

Report of a regional meeting on health of older women: policy, gender and delivery of service issues

Bangkok, Thailand
23–25 September 2014



**World Health
Organization**
Regional Office for South-East Asia

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1 Introduction

A regional meeting on Health of Older Women: Policy, Gender, and Delivery of Service Issues, was organized by the World Health Organization's Regional Office for South-East Asia (WHO-SEARO) in collaboration with the Department of Ageing and Life-Course, WHO-headquarters, and the Elderly Health Division, Department of Health, Ministry of Public Health, Royal Thai Government, Bangkok, Thailand from 23–25 September 2014.

The general objective of the meeting was to promote the health of older women in countries of South-East Asia Region, while the specific objectives were to review the status of health, health care needs and accessibility to health care services by older women in Member States of the Region; to examine and identify successful policies and practices, including relevant laws, legislation and acts related to the promotion of gender and rights issues related to older women; and to develop a framework of action for strengthening and promoting the health of older women in South-East Asia.

Representatives from the 11 Member States of the Region participated in the meeting: Bangladesh, Bhutan, Democratic People's Republic of Korea, India, 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) – Thailand; United Nations Population Fund-Asia Pacific (UNFPA) – Asia and the Pacific Regional Office; HelpAge International – East Asia and Pacific Regional Office; International Menopausal Society - India; the International Federation of Ageing - India; and observers from Indonesia also participated. Several experts on gender policy, gerontology and public health served as resource persons.



The meeting was inaugurated by Dr Nuttaporn Wongsuttipakorn, Deputy Director, Department of Health, Ministry of Public Health, Royal Thai Government. Welcoming the participants, he pointed out that health issues of the elderly were important in every country that has an ageing society or will have aged society in the future and that elderly women's health is a special concern because women live longer than men and are vulnerable to social, economic and health problems as age increases. In Thailand, the population in 2014 showed that women outnumbered men by around 1.8 million, and the total number of the elderly is around 10 million. Life expectancy of the elderly women is 78.2 years, and for men it is 71.3 years. Thus, women live longer, but loss of life occurs at the ages between 72 to 78 years and over. Most of the elderly have chronic diseases and disability. Thailand encourages health promotion and the right of women as indicated in the 11th National Economic and Social Development Plan, and has policies, strategies, using the life-course approach so as to prepare for a good quality of life at all ages.

As indicated in the objectives of this meeting that it was to promote the health of elderly females in countries in South-East Asia through understanding the health status, health care needs, facilities in health services for elderly women and successful policies and practices, as well as legislation, laws and acts; a draft framework of action in promoting health of elderly women in South-East Asia will be the result of this meeting. In conclusion, the Deputy Director thanked WHO for organizing this meeting in coordination with countries in this Region, as this will help elderly women to add quality years to their lives.

The message from Dr Poonam Khetrpal Singh, WHO Regional Director for South-East Asia was delivered by Dr Yonas Tegegn — WHO Representative to Thailand. In her message, Dr Singh welcomed the participants and expressed her deep gratitude to the Royal Thai Government for agreeing to hold the meeting in Bangkok. She was happy to see representatives from different disciplines in the Member States of the South-East Asia Region along with resource persons and colleagues from partner agencies. The meeting would provide a forum for experts and administrators from programmes as varied as geriatrics, gender, equity and rights, and reproductive health, to examine all issues pertaining to the health of older women, in a comprehensive manner using a multisectoral approach.



Dr Singh pointed out that populations around the world are ageing rapidly and we may soon have a situation where an 'ageing society' will transform itself to an 'aged society'. In South-East Asia, the number of persons above 60 years will double by 2025 and triple by 2050, compared to the figure in 2000. Older women will outnumber older men as life expectancy of women is 6–8 years longer than men.

Much before they reach the sixth decade of life, men and women follow diverse patterns in terms of social and economic status as well as morbidity. While considering the overall gender difference in the elderly, two issues emerge. First is the feminization of ageing, where older women tend to outnumber older men in any of the age segments, a difference that gathers momentum with advancing age. Second is the relative load of morbidities that women tend to accumulate during their long years of reproductive life followed by morbidities associated with the menopausal and post-menopausal phases of life. In summary, the increased number of older women, their age-related social, economic and physiological decline and relative high prevalence of chronic diseases is a matter of serious public health and socio-economic concern.

Although specific information on the health of older women is limited, available information indicates that a large proportion of older women in Member States of the South-East Asia Region are marginalized and vulnerable to many health problems due to not only deterioration in age, but also because of low socio-economic and cultural status. Longevity with poor health, inadequate support from family members and the community do not contribute positively toward well-being and quality of life of older women. Older women are more likely to be widowed, have low economic security, less involvement in the labour force and more care-giving responsibilities than elderly men.

