A focus on ageing is not only to prolong life but also to improve the quality of life of the elderly. Healthy ageing is a process of optimizing opportunities for physical, social and mental health to enable the elderly to take an active part in society without discrimination, and to enjoy an independent and good life. A regional meeting to strengthen healthy ageing programmes in the South-East Asia Region was organized by the World Health Organization’s Regional Office for South-East Asia [WHO SEARO] in collaboration with the Ministry of Health and the Ministry of Social Services, Government of Sri Lanka, in Colombo, Sri Lanka, from 17-20 October 2012.

The regional meeting was attended by representatives from the nine Member States of the WHO South-East Asia Region and included Bhutan, Democratic People’s Republic of Korea, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor Leste. In addition, representatives from the Social Affairs Department of the United Nations Economic and Social Commission for Asia and Pacific (UN-ESCAP); United Nations Population Fund (UNFPA) India Office; International Federation of Ageing; HelpAge-Sri Lanka; and observers from Indonesia and Sri Lanka also participated.

The meeting report contains a review of the status of healthy ageing programmes in the Member States of the Region and the determination of the approaches for care of the elderly, including adequate financing and long-term and ambulatory care. A thorough review of the draft regional strategy on health ageing was also undertaken. The regional strategy on healthy ageing intends to encourage Member States to initiate, develop and sustain a multisectoral approach and measures for the promotion of ageing among all population groups following a life-course approach.
Strengthen Healthy Ageing Programmes in the South-East Asia Region

Report of a regional meeting

World Health Organization
Regional Office for South-East Asia
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1. **Introduction**

A regional meeting to strengthen healthy ageing programmes in the South-East Asia Region was organized by the World Health Organization’s Regional Office for South-East Asia [WHO-SEARO] in collaboration with the Ministry of Health and the Ministry of Social Services, Government of Sri Lanka, in Colombo, Sri Lanka, from 17 – 20 October 2012.

The general objective of the meeting was to promote and strengthen healthy ageing programmes in South-East Asia Region, while the specific objectives were to review the status of healthy ageing programme in Member States; to review and finalize the draft Regional Strategy for Healthy Ageing; to identify and agree upon the approaches for care of the elderly including adequate financing and long-term ambulatory care.

Representatives from nine Member States of the Region participated in the meeting: Bhutan, Democratic People’s Republic of Korea, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. In addition, representatives from the Social Affairs Department of the United Nations Economic and Social Commission for Asia and Pacific [UN-ESCAP]; United Nations Population Fund [UNFPA] – India Office; International Federation of Ageing; HelpAge-Sri Lanka; and observers from Indonesia and Sri Lanka also participated. Several experts on geriatrics, gerontology and public health served as resource persons.

The meeting was inaugurated by Honourable Maithrapala Sirisena, Minister of Health, Sri Lanka. Welcoming the participants the Minister pointed out that Sri Lanka faced a rapidly ageing population due to an increase in the life expectancy of the country’s population along with a declining death rate. The Government of Sri Lanka has been trying through different programmes to make the lives of the ageing population happy and healthy. A national plan for ageing was formulated in 2010 and a number of social security schemes were put in place to support people from diverse backgrounds in their old age.
The Honourable Minister added that special identity cards have been issued to the elders to obtain priority services. These identity cards assured various benefits for the elderly population in obtaining public services from hospitals, banks and other public institutions. Assistive devices such as hearing aids, eye glasses, wheel chairs and crutches are provided free of charge to the needy elders. The Parliament has also passed regulations to make public buildings, public places and public services accessible to the elderly persons and those with disabilities. Care giving is a natural occurrence in Sri Lankan culture. In many Sri Lankan families, parents move in with their children when the children get married. The parents then help raise their grandchildren even when they themselves need care. The children and grandchildren are prepared to care for their parents (and grandparents) until the end of their life.

Throughout history, the cultures of the world have defined the success of people by the way they treat their elders. The family remains the most important and trustworthy and dependable source for taking care of the elders. In conclusion, the Honourable Minister stated that one should be realistic about old age and see it as a natural and inevitable process. This will help us to gracefully accept the situation and use our energy in meaningful activities.

The message from Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia was read out by Dr Firdosi Mehta, WHO Representative in Sri Lanka.

In his message, Dr Plianbangchang welcomed the participants and expressed his gratitude to the Government of Sri Lanka for hosting this consultation. He pointed out that the around 142 million people or just about 8% of the population of the WHO South-East Asia Region are above the age of 60 years. By 2025, the estimated proportion of the population over 60 years in countries of the Region will be twice that of the proportion of the elderly population in 2000, and by 2050 this proportion will have increased to three times the proportion of 2000. While development and progress have brought about improved quality of life, it has also led to increased life expectancy such that by 2045 it is estimated that the average life expectancy at birth among the population of the Region will be above 75 years. Longer life is associated with chronic diseases and disabilities in old age. This affects the overall quality of life and poses a challenge for
families, communities and national governments. With nuclear families replacing joint families and with large rural-to-urban migrations of the younger population, the age-old balance of care of the old and very old at home is being affected.

Dr Plianbangchang emphasized that 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. Prolonging and saving lives of the elderly population, and protecting health and removing disability and pain are achieved through a well-articulated combination of healthy lifestyle across the life-course, an age-friendly environment and improved detection and prevention of diseases. Several critical questions emerge from population ageing and concern policy and decision-makers, nongovernmental organizations and some sectors of the private sector. These include the economic effects of ageing on health care and social support systems; new ways of ensuring the independence, quality of life and normal activity level of older persons; and the social, economic and health problems of elderly females and very old persons. An increase in the proportion of older persons will require adaptations of the health care and social support systems to meet this emerging challenge.

In conclusion, Dr Plianbangchang mentioned that this meeting was being organized to promote and strengthen healthy ageing programmes in South-East Asia. As part of this exercise, the status of healthy ageing programmes in the Member States of the Region will be reviewed and the approaches for care of the elderly, including adequate financing and long-term and ambulatory care will be determined and agreed upon. Another key outcome of this meeting would be a thorough review of the draft regional strategy on healthy ageing. The regional strategy on healthy ageing intends to encourage Member States to initiate, develop and sustain a multisectoral approach and measures for the promotion of ageing among all population groups following a life-course approach.

In explaining the objectives and mechanics of the meeting, Dr Kunal Bagchi, Regional Adviser, WHO-SEARO, said that the meeting is the culmination of a series of activities undertaken by WHO-SEARO. In 2009, a strategic framework for active healthy ageing was introduced to Member
States followed by technical support to strengthen particular areas of healthy ageing programmes and identify constraints. Several international organizations have conducted regional and national surveys on different aspects of ageing with the accumulation of considerable information and knowledge about ageing.

The theme for the World Health Day of 2012 was ageing and health with the slogan ‘good health adds life to years’. The World Health Day was celebrated in all the Member States of South-East Asia Region and generated considerable interest among the general population and the media. The Thirtieth Meeting of Ministers of Health of countries of the South-East Asia Region of WHO adopted the Yogyakarta Declaration on ageing and health with 14 action points in 2012. A draft regional strategy for healthy ageing has been formulated for review by Member States.

Several technical presentations on several aspects of ageing and elderly health care will be presented including: demographic, social and health implications of ageing; age-friendly primary health care and cities; gender and ageing, geriatrics training and long-term care; networking; and highlights from the draft regional strategy on healthy ageing. All invited Member States will report on the status of programmes for elderly and healthy ageing in their countries. Based on information from all these presentations, participants will undertake a detailed review of the draft strategy. The expected outcomes of the regional meeting are: information on the existing national programmes for elderly care and healthy ageing in the Member States of the South-East Asia Region; sharing of experiences and programmatic knowledge on elderly care between Member States; and a review of the draft regional strategy for healthy ageing.

Dr R.R.M.L.R Siyambalagoda from Sri Lanka and Dr Nantasak Thamanavat from Thailand were nominated as the Chairperson and Co-Chairperson while Dr Nugroho Abikusno from Indonesia was nominated as the Rapporteur.

During the first plenary session, entitled “Setting the stage”, presentations on demographic issues and findings from regional surveys on ageing; social and health implications of ageing; gender and ageing; and age-friendly primary care; and an age-friendly city approach in Sri Lanka were made. The session concluded with video-presentations on “global
overview of healthy ageing” and “age-friendly cities approach”, both from the Department of Ageing and Life-course, WHO-HQ.

In the subsequent plenary sessions, representatives from Bhutan, Democratic People’s Republic of Korea and Indonesia presented reports on the status of ageing and elderly care programmes in their countries. This was followed by presentations on issues and implications relating to training in geriatrics and long-term care of the elderly.

On the second day of the meeting, representatives from Sri Lanka, Maldives, Myanmar, Nepal, Thailand and Timor-Leste presented reports on the status of ageing and elderly care programmes in their countries. A plenary session on “Networking and Healthy Ageing” included presentations on the role of civil society and international nongovernmental organizations to promote healthy ageing through effective networking by HelpAge Sri Lanka and International Federation of Ageing.

Highlights from the draft regional strategy for healthy ageing were introduced to the participants followed by group work on a critical review of the draft regional strategy and identification and agreement upon approaches for care of the elderly including adequate financing and long-term ambulatory care.

For the purpose of group work, participants were divided into three groups: Bhutan, Nepal and Thailand into one group; Maldives, Myanmar and Sri Lanka into the second group; and the Democratic People’s Republic of Korea, Indonesia and Timor-Leste into the third group. Each group was provided with a set of queries on which to base their reviews. A number of technical experts served as resource persons for each group.

On the third day of the meeting, participants visited “Sahanodaya Elderly Care Home” in Dehiwala that housed 30 elderly persons without any social or economic support. The facility was managed by a religious organization and was entirely self-funded. This was followed by a visit to an ‘Elderly Club’ located in Kalutara, where members of the club presented a dynamic cultural show showcasing their handicrafts and previous year’s activities for the visitors.
2. Technical presentations

2.1 Demographic issues to ageing in South-East Asia

Marco Roncarati, Social Development Division, United Nations Economic and Social Commission for Asia and Pacific [UN-ESCAP], Thailand.

