Editorial

An estimated 142 million people or 8% of the population above the age of 60 years now live in the countries comprising the South-East Asia (SEA) Region of the World Health Organization (WHO). Increase in the ageing population affects the costs of health care and related social support systems; ways in which the quality of life and activity of older people can be ensured; and the roles that the family, the community and the state will play in taking care of older people, particularly those in need of care and assistance.

The theme for the World Health Day 2012 is “Health and Ageing” with the message that “good health adds life to years”. The focus of activities related to the World Health Day theme will be on how good health throughout life can help older men and women lead full and productive lives and be a resource for their families and communities. Ageing concerns each and every one of us – whether young or old, male or female, rich or poor – no matter where we live.

This special volume of the Regional Health Forum discusses the social, gender and health dimensions of ageing, the civil society’s perspective of ageing and experiences from several Member States of the SEA Region on their programmes promoting active healthy ageing.

The article Population ageing and health of the elderly in the Democratic People’s Republic of Korea reports that the proportion of the population above the age of 60 years has continued to increase over the past two decades with a further surge expected by 2015. In recognition of this demographic change, the government established several health interventions and almost 93% of the elderly population sought health care from the existing national primary health care network. Additional demographic and health assessments are under way to understand the dimension of ageing better and develop appropriate and effective interventions.

Indira Jai Prakash in her article Social dimensions of ageing and health refers to the increase in proportion of the ageing population. The quality of life at any age is influenced by financial security, emotional security and health, although the relationship between the socioeconomic status and health remains less clear in developing countries. Her article contends that ageing is a multidimensional process of interaction among multiple domains – biological, social, cultural, economic and psychological, and that the life-course approach that addresses the health and economic needs of poor people, as well as the issue of accessible and affordable health service will be conducive to promote active ageing.

Ageing and health in Nepal by Meghraj Dhakal reports that reduction in the mortality rate of the population and increase in life expectancy have led to a rise in the proportion of the older population in Nepal, currently estimated at 6.5% of the population, with the related rise in the elderly dependency ratio, both of which have impacted the socioeconomic and health policies in Nepal. The government has established a sectoral policy for the elderly and introduced several programmes for the welfare of the elderly, including financial support to those aged 75 years and
over. Dhakal concludes by stating that advocacy for and awareness on ageing should be inculcated among the younger generation, and that the issues of gerontology and geriatrics should be introduced at various academic levels and disciplines.

The article Making the world age-friendly: one city at a time by Kelly Fitzgerald and Christine Mair discusses how the urban landscape and its infrastructure must change to meet the needs of older adults. The World Health Organization developed the Global Network of Age-friendly Cities and Communities as part of the Age-friendly Environments Programme. This network supports cities seeking to become more “age-friendly” through new structures and opportunities that allow for older adults’ healthy and active ageing lifestyles. By creating and cultivating this network, WHO has started a global trend towards supporting countries to be more inclusive of and sensitive to the needs of older adults.

Professor Myint Han in his article Health care of the elderly in Myanmar reports that a national policy on ageing has been formulated and is in the process of receiving approval. The programme on health care of the elderly in Myanmar aims to increase the accessibility of geriatric care services for the elderly; training for several categories of health staff are included in the programme. The programme is providing at least 20% of the ambulatory elderly with geriatric clinical services through the primary health care approach. It also encourages home-based geriatric care through families, health volunteers and nongovernmental organizations.

The article Implications of ageing in Maldives by Razeena Didi reports that life expectancy has been increasing in the country for both sexes, and that an estimated 3% population is now above the age of 65 years. This demographic shift has consequences in shaping the social and public policy in Maldives. The Maldives health policy advocates equitable distribution of health-care services to all citizens including the elderly population and provision of health insurance coverage for people 65 years and above. Easy access to health services continues to be a major concern for the elderly population, particularly those living in the outer islands.

Narimah Awin’s article The plight of older women: from understanding to response discusses that with increase in the global population, feminization of age has become another reality. Most countries are faced with two major constraints – the paucity of information on the plight of the elderly women and poor integration of related services. Older women can be perceived as being the victim of the “triple jeopardy” of sexism, disempowerment and ageism. Thus, health care of older people has important gender dimensions. While integrating women’s health, gender and ageing horizontally, Awin argues, it is critical that vertical integration between the levels of care also takes place with special attention given to primary health care.

The article Ageing and health – an international nongovernmental organization’s view by Mark Gorman of HelpAge International mentions that for older people, the progress in health has been unequal. In developing countries, health priorities reflect the priorities articulated in the Millennium Development Goals, whereas chronic diseases, most associated with older age, have low or minimal priority in existing health policies and programmes. Nongovernmental organizations, as Gorman writes, have a significant role to play in promoting age-friendly care under various situations.
The article Promoting ageing and health – the Sri Lankan experience details the response of the government to address the challenge posed by the rapidly ageing population. This includes the Protection of the Rights of Elders Act, establishment of a national council and a national secretariat for elders, and formulation of national policy on elders and national plan of action on ageing.

In the article Impact of dementia and Alzheimer’s disease on the community, Vijay Chandra reviews the public health aspects of dementia and Alzheimer’s disease as these affect the populations in countries of the SEA Region. The article lists several preventive measures against Alzheimer’s disease.

In Ubolratana Popattanachai’s article Nursing and health care of the elderly, the role of nurses in providing health care to the elderly population in Thailand is discussed. The article is based on a study on professional nurses, their peers and patients.
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Abstract

The proportion of population above the age of 60 years has been increasing over the past two decades in the Democratic People’s Republic of Korea. In 1998, 8.9% of the population were over the age of 60 years; 12.5% in 2004; 13.0% in 2006; and 13.1% in 2008. It is assumed that in 2017, this proportion will be 14% of the population; by 2020 around 15% of the population; and will become approximately 20% by 2030. Due to this rapid increase in the proportion of population above the age of 60 years, issues related to ageing and health care of the elderly have been recognized by the government as being critical. While almost 93% of the elderly population seek health care from the existing primary health care network in the country, the rapid increase in the elderly population requires review of the existing health facilities. The government has initiated analyses of the population ageing issues, as well as of the related demographic, socioeconomic and health aspects of ageing, and continues to identify appropriate interventions.

The Democratic People’s Republic of Korea (DPR Korea) occupies the northern half of the Korean Peninsula with a total land area of 123,138 square kilometres. The total population of DPR Korea was estimated at around 24 million in 2008 with over 60% of the population residing in urban areas. The proportion of population above the age of 60 years has been increasing over the past two decades. In 1998, 8.9% of the population was over the age of 60 years; 12.5% in 2004; 13.0% in 2006; and 13.1% in 2008. It is assumed that in 2017, this proportion will be 14% of the population; by 2020 around 15% of the population; and will become approximately 20% by 2030 [Table 1]. The proportion of elderly women has also been found to be more than that of men.

Table 2 depicts the increase in the proportion of population above the age of 60 years, 65 years and 80 years. It is to be noted that the Annual Population Growth Rate (APGR) for the entire national population was 0.84%, while during the same period, the APGR of the elderly population was 3.48%, almost four times that of the total population, indicating rapid ageing of the nation’s population.

The average life expectancy at birth has been increasing gradually, much of it due to the nation’s policy of ensuring well-being and health of the people; subsidies from the State; increased investments in public health; and improvements in the living standards of the population [Table 1].

A combination of factors – social, political and cultural – has led to an increase in the proportion of elder females as compared to males. The 2008 census data showed that 93% males over the age of sixty years were married, whereas 40% females in the same age group were married. Around 59% women
Table 1: Elderly population in DPR Korea

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% of 60 yrs and over</td>
<td>8.9%</td>
<td>12.5%</td>
<td>13.0%</td>
<td>13.1%</td>
<td>14%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>Life expectancy at birth [in years]</td>
<td>72.7</td>
<td>68.2</td>
<td>69.2</td>
<td>69.3</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Table 2: Breakdown of elderly population in DPR Korea [1993 – 2008]

<table>
<thead>
<tr>
<th>Age</th>
<th>1993</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Proportion of population (%)</td>
</tr>
<tr>
<td>Above 60 years</td>
<td>1 888 630</td>
<td>8.9%</td>
</tr>
<tr>
<td>Above 65 years</td>
<td>1 140 036</td>
<td>5.4%</td>
</tr>
<tr>
<td>Above 80 years</td>
<td>107 182</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

[Source: Adapted from National Census Data, 1993 and 2008, Government of DPR Korea]

above the age of 60 years were widows while only 7% males in the same age group were widowers.

Due to this rapid increase in the proportion of population above the age of 60 years, issues related to ageing and health care of the elderly have been recognized by the government as critical issues. The government has initiated analyses of the population ageing issues, as well as the related demographic, socioeconomic and health aspects of ageing, and is identifying appropriate interventions.

The age for retirement is 60 years for males and 55 years for females. The State of Elderly Population Report in 2007 indicated that 65% population above the age of 60 years remained active. The activities were related to support to the family – agricultural and small-scale industry. The elderly population were also involved in looking after young family members and doing routine household chores.

Table 3 indicates the types of activities undertaken by the elderly population (over 60 years age) in DPR Korea. The proportion of elderly population in gainful employment reduces with age, starting from 8.7% among those in the 60 – 69-year age group, declining to 2.8% in the 70 – 79-year age group. Comparatively, more elderly persons remained active in carrying out routine household activities. Over 67% were doing routine household work in the age group 60 – 69 years, while this figure was around 53% in the age group 70 – 79 years, declining to 13% in the age group of 80 years and more. In view of this ability to continue working effectively with advancing age and the fact that most elderly had had secondary-level education or higher, the government is considering raising the retirement age.
Table 3: Activities undertaken by the elderly population (60 years and above)

<table>
<thead>
<tr>
<th>Age</th>
<th>Gainfully employed</th>
<th>Routine household</th>
<th>No reported activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 – 69 years</td>
<td>8.7</td>
<td>67.4</td>
<td>23.9</td>
</tr>
<tr>
<td>70 – 79 years</td>
<td>2.8</td>
<td>53.0</td>
<td>44.2</td>
</tr>
<tr>
<td>80+ years</td>
<td>0.0</td>
<td>13.4</td>
<td>86.6</td>
</tr>
<tr>
<td>Total</td>
<td>6.2</td>
<td>58.9</td>
<td>34.9</td>
</tr>
</tbody>
</table>

The health of the ageing population is considered important by national authorities. Disability due to old age requires urgent attention for which the government has introduced support measures — providing aid, improving the environment and mobilizing additional resources for programmes — to limit the disability of the elderly population. The 2008 census reported that 10.3% of the elderly population had visual disorders; 8.8% had hearing disorders and memory disorder was identified in 7.7% of the elderly population. Also, 11.4% of the elderly population reported difficulty in walking and climbing stairs. In total, almost a million of the nation’s elderly population reported some types of health and physical disabilities [Table 4].

Table 4: Proportion of disabilities among those 60 years and above

<table>
<thead>
<tr>
<th>Type of disorder</th>
<th>Degree of disability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mild</td>
</tr>
<tr>
<td>Visual</td>
<td>8.8</td>
</tr>
<tr>
<td>Hearing</td>
<td>7.3</td>
</tr>
<tr>
<td>Walking/ climbing stairs</td>
<td>8.7</td>
</tr>
<tr>
<td>Memory</td>
<td>6.5</td>
</tr>
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[Severe disorder means existence of multiple disabilities; very severe disability means total loss of function.]

Research conducted by the Population Centre, DPR Korea in 2007, found that the semi-dependent elderly persons required more time and resources as compared to the fully-dependent elderly persons. As the proportion of elderly persons is expected to increase, rehabilitation interventions should also be increased in order to cope with the increased demand. At the same time, nursing and care of the very old persons and those with very severe disabilities will also require attention.

The 2007 State of the Elderly Population survey reported that circulatory, digestive, musculo-skeletal, connective tissue and neurological disorders were commonly encountered in the elderly population. Cardiac and circulatory disorders formed the majority of disorders. Of the elderly population, 17.8% had hypertension; 15.2% had backpain; 12.1% had cardiac problems; arthritis was reported in 10.1% and digestive disorders among 9.5% of the elderly population. Most disorders were reported to be higher among populations living in urban areas as compared with those in rural areas [1.3 – 1.7 times]. The major illnesses being circulatory and cardiac in nature, it is being emphasized that there should be a national programme to control high blood pressure as part of overall health promotion among the elderly population.

The majority population including the elderly, seek health care from the dong / ri [peoples’ hospital and clinic] as part of primary health care. These facilities are easily accessible to the population including the elderly and provide free health care to all. Over 93% population sought health care from the primary health-care facilities while only 7% required care at home. With the availability of better care at primary health-care facilities, the proportion of elderly population surviving to older age groups will increase. National programmes will also need to keep this fact into consideration [Table 5].
Table 5: Facility-wise health care provided to the elderly population

<table>
<thead>
<tr>
<th>Age</th>
<th>Provincial hospital</th>
<th>District hospital</th>
<th>Clinic</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 – 69 years</td>
<td>5.5%</td>
<td>20.1%</td>
<td>67.9%</td>
<td>6.5%</td>
</tr>
<tr>
<td>70 – 79 years</td>
<td>3.8%</td>
<td>17.2%</td>
<td>72.3%</td>
<td>6.8%</td>
</tr>
<tr>
<td>80+ years</td>
<td>2.6%</td>
<td>12.5%</td>
<td>74.3%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Total</td>
<td>4.7%</td>
<td>18.6%</td>
<td>69.8%</td>
<td>6.9%</td>
</tr>
</tbody>
</table>


Concluding remarks

Experiences and information from various research studies and surveys indicate that from 2015 there will be a further surge in proportion of the elderly population. By 2030, the total number of people over the age of sixty years in the country may exceed five million, which translates to one per five people to be sixty years or above, if the present trend persists. It is important to develop an appropriate national strategy to ensure promotion of the health of the elderly population, as well as healthy ageing of the population.

Appropriate health interventions are necessary to address the different health issues of the elderly population including specialized treatment programmes. In medical schools the subjects of geriatrics and gerontology should be included in the training curricula. Sufficient number of health staff would also need to be trained in geriatrics and gerontological services.

While the 2007 Survey of Elderly Population had collected information on the status of disease and symptoms of the elderly population, the data were not exactly representative of the situation. Additional demographic and health research on the elderly population will be necessary to develop appropriate health interventions.

References and bibliography

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(10) Korea Journal (2011)
Social dimensions of ageing and health

Indira Jai Prakash*

Abstract
Population ageing is posing a challenge to health care and social security systems in many developing countries. The major issue is the impact of socioeconomic and psychological factors on the health of older people. With age, the socioeconomic disadvantage in health appears to accumulate making older people vulnerable. Inequities in health may get compounded by the effect of gender, nationality and ethnic status. A life-course approach addressing the health and economic needs of poor people and more accessible and affordable health service are conducive to promote active ageing. A change in the mindset that allows governments to perceive older people as resources and as partners in development rather than as “beneficiaries” would also help in formulating appropriate policies and programmes.

The proportion of older people is increasing in almost all countries of the world. This is due to population ageing — a demographic trend in which there is a decline in both birth rate and death rate in a population. With an increase in life expectancy, adults will continue to live to the “ripe” old age. Every society has mechanisms to provide for its ageing population. But the rapidity with which the older segment (60 + years and above) is growing is unprecedented. It took France 115 years to increase the percentage of elderly from 7% to 14% (1865-1980). In Japan this demographic transition occurred in just 26 years (1970-1996). Developing countries are taking still shorter time to increase their share of the elderly. For example, Jamaica will take 18 years, (2015-2033) to double its ageing population from 7% to 14%. In Tunisia it will be just 15 years (2020- 2035). The number of elderly in the world is expected to touch one billion mark by 2020 (Atal, 2000)1. Population ageing will have a major impact on health-care expenditures, patterns of production and consumption, trends in labour market, social security measures and kinds of formal and informal care services. Most developing nations have not yet succeeded in putting appropriate economic, social and health-care systems in place to ensure quality of life of older people.

Quality of life at any age is influenced by financial security, emotional security and health. The most common domain cited in terms of disadvantage of the ageing process is “health”. As more people reach old age and live longer, access to affordable and appropriate health care becomes a dominant need. Health is a key factor in personal well-being and social development. Starting from the early 1950s the development of social epidemiology and medical sociology has transformed scientific and popular understanding of health and illness. There is a shift from a purely biological viewpoint to understanding the socioeconomic and psychological determinants of health (House, 2002)². The conditions in which people are born, grow, live, work and age, add a social dimension to biological/genetic factors in health. Social circumstances, in turn, are shaped by local, national resources and their

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distribution, which are themselves influenced by policy choices. Inequities in social determinants lead to health inequities - the unfair and avoidable differences in health status seen within and between countries. Responding to the increasing concern about persisting and widening health inequities, the World Health Organization (WHO) established the Commission on Social Determinants of Health in 2005. In October 2011 in Brazil, The Rio Political Declaration on Social Determinants of Health was adopted during the World Conference on Social Determinants of Health. The declaration expresses global political commitment to reduce health inequities and to achieve other global priorities. It will help to build momentum within countries for the development of dedicated national action plans and strategies.

This WHO initiative to focus on the social dimensions of health has solid research backing. There is a large international literature concerned with the income-health connection that is more than five decades old. The first Whitehall study, begun in 1967, showed the relationship of socioeconomic status (SES) to mortality that persisted even after 25 years for both men and women (Marmot and Shipley, 1996)3. Inequalities within a single country and the relationship between aggregate inequality and population health across countries have been researched since then. Does wealth improve health? It appears so. Inverse association between socioeconomic status and health is the central finding from much research on the social determinants of health (House 2002)2. There is a well-documented but poorly understood “gradient” linking socioeconomic status to a wide range of health outcomes (Deaton and Paxson, 1998)4. This so-called “socioeconomic gradient in health” has been observed across different time periods and age groups using a wide range of SES indicators, health measures and methodologies (Smith and Goldman, 2007)5. The relationship between socioeconomic status (SES) and health is well–established in Western industrialized countries. Individuals with lower SES experience higher rates of mortality and are more likely to suffer from multiple health problems. This trend is seen in studies conducted in the United Kingdom of Great Britain and Northern Ireland (Banks, 2007)6 and the United States of America (Schnittker, 2004)7. There exists a steep negative health gradient for men in both countries where men at the bottom of the economic hierarchy are in much worse health than those at the top. This social health gradient exists whether education, income or financial wealth is used as the marker of one’s SES status. Based on data from two national longitudinal surveys, Buckley et al.8 report a similar SES-health link in Canada (2005). In urban Mexico, Smith and Goldman (2007)9 found a similar pattern where higher education and affluence were associated with better health. The result from studies in Latin American cities also finds evidence of a SES gradient in SRH (self-reported health) and disability (PAHO, 2003)9.

The relationship between SES and health is less clear in developing countries. In a population-based cohort study in South India, people with low socioeconomic status (SES) had almost two-fold higher mortality rates across all age groups compared with people with high SES (Mohan and Muliyil, 2009)10. Several studies in Asia show that higher education and affluence are associated with better self-rated health and lower mortality, but that the association with functional limitations and chronic conditions is less consistent and generally weaker (for e.g. Zimmer et al. 2004)11. Similarly, a longitudinal study in a peri-urban area of Costa Rica finds that mortality tends to be lower among the more educated, but is not related to wealth (Rosero-Bixby, Dow, and Lacle, 2005)12. Though wealth impacts health, the relation appears complex (Hertzman, 1999)13. Above a particular income level, the health-wealth curve flattens out and increase in per capita income does not necessarily relate to increase in health status. Yet, the traditional SES-health
relationship persists in poorer countries of the world. Despite its regularity, the slope of the gradient varies from country to country, suggesting that it is modifiable. The gradient, for example, is reported to be steeper in the United States as compared with the United Kingdom (Banks, 2007). Countries with relatively unequal income distribution tend to have steeper gradients in health status (Hertzman, 1999). The question: **Are people in poor health because they are poor or are they poor because of poor health?** is a complex one. Establishing the direction of causality is of both research and practical importance. A longitudinal-based research shows that the relationship between SES and health is particularly one of social causation (i.e., social position affecting health status) as opposed to the opposite (i.e., health selection).