The longer life expectancy, increased proportion of older women than men and the fact that older women encounter a complex web of health and socioeconomic challenges, has been acknowledged by WHO and Member States on several occasions. The Yogyakarta Declaration on Ageing and Health (2012) by the Health Ministers of South-East Asia had referred to the specific health problems of older women; the South-East Asia regional strategy for healthy ageing has strongly articulated the need for specific



health and social programmes for older women; a regional consultation on long-term care of elderly persons recognized that older women required more long-term care as compared to older males; and the World Health Assembly Resolution WHA66.3 'Strengthening noncommunicable disease policies to promote active ageing', had mentioned the need to consider the health of older women. In view of these factors, the Regional Director emphasized that now is an opportune time to focus attention to address issues related to the policy, gender and health services of older women in countries of South-East Asia.

In conclusion, Dr Singh mentioned that the overall objective of this regional meeting is to promote the health of older women in countries of South-East Asia while examining the health status and care available to older women, examining different successful policies and practices including a framework of action, related to the health of older women. The meeting envisages that the framework for action will have two overarching priority areas - to strengthen health systems to better respond to the health needs of older women and in expanding human rights commitments and standards to promote women's health through a life-course approach by taking into account the gender perspective. These are difficult tasks. In her opinion, given the composition of this group she expressed confidence that all objectives of this meeting will be achieved with great success.

The objectives and mechanics of the meeting were presented by Dr Kunal Bagchi, Regional Adviser, WHO-SEARO. He pointed out that in the South-East Asia Region, the population of the elderly is dramatically increasing and raises several critical questions on economic effects, quality of life, humanitarian crises; and health problems. Dr Bagchi mentioned the developments in strengthening programmes for healthy ageing in South-East Asia including the observance of World Health Day 2012 with the theme Ageing & Health; the Yogyakarta Declaration on Ageing and Health 2012; and the regional meeting to strengthen healthy ageing programmes in the South-East Asia Region among others.

Dr Bagchi said that several technical presentations on various aspects of ageing and elderly health care will be made including: global overview of ageing and health; economic and social support issues affecting older women in Asia; key issues and concerns in the health of women beyond reproductive years; health of older women in the post-2015 agenda;



gender, equity and rights issues in the South-East Asia Region; overview of legislation, laws and acts for improving the health and care of older women in South-East Asia; and the management of chronic diseases in older women. All participating Member States will also report on the status of programmes for the elderly and healthy ageing in their countries. Based on the information from these presentations, the participants will review existing programmes and draft national frameworks for the elderly and healthy ageing. The expected outcomes of the regional meeting are: strengthening of health systems to better respond to the needs of elderly women and advocating for universal health coverage for women as they age; and expanding human rights commitments and standards to promote women's health through a life-course approach.

Dr Ekachai Piensriwatchara, Director of the Elderly Health Division, Ministry of Public Health, Thailand and Dr Upik Rukmini, Chief, Section of Standardization, Directorate of Basic Health Care, Ministry of Health, Indonesia were nominated as the Chairperson and the Co-Chair, respectively. Dr Wantana Maneesriwongul from the WHO collaborating centre for Nursing and Midwifery Development, Ramathibodi School of Nursing, Thailand was nominated as the Rapporteur.

During the first plenary session, presentations on the global overview of ageing and health: priorities and future direction; economic and social support issues affecting older women in Asia; and health of women beyond reproductive years were made. These were followed by presentations on the health of older women in the post-2015 agenda, gender, equity and rights issues in the South-East Asia Region; and overview of legislation, laws and acts for improving the health and care of older women in countries of South-East Asia and the management of diseases in older women. These were given by speakers from WHO-SEARO, United Nations and partner organizations.

On the second day of the meeting, representatives from Member States presented their reports on the status of elderly and ageing healthcare in their countries. This was followed by presentations from partner organizations and group work on developing an outline of a national framework and action points for promoting the health of older women.



For the purpose of group work, participants were divided into three groups: Bangladesh, Bhutan, India and Nepal in group A; Democratic People's Republic of Korea, Indonesia, Myanmar and Thailand in group B; and Maldives, Sri Lanka and Timor-Leste in Group C. A number of technical experts served as resource persons for each group. The participants were requested to select up to five priority areas for addressing the health of older women in their country and to describe what can be done in the next two years to address the selected priorities or areas of work. Member States were asked to describe activities and potential short-term results based on current resources.

On the third day of the meeting, each group presented the consolidated national frameworks from each Member State. This was followed by the formulation and presentation of conclusions and recommendations as agreed upon by Member States. The meeting ended with closing remarks from the Honorable Minister of Public Health, Thailand conveying his gratitude to all Member States, to WHO-SEARO and all partner organizations for their participation and contribution for the success of the meeting. In addition, he expressed his hope to achieve success in terms of ending poverty and hunger and reducing inequality, in promoting a healthy life and well-being and a friendly environment for older people.