Demographic trends in the Asia and Pacific region in 2012 indicate that 65% of the nearly half a billion people over the age of 60 years are women and about 50% of the older persons are poor. The number of older persons will triple from 419 million in 2010 to more than 1.2 billion by 2050 and by this time, one in four persons in the Region will be over 60 years. Since the 1960s, the average total fertility rate has continued to decline while from the 1980s the proportion of the population over the age of 60 has continued to rise. It is to be noted that only about 30% of the older persons receive some form of pension in developing countries of the Region. Women constitute a majority of the older population due to their longer life expectancy and they represent an even greater majority of the ‘oldest old population’ (80 years and older) and are more vulnerable to poverty and social isolation. In several large countries of Asia and Pacific like Australia, China, Indonesia, Japan, Thailand and, to some extent, India, the proportion of persons 65 years and above is more than those aged 20 – 64 years which means that there are fewer people in the workforce to support the growing number of older persons.

Several physiological changes occur with ageing including slowing of nerve conducting velocity; reduction in kidney blood flow, maximum breathing capacity and work rate as well as oxygen uptake. In the areas of health advancement and well-being, eight of the 11 Member States of the South-East Asia Region have health care policies and plans for older persons, most of which have been adopted to ensure accessible, affordable and available health care services, including geriatric care and primary care as well as gerontology training. However, appropriate resources to implement the above plans and policies remain a challenge. Significant gaps remain in the provision of mental health services for the elderly population, support for older persons with HIV/AIDS, prevention of chronic diseases, and in improving the health of elderly females.
UN-ESCAP undertook three surveys in 2002, 2005 and 2011. The first survey established a consensus among countries pledging their commitments to the implementation of the Madrid Implementation Plan of Action on Ageing (MIPAA) and the Macao Plan of Action on Ageing. The survey in 2005 mapped out progress achieved against the 239 objectives of MIPAA, updated by 2011 and coinciding with the preparation for commemoration of the 10th anniversary of MIPAA in 2012. The survey findings provided a greater understanding of the many steps and measures that countries have taken to meet the goals and objectives of MIPAA. Future data collection should enable further cross-country monitoring and sharing of good practices.

ESCAP undertook an Asia-Pacific Intergovernmental Meeting with the participation of 30 members and associate members a second review and appraisal of the MIPAA in 2012. The meeting recommended:

- According priority to older persons in national policies and frameworks.
- Ensuring multisectoral responses and mainstreaming of ageing into national policies.
- Increasing national capacity and resources.
- Developing comprehensive social protection schemes.

Older persons have a wealth of experiences. Health promotion and productive ageing enhance well-being along with greater investments in social protection across the lifecycle, allowing the elderly to contribute to socio-economic development.

### 2.2 Population ageing implications for social and health policy: the India example

**Andres Thompson, United Nations Population Fund (UNFPA)-India, India**

Within a decade there will be 1 million older persons worldwide and by 2050, nearly 80% of the world’s older persons will be living in developing countries with China and India contributing to over a third of this number. By 2011, an estimated 90 million elderly people were living in India, a
figure that was expected to increase to 173 million by 2026 constituting 12% of the population. By 2050, around 20% [323 million] of India’s population will be over 60 years. China’s pace of ageing will occur faster due to its one child policy and quicker reduction in various mortality rates but eventually, by the end of this century, India will catch up.

India started experiencing rapid demographic transition since the 1980s and due to this a ‘demographic window’ of opportunity was experienced in the form of a ‘youth bulge’. The growth rate in the working population witnessed a peak around 2000 in comparison to the overall growth rates in the dependent population. This ‘youth bulge’ is going to be felt till 2025 subsequent to which the growth rate of the elderly is like to take over and peak after mid-2040. In fact, starting from 2010, a steady increase in old age dependency has been projected. The needs of the youth and the elderly should therefore be addressed within the varied demographic fabric of the country.

Profile of the elderly population in India may be summarized as:

- Nearly 9% of the population is over 60 years
- The proportion of the elderly population is increasing, both in rural and urban areas, and among men as well as women; a substantial proportion of the rural elderly is from poor communities and usually from the poorest quintile
- The proportion of widows is increasing with the phenomenon of ‘feminization of ageing’ and the gender dimensions in population ageing is pronounced and an area of concern
- Literacy among the elderly is high (estimated 64%) and often as high as 81% in women
- Increasing overall life expectancy and higher old: older (80+) ratio
- Migration of young adult population with parents and older relatives left behind
- Of the estimated 450 million workforce in India, 20 million is in the salaried private sector and 20 million civil servants are eligible for pension.
Findings from various national studies indicate differences in the ‘economy-wide’ consumption by India’s relatively large young population and its elderly population. It is estimated that a majority of family support goes to family members below 20 years with little or any going to family members aged 60 years or above. These findings confirm the widespread assumption that in the absence of a viable social security net, the family provides for Indian elders.

The family structure and living arrangements of the elderly in India are changing where one in three households in the country have an elderly person and four out of five elderly men and one out five elderly women are heads of households. The proportion of female-headed households has increased from 13% to 21% between 1992 and 2006.

Private spending on health in India is 74% of the total spending on health, out of which 90% is ‘out-of-pocket’ expenditure, the rest being covered by health insurance. Out-of-pocket expenditure on health in India is the highest in Asia. With an increase in the proportion of older persons, geriatric problems will increase which will imply an increase in the hospitalization rate and more dependency on the private sector. For the very old [80 years and above], long-term care at the institutional and family levels will become a major issue.

It has been estimated that one-half (47%) of older Indians have at least one chronic disease such as asthma, angina, arthritis, depression or diabetes. The ageing of India’s population will lead to an increase in the prevalence of chronic conditions such as diabetes or hypertension. By one measure, nearly 45% of India’s disease burden is projected to be borne by older adults in 2030 when the population age groups with high levels of chronic condition will account for a much greater share of the total population. The elderly population are vulnerable on several counts:

- 90% of the elderly population in India are excluded from any formal pension
- Only 20% of the elderly population has some form of health insurance
- The elderly population is subjected to both petty and violent incidents
A significant number of elderly had reported facing abuse, particularly at the family level.

Several national social assistance programmes to assist the elderly population are found in India. For example, the Indira Gandhi National Old Age Pension Scheme is meant for people 60 years and above living below the poverty line. A monthly pension of INR 200 is provided up to the age of 79 years and INR 500 thereafter. However, adequate assistance is yet to reach most of the elderly population, particularly those in need. Poor administration, lack of awareness and interest has resulted in this state of affairs.

There are several policy and programme gaps in providing support and assistance to the elderly population in the country. There is no policy priority, the National Council for Older Persons has a limited role and the Senior Citizens Act of 2007 has yet to be applied in all the states. There is lack of coordination among partners with no accountability and measurable time-bound results. The nodal ministry for the elderly has inadequate monitoring and implementation mechanisms in place, several key positions remain vacant and there is considerable reliance on nongovernmental organizations/civil society sector for the delivery of services.

While the rise of the population is both an opportunity and a challenge, concerted multi-sectoral actions with the involvement of all stakeholders will be needed. It is imperative to get concerned ministries and departments to consolidate these initiatives. The proposed advocacy objective is to engage with, orient and support a governmental ‘supra body’ to orchestrate inter-sectoral responses needed to adopt and implement the National Policy for Senior Citizens (2011). This ‘supra body’ could be a high powered body that is already mandated to advise various ministries. This would be followed by the rolling out of an advocacy strategy, involving all stakeholders and drawing upon their expertise.

Some of the policy suggestions are:

- Universal pension for all those 75 years and above, irrespective of their economic status.
- Special incentives for all elderly destitute, especially women and disabled women and widows.
Strengthen Healthy Ageing Programmes in the South-East Asia Region

- Introduction of medical gerontology and geriatrics in the medical syllabus including social gerontology to promote community-based care.
- Constitution of a high-powered political ‘advisory body’ with effective connection with various sectors of the government.

Mr Thompson concluded by remarking that old age can, and should be, a happy time and one should find solutions!

2.3 Towards age-friendly primary health care

*Sudhansh Malhotra, WHO-SEARO*

Primary health care (PHC) is essential health care made available at a cost the country and community can afford with methods that are practical, scientifically sound and socially acceptable. There is some distinction between primary care and primary health care. Primary care is the client’s first point of entry into the health system when medical assistance is sought. Primary health care on the other hand is a multi-disciplinary approach encompassing a continuum of care: promotion, prevention, treatment and rehabilitation by addressing social, cultural, economic and environmental factors that affect people’s health. Primary health care must be accessible and be ‘friendly’ to persons of all ages. The underpinning principles of primary health care are: equity, universal coverage, intersectoral collaboration, community participation and appropriate technology.

The evolving paradigm of PHC is summarized in the table below:

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<tr>
<th>Early attempts at implementing PHC</th>
<th>Current concerns of PHC reforms</th>
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<tr>
<td>Extended access to a basic package of health interventions and essential drugs for the rural poor</td>
<td>Transformation and regulation of existing health systems, aiming for universal access and social health protection</td>
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<td>Concentration on mother and child health</td>
<td>Dealing with the health of everyone in the community</td>
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<tr>
<td>Improvement of hygiene, water, sanitation and health education at village level</td>
<td>A comprehensive response to people’s expectations and needs, spanning the range of risks and illnesses</td>
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<th>Early attempts at implementing PHC</th>
<th>Current concerns of PHC reforms</th>
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<td>Simple technology for volunteer, non-professional community health workers</td>
<td>Teams of health workers facilitating access to and appropriate use of technology and medicines</td>
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<tr>
<td>Participation as the mobilization of local resources and health-centre management through local health committees</td>
<td>Institutionalized participation of civil society in policy dialogue and accountability mechanisms</td>
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<tr>
<td>Government-funded and delivered services with a centralized top-down management</td>
<td>Pluralistic health systems operating in a globalized context</td>
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<tr>
<td>Management of growing scarcity and downsizing</td>
<td>Guiding the growth resources for health towards universal coverage</td>
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<tr>
<td>Bilateral and technical assistance</td>
<td>Global solidarity and joint learning</td>
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<tr>
<td>Primary care as the antithesis of the hospital</td>
<td>Primary care as coordinator of a comprehensive response at all levels</td>
</tr>
<tr>
<td>PHC is cheap and requires only a modest investment</td>
<td>PHC is not cheap. It requires considerable investment, but it provides better value for money</td>
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The need for an age-friendly primary health care has become an important issue because of the demographic imperative of ageing which requires the systems to become prepared to address this challenge. By 2050 there will be more people above 60 years than children under 15 years and the vast majority of over 2 billion older people will be living in developing countries. While it took the industrialized countries several decades to respond to the demographic shift towards old age, developing countries will ‘become old’ before achieving economic prosperity.