Does the overall level of health inequality within a cohort change as people age? Will inequalities accumulate or even out? Answer to these questions are critical for developing countries struggling to respond to growing health needs of elderly with limited resources. Individuals with higher and lower SES may experience different health trajectories because of early life experiences and health behaviour. The cumulative effects of earlier healthier living and other psycho-socio-economic advantages may postpone or compress morbidity and disability to a shorter period at the end of life. Alternatively, SES differences in exposure to risk factors may fade away among older adults. Exposure to extensive public welfare policies may reduce inequalities experienced by poorer adults. Beckett (2000) suggests that SES difference expands through the late middle age and declines thereafter. Prus (2007) however, reports that both SES and total health inequality increase hand in hand with age. Even in Canada with a well-established public health plan, SES differences in health increased with age for both men and women (Buckley, 2005). The magnitude of health inequalities in old age will depend on social welfare policies, cultural contexts and availability of familial or other social support.

The potential for healthy ageing hinges on economic resources in old age for poor people. To achieve postponement of disability and morbidity for all persons, welfare measures should focus on the poorest of the poor and at earlier stages of the life-course.

There is undoubtedly a strong link between income and health. Poorer people are more prone to lifestyles with enhanced risk factors. They usually have less access to health care, including preventative health care. Their personal and work environment may be unhealthy, even dangerous. Unemployment has adverse health consequences. With age, exit from the workforce, coupled with the rising cost of living, will reduce their economic resources. Increased demand and inequitable supply in socioeconomic and medical resources will add to the problem. The provision of medicare at older ages could mitigate the problem by making health care available to everyone. Comprehensive medical-social security cover for the entire population throughout the life-course is an ideal realized in practice in very few countries. Even in the United States, perceived by many developing countries as the fabled land of opportunity and success, there is a “crisis in ageing”. Poverty, age discrimination, rationing of health care, uncertain economy and private pension crises, made the American gerontologist Robert Butler ask a poignant question, “why survive?”

Little is known of SES-health link differences by sex in developing countries. Gender significantly influences many variables related to quality of life. In all societies, women constitute a larger proportion of the poor and they lag behind men in almost every social and economic status indicator (Cohen 1998). On average, women live seven to eight years longer than men. However, older women experience more chronic illnesses and functional impairments, report more depressive symptoms, experience higher levels of psychological distress, and have higher rates of prescription drug use than do older...
men. Gender roles influence the type and amount of social support received by older women. Widowhood, economic dependence, rural background and cultural-social restrictions affect women’s lives adversely (Prakash, 2010)19. Research on sex differences in the SES-health relationship has been mixed. There are studies reporting the gradient to be similar, reversed, and even absent (Smith and Goldman, 2007)5. Inverse association of literacy status with all-cause mortality was observed in older Indian men and women, while, for CVD mortality it was observed only in men (Pednekar, et al. 2011)20. Mutaner et al. (2003)21 found social class indicators less useful as correlates of health and mental health among Spanish women than in men. Liang et al. (2000)22 observed the gender (by SES interaction) effect on old age mortality in China and recommended improving education among women as a high priority for policy-makers.

The role of non-economic factors such as gender, race and ethnicity cannot be ignored as they impact health and wealth in many ways. Health differences in different SES groups are not only due to material (resources) differences but also due to personal, cultural and lifestyle differences. Material factors are the direct effects of SES on health, while lifestyle and psychosocial factors are the indirect effects. Those with higher education, for example, tend to have higher occupational status and earnings and, thus, adequate financial resources to support the purchase of good housing, nutrition, and private health care, all of which are directly tied to better health. SES also influences health indirectly, as position in the socioeconomic structure affects psychosocial (e.g. negative life events, chronic stressors, coping skills, and social support) and health-related lifestyle preferences and behaviours (e.g. smoking, drinking, exercise, acquisition/interpretation of health-education information), which in turn affect health. Research supports a holistic approach to health that takes into consideration social support and personality factors. Social support and networks are increasingly recognized as important determinants of health in elderly (Stoddart et al. 2010)23. Psychosocial factors are often ignored in health research. The social support network protects against harm and promotes emotional and physical well-being. Lachman and Agrigoraei (2010)24 identify modifiable psycho-social and physical factors that are protective in nature, influencing the functional health of the elderly. Feelings of loneliness and isolation affect older adults’ health in a number of ways. They can create stress, lower self-esteem or contribute to depression, which may have physical health consequences. One’s personality can influence the SES health gradient in two ways. It may mediate the association between social class and health or it is possible that personality differences may actually produce social class differences25. Understanding this link requires research collaboration between psychologists and epidemiologists.

**Implications for policies and programmes**

Obviously, the SES gradient in ageing and health is more complex than it appears. Whatever the explanations and theories regarding this phenomenon, the bottom line is that older people who are poorer are more vulnerable and face higher morbidity and mortality risks. It is undisputed that population ageing will throw up several challenges to all societies. But its magnitude and manifestations are not the same everywhere. The level of development, existing policies and several political and cultural factors will determine to what extent the challenge will become a problem. As such there cannot be a single strategy for dealing with these problems, but there can only be a common commitment (Atal 2000)1. Governments are also aware that a more equitable distribution of resources and equity in providing services needs to be achieved. Improving the socioeconomic position of disadvantaged strata has been the agenda of many governments. The United Nations, the World Health Organization and
the Pan American Health Organization documents have repeatedly stressed the need to ameliorate the basic inequalities in societies to address the needs of the elderly. Obviously more has to be done with greater focus, consistency and intensity. How countries will generate additional resources and strategies to overcome existing inequalities will depend on political will and careful planning.

Needless to say, reduction in poverty and illiteracy levels forms the basis for improvement. Special care has to be taken to address the special needs of vulnerable groups such as women, and the frail, disabled and ethnic minorities. The widening health gap observed between SES groups suggests that policies of income redistribution should be targeted at the lowest SES groups. Governments should strive to make equal access to services and health care a reality. Dunlop et al. (2000)\textsuperscript{26} find that patients’ utilization of specialist visits is greater for those in the higher socioeconomic groups. Perception of medical care as unaffordable, cost of transportation, and loss of work are factors that often prevent poor people from accessing health care. Strengthening primary health-care services and integrating geriatric services in local centres is one way to ensure that health needs of the elderly are adequately met. The SES gradient in health is seen to be sensitive to social conditions. Governments need to work to reduce the overall levels of income- and education-based health inequality.

There is some consensus that health inequities tend to increase with age, which in turn is associated with SES levels. This would suggest that to postpone morbidity and disability, measures should be targeted towards low SES groups. In the earlier lifestage itself, the poorest of the poor need to receive financial support and health interventions to overcome their disadvantage that is cumulative. The expansion in the gap in longevity and health coincides with lifestyle problems such as relative increase in obesity, smoking and alcohol consumption, etc. In some countries like India, undernutrition as opposed to obesity, may be more of a risk factor for mortality in the older cohort. Health promotion policies, programmes and services aimed at modifying the rates of obesity, exercise, stress, poor diet and drug use, etc. should also be responsive to the needs of lower SES persons.

Physical and emotional isolation is a high-risk factor negatively affecting the health and well-being of older persons. Adequate social support, both emotional and instrumental, can have positive health-relevant effects. Voluntary organizations, community-based organizations (CBOs) and nongovernmental organizations (NGOs), and local senior clubs could be effectively used to enhance social support for the elderly, especially those living alone. There is also some evidence that those with better education are more likely to follow medical advice (that is, to have better treatment adherence) and hence to benefit more from health education and health promotion programmes. Without doubt, literacy is an empowering tool. Even in communities with low rates of literacy, adult literacy programmes with emphasis on health education and lifestyle modification could be implemented. Nongovernmental organizations could be used effectively for this purpose. In particular, improving education among women in underdeveloped areas must remain a high priority for policy-makers.

Policies and programmes need to be based on sound data from reliable sources. Multidisciplinary research to identify indicators of health inequality and preventive and protective factors would help formulate more effective policies and programmes. Similarly, SES differences in health behaviours later in life, that may act as buffers or risk factors, need to be well researched. Understanding which social conditions exacerbate health inequality would help to identify indirect paths from policy to health inequality. Deaton\textsuperscript{27} suggests (2002) that if certain patterns of
economic growth exacerbate health inequalities, policy could be directed towards altering the pattern (not necessarily the pace) of economic growth. Or, if increase in income inequality across many advanced industrial countries is associated with higher levels of health inequality, then a case could be made for efforts at income redistribution. Periodic evaluation to demonstrate the effectiveness of certain policy innovations and programmes would provide useful feedback.

Ensuring independence, care, participation and dignity to the growing millions of older people is not an easy task, nor should it be sidelined in developmental programmes. It should be acknowledged that ageing is a multidimensional process of interaction among multiple domains – biological, social, cultural, economic and psychological. A paradigm shift from viewing ageing as a problem, to viewing it as another life phase with opportunities for development is more conducive to active ageing programmes. A change in the “State doling out to older beneficiaries” approach to “old people as a resource” should guide policies. As Kaplan and Berkman (2011) rightly state, it would be a folly to focus on health alone without consideration for the social environment, or mobilize essential services without assessing or addressing the perceptions of the older people. Hence, involving older people in all programmes and the policy-decision process as participants is essential to achieve equity in health care.

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Ageing and health in Nepal

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Abstract

The combined effect of lowered fertility and improved health and longevity has generated growing numbers and proportions of the elderly throughout the world. This desk-review study is based on available secondary information from published and unpublished sources including web searches. The dependency ratio is showing an increasing trend in Nepal because of youth migration. Therefore, a holistic package including a special geriatrics programme is needed to ensure the welfare of senior citizens.

Background

Nepal, like many other countries in South-East Asia, has been successful in lowering the fertility and mortality rates and increasing the life expectancy of people in the interest of national development. According to the Nepal Demographic Health Survey 2011, the total fertility decreased to 2.6 from 3.1 in 2006. However, a continued increase in the percentage of aged persons in the population is creating humanitarian, social and economic problems in many less developed countries like Nepal. Past high fertility rates, combined with the decline in mortality has resulted in substantial growth in the number of old persons and, in conjunction with the subsequent fertility decline, to an increasing share of the elderly in the overall population. Following the migration of younger people from less developed to developed countries along with mitigation from rural to urban areas, rural older people are feeling isolated, lonely and deprived of care. Policy-makers, planners and demographers in Nepal are trying to analyse the dynamics of ageing in order to re-address the ageing policy and its related programmes. Thus, the objective of this paper is to review the current status of the ageing population including the policy, programmes and the institutional mechanisms needed to improve the well-being of the elderly.

Current practices and their implications for ageing

According to the Community-based Survey of 2001, the total population of Nepal was 23.1 million, living in an area of 147,181 square kilometres. The population of the elderly was 1.5 million, which constituted 6.5% of the total population. During 1991-2001, the annual elderly population growth rate was 3.39%, which was higher than the annual population growth rate of 2.3%. The 2001 census data showed that 85% population lived in villages whereas the urban population was only 15%. Children under 15 years constituted 39% of the population and the elderly accounted (>= 60 years) for 6%. The elderly dependency rate computed for different time periods shows an increasing trend from 7.5% in 1911 to 12.01% in 2001. The elderly population growth rate per year has always been more...
than the total population growth rate in Nepal. This rapid increase in the proportion and absolute number of the elderly among the total population will have an impact on socio-economic and health policies and culture in future. In Nepal, life expectancy was 31 years in 1961, which almost doubled and reached 61.5 years in 2001. Life expectancy which was 55 years for males and 53.5 years for females in 1991, reached 61.8 years for males and 61.9 years for females in 2001. The marital status of the elderly is important for their support systems and their well-being. In 1961, only 73.17% and 32.13% of the elderly males and females were married. This increased to 88.3% for males and 71.7% for females in 2009. Among those aged 60 and above, the death rate among males is significantly higher than females. The death rate of males among the age group 60 to 64 is 17.96%; while in the same age group for females the death rate is almost 4% less, i.e. 14.02%. The death rate among the elderly above 75 years is very high among males (80.41%) while it is low (62.13%) among females of the same age group.

Traditionally, Hindus followed the practice of Banasram (settling in the forest) after attaining the age of 50 years by handing over all rights and properties to their heirs. This was perhaps meant to minimize the negative impact of ageing in the social order. Also, till recently, many old Nepalese went to Banares and Badri Kedar, in India, very holy places for Hindus, to spend their last years. The higher the age of a person, the higher his/her social status. The eldest person in the household was considered the household head, irrespective of the authority that the elder person could have used in making household decisions along with the community. Almost all social and religious activities are guided as well as performed by him. His views and words are taken as the rules and regulations to be followed by the community/family members. Also, individuals who survive more than 75 years are considered as those who have attained “godhood”. In Nepalese society, elderly persons are felicitated as gods when they attain a certain age through a special ceremony (called Janku and chaurasi). This reflects the high respect shown by the Nepalese towards their elderly. Pancha debal, now called Pashupati Biddhashram, Kathmandu, an old people’s home was established by the late King Rajendra Bir Bikram Sahadev in 1981 to provide accommodation (living arrangement) for old people.

The government fixed 58 years for retirement in general administration cadre, and two years more for the health services. It is 63 years for the judiciary and university services, and 65 years for the Chief Justice and other members of constitutional bodies. However, in the agricultural and political sectors such a distinction for retirement age is not evident. Demographically, the age of senior citizens can be classified into two clusters (a) active life (b) care life. Active life is productive age recognized up to 75 years and care life is 75 and beyond. There is no retirement age for members of political parties, social workers and consultants. Thus, many retired persons are practising as consultants to maintain their capacity and health. Generally in Nepal, individuals over 60 years are considered elderly.

Acts and regulations: social security, policy, strategy and programme for ageing

The Directive Principles of the Interim Constitution of Nepal 2006 (2063 Nepali fiscal year) state that the State shall pursue the policy of making a special provision for education, health and social security and for the protection and progress of children, the helpless, women and the old, disabled and weak. Moreover, the Civil Code has provisions for the elderly people in its section on property rights. The Local-Self Governance Act 1999, carries the provision for protection and development of orphans, the helpless, women, older people and the disabled.
A separate sectoral policy for the elderly was first developed in the ninth five-year plan. The current three-year interim plan (2011-2013) has adopted the following vision, mission, strategy and interventions for senior citizens.

**Vision:** To provide an opportunity for comfortable, secured and satisfactory lifestyle of senior citizens by ensuring their fundamental rights.

**Mission:** Expansion of the advocacy programme to create an appropriate environment for healthy, secured, honourable and comfortable life of senior citizens.

**Strategy:** Several strategies have been developed like: utilize experience, skills and knowledge; establishment of geriatrics ward in all zonal-level hospitals; old age homes in every developmental region for the elderly with support of NGOs and private organizations; income generation programme for the elderly according to their wish and skills; and utilizing the experience of the elderly in different development programmes. Recently, emerging issues of senior citizens were recognized by the Second Long Term Health Plan (SLHP, 1997-2017). In Nepal senior citizens are assets of the nation because they carry social values, tradition and culture. The Senior Citizens Policy and Working Policy-2058 (2002), the Health Care Implementation Guidelines for older people, (2005), the National Action Plan for Senior citizens (2006), and the Senior Citizens Act (2007) have been formulated.

Various programmes have been launched for the welfare of the elderly. For the first time, the government provided an old age allowance of Nepali Rupees (Rs) 100 per month to senior citizens aged 75 years and above in 1995 as social security in the eighth national plan. Since then this old age allowance programme has continued. In 2006-2007 the amount was raised to Rs 200 per month and in fiscal years 2008-2009 the government increased the amount to Rs 500 per month for senior citizens and reduced the age to 70 years and above. A special subsidiary policy has been formulated for the Karnali area (the remote area of Nepal) that provides 500 Nepali rupees each to those above 60 years. The government has adopted the Jyeshtha Nagarik Swasthya Upachar Nirdeshika (Senior Citizens Treatment Guidelines) 2061 to deliver health care-services to the elderly.

Recently, the Ministry of Health and Population (MoHP) conceptualized an ageing survey to explore the various issues for evidence-based planning for the elderly. Moreover, the MoHP has also conceptualized specialized geriatric programmes and home visits for the welfare of the elderly and expanded the advocacy programme all over the country through local-level population management programmes.

**Institutional mechanism**

The Ministry of Women, Children and Social Welfare, MoHP, the Ministry of Local Development, the National Planning Commission, and the Ministry of Finance are the main agencies responsible for taking care of the health needs of the ageing people. According to the directory of elderly people-related institutions in Nepal (2004), there are 52 government-registered and currently functioning institutions, 82 government-registered but currently defunct and seven elderly-related institutions not registered but currently functioning in the country. In addition, there are seven government-ministries/committees (ministries of women, children and social welfare; health and population; education and sports; information and communication; local development: labour and transportation; and social welfare committee) together with partners.

**Challenges of an ageing population**

While improvement in technology has contributed to increasing life expectancy, the financial burden on an individual as well as the community is also increasing due to the
higher cost of treatment of elderly people. Therefore, the new challenge is how to bring efficiency in medical treatment of the elderly. Moreover, the growth of the older segments of the population will lead to a reduction in the size of the workforce and a simultaneous growth in the percentage of the population over retirement age. Because of this, the dependency ratio of ageing people is high in Nepal.

Furthermore, young people are much more interested to work in the formal sector rather than in the informal or agriculture sector. Migration from rural to urban areas and to big cities or foreign countries is increasing due to the expectation of high income and better education. In such situations, the elderly are unable to manage their land and household activities. As a result, agriculture production is decreasing, raising questions of food security and nutrition problems. Various surveys show that though the number of people living below the poverty line is showing a decreasing trend, it is characterized by greater spatial inequalities, poverty, stagnant economy, illiteracy and poor health status. Thus, the challenge is how to enable them to lead a productive life.

The dispersal of family members, leading to the breakdown of the large/joint/extended family and the new status and role of women is making the caring of the elderly population very difficult. It is imperative that the elderly are not deprived of their independence, their sense of responsibility, their personality and their feelings. They should not feel that the family and community are neglecting them. Any breakdown of these basic components can affect their mental health, which, in turn, can reduce their physical and psychological activity, leading to rapid deterioration in health and untimely death. Again, another challenge is how to bridge the gap between senior citizens and the young?

In the traditional family support system, sons are considered as the means of security in old age. Due to the breakdown of the traditional large family system in Nepal the traditional family support system for the elderly parents is being eroded. Sons consider taking care of their parents as a burden rather than their moral obligation.

In fact, the elderly people are the pride of the nation. They are the living history. They are assets of the nation. They are rich in experience, knowledge and skills that can be useful for the younger generation to learn from and provide continuity to the traditional skills. Thus, the additional challenge is how to utilize their experience productively. The offspring sometimes help financially if they are earning well but faced with hardship they may be unable to help and thus the parents are left alone to fend for themselves. It is generally felt by the elderly that once the children leave home for education or employment they do not return permanently.

Older people from all classes, ethnic, caste and gender backgrounds share a common view: love, affection, care and protection are as important for them as warm clothes in winter. Almost all the elderly like to live with their families. The elderly who live in old age homes get health care, timely food, freedom and other facilities but still suffer from psychological depression. The major challenge is how to change junior citizens’ feelings towards senior citizens.

Health economists argue that as individuals grow older, the overall stock of health begins to depreciate and thus, there is a direct relationship between age and demand for medical care. However, this concept is not taken seriously by policy-makers and planners.

Various programmes have been conceptualized for the welfare of the elderly. Among these programmes, geriatric care programmes for older persons have not been developed well due to the poor knowledge among clinical staff and policy-makers. Thus, there is a need for capacity development at various levels.
Conclusion and recommendations

It is high time for the younger generation, who will be the future elderly, to be aware, and to understand the challenges facing the elderly. They should start immediately to save for future security, develop a positive attitude in children towards the elderly, so that they may not have to face the same situation as today’s destitute and vulnerable elderly who need to depend on others.

The elderly have long and rich experience and are an inseparable part of society. Therefore their needs, problems and prospects require a holistic solution and not a fragmented approach. However, the changing lifestyle in Nepal from traditional ways to modern ways may pose a serious problem for the elderly in the decades to come. Therefore, there is a need to revise and strengthen the existing curriculum in the formal and informal education system of the country to incorporate subjects of gerontology and geriatrics.

Moreover, activities such as poetry and essay competitions at different levels (school, community, district and national) should be organized in order to raise people’s awareness on the health needs of the elderly.

