Most individuals now reach old age, and the proportion of elderly persons in the Member States of the WHO’s South-East Asia Region will continue to increase over the years. This demographic shift to a large proportion of elderly persons will challenge the existing public health and social services in the Member States. The focus on ageing is not only to prolong life but also to improve the quality of life of elderly persons. Healthy ageing is a process of optimizing opportunities for physical, social and mental health to enable the elderly persons to take an active part in society without discrimination and to enjoy an independent and good life. This Regional Strategy for Healthy Ageing has been formulated to assist Member States to establish core interventions for promoting and strengthening healthy ageing with the overall goal to promote healthy ageing and care of the aged throughout the life-course.
Regional strategy for healthy ageing
(2013–2018)
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As we move through the twenty-first century, development and progress have brought improvements in the overall quality of life and health. With increasing life expectancy, people are living longer resulting in an ever-growing proportion of old people in the general population. This rapid population transition is occurring at a pace and magnitude that is well beyond the scope and capacities of most countries, particularly those in the developing part of the world. The challenges that a society that is ageing encounters are numerous and complex. The traditional norms and patterns of society are undergoing rapid changes, affecting the manner in which society had taken care of its older members. Longer life is associated with chronic diseases accompanied by long-term care and end-of-life care, factors that put increasing demands on the existing health and related social and economic-care services.

The World Health Organization has declared that the focus on ageing should not only be to prolong life but to improve the overall quality of life of older persons. Optimized opportunities for physical, social and mental health would enable older persons to take an active part in society without discrimination and enjoy an independent good life. This is what constitutes healthy ageing.
The World Health Organization’s Regional Office for South-East Asia has undertaken a series of activities to promote healthy ageing in Member States of the Region. The Regional Office has developed a Regional Strategy for Healthy Ageing, with the goal of promoting healthy ageing and care of the aged through the life-course. I am confident that Member States will find the strategic elements contained in this volume useful and relevant in responding to the needs of the ageing populations of our Region.

Dr Poonam Khetrapal Singh
Regional Director
Acknowledgements

The contributions of several experts to the development of the Regional Strategy for Healthy Ageing (2013–2018), are gratefully acknowledged. Special thanks are also conveyed to the following persons for reviewing the draft Regional Strategy for Healthy Ageing (2013–2018) and for providing valuable comments.

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<table>
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<tr>
<td>AFHCP</td>
<td>Age-friendly Health Care Programme, Timor-Leste</td>
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<tr>
<td>CBR</td>
<td>crude birth rate</td>
</tr>
<tr>
<td>CDR</td>
<td>crude death rate</td>
</tr>
<tr>
<td>LISAI</td>
<td>Livrinho Saude Amigavel ba Idosos, Timor-Leste</td>
</tr>
<tr>
<td>LTC</td>
<td>long-term care</td>
</tr>
<tr>
<td>MIPAA</td>
<td>Madrid International Plan of Action on Ageing</td>
</tr>
<tr>
<td>NPOP</td>
<td>National Policy on Older Persons, India</td>
</tr>
<tr>
<td>PEN</td>
<td>package of essential interventions, Bhutan</td>
</tr>
<tr>
<td>SEA</td>
<td>South-East Asia</td>
</tr>
<tr>
<td>UN-ESCAP</td>
<td>United Nations Economic and Social Commission for Asia and Pacific</td>
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</table>
Executive summary

Ageing is a lifelong and inevitable process. It is a progressive change in the physical, mental and social status of individuals, which begins right from the mother’s womb. The nourishment and care that the mother and her unborn baby receive determine how the newborn will fare in the world. Exposure to behavioural health risks such as smoking, alcohol consumption, poor diet, a sedentary lifestyle or to toxic substances at work also influences health outcomes in older age.

More people now survive the challenge of childbirth and childhood to reach old age. This trend is not restricted to the resource-rich countries, but has become a global phenomenon including countries of the World Health Organization (WHO) South-East Asia (SEA) Region. It has been estimated that nearly 142 million people or about 8% of the population of the South-East Asia Region are over 60 years. This number will continue to increase and by 2025, it is estimated that proportion of the population over 60 years will be twice that of 2000, and by 2050, it will have further increased to three times the proportion of 2000. There is, therefore, an urgent need to focus attention on the ageing population because of this increasing trend.

The focus on ageing is not only to prolong life, but also to improve the quality of life of older persons. Healthy ageing is a process of optimizing opportunities for physical, social and mental health to enable older persons to take an active part in society without discrimination, and to enjoy an independent and good life.

The WHO Regional Office for South-East Asia has undertaken a series of activities to promote healthy ageing in the Member States of the Region. A strategic framework for healthy ageing was introduced to Member States in 2009 followed by appropriate technical support to strengthen particular
areas of healthy ageing programmes and identify constraints. Close linkages were maintained with all concerned partner agencies.

The draft regional strategy for healthy ageing was disseminated to Member States and subsequently reviewed in depth in 2012 at a regional meeting of national managers of healthy ageing programmes with the additional participation of experts in geriatrics and gerontology.

The goal of the regional strategy for healthy ageing is to promote healthy ageing and care of the aged through the life-course.

The strategy is built on a number of guiding principles: rights of elderly persons; age-friendly primary health care as the cornerstone of active ageing; participation of elderly persons in society; adopting a multidisciplinary and multisectoral approach; gender and equity; and a life-course approach. There are several key policy directions: policy and strategy formulation; development of human resources for quality health care; raising the awareness of the population to active ageing; long-term care (LTC); mental health needs of elderly persons; and financing of the care of the elderly.

The strategy has a five-year timeframe (2013–2018) and identifies six strategic elements, each with an objective and several activities:

1. developing a country-driven, outcome-oriented integrated and multisectoral policy and plan of action for healthy ageing;
2. adapting the health systems to the challenges of the ageing population and to meet their health needs;
3. making provisions for LTC of the elderly population;
4. developing appropriate human resources necessary for meeting the health needs of older persons;
5. adopting a life-course approach to promote healthy ageing; and
6. using a multisectoral approach and partnerships.

A number of indicators have been identified for assessing progress in promoting healthy ageing in the countries of the Region, some of which are indicated below. While these indicators have been designed to measure progress in the implementation of the regional strategy, Member States are encouraged to formulate relevant processes and output indicators to measure progress in implementation in their respective countries. The common timeframe for achieving all indicators is between 2013 and 2018, which is the time-limit of the strategy.
Introduction

Ageing is a lifelong and inevitable process. It is a progressive change in the physical, mental and social status of individuals, which begins right from the mother’s womb and ends with death. This journey into the uncharted realms of old age is an adventure of continual learning, adjustment and, most important of all, mentoring what is good and admirable. The nourishment and care that the mother and her unborn baby receive determine how the newborn will fare in the world. Undernutrition in the womb may lead to disease in adult life, such as circulatory disease, diabetes and disorders of fat metabolism. Obese or overweight children and adolescents run the risk of developing chronic diseases like diabetes, circulatory disease, cancer and musculoskeletal disorders in adult life and old age.

An individual’s functional capacity continues to grow throughout childhood and adolescence, reaching its peak in early adulthood and declining naturally thereafter. The slope of this decline is determined by several external factors such as access to housing, adequate and safe water supply, nutrition and health care; employment opportunities; educational level; extent of integration of the elderly population into society and gender balance. Exposure to behavioural health risks such as smoking, alcohol consumption, poor diet, a sedentary lifestyle or exposure to toxic substances at work [during a person’s adult life] also influence health outcomes in older age.
Healthy ageing activities at the global level

In 1948, the United Nations (UN) General Assembly adopted and proclaimed the Universal Declaration of Human Rights. Article 25 of the Declaration addresses the right of individuals to a standard of living for health and wellbeing, and more importantly, to their security in old age. The same year, Argentina submitted a draft declaration of Old Age Rights to the UN General Assembly. In 1969, an item entitled “Question of the elderly and the aged” was put on the Assembly’s agenda at the request of Malta.

In 1970, the UN Secretary-General issued a preliminary report (UN Doc. A/8364) which pointed out that “the world is faced today with a paradoxical situation in which society is doing everything possible to increase the absolute and relative numbers of old people (through efforts to reduce death rates and birth rates respectively), but at the same time society is neglecting to utilize their vast potential and very often creating socio-economic conditions which place a handicap on their physical and psychological adjustment.”

The General Assembly of the United Nations through resolution 33/52 decided to convene a World Assembly on Ageing in 1982. The purpose of the World Assembly was to provide a forum “to launch an international action programme aimed at guaranteeing economic and social security to older persons, as well as opportunities to contribute to national development.” In its resolution 35/129, the General Assembly further indicated its desire that the World Assembly on Ageing “should result in societies responding more fully to the socio-economic implications of the ageing of populations, and to the specific needs of older persons”.
The first Assembly on Ageing was held in 1982 in Vienna, Austria. The ‘International Plan of Action on Ageing’ adopted by the Assembly was the first international instrument on ageing, and it helped in guiding the formulation of policies and programmes on ageing. It was endorsed by the UN General Assembly in 1982 (resolution 37/51) and is sometimes referred to as the ‘Vienna Plan’ after the city of origin. It is also frequently referred to as the ‘International Plan’, emphasizing its relevance for all regions of the world.

The ‘International Plan of Action on Ageing’ is aimed at strengthening the capacities of governments and civil society to deal effectively with the ageing of populations as well as to address the developmental potential and dependency needs of older persons. The ‘Plan’ was part of an international framework of standards and strategies developed by the international community in recent decades. It should, therefore, be considered in relation to agreed standards and strategies in the areas of human rights, advancement of women, families, population, youth, persons with disability, sustainable development, welfare, health, housing, income security and employment, and education.

The UN endorsement was reaffirmed in 1987 by the Assembly (resolution 42/51) which also requested the Secretary-General to continue to monitor progress in the implementation of the plan of action and welcomed the establishment of the International Institute on Ageing in Malta.

In 1990, the General Assembly designated 1 October as the International Day of Older Persons (resolution 45/106). In 1991, the General Assembly adopted the United Nations Principles for Older Persons (resolution 46/91). The principles were to ‘Add life to the years that have been added to life’. The 18 principles fall into five clusters relating to the status of older persons – independence, participation, care, self-fulfilment and dignity.

The decision to observe 1999 as the International Year of Older Persons and to promote its theme, “a society for all ages” came in 1992 with the adoption by the UN General Assembly of resolution 47/5, the Proclamation on Ageing, “in recognition of humanity’s demographic coming of age and the promise it holds for maturing attitudes and capabilities in social, economic, cultural and spiritual undertakings, not least for global peace and development in the next century”.
The concept of a “society for all ages” is rooted in the programme of action adopted at the World Summit for Social Development in Copenhagen in 1995. Viewed as the fundamental aim of social integration, it is a society where “…every individual, each with rights and responsibilities, has an active role to play”. By integrating “age” into a society for all, the approach becomes multigenerational and holistic, whereby “generations invest in one another and share in the fruits of that investment, guided by the twin principles of reciprocity and equity”.

The Conceptual Framework for the International Year of Older Persons, 1999, comprised four issues- situation of older persons, individual lifelong development, relationship between the generations, and interrelationship of population ageing and development.

Several World Health Assembly resolutions on ageing and health have focused global attention on the public health importance of ageing and the urgent need to establish mechanisms for addressing the needs of an ageing population. For example, in 2005, resolution WHA58.16 requested WHO to initiate and provide support to a number of activities in order to strengthen work on active, healthy ageing. This resolution also emphasized the need to raise awareness of the challenges of the ageing of societies, the health and social needs of older persons, and their contributions to society.

In 2012, the Sixty-fifth World Health Assembly adopted resolution WHA65.3 which referred to strengthening noncommunicable disease policies to promote active ageing and urged Member States to develop, implement, monitor and evaluate policies, programmes and multisectoral actions on noncommunicable diseases prevention and health promotion. This was in order to strengthen healthy ageing policies and programmes and promote the highest standards of health and wellbeing for older persons.

WHO has also contributed to the document Active ageing; a policy framework: WHO 2002. The document stresses that good health is central to ensuring that social and economic benefits are fully realized, and the development of sustainable health and social care systems is crucial if costs are to be controlled.

There is thus a need for powerful international and national advocacy to ensure that the centrality of health is understood and that the opportunities arising from it are fully appreciated. To strengthen action in this area, partnerships with many organizations including the International
Association of Gerontology and Geriatrics and the International Federation on Ageing have been established.

WHO provides technical assistance on key issues and promotes the incorporation of this evidence into policy and actions at country level. A new initiative on “Knowledge translation on ageing and health” intends to support Member States in identifying priorities for action and developing evidence-based policy options.

WHO is working to support the development of physical and social environments that foster active and healthy ageing through the WHO Global Network of Age-friendly Cities and Communities. This network encourages the exchange of experiences and mutual learning between cities and communities that are creating inclusive and accessible “age-friendly” environments. The first global report on ageing and health is expected to be released in 2015. This will constitute a crucial resource for Member States in defining what is currently known, providing examples of innovative responses and identifying the gaps in existing knowledge.
A regional meeting on a plan of action on ageing for Asia and the Pacific was convened by the Economic and Social Commission for Asia and Pacific Secretariat [UN-ESCAP] at Macao from 28 September to 1 October 1998. The meeting adopted the Macao Declaration and Plan of Action on Ageing for Asia and the Pacific.

The United Nations Second World Assembly on Ageing (Madrid, 8–12 April 2002) unanimously adopted the Madrid Political Declaration and International Plan of Action on Ageing in 2002. WHO’s contributions to the Assembly included the submission of a policy framework [Active Ageing: a policy framework] and the formulation of regional action plans for implementing the International Plan, notably by the United Nations Economic Commissions for Europe, Asia–Pacific, Latin America and the Caribbean. A political declaration and an international plan of action were adopted in the same year, focusing on older persons and development; advancing health and well-being into old age; and ensuring an enabling and supportive environment.