Need for age-friendly PHC is based on economic arguments and cost-effective care of the elderly population and ensuring their sustained economic contribution through active healthy ageing. A life-course approach to healthy ageing requires a comprehensive strategy for promoting health, preventing disease including treatment and rehabilitation. In addition, an age-friendly PHC would need to aim for independence rather than dependence; activity rather than inactivity; and participation rather than marginalization. Older people expect an
understanding attitude, gender-sensitive services and well-trained, empathetic and communicative providers from their health systems. The overall environment and quality of care should reflect an age-friendly management system. There are several strategies for improving age-friendly PHC-based health systems:

- Improving the attitude, education and training of health care providers so that they can assess and treat conditions that affect older persons and empower them to remain healthy.
- Make physical access easier for older persons who may have mobility, vision or hearing impairment.

2.4 Elderly care perspective in Sri Lanka

Anil Dissanayake, Ministry of Health, 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 of Sri Lanka is expected to double 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 the age of 60 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; increased care required for responding to mental health issues, etc.

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 crises’.

Development of human resource has been undertaken in order to provide a high standard of elderly care which includes a new post-graduate specialty in geriatrics, introduction of elderly care in the curriculum of the basic and post-basic training of health personnel, local and foreign in-service training of community care givers. 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.

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 on-going activities are: conducting pre-retirement health promotion programmes in the public and private sector organizations; early detection of common NCDs including cancer through frequent screening programmes and working with the 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 work through the community health care team and maintain 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 inter-generational 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.

### 2.5 Gender and ageing – “Women, ageing and health”, “men, ageing and health” Narimah Awin, WHO-SEARO

Gender, ageing and health issues have been addressed but separately. For example, in the declaration on Health for All through the primary health care approach, the plight of older people and their vulnerability and the disadvantages faced by both ageing men and women had been identified as issues to be addressed.

The subject of this presentation could be linked to demography on the feminization of ageing; how ageing is being managed at the primary health care level; what is the overall perception on ageing, that is, is there gender difference; or is it a gender and ageing issue.

Feminization of ageing occurs as women live longer than men and as a result, the number of older women is more than older men. However, longer lives do not mean healthier lives as vulnerabilities of women continue throughout the life-course. Feminization of ageing can also be equated to feminization of poverty. Other vulnerabilities like divorce, widowhood, status as refugee and ethnic minority, also compound the situation.

Several guidelines and models are available to ensure ‘adding life to years’ and caring for the elderly persons. However, in developing countries,
the population is ageing rapidly without any significant increase in resources which remains a key constraint. Attention was drawn to the document, ‘Women, aging and health: a framework for action, with focus on gender’ published by WHO in 2007. In this document, a framework for action had identified four components: a life-course approach; determinants-of-health approach; three pillars of action; and the use of a gender and age-responsive lens.

In the life-course approach, it was said that the status of women’s lives in old age is shaped throughout their lives by factors over which they have little or no control. If longer lives for women are to be years of quality, policies should be geared towards problems that begin in infancy and childhood and should cover the whole life-span.

The various determinants of active healthy ageing include health services behaviour, as well as personal, physical, social and economic issues. Gender, along with culture, is the lens through which the various policy options and how these would input the well-being of both men and women should be considered.

The three pillars of active ageing are based on the process of optimizing opportunities for health, participation and security in order to enhance the quality of life as people age. Women remain the foundation for the three pillars of active ageing.

Gender issues related to older men depend on several factors that include societal expectations of men, general lifestyles of men as they age and how men take care of their health in relation to the health of women, particularly as spouses. Gender is important in determining how we age and applies to both men and women. There are powerful economic, social, political and cultural determinants that influence how women age with far-reaching consequences for health and overall quality of life and costs to the health system.
2.6 Framework for geriatrics training: implications for Member States of the South-East Asia Region

A.B. Dey, Temporary Adviser, WHO-SEARO

In the treatment of the elderly, a complementary strategy is needed instead of the single-disease framework by which most medical care, medical research and medical education is configured. A personalized, comprehensive continuity of care is needed where the health professionals need to know about older patients not only because the number of elderly patients is increasing along with the cost of health care, but a significant number of elderly persons suffer from multi-morbidity and disability complex.

The roles of families and society are changing along with the provision of care for the elderly. The health system has yet to respond adequately to this challenge, where acute care is considered a priority and long-term care is considered a burden. The significance of chronic diseases in the population particularly the elderly is yet to be realized in most developing countries. So far the political system has also favoured the visible health system where cure remains visible and easily appreciated by all.

Old age care remains a difficult issue. Health professionals during their usual course of training are not adequately exposed to the concepts and practices of geriatrics including elderly health care. The need for geriatrics training in most SEAR Member States of the Region has been felt only recently. It remains an ‘appendage’ of either internal medicine or community medicine training. A few departments with distinct identity exist in the Region while training programmes in ‘social gerontology’ are now available in some Member States.

Teaching of elderly health care could be either at the ‘pre-qualification stage’ or training after acquiring the ‘qualifying education’ in medical studies. Training at the ‘pre-qualification’ stage is the need of the hour in most Member States of the Region, particularly at the undergraduate level in medical schools. This will involve:

- Modification of the existing curriculum with the inclusion of ageing/age care among the topics.
A minimum of 12 hours of theory comprising disease-specific modules, syndrome management modules and modules on active healthy ageing.

A minimum of three weeks of clinical posting in geriatrics at the penultimate stage of graduation.

Similar changes are essential in nursing and para-professional courses related to health.

Training in geriatrics and principles of elderly health care after qualifying education in medical studies may be imparted either as specialized post-graduate studies in medicine, nursing or physiotherapy or through part-time diploma courses and fellowship programmes of short, intermediate and long durations. In all such instances, the depth of training will depend on the need and the situation.

Reference was made to a WHO-supported training of national staff in geriatrics between 1998 and 2001 that led to the training of 180 teachers of medicine in 100 medical schools and 1800 medical officers at 35 locations. Such training was envisaged to provide a critical mass for starting the national programme for health care of the elderly. However, such a situation did not develop as most of the individuals who attended the training session returned to their original activities. Sustaining better health care for the elderly requires changes for a better selection of candidates for training and a system ensuring that they discharge their new knowledge and skills of elderly health care.

There are several implications for developing a common framework for geriatrics training. There are similarities in the rate of population ageing, socio-cultural values and the functioning of the health system. As such, it is possible to devise a teaching/training system that may be applicable in most Member States of the Region. There are several options for developing a common framework for training/teaching: uniform training manuals; web-based training programmes and virtual training programmes under the aegis of WHO-SEARO; state/national/internationally-funded fellowships; and continuing medical education (CME) programmes. Essentials of such training/teaching should have clearly defined objectives ensuring proper content, assessment tools and various options for imparting information. In recent years several off-site/distant education methodologies have been
used. The presentation cited some examples like correct way of physical assessment of older persons and current knowledge on technical issues, as part of existing off-site/distant education.

2.7 Long-term Care of the Elderly Population in Thailand

Ekachai Piensriwatchara and Puangpen Chanprasert,
Department of Health, Thailand

The proportion of elderly population is increasing in Thailand, from 10.2% of the total population in 2003 to 11.7% in 2011. It is estimated to reach 20% by 2025. Several social, health and economic issues are associated with an elderly population. The prevalence of chronic diseases is four times more in the elderly population, dependency increases as the population ages along with increased need for accessing the health care system and need for health care at home.

The World Health Organization defines long-term care (LTC) as a system of activities undertaken by informal caregivers, or professionals to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest possible degree of independence, autonomy, participation, personal fulfillment, and human dignity.

The Elderly People Act of 2003 and the 2nd National Plan for the Elderly People (B.E 2002 – 2021) and the second meeting of the Thai National Health Assembly in 2009 – development of long-term care system for dependent elderly – have all contributed to the emergence of strong supportive programmes for the elderly population.

The Ministry of Public Health has developed a strategy on health development for the elderly that comprises developing an appropriate health service system for the elderly, human resource development for elderly care, integration of management of elderly care; knowledge management and research on elderly health; building and strengthening capacity of the community and elderly network at all levels.

The LTC project was implemented as an integrated model. The network comprised the local administration, elderly club, volunteers, people in the community, health and other government agencies at the
sub-district, district and provincial levels, health promoting temple and NGOs. Each level has an implementation plan for the care and services for elderly people care, i.e. home visits, home care, services / care for special problems, training of caregivers and volunteers, etc.

In Thailand, several civil society organizations through village health volunteers or community volunteer caregivers, provide home care to older people. For example, the Association of the Senior Citizens Council of Thailand set up a “Friends Help Friends” project, in which members are trained to be volunteers and visit elderly members who are ill at home. At present, there are over 25000 senior citizens groups or elderly clubs set up by individual communities. The cooperation between local governments and civil society is a good example of how the sub-district health security fund is financed jointly by the central state authorities, local government and the community. The fund is used to provide LTC services, transportation, care centres or rehabilitation centres in the community.

There are a number of laws that cover services for the elderly. According to the Constitution of the Kingdom of Thailand 2007, these laws aim to develop the institution of family and the community as well as to provide aids and welfare to the elderly. Another law is the Decentralization Act 2006 which determined the plans and process of decentralization to local organizations. It is clear that older people should live within the community with their families. Another legislation is the Elderly Act which stipulates that older people have the right to be protected, promoted and supported in various areas. In addition, the Second National Plan for Older People includes measures to develop and integrate health and social service systems through community-based home services. A resolution adopted at the second meeting of the National Health Assembly included development of LTC for dependent older people.