Policies and programmes to promote the role of private insurance companies in financing health services to attract the young and healthy individuals who have low probability of using services should be pursued. There is a need to review/assess the present provision for compulsory retirement and to increase the retirement age, as continued employment provides a sense of worth, dignity and financial independence to older persons. Relevant documents published by the UN and its agencies on the subject should be translated and adapted to the country context. There is an urgent need to make a concrete plan and policy to change the attitude of family members, policy-makers, planners and professionals in the community towards the elderly people.
Making the world age-friendly: one city at a time

Kelly G. Fitzgerald* and Christine A. Mair**

Abstract
Global ageing populations are causing governments, urban planners, architects, other groups, and individuals, including older people, to begin to think about how the urban landscape and its infrastructure must change to meet the needs of older adults. To address this issue, the World Health Organization (WHO) developed the Global Network of Age-friendly Cities and Communities as part of the Age-friendly Environments Programme. This network supports cities seeking to become more “age-friendly” through new structures and opportunities that allow for older adults’ healthy and active ageing lifestyles. To become an age-friendly city and a member of the global network, cities apply with a five-year plan of practical improvements that can vary based upon city resources. By creating and cultivating this network, WHO has started a global trend towards supporting countries to be more inclusive of and sensitive to the needs of older adults. By the end of 2011, over 140 cities indicated their commitment to making their environments age-friendly by joining the global network. It is expected that hundreds more will join the network by the end of 2012 alone, expanding this community mentality and helping to make the world age-friendly, one city at a time.

Introduction
Global ageing is forcing cities around the world to reconsider how they will support their growing older populations. By 2050, almost two billion people will be aged 60 and over. This means the world’s older population will approximately double from 2006 to 2050. Perhaps most importantly, this will mark one of the most historic demographic shifts in human history. For the first time ever, people over the age of 65 will outnumber those under the age of five globally. The implications of this historic shift are still not fully known, yet it is important to recognize that the transition will not be uniform across nations.

While developed countries are experiencing a gradual change in the age structure of their population, the most dramatic population shifts will occur outside the developed world in low- or middle-income nations. By mid-century, 80% of the globe’s older population will reside outside of the “developed” world. Not only will low-to-middle-income nations share the bulk of the older population, they will also do so at a very rapid rate. In so-called “developing” nations, the aggregate growth rate of the elderly population is over twice that of the “developed” world. Further, the National Institute on Ageing estimates that although most “developed” nations took approximately 25 to 115 years to transition from 7% to 14% of the nation’s population over 65, many low-to-middle-income countries will make this transition in a brief 20 to 40 years. While many higher income nations experienced their ageing population shift over the last century (or are currently experiencing it), a majority of low-to-middle-income nations have yet to transition. These trends foreshadow massive

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infrastructural, individual, and family-based challenges regarding ageing populations in the 21st century.

While global populations are expanding and ageing, urban areas are also growing. This unique combination of demographic expansion and urbanization creates a new opportunity over the next century to outfit cities cross-nationally with the tools needed to prepare for expanding ageing populations. Therefore, we ask: What can cities do to ensure that older people will remain independent, socially engaged and enjoy a high level of well-being for as long as possible before requiring more intense care and perhaps institutionalization? The answer comes from a recent initiative by WHO. Specifically, the WHO Ageing and Life-course Programme developed a method of working with cities in order to improve healthy ageing across the globe. Although the world economy is struggling in certain parts of the globe, cities can take important steps that range in cost and commitment in order to improve the quality of life for older adults. Preparing for a boom in the urban ageing population means more than simply reforming global economic policies. Seemingly simple changes to a city environment, such as offering computer classes, creating a map of public toilets, or lengthening the time of crosswalk signals, have the potential to transform the lifestyles of older adults in a manner that enhances well-being and comfort in an ageing world.

The WHO Global Network of Age-friendly Cities and Communities

Redesigning urban environments to foster the health, social engagement and productivity of older people can be a challenge. Therefore, WHO opted to take a global community approach by creating a programme that encourages cities to work to improve the quality of life of older adults. Each city interested in being designated as “age-friendly” by WHO develops and implements a detailed, practical plan for improving the quality of life of its older inhabitants. Although cities promote age-friendly changes independently, they can connect and communicate with other urban locations that have the same age-friendly goal. In this manner, cities learn from the success stories of other urban environments, share strategies, and work together as a global community to enhance and prolong the well-being of ageing adults. This project, which was started in 2009, is known as the WHO Global Network of Age-friendly Cities and Communities (further referred to in this paper as “the Network”) and is part of the Age-friendly Environments Programme (created in 2006).

What types of age-friendly changes are the most beneficial for older adults, families, care-givers, and service providers concerned with older adults’ health and safety? In order to address this question, WHO began by conducting a focus group project that allowed older adults, as well as care-givers and service providers, from 33 cities located around the world to identify traits of their urban environment that could be altered to foster active ageing. Through these focus groups, ageing scholars identified eight key areas for potential city environment improvement that collectively address opportunities to better older adults’ physical, social and cultural landscapes. These eight domains for improvement include: (i) outdoor spaces and buildings; (ii) transportation; (iii) housing; (iv) social participation; (v) respect and social inclusion; (vi) civic participation and employment; (vii) communication and information; and (viii) community support and health services. Following this study, WHO developed the eight domains into a detailed guide for cities seeking to join the community of age-friendly cities. This tool, called “Global Age-friendly Cities: A Guide,” helps individuals and groups such as governments, citizen groups, the private sector and voluntary organizations coordinate to achieve age-friendly status for their city. Cities that have submitted a detailed, practical, WHO-
approved plan for age-friendly status are considered to be members of the Global Network of Age-friendly Cities and Communities, which was formally established to “link participating municipalities, foster evaluation of age-friendly initiatives, and provide technical support”\(^6\).\(^7\)

Specifically, the WHO guide to age-friendliness emphasizes the concept of “active ageing,” which is “the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age” through material and social means\(^6\). Broadly, WHO views older adults as an asset to society and seeks to encourage families, communities, and local and national economies to work together to create positive outcomes for older adults cross-nationally. In other words, the practical goal is for cities seeking the Network membership to focus on redesigning urban structures, public policy, and community services in a manner that acknowledges the diverse capabilities and lifestyle decisions of ageing individuals, while promoting timely responses to the “needs and preferences” of older people\(^6\). In addition, these redesign features should aim to protect the most at-risk older adults and encourage the inclusion of all older adults as important, contributing members of the city’s local community. On a more detailed level, participation in the Network requires the city to formally commit to a process of continual improvement\(^3\). The role of WHO headquarters, regional offices, and country offices within the Network includes:

1. coordination of the Age-friendly Cities programme,
2. identification and dissemination of best practices,
3. development of implementation guidelines,
4. technical support and training, and
5. review of progress and plans.

Cities can either join the Network independently, or in coordination with other cities in the country as part of a national programme, provided they develop a plan for age-friendly improvements. Cities can remain members of the Network as long as they demonstrate continual improvement towards their stated age-friendly goals. By the end of 2011, 41 individual cities, which are not part of a national programme, had joined the Network. By March 2012, it is expected that at least 30 more individual cities will apply for membership. Some WHO Member States have taken the initiative to establish their own programmes at the national or state/provincial level. For example, Canada has a national programme but Quebec has a separate provincial programme that does not fall under the Canadian national programme. WHO works with these national programmes to ensure that participating cities become members of the WHO global network. Eight national programmes have been established and the total number of member cities within these national programmes is increasing rapidly. As of the end of 2011, there were over 100 cities with several hundred more planning to seek membership within the first quarter of 2012.

**Network membership**

Prior to applying for membership in the Network, cities are not expected to have completed any activities towards making them age-friendly. Rather, cities must show that they plan to address the eight domains previously discussed over the span of five years. Age-friendly status is accomplished through four stages over those five years, forming a cycle of continual improvement. Recognizing that all cities and their populations are different, the cyclical process is flexible and allows for the diversity of cities around the world. Assessment of action plans and progress will take into account the financial and social circumstances of each city and region. Initially, prospective member cities are required to complete an online application form, which includes submitting a letter from their Mayor or
municipal administration, to the WHO headquarters in Geneva indicating their commitment to the Network. (The online application can be found here: http://www.who.int/ageing/application_form/en/index.html.) Applications to create a national programme follow nearly the same procedure, except that management of national programmes must be conducted in coordination with the WHO global network in order to ensure smooth management of cities’ applications and coordinated activities as a national group. A brief description of the four stages required during the five-year cycle follows.

Planning (Years 1-2)

There are four activities that must be accomplished in the first stage.

(1) Involving older people

The key piece to ensuring that programme is effectively developed to meet the needs of the intended user is to involve the user—in this case, older adults—at every stage of programme development, implementation and evaluation. Reflecting on issues of ageing and urbanization as they relate to age-friendly city redesign, Beard and Petitot note “If older people can maintain their health until the last years of life, and if they live in an environment that allows their ongoing productive engagement in society, ageing populations might instead be considered an overlooked societal resource”3. Cities should establish a mechanism to involve older people through the cycle. For example, older people can help to assess a city’s strengths and weaknesses based on the checklist provided by WHO and found on the WHO website. They can also provide suggestions for change and participate in implementing projects. Following assessment and implementation, older people can continue to contribute by helping to monitor a city’s progress as advocates or advisers6.

(2) Conducting a baseline assessment

Cities are also required to develop a baseline assessment to determine the current age-friendliness of the city. This activity will vary from city to city but could range from a review of current policies to a more detailed activity such as developing a survey to ask older people what they think would make their city age-friendly.

(3) Plan of action

Based on the findings of the assessment, cities must develop a three-year city-wide plan of action. The plan of action will range from city to city and can be as simple as including activities such as installing more park benches and longer street-crossing time. Plans can also be more detailed, such as developing a better social service programme to ensure different city services work together to address the older populations’ needs. Social service programme development can include anything from emergency management to health services.

(4) Identification of indicators

In order to monitor progress on its plan of action, each city must develop its own, specific indicators (WHO is in the process of developing a brief guide on possible indicators). For example, based on the example given above, an indicator can be as simple as stating 20 new park benches will be installed by a certain date. If by that certain date those benches are installed, the indicator shows that the city is progressing in its age-friendliness. If only 10 benches are installed by the goal date, this shows that the city has only partially progressed in its improvement and may need to evaluate why the goal was not met.

Implementation (Years 3-5)

Upon completion of the planning phase and no later than two years after joining the
Network, cities will submit their action plan to WHO for review and endorsement. Upon endorsement by WHO, cities will then have a three-year period of implementation.

**Progress evaluation (end of Year 5)**

At the end of the first period of implementation, cities must submit a progress report to WHO outlining progress against indicators developed in stage 1.

**Continual improvement**

Following evidence of progress on the original action plan towards age-friendliness, cities enter the final phase of “continual improvement.” This phase involves the creation of a new action plan and indicators to be pursued over a flexible amount of time (up to five years). At the conclusion of this new period, cities are assessed again for progress. As long as cities maintain steps towards age-friendliness, they can continue to be members of the Network and pursue further cycles of planning, implementation and evaluation.

**Conclusion**

One guiding principle of the future of WHO’s concept of “age-friendly” is diversity. With the Global Network of Age-friendly Cities and Communities, WHO has established cross-national diversity in its campaign to improve the lives of older adults. Considering the pressing issue of rapidly growing ageing and urban populations—particularly in middle- and low-income nations—this is an important first step. The growing success of this programme can serve as a future model for extending and publicizing this type of practical, sustained approach to age-friendliness in new social settings and geographic locales.

For example, hospitals and workplaces, rural communities, and family households could all benefit from an age-friendly model. Similar to cities, these spaces should “anticipate users with different capacities instead of designing for the mythical ‘average’ (i.e. young) person”. Although hospitals and workplaces may be partially equipped for such scenarios, there is room for “continual improvement.” Like the city model, changes should be structural as well as social. Issues such as available public seating, facilities, and accessible architecture continue to challenge hospitals and workplaces. In addition, improved access to information through available reading materials, technology and so forth could also be enhanced. Such changes would benefit not only older adults, but people of all ages that do not fit the assumption of “average” function and/or physical capabilities. The same types of improvements would also greatly benefit rural communities, which often lack infrastructural advantages and in many nations—due to youth emigration into urban areas—house a high proportion of older adults. Canada is currently developing an age-friendly rural initiative in a number of small towns and villages that may offer new inspiration to the global rural community. Finally, families could also benefit from age-based awareness. Ultimately, the WHO age-friendly model draws from a life-course perspective, which considers the lives of individuals at all ages and values the role of intergenerational relationships. Ideally, age-friendly cities, hospitals and workplaces, rural communities, and households should yield an environment that cultivates intergenerational solidarity.

Overall, these examples indicate that rather than focusing on disablement, the future of age-friendliness can operate as a broader source of empowerment and enablement for a diverse community at global, national, city, local and household levels. Or, in the words of the WHO Guide to Age-friendly Cities, “…respect and consideration for the individual should be major values on the street, at home and on the road; in public and commercial services, in employment and in care settings.” By promoting steady, practical adjustments to cityscapes worldwide, the WHO Age-friendly
Environments Programme and the Global Network of Age-friendly Cities yields measureable improvements to older adults’ quality of life cross-nationally. Further, this important initiative has the potential to inspire a paradigm shift in a rapidly urbanizing and ageing world, fostering community support for diversity, one city at a time.

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Health care of the elderly in Myanmar

Professor Myint Han*

Abstract
The world is ageing fast. A huge demographic change has taken place in Asia causing changes in the dependency ratio and structure of population. Myanmar is also facing the emerging issue of a growing number of older people. Among the population of six million older people 10% are estimated to be vulnerable persons. Policy initiatives are required to assess the loss of care-giving by family members. The caring models in Myanmar are homes for the aged and volunteer-based home care. Studies in Myanmar have revealed that older people and family care-givers prefer to care for the elderly at home. Home-based care service, community-based care service and day care centres are considered appropriate in the Myanmar context as they are cost-effective and suitable for Myanmar people and these models should be considered if needed. In Myanmar, a national policy on ageing has been formulated and is in the process of approval.

The Health Care for the Elderly programme in Myanmar aims to promote the health and to increase the accessibility of geriatric care services for the elderly. The programme is providing at least 20% of ambulatory elderly with geriatric clinical services through the primary health care approach in the project townships. It also encourages home-based geriatric care through families, health volunteers and nongovernmental organizations (NGOs). Training programmes for health staff, voluntary health workers, family members and community volunteers are also included in the programme.

The social welfare department and various organizations are also taking part in the social and health care of the elderly.

There are certain areas to focus on and expand in future. These include awareness programmes on ageing, income generation, greater participation of older people in societal development, disaster preparation, policy development in old-age-oriented approach and social care.

Introduction
The world is ageing fast. By 2045, for the first time in history, people aged 60 and above will outnumber children under 14 globally. A huge demographic change has taken place in Asia causing a change in the dependency ratio and structures of population. It often used to be said,* old age was not a problem, keeping children alive was a problem*. Now, ageing is on top of the social agenda in Asia.

Being a developing country, Myanmar is also facing the emerging issue of a growing number of older people. Since most people in Myanmar live in rural areas, "rural ageing" is an important issue.

Ageing is a triumph of our times — a result of improved public health and development. Older people contribute significantly to their families and society and should not be viewed as a burden. However, over 160 million people live in poverty across the world.

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Industrialized countries have developed relatively comprehensive health-care policies and programmes for older persons including community-based and residential services.

In Myanmar, older people are supported mainly by families. The government and communities are now working together to fulfil the needs of the growing number of older people based on the concept of active and healthy ageing.

Religion, culture and ageing

In Myanmar, religion and culture are closely linked and play a central role in care of the elderly. Traditionally, care of the elderly has been considered as a noble practice. Younger family members serve the needs of the elderly with great pride. People live in extended families with the younger generation. The nature of the family structure enables the family to take care of the elderly who, in turn, also play a meaningful role as advisers and community leaders within their capacities.

However, the traditional family care system is gradually getting eroding due to a decrease in childbirth, migration of younger people, engagement of more family members in jobs and due to rapid urbanization. The Myanmar society generally values and treats older people with respect. However, this impressive practice has somewhat decreased in some rural and urban areas. Because of the increasing trend of smaller families getting separated from elderly relatives through rapid urbanization, policy initiatives are required to counter the loss of care provided by family members to the elderly.

Ageing population

The estimated population of Myanmar is 58.37 million and the population of people over 60 years is estimated to be six million. Therefore, 10% of the population is over 60 years and it is expected to increase rapidly. This is primarily due to decreased birth rate, good nutrition and effective health care. Longevity in Myanmar has also increased. Life expectancy for males is 63.9 years and for females it is 67.4 years.

Among the population of six million older people 10% are estimated to be vulnerable persons. Of this group, 30% are being looked after by extended families. Therefore, it is essential for the community to take care of the remaining 70% of the vulnerable group.

Status of the elderly

A multi-country study on the health of the elderly, supported by WHO, and undertaken from 1989 to 1992 in Indonesia, Myanmar, Nepal, Sri Lanka and Thailand revealed common health problems. In Myanmar these were high blood pressure and heart diseases, strokes, cancers, lung diseases related to smoking and musculo-skeletal problems.

Various studies conducted in Myanmar on the elderly have shown that an active lifestyle by working in the field or at home was a positive factor for better health, and that the role of the elderly in the family or community was considered as contributing factor for healthy ageing. In this context it was observed that family and community support was the key issue. In terms of social needs, community support was more commonly seen in rural areas.

One positive aspect seen in the studies was that care-givers did not approve of institutional stay and preferred to keep the elderly at their homes. This highlighted their desire to maintain the traditional family care system to care for the elderly. Care models other than institutional care are required for the frail elderly. The studies also highlighted the need for comprehensive geriatric services comprising home visit, outreach activities, out-patient care, inpatient care and long-stay rehabilitation services.

One study showed that social problems were observed in nearly 35% of the study population, which highlighted the need to
study more social issues in detail in order to develop appropriate policy and intervention measures.

**Caring models**

In addition to family care, there are two ways of taking care of the elderly in Myanmar. The first is the very traditional way of caring. A Home for the Aged was first established in 1898 by a well known lady, Daw Oo Zonn. Since then many homes for the aged have been established in various places in the country depending on the needs of the local community. At present there are 62 homes for the aged across the country covering over 2000 older people.

Another model of caring is the volunteer-based home care programme introduced in Myanmar in 2004, which is now caring for approximately 30,000 older people. The other caring models practised by international bodies are: home-based care service, community-based care service, group home care service, and day-care centre, etc. Among these models, home-based care service, community-based care service and day-care centre are considered appropriate in the Myanmar context as they are cost-effective and suitable for the Myanmar people.

**National policies, legislation and initiatives**

Demographic change has resulted in an unprecedented number of older people worldwide, thereby increasing pressure on respective governments and society as a whole. The UN Convention on Rights of Older Persons ensures that older men and women can realize their rights; civil society organizations play a key role in this.

Countries such as Bangladesh, Cambodia, Malaysia and Maldives have national policies for the care of older people. In a number of countries such as Australia, India, Japan and Singapore, programmes for the health of older persons are well established. There are government-endorsed national strategies on ageing and a package of services and benefits that address the health needs of the infirm, sick and disabled elderly alike.

The Fifty-eighth World Health Assembly adopted resolution WHA 58.16 on “Strengthening active and healthy ageing”, which recommended a wide range of actions for Member States and WHO. It suggested developing, implementing and evaluating policies and programmes that promote healthy and active ageing.

In the Constitution of the Union of Myanmar, Article 32 (a) states that the Union shall take care of mothers and children, orphans, children of fallen defense services personnel, the aged and disabled.

In Myanmar, a National Policy on Ageing has been formulated and is in the process of approval. In many other countries, lack of policies for older persons does not preclude provision of services as they are often part of general government welfare services for all disadvantaged groups in the countries.

In Myanmar, health care of the elderly is reflected in the general health-care system. With WHO support the Health Care for the Elderly programme has been implemented in various areas.

**Health Care for the Elderly programme**

In the National Health Plan (NHP) (1993-1996), health care for the elderly was one of the subprogrammes under the umbrella of the Community Health Care programme. It was also included in the NHP (1996-2000) and thereafter. It is an integral part of primary health care. The General objective of the programme is to promote health of the elderly in Myanmar and to increase the accessibility of geriatric care services for the elderly. To fulfil the general objective, the Elderly Health Care
programme aims to provide at least 20% of the ambulatory elderly with geriatric clinical services through the primary health-care approach in the project townships. It also encourages home-based geriatric care through families, health volunteers and nongovernmental organizations. Training programmes for health staff, voluntary health workers, family members and community volunteers are also included in the programme.

An important part of the programme is establishing “Wednesday” geriatric clinics in the project areas including the rural health centres. The programme also increases awareness on ageing issues in the community. Research on the elderly situation in both urban and rural areas is also one of the activities.