Some of the declarations of the international plan of action were: development of policies to prevent ill-health among older persons; access to food and adequate nutrition for older persons; development and strengthening of primary health care services to meet the special needs of older persons; involvement of older persons in the development and strengthening of primary and LTC services; promotion of full participation of older persons with disabilities in all social activities; elimination of social and economic inequalities based on age, gender or any other ground; development of mental health care services ranging from prevention to early intervention; provision of adequate information, training in care-giving skills
and recognition of the contribution of older persons as sole caregivers of children of parents with chronic diseases.

A regional survey on national policies and programmes on ageing was conducted by the ESCAP secretariat in June 2002. The findings from the survey were reviewed at the Asia–Pacific Seminar on Regional Follow-up to the Second World Assembly on Ageing (Shanghai, China, 23–26 September 2002). Priorities were identified along with key actions to enhance the implementation of commitments made under the Madrid and Macao plans of action. It adopted the regional implementation strategy for the Madrid International Plan of Action on Ageing 2002 and the Macao Plan of Action on Ageing for Asia and the Pacific 1999, known as the Shanghai Implementation Strategy.

The major areas for action recommended in the Shanghai Implementation Strategy were: (a) older persons and development; (b) advancing health and well-being into old age; (c) ensuring enabling and supportive environments; and (d) implementation and follow-up. In each area, key action points are identified for national and regional actions which take into consideration the results of the 2002 survey on ageing and national circumstances.

To review the recommendations of the Madrid International Plan of Action on Ageing (MIPAA), the UN-ESCAP organized a regional meeting in Macao in 2007. An additional 12 recommendations were developed for implementation and follow-up, the consolidated form of which is termed as ‘The Macao Outcome Document of the High-Level Meeting on the Regional Review of the Implementation of the Madrid International Plan of Action on Ageing’.

In 2012, a regional meeting to review progress after a decade of MIPAA in its Member States was organized by UN-ESCAP in Thailand. Key findings from a regional survey were presented along with inputs from Member States, donors, civil society and international partner organizations. The concerned staff from WHO Western Pacific and South-East Asia regional offices participated in the meeting and presented a joint statement on activities undertaken by WHO to promote healthy ageing in its Member States.
A workshop on active and healthy ageing for mega-countries was organized by the World Health Organization’s Regional office for South-East Asia in 1999 with the objective of strengthening active and healthy ageing programmes in Member States. Based on the recommendations of the workshop, an intercountry programme was developed for initiating a situation analysis and establishing an integrated home-based care programme in the countries.

Several strategies to achieve the goal of active and healthy ageing were suggested: national policy on ageing and health; nation-wide mass awareness campaign on special needs of the elderly; an advocacy strategy; promotive and preventive health care; training of health providers at all health-care levels; preventive steps against the development of noncommunicable diseases and adequate and comprehensive information on ageing and the elderly through strengthening of the information infrastructure.

In 2004, the Regional Office published a report, *Health of the elderly in South-East Asia: a profile*, which documented the ageing population in the Region in terms of changing health indicators, as well as socioeconomic, cultural and political factors known to influence the health outcomes of the elderly in the Region.

A regional consultation on active and healthy ageing was organized by the Regional Office in India in 2007 which reviewed the concept of active and healthy ageing in South-East Asia in three areas: (i) health promotion;
(ii) health systems response; and (iii) socioeconomic determinants of health in active and healthy ageing, using a life-course approach.

The regional consultation provided an opportunity to examine the demographic trends and characteristics and analyse the social and economic determinants of active and healthy ageing. It also provided a platform for debating the successes, challenges and possible solutions among population demographers, public health experts, health economists and policy-makers. Participants concluded that a multifaceted approach involving communities, civil society groups, the public and private sectors, and international as well as bilateral partners, was required to adequately address healthy ageing in Member States of the South-East Asia Region. The World Health Organization was requested to assist Member States to strengthen their health systems, particularly the primary prevention services, LTC at both the community and institution levels and mechanisms for financing health care.

In 2009, a regional consultation to review a strategic framework for active healthy ageing in the South-East Asia Region was organized by the Regional Office in Sri Lanka. The consultation, which was a follow-up to an earlier meeting in 2007, focused on three areas: sharing of experiences on polices and programme interventions between the Member States; reviewing the draft regional strategic framework; and identifying challenges related to effective healthy ageing. A detailed situation analysis of healthy ageing and related programmes in Member States of the Region was provided, followed by an outline of a strategic framework for healthy ageing in the Region.

The theme of World Health Day 2012 was “Ageing and Health” with the slogan “good health adds life to years” to bring global attention to bear on issues related to ageing and health. The Regional Office utilized the Day to conduct an extensive range of advocacy and awareness activities to promote healthy ageing in its Member States.

The Thirtieth meeting of Ministers of Health of countries of the WHO South-East Asia Region in September 2012 adopted the “Yogyakarta Declaration on Ageing and Health”. The declaration identified 14 activities to be undertaken to promote ageing and health and urged all Member States and WHO, along with all other interested partners, to provide necessary inputs.

A regional meeting with the objective to promote and strengthen healthy ageing programmes in the South-East Region was organized in
Sri Lanka in 2012. The specific objectives were to review the status of healthy ageing programmes in Member States and to review the draft regional strategy for healthy ageing.

An expert group consultation was organized by the Regional Office in 2013 to review the comments and suggestions provided by the Member States and finalize the regional strategy for healthy ageing.

The goal of the strategy is to develop and sustain a multisectoral approach for the promotion of healthy ageing and care of the aged based on a life-course approach. The strategy is built on six guiding principles and six policy directions. The strategy has a time-frame of five years (2013–2018) and has identified six strategic elements, each with an objective and several activities:

- **Strategic Element 1**: Developing a country-driven, outcome-oriented, integrated multisectoral policy and plan of action for healthy ageing;
- **Strategic Element 2**: Adapting the health systems to the challenges of the ageing population and to meet their health needs;
- **Strategic Element 3**: Making provisions for long-term care of the elderly population;
- **Strategic Element 4**: Developing appropriate human resources necessary for meeting the health needs of older persons;
- **Strategic Element 5**: Adopting a life-course approach to promote healthy ageing;
- **Strategic Element 6**: Using a multisectoral approach and partnerships.

A number of indicators have been identified for assessing progress in promoting healthy ageing in Member States. However, Member States are encouraged to formulate relevant process and output indicators to measure progress in implementation in their countries. The common timeframe for achieving all indicators is between 2013 and 2018.
Demographics of healthy ageing in South-East Asia

Ageing of the population is an ever expanding global demographic phenomenon and is also encountered in Member States of South-East Asia Region. As indicated in the graph below, an estimated 8% of the population of countries in the Region is aged 60 years and above while in some countries like the Democratic People’s Republic of Korea, Sri Lanka and Thailand, this proportion is 13% and above.

Source: World health statistics 2013
A projection for increase in the proportion of population aged 60 years and above in the countries of the Region between 2012 and 2050 is presented in the table below. By 2050, most countries would have between a quarter and a fifth of their populations aged 60 years and above.

*Increase in the proportion of population 60 years and above in SEAR countries 2012–2050*

<table>
<thead>
<tr>
<th>Country</th>
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<th>2050</th>
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<td>Bangladesh</td>
<td>6.8</td>
<td>22</td>
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<tr>
<td>Bhutan</td>
<td>7.2</td>
<td>24</td>
</tr>
<tr>
<td>Democratic People’s Republic of Korea</td>
<td>13.5</td>
<td>23</td>
</tr>
<tr>
<td>India</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>Indonesia</td>
<td>8.5</td>
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<tr>
<td>Maldives</td>
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<td>31</td>
</tr>
<tr>
<td>Myanmar</td>
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<td>Nepal</td>
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<td>Timor-Leste</td>
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<td>7</td>
</tr>
<tr>
<td>SEAR</td>
<td>8.9</td>
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</tr>
</tbody>
</table>


The graph below depicts the same population projection between 2012 and 2050 in the countries of the South-East Asia Region.
Population 60 years and above (%) 2012–2050: SEAR countries


Life expectancy at birth has continued to increase over the years. Comparison between life expectancies for both sexes between 1990 and 2011 demonstrates an increase in all countries of the Region, as depicted in the graph below.

*Comparison of life expectancy at birth for both sexes 1990–2011: SEAR countries*

Source: *World health statistics 2013*
During the same period, female life expectancy at birth has steadily increased at a faster rate as compared to males. Life expectancy at birth for females in Maldives, Sri Lanka and Thailand is around 78 years. A spectacular increase has been noticed in Maldives, where life expectancy increased from 57 years in 1990 to 78 years by 2011. Increases in life expectancy for both males and females between 1990 and 2011, as reported from the countries of the Region are indicated in the table below.

**Comparison of life expectancy at birth for combined sexes, males and females in countries of SEAR, 1990–2011**

<table>
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*Source: World Health Statistics 2013*

With an increase in female life expectancy, more females live to old age as compared to males. The graph below provides a comparison of sex ratios (men per 100 women) in 2012 and 2050. Other than Bangladesh and Maldives, in all other countries, older females will outnumber older males.
Comparison of sex ratios (men/100 women) in SEAR countries: 2012–2050

Healthy ageing initiatives in Member States

Bangladesh

As per the national census of 2001, the population between the ages of 60 and 64 years was over 2.8 million; those between 65–69 years totalled 1.5 million, while those above 70 years were around 3.3 million. An increase in the numbers for these three age groups has been noted. According to traditional and religious beliefs, elderly persons are respected and taken care of at the family as well as community levels. Elderly persons are seen as key to family ties and symbols of identity, and as venerable counsellors and guardians.

The Ministry of Social Welfare finalized the National Policy on Ageing in 2007. The policy was formulated in line with the Madrid International Plan of Action with the following objectives:

- to ensure the dignity of elderly people in society;
- to identify and address the problems of the elderly people;
- to change the attitude of the masses towards the elderly population;
- to create new programmes to address the needs of the elderly for their socioeconomic development;
to develop special measures to help the elderly during emergencies like natural calamities, cyclones, and earthquakes;

• to ensure social security, health care, employment and rehabilitation of the elderly.

The focus of the national policy is to reduce poverty among older people and ensure the dignity of older persons; to identify and address the problems of the elderly population; to change the attitude of younger people to ageing; to ensure appropriate social, health and economic support for the elderly population; and to implement special measures for the elderly population during natural calamities and humanitarian crises.

Several interventions have been launched by the government such as the rural social services programme; national population activities through the rural mothers’ centres; and urban community development programme.

The Ministry of Social Welfare was entrusted with the implementation of the national policy on ageing. An interministerial action plan was formulated and integration of public, private and international efforts was proposed for the implementation of various programmes. Budgetary allocation was made for different activities under the programme and efforts made for collection of data on older people, formulation of rules and regulations and creating national awareness of old-age issues. For effective implementation at various levels, national guidelines were prepared for the formation of committees on ageing at the national, district and sub district levels, with clearly defined responsibilities.

Old age allowance for the poor and distressed older people is a constitutional provision in Bangladesh. Article 15 of the Constitution ensures the rights and privileges of the elderly population. The Government of Bangladesh has accorded great importance to social safety net programmes and of the 27 such programmes, food for work, cash for work, vulnerable group feeding, gratuitous relief fund, natural disaster fund for risk mitigation, vulnerable group development and fund for housing of distressed are directed at older people. The Ministry of Social Welfare is also operating four micro-credit programmes that provide direct benefits to the elderly.

Two million aged persons receive 300 Bangladeshi takas per month as part of the Old Age Allowances Programme of the government. In addition, about 1.2 million public service employees receive a pension after the retirement age of 57 years. The Pay Commission recently increased the
pension amounts by 50%. Pension benefits for retired employees in the organized sector provide income security to a large number of older people. A majority of the older population from the unorganized labour force residing in rural areas of Bangladesh, however, receive no pension.

The public sector per capita expenditure on health in Bangladesh has shown a rising trend over the years. The government has given importance to health care services for the elderly. The State-funded Health, Nutrition and Population Sector Programme (HNPS) delivers essential services at grass-root level and covers nutrition, communicable disease control, and curative health care and health education. Upazilla (sub-district) health complexes and family welfare centres provide health services for the elderly. The Government’s Hospital Social Services Programme as well as private hospitals provide medical assistance, counselling and rehabilitation services that target older people in need. Nongovernmental organizations and civil society are encouraged for promoting primary and community-based health care and nutrition services for the elderly population.

The Government of Bangladesh has put considerable emphasis on advocacy programmes and events like the International Day of Older Persons and International Family Day for improving the quality of life of the elderly. Bangladesh has a strong civil society involvement in old age care and at the time of registration, the Government gives preference to nongovernmental or civil society organizations dealing with the issues of the elderly. A prominent NGO, “Probin Hitaishi Sangha” receives funding from the Ministry of Social Welfare for its activities.

**Bhutan**

Bhutan is divided into 20 districts, several sub-districts and 205 “gewogs” or local governments. The transition to parliamentary democracy took place in 2008.

The current government policy aims at reduction of poverty by 50% from the existing level of 23.9%, and several pro-poor land reforms have been introduced to this end. The Asian Development Bank assessment of poverty (Bhutan Living Standard Survey 2012) shows that the poverty rate has declined to 12%. The economic growth rate is estimated at 6.7% and per capita GDP has increased to US$ 2109.30.
The total population is 708,265 spread over a land area of 38,394 km². An estimated 5% or 33,759 people are over 65 years. The ageing index per 100 children is 15.7 (10.1 in 2004) with a dependency old age ratio of 7.3. Life expectancy at birth has been increasing gradually, from 66.1 years in 2000 to 67.4 years in 2010 and to 68.1 years in 2012.