2 Technical presentations

Global overview of ageing and health priorities and future direction

Islene Araujo, Senior Policy and Strategy Adviser, WHO/Ageing and Life-course/HQ/Geneva

There will be a drastic increase in the proportion of the population aged 60 and above in 2050 compared to the data in 2012. In 2012, Japan had over 30% of people above 60 years but in 2050, a different picture of the ageing population will emerge. The increasing rate may imply a problem but if we view it from a different lens, it is actually a source of strength and opportunity.

There is a need to act on ageing for various reasons namely: economic reasons; for upholding human rights; and for social cohesion or the formation of societies that are cohesive, peaceful, equitable and secure thus requiring that we attend to the needs of all. However, due to various reasons it is very difficult for policy makers to address these issues. To date only a few countries have policies on health. Issues countries are facing include the heterogeneity of older age groups, disparity and discrimination. All people age in a different way. There can be a 60-year-old who is active and well educated or a 60-year-old who is frail and disabled. Society needs to look at the needs from two sides—the strong and the vulnerable. Different people age in different ways.

The next issue is disparity and the situation varies across and within countries. Cardiovascular disease and COPD remain the top causes of morbidity across countries; however, there is a difference in the time it takes to address these concerns. Some countries are able to address this quicker, while less developed nations take more time. The third issue is discrimination—social stigma. Women reflect gender discrimination and gender inequality. Violence against women for instance occurs across the lifetime but is hidden. When women reach 60 years, no one talks about



violence anymore such as verbal abuse related to caregiver relationship and caregiver roles.

The ALC department in WHO/HQ is preparing a framework (Figure 1) to help older adults and address global ageing. Looking at the framework on the concept of health for an older adult, well-being for an ageing person means having a role to take, attachment, enjoyment, having a control over their own lives, security and personal development. WHO is working on redefining the concept of disease from being a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity to a function approach. Ageing is a normal phenomenon and people experience diseases, disability and degeneration; however, one can still be productive and engage in society. The International Classification of Functioning has identified three crucial aspects in the health of the elderly—emotional, cognitive and physical functioning. As a person ages, one needs to learn to adapt to changes and losses.

Health is an interaction between functioning and resilience. Environmental and personal factors affect resilience. Without a conducive environment, adaptation will be difficult. It is WHO's goal to enable the best possible functioning and resilience. Entry points to achieve this goal include: an integrated, older person-centered, health services on disease prevention, detection, acute care, chronic care, rehabilitation, palliative care, and long-term care; health promotion across the life-course; and enabling environments. This proposed framework is under revision and is currently open to questions and recommendations. Basically, there are three approaches to a life-course approach to the health of ageing populations namely—health promotion across the life-course; integrated older person-centered care (primary/acute/chronic/long-term care); and age-friendly environments achieved through innovation, knowledge generation and transfer (Figure 2).

Currently, WHO is preparing the World Report on Ageing and Health by 2015 followed by the Global Strategy and Action Plan by 2016. It is also providing support to Member States' knowledge and translation models; establishing the Strategic Advisory Group of Experts on Ageing and Health (SAGEAH); and to produce a Knowledge and Action Network on Ageing as well as Guidelines on Frailty.



Figure 1: Health for an older adult, WHO 2014

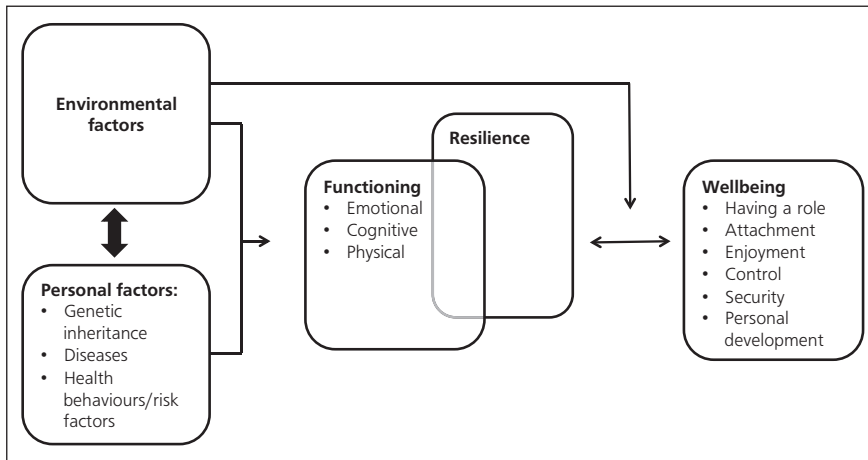
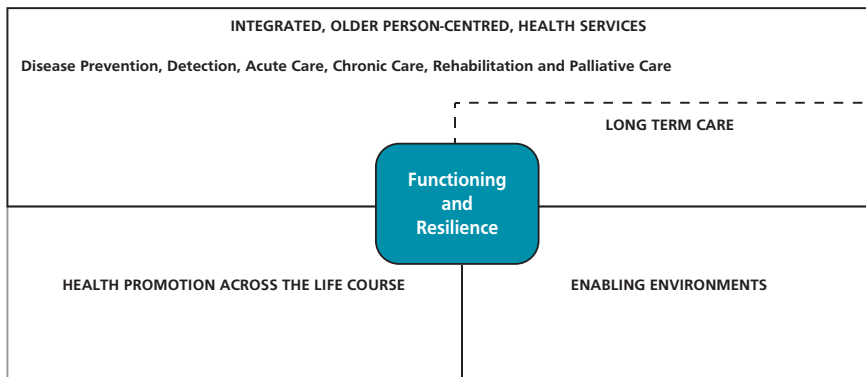