To implement these objectives, there is coordination and collaboration among local NGOs such as Myanmar Mother and Children Welfare Association (MMCWA), Myanmar Red Cross, Fire Brigade, Myanmar Women Federation (MWF), Voluntary Home Care services from Social Welfare Department and various NGOs, both local and international.

**Elderly clinics**

In addition to health care provision, oral care and eye care are included in the elderly clinics since visual and dental problems are common in elderly people. Prevention of falls is also emphasized. Cataract surgery, distribution of free eye glasses and dental treatment are also important activities of the elderly health-care programme.

For health promotion, physical exercise lessons suitable for older people are demonstrated by the health staff who encourage them to exercise regularly. Yoga and Tai Chi exercises are beneficial for the elderly in terms of prevention of heart disease and prevention of falls. Older people are encouraged to perform these exercises in groups. Lifestyle modifications are also included in counselling as they are essential for active and healthy ageing.

Depending on the availability, screening procedures for high blood pressure, diabetes, heart disease and other important diseases like osteoporosis and cancer are performed and appropriate treatment initiated, and the elderly are encouraged to come for regular follow-up. A proper referral system is set up in elderly clinics for those who need further treatment at tertiary centres. A rehabilitation programme for people with mobility problems, joint problems and for post-stroke patients is also available.

Nutritional counselling and health education for the patients as well as family care-givers are important functions of elderly clinics.

In certain elderly clinics, there are group vaccination programmes for pneumonia and influenza for those at risk.

Elderly clinics also serve as an initial place to identify people who need social care. Appropriate action is taken to have services like home-care services.

It is noted that elderly clinics serve as places to combat loneliness as elderly people can meet each other and group recreational activities can also be initiated.

Medical conditions seen in elderly clinics include high blood pressure, chronic lung diseases, musculo-skeletal problems, heart diseases and diabetes mellitus.

The elderly health-care programme has been implemented in (88) townships in various states and divisions covering 20% of the total townships in the whole country including rural areas. It is being expanded to four townships yearly.
Social care

Home for the aged

These are places where older people are provided food, shelter, health care, social care and protection. The Department of Social Welfare provides rice, funds for food and clothes.

ROK-ASEAN home care for older people

It is basically a volunteer-based home care programme that is being implemented phase by phase since 2004 in Myanmar. It is a replication of the home-care model of the Republic of Korea and other ASEAN countries.

National YMCA

The national YMCA aims to improve the health and social conditions of the poor, frail and lonely older persons to a certain level by motivating volunteers. The home-care model is utilized to fulfill the objectives. The main activities include recruiting volunteers and training for home care, and to organize get-togethers for older persons.

Myanmar Maternal and Child Welfare Association (MMCWA)

The MMCWA has participated in elderly care since 1998 with the objectives of enabling older people to become active ageing persons and assisting in psychosocial support for a healthy and happy family life.

Activities include free medical treatment, provision of eye care, dental care, cataract surgery, demonstration of physical activities, financial and material assistance to the needy and other social activities such as group visits to the pagodas.

HelpAge International (HAI)

The vision of HAI is to help older people to lead dignified, active, healthy and secure lives. The HAI organizes OPSHG (Older Persons Self Help Groups) in some targeted areas in Myanmar mainly in villages. These are multi-functional community-based organizations formed by older women and men through a democratic practice.

The main activities of OPSHGs are fund-raising, livelihood and income generation ventures, health care and home care. It has future plans to expand its activities.

Support group for elderly doctors (SGED)

This support group has been formed by a group of doctors with the objectives of supporting and rendering help in three identified areas: financial, social and services to elderly doctors above 70 years of age. The SGED is taking care of 617 elderly doctors including those who live on their own.

The functions of SGED are: day-care centre development and preparation of home-based physiotherapy care project. Research programmes, academic training programmes and publication of newsletter are the other activities of SGED.

World Vision (Myanmar), Global Vision, Caritus Thailand, Myanmar Women Affairs Federation (MWAF) and the Myanmar Baptist Churches Union (MBCU) are the organizations taking part in the care of the elderly.

The International Day for Elderly is usually held in the country on 1 October. On that occasion the elderly are provided with gifts and medical, oral and eye care by health personnel in collaboration with local NGOs and health volunteers.
Future

To be aware of the ageing world and ageing issues in Myanmar, continuous awareness programmes targeting older people and society are needed. The awareness message should be culturally appropriate with the focus on lifelong healthy lifestyle. It is also crucial to focus on health promotion and the preventive approach for healthy and active ageing.

To remain active in old age, strategies are required for employment opportunities since a productive life improves physical and mental well-being. Income generation or experience sharing can also ensure greater participation of older people in society.

The role of older people has to be recognized in the future and it is crucial to encourage an old age-oriented approach in all policy development.

Experiences of older people affected by the Cyclone Nargis highlighted the need for protective measures for the elderly in disaster situations.

Since the growing elderly population will demand more health-care resources, the health system should become more age-friendly with efficient geriatric health-care services.

As social security and financial security are important issues in addition to health security in older people, a national policy should be developed to formulate comprehensive strategies on ageing.

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Implications of ageing in Maldives

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Survival to advanced age is one of the great accomplishments of the modern era. This significant issue of the 21st century has major implications for health, policy-making and programme development, particularly for a country like Maldives.

Maldives is a developing country with limited natural and human resources and a unique geography that fragments the population across many small islands. These constraints add to the cost of providing social health-care services for the elderly.

Over the past few decades dramatic demographic transformations have taken place both in developed and developing countries. According to the United Nations (UNDP-2000), the proportion of older people in the population increased from 6% in 1950 to 8% in 2000 globally. It is estimated that the number of older people will increase from 606 million in 2000 to nearly two billion in 2050. Similarly, it was reported that in 1999 (United Nations-1999) one in every 10 persons was aged 60 years or over, a figure expected to increase to one person in every five by 2050 and one in three by 2150. This trend towards an ageing population has been driven by the process of social development (Davies, 1998) that includes improved nutrition and housing, and better health care. These improvements have resulted in a decline in mortality and an increase in fertility which, in turn, have contributed to longer life expectancy. Hence, the proportion of older people has and will grow significantly in the coming decades.

Although the percentage of older people is higher in developed countries, the pace of ageing in developing countries is more rapid and the transition from young to old more compressed in time (United Nations-1999). It is estimated that by 2025 two thirds of the global population of people 65 years and over will be in developing countries (Davies, 1998). In Maldives, life expectancy has increased steadily. According to the 2000 census life expectancy for males was 72.3 and for females it was 73.7 and 3% of the population was 65 years (Ministry of Planning and Development, 2001a).

The International Labour Organization (2000) also warned that by 2025 over 75% of the older people in the world would be in Asia. Not only has the number of older people in developing countries increased, the pattern of disease has changed for nearly all the developing regions; there is a predicted increase in noncommunicable diseases such as cardiovascular disease, cancer, pulmonary diseases and other chronic illnesses (Davies, 1998). As a result, there will be a gradual deterioration in the ratio between the economically active and inactive within the population. This worrying trend not only has major implications for socioeconomic development, but also for the provision of health services and health care for the older people.

The exact nature of the health needs of the expanding elderly population will relate, in part, to the general state of psychological wellness in this group. More attention will also need to be paid to issues relevant to all

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segments of the ageing population, including increased health-care costs, disability, later retirement, and care-giving for the impaired. It is projected that most of the elderly would be widowed women by 2015.

These demographic shifts will have a number of significant consequences in shaping social and public policy in Maldives. For example, the increase in number in the group aged 65 and above will necessitate significant expansion in services to address health issues.

The ageing process can have a profound effect on the nutritional status of the elderly, which is influenced by social, psychological and economic factors. As we grow older, many aspects of our lives change, leading to changes in selection, preparation and consumption of food. Twice as many older adults live in poverty compared with younger adults as a result of a decrease in income and increase in living costs such as medication, specialized aids and so forth. Psychological factors may also play a significant role in influencing nutritional status, and cognitive defects may affect an individual’s ability to prepare food or even to recognize hunger. Dementia is seen in many age-related diseases and illnesses including Alzheimer’s disease, stroke, and other cerebrovascular incidents. An elderly person who experiences dementia may forget to eat or have difficulty differentiating between meals and may only rely on certain foods. Stressful life events such as illness or death of a family member, depression and loneliness can also influence nutritional status. Age-associated changes in the oral cavity and gastrointestinal tract may have a significant effect on nutritional status. For example, an age-related decrease in gastric acid and enzyme production may reduce absorption of vitamin B12, iron folic acid, and possibly zinc as well as calcium. Altered gastrointestinal motility may contribute to constipation resulting in poor appetite.

In Maldives, one of two bone diseases that are common in most of the elderly over the age of 65 are osteoporosis and osteoarthritis. Osteoporosis occurs more often in menopausal women due to the bone loss associated with a decrease in estrogen. Women are known to lose as much as 20% of their bone mass during the first five to ten years of menopause (Leibman 2002).

Depression is another big problem among the elderly population and we are no exception to this. For the elderly person and family, onset of depression in late life is doubly difficult to fathom, sometimes blurred with multiple physical signs and complaints of ageing. However, it is useful to remember that new psychological challenges during ageing can be stressful and confusing in the best of circumstances for healthy individuals too. Emotionally, one can reasonably accept for example, some physical disease in oneself or one’s spouse that will temporarily interfere with everyday routine. There will also be grief and sorrow when there are losses of friends and relatives due to disabilities, relocation or death. In addition, it is likely that some family entanglements and misunderstandings from the past will resurface, adding confusion and emotional strain. Finally, the awareness that life will be limited and the acceptance of the fact that some form of help will be required, in the form of either physical, financial, social or emotional assistance can be frustrating and upsetting. These profound events lead to depression in the elderly. Thus, the elderly are at risk of getting trapped in a vicious cycle of mental and physical illness that can lead to depression and so on.

Over the years, tremendous strides have been made in identifying and increasing awareness about the patterns of abusive relationships, child abuse and domestic violence. These have received significantly more recognition than abuse of elders and continue to receive more attention in the public and medical domains, although abuse clearly occurs in persons of all ages. As a result of an increase in the elderly population who need care, the number of those abused will also increase.
Each year hundreds of thousands of older persons are abused, neglected and exploited. Many are people who are older, frail and vulnerable, who cannot help themselves and depend on others to meet their most basic needs. Abusers of the elderly are both men and women, and may be family members, friends and “trusted others” (Hudson, M.1991).

Mistreatment of the elderly is a multi-dimensional phenomenon that encompasses a broad range of behaviours, events and circumstances. Unlike random acts of violence or exploitation, abuse of the elderly usually consists of repetitive instances of misconduct. It also encompasses any act of commission or omission that results in harm or threatened harm to the health and welfare of an elderly person. In general, abuse of the elderly is a term referring to any intentional or neglectful act by a care-giver or any person that causes harm or risk to a vulnerable adult.

Presently, Maldives is moving away from the pattern of an extended family to a nuclear family. The tradition was that the elderly were looked after by the family members. Unfortunately, care-giving for the elderly usually comes at a particular moment in the family cycle when children become adults. They may have children or grandchildren of their own. Taking on the responsibility for support of parents may just be one more task that is added to the ones that are already performed with competence and energy. The adult child may be dealing not only with the problems of parents but those of his own family. A son or daughter may be having substance abuse problem, a failing marriage etc. In these situations the stress may be so much that the care-giver cannot take on additional responsibilities. Sometimes the adult child has to take care of a parent who has abused them. The situation becomes worse when a woman who has been sexually and physically abused is required to take care of the father who was the abuser. In Male’ the capital of Maldives the housing situation is really bad — in most nuclear families there is no room for elderly parents. So it is time for the government to look for alternative care for the elderly.

With the rapid increase in the older population, providing health-care services to meet the needs of the elderly has become a major challenge for all countries, but more so for developing countries such as Maldives. A wide array of health services is needed to prevent illness, minimize disability, and promote a level of wellness among the elderly population. It is well documented that chronic illnesses and other impairments associated with ageing can limit the older person’s capacity to perform activities of daily living and enjoy life.

As Maldivians live longer, health promotion and homes for the elderly become more important. Although the Maldives health policy advocates equitable distribution of health-care services to all citizens, having easy access to health services is a major concern for the elderly living in the outer islands, though there is health insurance coverage for people above 65 years. The government has achieved a great deal in the past decade to improve the health of the general population but not much has been done in the area of elderly population. The future role and scope of elderly care services are difficult to predict, but this is a matter that cannot be left to chance. We need to find ways to look after the elderly be it through nursing homes or residential care facilities.

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The plight of older women: from understanding to response

Narimah Awin*

Abstract
Population ageing is a global reality, and accompanying this is the feminization of ageing. To respond to this, countries face two major constraints – the paucity of information on the plight of the elderly, and poor integration of related services. Older women can be perceived as being the victim of the “triple jeopardy” of sexism, disempowerment and ageism. Thus, health care of older people has important gender dimensions. To address the wide-ranging needs resulting from the interaction between sex, gender and ageing, the health sector needs to see these in a linked and coherent manner, and this can be achieved by integration and mainstreaming. Integration increases efficiency, enhances client satisfaction and reduces the problem of lack of information. Integration calls for an understanding of the implications of ageing, gender and women’s health on each other. Integration does not merely connote a “sharing” of concepts, values and actions. It should identify priorities, determine how things are structured and work done, and effectively share information. While integrating women’s health, gender and ageing horizontally, it is critical that vertical integration between the levels of care also takes place. In this regard, primary health care (PHC) deserves special attention. There are several opportunities for integration of women’s health, gender and ageing. There are also challenges such as negative perceptions on both ageing and sexual and reproductive health, weak capacity of health systems, and possible conflict of stakeholders’ interest.

Introduction
Population ageing is a global reality, and is especially challenging for developing countries that are “becoming old before they become rich” compared with developed countries that “became rich before they became old”. In 2009, the percentage of the world population over age 60 was 11% globally, with marked variation among the WHO regions, the highest being in the European (19%), American (13%) and the Western Pacific (13%) regions, and significantly lower in the South-East Asia (8%), Eastern Mediterranean (6%) and African (5%) regions. While countries of the South-East Asia (SEA) Region have begun to respond to population ageing, they face two major constraints. The first is paucity of data and information on the profile of the elderly, which are needed to understand the “plight” of older persons, and which in turn are needed to formulate evidence-based policies, programmes and services; and related to this is the additional problem of lack of gender disaggregated data that can reveal the difference, if any, in the “plight” of older men and older women. The second constraint is insufficient integration with little attempts made to mainstream ageing into services for women’s health, of which sexual and reproductive health is a major component. These two constraints are interrelated; an understanding of the plight of older women will facilitate integration, and an integrated approach will lead to improved information and understanding of the problem.

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Population ageing and women

In almost all countries of the world, women live longer than men. Globally, the number of women aged 65 and above in 1990 was estimated to be 189 million; in 2015 this is expected to be 335 million. This sex differential is reflected in the higher ratio of women versus men in older age groups. In 2002, in Europe, there were 678 men for every 1000 women aged 60 and older; in less developed countries, there were 879 men for 1000 women. To further illustrate the influence of socioeconomic development, in Europe, on the average, women outlive men by eight years, while in Africa, this difference is only three years. From this socioeconomic perspective, two scenarios emerge. Most women who enjoy healthy older years are in industrialized countries, and they tend to have completed at least basic education, have had few children and access to health care, good nutrition, and minimal exposure to work-related stress and injury. Their old age concerns focus on issues such as hormone replacement therapy and degenerative conditions such as osteoporosis and arthritis. On the other hand, many older women in developing countries suffer from chronic health problems caused by years of neglect, discrimination and hardship. Their health reflects inadequate access to basic services and the hardships of childbearing and physical labour. The “feminization of ageing” coupled with the tendency for women to marry men older than themselves result in a disproportionate number of widows compared to widowers.

The plight of older women – the triple jeopardy

Because women live to a very old age, they are more likely than men to experience disabilities and multiple health problems associated with old age. Women are also more likely than men to experience domestic violence and discrimination in access to education, income, food, meaningful work, social security and political power. These cumulative disadvantages over the lifecourse place women, in particular vulnerability in old age. Added to these complexities is the economical vulnerability of women, especially older women. Therefore, the plight of older women can be portrayed by vulnerabilities arising from the following three social trends:

- “Sexism”: A woman, based on her sex (a biological construct) and her gender (a social construct), has unique health needs, especially sexual and reproductive needs, and due to the negative phenomenon of “sexism”, these needs are often not met.
- “Disempowerment”: Also resulting from the social construct of gender, a woman is socially disempowered, leading to inequality that places women at a severe disadvantage; this economic differential has led to the “feminization of poverty”.
- “Ageism”: As aged or elderly persons, both men and women are vulnerable to discrimination and exclusion, but the implications and burden on women are different and more serious than those for men.

Understanding the plight of older women

The “plight” of older women in the SEA Region is not well understood, as there is paucity of data and information. Health and ill-health are elusive concepts that are difficult to measure. The assessment of health status among the elderly is essentially limited to the use of mortality data since universally this is the only source available. Understandably this is inadequate and inappropriate for many conditions. Other sources of information on the health of populations come from various sources - respondents’ reports of signs and symptoms, diagnosed conditions, perceived health status or ability to perform specified...
activities. All of these, if available can be used to measure and understand the “plight” of older women.

While older men and women are afflicted by the same common chronic diseases, such as cardiovascular diseases, diabetes, musculoskeletal problems, incontinence; health care of older people has an important gender dimension. Rates and trends and types of diseases differ between men and women because of biological characteristics and socially determined roles. There are gender variations in perceptions of health and ill-health, health expectations and the ideas of appropriate behaviour. For example several studies have shown that elderly men are more likely than elderly women to say that they cannot cook a meal on their own. Even allowing for this and other potential biases, and in spite of the paucity of information, it is clear that the prevalence of health impairments and disabilities in later life is higher among women than among men. Household surveys to compute activities of daily living (ADL) show higher rates of disabilities among women in all elderly age groups. The reasons for these gender differentials are not fully understood. Biological differences can explain for some conditions such as osteoporosis. Selective survival is another possible explanation; as more men die at younger age, those who do survive to old age may have particularly favourable characteristics. In terms of health-seeking behaviour, more older women than older men seek health care – but older women’s “female” concerns are often trivialized.

"Men aren’t like women, women go in normally once a year and have blood tests and mammogram and off we go, but men don’t like doctors and that is understandable" (Older woman, Australia).

To address the wide-ranging needs resulting from the interaction between sex, gender and ageing, the health sector needs to see these in a linked manner, and this can be achieved by integrating and mainstreaming these at policy, programme and service delivery levels. Before the subject of integration and mainstreaming is discussed, it is pertinent to examine some basic concepts in the domains of women’s health (especially reproductive health), gender, and ageing.

**Women’s health: sexual and reproductive health and gender**

While women’s health has a broad scope, and women also suffer conditions that men suffer from, discussion will limit itself to sexual and reproductive health. The definitions of reproductive health and sexual health adopted by the International Conference on Population and Development in 1994 are useful. Inherent in these definitions is the centrality of rights, and the recognition that the attainment of health and sexual and reproductive health is a human right. This perspective underscores the importance of gender. The movement from the sex focus to the gender focus, which is essentially moving from the biological to the social aspects, means that the rights perspective has become even broader in scope and also more complex. The social disadvantages faced by women occur throughout the lifecourse, and persist into old age, and indeed the plight of the elderly woman is the result of these accumulated disadvantages.

**Ageing and women**

The definition, concept and perception of “old age” varies among cultures and countries; while this applies to both men and women, it is more true for women. Cultural influences also define when one becomes “old”, especially women. The “fear” of ageing is more obvious in women than in men, and the reasons are mostly socio-cultural. Active ageing is defined as the process of optimizing opportunities for health, participation and security in order to enhance the quality of life as people age. The word “active” has positive connotations that
not only view healthy and productive lives in older years, but also for older people to continue to participate in society, and be respected as a resource for society. This definition also recognizes the life-course perspective, and that interventions must be available at every stage of life, not only after old age sets in. These basic concepts have particular relevance to women. Even more relevant is the fact that the two cross-cutting determinants of ageing are gender and culture, as shown in the figure above. These two cross-cutting determinants are themselves interrelated – in many cultures, girls and women are accorded a lower status. But in these same societies, old age is respected and venerated. Thus age has an influence on woman’s status in society.

**Putting them together**

To achieve integration it is useful to review the implications of ageing and gender on the overall health of women including sexual and reproductive health.