The crude death rate (CDR per 1000 persons) declined from 8.6 in 2000 to 7.8 in 2010 and was 7.7/1000 population in 2012. At the same time, the crude birth rate (CBR per 1000 live births) declined from 34.1 in 2000 to 19.7 in 2010 and was 18.5 in 2012. Both factors – CBR and CDR – have contributed to an increase in the proportion of persons surviving to old age.

There is no formal policy on healthy ageing Bhutan as the healthy ageing programme is at an early stage of development. In response to the rapidly increasing proportion of older persons, the Ministry of Health has established a geriatric care programme to promote productivity, vitality and happiness among the elderly citizens by addressing their needs. A pilot project was introduced in the Khaling community (eastern Dzongkhag) to determine the feasibility of providing community-based health care for elderly citizens with support provided by Kyoto University in Japan.

The Royal Society of Senior Citizen’s Association consisting of retired senior government officials was established to formulate policy directives and strategies for the promotion of healthy ageing. The government has also created the National Pension and Provident Fund to provide old-age retirement benefits. The Ministry of Health is planning to work towards providing better services to the elderly population seeking health services, and to reduce the waiting time at hospitals and health centres. Community-based health care is provided by 1200 village health workers. Professional care and the process of referrals begin at the 518 “outreach clinics”. There are 181 basic health units (Grade I & II), 30 district hospitals, two regional referral hospitals and the national referral hospital that address health issues of the elderly population. Complicated cases are referred to specialized hospitals in India.

With an increase in chronic diseases and disabilities among the elderly population, the department of medical services had piloted a project for the community-based medical care of the elderly in one district in 2010 and subsequently to four other health centres in three districts in 2011. The aim of this project was to promote health care and quality of life of the elderly citizens at the community level. The project also aimed to prevent
and control lifestyle-related disorders and to provide effective and efficient care for elderly citizens. The focus was on early detection and control of lifestyle-related diseases such as diabetes and hypertension, and maintaining activities of daily living among elderly citizens in the community.

The Ministry of Health has also piloted the Package of Essential (PEN) interventions with WHO support as part of a global initiative. Bhutan has always relied on the community’s support in delivering basic health services to the remote rural areas, especially by using village health workers. Traditional medicine – always valued by the elderly citizens – is also provided by the district hospitals.

As per the Yogyakarta Declaration on Ageing and Health 2012, the Ministry of Health is focusing on developing a coherent, comprehensive and integrated approach to promote healthy ageing during the Eleventh Five-Year Plan period (2013–2018). These activities would focus on developing and strengthening the national policy on healthy ageing. Considering the economic aspects of LTC of the elderly, both at the facility and household levels, availability of sufficient resources would have to be ensured. The primary health care system would need to be strengthened to address the health needs of the elderly, including in-service training of health professionals. This would require establishing community-based medical care to address the noncommunicable diseases of elderly persons.

Inadequate numbers and categories of human resources for health have been a constraint in the expansion of health services in Bhutan. Adequate training protocols for training different categories of health staff are lacking. Bhutan’s ability to sustain the provision of quality health care services is a challenge in a rapidly changing economic environment where people’s expectations and demands regarding health care have increased in tandem with the level of education in the country.

**Democratic People’s Republic of Korea**

The Democratic People’s Republic of Korea occupies an area of 223 370 km², while its northern part covers 123 138 km² with a population of 24.05 million. There are two special municipalities and nine provinces divided into cities and counties which are subdivided into Up, GU and RI.
According to the population censuses of 1993 and 2008, the percentage of the elderly population aged 60+ increased from 8.9% in 1993 to 13.1% in 2008, and the number of the aged population increased 1.7 times from 1.89 million to 3.15 million. The growth rate of the elderly population is much higher than that of the total population. During the period of 1993 and 2008, the elderly population aged 60+ increased by 4.5% annually, while the total number of population rose by less than 1% every year. This is a clear manifestation of the fact that caring of the elderly has been recognized as an issue of national importance.

Average life expectancy in the Democratic Peoples’ Republic of Korea is increasing. In 2004, it was 68.2 years (females 72.1 years and males 64.1 years). By 2006, average life expectancy was 69.2 years (females 72.8 years and males 65.2 years). By 2008 (as identified during the second national census), average life expectancy was 69.3 years (females 72.7 years and males 65.6 years).

Since its inception, the Government has been enforcing people-oriented policies to take care of the older people’s lives and health and has developed and enriched its social insurance and social security services for the elderly, keeping pace with the demands of the changing times and reality. Following the Labour Law and the Laws on Social Insurance proclaimed in 1946, the State enacted the Socialist Constitution of Democratic Peoples’ Republic of Korea in 1992 and the Democratic People’s Republic of Korea Law on the Care for the Disabled in 2003. All these legal provisions have enabled the State to assume full responsibility for the caring and protection of the lives and health of older people.

The Democratic Peoples’ Republic of Korea Law on the Care for the Elderly was adopted on 26 April 2007 through Decree Number 2214 of the Presidium of the Supreme People’s Assembly to ensure the rights and interests of the older people and to help them enjoy a worthy and happy life, both mentally and physically, by establishing strict systems and disciplines for elderly care. Detailed rules and regulations are specified for implementing the Law.

On 30 April 2003, the Korean Association for Helping Age was established in realization of the fact that population ageing was emerging as an important national issue. Following the adoption of MIPAA, the Korean Federation for Care of the Aged was established to organize and supervise elderly care in a unified way. Commissions for the care of the aged were
established in every province and municipality and evolved into a social mechanism for elderly care. The meeting of the National Commission for the Care of the Aged is held annually, while the Commission meetings of provinces, municipalities and counties are held twice a year.

Article 74 of the Democratic Peoples’ Republic of Korea Socialist Labour Law stipulates that men and women over 60 years and 55 years respectively shall be provided with pensions in proportion to the terms of their service rendered to society. Article 14 of the Democratic Peoples’ Republic of Korea Law on the Care for the Elderly requires that the elderly shall be provided with various types of pensions and subsidies by the government. The Government grants subsidies to older people who need special support, including those living without offspring and those without any care. All citizens aged 90 years and over are registered and provided additional subsidies apart from pensions. Similarly, elderly persons who had provided services to the country are recognized and treated with honour and respect. The younger generation is also taught about the value of respecting older persons. The Government arranges cultural and social activities for the elderly to meet their emotional and physical needs. October 1 of every year is celebrated as the Day of the Older Persons.

In April 2012, World Health Day with its theme of active healthy ageing was celebrated and various campaigns launched. In July 2012, the Government organized the Festival of Veterans with the participation of veterans from all over the country.

A national survey on the care of the elderly was undertaken in 2007 by the population centres with the involvement of the Ministry of Public Health, the Central Bureau of Statistics and the Korean Federation for the Care of the Aged with support provided by an international NGO, and bilateral and international agencies. The survey included 1394 households comprising 2035 persons aged 60 years and above. The findings, as represented in the table below, show that high blood pressure, backache, cardiovascular diseases, arthritis and digestive complaints were the common ailments affecting the elderly population.

According to the survey conducted by the population centres in 2007, a number of older persons had positive views about their health. Around 43% of the elderly answered that they were in ‘good health’, while 33% replied ‘normal’ and the rest ‘in poor health’. However, when they were asked whether they had diseases or not, 57% of the elderly answered ‘yes’. The most frequently occurring diseases were high blood pressure (17.8%),
back pain (15.2%), heart disease (12.1%) and arthritis (10.1%). Outbreak rates for diseases and symptoms of the elderly in urban areas were higher than rural areas. The rate of heart disease was relatively high among females while digestive problems were higher among males.

The “section doctors” provide regular health care to the older adults. Elderly persons are also encouraged to continue with their jobs in accordance with their requirements. Specialized treatment is provided at the geriatrics departments of provincial hospitals and at the geriatrics centre of the Korean Red Cross General.

The table overleaf indicates the initial contact points of medical care for the elderly population as identified through a sample survey conducted in 2007.
Proportion of elderly population seeking health care at different health facilities

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Provincial hospitals (%)</th>
<th>City (district), County hospitals (%)</th>
<th>Clinics (%)</th>
<th>Self-treatment (%)</th>
<th>Surveyed elderly</th>
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</thead>
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<tr>
<td>60–69</td>
<td>5.5</td>
<td>20.1</td>
<td>67.9</td>
<td>6.5</td>
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<td>70–79</td>
<td>3.8</td>
<td>17.2</td>
<td>72.3</td>
<td>6.8</td>
<td>635</td>
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<tr>
<td>80+</td>
<td>2.6</td>
<td>12.5</td>
<td>74.3</td>
<td>10.5</td>
<td>152</td>
</tr>
<tr>
<td>Total</td>
<td>4.7</td>
<td>18.6</td>
<td>69.8</td>
<td>6.9</td>
<td>2013</td>
</tr>
</tbody>
</table>

Source: Population Centre-national sample survey (2007), Democratic People’s Republic of Korea

Available information indicates that 69.8% of the elderly were being treated in clinics while 23.3% of them received treatment from hospitals in districts, counties or provinces. A majority of the elderly sought medical care from the nearest clinics and this tendency was stronger as the population got older. Enhancing the services at the local clinics for the elderly would, therefore, be an important issue in the promotion of health care for the elderly.

As a result of these initiatives, the management of various cardiovascular and orthopaedic conditions has improved. Long-term care at the primary and specialty hospitals, at old age home” and at the community and family levels has similarly progressed and continuing efforts are being made to further improve the same.

The subjects of geriatrics and gerontology in the curriculum and training of medical graduates at medical schools and further emphasis on geriatrics and gerontology during pre-service training have been initiated.

Article 18 of the Democratic People’s Republic of Korea Law on the Care for the Elderly stipulates that public health agencies and medical institutions should register all older persons in given areas and see to it that doctors provide due medical care to them including regular visits to the patients’ houses for their health examinations and medical treatment. Medical care for older persons is provided through universal free medical care system of the State.
India

The increase in life-expectancy necessitates old age-specific health management to address age-related health problems, particularly considering the large number of elderly persons in the vast rural population.

The Government of India adopted the National Policy on Older Persons (NPOP) in 1999 to reaffirm its commitment of ensuring the well-being of the elderly population in a holistic manner. In reiteration of the mandate enshrined in the Constitution of India, NPOP brought the concern of older persons on top of the national agenda. NPOP promises to provide social, health and financial security among others, to the elderly population at all levels and envisages a productive partnership in the country’s development process with them. NPOP appreciates the special needs of the elderly population and lays emphasis on empowering communities as well as individuals to adequately meet the challenges of the process of ageing.

NPOP provides for financial, social and health security; shelter, education and information; welfare and institutional care; protection of life and property; preparation for old age care; and advocacy. The policy was subsequently translated into a plan of action allocating responsibilities to various sectors of the Government.

Some of the key initiatives of NPOP are: National Social Assistance Programme and the National Old Age Pension Scheme; concessions in travel, income tax, higher bank interest on long-term savings, reverse mortgage system, and easy insurance premiums for senior citizens. There are also provisions for financial support through the Integrated Programme for Older Persons, for setting up and maintenance of day care centres, mobile medical units, and old age homes. The Government of India enacted the Maintenance and Welfare of Parents and Senior Citizens Act in 2007 to provide legal back-up to old age care and ensure that family members took care of their elderly parents or relatives.

The National Policy on Senior Citizens (2011) focuses on mainstreaming senior citizens, especially older women; promoting the concept of Ageing in Place; recognizing senior citizens as a valuable resource for the country; and providing them with equal opportunities. States are advised to implement the Maintenance and Welfare of Parents and Senior Citizens Act, 2007; establish tribunals so that elderly parents unable to
maintain themselves are not abandoned and neglected, and set up homes with assisted living facilities for abandoned senior citizens in every district.

The National Programme for the Health Care for the Elderly (NPHCE) was inspired by the international and national commitments of the Government of India like the UN Convention on the Rights of Persons with Disabilities (UNCRPD), National Policy on Older Persons and The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 dealing with provisions for medical care of senior citizens. The main objective of the programme is to provide preventive, curative and rehabilitative services to the elderly at various levels of the health care delivery system of the country. Further, strengthening of the referral system, developing specialized manpower and promoting research in diseases related to old age are also envisaged. Approved by the Ministry of Finance in 2010, it is expected to be expanded to the entire country during the Twelfth Five Year Plan.

In recent years, innovative initiatives like helpline services for older persons, community training in computers for older persons, and a single-window system for obtaining official documents, have also been introduced by the central and state governments.

In order to ensure that professionally trained carers are available to meet the need for elderly persons at homes in view of the changing family context, the Ministry of Social Justice and Empowerment in 2012 launched the ‘National Initiative on Care for Elderly (NICE)’ through the National Institute of Social Defence by including a training programme for managers of old age care institutions. An ambitious programme for providing geriatric health care at all levels of the health system, from medical school to primary health care centres and outreach care for bed-ridden older persons has been proposed by the government. Several nongovernmental organizations as well as civil society are now significantly involved in providing care and support to the elderly population in the country.

**Indonesia**

There are over 17,000 islands comprising the Indonesian archipelago, of which only 6000 are inhabited. The total population is 237 million.