In 2009, the Ministry of Public Health declared a regulation under Public Health Act 1992: business that may harm health-- “the business on elderly home care” with recommendations for a Public Health Committee as a guideline for local government to issue legislation to control business for elderly care in each administration area. In addition, a draft regulation on nursing home registration was done by a sub-committee on LTC and is in the process of legislation. In the same year, the Minister of Public Health declared policy (No. 6) on providing services to older people. The strategies
included development of health service system for the elderly, human resource development on elderly care, building and strengthening capacity of the community and elderly networks at all levels, integration of management for elderly care, and knowledge management and research on the health of the elderly.

The Project on Community Based Integrated Services of Health Care and Social Welfare for Thai Older Persons (CTOP Project) was implemented during 2006-2011 in co-operation between the Royal Thai Government, Ministry of Public Health and JICA (Japan International Cooperation Agency) in four sites of Thailand, Nonthaburi, Khon Kaen, Suratthani and Chieng-rai to find a model/models to provide care for the elderly.

The National Assembly adopted a resolution on LTC in 2009 to urge all institutions responsible for elderly people to launch programmes on LTC. The National Committee on Elderly Persons set-up a sub-committee to launch the LTC issue. The sub-committee held meetings with all stakeholders and came out with an implementation plan which included responsible organizations to implement the plan from 2011 to 2013. The department of health started a LTC Project in 2010 in accordance with the CTOP project by the Bureau of Health Promotion (BHP) as a pilot project implemented in 12 regional health promotion centres. Twelve model ‘Tambols’ on LTC were developed successfully. In 2011 and 2012, the LTC project became one of the important projects to promote the health of the elderly. ‘Tambols’ on long-term care was set as an indicator of the project and 154 model ‘tambols’ on LTC were set as a target of the project in 2012.

The concept of the LTC project was integration of services (health and social services) by multidisciplinary approaches for dependent elderly persons in the community to have good quality of life and maintain their dignity. The criteria of a model tambol for long-term care are: (a) establishment of an elderly club; (b) data on the elderly population classified into 3 categories of ‘activities of daily living’ [ADL] assessment; (c) availability of volunteers to take care of the elderly in the community; (d) an effective home health care system of Home Health Care; (e) preventive and promotive health programmes. The ten abilities as per ADLS were eating, self-cleaning (face cleaning, combing hair, tooth
brushing, shaving in 24 – 48 hours), transferring, using toilet, moving inside home, putting on clothes, walking one flight of stairs, bathing, controlling defecation.

From 2010 to 2012, 861 tambols (sub-districts) were developed to be model tambols on LTC in 77 provinces of Thailand. The key success factors of the project were: (1) LTC for dependent elderly was set as a policy at all levels; (2) good cooperation of all sectors involved at each level and across levels; (3) periodic monitoring and evaluation; (4) recognition of good practice model and enforcement, (5) promotion of exchange of experiences at provincial, regional and national levels.

The lessons learnt were: (1) policy implication at all levels and clear process of implementation are important to implement the project successfully; (2) raising awareness of all concerned sectors concerned on an aged society and on burden to the family and society highlighted the need for joint efforts to prepare for the future; (3) primary health care strategy still works in developing countries where there is a shortage of budget and health personnel; (4) data collection, analysis, strategic road map and planning done by community with technical support from health sector, local administration and network is sustainable for LTC project for the elderly and disabled people in the community; (5) monitoring and supervision by health personnel is essential during implementation of the project; (6) LTC project in the community requires integrated services with multidisciplinary network cooperation where the local administration is an important component in supporting the implementation of LTC and its sustainability. Model tambol on LTC for the elderly can be done in any community setting based on the country-context and appropriate networking.

In the overall management structure, the national committee is responsible for policy, laws and standards while the provincial committee is responsible for monitoring and evaluation, control of standards and support mechanism. At the level of the local administration committee (municipality or sub-district administration) implementation of programme activities and creation of local bodies takes place.
Structure of the provision of long-term care in Thailand

Responsibilities of different public health facilities in relation to the provision of long-term care:

| Centres of Excellence | • Research & Development  
|                       | • Training of Personnel  
|                       | • Specialized Services  
| Provincial Hospital   | • Training of Personnel  
|                       | • Acute Care  
| District Hospital     | • Training of volunteers and general public  
|                       | • Intermediate Care  
|                       | • Home health care  
| Health Centre         | • Care Manager  
|                       | • Primary health care in the community  
|                       | • Home health care  

Central Administration → Policy / Laws / Standards

Ministry of Public Health → First / second / third levels of care  
• Home health care  
• Care Manager

Ministry of Social Development

Local Administration

Provincial Hospital

District Hospital

Health Centre

Elderly Persons → Family Volunteer

Family

Community

NGOs / Private Sector

Central Administration

Ministry of Social Development
2.8 Networking to promote healthy ageing

K. R. Gangadharan, International Federation of Ageing

Recent studies have shown that people continue to lead unhealthy lifestyles despite fears of long-term chronic diseases. For example, a majority do not exercise regularly, a large number consume alcohol and smoke. Healthy ageing is defined as a process of optimizing opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent, disease- and disability-free quality of life. Health promotion is a pre-requisite for an independent life in old age. A healthy population reduces health care spending and lowers the burden on the health system.

Networking among civil society, elderly citizens groups, the public and the private elderly care providers and other stakeholders increases capacities for developing, implementing and evaluating policies for older persons while also fostering creation of knowledge and sharing of experiences and practices by different organizations responsible for healthy ageing. Key persons like health professionals and community leaders form the basic components of networking. Networking may assume many dimensions including senior clubs, exchange visits, newsletters, workshops/meetings/research studies, involvement with youth and bridging the inter-generational gap. Networking offers several benefits to the elderly around the world despite cultural differences.

The International Federation of Ageing [IFA] has consultative/working status with ECOSOC, WHO, UNESCO and several other international organizations. IFA hosts bi-annual conferences of leaders and experts in the field of ageing with the participation of ministers, decision-makers, the corporate community and representatives of NGOs.

Three important international events focusing on ageing and the elderly population were mentioned – the International workshop on ageing and healthy environments and the International Istanbul Initiative on Ageing, both in 2013; and the 12th Global Conference on Ageing in 2014 in India.
2.9 Regional strategy for health ageing

*Kunal Bagchi, WHO-SEARO*

An estimated 142 million people or 8% of the population of WHO’s South-East Asia Region are more than 60 years old. It is further estimated that by 2025, the proportion of people above 60 years will be twice that of the proportion in 2000; and by 2050, this proportion will be three times the figure in 2000.

Development and progress have resulted in improved quality of life and an increase in life expectancy. By 2050, the average life expectancy at birth in most countries of the South-East Asia Region will be 75 years.

The process of ageing begins in the womb. The 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 disease 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.

Ageing raises several critical questions: economic effects of ageing on the health care and social support systems; ensuring independence, quality of life and activity of older persons; maintaining a balance between family and state in caring for older people; humanitarian crises and older population; social, economic and health problems of elderly females and very old persons. Old age homes and ‘sheltered living’ are commonly considered as responding to long-term care; these mostly function outside any formal regulated sector. Changing patterns of society are also affecting the age-old balance of care of the old and very old persons at home where nuclear families are now replacing the joint families along with rural to urban migrations. Older women outnumber and outlive older men, a ratio that persists as the population ages. Elderly women experience health challenges through the reproductive part of their lives and chronic diseases during the latter part of life. Two key aspects of female life are strongly interlinked and have considerable impact on ageing – gender discrimination starting from birth till the terminal stages of life; and widowhood.
Ageing concerns each and every one of us – whether young or old, male or female, rich or poor – no matter where we live. Healthy ageing extends life expectancy and quality of life for all people as they age, including those who are in need of care. It is to be noted that healthy ageing promotes the physical, social and mental health of older persons and enables them to take an active part in society without discrimination and enjoy an independent and good quality of life. Some of the selected global and regional initiatives are indicated below:

| United Nations World Assembly on Ageing (1982) | Madrid International Plan on Ageing was established with three priority directions: older persons are to be intrinsically linked with the development; advancing health and well-being into old age; and ensuring an enabling and supportive environment. |
| Fifty-eighth World Health Assembly | Resolution WHA 58.16 on Strengthening Active and Healthy Ageing [May 2005]. |
| World Health Organization – South-East Asia Regional Office | • Workshop on active and healthy ageing for mega countries in 1999.  
• Regional consultation on active and healthy ageing in 2007 with three themes: health promotion using a life-course approach; strengthening health systems; and addressing social and economic determinants of ageing.  
• Regional consultation on a strategic framework for active healthy ageing in the South-East Asia Region in 2009. |

WHO-SEARO’s ‘strategic framework for healthy ageing’ formulated in 2009 had the objective to guide and provide technical support to develop and implement policies and programmes for healthy ageing and old-age care. The components of the strategic framework were formulation, monitoring and review of national polices on older persons; focus on age-friendly primary health care; adequate human resources and infrastructure for quality health care; research for evidence-based practice; networks of multi-disciplinary professionals, awareness programmes on active-ageing; and participation of older population in society.
Several activities to promote healthy ageing have been undertaken in the Region:

- Targeted support for the elderly population in Bhutan, Myanmar, Maldives and Nepal;
- Wide range of interventions and regulations to promote healthy ageing established in Bangladesh, DPR Korea, India, Indonesia, Sri Lanka and Thailand;
- Several nongovernmental organizations are active in advocacy, health care, financial security and psychosocial support;
- National policies/plans of action to promote healthy ageing exist in nine Member States of the Region;
- Training in geriatrics for primary health care physicians [Myanmar, Maldives and Sri Lanka] with the possibility of extension to other Member States.