Figure 2: Entry points for healthy ageing, WHO 2014



Economic and social support issues affecting older women in Asia

Srinivas Tata, Chief, Social Policy and Population Section, Social Development Division, United Nations ESCAP, Thailand

There is a need to look at the real numbers of people affected in addition to population percentages when discussing health issues of the ageing population. Percentages tend to hide the real numbers. There is a growing percentage of population aged 60 years and above in different WHO Regions—East and North-East Asia, North and Central Asia, ESCAP region, South-East Asia, Pacific and the South and South-West Asia.

In the percentage of population 60 years and above in 2014 and in the projected numbers for 2050, women always outnumber men. Thus, our primary clientele is women and older persons in general; older persons are not homogenous. They have different health and care needs. There is the ageing society with 7–14% of the population above 65 years, the aged society with 14–21% and the hyper-aged society with 21% or more. Recognizing the difference, health policy has to be a two-fold strategy—for the younger old and the older old because some young olds even become caregivers for the older old.

The speed of ageing is faster especially in Thailand, Japan, Sri Lanka, and Viet Nam as compared to countries like the United States of America and France. Thus, there is not much time to prepare. This is not a crisis but an opportunity. The old-age support ratio by sub-region in 2012 (persons 15–64 years/persons 65+) is high in South-East Asia (10) and South and South-West Asia (11). Ageing society: 7–14% of the population are 65 years or older.

In most countries where data are available, except Armenia, the percentage of women of working age who are legally covered by a contributory pension is lower for women in total. For example in the Islamic Republic of Iran, 34 % of the total working-age population are covered by contributory pension, but only about 9 % of working women. In Bangladesh, Nepal, and India, the percentage of the working-age population covered by a contributory pension is generally very low – but for women, it is even less, about half of the total percentage.

The reason why women are less likely to be legally covered by a contributory pension is simple — because their labour force participation is still low in many countries of the Region — in many countries more than half of the women of working age do not actively participate in the labour force. Women's labour force participation is as low as 18 % in Afghanistan, but also in a developed country, such as Japan, only 49 % of women are in the labour force. Moreover, even in some countries, where labour force participation is relatively high, it is often in agriculture — a sector typically not covered by contributory pensions.



For example, Maldives has published relatively detailed data on social protection beneficiaries in their statistical yearbook. It is seen that the number of women receiving pensions is lower than the number of men, particularly when it comes to the contributory pension, where the number of women receiving pensions is less than men. The same picture emerges in the case of current contributors to the pension system. In 2012, about 50 000 men contributed to the pension system of the Maldives, but only about 20 000 women. This is a reflection of women's lower labour force participation and if women do participate in the labour force, they are more likely to be in vulnerable employment, without access to social protection schemes, such as contributory pensions. So they are typically left with the basic pension with low benefit levels.

The percentage of married population over 60 years includes more males than females. Older women are more likely to live alone. In Bhutan for example, life expectancy after 60 is 19.6 while healthy life expectancy is only at 14.6. Almost one-fourth of the years lived after 60 will be lost. Thus, older women are vulnerable and need to be the centre for health focus. Specific issues to consider are:

- ◆ Ageing has a strong gender dimension globally and regionally
- ◆ Women are more likely to be alone in the golden years when they require support
- ◆ Older women are less likely to be receiving pensions and income support
- ◆ Older women have less resources and assets in their name
- ◆ Older women have specific health and care needs
- ◆ Older women are more likely to be abused

Considering the issues presented, efforts can be directed to targeting social pensions more to women; orient health systems and long-term care to the specific needs of older women; and implement laws to prevent abuse of older women.



Health of women beyond reproductive years: key issues and concerns

Islene Araujo, Senior Policy and Strategy Adviser, WHO/Ageing and Life-course/HQ/Geneva

In 2010, WHO launched the women's health report, a compilation on women's health. It highlighted the necessity to address the health of women beyond reproductive years. There are global initiatives but these do not address the problems faced by women in the 21st century. Does this reflect the value of women as child-bearers and as caregivers only? Three issues are important to understand women's health in the world today. These are: increasing life expectancy of women; the so-called "health transition"; and the huge diversity and inequities that are seen in older women's health, both between and within countries. There have been improvements in the life expectancy of women over the years. In at least 35 countries, the life expectancy of women is now more than 80 years.