As one of the goals of health development, life expectancy increased from 70.6 years in 2010 to 72 years in 2014. Today, Indonesia is one of the top five countries in the world with a rapidly ageing population. An
estimated 9.6% or 18.1 million people in the country are over 60 years and this figure is expected to reach 29.1 million in 2020 and 36 million in 2025. There is a wide range of elderly index among provinces: Yogyakarta is the highest whereas Papua is the lowest. This figure has to be considered against the local issues related to programmes on ageing in each province.

The 2007 national basic health research data identified stroke, chronic respiratory infections, tuberculosis, hypertension, coronary heart disease and cardiovascular diseases as the top six causes of death among the older population. Osteoarthritis and other joint problems, oral disorders, hypertension, cataract, stroke and cardiovascular diseases were identified as the top six causes of morbidity among the elderly.

The national policy on older persons has the general objective of improving the health status of older persons so that they live longer; remain happy, healthy, productive and independent. The specific objectives are to increase: (1) awareness of ageing to promote health status of the elderly, (2) capacity and awareness of families and communities to promote and maintain health in old age; and (3) access to and provide quality health services to older persons.

The overall policy facilitates the health of older persons as part of family health efforts, through primary health care and referrals. Services are implemented through a holistic and multisectoral approach with the focus on social and local cultural values. Prevention and promotion are implemented comprehensively with curative and rehabilitative efforts. There is increased participation of older persons along with other members of the community and the private sector, based on mutual assistance and guidance by the central and provincial governments. A comprehensive national infrastructure exists for delivering health care to older persons, starting from community-based services to the sub district, district, and provinces and all the way up to the central level.

There are a large number of legislative measures, decrees and acts for the welfare of the elderly in Indonesia. These include:

- Law No. 13/1998 on the welfare of older persons;
- Presidential Decree No. 52/2004 on national commission for older persons (ageing);
- Government of Indonesia decree No. 43/2004 on efforts to improve older persons’ welfare;
• Presidential decree No. 52/2004 and 93/M/2005 on membership of national commission for older persons; and

• Minister of Home Affairs Decree No 19/2011 on Basic Guidelines for Social Services including for older persons at Integrated Services Post (Posyandu).

The national plan of action on older people’s welfare involves a large number of ministries and government agencies including the ministries of social affairs, social services and rehabilitation, health, transportation, manpower and transmigration, women empowerment, law and human resources, religious spiritual services, culture and tourism, information, national education and national planning body and family empowerment.

Health programmes for older persons are aimed at increasing and improving health services for older persons in primary health care programmes, including increased health referrals, promotion of IEC, home care, increased community empowerment through older person’s groups, and development of institutions for the care of older persons.

Health care at the hospital level involves providing services to older persons with the involvement of the older population at the district and provincial levels. Activities for older groups are facilitated by health volunteers who are themselves older persons. The focus of activities is on promotion and prevention, where older participants are provided with protocols to monitor their health status.

Geriatric services are provided at the district and provincial hospitals. Presently, only eight hospitals have geriatric clinics - Jakarta, Karyadi in Semarang, Sarjito in Yogyakarta, Hasan Sadikin in Bandung, Sutomo in Surabaya, Wahidin Sudiro Husodo in Makassar, Sanglah in Denpasar and Muwardi in Surakarta. Comprehensive health services are provided at homes by empowering the older persons and family members or at the health centres as part of public health care programmes.

Social and economic support programmes for the elderly are conducted through day care and home care. In 2002, only 1.2 million older persons received pension. It is estimated that 4.1 million older persons have no social security.

The main priority is for older persons suffering from psychosis and dementia to receive care at the government mental health hospitals. It is proposed to develop community-based LTC for older persons involving
the private sector and the community through training of caregivers. The existing training activities are: training in geriatrics and counselling for health providers in health centres, geriatric training for internists and training for caregivers.

The older population and the community consider illness as a natural process and part of ageing and as such, do not seek health care. Poverty, neglect and disability among the older person cause dependence. It is estimated that 3.3 million older persons require social services. In spite of the ever-increasing needs, ageing is not considered an important issue in social welfare programmes in the country.

Maldives

The country consists of a chain of 1190 small islands spread over an area of 900 km² divided into 20 administrative atolls. The population of 320,000 is dispersed over 200 islands. The proportion of elderly persons above 65 years is projected to be 4.8% by 2015, 6.15% by 2025 and 12.7% by 2045. The population is experiencing rapid internal and external migrations with one-third eventually living in the capital, Malé. At the same time, there is sociocultural transition, rapid change in lifestyle and development of political and religious divisions.

Support to the elderly has been mainly from a welfare point of view as provided through the elderly allowance. General health insurance of the population has also benefitted the elderly.

There are no studies to ascertain the level of morbidity or quality of life among the elderly population. It has been observed that the elderly are often hospitalized for chronic illnesses, although no accurate data are available. An NCD risk factor survey was conducted in 2003–2004 which indicated high prevalence of risk factors for major cardiovascular diseases and cancer; 80% of mortality among the adults was attributable to chronic noncommunicable diseases.

A draft strategy for active and healthy ageing/elderly health care in Maldives and a policy for the elderly were formulated in 2010 and 2012 respectively. The services, roles and responsibilities of various departments and ministries in the area of care of the elderly are as indicated:
• The Ministry of Gender, Family and Human Rights is mandated to address and advocate for the rights of the elderly.

• The Family and Child Development department is responsible for advocacy and programmes focussing on the elderly population and educating the public through the media.

• The Department of Gender and Family Protection Services provides institutional care for the elderly in the homes for people with special needs.

• Family children centres conduct programmes at island level.

• Other stakeholders are the Centre for Community Health and Disease Control, Ministry of Health that maintains a healthy ageing unit; the Human Rights Commission; the National Social Protection Agency; and the Maldives Police Service.

Civil society, with assistance from the government, provides relevant health information to the elderly population and trains the caregivers.

The Ministry of Health has also produced information on various health problems affecting the elderly. The elderly are encouraged to participate in various health activities.

Long-term care is provided through the homes for people with special needs. There is a plan to build LTC institutions. In the islands, health workers have been issued guidelines for conducting home visits. Although these guidelines are not specific for the elderly population, elderly persons requiring LTC at home may also derive some benefits. There are several legislative measures and acts to support and care for the elderly population:

• Under the chapters of the Constitution on Fundamental Rights and Freedom, Article 35B, the elderly and disadvantaged persons are entitled to protection and special assistance from the family, the community and the State.

• The Pension Act was adopted in May 2009 to provide old-age pension and retirement pensions of MVR 2000 equivalent to US$ 130/month to all elderly above the age of 65 years.

• The Universal Health Insurance Act enables access to health care by the elderly. Services include outpatient services, physiotherapy and medications, among others.

• There is provision for single parent/disability allowance.
There are a limited number of trained personnel for the care of the elderly, although local NGOs with expertise in this field have been active in conducting training workshops. There is a possibility of establishing a training facility at the Faculty of Health Sciences, Maldives National University.

There are several constraints:

- strengthening national capacity for activities in effective ageing and health care of the elderly;
- establishing a clearly defined national policy for the elderly;
- formulating a clear strategy for LTC of the elderly population including institutional facility and domiciliary support;
- involving civil society/nongovernmental organizations in elderly care.
- conducting research on aspects of ageing and chronic diseases of the elderly and compiling accurate data.

Myanmar

Myanmar has a population of 59.78 million of which 9.1% or an estimated 5.46 million people are above 60 years. There is a rapid change in the population structure with the following characteristics:

- The proportion of people over 60 years is increasing.
- The proportion of children is reducing over time.
- There is an increase in the proportion of oldest old, that is, those over 80 years.
- The majority of the oldest old are women.
- There is an increase in the proportion of workers who are old.

National surveys have reported that the leading causes of morbidity among the elderly are: cataract, essential hypertension, cardiovascular diseases like chronic ischaemic heart disease, diarrhoea and gastroenteritis, tuberculosis of the lung, chronic obstructive pulmonary disease, stroke and diabetes mellitus. The common causes of mortality among the elderly are: cardiovascular diseases, stroke, malignant neoplasm of bronchus and lung, tuberculosis, and chronic obstructive pulmonary diseases.
The national plan of action for older persons and the national policy are being implemented and the national policy for the elderly is in the process of approval. The Second National Health plan (1993–2006) included a programme on healthy ageing. The Constitution of the Republic of the Union of Myanmar (2008) in Article 32, mentions that the Union shall care for mothers and children, orphans, children of deceased defence service personnel, the aged and the disabled.

The elderly health care project exists in 88 townships. A wide range of services are offered at the district/township level. Weekly clinics for older people provide training in basic management to older persons; demonstrate physical exercises, conduct required surgical interventions, health education and counselling. The services also include collection and compilation of data and information on the elderly population as well as their health issues and needs.

Services at the rural health centres include: weekly clinics providing basic curative care for minor ailments; health education and counselling to older persons and family members, demonstrations of physical exercises; and referral of those requiring more medical attention to the nearest township hospital. Relevant data on the elderly and their health issues and needs are also compiled during the weekly clinic days.

Local NGOs and community volunteers are sensitized to emerging health problems among the elderly and how these groups could help the health staff in caring for elderly people, including assessing the health conditions of the elderly population at the community level. Basic principles of elderly care and referral procedures to the rural health centres are also imparted.

The Government has introduced several social and economic support programmes for the elderly population: home for the aged; Republic of Korea (ROK)—ASEAN home care programme; older people self-help group; rural development and ageing; and two pilot studies – day care centre and paid home care.

There are 70 homes for the aged in the country, covering about 2300 older persons, providing rice, funds for food, clothes and salary for the administrators, along with necessary technical assistance.

The first phase (2004–2006) of the ROK-ASEAN home care for the older people programme was introduced in two townships with the
involvement of the national YMCA. The second phase of the project (2006–2009) was introduced in 25 townships with the involvement of three partners. The third phase (2009–2012) has maintained the delivery of home care activities while expanding the reach to 154 townships involving 10 partner organizations.

The Older People’s Self-help Group [OPSHG] programme includes 18 villages in the secondary region; 43 villages in the Ayerawaddy Region and two wards in the Sagon township of Yangon. This programme covers 20,000 older persons and their families. An OPSHG comprises a main committee and several sub-committees dealing with fund-raising, health, home care, among others. OPSHG activities include fund-raising, improving livelihood and income generation.

The Rural Development on Ageing (RDA) programme has the principle of reducing economic vulnerability through an equitable/inclusive approach to livelihoods (REVEAL). The programme covers 30 villages and 10,000 older persons and their families as beneficiaries. The key activities are: livelihood support to households with older people – cash and kind; social care at home; risk reduction during disasters; community capacity development; and income generation activities.

Long-term care is provided to older persons who do not require special nursing care and support. Some community-based organizations are supporting frail elderly persons who live alone.

A two-day training programme in basic geriatric care and physical exercise for the elderly is provided to the health staff. There is training for volunteers in elderly health care promoting home care. The Department of Social Welfare trains home care volunteers in social care and support.

Relevant legislation, as well as acts and laws for the support and care of the elderly population are yet to be established. However, the strong norms and values related to the care for the elderly that are held by the people of Myanmar are clearly reflected in the living arrangements for the elderly. Almost 90% of the elderly live with their children where the households also include other relatives and grandchildren.

Several initiatives are proposed for the future: providing and strengthening support to the policy, strategies and programmes for the elderly; finding ways to maintain and preserve traditional family norms and
values related to elderly care; strengthening intergenerational ties in order to preserve the quality of the relationship between the elderly and younger family members; and supporting employment opportunities that allow elderly workers to play an effective role in social and economic development of the country.

Nepal

The average life expectancy in Nepal was 60.4 years and in 2006, it was reported at 67.1 years (WHO 2012). The proportion of elderly persons has been increasing rapidly over the years. It grew from 5% in 1952–1954 to 6.5% in 2001 and 8.1% in 2011, which accounts for an increase of nearly 2.46 million elderly. While the population of older persons continues to grow at a faster pace, the physical, social and health care required for them have not expanded in equal proportion (CBS, 2011).

<table>
<thead>
<tr>
<th>Year</th>
<th>% of 60 years and +</th>
<th>Total number of people 60 years and +</th>
</tr>
</thead>
<tbody>
<tr>
<td>1952–1954</td>
<td>5.6</td>
<td>412 831</td>
</tr>
<tr>
<td>1981</td>
<td>5.7</td>
<td>856 302</td>
</tr>
<tr>
<td>2001</td>
<td>6.5</td>
<td>1 504 982</td>
</tr>
<tr>
<td>2011</td>
<td>9.1</td>
<td>2 422 494</td>
</tr>
</tbody>
</table>

Source: Central Bureau of Statistics, 2011

The Civil Code, 1963 section 10 stated that “If the parents want to live with a particular son or daughter, it has to be clearly stated in the Bandapatra (the legal note on property distribution) that son and daughter should take care of the parents”.

The Local Self-Governance Act, 1998, provisioned for the protection and development of orphaned, helpless women, elderly people and the disabled and in 1999, under the heading of duties, rights, and responsibilities of village development committees.

The Senior Citizen Policy 2058 (2001) envisaged incorporating economic benefits, social security, health service facilities and honour, participation and involvement, and education as well as entertainment
aspects to support the elderly people live a dignified life. The policy aimed to enhance the respect and dignity of the elderly in their family, society and nation. It was determined to improve the potential of the elderly, so that they continue to be active and productive in national development, and to create opportunities to assist them to continue to be self-reliant.

Prior to the Ninth Development Plan, there was no separate activity for the elderly. A universal non-contributory pension scheme was instituted towards the end of the Eighth Plan period and it was only during the Ninth Plan that a separate section on senior citizens was included.