The Thirtieth meeting of the Health Ministers of Countries of WHO’s South-East Asia Region issued the Yogyakarta Declaration on Ageing and Health in September 2012. The “Yogyakarta Declaration” has articulated 14 action points, some of which include:

- Recognizing healthy ageing as a national priority with strong political and social commitment;
- Instituting a coherent, comprehensive and integrated approach to promote healthy ageing;
- Strengthening the primary health systems to address the health needs of the elderly population and social support care, including formal and informal capacity-building mechanisms to develop and assist health professionals and social support caregivers;
- Developing and strengthening national policy and promoting effective implementation for healthy ageing, and formulating multisectoral national alliances for promoting healthy ageing with special attention to elderly females.

The draft regional strategy for healthy ageing has been developed with the goal to encourage Member States to initiate, develop and sustain a
multisectoral approach and measures for the promotion of healthy ageing among all population groups, following a life-course approach. The duration of the strategy will be five years. Several guiding principles have been articulated in the strategy: policy and strategy formulation; primary health care as the cornerstone of active ageing; development of human resources for quality health care; creation and maintenance of multidisciplinary networks to facilitate care of the elderly; raising awareness of the population to active ageing; long-term care; and participation of the older population in society.

There are four strategic elements of the draft strategy: developing a country-driven, outcome oriented, integrated and multisectoral policy and plan of action for health ageing; adaptation of the health systems to the challenges of population ageing and the health needs of the elderly population; long-term care of the elderly population; developing appropriate human resources necessary for meeting the health needs of older persons.

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

- Formulation of comprehensive national policy / plan of action for healthy ageing;
- Legal frameworks and mechanisms for protecting rights of older persons;
- Age-friendly cities movement; and
- Projects and initiatives with gender-based orientation.

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

- Healthy ageing as an essential component of national primary health care programmes;
- Prevention and management of chronic degenerative diseases of the elderly population; and
- Implementation and adaptation of self-care programmes of older persons.
Strategic Element 3: Long-term care of the elderly population:

- Self-care programmes for the long-term care of older adults;
- Intersectoral system to develop protocols, regulations and monitoring mechanisms;
- Support activities of the informal and formal care-givers; and
- Increased involvement of the family and primary care physicians.

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

- Defining basic competencies required of health workers;
- Inclusion of key geriatrics and gerontology issues in the training curricula of health care providers; and
- Tools to strengthen competencies of different categories of social and community workers for care of older persons.

The draft regional strategy calls for a multisectoral approach and partnerships involving relevant structures and the creation of a high-level national structure/body chaired preferably by the Head of State. Along with the relevant ministries of a Member State, involvement of civil society, nongovernmental organizations, media and the UN/bilateral partner will also become necessary.

Several indicators have been identified in the draft strategy:

- Number of Member States that have formulated national policy/plan of action on healthy ageing;
- Number of Member States that have established national databases on older persons including information on population, economic status, income, health profile, housing and ownership;
- Number of Member States that have produced protocols, manuals and guidelines on training of health staff in aspects of healthy ageing;
- Number of Member States that have established geriatric units at health facilities along with the availability of health professionals trained in the principles and practices of geriatrics; and
2.10 Sri Lanka’s age-friendly/disabled-friendly city (Moneragala)

Senarath Attanayake, Provincial Councillor, Sri Lanka

The age-friendly/disabled-friendly cities concept was introduced in 2005 at the 18th world congress of gerontology and geriatrics in Brazil. In order to qualify for registration as an ‘age-friendly city’, eight criteria have to be met – transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, community support and health services and lastly, outdoor spaces and buildings. Currently 105 cities are registered as ‘age-friendly cities’.


Moneragala District/Wellawaya division was chosen as an age-friendly/disabled-friendly city. Moneragala district has a population of 430000 and 11 administrative divisions. 98% of the population live in villages and have an agriculture-based economy. Wellawaya division is the most populated division in the district where 40% of the population were recipients of ‘Samurdhi’.

Several activities in relation to age-friendly city were completed by October 2012: discussions with policy makers, political authorities, and technical partners at the central and local levels along with the implementing authorities. Later an application was sent to WHO-HQ to register Moneragala as part of WHO’s Global Network of Age-friendly cities.

The first phase of the project began in 2012-2013 and consisted of collection of baseline data, accessibility and signage audit. Training and
awareness-building exercises were carried out along with improving accessibility to primary healthcare facilities, government offices and institutions, community-gathering centres and public transportation sites. An action plan for the period 2012 – 2022 was developed that addressed the eight components of an age-friendly city: outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, community support and health services. In order to improve civic participation, training and involvement of community volunteers, partnerships with civil society and the private sector are emphasized along with improved flow of information through the oral, print and electronic media. Civil administration consists of the ‘gramaniladhari’, ‘samurdhi’ officers, agricultural research officers, sports clubs, women’s, youth, elders and rural development committees.

In implementing the age-friendly/disabled-friendly cities approach, the following agencies have been involved: Uva provincial council; divisional secretariat of Wellawaya and Moneragala; Regional Director of the health services at Moneragala; provincial road safety cell; NGOs; the civil engineering department of the Moratuwa University; and the private sector. The ministries of social services, health, and transportation are involved along with the Sri Lanka Medical Association and the World Health Organization, in providing technical support for implementing the age-friendly/disabled-friendly cities concept.

For ensuring age-friendly primary health care, due attention has been given to the formulation of appropriate management guidelines, patient-information system, health education and counselling. ‘Access audit’ relates to ramps, handrails/grab bars, floor plans, doors and toilets for the primary health care facility. The signage audit consists of the design and placement of signs at the health and other facilities used by the elderly population.

### 2.11 Role of civil society in promoting healthy ageing

**Samantha Liyanawaduge, HelpAge Sri Lanka**

The health care objectives of HelpAge Sri Lanka include:

- Improving the health status of older persons through direct and indirect health care services.
Assisting the marginalized older persons and to reach out to those who are disabled or otherwise compromised, in accessing available health care.

Improving the socio-economic status of older persons by helping them to become more productive and facilitating the use of their skills through sensitization and training.

Interfacing between local service providers and older persons and sensitizing the community by establishing links with the health and social protection programmes.

Serving as a resource bank for data, information and knowledge on health needs of older persons and elderly care.

HelpAge Sri Lanka has identified several problems faced by the elderly and the existing needs. For example, the problem of failing health is related to addressing health needs; inclusion in social activities is needed to overcome isolation of the elderly; care, protection and reassurance are required to address neglect, abuse and fear; boredom or idleness can be overcome through productive and gainful occupation in old age. HelpAge has also determined that equity issues are relevant in overcoming all the problems.

HelpAge has adopted a two-pronged approach in the delivery of its services: (i) programmes and projects; (ii) advocacy.

Programmes and projects include:

- Direct and indirect health service
  - Delivery of primary health care; mobile medical units; mass camps for eye care and cataract surgeries; free medicine; home visits by doctors; facilitating links with health providers, laboratories and national programmes; training staff of mobile medical units and those providing other types of health and social services;

- Direct and indirect social service
  - Counselling of the elderly; home visits by social service officers and volunteers; facilitating links with the national social protection programmes;
Strengthen Healthy Ageing Programmes in the South-East Asia Region

- Disaster risk reduction
  - Disaster mapping by all Mobile Medical Units;
- Advocacy
  - Collection of data, analysis and feedback; documentation; proactive advocacy.

Other services provided by HelpAge-Sri Lanka include: simple surgical and laboratory procedures; training elderly persons on common health and social issues; linkages with other NGOs on social protection projects.

Civil society plays important roles in promoting the social, health and economic aspects of healthy ageing including:

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<tr>
<th>Social issues</th>
<th>Health issues</th>
<th>Economic issues</th>
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<tr>
<td>Media campaigns to create awareness.</td>
<td>Need for a national policy on healthy ageing.</td>
<td>Proportionate increase in budgetary allocations for ageing population.</td>
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<td>Encourage Research Institutes to undertake research.</td>
<td>Primary health care/mobile medical care facilities to be made available widely in rural areas particularly where there is no access to government hospitals.</td>
<td>Finance facilities to be made available for senior citizens above 60 years.</td>
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<td>Promote setting up of Senior Citizen’s Committees (SCCs).</td>
<td>Enhance the role of family health workers.</td>
<td>Senior citizen’s allowance/social pension schemes should be introduced for needy senior citizens.</td>
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<td>Set up Day Centres in strategic locations for senior citizens.</td>
<td>Geriatric courses should be introduced at undergraduate and postgraduate levels.</td>
<td>Compulsory retirement schemes should be abolished and opportunities should be made available for working</td>
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<tr>
<td>Organize various cultural, recreational and social activities.</td>
<td>Promote home care/volunteer services to</td>
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<td>Design social protection mechanisms such as insurance policies.</td>
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<td>Gerontology courses</td>
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Social issues

(include old age psychology) need to be developed by training institutions and universities.

- Encourage care for vulnerable senior citizens to be provided by their own family.
- Promote special programmes to recognize those who provide care for their vulnerable senior citizens.

Health issues

assist vulnerable senior citizens living in their own houses.

- Awareness programmes on hygiene, sanitation, nutritional food, eating habits.

Economic issues

groups without age discrimination.

- All services should be made available to senior citizens irrespective of their age: learning opportunities, vocational training, capacity building, marketing assistance.
- Facilitate planning for life after retirement.

2.12 WHO initiative toward age-friendly cities

Lisa Warth, WHO/HQ, Geneva

Both physical and social environments shape our ability to live active and healthy lives as we age and our abilities change. Age-friendly communities that are enabling – i.e. physically accessible to people of all abilities and socially inclusive – allow people to remain active and healthy for longer. Easy access to quality social and medical care services are an essential part of age-friendly environments. Large and small, urban and rural, communities around the world are finding creative ways to respond to the needs of their older residents. In order to turn the vision into reality, it is necessary to undertake three key steps: joining forces to involve older people and to build broad alliances of partners for change; planning the journey by determining what older residents want and need through an age-friendly assessment; and making it happen, including tracking progress and evaluating results.
The WHO Global Network of Age-friendly Cities and Communities aims to foster the exchange of experience and mutual learning between cities and communities worldwide that strive to create accessible and inclusive physical and social urban environments for their older residents to enable healthy and active ageing and a good quality of life in older age. The Global Network was created in 2010, and currently has 135 direct member cities and communities in 21 countries worldwide, and membership is expanding rapidly. Through its 10 affiliated programmes in Canada, France, Ireland, Slovenia, Spain, Portugal, the Russian Federation (Republic of Bashkortostan), the UK and the United States, the Network reaches out to hundreds more cities and communities enrolled in age-friendly programmes.

