and training in rural and remote areas and to apply, as much as possible, the new and emerging communication technologies to facilitate and enhance these programs.

References

Acanfora, M. (2000). *Training for healthy rural aging: from theory to practice.* Paper presented at the Rural Aging: A Global Challenge International Conference, Charleston, WV.

Andrews, GR. (2000). *Innovative approaches to providing education and training for care of older persons in rural and remote areas in developed and developing countries.* Paper presented at the Rural Aging: A Global Challenge International Conference, Charleston, WV.

Correll, D. (1993). Aging and care for the aged: misguided concepts lead to poor practices. *Ageing International,* 20(2), 60.

Gutman, GM. (2000). *Distance education in gerontology and geriatrics: current status and future potential.* Paper presented at the Rural Aging: A Global Challenge International Conference, Charleston, WV.

Havens, B. (2000). *When distances and climate intervene.* Paper presented at the Rural Aging: A Global Challenge International Conference, Charleston, WV.

HelpAge International. (1999). *The Ageing and Development Report.* London: Earthscan.

Townsend, P. (1997). Ageism and social policy. In Phillipson, C & Walker, A (Eds.), *Ageing and Social Policy,* (pp. 15–44). Hants, England: Gower Publishing.

Troisi, J. (1989a). *Manpower Training Needs in the Field of Aging in Developing Countries.* Malta: United Nations International Institute on Ageing.

Troisi, J. (1989b). *The Organisation of Comprehensive Services for the Elderly in the Community,* IRP\HEE 115.2.3, Copenhagen: WHO.

Troisi, J. (1995). The elderly and changing family roles: the Maltese and European experiences. In Formosa, S (Ed.), *Age Vault,* (pp. 55–68). Malta: United Nations International Institute on Ageing.

Troisi, J. (1996a). Ageing in a changing world: Older persons as a resource. In Calleja, J (Ed.), *Meeting the Challenges of Ageing Populations in the Developing World,* (pp. 63–78). Malta: United Nations International Institute on Ageing.

Troisi, J. (1996b). Training primary health care workers in the care of older persons. *WHO Euro Consultation on Development of Curricula for Primary Care Workers in the Care of Older Persons.* Malta.

Troisi, J. (1998, June 12). Perspectives and directions on aging in Malta. *The Sunday Times.* Valletta, Malta.

United Nations. (1988). *Vienna International Plan of Action on Aging.* Department of Public Information, 88–11724.

United Nations. (1999). *World Population Prospects. The 1998 Revision, Vol. 1: Comprehensive Tables.* New York, NY: Author.

United Nations Economic and Social Council. (1987). Resolution No 1987/41.

World Health Organisation. (1998). *The World Health Report 1998. Life in the 21st Century. A Vision for All.* Geneva, Switzerland: Author.