In 2002, the Ministry of Women, Children and Social Welfare developed a senior citizens policy and a working policy, which may be summarized as follows:

- to recognize the knowledge, skill and expertise of senior citizens to be utilized by the Government;
- to enact new legislation for the security of senior citizens;
- to initiate various programmes to enhance respect and dignity of senior citizens;
- to initiate a national pension scheme; and
- to establish a central level committee to integrate, coordinate and monitor the programmes for senior citizens.

The Ministry of Women, Children and Social Welfare also formulated a national workplan for senior citizens. A log-frame approach was tabulated which included: economic aspect, social security, health and nutrition, participation and legislation. The three-year plan of the Government of Nepal (2010–2013) had established a working policy, strategy and plan of action. The strategy consists of utilization of knowledge, skill and experience of senior citizens in the interest of the nation; expanding the accessibility of senior citizens to economic and social security programmes; promoting and expanding economic and social security programmes; launching special programmes for senior citizens who are abandoned, victims of violence or with some degree of disability and vulnerability. The working policy consists of policy formulation and implementation to utilize the knowledge, skill and experience of senior citizens; collection and analyses of data about the knowledge, skill and experience of senior citizens in order to utilize them; revision, strengthening and expansion of the social security provisions; state grant for shelter homes, social care centres or mobile health clinics for
senior citizens; closer collaboration with civil society and the private sector; establishment of a commission, board or council for senior citizens; and strengthening the existing services in the community.

The National Planning Commission has plans to construct 3915 day care centres/clubs for senior citizens as part of every village development committee; five old age homes; one 100-bed hospital for senior citizens; a total of 210 geriatric beds in each regional and zonal hospital (10 beds each); and five senior citizens’ villages.

The delivery of services to the elderly population is multisectoral, with the involvement of the ministries of women, children and social welfare, local development, health and population, information and communication. In addition, the private sector is also to be involved.

The Ministry of Women, Children and Social Welfare will provide financial support to institutions (old age homes, day care centres and research programmes); public awareness through publications; celebration of different international days and dissemination of information through posters, pamphlets, and rallies among others; reimbursement of health expenditure up to Nepali Rupees (NR) 4000 a year to indigent individuals through a committee under the Chief District Officer; annual training of caregivers, in all the five development regions at separate places, with private–public partnership.

The Ministry of Local Development is expected to provide universal non-contributory pension through the village development committees and through some banks, as appropriate. The Ministry of Health and Population provides free health care through sub-health posts, health posts, primary health centres and hospitals as well as through health camps. The Ministry of Information and Communication provides public awareness through the Nepal Radio and Television services. It is to be noted that almost all the old age homes, day-care centres and advocacy organizations are run by the private sector.

At present, the existing health programmes for the elderly population include: policy and programmes for providing free basic health services for all including provision of essential drugs; 10 free geriatric beds at the Patan hospital, Bharatpur hospital, Naradevi Ayurvedic Hospital and Manmohan Foundation Hospital; financial support to indigent poor population for serious ailments up to NR 50 000; free dialysis and treatment for heart conditions, cancer patients, Parkinson’s and Alzheimer’s diseases to all
poor persons aged 75 years and above in different private hospitals; and free treatment to those over 75 years at the government-run Bir hospital. Long-term care of the elderly is provided in old age homes only. There is no "hospice" especially for the elderly and this need is particularly felt for those with Alzheimer’s disease.

The social and economic support programmes for the elderly consist of universal non-contributory pension scheme providing NR 100 to all elderly persons 75 years and over. This scheme was started in 1994 (NPC, 2012) and recently the pension was increased to NR 500 and the age eligibility lowered to 70 years [for Karnali zone and dalits, the age eligibility is 60 years and above]. The Pashupati Bridhashram runs a free home for destitute and abandoned senior citizens and currently has 232 inmates.


There is no institution to impart training to health workers and social support workers for the elderly population residing in the old age homes or receiving services at day-care centres. The Ministry of Women, Children and Social Welfare, in collaboration with the National Senior Citizens’ Federation (NASCIF), organizes training for caregivers, administrative staff and volunteers from institutions working for senior citizens in all the five development regions at different places every year.

**Sri Lanka**

Life expectancy at birth in Sri Lanka currently stands at 70.3 years for males and 77.9 years for females. The elderly population is expected to increase from 9.2% in 2001 to 20.7% by 2031, much of it due to greater female longevity, migration (more at the international level), and declining fertility. Correspondingly, the age-dependency ratio is expected to increase from 14.3% in 2001 to 32.8% in 2031. In terms of numbers, in 1991, there were 1.4 million people over 60 years in the country, reaching 1.9 million and 2.8 million in 2001 and 2011 respectively. By 2021, this number is expected to reach 4 million.

It is to be noted that while European countries took more than a century to reach such a high proportion of elderly persons, Sri Lanka is
witnessing this demographic shift in a span of 20 years, thereby rendering the problem more challenging. Several issues have emerged: protection of rights and provision of social security; health demands due to the physical changes related to age; rapid increase in noncommunicable diseases and disability; and increased care required for responding to mental health issues, among others.

At the national level, several legislative provisions have been enacted: national policy and national charter on elders; Rights of the Elders Act number 9 in 2000 (revised in 2011) that provides for the establishment of a national council, secretariat, fund and maintenance board for the elderly.

Elderly health care has been identified as a priority area in the Health Master Plan in accordance with the National Charter for Senior Citizens. The Ministry of Health follows the regulations of the Act on Protection of the Rights of Elders and health-care services for the elderly are planned according to the national plan of action for elderly health care. Caring for the elderly in disaster situations has been strengthened based on experience gathered during the internally-displaced conflict and the Tsunami crisis.

Development of human resources has been undertaken in order to provide a high standard of elderly care which includes a new postgraduate specialty in geriatrics, introduction of elderly care in the curriculum of the basic and post-basic training of health personnel, local and foreign inservice training of community caregivers. In addition, a special budgetary allocation has been made for the development of wards for the elderly in both the modern and indigenous medical sectors in the public sector hospitals in 2012. Considerable funds are spent from the annual health budget for health care of the elderly, although the exact amount is difficult to calculate. There is a directorate in the Ministry of Health dealing with elderly health care which works closely with the provincial health ministries.


The Act No. 9 (2000) and the National Charter for Senior Citizens was enacted to promote and protect the welfare and rights of elders. The National Council for Elders was established as prescribed by this Act and
in order to implement the decision of the Council, the National Secretariat for Elders was established. The mission of the National Charter for Senior Citizens is to ensure and reinforce the values of independence, dignity and participation, self-fulfillment and a good quality of life in a caring, accepting and respecting community.

The National Policy on Elders was based on the recommendations of the second World Assembly on Ageing held in Madrid and has three priority areas: elders and development; advancing health and well-being in old age; and ensuring an enabling and supporting environment. The National Charter and the National Policy for Elders were adopted by the Cabinet of Ministers in 2006. In line with the priority areas and strategies of the national policy, the national plan of action was developed encompassing the period 2012–2021.

The principal functions of the national council are promotion and protection of the welfare and rights of the elders in Sri Lanka; and assistance to the elderly to live with self-respect, independence and dignity.

The National Secretariat for Elders was established under the Protection of the Rights of Elders Act No.9 (2000) and functions under the Ministry of Social Services. It is the prime administrative body engaged in implementing programmes approved by the Council.

Day centres for the elderly population are locations where people over 60 years could be engaged in social activities during the day with others of the same age group. There are 230 day centres for the elderly in Sri Lanka. The Government has provided Sri Lankan Rupees (SLR) 25,000 to each day centre for the purchase of necessary equipment and SLR 10,000 for introducing income-generation activities.

Several communication and educational programmes have been developed for the elderly population, focusing on health, mental, social and spiritual issues relating to ageing and legal empowerment of the elderly population. For example, a *Handbook for Elders* was issued by the National Secretariat for Elders in Sinhala, English and Tamil. The handbook contains articles on positive aspects of ageing, elders’ contribution to society and advice on common diseases, on prevention of diseases and domestic accidents, seeking legal advice and obtaining government-issued pension and identity cards. Several magazines are also produced targeting the elderly population.
The “Wadihitivo” magazine is a collection of articles written by intellectuals on various subjects that may be useful to the elderly; *Counselling for elders* contains important physiological information for both elders and caregivers; *Healthy ageing* contains important and interesting articles that help elders to lead a healthy life. In addition, pre-retirement seminars are conducted for employees of the public sector who are reaching the retirement age, so that they may be prepared for an active retired life and are aware of related issues. There are online counselling services as well as similar services available through counsellors attached to the divisional secretariats.

Training programmes are conducted for those providing home care to the elderly and the government also has provision of home care through trained home caregivers.

Establishment of homes for the aged is regulated through Gazette No.1749 of 9 March 2012 which provides standards for homes for the aged. There is also provision of financial support to homes for the aged. As part of disability limitation, eyeglasses, hearing aids, wheelchairs and walking aids are provided to the elderly population in need.

As part of social security activities, special identity cards are provided to the elderly persons that entitle them to a 5% discount on the purchase of medicines, higher interest rates for fixed-term deposits in banks and priority in obtaining public and private sector services. The Maintenance Board for Elders ensures that maintenance is provided by children to elderly parents. Needy elders over 70 years and those without any family support are provided monthly financial assistance through sponsors. Several pension/provident fund/social security benefits exist for those working in the public sector, private sector or are self-employed.

Regulations have recently been passed by the Parliament to make all public places including service areas and buildings accessible to the disabled and benefitting the older persons.

In the area of preventive health services, elderly health care has been integrated with the overall public health care services as a priority issue where active healthy ageing is promoted. Among the several ongoing activities are: conducting pre-retirement health promotion programmes in public and private sector organizations; early detection of common NCDs including cancer through frequent screening programmes, and working with community health care teams.
Although the community mental health programme has been well-established in Sri Lanka over the past few years, absence of regular screening has hindered the quality of an effective programme. All activities at the periphery are conducted through the community health-care team with close linkages with different partners including the private sector, donors and civil society. In the school health programme, awareness and social values are emphasized to reduce the intergenerational gap.

Elderly health-care services are integrated with the general health care system and are provided free at the point of delivery for all citizens, giving priority to the elderly for relevant services, which assures high-cost interventions such as bypass surgeries and other cardiac surgeries, organ transplants, joint replacements and neurological interventions. New concepts have been introduced for elderly care such as the establishment of stroke units and geriatric units in teaching and tertiary care hospitals. Conversion of all health institutions as elderly-friendly is being carried out along with the establishment of hospices, long-stay rehabilitation hospitals in the periphery and special eye camps for the prevention of blindness. A programme to prevent deafness and hearing impairment for the elderly has also been introduced recently.

Several challenges remain, like the high cost of health care for the elderly, ensuring age-friendly health services, allocation of additional resources, effective advocacy and awareness, and sensitization of health-care providers. Updated data on all aspects of the ageing population and research on ageing and health care of the elderly are other important challenges.

**Thailand**

The National Commission on the Elderly adopted the Strategic Plan for Long-Term Care in 2009, the Local Administration and Elderly Development Plan in 2010 and the Employment Opportunity for Elderly in 2011. The strategic components of LTC consist of screening for LTC need; establishing standards for nursing and resident-care homes and caregivers from the formal and the informal sectors; developing professional human resources for elderly care; LTC insurance; and addressing the financial aspects of LTC.

The fourth national health examination survey conducted between 2008 and 2009 was published in 2010. The survey looked into dependency level, education, housing and environment, income and health status.
Information on the prevalence of chronic diseases in the elderly population is provided in the table below:

**Prevalence of chronic diseases in the elderly population**

<table>
<thead>
<tr>
<th>Disease/Condition</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>48.0%</td>
</tr>
<tr>
<td>Metabolic syndrome</td>
<td>36.8%</td>
</tr>
<tr>
<td>Abdominal obesity</td>
<td>36.0%</td>
</tr>
<tr>
<td>Obesity</td>
<td>29.9%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>15.9%</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>19.8%</td>
</tr>
<tr>
<td>Depression</td>
<td>9.3%</td>
</tr>
<tr>
<td>Asthma</td>
<td>4.3%</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>3.9%</td>
</tr>
<tr>
<td>Stroke</td>
<td>3.5%</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>2.5%</td>
</tr>
<tr>
<td>Gout</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

Source: Fourth national health examination survey, 2010

As per information from the Burden of Diseases Study: DALY 2009 Thai Working Group of the Ministry of Public Health, the top 10 causes of DALYs in population 60 years and above is indicated below in Table 1.

There are 25 regional-level hospitals, 69 provincial-level hospitals, 741 community-level hospitals and 9783 primary health centres/health promotion hospitals that provide special services including geriatric care and an elderly-friendly environment to the elderly population. Some examples of healthy ageing [2009–2012] activities in Thailand are: development of a community model for LTC; handbook for the elderly population in the Muslim community; community rehabilitation model for elderly Muslim population and a disaster preparedness programme for the elderly. Another programme for the care of the elderly is referred to as Five Happiness Dimensions in Elderly and consists of five promotional activities for health, recreation, integrity, cognition and peacefulness.
The Community Model for Long-Term Care of the Elderly is an integrated set of services provided at the community level. It comprises identifying partially and totally dependent elderly by their activity of daily living, elderly care volunteers in communities, elderly clubs, oral health care, home health care, training and support to health volunteers and caregivers, and ensuring care of the elderly who are partially and totally dependent. Several models for LTC of the elderly units have been set up at the community level, as a result of which a significant number of elderly persons are now able to lead a largely-independent way of life. In 2013, there were 701 LTC model communities all over the country. Primary health centres are also equipped with facilities for rehabilitation and disability limitation.

The elderly clubs organize health promotion activities including physical activity, information on nutrition and self-care, traditional, cultural and social activities, occupational training, and volunteer activities including support to LTC activities.