The WHO Global Network cycle is a five year process of continual improvement. The first stage, joining the Network, involves establishing mechanisms to include older people, a baseline assessment of age-friendliness, developing an action plan, and identifying indicators of progress over time. The second stage, implementation, comprises implementing the action plan, monitoring indicators, and reporting on progress. The third cycle, evaluating progress and continual improvement, includes measuring progress over time, identifying instances of success as well as gaps in performance, and developing a new action plan for the future. The Global Age-Friendly Cities Guide\(^1\) outlines a framework for assessing the age-friendliness of a city in eight age domains: outdoor spaces and building, transportation, housing, communication and information, community support and health services, social and civic participation, respect and social inclusion, and employment. There is also a checklist\(^2\) of essential features of age-friendly cities available on the website in a variety of languages.

Membership in the Global Network provides partners with access to a collaborative network of cities worldwide, allowing them to exchange information and good practices and share assessment methodologies. For more information on the Network, its members and how to join, please visit the e-portal Age-Friendly World\(^3\).

\(^1\) http://whqlibdoc.who.int/publications/2007/9789241547307_eng.pdf
\(^2\) http://who.int/ageing/publications/Age_friendly_cities_checklist.pdf
\(^3\) http://www.agefriendlyworld.org/cities-and-communities
3. **Country Reports**

3.1 **Bhutan**  
*Yeshi Wangdi, Ministry of Health*

Bhutan is divided into 20 districts and subsequently into sub-districts and 205 ‘gewogs’ or local governments. The transition to Parliamentary form of democracy took place in 2008.

The current government policy is reduction of poverty by half from the existing level of 23.9% and several pro-poor land reforms have been introduced. The economic growth rate is estimated at 6.7% and per capita GDP has increased to US$ 2109.30. The total population is 708265 spread over a land area of 38394 sq. km. An estimated 5% or 33759 people are over 65 years old. The ageing index per 100 children is 15.7 (10.1 in 2004) and 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) has declined from 8.6 in 2000 to 7.8 in 2010 and was 7.7 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.

The ‘healthy ageing’ programme in Bhutan is at an early stage of development and there is no formal policy on ‘healthy ageing’. However, in response to the rapidly increasing proportion of older persons the Ministry of Health has established a ‘geriatric care’ programme to address the need of the elderly population in the country to promote productivity, vitality and happiness among the elderly citizens. A pilot project was launched in the Khaling community (eastern Dzongkhag) to determine the feasibility of providing community-based health care for elderly citizens.

The Royal Society of Senior Citizen’s Association (RSSCA) 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...
(NPPF) to provide old age retirement benefits. 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. Further, referrals are sent to specialized hospitals in India.

With the increase in chronic diseases and disabilities among the elderly population, the department of medical services had piloted the ‘community-based medical care for the elderly project’ in T/gang district in 2010 and subsequently to four other health centres in three districts in 2011. The aim of this project is to promote health care and quality of life (QOL) of the elderly citizens at the community level. The project also aims to prevent and control lifestyle-related disorders and to provide effective and efficient care for elderly citizens. The focus is on early detection and control of lifestyle-related diseases such as diabetes and hypertension, and maintaining ‘activities of daily living’ (ADL) 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 the 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 focussing on developing a coherent, comprehensive and integrated approach to promote healthy ageing during the 11th Five Year Plan period (2013-2018). These activities will focus on developing and strengthening the national policy on healthy ageing. Provision of sufficient resources will be required taking into consideration the economic aspects of long-term care of the elderly citizens both at the facility and household levels. The primary health care system will have to be strengthened to address the health needs of the elderly population including in-service training of health professionals. This will also 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 to the expansion of health services in Bhutan. Adequate training protocols for training different categories of health staff are lacking. Bhutan’s success in providing quality health care services has sustainability relevance in a rapidly changing economic environment where people’s expectations and demands in health care have increased in alignment with the level of education in the country.

3.2 Democratic People’s Republic of Korea

*Dr O Ryong Chol, Ministry of Health*

The Democratic People’s Republic of Korea (DPR Korea) occupies an area of 123138 square kilometres with a population of 24.05 million. There are nine provinces divided into city, province and county – ‘Up’, ‘Gu’ and ‘Ri’. The average life expectancy in DPR 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). An estimated 12.5% of the total population was above 60 years in 2004. This number increased to 13.0% in 2006.

The Socialist Constitution of DPR Korea in 1972; the socialist Labour Law of DPR Korea in 1978; the Family Law of DPR Korea in 1992; the Law of DPR Korea on the care of the elderly and in 2010, launching of the Day for the Elderly, all contain policies and social measures for the care of the elderly.

The government has established pensions for all men aged 60 years and above and for all females aged 55 years and above. All DPR Korea citizens above the age of 90 years are registered and receive special support.

A national survey on 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, the Korean Federation for the Care of the Aged with support provided by an international NGO, bilateral and international agencies. The survey included 1394 households comprising 2035 persons aged 60 years and above. The findings showed that the
common ailments affecting the elderly population included high blood pressure, backache, cardiovascular diseases, arthritis and digestive complaints in 78% of the population.

At the primary health care level, the ‘section doctor’ provides regular health care to older adults. Elderly persons are also encouraged to continue with their jobs in accordance with their requirements.

Elders who had provided services to the country are recognized and treated with honour and respect. The younger generation is also taught about the values of respecting elder people. 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 for the elderly’ and in 2003, the ‘Korean Federation for the Care of the Elderly’ was established. In April 2012, the World Health Day with its theme ‘active healthy ageing’ was celebrated and various campaigns were launched. In July 2012, the Government organized the ‘greatest festival of veterans’ with the participation of ‘veterans’ from all over the country. As a result of these initiatives, the management of various cardiovascular and orthopaedic conditions has been improved. Long-term care in primary and speciality hospitals, at old age homes and at the community and family levels has been improved 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 also been initiated.
3.3 **Indonesia**  
*Dr Upik Rukmini, Ministry of Health & National Commission for Older Persons*

Indonesia lies geographically at the cross-roads between Asia and the Indian Ocean and bridges the two continents of Asia and Australia. There are over 17,000 islands comprising the Indonesia Archipelago of which only 6,000 are inhabited. The total population is 237 million.

One of the goals of health development has been to increase life expectancy 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 the age of 60 years and this figure is expected to reach 29.1 million in 2020 and 36 million in 2025.

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

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

The overall policy facilitates provision of 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 the elderly population 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 the older population, starting from the community-based services to the sub-district, district, and provinces and all the way to the central level.

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

- Law No. 6/1974 on basic provision of social welfare;
- 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 person’s welfare; and
- Presidential decree No. 52/2004 and 93/M/2005 on membership of national commission for older persons.
The national plan of action on older people’s welfare involves a large number of ministries and agencies of the government:

- Ministry of Social Affairs, social services and rehabilitation;
- Ministry of Health / health services;
- Ministry of Transportation;
- Ministry of Manpower and Transmigration;
- State Ministry of Women Empowerment;
- Ministry of Law and Human Resources;
- National Planning Body and Family Empowerment;
- Ministry of Religious Spiritual Services;
- Ministry of Culture and Tourism;
- Ministry of Information; and
- Ministry of National Education.

The health programmes for the elderly are aimed at an increase and improvement of health services for the elderly in primary health care programmes including increased health referrals for the elderly, promotion of IEC for older persons, home care for elderly and family, increased community empowerment through elderly groups, and development of institutions for elderly care.

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

Geriatric services are provided at the district and provincial hospitals. As part of the National Commitment RPJMN 2010 – 2014, 60% of the Class A & B hospitals have geriatric clinics. 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 Mojowarno in Surakarta.
Comprehensive health services are provided at homes for the elderly by empowering the elderly and the 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 elderly persons suffering from psychosis and dementia to receive care at the government mental health hospitals. It is proposed to develop community-based long-term care for the elderly that involves the community through training of care givers and the private sector. The existing training activities are geriatrics training for health providers in health centres, elderly counselling training for providers in health centres, geriatric training for internists and training for care-givers.

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

3.4 Maldives

Ms Zulaikha Shabeen, Ministry of Gender, Family and Human Rights, Ministry of Health

The country consists of a chain of 1190 small islands spread over an area of 900 sq. Km. divided into 20 administrative atolls. The population of 320 000 is dispensed 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, Male. At the same time there is socio-cultural transition, rapid changes 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 ascertaining 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. A ‘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 the Maldives was formulated in 2010 and a draft Policy for the Elderly in 2012. The services, roles and responsibilities of various departments, ministries etc. In the area of care of the elderly are as indicated below:

- 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 “Home for People with Special Needs”.
- Family Children Centres conduct programmes at island level.
- Other stakeholders are the Ministry of Health’s Centre for Community Health and Disease Control that maintains a ‘healthy ageing unit’; Human Rights Commission; 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 “Home for People with Special Needs”. There is a plan to build “long-term care’
Strengthen Healthy Ageing Programmes in the South-East Asia Region

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 long-term care at home may also derive some benefits. There are several legislative measures and acts to support and care for the elderly population.

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

- A ‘Pension Act (May 2009)’ was adopted to provide an old-age pension and a retirement pension of MVR 2000 equivalent to USD 130/month to all elderly above the age of 65 years.

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

- There is a provision for single parent allowance/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, however, several constraints. These include:

- Need for strengthening national capacity for activities in effective ageing and health care of the elderly.

- Establishing a clearly defined national policy for the elderly.

- Clear strategy for long-term care of the elderly population including institutional facility and domiciliary support.