- There are diseases that are common to men and women when they age, as well disabling conditions (immobility, instability, incontinence, intellectual impairment), so women need to be given the same attention as men.
- There are conditions that are specific to women in older age, especially menopause, but also breast cancer and cancers of the reproductive system including cervical cancer.
- The sexual and reproductive health needs of older women can be perceived from several aspects – menopause, fertility control (it is a misconception that family planning needs cease for all older women), sexual difficulties.
- Some lifestyle-related diseases that are pertinent to both men and women, have specific impact on women - such as obesity and hazards of tobacco (women may not smoke but can be exposed to the hazards of...
passive smoking) and these can arise during or have residues in older age.

- Policies in the non-health sectors have impact on both men and women, but the impact on women and on older women, may be different—social and health services, housing, education, transport, employment, pension schemes, tax policies.

- The double burden that women have to bear by being the sufferers of the conditions of old age, and at the same time, they are often the custodians of health of others including of other older persons; this is a socially determined gender-based tradition.

- Women are often being targeted for and are more vulnerable to promotion and advertising related to “anti-ageing” modalities and products; cosmetic products and cosmetic surgery are the most promoted.

- Abuse and violence against older women can occur at any stage of their lives including in old age; indeed elderly abuse is a social ill that affects both men and women.

### Need for response – integration and mainstreaming

Many Member States of WHO-SEAR have begun to respond to the ageing of the population, and some may have taken into account the gender differential, but obviously this is not yet sufficient. WHO has recommended Member States to adopt specific strategies—policy formulation, advocacy, programme development, information, training and research. In developing programmes and services, it has emerged that one major weakness is the failure to integrate or mainstream ageing into women’s health, and vice versa.

Integration and mainstreaming is essential to address the wide-ranging needs of these different situations, at policy, programme and service delivery levels. Integration increases efficiency by reducing duplication and overheads, and by bringing multiple services in a single visit; it also brings about a more client-centred approach to health care.

Integration of these will also reduce the current problem of lack of information. The information systems in the SRH and gender domain focus on women of reproductive age group, with relative neglect on the needs of older women; and likewise there is lack of information of the sexual and reproductive health (SRH) needs of older people, both men and women, in programmes on ageing. Hence there is very little knowledge on the “plight” of older women, which is needed to formulate evidence-based policies, programmes and services.

It is therefore the duty of the health policy-maker and service provider to ensure integration or mainstreaming of these three domains of women’s health, gender and ageing. Any two of these three domains can be integrated with or mainstreamed into the third one. It is generally true that in almost all countries, gender has been or at least has begun to be, integrated with women’s health and SRH. Thus, it is prudent that these two domains be mainstreamed into programmes and services related to ageing; or vice versa.
wherein the programmes and services for ageing are integrated or mainstreamed into the programmes and services for women’s health and gender. The end result will be the same with either approach.

With gender and culture as the two cross-cutting determinants of active ageing, there is no other way of effectively providing care to older people except using an integrated approach. What do integration and mainstreaming imply?

**Opportunities and challenges in integration and mainstreaming**

The opportunities for integrating women’s health/SRH, gender and ageing are many, including:

- As mentioned earlier, integration has been strongly advocated in reproductive health, and gender issues have become well integrated in RH; therefore extending this approach to other areas such as ageing is not embarking on the unfamiliar.
- The disenchantment of several programme managers with what used to be the trend in the past, that of an un-integrated, vertical, stand-alone approach.
- This current high level of interest and advocacy is also from governments and donors, with international conferences providing strong platforms such as the International Conference on Population and Development (ICPD 1994) for women and gender; and the First and Second World Assemblies on Ageing in 2000 and 2002 respectively for ageing. While these conferences specifically call for strengthening of the relevant area of concern (sexual and reproductive health and rights, gender; and ageing), they all, either explicitly or implicitly, call for integration.
- Following this, there are now several models and good practices for integration and mainstreaming, such as the experience in some countries in linking maternal and reproductive health services with HIV/STI services; and as mentioned earlier, gender mainstreaming has made a strong foothold in several health programmes.

Notwithstanding these opportunities there are challenges for integration and some of these are:

- Negative perceptions on ageing and SRH - one unfortunate negative trend is “ageism”, the mistaken perception that the elderly are a “problem” or a “tolerated burden”; which leads to the views of dependency and paternalism, and even to social discrimination and abuse. Similarly, SRH is viewed negatively because several components especially sexuality is a sensitive issue.
- Perceived difficulties for integration – there is often a fear surrounding integration because of inherent organizational difficulties, which can be ameliorated by “starting small” such as improving linkages and referrals. Integration does indeed call for changes to the system, but establishing a structure for service integration can facilitate, but does not guarantee implementation of services, especially due to complexity of service packages for both ageing and SRH; the existence of established vertical programmes, and weak administrative capacity in some countries. Changes are needed in referral system, medical support for an expanded service, updated guidelines, integration of records, delegation of activities, competence of personnel, supervision and evaluation.
Donor interests: Women’s health especially, sexual and reproductive health, depends on donor support in many low-resource countries. Effective donor collaboration greatly facilitates integration efforts. Different donor priorities may result in an unbalanced perception and evaluation of integrated services. Donors and recipients need to address issues of resource sharing, assuming joint responsibility for successes and failures, and balancing local priorities with agency interests.

National programme constituencies: Programmes are most likely to succeed if they include a wide range of constituencies, such as policymakers, women’s advocacy groups, grass-roots organizations, service providers and client representatives.

The organization of government ministries/agencies: Personnel, resources, and policies are organized separately, which makes integration challenging.

Conclusion

Population ageing is a worldwide phenomenon. For developing countries such as those in the SEA Region, the challenge is huge because their health and welfare systems are generally not ready to meet the needs of an ageing population, unlike the developed countries. One of the challenges is to ensure that older women, who face the triple jeopardy of being a woman, an older person, and often a socially disadvantaged person, are provided with services to alleviate their plight. To address these adequately and coherently, the health sector has to ensure that information is made available to understand the plight of older women, and to design an appropriate response based on this understanding. An appropriate response is to integrate or mainstream the services related to women’s health, gender and ageing with one another.

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The choice of “ageing and health” for this year’s World Health Day theme is timely. Major achievements in public health in the last century benefitted older people, many of whom live longer and healthier lives. However, for older people as for other age groups, progress in health has been deeply unequal. In developing countries, health priorities reflect those prioritised by the Millennium Development Goals, with the focus on communicable diseases, primary health care for children and mothers, and reproductive health. Despite demographic and epidemiological transitions clearly placing the greatest burden of disease in developing countries on noncommunicable conditions most associated with older age, addressing older people’s health needs has low (or no) priority in health policies and programmes.

Poor health is an aspect of poverty. Poor health is also impoverishing, as the greatest out-of-pocket expenses for health are in households with older people and dependent children. While biological and genetic factors play roles in declining physical and mental capacity, older people’s health status is also influenced by the access to social security, adequate housing, food, water, freedom from violence and abuse, education and work. In many developing countries chronic ill-health and premature mortality are concentrated among the older poor.

Challenge of noncommunicable diseases

Ageing brings with it an increased risk of developing chronic disease and disability. Noncommunicable diseases (NCDs) are already the single largest cause of both mortality and morbidity in most developing countries. Those over 60 years accounted for 75% of the 35 million deaths from NCDs worldwide in 2004, with the majority occurring in developing countries. Noncommunicable diseases are often thought of as “diseases of affluence” but the opposite is often the case, since risks are often greatest in poor and deprived communities, worsened by exposure to lifetime health hazards. Large numbers of older people suffering from chronic illness such as heart disease, stroke and diabetes are living in developing countries. For example, two thirds of the 177 million people with type-2 diabetes are estimated to live in the developing world. Type 2 diabetes prevalence increases significantly with age, and the greatest increase in prevalence is expected to occur in Asia and Africa, where most patients will probably be found by 2030. The increase in incidence of diabetes in developing countries seems to be following trends such as urbanization and lifestyle changes, perhaps most importantly “Western-style” diets (not confined to more affluent groups).
The rapid increase of the oldest-old populations and the feminization of ageing will mean even greater risks of long-term physical and mental frailty especially among women. For women in developing countries who survive to middle age, life expectancy approaches that of women in the developed world\(^6\). At age 65, women in developing countries now have about three quarters of the remaining life expectancy of their counterparts in the developed world. They are at risk of “multiple jeopardy” where social disadvantages (such as widowhood and reduced family support) combine to worsen age-related conditions. Older women are prominent among the two thirds of sufferers from Alzheimer’s disease and other dementias who are already living in developing countries, numbers that are growing rapidly\(^7\).

**Disability and ageing**

Chronic diseases are now the main cause not only of death but also disability in most developing countries, and prevalence levels of old age disability are also growing. Disability is strongly associated with ageing, especially in poor countries. Poverty and exposure to harsh, hazardous living conditions over the life-course contribute to disability in old age. A study of older Cambodians, for example, identifies the social disruption due to conflict, low levels of development and poor environmental and living conditions as key factors in raised levels of disability compared to elsewhere in Asia\(^8\).

Certain disabilities are predominantly concentrated in older populations. For example blindness and visual impairment rise exponentially with ageing. Over 80% of all people who are visually impaired are aged 50 and older (although they represent only 19% of the world’s population) and the great majority (over 80%) live in the developing world\(^9\). Again there are significant gender differences in disability; women are more likely than men to live longer with disability.

**Barriers to accessing health services for older people**

Older people face many obstacles to obtaining health care. Mobility is frequently cited as a critical problem, because of the remoteness of health facilities and the cost of reaching them. Physical environments are not age-friendly in many countries, while attitudinal problems also limit older people’s access. The training of health professionals continues to neglect ageing, and older people consistently experience discrimination and abuse when accessing health services. The awareness of older people themselves regarding both their own health status and their entitlements is also low in many instances. Health promotion among older people is neglected in favour of other age groups. Financial barriers are another key limitation for older people. In many countries out-of-pocket expenses account for the overwhelming proportion of health expenditure. Moreover, health costs are often greatest in the last years of life, a time where older people are unlikely to be able to work to make a living.

**HIV and AIDS**

In many countries older people play a key role as care-givers to their children living with HIV and AIDS as well as orphaned grandchildren. There is also growing evidence that HIV infection rates among older people are becoming significant. However, this and the consequent need to support older people’s health status are poorly reflected in policy or practice responses to HIV and AIDS, and in monitoring of goals to reduce the incidence of the disease.

**Access to health care in crises**

Older people are particularly vulnerable in humanitarian disasters and political emergencies, and their health needs are likely to be disproportionately greater than those of
other age groups. There is evidence of higher mortality and morbidity of older people both during and after emergencies. However, their physical and mental health, particularly relating to chronic illness, are more often than not a low priority (or not addressed at all) in humanitarian responses\textsuperscript{10}. Climate change is also impacting on older people, but as yet this has not been well explored\textsuperscript{11}.

**Potential for response — the role of nongovernmental organizations**

Despite these considerable barriers to access to age-friendly health care for older people in many developing countries opportunities exist and are being taken. It is here that nongovernmental organizations (NGOs) have a significant role to play. The following examples emphasize that good practice with significant impacts on older people also have the potential to improve health outcomes across the whole life-course.

**Awareness-raising and training of health professionals on older people’s health**

Change in the knowledge, attitudes and practices of health professionals is critical for improving access to quality health services for older people. This involves challenging entrenched views and creating a more positive image of ageing and health. In Mozambique until recently there were no health staff with expertise in older people’s health issues; the focus of health policy is on reducing infant and maternal mortality and malaria and HIV\textsuperscript{12}. A recent training initiative recognized that while the numbers choosing geriatric medicine will remain low, this can be mitigated if all newly trained staff were familiar with age-care principles. Older peoples’ health issues were thus incorporated into the mid-level staff curriculum, adding a module on older peoples’ health in nursing training. Similar programmes have been developed elsewhere, with the focus on lower level professionals and/or volunteers. In China, a programme is working on developing village doctors’ understanding of the health needs of older people\textsuperscript{13}. In Cambodia, primary health care training on the medical needs of older people is being provided by Provincial Health Department staff to village health volunteers and staff at local health centres\textsuperscript{14}.

**Primary prevention and older people**

In recent years WHO has put increasing priority on primary prevention programmes where awareness, health education and promotion are emphasized. However these programmes rarely include older people, a serious omission, since their inclusion has major potential to impact on a wide range of NCDs. This could also have a significant intergenerational impact. For example, successful anti-smoking campaigns would have major benefits on the health both of older men and young women, two groups identified to be especially at high risk for lung cancer in Asia\textsuperscript{15}. Appropriate information together with help in self-management could greatly reduce the need for health services by older people. In India and Pakistan, education programmes have been implemented to help older people in wider communities to protect their sight by providing education on eye health care and personal hygiene\textsuperscript{16}. Programmes such as these have major benefits for older people’s health, and it is important that NGOs advocate for their inclusion.

**Community outreach and self-health care**

Primary health-care services with basic screening and management of chronic diseases, as well as ensuring that viable referral systems are in place, are a further set of interventions that would have a significant beneficial effect for older people as well as other age groups. Nongovernmental organizations can play a role, both to provide
such services to supplement existing facilities, and to advocate for better access to public services for older people.

**Outreach for older people at community level – mobile medical units**

One key challenge for many older people is that age-related mobility reduction combined with the lack of transport makes access to health services difficult or impossible. Mobile medical units have therefore been used in a number of contexts to provide a basic “first line” service for older people at community level.

HelpAge India and HelpAge Sri Lanka use mobile units to reach older people in communities who would not otherwise get access to health services. The units provide screening and basic treatment, as well as referring older people to other health facilities. Chronic conditions are identified and treated on a regular basis since the units operate a scheduled timetable of visits. Services include screening and management of chronic conditions such as heart disease and diabetes, provision of eyeglasses, and referrals (for example for cataract operations). The HelpAge India programme has developed a range of social as well as health services using the mobile units.

Programmes with similar objectives but different approaches run elsewhere. In rural Cambodia, health camps run by Older Peoples’ Associations provide regular health check-ups, make referrals and provide health education; a similar programme is run by a community NGO with retired tea plantation workers in Sri Lanka. These programmes typically reveal a significant number of undetected conditions. However, such programmes are only viable where referral to a secondary service is possible.

**Improved basic health care coverage and access for older people**

In many low- and middle-income countries it is crucial to improve access to basic-level health-care services for all age groups, not just older people. However, the specific health status of older people requires that coverage and access are not merely “equal” but also “equitable” (that is, health services adjust to the particular requirements of older patients, as those of people with disabilities or mothers and children).

**WHO’s guidance on “age-friendly” primary health care**

One approach to this is WHO’s “age-friendly” primary health care. For WHO it is critical that health-care workers “are well versed in the diagnosis and management of the so called “four giants” of geriatrics (memory loss, urinary incontinence, depression and falls/immobility) as well as the chronic diseases that are common in later life and that can often be prevented or delayed.”

In most health systems preventative health care and early disease screening takes place in primary health care (PHC) centres, which thus play a critical role in the health of older people worldwide at the local level, and WHO has developed guidelines for the application of “age-friendly” PHC. These address PHC management through adapting procedures to the needs of older persons, supporting a continuum of care between the primary, secondary and tertiary care levels, and ensuring participation of older people in decisions on PHC organization. They also cover basic training and information in age, gender and culturally-sensitive practices, as well as adaptation of the physical environment.
These guidelines provide a practical and adaptable approach. They are “age-friendly” in applying across the life-course, recognizing that what is good for older people also benefits other age groups. However they have not yet achieved wide recognition or application. This is unfortunate, since in cases they have been piloted with success. A PHC centre in Khon Kaen, Thailand, trialled a programme building from awareness of the “age-friendly” concept, through behaviour change and environmental adaptation to service and outreach development. The pilot noted that despite barriers due to priority shifts in the PHC management, with the support of skilled gerontological nursing professionals effective services were established19.

Entitlement to universal access to basic health care for older people

A key role for NGOs working to support older people’s health care is to advocate for as wide as possible access to health services. In some countries policies of free care for older patients exist on paper but not always in practice. For example Tanzania’s Ministry of Health and Social Welfare revised its cost-sharing policy to ensure that free services at government facilities were an entitlement for those over 60. However older people may still have to pay at hospitals, so the HelpAge programme, with national age-care organizations, held meetings with Ministry of Health officials and district councils, NGOs and older people’s organizations. This interaction increased the confidence of two councils to deliver health entitlements to older people and children. Training programmes involving district-level health officials, local councils and older people strengthened the understanding of health policy and application, leading to a marked increase of older people attending health facilities and improved services from staff.

Similar projects focus on empowering older people to campaign for their right to access affordable health care. Older people have been trained to monitor health services provision, to influence government policies and planning20. They have also been supported to overcome administrative barriers to accessing free health care by helping them to obtain identity cards21. In Ghana support provided to increase the number of older people registered with the National Hospital Insurance Scheme led to reports of improved health due to an increased use of health facilities22. In Bolivia and Viet Nam, HelpAge support older people to access their social health insurance benefits23.

Coping with the rise of NCDs and disability

As noted above, the prevalence of NCDs is rising rapidly in developing countries, where they are contributing the majority of the additional burden of disease. Although global health policy is beginning to respond, the single most important risk factor for chronic illness, population ageing, remains neglected24. The rise of NCDs is also linked with increasing levels of disability at older ages, which both lowers individual quality of life and strains health services. In many developing countries older people may suffer from a double burden of co-morbidities due to NCDs and infectious disease25. Older people and their families face severe financial and emotional stress when dealing with chronic conditions and disability. Typically, individual and household expenditures by and for older people can range between one quarter and one half of income, rising dramatically in health crises. Costs are not just borne by individuals but by economies. In India, the estimated economic loss in national income in 2005 from heart disease, stroke, stroke and diabetes was US$ 9 billion, increasing to US$ 54 billion in 201526.
Managing NCDs for older people

Both governments and NGOs can contribute to alleviating the NCD burden for older people, as examples from Indonesia and Kyrgyzstan illustrate. Indonesia’s PHC system has been developed through the establishment of primary health centres down to the subdistrict and village level. To promote age-friendly primary health care doctor and nurse teams are assigned to provide services including home visits to older people. Targets have been established for designated age-friendly primary health centres in each district, rising to 600 by 2014. Adaptation of MCH clinics to include a monthly clinic targeted at older people and establishment of geriatric clinics in district hospitals are also being developed27.

In Kyrgyzstan following the radical decline of the public sector after the collapse of the Soviet Union and the consequent independence of the country, there was an urgent need to address the situation of chronic illness such as diabetes, not only from a health care delivery perspective, but also in raising awareness especially among at-risk groups. A project led by the Diabetes Association of Kyrgyzstan, with support from NGO partners, aims to improve knowledge, awareness and skills among health professionals and at-risk groups, particularly older people. The project makes use of existing networks of older people’s self-help groups to distribute information, to their own members, relatives and the wider community. Group members act as supporters to at-risk older persons, and meetings are opportunities to disseminate information and offer peer support. The groups also play a key role in connecting at-risk older people and those with diabetes to health services. The groups monitor access on a regular basis to build a picture of the availability of services to older patients. Here older volunteers are the means to address a key NCD where health services are thinly spread. Nevertheless there are services, and links with them are critical to supplement the activities of the support groups.

Supporting older people’s concerns on health—NGOs’ role

Much remains to be done, and NGOs can play important roles as partners to governments and international organizations in a number of ways. The lesson to be learnt from the cases mentioned in this paper is that emphasis on extending and ensuring access to existing programmes, rather than creating new and parallel systems, can achieve positive outcomes. At the global policy level it is important to support the World Health Organization to promote and implement the “age-friendly primary health care” programme as an integral element of national health programmes. At national level there is potential for both policy development and implementation. The examples listed here of mainstreaming older people into health service access demonstrate the importance of integrating ageing issues into wider national health policies and actions.

At practice level there is an urgent need to replicate the training and professional development programmes outlined here. In the coming years health professionals at all levels will see significant transitions in the health priorities they will need to address with population ageing.

Better access to health services for older people through the removal of user fees needs to be seen as part of the impetus for universal access to primary health care. WHO’s Global Health Report emphasises moving towards universal coverage. “A commitment to universal coverage means...that all people within a country should receive some degree of financial protection from the costs of at least some basic health services”28. This in turn calls for well-designed health financing schemes relevant to the needs of vulnerable groups such as older people. Nongovernmental organizations can assist governments to deliver these commitments, particularly through supporting awareness-raising among both
health service professionals and older people themselves.