Table 1: Causes of DALYs in population over 60 years

<table>
<thead>
<tr>
<th>Rank</th>
<th>Male</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disease</td>
<td>DALY</td>
</tr>
<tr>
<td>1</td>
<td>Stroke</td>
<td>174</td>
</tr>
<tr>
<td>2</td>
<td>Ischaemic heart disease</td>
<td>118</td>
</tr>
<tr>
<td>3</td>
<td>COPD</td>
<td>116</td>
</tr>
<tr>
<td>4</td>
<td>Diabetes</td>
<td>96</td>
</tr>
<tr>
<td>5</td>
<td>Liver cancer</td>
<td>93</td>
</tr>
<tr>
<td>6</td>
<td>Bronchus &amp; lung cancer</td>
<td>74</td>
</tr>
<tr>
<td>7</td>
<td>Osteoarthritis</td>
<td>37</td>
</tr>
<tr>
<td>8</td>
<td>Tuberculosis</td>
<td>37</td>
</tr>
<tr>
<td>9</td>
<td>Nephritis &amp; nephrosis</td>
<td>37</td>
</tr>
<tr>
<td>10</td>
<td>Dementia</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>All causes</td>
<td>1528</td>
</tr>
</tbody>
</table>

Source: Burden of Diseases Study: DALY 2009 Thai Working Group of the Ministry of Public Health
The Royal Thai Government has introduced several laws, acts and legislation for older persons. The Act on Older Persons, 2003 focuses on the rights of the elderly; establishment of a national committee on the elderly chaired by the Honourable Prime Minister; institution of tax privileges for the elderly population; and the creation of an elderly fund that provides interest-free loans and supports activities for older persons. In addition, the Royal Thai Government has a policy on tax exemption for those who are taking care of their parents at 30,000 Thai Baht/parent.

The second National Plan for Older Persons covering the period 2002–2021 and revised in 2009 includes comprehensive socioeconomic security for the elderly and preparation of the Thai population to quality ageing. Income security for older persons in Thailand is provided through the universal old-age allowance, the old-age insurance programme, the elderly fund and through the establishment of the National Savings Fund. In addition to the Elderly Club, social support is provided by community volunteers through informal care to the elderly; Older Persons Brain Bank where knowledge and skills of the older generation are passed on to the younger generation through creative activities, and introduction of the prototype age-friendly houses.

The key challenges to ensuring adequate healthy ageing activities in Thailand are LTC insurance, secure income, educational opportunities for the elderly, training and support to informal caregivers, ensuring comprehensive home health care, encouraging the large-scale introduction of the prototype age-friendly housing and supportive environment. Several follow-up activities are underway like monitoring the implementation of the Second National Plan for Older Persons, compilation of the situation of the elderly population, and undertaking a national survey on older persons.

Thailand took part in the Second Review and Appraisal of the Madrid International Plan of Action on Ageing held by UN-ESCAP in Bangkok in September 2012. This participation led to the identification of additional challenges – preparation for the establishment of the National Savings Fund, preparing LTC for the elderly, promoting the capacities of elderly persons and enhancing the capacities of local authorities on issues relating to the elderly population.
**Timor-Leste**

Timor-Leste gained independence in 2002. It has a land area of 14 000 km² and consists of 13 districts, 65 sub-districts, 442 villages (**suko**) and 2336 hamlets (**alteias**). The population is mainly rural with 70% living in rural areas. The country has two seasons, the wet season from November to April and the dry season from June to October.

As per the 2010 census, the total population stands at 1 066 409 and is currently growing at the rate of 2.4% per annum. The older population (60 years and above) is 87 567 or roughly 8.2% of the total population. The male to female ratio stands at 42 239 (49.3%):45 328 (51.7%).

The health policies of Timor-Leste have been focused on communicable diseases control and maternal and child health. There is now an increase in chronic illnesses which requires a readjustment of the existing approach. There is one national referral hospital located in the capital Dili, five referral hospitals spread over the country, 67 community health centres and 213 health posts providing health care to the population.

Extended family groupings are the strongest traditional social networks for Timorese people, with the core family unit consisting of a married couple and their unmarried children. Traditionally, families have remained the foundation for support and care of older people. Since achieving independence, there has been considerable movement of the population within the country with the elderly population moving between the districts to remain with their families.

There is no specific policy/plan of action/strategy for healthy ageing. However, the Constitution, the national strategic development plan [2011–2030] and the national health sector strategic plan (**NHSSP**) [2011–2030] mention the demographic effect of ageing and need for elderly care programmes. The Government intends to provide better access to quality age-friendly and old-age-specific health services with a focus on improving the skills of primary health care providers and introducing community service models, such as home care programmes.

The Constitution gives all citizens the right to security and social assistance where the State has the obligation to promote an economically sustainable social security system that provides a guaranteed income and support for all citizens when they are unable to work. Since 2008, all citizens of Timor-Leste over 60 years and those with proven inability to work are
### Morbidity profile of the older population in Timor-Leste

<table>
<thead>
<tr>
<th>Cause of admission</th>
<th>Proportion of patients in the older age group from each category (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebrovascular diseases</td>
<td>67%</td>
</tr>
<tr>
<td>Cardiovascular diseases</td>
<td>54%</td>
</tr>
<tr>
<td>Liver diseases</td>
<td>41%</td>
</tr>
<tr>
<td>Meningitis/encephalitis</td>
<td>16%</td>
</tr>
<tr>
<td>Asthma</td>
<td>14%</td>
</tr>
<tr>
<td>Bronchopneumonia/pneumonia</td>
<td>11%</td>
</tr>
<tr>
<td>Malaria</td>
<td>10%</td>
</tr>
<tr>
<td>Renal/urinary tract infections</td>
<td>7%</td>
</tr>
<tr>
<td>Diarrhoeal diseases</td>
<td>6%</td>
</tr>
<tr>
<td>All forms of tuberculosis</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

Source: National hospital admissions, 2011

Entitled to financial support of US$ 30 per month. Financial benefits paid to the elderly population have increased over the years, indicating a wider coverage of the population.

The social scheme for older persons is established by Decree/Law No. 19/2008 of 19 June 2008 which provides for a support allowance for the elderly population and those with disabilities. This benefit is a non-contributory one and is based on the age of the beneficiary. Article 5 of the Law states that individuals entitled to benefit from the scheme will be a citizen of Timor-Leste residing within the national territory for at least two years before the date of submission of application for the benefit and at least 60 years old.

The nodal agency for healthy ageing programmes is the Chronic Disease and Disability Unit in the Noncommunicable Disease Department of the Community Health Directorate. This unit supervises the conduct of the ‘Livrinho Saude Amigavel ba Idosus (LISAI)’ or AFHCP (Age-friendly health care programme) for the population aged 60 years and above at all health facilities. Health-care services are provided to the elderly while relevant information is collected on a regular basis on the health status of the elderly population.
There are no special social support programmes for elderly females other than those services provided through the regular health systems, LISAI or AFHCP, and the monthly benefit of US$ 30. There are no LTC institutions for the elderly and community-level care is provided through LISAI or AFHCP.

The Chronic Disease and Disability Unit provides training to the health workers on the implementation of the LISAI or AFHCP for those 60 years and above. There is, however, no specific training provided for identification and management of common problems of the elderly.
Goal

To promote healthy ageing and care of the aged through the life-course

Duration

The proposed duration of the Regional Strategy for Healthy Ageing is five years [2013–2018].

Ageing of the population and its impact on the economic, social and health situations have been recognized by all the Member States of the World Health Organization’s Regional Office for South-East Asia. Several interventions have been established by the Member States to address these issues, although with some variations in magnitude and coverage. The “Regional Strategy for Healthy Ageing” has been formulated to assist Member States in establishing core interventions to promote and strengthen healthy ageing in respective countries. The Regional Strategy is built upon six guiding principles and six key policy directions.

Guiding principles

1. Rights of elderly persons

The rights of the elderly persons have been championed by the United Nations since its inception and enshrined in the Universal Declaration of
Human Rights adopted and proclaimed by the General Assembly of the United Nations in 1948. Article 25 of the Declaration addressed the right to standard of living for the health and wellbeing of individuals, and more importantly, to security of persons in old age.

Ensuring the rights of elderly persons was also reflected in the Second World Assembly on Ageing in Madrid that adopted an International Plan of Action on Ageing (IPAA), 2002, to respond to the opportunities and challenges of population ageing in the twenty-first century and to promote the development of a society for all ages. Article 5 of the Political Declaration of the IPAA reaffirmed the commitments of the Members to spare no effort to strengthen the rule of law and promote gender equality, as well as to promote and protect human rights and fundamental freedoms of elderly persons, eliminating all forms of age discrimination, neglect, abuse and violence against elderly persons while enhancing their dignity in society.

2. **Age-friendly primary health care as the cornerstone of healthy ageing**

Good health is imperative for older people to remain independent and continue to contribute to their families and communities. Older people in most parts of the Region live in the community where they have spent the best part of their lives. An effective strategy to keep the elderly active and help them age with dignity is to provide most of their care in a community setting.

Primary health care needs to be strengthened to become the centre for all care provision. The credibility of primary health care services is directly dependent on the efficacy of the clinical care they provide, which, in turn, will influence promotive and preventive care. The development of appropriate primary health care for the elderly will require defining the composition and responsibility of a team of health professionals in primary health care; the provision of clear guidelines for a health promotion and prevention strategy; and definition and advocacy for maintaining minimum standards of care in the primary care setting.

As noncommunicable diseases become more prevalent among older persons, there is an urgent need to prevent noncommunicable disease-related disabilities and to plan for LTC. Ageing is among the major contributory factors to the rising incidence and prevalence of noncommunicable diseases, which are leading causes of preventable morbidity and disability.
Age-friendly primary health care minimizes the consequences of noncommunicable diseases through early detection, prevention and quality of care, and provides long-term palliative care for those with advanced disease, both at the levels of the family and institution. Such an approach requires appropriate training of several different categories of health-care providers and needs to be supplemented by affordable LTC for those who can no longer retain their independence.

A qualitative situation analysis is essential in each Member State before standards are defined. This step should logically be followed by an analysis of data and the creation of models of care, depending on available resources and prioritization.

3. Participation of elderly persons in society

Participation of the older population in society may range from involvement in economic development activities, formal and informal work and voluntary activities as they age, according to their individual needs, preferences and capacities. Such activities may include inclusion of elderly persons in the planning, implementation and evaluation of social development initiatives and efforts to reduce poverty; elimination of age discrimination by enactment of labour market and employment policies and programmes that enable the participation of people in meaningful work; a diverse system of pension schemes and more flexible retirement options (e.g. gradual or partial retirement); enactment of policies and programmes that recognize and support the contribution that older women and men make in unpaid work in the informal sector and in care-giving in the home.

4. Adopting a multidisciplinary and multisectoral approach

Elderly populations have varying and complex social and health-care needs. For example, while dementia may be addressed with health inputs, the social and financial insecurities that may co-exist require inputs from the social welfare and finance sectors. A multidisciplinary and multisectoral approach, comprising professionals and general staff from several relevant sectors, should be considered as the key mode of care delivery for the elderly populations.
5. **Gender and equity**

Worldwide improvements in health, sanitation and nutrition have enabled an increase in life expectancy where women outlive men and represent a growing proportion of all older people. Elderly women are increasingly burdened with noncommunicable diseases, much of which could be avoided if they had access to necessary care. Women often face disproportionate difficulty in getting the care they need, reflecting the gender inequalities that they have encountered throughout life and that are exacerbated in old age. Although women’s educational situation and labour force participation has improved, elderly women are more likely to have less financial resources than elderly men. Most elderly women prefer to stay in their homes, depending on assistance from family and friends. However, not all elderly women have an adequate support network which can lead to social isolation, contributing to loneliness, worsening health and even death. Absence of social support particularly impacts women, given their increased chances of outliving a spouse and the shift from extended to single-generation families. Elderly women are also at an increased risk of abuse and neglect for a number of reasons. These vulnerabilities are compounded by lower financial resources of the elderly, making them reluctant to leave an abusive relationship. Gender-sensitive interventions require an understanding of the social drivers and consequences that influence both care needs and provision.

6. **Life-course approach**

The process of ageing begins right from the mother’s womb. Nourishment and care received by the mother and her unborn baby determine the health of the newborn. Undernutrition in the womb leads to disease in adult life, such as circulatory disease, diabetes and disorders of lipid metabolism. Obese or overweight adolescents are at risk of developing chronic diseases in adult life and old age. Chronic diseases and disabilities in old age affect the overall quality of life and pose challenges for the families, communities and national governments. Healthy ageing policies and programmes should be based on a life-course perspective that recognizes the influence of earlier life experiences and do not compromise the needs of future older citizens.
Key policy directions

7. Policy and strategy formulation

As the first step, formulation of a national policy or strategy and modification of existing policy/strategy adopted earlier in line with current thinking and approaches should be considered. Some degree of prioritization will be essential to show short-term results in order to attract public attention. The care of the elderly is not the sole responsibility of the Ministry of Health and other ministries such as finance, law, transport, communication, labour, social welfare, education as well as civil society, nongovernmental organizations and faith-based organizations also have an important role to play. In addition, a good national policy and its implementation require political will, clear planning and role-defining as also the importance of taking social, cultural and economic realities into consideration.

8. Development of human resources for quality health care

Training of health professionals in providing good quality health care to the elderly at all levels of health care (primary, secondary, tertiary), at both the pre-qualification stage (in medical school, nursing school, etc.) and in-service (primary care physicians, community health workers, etc.) should be considered an important activity. Health care of the elderly should be considered from several angles: ambulatory care, home care, short-term and long-term institutional care. The training inputs for each of these are distinct and need to be developed at regional and national levels, taking cultural and social diversity into account.