- Involvement of civil society/nongovernmental organizations in elderly care.

- Research on aspects of ageing and chronic diseases of the elderly and compilation of accurate data.
3.5 Myanmar

Thuzar Chit Tin, Department of Health

Myanmar has a population of 59.78 million of whom 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;
- proportion of children is reducing over time
- increase in the proportion of oldest old, that is, those over the age of 80 years.
- majority of the oldest old are women;
- 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, fallen defence service personnel’s children, 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 basic management to older persons, demonstrate physical exercises, 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 the older persons and family members, demonstrating physical exercises; and referral of these requiring more medical attentions 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 project’s reach to 154 townships involving 10 partner organizations.

The ‘older peoples self-help groups [OPSHG]’ programme includes 18 villages in the secondary region; 43 villages in the Ayeyawaddy Region and two wards in Sagon township in Yangon. This programme covers 20000 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/including approach to livelihoods” (REVEAL). The programme covers 30 villages and 10000 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 disaster; 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.

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.

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.

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; strengthen inter-generational ties in order to preserve the quality of the relationship between the elderly and younger family members; support employment opportunities that allow elderly workers to play an effective role in social and economic development of the country.

3.6 Nepal

Gouri Shankar Lal Das, National Senior Citizen Federation
Shambhu Pahadi, Bir Hospital

The average life expectancy in Nepal was 60.4 years and in 2006 it was reported at 64.1 years. The proportion of elderly persons has been
increasing rapidly over the years. It grew from 5% in 1952/54 to 9.1% in 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>1952/54</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>

Prior to the Ninth Development Plan, there was no separate activity for the elderly population. 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 laid down 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.
- To establish a central level committee to integrate, coordinate and monitor the programmes for senior citizens.

The Ministry of Women, Children and Social Welfare (MOWCSW) also formulated a national working plan for senior citizens. A-log frame approach was tabulated which included: economic aspect; social security; health and nutrition; participation and attachment; legislation; and miscellaneous. The current three-year plan of the Government of Nepal (2010 – 2013) has laid down a strategy, working policy 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 formulated and implemented to utilize 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; social security provisions to be reviewed, strengthened and expanded; state grant for shelter homes, social care centres or mobile health clinics for senior citizens; closer collaboration with civil society and the private sector; establishing a commission, board or council for senior citizens; and strengthen 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’s 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 posters, pamphlets, and rallies among others with public-private partnership (PPP); reimbursement of health expenditure up to Rs 4000 a year to the indigent individuals through a committee under the Chief District Officer; training to care givers- every year, 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 Nepali rupees 50000; free dialysis and treatment for heart conditions, cancer patients, Parkinsonism and Alzheimer’s diseases to all poor persons 75 years and over in different private hospitals; and free treatment to those 75 years and over in 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 population consist of universal non-contributory pension scheme providing Nepali rupees 100 to all elderly persons 75 years and over. This scheme was started in 1996 and recently the pension was increased to Rupees 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.

The government promulgated the Senior Citizens Related Act in 2006 and Senior Citizens Related Rules in 2008. The provision of protection for senior citizens in the “Fundamental Rights Chapter of the Interim Constitution” is considered weak.

There is no institution to impart training to health workers and social support workers for the elderly. 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.
3.7 Sri Lanka

P.K.S. Subhodini, Ministry of Social Services

The presentation began with quotations from Mahinda Chinthana – 2010: “it is our responsibility to create a better environment for the senior citizens to live with dignity. Senior citizens, who have devoted their lives to their children and the country, will not be allowed to be lonely”. “Let us acknowledge elders as a precious resource that needs to be nurtured, recognized and celebrated with due respect.”

**Statistics on the elderly population**

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
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<tbody>
<tr>
<td>Total population</td>
<td>20 450 000</td>
</tr>
<tr>
<td>Total population over 60 years</td>
<td>1 891 000</td>
</tr>
<tr>
<td>As proportion of total population</td>
<td>9.3%</td>
</tr>
<tr>
<td>Total number [proportion] of male population over 60 years</td>
<td>893 000 (47.2%)</td>
</tr>
<tr>
<td>Proportion of elderly males to total population</td>
<td>4.4%</td>
</tr>
<tr>
<td>Total number [proportion] of female population over 60 years</td>
<td>999 000 (52.8%)</td>
</tr>
<tr>
<td>Proportion of elderly females to total population</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

Source: Department of Census and Statistics 2009 – Sri Lanka


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-fulfilment 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; 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 to assist 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.

<table>
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<tr>
<th>Formation of Elders Committees</th>
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<tbody>
<tr>
<td>Village-level committees</td>
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<tr>
<td>Divisional-level committees</td>
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<td>District-level committees</td>
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<tr>
<td>Provincial-level committees</td>
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<td>National-level committee</td>
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Financial assistance (one time) is provided to registered committees enabling them to engage in fund-raising activities as follows:

- Village-level committees Rupees 5000
- Divisional-level committees Rupees 7500

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 Rupees 25000 to each day centre.
for the purchase of necessary equipment and Rupees 10000 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 identify cards. Several magazines are also produced targeting the elderly population. The ‘Wadihitivó’ 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 care-givers; “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 and also provision of counselling services through counsellors attached to the divisional secretariats.

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

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, eye glasses, 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 public service areas and public buildings accessible to the disabled and benefitting the older persons.

3.8 Thailand

*Nantasak Thamanavat*, Ministry of Public Health

*Siriwan Aruntippaitune*, Ministry of Social Development and Human Security

“The potential of older persons is a powerful basis for future development”.

The National Commission on the Elderly adopted the long-term care strategic plan in 2009, the local administration and elderly development plan in 2010 and the employment opportunity for elderly in 2011. The strategic components of long-term care consists of screening for long-term care 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; long-term care insurance; and addressing the financial aspects of long-term care.

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:

<table>
<thead>
<tr>
<th>Disease/Condition</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>48 %</td>
</tr>
<tr>
<td>Metabolic Syndrome</td>
<td>36.8 %</td>
</tr>
<tr>
<td>Abdominal Obesity</td>
<td>36 %</td>
</tr>
<tr>
<td>Obesity</td>
<td>29.9 %</td>
</tr>
<tr>
<td>Diabetes</td>
<td>15.9 %</td>
</tr>
</tbody>
</table>
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:

### Causes of DALYs in population over 60 years

<table>
<thead>
<tr>
<th>Rank</th>
<th>Disease</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Stroke</td>
<td>174</td>
<td>216</td>
</tr>
<tr>
<td>2</td>
<td>Ischaemic Heart Disease</td>
<td>118</td>
<td>205</td>
</tr>
<tr>
<td>3</td>
<td>COPD</td>
<td>116</td>
<td>130</td>
</tr>
<tr>
<td>4</td>
<td>Diabetes</td>
<td>96</td>
<td>98</td>
</tr>
<tr>
<td>5</td>
<td>Liver Cancer</td>
<td>93</td>
<td>82</td>
</tr>
<tr>
<td>6</td>
<td>Bronchus &amp; Lung Cancer</td>
<td>74</td>
<td>60</td>
</tr>
<tr>
<td>7</td>
<td>Osteoarthritis</td>
<td>37</td>
<td>55</td>
</tr>
<tr>
<td>8</td>
<td>Tuberculosis</td>
<td>37</td>
<td>55</td>
</tr>
<tr>
<td>9</td>
<td>Nephritis &amp; nephrosis</td>
<td>37</td>
<td>47</td>
</tr>
<tr>
<td>10</td>
<td>Dementia</td>
<td>36</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>All causes</td>
<td>1528</td>
<td>1748</td>
</tr>
</tbody>
</table>

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 to the elderly population and provide an elderly-friendly environment. Some examples of healthy ageing [2009-2012] activities in Thailand are: development of a community model for long term care; handbook for the elderly population from the Muslim community; disaster preparedness programme for elderly; community rehabilitation model for elderly Muslim population. The programme for “Five Happiness Dimensions in Elderly” consist of health, recreation, integrity, cognition and peacefulness.

The “Community Model for long-term care of the elderly” comprises elderly clubs, providing oral health care, home health care, maintenance of family folders, training and support to health volunteers, and ensuring care of the elderly who are not individually dependent. Primary health centres are also equipped with instruments for rehabilitation and disability limitation.

The elderly clubs organize health promotion activities that include physical activity, information on nutrition and self-care, traditional, cultural and social activities, and occupational training.

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, instituting tax privileges for the elderly population and the creation of an elderly fund that provides interest-free loans and support activities for older persons.

The second National Plan for Older Persons covering the period 2002 – 2021 and revised in 2009 includes comprehensive socio-economic 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 people, “Older Persons Brain Bank” where transfer, 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 long-term care 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 2nd 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 the United Nations Economic and Social Commission for Asia and Pacific in Bangkok in September 2012. This participation led to the identification of additional challenges – preparation for the establishment of the National Savings Fund, preparing “long-term care for the elderly”, promoting the capacities of elderly persons and enhancing the capacities of local authorities on issues relating to the elderly population.

3.9 Timor-Leste

Basilio Martins and Francisco Soares, Ministry of Health

Timor-Leste gained independence in 2002 after centuries of Portuguese rule and 25 years of Indonesian occupation. Timor-Leste has a land area of 14,000 square kilometres and consists of 13 districts, 65 sub-districts, 442 villages (Suco) and 2,336 hamlets (aldeias). 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.

The health policies of Timor-Leste have been focused on controlling communicable diseases and on 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.

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%) to 45,328 (51.7%).

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.

The morbidity profile of the older population as per hospital admissions is as indicated below:

<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>Diarrheal diseases</td>
<td>6%</td>
</tr>
<tr>
<td>All forms of tuberculosis</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

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

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 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.

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 thirty US dollars.

There are no long-term care institutions for the elderly in and community-level care is provided through LISAI or AFHCP.

The social scheme for older persons is established by decree/law No. 19/2008 of 19 June 2008 which is the 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 (2) years before the date of submission of application for the benefit and at least 60 years old.