Globally, cardiovascular disease (often thought to be a "male disease") is the leading killer of women, 60 years old and above, and in fact in all age groups. This is followed by stroke, chronic obstructive pulmonary disease, lower respiratory infections and diabetes mellitus. In high-income countries, women live till about 80 years, in middle-income countries till about 70 years while in low-income countries, women die early. The latter is also related to high infant mortality rates in low-income countries. Nearly 50% of deaths among women in the South-East Asia Region is from chronic noncommunicable diseases. Percentages of death from CVD, cancer, and cerebrovascular disease are slightly higher in women compared to men. A strong risk factor for CVD and disability is obesity. It is also associated with frailty and Alzheimer's disease. The prevalence of obesity is much higher in women above 30 years than men in the Region (in men over 30 years, prevalence ranges from less than 0.3 to 11.2)

Looking at the proposed WHO framework, there is limited data as to functioning and resilience among ageing women. No data is collected in health services because no health services are offered for this group. There is a need to provide services to monitor ageing women's emotional and physical decline. Frailty is more prevalent among women as well as dementias, most importantly Alzheimer's. Women also reach the disability



threshold (when women need assistance with activities of daily living) two years earlier than men and the prevalence of dependency is higher among women since they are the biggest receivers and also givers of care. Women are the unpaid caregivers and receivers of care. It is an overwhelming activity that is more likely to affect their wellbeing. In China, for instance, the psychological morbidity in women caring for a care-dependent older person ranges from 2.9% to 3.6%; in India from around 9.4% to 20% and in Mexico from 23% to 33%.

In most countries of the Region and low-and middle-income countries, women experience economic deprivation across all stages of life. Additionally, it is not only the caregiving role that affects their wellbeing and quality of life but also economic activity. Some women give up work to care for a dependent person in the family; therefore, they do not get opportunities to build up their old age pensions. They first take care of the husbands who often die earlier. The death of the husband is followed frequently in most cultures, by property-grabbing by family members leaving the widow economically dependent, isolated and marginalized.

Women and ageing is a story of neglect. Many of the health problems faced by women in old age are the result of risk factors experienced when they were younger – smoking, sedentary lifestyles, and unhealthy diets. Functional decline remains unprevented and unmanaged; and because many older women have worked all their lives in the informal sector or in unpaid activities, health care is inaccessible, unaffordable or both. Establishing older people-centred services requires the consideration of integrating prevention, care, treatment, rehabilitation and palliative care with all the characteristics of a well-functioning health service. Older people-centered and integrated health services mean (a) transforming services for older people with a fundamental shift towards care that is co-ordinated around the full range of an individual's needs (rather than care around single diseases) integrated across sectors; (b) care that prioritizes prevention rather than acute care, is community-based with support for maintaining participation, independence and functioning and has a mix of services.

The starting point is to clarify what are the needs. There is a need for care that prioritizes prevention and support for maintaining independence/



functioning and with a mix of services in the right place and in the right time. With the goal to enable the best potential functioning and resilience, the following objectives are outlined:

- (i) Health promotion and prevention
- (ii) Management of complex co-morbidities, impairments, dementia and frailty
- (iii) Available community and home-based health care
- (iv) Quality acute hospital care
- (v) Good rehabilitation
- (vi) Choice, control and support towards the end of life

A framework for action in the Region focuses on promoting healthy ageing, management of chronic diseases, avoidance of dependency by preventing and managing frailty, dementia and sensory impairment at primary health care level; establishment of long-term care and addressing gender inequalities.

The health of older women in the post-2015 agenda

Wame Baravilala, Technical Adviser, Maternal and Reproductive Health, United Nations Population Fund, Asia and Pacific Regional Office

The empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself and is essential for the achievement of sustainable development. Greater investments in health and education services for all people—in particular women, to enable their full and equal participation in civil, cultural, economic, political and social life are essential to achieving the objectives of the UNPF Programme of Action (PoA). In 2002, the UNFPA released a Statement at the Second World Assembly on Ageing “The issues of ageing must be at the centre of the global development agenda. [...] We must meet the needs of the older persons who are alive today and plan ahead to meet the needs of the elderly tomorrow. [...]”

Indeed, Asia has the fastest growing ageing population. Overall the world ageing population shifted from 8% (1950), to 11% (2010), to 22% (2050), demonstrating that globally the older population is growing faster



than any other age group. The population ageing projections especially for East Asia and South-East Asia show a very rapid ageing process, with the proportion of those aged 60+ years becoming more than 30 % of the population for East Asia by 2050. The rapidity of the ageing process in Asian countries adds a new dimension to its policy planning, framework and national development, particularly on issues such as feminization, poverty, health, gender, income security as well as changes in family structure and living arrangements.