9. Raising the awareness of the population to active ageing

The full implications of an ageing population have yet to be sufficiently recognized by Member States or the general population. This has resulted in weak support with regard to the care of this segment of the population through the public sector. Appropriate messages need to be developed that not only convey the needs of older people, but also highlight the actual and potential contributions of older people at home and in society. Reinforcing the cultural norm of looking after older parents and relatives is an important component of national strategies. Strengthening these cultural norms among adolescents and youth is another important approach. For example, appropriate messages on inculcating responsibility for taking care of elderly relatives could be incorporated in the school curriculum.
10. Long-term care

Population ageing is accompanied by a longer exposure to recognized or unrecognized health risks. Such health risks, along with a biological decline in the structure and function of various organ systems and socioeconomic challenges posed by an increasing ageing population render the elderly vulnerable to a large burden of diseases, posing a major challenge. A substantial number of older people have long periods of dependence and need LTC where the quantum of care varies from individual to individual. Traditionally, LTC of older family members used to be an issue for the family. With changing economic and social norms, families find it increasingly difficult to undertake support and care of elderly family members at home. In many instances, external support is required. Formulation of integrated multisectoral and multidisciplinary LTC services for the elderly population are essential in Member States.

11. Mental health needs of elderly persons

Mental health problems are a leading cause of disability and of reduced quality of life. A significant increase in the number of elderly persons with mental health issues can be expected from population ageing. Strategies to cope with such diseases would include medication, psychosocial support, cognitive training programmes, training for caregivers in the family and caregiving staff and specific structures of inpatient care. Appropriate strategies to increase the level of assessment and diagnosis of mental disorders at an early stage would include multidisciplinary research on these disorders in different settings and environment.

12. Financing of the care of the elderly

The ageing of population is accompanied by changing health-care needs, in particular, the increasing demands for LTC services. As a result, Member States will need to explore financial arrangements to ensure that their elderly populations are not denied access to LTC because they cannot afford it. In addition to making funds available, setting the right financial incentives are also important. Financing mechanisms can be used to encourage the integration of services, improve responsiveness and avoid cost-shifting in health systems. Effective financing is important in providing universal health coverage (UHC) to all individuals with LTC needs. However, there is a general lack of coherent national responses in most Member States to meet
the needs of LTC. Policy reforms are needed to recognize the importance of investing in LTC, aligning financing to the provision of LTC and building coherence towards the integration of LTC into the health care system. As the proportion of the elderly population continues to increase, Member States will need to consider how they can rapidly scale-up their LTC financial resources and strengthen their service infrastructure.

Strategic elements and major activities

**Strategic Element 1:** Developing a country-driven, outcome-oriented, integrated multisectoral policy and plan of action for healthy ageing.

**Strategic Element 2:** Adaptation of the health systems to the challenges of population ageing and to meet the health needs of the elderly population.

**Strategic Element 3:** Long-term care of the elderly population.

**Strategic Element 4:** Developing appropriate human resources necessary for meeting the health needs of older persons.

**Strategic Element 5:** Adoption of a life-course approach to promote healthy ageing.

**Strategic Element 6:** Multisectoral approach and partnership.

**Strategic Element 1: Developing a country-driven, outcome-oriented, integrated multisectoral policy and plan of action for healthy ageing**

**Objective:** To formulate and implement a national policy and plan of action for healthy ageing with the involvement of multiple-related sectors.

**Rationale:** Improving health conditions and reducing disability in the older population demands commitment and shared responsibility. Lack of adequate political commitment has been a key reason for the absence of an effective policy and plan of action on healthy ageing in most Member States. Another important impediment to the implementation of effective programmes for healthy ageing has been the lack of orientation among the programme providers to age-related problems, interventions and their significance. Creation of an enabling environment for the formulation of appropriate policies and their regulatory frameworks to meet the challenge of ageing would be necessary.
**Activities:** Formulation and implementation of a national policy and plan of action for healthy ageing with the involvement of multiple-related sectors that would include:

1. formulation and implementation of legal frameworks and mechanisms for protecting the rights of older persons;
2. development of national databases on all aspects of ageing;
3. projects and initiatives that are gender-sensitive in nature and content;
4. provision of economic and social protection and benefits including accessibility to health care;
5. establishment of an appropriate focal point/nodal agency for the implementation of healthy ageing policy/programme;
6. addressing healthy ageing through the adoption of a life-course approach;
7. development of appropriate information, education and communication (IEC) materials for health promotion;
8. promotion of age-friendly environment including cities, communities and other settings as appropriate;
9. establishment of specific activities to protect the health and psychosocial wellbeing of older persons in disaster/humanitarian crisis situations;
10. promotion of research to provide evidence for effective implementation of policy and programmes;

**Strategic Element 2: Adaptation of the health systems to the challenges of population ageing and to meet the health needs of the elderly**

**Objective:** To design interventions and initiatives that provide a package of preventive, promotive, curative and rehabilitative measures to ensure active healthy ageing throughout the life-cycle.

**Rationale:** A primary-health-care-based system with life-cycle approaches to frame actions taken from the early stages of life that help ensure healthy ageing.
Activities:

(1) promotion of healthy ageing as an essential component of the national primary health care programme for ensuring improved access to health and related interventions;

(2) advocacy for the involvement of primary health care and family physicians, including those in the private sector, in the care of the elderly and promotion of healthy ageing;

(3) promotion of interventions to improve the access of older persons to services, diagnostic technologies, essential drugs and prosthetics;

(4) strengthening primary health care for the prevention, management and referrals of NCDs, other chronic diseases and mental health problems.

Strategic Element 3: Long-term care of the elderly population

Objective: To establish and strengthen programmes to ensure that all older persons in need of care have access to LTC services regardless of age, gender, income and other considerations. Such programmes should be carefully shaped to avoid fragmentation of care provision and constructed for a seamless system of care.

Rationale: The ageing process renders older persons vulnerable to frailty which is accentuated by malnutrition, cognitive impairment, heart failure and chronic inflammation/infection. With advancing age, the disabling impact of chronic diseases also becomes evident with dependence of the older persons on care provided for all activities related to living. A substantial number of older people have long periods of dependence and need LTC, although the quantum of care may vary from individual to individual.

Activities:

(1) design and establishment of an intersectoral system including protocols, regulations and monitoring mechanisms for institutions and communities providing LTC to the elderly population;

(2) development of programmes to support activities of the informal and formal care-givers, including the introduction of incentives and support to those opting to provide LTC in urban, rural and remote areas;
Regional strategy for healthy ageing (2013–2018)

(3) advocacy for the involvement of primary care and family physicians in the LTC of the elderly, including the development of appropriate training and support mechanisms for their effective participation;

(4) promotion of community involvement in the implementation of LTC programmes to ensure local ownership and sustainability;

(5) involvement of the younger generation in all healthy ageing activities;

(6) implementation and adaptation of self-care programmes for the LTC of elderly persons including development of training activities for older adult, self-care;

Strategic Element 4: Developing appropriate human resources necessary for meeting the health needs of older persons

Objective: To upgrade knowledge and skills of personnel delivering health care services (including medical and paramedical personnel).

Rationale: Health systems are challenged to provide care and support for users whose characteristics and needs differ from those of the general population. As such, health-care workers of all categories need new competencies that will enable them to meet the health-care needs of the elderly population.

Activities:

(1) definition of basic competencies required of health workers in the area of health and ageing;

(2) preparation and dissemination of tools to strengthen the competencies of different categories of social and community workers involved in the care of older persons;

(3) promoting the inclusion of ageing and health issues in the undergraduate and postgraduate studies of all professionals in health and related services;

(4) inclusion of key geriatrics and gerontological issues in pre- and in-service training curricula of health professionals;

(5) advanced training in geriatrics and gerontology for relevant health and social professionals;
Regional strategy for healthy ageing (2013–2018)

(6) utilization of health professionals in the private sector for carrying out healthy ageing policies of the government, after adequate training and orientation;

(7) creation of an environment for the retention of health professionals through effective policies and legal framework.

Strategic Element 5: Adoption of a life-course approach to promote healthy ageing

Objective: To empower individuals, reorient health systems and create an enabling environment for the adoption of healthy behaviours throughout the life-course for healthy longevity and prevention of chronic diseases.

Rationale: A life-course perspective on ageing recognizes that individual diversity tends to increase with age and that older people are not one homogeneous group. A life-course perspective supports activities in early life that are designed to enhance growth and development, prevent disease and ensure the highest capacity possible. In adult life, interventions need to support optimal functioning and to prevent, reverse or slow down the onset of disease. In later life, activities need to focus on maintaining independence, preventing and delaying disease and improving the quality of life for older people who live with some degree of illness or disability.

Activities:

(1) Health system interventions for the provision of:
   (a) effective maternal, reproductive and child health programmes to ensure safe motherhood and fetal development;
   (b) child health programmes to protect against vaccine-preventable diseases, undernutrition, obesity and infectious diseases in childhood;
   (c) adolescent health programmes to prevent adoption of risky health behaviour (smoking, sedentary lifestyle, malnutrition and sexually transmitted diseases); and
   (d) primary health care system to provide screening, early detection and management of diseases including NCDs and mental health throughout adulthood.

(2) Prevention of noncommunicable diseases by promoting good health practices throughout life;
(3) Creation of social and physical environment that foster the health and participation of older people through:

(a) promotion of age-friendly environment including cities, communities and other settings as appropriate for each country situation;
(b) changing attitudes towards older persons;
(c) promoting participation of older persons in all activities and recognizing their contributions to society; and
(d) promoting appropriate technology to improve the quality of life of older persons.

**Strategic Element 6: Multisectoral approach and partnership**

**Objective:** To build effective networks and partnerships among all relevant sectors for developing and implementing a national plan of action.

**Rationale:** Promotion and improvement of the health of elderly population will need a multisectoral approach involving sectors such as social welfare, finance, health, law, education, urban planning and development, police and security, civil society, senior citizens’ associations, railways and civil aviation, media, the private sector and the political leadership. A high-level national structure or body will be needed to coordinate the plan of action and monitor the implementation of activities and measure progress.

**Activities:**

1. National authorities to provide supportive administrative mechanisms, adequate budget allocations and ensure the involvement of all relevant government sectors in the formulation, monitoring and evaluation of the healthy ageing policy and plan of action;
2. Political leadership at all levels to ensure formulation and enforcement of appropriate laws, legislation and acts in the proper implementation of all programmes in support of the elderly population;
3. Academia and research institutions to provide improved understanding of the different dimensions of ageing and develop appropriate training protocols for elderly care including health;
(4) civil society, in particular organizations of older persons, would be an integral partner in the formulation and delivery of national plan of action and assist in advocating the rights of the elderly, emphasize the importance of the elderly population to national development, and implement programmes related to care and support to the elderly population at the grass-roots level;

(5) creation of an environment that encourages the private sector to be involved in carrying out the national plan of action on healthy ageing through actions such as corporate social responsibility initiatives, simple, assisted devices to limit disabilities and frailty, affordable and accessible essential medicines and participation in the ambulatory and palliative LTC of the elderly population;

(6) media would support awareness-raising campaigns about the rights of the elderly persons, positive images of ageing, inform the population about programmes for the elderly and alert the authorities about infringement of rights, neglect or abuse of elderly persons; and

(7) WHO, in partnership with other organizations within and outside the UN system, to support and assist in the development and implementation of the national policy and plan of action, provide necessary policy and technical advice in different areas including human resource development and stimulate intercountry collaboration mechanisms.

**Indicators**

**Regional level**

(1) number of Member States that have formulated national policy and plan of action on healthy ageing;

(2) number of Member States that have established national databases on older persons including information on population, economic status, income, health profile, housing and ownership;

(3) number of Member States that have established units/departments for promoting healthy ageing programmes in the Ministry of Health and/or other relevant ministries;
(4) number of Member States that have established administrative mechanisms to achieve multisectoral cooperation in elderly care;

(5) number of Member States that have formulated LTC policy with a regulatory and monitoring mechanism for LTC institutions in the formal and informal sectors;

(6) number of Member States that have produced protocols, manuals and guidelines on training of health staff in aspects of healthy ageing;

(7) number of Member States that have established geriatrics unit at health facilities; and

(8) number of Member States that have established specialization in geriatrics/gerontology at postgraduate level.

**National level**

(1) existence of a national policy and plan of action on healthy ageing including systems for regular monitoring and evaluation of implementation;

(2) appropriate indicators to measure the extent of intersectoral coordination in the implementation of national policies and plans of action;

(3) number of age-friendly primary health centres;

(4) number of medical schools with specialization in geriatrics/gerontology;

(5) number of geriatricians in public and private health sector;

(6) number of health facilities with geriatrics unit at the secondary and tertiary levels;

(7) number of doctors, nurses and paramedics that have undergone training in geriatrics/gerontology; and

(8) existence of unit/department for promoting healthy ageing programmes in the Ministry of Health and/or other relevant ministry (ies).