Finally, ensuring involvement of older people is critical. We have noted the role that older people’s groups can play in strengthening the accountability of health providers to service users. Ensuring that the voices of older people are heard in the development of age-friendly health services remains the key challenge for NGOs.

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Promoting ageing and health – the Sri Lankan experience

Ministries of social services and health*

Introduction

Sri Lanka is a country with rapidly ageing population as a result of increase in life expectancy and decrease in birth rates. The unprecedented demographic transition taking place in Sri Lanka will result in the old and young representing an equal share of the population. The proportion of elderly people in Sri Lanka is expected to double between 2001 to 2031 from 9.2% to 20.7% whereas the proportion of children (below 15 years) is projected to drop from 26.3% to 16.1%1.

The feminization of ageing, especially at very old age, is a phenomenon that is consistent in the country. Greater female longevity depicts the gender rate being in favour of women as compared with men. Declining fertility and mortality rates have caused the aged to dependency ratio to increase. The aged to dependency ratio is expected to rise from 14.3% (2001) to 32.8% and 51.2% in the years 2031 and 2051 respectively.1

The successive governments of Sri Lanka have accorded high priority to health, education and social services sectors. Substantial budgetary allocations were made to these three sectors to ensure healthy living conditions of people in the country. At present Sri Lanka holds the unique position in South Asia as being one of the developing countries to provide universal health and education. As a result of welfare-oriented policies implemented by successive governments, Sri Lanka has been able to attain a relatively high standard in the areas of health, education and coverage of basic social services.

To face the challenges posed by rapidly ageing population, the Ministry of Social Services has taken several measures including enactment of legislations to protect the rights of elders, establishment of a separate secretariat for elders and implementing numerous programmes to enhance the living condition of elders in the country.

Legislative provisions

The enactment of Protection of the Rights of Elders Act Number 9 of 2000 is a breakthrough in the history of services for elders in Sri Lanka. The Act has made provisions for the establishment of a National Council for Elders, a National Secretariat for Elders, a National Fund for Elders and a Maintenance Board for Elders. Until the enactment of the Elders Act Number 9 of 2000, there was no specific legislation to provide for the general, social and financial security of older persons.2 This piece of consensual legislation, which established the National Council for Elders, provided for the first time in Sri Lanka the legal foundation for the development of a national policy.3 In 2011, amendments were made to the existing Act and the Protection of Rights of Elders (Amendment) Act was enacted that provided more rights to the elders.

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Establishment of National Council of Elders

The Council consists of 15 members representing the ministries of social services, health and finance, as well as elders and voluntary organizations that are engaged in providing services for elders and professionals. Other than the three ex-officio members all other members are appointed by His Excellency, the President. The principal function of the Council is promotion and protection of the welfare and the rights of elders in Sri Lanka, and to assist elders to live with self-respect, independence and dignity. Some of the other functions of the Council are to take all such measures as are necessary in consultation with the relevant ministries, provincial authorities, district and divisional secretariats, NGOs and private sector organizations to promote and protect the welfare and rights of elders. The Council meets monthly and discusses the issues related to elders and takes remedial measures to overcome them.

National Secretariat for Elders

The National Secretariat for Elders functions under the Ministry of Social Services and is the implementing arm of the National Council. The National Secretariat assists the Council in the discharge of its functions. It is headed by a director and is assisted by 100 Elders Rights Promotion Assistants who are attached to divisional secretariats. The Secretariat implements the programmes directly and when necessary allocates funds to provincial authorities and divisional secretariats for this purpose.

National fund

A national fund for the welfare of elders shall be established. It will constitute money allocated by the treasury and donations, bequests and grants from any source whatsoever, whether in Sri Lanka or abroad.

Maintenance Board

A Board has been established for determination of claims for maintenance made by elders. An elder who has a child or children and who is unable to maintain himself/herself may apply to the Board for an order that one or more of his children pay him a monthly allowance or a lump sum for his maintenance. Establishment of the Maintenance Board is a legal recognition of the existing Sri Lankan socioeconomic norms of caring for parents. The law provides for the first time in Sri Lanka a legal mechanism for neglected parents to receive maintenance from their children.

Provision for the protection of rights of elders

The following provisions have been made for the protection of rights of elders:

“Children shall not neglect their parents willfully and it shall be the duty and responsibility of children to provide care for, and to look into the needs of their parents.”

“The State shall provide appropriate residential facilities to destitute elders who are without children or abandoned by children”.

“No person shall on account of age, subject any elder, to any liability, restriction or condition with regard to access to or use of any building or place or institution…….”

“No person shall on account of age, deny any elder, the use or enjoyment of any facility, benefit, advantage or service ……..”

National Policy and National Charter

The National Charter and National Policy on elders were adopted by the Cabinet in 2006. The following strategies were grouped in terms of the three priority areas decided at the Second World Assembly on Ageing.
The priority areas are as follows:

1. Elders and development
2. Advancing health and well-being; and
3. Ensuring, enabling and supportive environment.

The following (17) are the strategies:

(1) Mainstream ageing into development policy and promote full integration and participation of senior citizens.
(2) Create awareness of ageing population and positive attitudes towards ageing and senior citizens.
(3) Provide access to appropriate education and training.
(4) Provide social welfare and protection.
(5) Insure income security and promote suitable employment.
(6) Ensure gender-specific issues in ageing.
(7) Ensure provision of services for persons in special circumstances.
(8) Ensure health and well-being in old age through healthy nutrition and recreation.
(9) Counselling services.
(10) Promote appropriate housing, transportation and living environment.
(11) Strengthen the family unit to take care of parents and other senior citizens.
(12) Provide legal protection.
(13) Ensure consumer protection.
(14) Encourage community participation.
(15) Cater to cultural and spiritual needs.
(16) Conduct research and disseminate information.
(17) Develop an implementation and follow-up mechanism.

National Plan of Action on Ageing (2012-2021)

The National Secretariat in collaboration with WHO formulated the National Plan of Ageing in 2010. The plan was developed in line with the priority areas and strategies of the National Policy. Activities, timeframe and responsible partners were identified in line with the priority areas and strategies. The plan is expected to be submitted to the Department of National Planning for allocation of funds for its implementation.

Establishment of Elders’ Committee at village, divisional and district levels

Let us empower the elders to protect their rights and promote welfare!

This is the primary idea of establishing elders’ committees. The National Secretariat commenced this programme in 2003 and has achieved remarkable progress. In order to organize elders all over the island, committees have been established at different administrative levels, including provincial, district, division and Grama Niladari levels. The village-level elders’ committees were established with the aim of protecting the rights of elders, promoting welfare, participation in decision-making and enhancing social, economic, cultural and spiritual development of elders. In order to expand and make the services more fruitful, elders’ committees were set up at divisional level combining all village-level committees. District committees are set up by combining all divisional committees while provincial committees are set up by combining all district committees. A national-level committee is also expected to be set up.
as well. Guidelines have been issued by the Secretariat for the smooth functioning of these committees. The Secretariat continues to provide support to such committees by conducting progress review meetings and awareness-raising programmes. To strengthen the financial capability of committees the Secretariat grants Sri Lankan Rupees (Rs) 5000 to each registered village-level committee, Rs 7500 to a divisional committee and Rs 15000 to a district committee. The Cabinet of Ministers has granted approval to award direct contracts for construction work to village-level elders' committees with the aim of improving their financial situation. Some committees have been able to generate more funds and have provided scholarships to needy schoolchildren, as well as housing and self-employment grants to needy elders. The elders’ committees organize pilgrimages and cultural and religious programmes for the psycho-social development of elders.

Raising awareness

Awareness programmes are conducted all over the island to educate the elders and general public. The Legal Aid Foundation in collaboration with National Secretariat has conducted a number of programmes island-wide, for the legal empowerment of elders. Photography and poster exhibitions and essay competitions on older persons have been conducted to raise awareness among the general public including schoolchildren. Older persons with outstanding qualities were conferred with awards. Leaflets and handbooks on elders are issued at mobile workshops. Print and electronic media programmes are also conducted to raise awareness among the general public on challenges of population ageing. The handbook on elders printed in Sinhala, Tamil and English languages carries articles on positive aspects on ageing, prevention of diseases, leading a healthy and active life, and information on obtaining various services, etc.

The magazine “Wedihitiyo” contains articles written by intellectuals and elders.

“Counselling for elders” is another valuable publication issued in 2009. The book contains articles on counselling and it enhances the skills of care-givers and provides knowledge for elders. The publication on “Healthy Ageing” contains articles in three languages and is useful for elders to lead a healthy life.

Day centres

A day centre is a place for elders to get away from loneliness and isolation. It is cost-effective as compared with a home for the aged and it helps elders maintain their family ties. Some elders are confined to their own homes and lead an isolated and lonely life during the day time. Day centres enhance opportunities for elders to actively participate in many activities. They provide recreational, educational, spiritual and cultural programmes. Elders can engage in productive activities during the day time with their peers and exchange views and have discussions on various subjects. A day centre can be set up in a common building. The Elders’ Secretariat provides financial assistance of Rs 25 000 to each centre for purchase of required goods such as chairs, kitchen utensils and cupboards, etc. In addition, Rs 10 000 are granted to start self-employment ventures.

Pre-retirement seminars for a healthy and active life

For whom: Employees of the public sector who are close to retirement

The objectives of these seminars are to prepare the public sector officers for an active, productive and healthy life after retirement, and to educate them to plan and prepare for old age. The national secretariat conducts two day seminars at national, provincial and district levels. The Ministry of Health also
conducted pre-retirement seminars to promote a healthy and active life following retirement. The speakers include medical officers, psychologists, sociologists and other intellectuals. This has immensely benefitted the public officers who are close to retirement.

Counselling

A counselling division has been established in the Ministry of Social Services and 100 counsellors have been attached to divisional secretariats. A 24-hour online counselling service is available for those who need counselling. Establishment of counselling centres, increasing the attendance of clients by conducting awareness programmes for public sector officers, teachers, community leaders, and training active listeners, are some of the programmes conducted. A counselling section has been established at the National Secretariat where counselling sessions are held every Monday for elders.

‘Wedihity Awarana’ (sponsorship) scheme

Elders over 70 years of age and who do not have any income are entitled to receive financial assistance under this programme. This programme is implemented with contributions from well-wishers. Those who are willing to contribute can select elders from the list maintained by the secretariat and credit the money to the account of the National Secretariat for elders. The minimum contribution is Rs 3000 per year.

Home-care service

In Sri Lanka there is a great demand for care-givers to look after the frail elders. The Secretariat initiated the care-givers programme with the aim of meeting this growing need. Suitable persons to be trained as care-givers are selected by the divisional secretaries. Three-week training programmes are conducted in collaboration with the Ministry of Health. The service of trained care-givers can be obtained by contacting the Secretariat. A 24-hour hotline is available to obtain the service. Identifying the importance of trained and skilled care-givers at the community level, the Ministry of Health has commenced another training programme for care-givers selected through medical officers. The home-care service enables the frail elders to continue living as long as possible in their own homes with their family members. Home-care helps elders to maintain an optimum level of physical, mental and emotional well-being.

Standards for homes for the aged

In Sri Lanka there are three types of homes run by the State, voluntary organizations, religious bodies and private parties. The provincial authorities run three homes and divisional administration runs 25 cottage homes. About 200 homes are managed by voluntary organizations, religious bodies and private parties.

The Secretariat provides financial assistance to upgrade the homes for the aged run by provincial councils and religious bodies. Requests are made through the divisional secretaries and financial allocations are made after investigations.

The National Secretariat published Standards for Homes for the aged in 2004 with the aim of enhancing the quality of services provided to elders. This was distributed to all homes for the aged expecting them to provide a humane and secure service and to create elderly-friendly environment where residential elders are able to lead a life filled with physical and mental comfort.

Identity card for elders

Special identity cards for elders are issued by the Secretariat to enable them get preferential treatment when obtaining public services. The identity card ensures various benefits for elders in obtaining public services from hospitals,
post offices, banks and other public institutions, 5% discount when purchasing medicine from the outlets of the State Pharmaceutical Corporation, and higher interest rates for fixed deposits in certain banks. Separate counters have been arranged for elders by the Ministry of Health in major hospitals. The provisions of the Rights of Elders (Amended) Act No.5 of 2011 also apply to the private sector as well.

**Home gardening in homes for the aged**

Financial assistance is provided to start home gardens in homes for the aged. Capable elders are encouraged to grow vegetables required for consumption in homes.

**Dignified citizens — economic and social development**

This programme was started in collaboration with several ministries. The experience, knowledge and skills of elders were utilized for the following national development programmes:

- Promoting home gardening in line with the national agriculture development programme
- Green country—protection of environment
- Development of indigenous medicine
- Promoting rural industries.

**Issue of eye lenses and assistive devices**

Eye lenses and assistive devices such as hearing aids, wheelchairs, tricycles and crutches are provided free of charge for the needy elders. Eye lenses are issued on the required date enabling elders to get surgeries done on time. The provincial social service departments provide assistive devices.

**Registration of homes for the aged**

Every person or organization, whether voluntary or otherwise, engaged in the establishment and maintenance of any institution providing residential care for elders shall, if such institution has more than five elders residing therein, register such institution in accordance with the provisions of the relevant Act. Under this Act any person or organization that fails to comply with this requirement shall be guilty of offence. Organizations and individuals who are running such homes should apply for registration to the National Secretariat along with required documents.

**Commemoration of International Day for Elders**

The International Day of Elders is being observed on 1 October every year since 1991. This day is celebrated by raising awareness about issues affecting elders. It is also a day to appreciate the contributions that older persons make to the society. It is an event celebrated in many places around the country not only by public sector organizations but also by Ngoos and elders’ committees. Programmes are organized to raise awareness among the general public including children and media personnel in order to create a conducive environment for elders to lead a dignified, active and healthy life.

**Age-friendly cities**

The Parliament of Sri Lanka has passed regulations to make public buildings, public places and public services accessible to persons with disabilities. The National Secretariat for Persons with Disabilities has taken all measures to make this a reality by conducting training and awareness programmes to personnel including construction engineers and technical officers. An inter-ministerial committee has been
appointed to discuss the progress periodically. Currently the certificate of conformity for newly-constructed buildings is not issued unless the regulations are followed. This situation has immensely benefitted the elderly people who have mobility problems. At present, new buildings and roads are constructed in keeping with these regulations.

**Mobile programmes**

Mobile programmes are conducted island-wide with the aim of reaching the people in rural areas. Photographs for elders’ identity cards are taken free of charge and identity cards are issued the same day. Awareness-raising programmes regarding challenges of population ageing, rights of elders and obligations of people towards the betterment of older people are conducted through mobile services involving discussions, lectures and distribution of leaflets and other printed materials among general public. Spectacles for reading purposes are also issued to elders at these mobile programmes.

**Pension scheme**

A pension scheme is in operation under the Social Security Board. A donation was made by the Lotteries Board as the capital and at present 100 elders above 70 years, who do not have any income at all and who do not have anybody to look after them are being benefitted through this scheme in the form of a lifelong monthly pension of Rs 500.

**Social security for elders**

In Sri Lanka a number of social security schemes are in place for different categories of people to support them in their old age. Farmers’ pension and social security benefit scheme, Fishermen’s pension and social security benefit scheme and self-employed persons, pension and social security benefit scheme are voluntary and contributory pension schemes targeted for the people in the unorganized sector. The self-employed persons pension scheme commenced in 1996 under the Ministry of Social Services. The main objective was to provide social security for the workers in the informal sector in their old age. Since 2010 this scheme is managed by the Ministry of Finance.

**Public assistance monthly scheme**

The public assistance monthly scheme (PAMA) is the oldest financial assistance scheme managed by provincial social service departments in Sri Lanka catering to the ultra poor people. The majority of recipients of this scheme are older persons without any income. The monthly payments range from Sri Lankan Rs 250 – Rs 500 depending on the number of family members. It has been proposed to increase this amount from Rs 500 - Rs 1000 for elders who are over 70 years of age.

**Training of medical personnel on medicine for the elderly**

In order to deliver quality health services to elders, it is essential to equip the system with qualified medical personnel specializing in elderly care. The Postgraduate Institute of Medicine (PGIM) in collaboration with the Ministry of Health has taken steps to start postgraduate programmes on medicine for the elderly. Elderly care has been included in the undergraduate medical curriculum and basic training programmes for public health personnel are being provided to enhance the quality of health services. A short training course on medicine for the elderly was organized through the PGIM with support from WHO in 2011.
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(9) Protection of rights of Elders (Amendment) Act, No.5 of 2011 Section (5 b)
(11) Protection of Rights of Elders Act, No, 5 of 2011

Further readings

Impact of dementia and Alzheimer’s disease on the community

Vijay Chandra*

Normal ageing of the brain

The growth cycle is well known to all of us: when a baby is born, it is completely dependent on the mother; next, the child learns to recognize family members and express its need, then goes to school and university and, finally, grows up to be a healthy adult. Health remains stable for many years, till the onset of decline in bodily functions. The ageing process occurs in every living species, so also in human beings: graying of hair, wrinkling of the skin, and hardening of arteries, aches and pains in joints, weakening of eyesight. The aged often complain that their memory power has decreased over the past few years. While they recall events of the past, they tend to forget more recent events. Remembering names and finding the “right word” seem to be a problem but, as they have discovered, the words do come back later when they stop trying too hard. It is well known that learning gets harder as one grows older. These are the features of advancing years, which are to be expected, but are of no consequence, as they do not interfere with daily life. This basically implies that minor forgetfulness, such as forgetting where one has kept the keys, is of no consequence. Sometimes people get very concerned about minor forgetfulness that is completely normal in old age, and confuse it with Alzheimer’s disease (AD).

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This growth cycle of development from birth to teenage to adulthood and the gradual decline with age is depicted in the following graph:

In some people, increasing age is accompanied by a loss of intellectual capability so marked that it becomes a disease. This very rapid decline is shown in the above graph as Alzheimer’s disease.

Between the inevitable consequences of ageing and Alzheimer’s disease is the “grey area” (shaded grey in the diagram on page 56) in which some people suffer loss of intellectual functions that is more than mild and yet not severe enough to be considered Alzheimer’s disease. Scientists are unsure of the terminology vis-à-vis these patients. Many terms are in use, for example, minimal cognitive impairment or benign senescence of old age. This is an area of intense research to determine whether these cases will eventually progress to Alzheimer’s disease and, if so, who will progress and why, or which of these cases remain in the “grey area”.
Dementia vs Alzheimer’s disease

There is widespread misunderstanding that dementia and AD are the same. Many people use the terms interchangeably. But truly speaking, dementia is the end result of damage to the brain resulting in loss of intellectual function. There are many different causes of dementia, only one of which is AD.

Dementia

Dementia is a decline of intellectual function (medically called decline of cognition). Intellectual function has many components (memory, geographical orientation, problem solving, giving advice, calculations, etc). The most important component of intellectual function is memory, so people complain of “memory loss”. Thus, if a person is affected by dementia, he/she has deficits in many components of intellectual function. Each of these components can be checked separately by doctors or psychologists.

There are many causes of decline in intellectual function, i.e. many conditions can lead to dementia in a person, for example, iodine deficiency, brain tuberculosis, head trauma, multiple strokes, Alzheimer’s disease, and several other causes. Some of the causes of dementia can be prevented (iodine deficiency) or optimally treated (brain tuberculosis).

Alzheimer’s disease

Alzheimer’s disease is the commonest cause of dementia world-wide except in some communities where causes are endemic e.g. iodine deficiency disorders. The relative proportion of AD as the cause of dementia varies from 60 to 80% in different communities. The loss of intellectual function gradually progresses in AD, leading to increasing levels of disability to the point the person becomes bedridden and incapable of any meaningful function.

What happens to the brain in AD?

The brain shrinks in size. This shrinkage can be seen by doing a computerized tomography (CT) or magnetic resonance imaging (MRI) scan of the brain. But shrinkage of the brain is not diagnostic of AD. Many normal people, particularly the elderly have shrunken brains on CT/MRI but function completely normally. Thus the CT/MRI findings have to be clinically correlated.

Some abnormal proteins accumulate in the brain (e.g. beta amyloid, tau). But it has still not been established if the accumulation of these proteins “cause” AD. Moreover removing these proteins through chelating agents does not improve the person’s condition.

How is AD diagnosed?

The person should be evaluated by an experienced doctor who is familiar with memory disorders. The doctor should take a detailed history from family about the onset, progression and current condition in terms of intellectual function. Specific examples of patient’s deficits should be obtained.