Population ageing is a global phenomenon and is the result of social and economic progress: people are more able to avoid unwanted pregnancies and premature death. These positive and irreversible developments have profound repercussions for the social fabric of every country, and policies will need to ensure that adequate safety nets and social care services are effectively targeting the elderly. Asia's ageing population will also become the largest in the world. Specifically, South-East Asia shows a very varied demographic situation, although it is evident that all are facing the prospects of a significant ageing population in the future.

Throughout the Region people are living longer, helped by investments in human development—health and education- resulting in an increasing proportion of the Asian population living to an advanced age. Globally and in Asia women live longer than men, owing to the increased life expectancy of women compared to men. Older populations are therefore predominantly female. The difference is greater in the group of 80 years than in the 60-years age group.

Another phenomenon of modernization is high urbanization in developing countries. Especially younger age groups migrate to urban areas for employment. The transition from rural to urban has implications for the support system of the elderly. Old age poverty is different from that of other groups. First, diminished physical and sometimes mental strength, reduce opportunities for employment. Therefore there is a higher reliance on sources of support other than one's own labour, such as family transfers, savings and investments and public social security programmes. The incidence of poverty is expected to be higher among the older population, and particularly high among people over 80 years.



Given the influence of ageing population on society, UNFPA has formulated its vision for post-2015 as “People at the centre of development, respect for human rights.” To empower the people, UNFPA’s post-2015 priorities are as follows: universal access to sexual and reproductive health; access to timely and complete data for population trends and projections; stand-alone goals on adolescents and youth; and gender equality and women’s health.

The report of the International Conference on Population and Development (ICPD) indicated that the global community must do more to protect women’s rights, even beyond adolescence. Significant gains have been made, particularly with respect to maternal death, which has declined by nearly half (47%) since 1994. Yet, in one of its most alarming statements, the report says that one in three women worldwide still report they have experienced physical and/or sexual abuse and there are areas where many men openly admit rape without facing consequences. And, in no country are women equal to men in political or economic power.

The Post-2015 Health Framework is an integrated approach that uses universal health coverage to help focus on healthy life expectancy. It combines MDG 5 (maternal health), MDG 4 (child health), and MDG 6 (HIV/AIDS and malaria) and introducing better measures of accountability. Universal health care (UHC) could be an important way to reach marginalized women around the world but it should not be the only health goal. Suggested changes for the framework to improve care for elderly women include: reward positive health-seeking behaviour, especially for disadvantaged older women, “slum” and rural dwellers e.g. expand access to cash transfers or financial incentives; more funding for health promotion ; political will needed to promote and preferentially fund more public health activities (sports, tai chi, cycling); multisectoral involvement and partnership; and develop partnership with mobile telecom providers to reach more people.



Gender, equity and rights issues in the South-East Asia Region

Prakin Suchaxaya, Coordinator, Gender, Equity and Human Rights, WHO Regional Office for South-East Asia

Sex and gender are terms commonly used interchangeably; however, these are not the same. Sex refers to the biological and physiological characteristics that define men and women. Biological differences include chromosome, brain structure and hormones, reproductive roles and natural strengths. It refers to men and women categories. Gender, on the other hand, refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men or for women. It is due to culture, norms and values. Gender refers to the masculine or feminine categories. For instance, in terms of sex in the Asia Pacific, women comprise 51% of the population in most regions worldwide but only 49% in Asia Pacific. Women account for 48.2% of the population in India, 48.8% in Bangladesh, 50.4% in Nepal and 50.5% in Sri Lanka.

The term gender has been used with varying terminologies, namely: gender role, gender difference, gender discrimination, gender inequity, gender inequality, and gender egalitarianism. It is also associated with various issues—inadequate health service, difficult to access sexual and reproductive health and mental health service including counselling, poverty, inequitable access and opportunity for education, all forms of violence, child and forced marriage, honour killing, trafficking of women and girls, female genital cutting/mutilation, women-headed households and unpaid labour.

Gender discrimination takes place throughout the lifetime. The following are examples of gender discrimination: sex selection in Asia in favour of a son; abortion/female feticide; neglect of girl children, discriminatory feeding; female genital mutilation; child marriage-premature parenthood; lactating women and menstruating girls are asked to sleep in cowsheds; reproductive mortality, HIV/AIDS; sexual abuse, exploitation, trafficking; poor access to healthcare for girls and women; older women face double discrimination—gender and age; and violation of fundamental human rights, and especially reproductive rights of women lead to gender inequity.