(9) *Indicators for NCD [as appropriate]*
References


Annex

Country profiles on healthy ageing  [in Member States]

Bangladesh

<table>
<thead>
<tr>
<th>Elderly population (60+ years)</th>
<th>Life expectancy</th>
<th>Morbidity pattern [top 10 causes]</th>
<th>Mortality pattern [top 10 causes]</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.6 million (6.6%)</td>
<td>60.7 years</td>
<td>National-level information not available</td>
<td>National-level information not available</td>
</tr>
</tbody>
</table>

National policy/plan of action

**National Policy on Ageing (2007)**

Key objectives:
- ensuring dignity of elderly people in society
- identifying problems of the elderly and addressing them along with creation of new programmes targeting socioeconomic development
- developing social measures to help the elderly during humanitarian crises

Multisectoral approach

- Ministry of Social Welfare as the implementing agency
- Interministerial action plan with integration of public, private and international efforts
- National guidelines on the formation of committees at various levels of the administration

Legislative/administrative measures

- As part of Constitutional Provision (Article 15)
- Social safety net programmes including the elderly population
- Micro-credit programmes providing direct benefit to the elderly
- Retirement pension for public service employees

Health care

- Health services for elderly population through Upazilla Health Complex and family welfare centres as part of the health, nutrition and population sector programme
- Social services programmes at government and private hospitals provide the elderly population with medical assistance, counselling and rehabilitative services
Bhutan

<table>
<thead>
<tr>
<th>Elderly population (60+ years)</th>
<th>Life expectancy</th>
<th>Morbidity pattern [top 10 causes]</th>
<th>Mortality pattern [top 10 causes]</th>
</tr>
</thead>
<tbody>
<tr>
<td>33,759 (5%)</td>
<td>68.1 years</td>
<td>National-level information not available, but increase in chronic diseases and disabilities reported</td>
<td>National-level information not available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National policy/plan of action</th>
<th>Multisectoral approach</th>
<th>Legislative/administrative measures</th>
<th>Health care</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal policy</td>
<td>Royal Society of Senior Citizen’s Association established to formulate policy directives and strategies to promote healthy ageing</td>
<td>National Pension and Provident Fund created to provide old age retirement benefits</td>
<td>Community-based health care provided by 1200 village health workers</td>
</tr>
<tr>
<td>Geriatric care programme established</td>
<td>Pilot project (Khaling community) for community-based care – early detection and control of diseases and maintaining “activities of daily living”;</td>
<td></td>
<td>Secondary level care and referrals available at the 518 “outreach clinics”</td>
</tr>
<tr>
<td>“Package of Essential” (PEN) interventions to address common chronic diseases;</td>
<td></td>
<td></td>
<td>Additional care through 181 basic health units, 30 district hospitals, two regional and one national referral hospitals</td>
</tr>
</tbody>
</table>
### Democratic People’s Republic of Korea

<table>
<thead>
<tr>
<th>Elderly population (60+ years)</th>
<th>Life expectancy</th>
<th>Morbidity pattern [top 10 causes]</th>
<th>Mortality pattern [top 10 causes]</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.13 million (13%)</td>
<td>69.2 years</td>
<td>Hypertension, backache, CVD, arthritis, digestive complaints</td>
<td>National-level information not available</td>
</tr>
</tbody>
</table>

**National policy/plan of action**
- Multisectoral approach
- Legislative/administrative measures
- Health care

- No specific policy;
- Several laws contain social measures and policies for care of the elderly.
- Recognition and honour for elders who had served the country;
- Day of the Elderly celebrated every year.
- Socialistic Constitution (1972)
- Family Law (1992)
- Care of the Elderly Law (2010)
- Pension for men > 60 years and females > 55 years;
- All citizens > 90 years are registered and receive special support.
- ‘Section doctors’ provide services;
- Long-term care in primary and specialty hospitals, at old-age homes, community and family levels strengthened;
- Training in geriatrics and gerontology for health staff;  

### Indonesia

<table>
<thead>
<tr>
<th>Elderly population (60+ years)</th>
<th>Life expectancy</th>
<th>Morbidity pattern [top 10 causes]</th>
<th>Mortality pattern [top 10 causes]</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.1 million (7.6%)</td>
<td>70.93 years</td>
<td>Osteoarthritis, hypertension, cataract, stroke, CVD</td>
<td>Stroke, chronic respiratory infection, tuberculosis, hypertension CHD &amp; CVD</td>
</tr>
</tbody>
</table>

**National policy/plan of action**
- Multisectoral approach
- Legislative/administrative measures
- Health care

- Ministries of social affairs, health, transportation, women empowerment, religious & spiritual services, culture & tourism, information, national education, law and human resources
- Law No. 13/1998 on the welfare of older persons
- Government Decree No. 43/2004 on efforts to improve older persons’ welfare
- Presidential decree No. 52/2004 and 93/M/2005 on national commission for older persons (ageing)
- Law Number 36/2009 on the Health
- Provision of health care to older persons as part of family health efforts.
- Geriatric services are available at district and provincial hospitals.
- Activities for elderly groups are facilitated by elderly health volunteers.
- To develop primary health care for elderly through age-friendly primary health care.
## India

<table>
<thead>
<tr>
<th>Elderly population (60+ years)</th>
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<th>Morbidity pattern [top 10 causes]</th>
<th>Mortality pattern [top 10 causes]</th>
</tr>
</thead>
<tbody>
<tr>
<td>(7.6%)</td>
<td>64.2 years</td>
<td>National-level information not available</td>
<td>National-level information not available</td>
</tr>
</tbody>
</table>

**National policy/plan of action**

### National Policy on Older Persons (1999)
- Ministry of Social Justice and Empowerment is the nodal ministry with inputs from health, finance, banking and transportation ministries.
- Several civil society/NGOs providing elderly care and support

**Multisectoral approach**

**Legislative/administrative measures**

**Health care**

### National Social Assistance Programme
- National Old Age Pension Scheme
- National Initiative on Care for Elderly

## Maldives

<table>
<thead>
<tr>
<th>Elderly population (60+ years)</th>
<th>Life expectancy</th>
<th>Morbidity pattern [top 10 causes]</th>
<th>Mortality pattern [top 10 causes]</th>
</tr>
</thead>
<tbody>
<tr>
<td>15,360 (4.8%)</td>
<td>67.6 years</td>
<td>• NCD risk factor survey indicated high prevalence of risk factors for CVD and cancer; National-level information not available.</td>
<td>National-level information not available; 80% mortality among adults attributed to NCDs.</td>
</tr>
</tbody>
</table>

**National policy/plan of action**

### Draft strategy for healthy ageing in 2010 and draft Policy for the Elderly in 2012.
- Long-term care provided through “home for people with special needs”.

**Multisectoral approach**

**Legislative/administrative measures**

**Health care**

### Ministry of Social Justice and Empowerment
- Pension Act (2009)
- Fundamental Rights and Freedom in Constitution – Article 35 B
- Universal Health Insurance Act
- Single parent allowance

### Ministries of gender, family and human rights
- Limited technical capacity for expanding range of services

### Training facility in geriatrics at the Faculty of Health Sciences is proposed

### Universal Health Insurance Act provides OPD, medications and physiotherapy

### Geriatric health care at all levels of health system including outreach, introduced by the Government.
### Myanmar

<table>
<thead>
<tr>
<th>Elderly population (60+ years)</th>
<th>Life expectancy</th>
<th>Morbidity pattern [top 10 causes]</th>
<th>Mortality pattern [top 10 causes]</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.46 million (9.1%)</td>
<td>56.2 years</td>
<td>Cataract, hypertension, CVD, diarrhoea, gastroenteritis, tuberculosis, pulmonary disease, stroke and diabetes mellitus</td>
<td>CVD, stroke, malignancy of bronchus and lung, tuberculosis, chronic obstructive pulmonary disease</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
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<th>Legislative/administrative measures</th>
<th>Health care</th>
</tr>
</thead>
</table>
| • National plan of action for older persons and national policy for older persons under formulation.  
  • National health plan (1993–2006) included a programme on healthy ageing. | • Social and economic support programme introduced by Government  
  • Republic of Korea – ASEAN home care programme  
  • Older people self-help group, Paid home-care  
  • Civil society and local NGOs | • Constitution – Article 32 refers to the care of elderly population  
  • Relevant legislation, acts and laws for elderly care are yet to be established.  
  • 70 homes for the aged supporting 2300 older persons  
  • Tradition and culture ensures provision of care for the elderly. | • Elderly health care project in 88 townships  
  • Weekly clinics provide basic health care, physical activity, rehabilitation, referrals and counselling.  
  • Training of health staff in basic geriatric care. |
Nepal

<table>
<thead>
<tr>
<th>Elderly population (60+ years)</th>
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<th>Mortality pattern [top 10 causes]</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.42 million (9.1%)</td>
<td>67.1 Yrs.</td>
<td>National-level information not available</td>
<td>National-level information not available</td>
</tr>
</tbody>
</table>

**National policy/plan of action**

- Ninth Plan includes a section on senior citizens with objectives:
  - new legislation for the security of senior citizens;
  - programmes to enhance respect and dignity of senior citizens;
  - initiate a national pension scheme.

- Tenth Plan (2002–2007)
  - to make the living conditions of senior citizens comfortable, secure and dignified by using their knowledge, skill and experience.


- The Second three-year plan (2010–2013) aims at improving services, facilities and increasing awareness for healthy, safe and dignified living conditions for senior citizens.

**Multisectoral approach**

- Ministry of Women, Children and Social Welfare established a senior citizens’ working policy.
- Other ministries providing inputs are health and population, local development, information and communication.
- National Planning Commission

**Legislative/administrative measures**

- The Civil Code 1963
- Local Self Governance Act, 1998 and 1999
- Senior Citizens Act, 2006
- Senior Citizens Regulations 2065 (2008)
- National Senior Citizens Federation
- Universal non-contributory pension scheme

**Health care**

- Free geriatric beds at eight hospitals;
- Free care for chronic diseases to all poor persons 75 years and over;
- Long-term care provided in old-age homes;
- Basic health care through the primary health care system.
## Sri Lanka

<table>
<thead>
<tr>
<th>Elderly population (60+ years)</th>
<th>Life expectancy</th>
<th>Morbidity pattern [top 10 causes]</th>
<th>Mortality pattern [top 10 causes]</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.8 million (12.3%)</td>
<td>74.1 years</td>
<td>National-level information not available</td>
<td>National-level information not available</td>
</tr>
</tbody>
</table>

### National policy/plan of action
- Enactment of the Protection of Rights of Elders Act (2000)

### Multisectoral approach
Ministry of Social Welfare is the nodal ministry with inputs from the ministries of health, finance, social security, local administrations

### Legislative/administrative measures
- National Elders Charter, National Council for Elders, Maintenance Board for Elders

### Health care
- Health Master Plan – elderly health care as priority;
- Integration of elderly health care with overall public health care services;
- Postgraduate training in geriatrics and elderly health care in basic and post-basic training of health personnel;
- Geriatrics wards in public sector hospitals.
### Thailand

<table>
<thead>
<tr>
<th>Elderly population (60+ years)</th>
<th>Life expectancy</th>
<th>Morbidity pattern [top 10 causes]</th>
<th>Mortality pattern [top 10 causes]</th>
</tr>
</thead>
<tbody>
<tr>
<td>(11.7%)</td>
<td>70.8 years</td>
<td>Hypertension, metabolic syndrome, abdominal obesity, diabetes, osteoarthritis, depression, asthma, stroke, chronic kidney disease</td>
<td>National-level information not available</td>
</tr>
</tbody>
</table>

#### National policy/plan of action

- Second National Plan for the Older People

#### Multisectoral approach

Ministry of Public Health with assistance from the local administration, elderly clubs, community volunteers, civil society, health promoting temples

#### Legislative/administrative measures

- Constitution of Thailand (2007)
- Decentralization Act (2006)
- Elderly Act
- Public Health Act (1992)

#### Health care

- Strategy on health development for the elderly developed by the Ministry of Public Health
- Community-based integrated services of health care and social welfare for Thai Older Persons
- 25 regional-level, 69 provincial-level, 741 community-level hospitals and 9783 primary health centres provide health care to the elderly.
### Timor-Leste

<table>
<thead>
<tr>
<th>Elderly population (60+ years)</th>
<th>Life expectancy</th>
<th>Morbidity pattern [top 10 causes]</th>
<th>Mortality pattern [top 10 causes]</th>
</tr>
</thead>
<tbody>
<tr>
<td>87,567 (8.2%)</td>
<td>50 years</td>
<td>Cerebrovascular, cardiovascular, hepatobiliary, meningitis and encephalitis, asthma and respiratory and diarrhoeal diseases, malaria, all forms of tuberculosis</td>
<td>National-level information not available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National policy/plan of action</th>
<th>Multisectoral approach</th>
<th>Legislative/administrative measures</th>
<th>Health care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No specific policy/plan</td>
<td>Constitution gives all citizens right to economically sustainable social security system</td>
<td>Decree/Law No. 19/2008 - pension for all citizens &gt; 60 years</td>
<td>• Age-friendly health care (Livrinho Saude Amigavel ba Idosos-LISAI) provided as part of “Chronic Disease &amp; Disability Unit”;</td>
</tr>
<tr>
<td>National Constitution, Strategic Development Plan and the National Health Sector Strategic Plan (2011–2030) have considered population ageing and need for elderly care.</td>
<td></td>
<td>• Training of health workers on implementation of LISAI;</td>
<td>• No specialized geriatrics training for health staff.</td>
</tr>
</tbody>
</table>
Most individuals now reach old age, and the proportion of elderly persons in the Member States of the WHO's South-East Asia Region will continue to increase over the years. This demographic shift to a large proportion of elderly persons will challenge the existing public health and social services in the Member States. The focus on ageing is not only to prolong life but also to improve the quality of life of elderly persons. Healthy ageing is a process of optimizing opportunities for physical, social and mental health to enable the elderly persons to take an active part in society without discrimination and to enjoy an independent and good life. This Regional Strategy for Healthy Ageing has been formulated to assist Member States to establish core interventions for promoting and strengthening healthy ageing with the overall goal to promote healthy ageing and care of the aged throughout the life-course.