The second step is “interacting” with the patient. This should be conducted in a calm
environment that is not stressful to the patient; the intention should be to obtain an objective status of the patient. It is inappropriate to subject the patient to a school examination-like situation.

The next step is to conduct select psychometric tests that have been validated to the culture of the patient, for example, it is inappropriate to ask an illiterate person to spell words backwards. Deficits in psychometric tests cannot be used as the only basis of diagnosis of AD. The findings must be correlated with the patient condition.

The next step is to conduct some blood tests, an electroencephalogram (EEG) and then radiological tests (CT/MRI) of the brain. With the availability of modern diagnostic tools, a study of the brain fluid (cerebrospinal fluid) through removing some of this fluid by a lumbar puncture is usually not needed unless some infection is being considered. There is almost no need for a brain biopsy, except in very specific conditions.

The final diagnosis is made by combining all the above information. Lastly, when in doubt, doctors will examine the patient periodically every three to four months. If the patient has AD, his/her condition will deteriorate over time.

**Pseudodementia (depression)**

Depression (an exaggerated form of sadness) often presents as “memory loss”. This is because the person suffering from depression is unable to concentrate on what is going on in the environment and thus is not able to register the circumstances. When the person tries to recall what had been said or happened there is no “memory”. This is incorrectly considered “dementia”. Truly this should be called “pseudodementia”, that is a false dementia and an inappropriate conclusion of dementia.

Another common cause that presents as “pseudodementia” is anxiety. With increasing awareness about AD and dementia, people begin to test themselves repeatedly to see if their memory is intact. This repeated testing of oneself leads to tremendous anxiety if there are any errors. This is what happens in an examination setting among children.

Anxiety and depression are two of the common causes of “pseudodementia” in a community setting, particularly among older people.

**Are all communities equally affected?**

In the last decade of the twentieth century, there was a belief that AD does not occur in developing countries. Researchers thus set out to conduct scientifically appropriate cross-national studies comparing select developing countries with developed countries. Studies comparing a community in India with a community in the United States of America, a community in Nigeria with a community in the United States and comparing the Japanese population with people of Japanese origin leaving in Hawaii were conducted. These studies conclusively found that AD did occur both in India and Nigeria and also in Japan but the risk of getting AD in these three countries was much lower than in Hawaii or mainland United States.

After rigorous investigations, it was found that these differences were indeed valid. The investigators from India developed a hypothesis that perhaps a gene-environment interaction is the cause of AD. This theory is based on the observation that although the genetic pool of the population under study both in India and the United States was similar, the difference in risk could be due to the lower cholesterol level in the Indian population. High cholesterol, the main risk factor for cerebrovascular disease has also been implicated as a risk factor for AD. Thus the investigators hypothesized that the lower cholesterol in the Indian, Nigerian and Japanese population reduced the risk of AD.
Another interesting hypothesis is the use of spices in certain countries. These condiments have “anti-oxidant” properties. There are numerous reports on the benefits of garlic and turmeric.

An interesting observation about lower risk in select countries is the fact that the risk of getting AD can change among migrants within two generations of migration. The basis of this change, despite maintaining the same genetic pool, could be the increasing level of cholesterol that frequently happens as migrants adopt the food habits of people living in developed countries, where the food consumed is high in cholesterol.

What are the risk factors for AD?

There is great fear among family members of patient with AD, particularly the children. The question most commonly asked is “What is my risk of getting AD?” It should be noted that only about 2% cases of AD are directly inherited from parents, that is if one of the parents has AD, children are likely to get it. This mode of inheritance is called autosomal dominant.

Another genetic contribution to the risk of AD is the genetic pool (apolipoprotein E4) combined with a high cholesterol level. The apolipoprotein gene is transmitted in the family but the cholesterol level is mediated by the diet of a person. This combination is called gene-environment interaction as discussed above.

There are certain “external” risk factors that traditionally cause strokes such as high cholesterol, cigarette smoking, diabetes, high blood pressure, sedentary lifestyle and obesity, etc. However, it is now believed that the same risk factors can cause AD independent of strokes.

Current treatment and care

It should be noted that currently there is no complete cure for AD, although a substantial amount of research is in progress.

There are certain medications that can enhance the intellectual functioning of the brain. These medications (choline esterase inhibitors) neutralise a brain chemical that is believed to be one of the factors implicated in the cause of AD. However, these medications are beneficial only in limited number of cases and have a marginal degree of benefit. They also have some side-effects. Thus the current recommendation is to try this medication for about three months. If they are beneficial they could be continued, if not they should be discontinued.

There are certain distressing symptoms such as restlessness, talking constantly, use of foul language, sexual misconduct, and not sleeping at night, etc. These symptoms can easily be controlled by giving small doses of psychotropic medication. It should be noted that sedatives are relatively contraindicated in patients with AD as they cause severe drowsiness.

Caring for a patient with AD imposes a huge burden on the family, particularly in a nuclear family. The burden of caring invariably falls on the lady of the house. Care of the care-giver is a very important issue and every effort must be made to ensure that the care-giver gets sufficient rest and time to relax and to get away from the duty of caring. A practical solution is to have a trained care-giver at home. Training programmes for such domestic helpers need to be developed. Another solution is to divide the care-giving activity among all the family members.

Old age homes, as exist in western countries, have a very limited role in our part of the world. Most elderly people expect to stay at home and to be cared for by their children. Moreover even if old age homes were to be built, it will be very expensive to keep a person there. Moreover, there is limited
love and compassion in old age homes, which only a family can provide. The role of old age homes should therefore be limited to people who have no family members or for the elderly who are abused.

What you can do to protect yourself from Alzheimer’s disease

The most important thing to do is to lead a completely normal and healthy life. If one lives in fear of getting AD, one cannot enjoy the present and at the same time cannot prevent the future. The fact that there is no cure for AD should not make a person depressed or anxious. Worrying about the future affects the “mind”, which then affects the brain and the body.

Traditional practices such as yoga and meditation have been practised for centuries. These practices are good for the body and mind and are strongly encouraged. There is increasing scientific evidence of their benefits.

Control of risk factors such as cholesterol, blood sugar, blood pressure and obesity is highly desirable. Not only will this reduce the risk of AD but also reduce the risk of strokes, heart attack and numerous other diseases.

Lastly, maintaining a healthy lifestyle from the early years in life will contribute to a healthy old age, free of disease. A healthy lifestyle consists of nutritious diet, rich in fruits and vegetables; plenty of exercise appropriate for age; management of stress; good sleeping habits; and to gainfully engage with friends and family.

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Nursing and health care of the elderly

Ubolratana Popattanachai*

Abstract

Nurses play a critical role in providing health care for all age groups and in all varieties of health delivery systems. Their role assumes greater importance in certain settings (viz. rural areas where patient:physician ratio is very low) and for special categories of patients including the elderly whose care warrants specialized skills. Accordingly a need for enhancing the competency of nurses to augment their efficiency in patient care was felt. This study was undertaken for developing a cultural competence model and integrating it into the Nurse Practitioner (Primary Medical Care) Curriculum of Boromarajonani College of Nursing, Surat Thani, Thailand. The study was conducted in four steps: (i) analysing the data and identifying the problems; (ii) designing the Cultural Competence Model to be integrated into the Nurse Practitioner (Primary Medical Care) Curriculum; (iii) using the first and second drafts of the model as the lessons for training classes 7 and 8 of nurse practitioners in the Nurse Practitioner (Primary Medical Care) Curriculum; and (iv) monitoring the performance of nurse practitioners who had received such training in care of the elderly in the local social context.

The representative samples for this study included the 177 nurse practitioners (NPs) who received training in the Nurse Practitioner (Primary Medical Care) Curriculum at Boromarajonani College of Nursing, Surat Thani, 172 colleagues of those NPs, and 110 patients of those NPs. Data were collected by asking the sample population to fill in the questionnaires particularly prepared for this study, as well as by conducting interviews with them. Standard deviation was used to analyse the quantitative data collected through the questionnaires while the t-test was used to analyse the qualitative data collected through interviews with 12 NPs.

The result of this study revealed that NPs receiving training in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model became aware of their working capacity being significantly higher than that of those undergoing regular training without this model, especially with regard to preventive, promotive and curative health care of the elderly patients. Patients served by the trained NPs recognized the improvements in quality of service as indicated by the high average points of NPs’ performance. It was also found that those NPs achieved greater self-awareness, became aware of individual differences, and acknowledged individuality. In addition, they gained better understanding of elderly patients and their families’ decision-making on health, and could communicate health issues to people. Those NPs’ attitude towards working and how to work in communities improved substantially. The approach and results from this study can be used as a guideline for other countries in the WHO South-East Asia Region, but would need to be adjusted to suit individual cultures towards improving the quality of care especially for elderly members of the community.

Key words: 1. The Cultural Competence Model

2. The Nurse Practitioner (Primary Medical Care) Curriculum

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Health refers to the dynamics of physical, mental, social and spiritual well-being. In other words, it is the well-balanced combination of all those components. This combination results from the association of physical, mental, intellectual and social factors. Health-care workers have to be able to maintain people’s physical, mental and social health as well as recognize the relationship between ailments and various risk factors. Health care of the elderly is now recognized as a special area that demands exact skills and knowledge for effective delivery of health services. To be capable of doing that, not only are nurses required to have the basic knowledge about human biology, psychology and social sciences, they also need to treat patients with skill, generosity and attention. In the meantime, health-care workers have to be sensitive to patients’ feelings, considering their work as an opportunity to learn new things and motivate themselves to achieve the perfection and potential of humanity (Prawase, 2004). It is necessary for health-care workers to realize that community health-care services, in fact, are an integration of medical and social services—contributing to the concrete development of community health system including improved care of the elderly people (Pagaiya and Garner, 2005).

Currently, no doctors are affiliated with community health centres or primary health-care centres in Thailand. The development of nursing care workers’ potential and ability is, thus, held to be one of the keys to achieve the goal of providing quality health service; and to improve community dwellers’ health including care of the elderly. In the recent past, the country’s health-care education system usually focused on academic content and professional capacity or solely on the physical and mental dimensions, not including the social and spiritual ones that are of immense importance and value for elderly patients. As a result, it was not organized on the basis of the realities of life and society, and did not fully meet the requirements of contemporary care of the elderly.

It is also necessary to adjust the current health-care education to make health-care students gain a better understanding of human beings, as well as of what is going on in the society. Students would be required to promote people’s awareness of taking good care of one’s own health throughout life to ensure a healthy ageing process. Recognizing professional nurses as the vital mechanism of operating primary health-care units, the Boromarajonani College of Nursing, Surat Thani planned the Nurse Practitioner (Primary Medical Care) Curriculum to train professional nurses at primary health-care units to have professional knowledge and ability as well as a good attitude towards providing primary health care for patients. Following the educational reform of all institutes affiliated with the Boromarajonani College of Nursing, the Nurse Practitioner (NP) Curriculum and teaching methods were integrated into the prevailing social contexts. This led to the change of nurse practitioners’ attitude towards people’s health and ailments especially of elderly patients; nurses do not presuppose what patients did, and do not blame patients’ doings (Wongkhongkhathep, 2007).

The Boromarajonani College of Nursing, Surat Thani, revised the curriculum under the educational reform programme to train its NPs (primary medical care) to perform their duties with an even better understanding of what contributes to health behaviour of individuals, and, in the meantime, to develop people’s potential to independently take care of their own health.

Objective

The study aimed at developing the Cultural Competence Model to be integrated into the Nurse Practitioner (Primary Medical care) Curriculum.

Methodology

The population and representative samples of this study included:
Two hundred professional nurses from the Public Health Regions 15 and 17 who were trained in the Nurse Practitioner (Primary Medical care) Curriculum at the Boromarajonani College of Nursing from 2006 to 2007. Those nurses were divided into two groups including 100 nurses trained in the regular curriculum and another 100 nurses trained in the curriculum integrated into the Cultural Competence Model that included focus on care of elderly members of the community. In the context of Thailand, a professional nurse is a person who has graduated in nursing from a university and has passed a professional examination such as for doctors and engineers. Their duties are in the nature of general services or basic nursing care.

Two hundred professionals from the Public Health Regions 15 and 17. The ratio of colleagues to professional nurses stood at 1:1 (real population is used as a sample for this study). A practitioner nurse has the same qualification as a professional nurse and gets specific training for treating and diagnosing simple ailments. They are able to take certain decisions to manage patients or refer them to a doctor. This is one of the ways to solve the problem of insufficient doctors (physicians) in Thailand.

Two hundred patients of professional nurses from Public Health Regions 15 and 17. The ratio of patients to professional nurses stood at 1:1 (real population was used as the sample for this study).

The study was conducted in five steps:

Step 1: Collecting data from textbooks, documents, related studies, and individuals affected by nurse practitioners’ performance as well as analysing problems from such data.

Step 2: Designing the first draft of the Cultural Competence Model to be integrated into the Nurse Practitioner (Primary Medical Care) Curriculum with emphasis on proper care of the elderly.

Step 3: Using the first and second drafts of the Cultural Competence Model integrated into the Nurse Practitioner (Primary Medical Care) Curriculum to train the nurse practitioners of Class 7.

Step 4: Using the second draft of the Cultural Competence Model integrated into the Nurse Practitioner (Primary Medical Care) to train the nurse practitioners of Class 8.

Step 5: Assessing the work performance of NPs who were trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated with the Cultural Competence Model within a period of 6-12 months after the training in the social context of communities, especially the elderly members.

- Comparing the capacity of NPs trained in the curriculum integrated into the Cultural Competence Model as well as those trained in the regular curriculum.
- Presenting the Revised Cultural Competence Model integrated into the Nurse Practitioner (Primary Medical Care) Curriculum to all concerned.

Tools for data collection

The tools for data collection included:

1. Appraisal forms (comprising 20 items) for evaluating the cultural competence activities in three different areas;
(2) Questionnaires (comprising 37 questions) for evaluating the capacity of NPs working in primary health care units in four different areas;

(3) Interviewing forms (comprising 25 questions) for assessing patients’ awareness of NPs’ health-care services; and

(4) Lecture notes taken by professional nurses trained in the Nurse Practitioner (Primary Medical Care) Curriculum.

Data analysis
The analysis comprised the following steps:

(1) Using percentages to distribute the representative samples’ individual data.

(2) Using the t-test to make comparison of the scores of the NPs’ capacity on the basis of the awareness of NPs who were trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model and their colleagues.

(3) Using ATLAS.ti to analyse the qualitative data acquired by means of the in-depth interviews with nurse practitioners as well as their colleagues and patients.

Results/observations
The following results were obtained:

- The general information about the representative samples has been shown in the table below.

<table>
<thead>
<tr>
<th></th>
<th>Nurse practitioners trained in the regular Nurse Practitioner (Primary Medical Care) Curriculum</th>
<th>Nurse practitioners trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model</th>
<th>Colleagues of nurse practitioners trained in the regular Nurse Practitioners (Primary Medical Care) Curriculum</th>
<th>Colleagues of nurse practitioners trained in the Nurse Practitioners (Primary Medical Care) Curriculum integrated into the Cultural Competence Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>87</td>
<td>90</td>
<td>85</td>
<td>87</td>
</tr>
<tr>
<td>Gender (Females)</td>
<td>100% Adamant</td>
<td>100% Adamant</td>
<td>40% Adamant</td>
<td>37.97% Adamant</td>
</tr>
<tr>
<td>Average age (years)</td>
<td>40.07 Barton</td>
<td>36.18 Barton</td>
<td>35.80 Barton</td>
<td>40.48 Barton</td>
</tr>
<tr>
<td>Married</td>
<td>67.6% Europe</td>
<td>61.11% Europe</td>
<td>17.65% Europe</td>
<td>24.14 Europe</td>
</tr>
<tr>
<td>Bachelor of Science</td>
<td>88.5% uniune</td>
<td>95.56% uniune</td>
<td>88.24% uniune</td>
<td>96.55 uniune</td>
</tr>
<tr>
<td>Working at community health centre</td>
<td>77.01% nova</td>
<td>70% nova</td>
<td>75.29% nova</td>
<td>71.26% nova</td>
</tr>
<tr>
<td>Average years working as nurse</td>
<td>18.33 💏</td>
<td>14.28 💏</td>
<td>10.2 💏</td>
<td>7.5 💏</td>
</tr>
<tr>
<td>Average years working as nurse practitioners</td>
<td>6.65 💏</td>
<td>5.82 💏</td>
<td>3.0 💏</td>
<td>2.5 💏</td>
</tr>
<tr>
<td>Income per month in Thai Bahts</td>
<td>23 179 💏</td>
<td>19 752 💏</td>
<td>20 742 💏</td>
<td>20 793 💏</td>
</tr>
</tbody>
</table>
The patients included 110 individuals of whom 79.1% were females. Their ages ranged from 41 to 60 years with an average of 49.95 years. Many of these (38.2%) were agriculturists. Only 59.1% had had primary education while two third of these were being supported by government health insurance schemes. Of these, 29.9% had symptoms of respiratory infections. The average time for which they availed of the services was 3.51 months.

The difference in becoming aware of one’s own capacity in respect of NPs trained in the Regular Nurse Practitioner (Primary Medical Care) Curriculum and those trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model stood at 0.05.

Colleagues of NPs are aware that the working capacity of NPs trained in the Regular Nurse Practitioner (Primary medical Care) Curriculum and those trained in the curriculum integrated into the Cultural Competence Model in general and four specific areas including care of the elderly is significantly different. Such difference stood at 0.05.

Patients’ awareness of the services provided by NPs trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model was found to be high on average, especially awareness on NPs’ recognition of patients’ dignity, which got the highest score.

The results of implementing the Cultural Competence Model:

The Cultural Competence Model was implemented through diverse activities like viewing photographs of interviewing community dwellers while studying the actual condition of communities. These activities were carried out to make the NPs trained in the Curriculum integrated into the Cultural Competence Model change their attitude towards people’s health and illnesses; better understanding of the health needs of the elderly; develop their self-study skill; and have a sound understanding of other people’s views, logic and deeds. The result of evaluating cultural competence activities through appraisal forms indicates that the attitude towards activities, instructors and students is quite positive. Most NPs trained in the curriculum integrated into the Cultural Competence Model, according to the data collected from their lecture notes, have changed their attitude remarkably towards patients in a variety of ways as follows:

1. Instead of persisting with their conventional knowledge and experience in living their lives and providing health care for patients—an attitude that prevents them from learning new things, the NPs performed their duties on the basis of actual scenarios, keeping focus on age and the social context of patients.
2. The NPs have a better understanding of patients’ individual characteristics; individual patients have different views, beliefs, educational background, and experience in living their life. This is especially true for elderly people.
3. The NPs’ ways of working have already been adjusted—as evidenced by their even more comprehensive methods of collecting patients’ data. In the meantime, patients’ data, which are diverse, have been integrated as well. To improve nurse practitioner-patient relations and gain patients’ confidence, the NPs have
developed their skills at interpersonal communication like more attentively listening to what patients say while providing services for them.

- The work experience of NPs trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model (n=12), as assessed through in-depth interviews, demonstrated several gains that can be summarized as below:
  - Better understanding that the definition of health varies according to individual contexts and age.
  - Improved recognition that the background of individual patients and their families as well as their necessity and capacity (as in elderly patients) of taking decisions on health care.
  - Acknowledgement of the fact that emphasizing health communication is far better than treatment with medicines.
  - Changing NPs’ attitude towards community health-care provision.
  - Having more opportunities for access to community dwellers.

Discussion

Based upon Herbert Blumer’s Symbolic Interactionism (Farganis, 1993), the researcher has developed the Cultural Competence Model and integrated it into the curriculum on nursing science. Blumer’s theory states that individuals are the social products that are perceived and responded to by people. Individuals vary according to an individual’s perception and self-development. As human beings want to interact with or respond to other people, they need to have a sound understanding of the meaning of other people’s acts and speeches, and then act in accordance with such meaning or what the people with whom they interact really do. It is critical for communities and health-care providers to understand the realistic needs of the elderly. To develop the Cultural Competence Model, the researcher used some activities on Symbolic Interactionism—which include viewing some photographs of interviewing patients to encourage the NPs to eliminate their misunderstanding about patients, interviewing patients to enable the NPs to communicate with patients without presupposition or prejudice, conducting an in-depth study on the data collected on the basis of recognizing patients’ personal background and circumstances, interpreting the data collected without any presuppositions, and incorporating the adjustment of views and attitude towards patients to each course of study. The findings of this study agree with the concept of studies on activities to promote the learning process (Oitip Tongdee, 1987 and Carter, 2003). Both studies concluded that if the trainees or learners are aware and accept the importance of intervention or motivating parameters, it will change their attitude and will finally lead to a change in service behaviour and pattern. Another study done recently from the same institute (Songsri Kittiraktrakul, 2011) supported the concept of humanized health-care services that uses the idea of providing services to family members. It was found that health-care personnel provide services to all patients and customers without expecting anything in return as they consider that customers are their family members. This is especially true for the elderly who need greater social and psychological support.