In South Asia, women are socially, culturally and economically dependent on men; are largely excluded from making decisions; have limited access to and control over resources; are restricted in their mobility; often under threat of violence from male relatives; and are often felt to be an economic liability because of dowry system. Given the issues faced by women, the Universal Declaration of Human Rights, a landmark document, was adopted on 10 Dec 1948. It protects and promotes individual rights regardless of gender, race, religion and cultural background. There are six treaties that uphold the rights of women—the Covenant on Civil and Political Rights; the Covenant on Economic, Social and Cultural Rights; the Convention on the Rights of the Child; the Convention on the Elimination of All Forms of Discrimination against Women; the Convention on the Elimination of All Forms of Racial Discrimination; and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

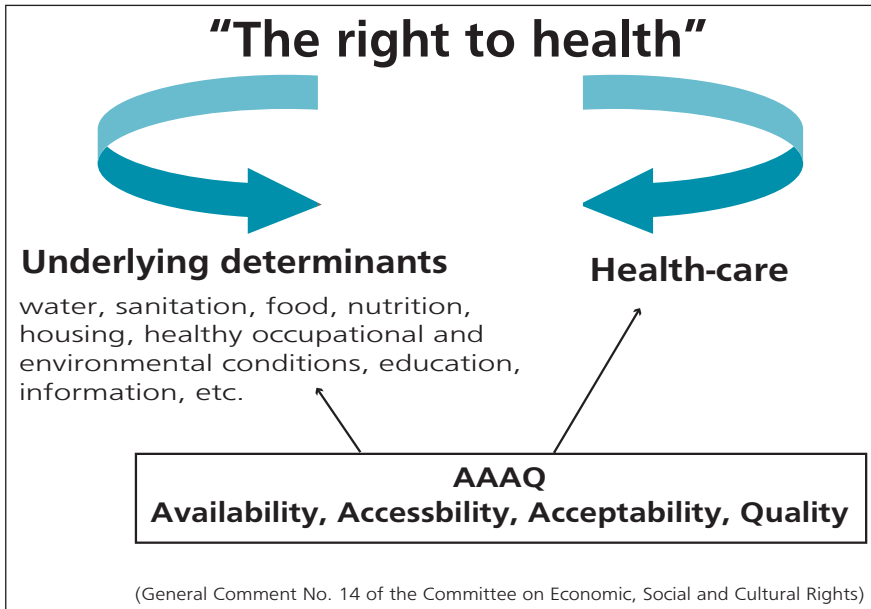
The WHO Constitution enshrines the highest attainable standard of health as a fundamental right of every human being. The right to health includes access to timely, acceptable, and affordable health care of appropriate quality. It does not mean the right to be healthy. The right to health has been enshrined in international and regional human rights treaties as well as national constitutions all over the world (see Figure 3).

The world needs a global health guardian, a custodian of values, a protector and defender of health, including the right to health” says Dr Margaret Chan, Director-General, WHO.

Equity is the state, quality, or ideal of being just, impartial and fair. It is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. Health equity is the study of differences in the quality of health and health care across different populations. This may include differences in the “presence of disease, health outcomes, or access to health care” across racial, ethnic, sexual orientation and socioeconomic groups. Social determinants of health (SDH) cause health inequity.



Figure 2: The right to health



Gender equality is achieved when women and men enjoy the same rights and opportunities across all sectors of society, including economic participation and decision-making, and when the different behaviours, aspirations and needs of women and men are equally valued and favoured. A result of the persistent discrimination of one group of people based upon gender manifests itself differently according to race, culture, politics, country, and economic situation.

Gender equality, also known as sex equality, gender egalitarianism, sexual equality or equality of the genders, refers to the view that men and women should receive equal treatment, and should not be discriminated against based on gender, unless there is a sound biological reason for different treatment. After World War II, a more general movement for gender equality developed based on women's liberation and feminism. The central issue was that the rights of women should be the same as of men.

The gender inequality index (GII) refers to reproductive health measured by maternal mortality ratio and adolescent birth rates; empowerment, measured by proportion of parliamentary seats occupied

by females and proportion of adult females and males aged 25 years and older with at least some secondary education; economic status expressed as labour market participation, measured by labour force participation rate of female and male populations aged 15 years and older.

Gender inequality remains a major barrier to human development. Girls and women have made major strides since 1990, but they have not yet gained gender equity. The disadvantages facing women and girls are a major source of inequality. All too often, women and girls are discriminated against in health, education, political representation, labour market, etc — with negative repercussions for development of their capabilities and their freedom of choice.

The gender inequality index (GII) is an index for measurement of gender disparity that was introduced in the 2010 Human Development Report 20th anniversary edition by the United Nations Development Programme (UNDP). According to the UNDP, this index is a composite measure which captures the loss of achievement within a country due to gender inequality. It uses three dimensions to do so: reproductive health, empowerment, and labour market participation. The new index was introduced as an experimental measure to remedy the shortcomings of the previous indicators, the Gender Development Index (GDI) and the Gender Empowerment Measure (GEM), both of which were introduced in the 1995 Human Development Report.

There is a gender gap between men and women in various situations as seen in the position of men and women in the European labour market; inequalities in the financial resources and economic situation of women and men; differences in terms of education and training; time trade-off between economic, care and other social activities; differences between women's and men's representation in the political and economic spheres; and the differences in terms of health status and access to health structures.