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.
4. **Group Work**

For the purpose of group work, participants were divided into three groups. Details of instructions to participants and composition of the three groups are provided in Annex 3.

Consolidated comments and suggestions from the three groups are provided. These comments and suggestions have been incorporated in the revised draft regional strategy for healthy ageing. Minor editorial changes suggested by the working groups have been incorporated in the revised draft of the regional strategy but are not reflected here.

- The overall structure and content of the draft regional strategy for healthy ageing was approved by the participants.
- An ‘Executive Summary’ should be included in the regional strategy.
- The section entitled ‘Introduction’ should mention mental health issues of the elderly and stress factors compromising the mental health of the elderly.
- All country details, including historical information on programmes on ageing, should be included as annexes in the strategy document. Country information about epidemiology, policy and programmatic interventions, should follow a consistent format for clarity. A table summarizing individual country details on policies, programmes and indicators could be developed to provide relevant information at a glance.
- The rights of the elderly should be one of the guiding principles of the regional strategy.
- The goal of the regional strategy would need to be re-worded as “To develop and sustain a multi-sectoral approach for the promotion of healthy ageing and care of the aged, based on a life-course approach.” The deletion of ‘goals’ from each strategic element was recommended to avoid repetitions.
- Several activities were suggested for insertion in appropriate strategic elements of the draft regional strategy:
  - “Advocate with the health ministers to initiate a separate unit/department with sufficient technical and financial resources to look after the welfare of the elderly”; this
activity should be linked to an appropriate indicator “number of Member States that have initiated units/departments for healthy ageing programmes”;

- “Allocate dedicated finances for the healthy ageing programmes”;

- “Provide assistance to Member States to develop the capacities of the civil society/organizations to deliver programmes for healthy ageing, ensuring accountability, accreditation and official recognitions to these organizations”;

- “Instituting mechanisms for the continued medical education (CME) related to aspects of healthy ageing”.

- It was recommended that the regional strategy should emphasize that the proposed indicators contained in the regional strategy have been designed to measure progress in the implementation of the regional strategy. However, Member States were encouraged to develop process and output indicators to measure progress in implementation at the country level.

- Additional paragraph to the ‘guiding principles’ for ‘long-term care’: “Integrated long-term care (LTC) services for elderly living alone in the community is essential for Member States that do not have formal institutions for LTC, to let the older people maintain good quality of life and dignity. The implementation may vary from country to country depending on the cultural setting, tradition and cooperation of networks.”

- It was recommended that the financing of long-term ambulatory care should be considered as a separate guiding principle and the World Health Organization would need to deliberate on this subject with experts in health financing from Member States.

- The words “political leadership” to replace “Members of Parliament”.

- Some new indicators were suggested:
  - Number of Member States that have initiated units/departments for promoting healthy ageing programmes in the Ministry of Health and/or other relevant ministry (ies);
– Number of Member States that have established administrative mechanisms to achieve multisectoral cooperation in elderly care;

– Number of Member States that have formulated long-term care (LTC) system with a regulatory and monitoring mechanism for LTC institutions in the formal and informal sectors.

5. Conclusions & Recommendations

Conclusions

(1) The proportion of the elderly population is increasing at an alarming rate. This demographic change is witnessed more prominently in developing countries as compared to the developed world. The developed world took several decades to experience this demographic change and had sufficient time to develop resources and programmes to deal with this challenge. For developing countries, the demographic shift has taken place over a short period denying sufficient time and resources to respond appropriately.

(2) All Member States now need to urgently examine the various options available to them to respond to this demographic challenge that has significant economic, social, health and political implications.

(3) Improving health of the elderly population and ensuring an environment conducive to healthy ageing extends beyond the health sector. A multisectoral approach with the primary involvement of social welfare and social security, health, education, employment, agriculture, transportation and finance needs to be adopted in every Member State.

(4) The “Yogyakarta Declaration on Ageing and Health”, adopted by the Ministers of Health of countries of the South-East Asia Region in 2012, has taken cognizance of the urgency of population ageing and identified 14 action points that encompass health and related social, economic and traditional cultural issues, in order to promote the health and overall well-being of the elderly population of this Region.
All Member States participating in this meeting have established a number of programmes to improve the health and socio-economic wellbeing of their elderly population. These range from initiatives/pilot projects in Bhutan, Maldives and Timor-Leste; large-scale programmes in the Democratic People’s Republic of Korea, Myanmar and Nepal; and national-level programmes in Indonesia, Sri Lanka and Thailand.

The administrative and logistical components of the “elderly care” and “healthy ageing” programmes in several Member States need to be strengthened. For example, many of the participating Member States lacked a national focal point or programme manager for programmes for the elderly.

Several innovative and situation-specific projects have been developed in Member States. Mention may be made of the “Elderly Clubs” and “Community-based home-care of the elderly”. Similar examples of “best practices” should be examined for wider applications not only in the country of origin but for introduction in other country situations, with or without modifications.

The draft Regional Strategy for Healthy Ageing encourages Member States to initiate, develop and sustain a multisectoral approach and measures for the promotion of healthy ageing among all population groups following a life-course approach.

Chronic illness/disease in old age is a process that is often beyond the control of an individual. In addition to initiatives for health promotion and disease prevention, curative/rehabilitative interventions and an age-friendly environment should be considered as a necessity.

Recommendations

(1) Ageing is an emerging social, economic, political and health challenge for all Member States and requires urgent attention. In this regard, Member States could refer to the action points identified in the “Yogyakarta Declaration for Ageing and Health” and adapt/adopt their national interventions accordingly.

(2) Multisectoral intervention is required with the involvement of social welfare and social security, health, population agencies, finance, employment and labour, food and agriculture sectors.
Additional sectors will get involved as per the need of a particular country situation. Total political leadership/commitment of Member States, in addition to the members of Parliament, will be needed in the multisectoral collaboration.

(3) The human rights aspect of ageing should be emphasized when formulating any intervention on elderly care and should be so highlighted in the regional strategy for healthy ageing.

(4) Participants recommended the inclusion of an Executive Summary to the regional strategy for healthy ageing. In addition, the document could be reduced in size and use a common flow of language. The timeframe for the strategy – five years – was supported.

(5) Terminology for older persons, elderly persons, aged should be standardized and uniformity retained.

(6) All information pertaining to Member States should be appended as an annex and information should be presented under specific sections like demography, epidemiology, programmes, best practices, lessons learnt, gaps, challenges and research evidence. Member States should inform the WHO Secretariat in writing about the changes and amendments to the country information.

(7) A balanced emphasis on healthy ageing and care of the elderly should be maintained in all interventions with reference to the need for health promotion at all stages of a life-course.

(8) Integrated long-term care for the elderly should be established in Member States through the formal sector with an accreditation/certification mechanism.

(9) Financing of long-term ambulatory care should be discussed by health care financing experts/researchers.

(10) A dedicated budget for the elderly should be considered and allocated with resources from all possible sources.

(11) Academia and research institutions should be involved in policy-based research on elderly care development, quality of life and social inclusion in society.

(12) The media should be involved to support campaigns about the right of older persons, positive attitudes and images of ageing, traditional values in the family and inter-generational solidarity.
Annex 1

Agenda

- Inaugural session
- Global and regional overview of healthy ageing
- Demographic changes and ageing
- Regional strategy on healthy ageing
- Country reports
- Health care financing
- Issues in geriatrics and gerontology training in Member States
- Long-term care
- Nongovernmental organization and civil society
- Group work
- Field visit
- Conclusions and recommendations
Annex 2

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Annex 3

**Group Work Instructions**

Participants were requested to review and comment on the draft regional strategy on healthy ageing regarding:

- Arrangement and presentation of different sections.
- Content, quality and accuracy of information provided in the [draft] strategy document on healthy ageing in your country about the demographic information and policy and programmes for the elderly population including the healthy ageing programme.
- Strategic elements and major activities identified including the objectives and identified approaches.
- Concept and components of the multisectoral approach identified in the [draft] strategy document.
- Selection and relevance of the proposed indicators.
- Any other related issue.
- Identify and agree upon approaches for the care of the elderly including adequate financing and long-term ambulatory care.

Participants were divided into three groups with each group having three Member States and several resource persons. (Two Member States [Bangladesh and India] did not send representatives to the meeting). Each group was required for prepare a report on the outcome of its group work and present it during a plenary session. This information would be used to revise the [draft] regional strategy.
### Allocation of participants into working groups

<table>
<thead>
<tr>
<th>Group 1 (Colombo)</th>
<th>Group 2 (Kandy)</th>
<th>Group 3 (Anuradhapura)</th>
</tr>
</thead>
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A focus on ageing is not only to prolong life but also to improve the quality of life of the elderly. Healthy ageing is a process of optimizing opportunities for physical, social and mental health to enable the elderly to take an active part in society without discrimination, and to enjoy an independent and good life. A regional meeting to strengthen healthy ageing programmes in the South-East Asia Region was organized by the World Health Organization’s Regional Office for South-East Asia [WHO SEARO] in collaboration with the Ministry of Health and the Ministry of Social Services, Government of Sri Lanka, in Colombo, Sri Lanka, from 17–20 October 2012.

The regional meeting was attended by representatives from the nine Member States of the WHO South-East Asia Region and included Bhutan, Democratic People’s Republic of Korea, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor Leste. In addition, representatives from the Social Affairs Department of the United Nations Economic and Social Commission for Asia and Pacific (UN-ESCAP); United Nations Population Fund (UNFPA) India Office; International Federation of Ageing; HelpAge-Sri Lanka; and observers from Indonesia and Sri Lanka also participated.

The meeting report contains a review of the status of healthy ageing programmes in the Member States of the Region and the determination of the approaches for care of the elderly, including adequate financing and long-term and ambulatory care. A thorough review of the draft regional strategy on health ageing was also undertaken. The regional strategy on healthy ageing intends to encourage Member States to initiate, develop and sustain a multisectoral approach and measures for the promotion of ageing among all population groups following a life-course approach.

Strengthen Healthy Ageing Programmes
in the South-East Asia Region

Report of a regional meeting
Colombo, Sri Lanka,
17-20 October 2012