Comparison of the work performance of NPs trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model with that of NPs trained in the regular curriculum

According to the awareness of NPs and their colleagues, the work performance of NPs trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model is superior to that of NPs trained in the regular curriculum.
Medical Care) Curriculum integrated into the Cultural Competence Model was significantly different from that of NPs trained in the regular curriculum. The difference stood at 0.05. This is because the Cultural Competence Model includes the activities that are consistent with NPs' own experiences in serving patients, understanding elderly members' needs and meeting specific interventions. The NPs are given theoretical lessons and assigned to put the lessons into practice by their instructors or specialists. Their lessons are associated with what they have learned or experienced such as viewing the photographs of communities, interviewing patients or conducting in-depth case studies—which makes the students aware of their own mistakes or deficiencies in providing health care to people. The interaction between nurse practitioners and other people or patients contributes to higher efficiency (Dunn and Dunn, 1998). Also, the NPs trained in the Curriculum integrated into the Cultural Competence Model become aware of the individual differences of people. These NPs, as a result, can use self-control and improve the paradigms of their working.

Patients become aware that health-care services provided by NPs trained in the curriculum integrated into the Cultural Competence Model have reached the acceptable level, as indicated by the high average point. This is probably because the NPs, after receiving training in the curriculum integrated into the Cultural Competence Model, improve their performance to respond to patients’ demands for health care including those of the elderly. The study conducted by Thawikiat Bunyaphaisancharoen et al. (2005) revealed that the general public’s expectations of the quality of health-care services include the immediacy of services around the clock, home visits, and follow-up treatments. This finding is consistent with that of the study conducted by Uthaiwan Sukimamin (2005) stating that the work performance of nurses at primary health-care units meets patients’ demands. In addition, such a finding is consistent with that of the research conducted by Somchit Nucharoenkun et al. (2007), which revealed that NPs whose performance is outstanding are familiar with local people; they listen to patients' demands. In the meantime the local people feel confident about and have faith in NPs’ professional skills. Besides, the result of this research is consistent with that of another qualitative study, which revealed that NPs trained in such curriculum really recognize individual’s basic necessities, communicate with patients to gain a better understanding of their problems, and devote more time for patients (Thawikiat Buncharoenphaisan et al., 2005).

After receiving training in the Curriculum integrated into the Cultural Competence Model, the NPs remarkably changed their views on servicing patients. The NPs perform their duty upon the basis of information that they gather; they do not persist with their conventional knowledge and experience in living their lives and providing health care for patients, which prevents them from learning new things. This reflects the NPs' self-awareness and a sound understanding of people.

The differences in individual people’s views, beliefs, knowledge and experience in living their lives contribute to differences in individual people’s health-care behaviour. This indicates that NPs accept patients’ individuality and special needs of the elderly. This is in conformity with the study of Bundura (1978) using the Modelling Process for changing the behaviour of people. The basic belief is that personal behaviour is developed through inter-relationship and involvement with other persons. In general, there are three basic components in the development of personal behaviour; one own’s personality, perception and other person’s behaviour, which affect their thinking and perception. By perceiving and noticing other person’s behaviour, we can introduce new and positive behaviour and get rid of negative behaviour.

The NPs have changed their ways of working—as evidenced by their even more
comprehensive methods of collecting patients’ data. Also, they have integrated patients’ data, which are diverse. To improve nurse practitioner-patient relations and gain patients’ confidence, the NPs have developed their skills at interpersonal communication like listening more attentively to what patients say while providing services for them. It is thus believed that NPs trained in the curriculum integrated into the Cultural Competence Model will be able to have a profound understanding of patients’ feelings, and work on health care in close collaboration with all groups of community dwellers, including the elderly, who have unique needs.

All the aforementioned changes are consistent with the result of Suni Wongkhongkhathep (2007)’s study on the Evaluation of the Integrated Teaching Methods for Teaching Nursing Students, which revealed that learning in real situations results in students gaining a sound understanding of people’s feelings, logic and acts; the nursing students listen more attentively to and have good relations with other people. Moreover, the changes are also consistent with the qualitative data collected from the nurse practitioners trained in the curriculum integrated into the Cultural Competence Model, revealing that the nurse practitioners’ better understanding of communities including elderly patients results from their training; the nurses’ perspective of patients has become wider, more profound, and more comprehensive so the actual problems can be discovered especially in special category of patients viz. the elderly. If a nurse practitioner, for example, takes a patient’s blood pressure and high blood pressure is detected, it is the NP’s responsibility to enquire about its likely causes such as stressful family background, unhealthy lifestyle and eating habits, and any other degenerative disorder, etc. before referring the patient to the doctor.

After receiving training in the curriculum integrated into the Cultural Competence Model, the nurse practitioners acknowledge that they better understand the meaning of health in patients’ individual contexts, patients’ social background, and patients and their family’s decision-making on health care. Furthermore, the NPs focus on communicating health matters rather than administering drugs to patients. They also change their attitude towards working in communities and gain an even more profound understanding of community dwellers. The result of this study indicates that the data on the work experience of nurse practitioners trained in the curriculum integrated into the Cultural Competence Model reflects a better quality of providing health-care services for patients, as well as a profound understanding of patients and their social contexts.

Good health in the ordinary sense refers to happiness or being happy, a state of being in which a person can work in or live his/her life normally. Poor health, on the other hand, refers to the physical illnesses that prevent people from working; as long as people can work, in a sense they are still in good health. This is not in line with the conventional definition that refers to physical and mental health or holistic health. There is hence a greater need to orient health practitioners to these terms through which they can relate better with communities especially in rural settings, as well as with those who are not part of the workforce because of their age.

In order to gain more profound and comprehensive insights into patients’ problems as well as to avoid making patients feel frustrated in following NPs’ knowledge and belief-oriented instructions, the nurse practitioners searched for data on individual patient’s context that affect their own decision-making on health care.

To change their attitude towards working with communities, the nurse practitioners regard community dwellers’ involvement and self-reliance on health care as important. To have a better understanding of the elderly, the NPs focus on interaction with patients’ families or a group of people, not with a single patient.
This is a proactive way of providing nursing services to patients. Nurse practitioners are required to play a major role in understanding patients’ ailments and looking after people when they fall ill.

This study aims at developing the Cultural Competence Model for enhancing the nurse practitioners’ working capacity to provide health-care services to patients on the basis of realizing patients’ individual differences. However, according to the results of this study, it is easy for some nurse practitioners to change their attitudes towards patients, while quite often some NPs resume working in a conventional manner. It is quite important for those NPs to get some time to gradually adjust themselves to the new working practices. As a consequence of this, the individual nurse practitioners are to be evaluated in terms of “what they have learnt” as well as “how they are supposed to learn”. The NPs collaborated actively in receiving training on the curriculum integrated into the Cultural Competence Model. This helped in promoting good relations between instructors and students.

Conclusion

It will be appropriate if those who are planning to improve human resources for health can take cognizance of the improvements through this model and use it extensively to enhance nurse practitioners’ capacity to provide holistic health-care services for patients, especially the elderly members of the community. This will be the right way to narrow the gap as well as lessen the conflict between health-care workers and patients, and probably the ideal way to provide efficient preventive, promotive and curative health services for the elderly and ageing populations.

References and bibliography

Comment

Notes and news

Regional consultation on strengthening HRH management

The Regional Director, Dr Samlee Plianbangchang, addressed the Regional Consultation on Strengthening Management of Human Resources for Health in the SEA Region, held in Bali, Indonesia, on 13-16 February 2012. Her Excellency, Dr Endang Rahayu Sedyaningsih, Minister of Health, Government of the Republic of Indonesia was among the distinguished participants and special invitees at the consultation.

Welcoming all delegates, the Regional Director thanked the Government of Indonesia for agreeing to host this meeting. He recalled the meeting in Bali in 2006 to finalize the Regional Strategic Plan for Strengthening the Health Workforce in the SEA Region. This consultation “would review the progress in implementing that Strategic Plan and identify ways and means to face the current challenges more effectively in the management of human resources for health (HRH) in the Region”, he said. The health workforce is the most important component of a health system, and to function efficiently, adequate numbers of human resources with a good balance in their categories is fundamental, he said.

Stressing that issues relating to HRH in the SEA Region require urgent attention and are an area of high priority for WHO, the Regional Director reiterated WHO’s commitment to dealing with these issues in a coordinated manner, and recalled the Dhaka Declaration on Strengthening the Health Workforce at the Regional Health Ministers’ Meeting at their 24th session in 2006. “The health challenges of the past years necessitate significant changes in national health policies. Reorientation of HRH is indeed needed to effectively realize such policy changes in the most cost-efficient manner, Dr Samlee said in conclusion.

Fourth Regional Meeting on Implementation of IHR 2005

The Fourth Regional Meeting on Implementation of the International Health Regulations (2005) was held in Bangkok, Thailand, on 7-9 December 2011. The Regional Director, Dr Samlee Plianbangchang, addressed the inauguration of the meeting. The meeting was also attended by Dr Somsak, Deputy Director-General, Department of Disease Control.

Recalling that the International Health Regulations (2005) came into force in June 2007, the Regional Director said that a number of specific features of countries of the WHO South-East Asia Region affect the implementation of these regulations. These diversities include those in terms of demography, climate, culture and socioeconomic status, and also significantly determine the disease patterns in Member States. These determinants also necessitate different approaches in planning and delivery of health services.

Dr Samlee also elucidated that such an assessment will provide for an important basis
for planning the next steps to ensure such core capacities. While full compliance with the provisions in IHR cannot be achieved on the target date, a new implementation plan needs to be developed by each country. Sharing of best practices and other practical experiences through intercountry collaboration is important in promoting and supporting country core capacity strengthening. In order to ensure effective containment of the spread of disease outbreaks across international borders, it is critically important to work together with neighbours to harmonize disease control efforts at border areas.

The Regional Director also drew attention to the recent recommendations of the “IHR Pandemic Review Committee”, that re-emphasized the “critical importance” of international support to Member States in order to ensure that they have the requisite capacities for implementing IHR.

While encouraging information-sharing among countries, especially on best practices in improving collaboration, the Regional Director stressed that the implementation of this plan “certainly needs generous back-up from all partners”. “Enhanced capacity of countries to effectively implement IHR will benefit the international community in the containment of the spread of diseases across borders and in ensuring international health security,” he concluded.

### Scaling up the adolescent health programme

The Regional Director, Dr Samlee Plianbangchang, addressed the inaugural session of the Regional Meeting of Programme Managers on Scaling Up of Adolescent Health Programme held in Bangkok, Thailand, on 14 October 2011. Among the distinguished delegates were Ms Nobuko Horibe, Regional Director, United Nations Population Fund (UNFPA), Asia Pacific Regional Office, and Dr Nitas Raiyawa, Deputy Permanent Secretary, Ministry of Public Health, Thailand. He termed the meeting a key conference on various issues related to the scaling up of adolescent health programmes.

Adolescence is a period of rapid transition in life from “childhood” to “adulthood”. This phase of life is full of opportunities and, at the same time, risks and vulnerabilities. In the WHO South-East Asia Region there are about 350 million adolescents comprising 22% of the population. Adolescence is perceived to be a “healthy period” of life because “mortality” is relatively low in this age group. This is, however, deceptive since adolescents face many challenges and several of these relate to their health, the Regional Director explained. It is important to keep in mind that health problems during adolescence and younger age may extend or continue to the next period of life. Globally, every year, 2.6 million young people die and most of these deaths are preventable, with 97% of these deaths occurring mostly in Asia and Africa.

The Regional Director pointed out that in the SEA Region, important causes of maternal mortality are haemorrhage, sepsis and complications from abortion. These causes account for a higher proportion of deaths among young women, including adolescent girls. Among young men, injury-related deaths are a significant cause of mortality. These include traffic accidents, violence, fire-related incidents and drowning. Moreover, it is estimated that nearly two third of all premature deaths and one third of the total disease burden in adults is associated with conditions initiated during adolescence.

While the main focus of adolescent health programmes is on sexual and reproductive health, including prevention of HIV infection, efforts have been intensified to address other important areas such as nutrition, healthy lifestyles, mental health and mental well-being, as well as prevention of violence and injuries. It is necessary to build strong partnerships with stakeholders to advocate sound physical, mental and social well-being of adolescents. Adolescents must be appropriately equipped
with relevant knowledge and skills and be provided with an enabling environment to encourage them to “demand” health services without fear. This movement in adolescent health and development would help countries in their efforts to achieve the MDGs, the Regional Director concluded.

South-East Asia Advisory Committee on Health Research

The Regional Director, Dr Samlee Plianbangchang, addressed the 32nd Meeting of the South-East Asia Advisory Committee on Health Research (SEA-ACHR) in Bangkok, Thailand, on 11 October 2011. The meeting was attended by Prof. Charas Suwanwela, Chairman of the University Council of Chulalongkorn University, along with distinguished members of SEA-ACHR.

The Advisory Committee on Health Research for the WHO South-East Asia Region was established in 1976 to advise the Regional Director on matters relating to health research of WHO in the Region and especially on policies, strategies and specific priorities. The SEA-ACHR is a part of the “global network” of WHO Advisory Committees on Health Research. The agenda of the ACHR Meeting is framed on the basis of the current trends and needs in health research in the Region, the Regional Director informed. The meeting was scheduled to pay particular attention to follow-up actions on the subjects of: (i) Regional Strategy on Research for Health; (ii) Regional Policy on Research Aspects of Immunization; (iii) Research and Development in areas of Vaccines and Drugs; and (iv) Strengthening Country Capacity in Health Research.

“In view of the fact that today “health” has gone far beyond the “health sector”, health development needs the involvement of disciplines in sectors other than health," the Regional Director explained in his address. In order to achieve the social goal of health for all, the Regional Director said, all other sectors must work together for health collectively or individually. The overarching goal was to achieve the level of health that would permit all people to lead a socially and economically productive and satisfied life. “Health concern” and “health protection” must be explicitly reflected in development policies and programmes of all sectors. Research to support today’s health development is no exception.

The Regional Director urged participants to ensure efficient use of all potential resources for research for health, especially resources that are locally available in sectors other than health such as agriculture, environment and industry. Effectiveness of efforts at the development and management of health policies and programmes depend on the availability and use of research-based evidence and information.

In conclusion, Dr Samlee said that the WHO system of ACHR had “served well as an important platform for promoting coordination and networking among researchers and research institutes ... in order to have better opportunities of getting access to resources for research worldwide”.

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Publications corner

**Eastern Mediterranean Health Journal**
Vol. 18 No. 1
2012-02-27
Price: CHF 20/ USD 24
Developing Countries: CHF 14.00

The Eastern Mediterranean Health Journal was launched in 1995 as a peer-reviewed medical journal. Starting January 2010, the Journal has been given a new format and is now published monthly. The EMHJ serves as a forum for the dissemination of biomedical information through the publication of scientific research papers on a range of topics related to public health, with particular relevance to the Eastern Mediterranean Region.

**Safety Evaluation of Certain Contaminants in Food**
Seventy-second Meeting of the Joint FAO/WHO Expert Committee on Food Additives (JECFA)
WHO Food Additives Series, No. 63
Price: CHF 90 / US$ 108
Developing countries: CHF 63

The detailed monographs in this volume summarize the technical, analytical, dietary exposure and toxicological data on a number of contaminants in food: acrylamide, arsenic, deoxyxyluloneloren, furan, mercury and perchlorate.

This volume and others in the WHO Food Additives series contain information that is useful to those who produce and use food additives and veterinary drugs and those involved with controlling contaminants in food, government and food regulatory officers, industrial testing laboratories, toxicological laboratories and universities.

**Taking Sex and Gender into Account in Emerging Infectious Disease Programmes**
WHO Regional Office for the Western Pacific
Price: Developing countries: CHF 14.00

Traditionally, little attention has been paid to sex and gender differences in infectious diseases. The general belief has been that since infectious diseases affect both males and females, it is best to focus public health attention during an outbreak on control and treatment, and to leave it to others to address social problems that may exist in society, such as gender inequalities after an outbreak has ended.

**Patient Safety Assessment Manual**
WHO Regional Office for the Eastern Mediterranean
Price CHF 25.00/US$ 30.00
Developing countries: CHF 17.50

Unsafe health care remains a problem of immense magnitude worldwide. The development of solutions and initiatives aimed at driving change towards greater patient safety has become a pressing need. As part of one such initiative, the patient safety friendly hospital initiative, WHO developed a set of patient safety standards and tools, with the aim
of assessing the patient safety programmes in hospitals and instilling a culture of safety. This manual contains the patient safety standards and a set of patient-friendly hospital assessment tools.

Priorities in Operational Research to Improve Tuberculosis Care and Control
Order Number 19300241
Price CHF 30.00 / US$ 36.00; developing countries: CHF 21.00

In 2010, the Stop TB Partnership, the World Health Organization Stop TB Department and the Global Fund to Fight AIDS, Tuberculosis and Malaria jointly organized an expert meeting and workshop on operational research, followed by international consultations. It provides a clear road map of priorities in operational research to help countries improve implementation of TB control activities in critical areas. The priority operational research questions outlined in this report are also aligned with the Stop TB Partnership’s Global Plan to Stop TB 2011-2015.

Evaluating Household Water Treatment Options
Health-Based Targets and Microbiological Performance Specifications
Price CHF 30.00 / US$ 36.00; developing countries: CHF 21.00

Household water treatment (HWT) is increasingly being promoted as a rapidly implementable and cost-effective interim approach to improve water quality. It is a key preventive component of the WHO/UNICEF comprehensive strategy on diarrhoea control.

The document provides a range of technical recommendations, including: A step-by-step overview of how to evaluate HWT microbiological performance. Elaboration of health-based water quality targets ranging from interim to highly protective, including establishment of default targets for use in data-scarce settings. Description of technology-specific laboratory testing protocols and guiding principles. Considerations relating to developing national technology evaluation programs.
Guidelines for contributors

THE Regional Health Forum seeks to inform and to act as a platform for debate by health personnel including policy-makers, health administrators, health educators and health communicators.

Contributions on current events, issues, theories and activities in all aspects of health development are welcome. Contributions should be original and contain something of interest to those engaged in health policy and practice, some lesson to be learned, some idea, something that worked, something that didn’t work, in fact anything that needs to be communicated and discussed on a broader scale. Articles, essays, notes, news and views across the spectrum of health development will be published.

Every year, the April issue of the Forum is dedicated to the World Health Day theme of the year.

Papers for submission should be forwarded to the Editor, Regional Health Forum, World Health Organization, Regional Office for South-East Asia, World Health House, Indraprastha Estate, Mahatma Gandhi Road, New Delhi 110002, India (E-mail address: editor@searo.who.int).

Contributions should:
- be in English;
- be written in an anecdotal, informal, lively and readable style (so that sophisticated technologies, for example, may be easily understood);
- be in MS Word and sent on-line to editor@searo.who.int
- not normally exceed 3000 words with an abstract (approx. 250 words) and a maximum of 30 references.

Letters to the editor should normally be between 500-1000 words with a maximum of six references.

Responsibility of authors

Authors are responsible for:
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- obtaining permission from appropriate governmental authorities if the contribution pertains to a government programme/project and contains material/statistics/data derived from government sources;
- ensuring that all abbreviations (if used) are explained;

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• giving their full names, the name and address of their institutions, and an exact description of their posts;
• declaring sources of funding for the work undertaken, and
• disclosing at the time of submission, information on financial conflict of interest that may influence the manuscript. They may also choose to declare other interests that could influence the results of the study or the conclusions of the manuscript. Such information will be held in confidence while the paper is under review, and if the article is accepted for publication the editors will usually discuss with the authors the manner in which such information is to be communicated to the reader.

Tables and illustrations
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• All illustrations and tables should be numbered consecutively and should be lightly marked on the back with the figure number, and the author’s name indicated.
• Graphs and figures should be clearly drawn and all data identified.
• Photographs should be on glossy paper, preferably in black and white.
• Each table should be submitted on a separate sheet of paper.

References
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