These health consequences continue in older age/elderly. A woman cannot receive needed health care because norms in her community prevent her from travelling alone to a clinic. A teenage boy dies in an accident because of trying to live up to his peers' expectations that young men should be "bold" risk-takers. A married woman contracts HIV



because societal standards encourage her husband's promiscuity while simultaneously preventing her from insisting on condom use. A country's lung cancer mortality rate for men far outstrips the corresponding rate for women because smoking is considered an attractive marker of masculinity, while it is frowned upon in women.

Violence against women and girls and children is a violation of human rights as per the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979). The root cause is gender inequity. It is an increasing public health concern because it leads to injury, trauma and death. In the South-East Asia Region, domestic violence and sexual violence are under-reported.

The prevalence of physical and/or sexual intimate partner violence in the last 12 months is measured by the proportion of ever-partnered women (aged 15–49 years) who experienced physical and/or sexual violence by a current or former husband/male intimate partner in the last 12 months; and the prevalence of sexual violence by a non-partner is measured by the proportion of women (aged 20–29 years) who have ever experienced sexual violence by a non-partner from the age of 15 onwards.

Overview of legislation, laws and acts for improving the health and care of older women in the countries of South-East Asia

Katayoun Taghavi, WHO/Ageing and Life-course/HQ/Geneva

Looking at the legislation, laws and acts for improving the health and care of older women in countries of South East-Asia, it is seen that few, if any policies exist that specifically target the inequities in health outcome between men and women. This is causing a problem due to the huge health disparities that exist. However, moving forward, the South-East Asia Region has a unique opportunity. First, this is an area of growing international interest. There is already commitment to address this issue at a ministerial level (Yogyakarta Declaration on Ageing and Health), and most countries have taken some initiatives. For example, access to medicines, identifying essential medicines and offering free or subsidized medicines, and, in special cases, introducing geriatrics into the medical curriculum.



The barriers to progress are the core issue. Questions like, should the responsibility to care for older people be taken by the family or the state or both? And, how will the responsibility be shared?—are important to address. In this Region, responses vary greatly. For instance, Nepal's Civil Code states that when parents are living with offspring, the family will take care of the parents. In Democratic People's Republic of Korea, the State assumes full responsibility for the lives and health of older people, and in Bangladesh older people are taken care of at the family as well as the community level. This issue is also at the core of the gender issue because traditionally within the family unit, it is a woman's role to be the carer. The implications are that, they engage in less education, they engage in less formal work, which means they are less entitled to social security and pensions in older age and lower education is also associated with suboptimal health outcomes.

A few countries have started programmes that shift some of this responsibility onto the state. Under the national programme for health care for the elderly, India has an outreach programme for bed-ridden people. Thailand's long-term care policy is another example which is explained in more detail in another presentation. Some countries have also taken the initiative to reimburse these informal workers – in Thailand for example, taking care of a parent entitles one to get a specific tax reduction per parent.

Prevention of chronic diseases in older women

Duru Shah, WHO-SEARO Temporary Adviser

International Menopause Society (IMS) is a professional organization of multi-disciplinary doctors globally with the mission to relieve sickness, preserve and protect good health and well-being of pre-and post-menopausal women during and after mid-life. The key strategic aim is to provide education to physicians to ensure gold standard treatment throughout the world and support women with good basic information and educate them on treatment options available.

World Menopause Day is a worldwide educational initiative to raise awareness on menopause and empower women to seek help and treatment. A patient information material translated into 12–18 languages



is provided. National Menopause Societies affiliated to IMS are encouraged to hold patient information days, health checks and to encourage women to seek advice. In maintaining health and preventing disease after the menopause lifestyle changes are necessary for a healthier life tomorrow. After menopause the probability of developing chronic diseases increases. Prevention is the key; managing lifestyle will lower the risks and will enhance quality of life.

The IMS education includes: World school for the study of menopause; worldwide programme of educational events; world congress every two years; guidelines and recommendations prepared to provide treatment based on the best science available; IMS Research Bursary; and Awards for Distinguished Research in Basic & Clinical services. Several events are held, a recent one was during 6–8 December 2013 in Mumbai India with the theme “Challenges in Women’s Health—New directions in the 21st Century”.

Women in the menopause and post-menopausal years face significant challenges. In the developed world, the percentage of women over 50 years has tripled in the last 100 years. The mean life expectancy of women in the United States has increased from 50 years to 81.7 years indicating that menopause will occur at a time when women have yet to experience more than one third of their total life span. In India, the life expectancy of women stands at 64 years (UNICEF - 2010).

At the beginning of the sixth decade of life, as age advances, chronic diseases begin to emerge. These diseases affect the quality and quantity of a woman’s life which leads to the question, “Can we reduce the disability, suffering & dependence which accompanies chronic disease?” The goal should be to see that women live longer in health and are not simply taking longer to die. Common chronic diseases or noncommunicable diseases (NCD) affecting women are obesity, metabolic syndrome, diabetes, cardiovascular disease (accelerates in women after menopause), osteoporosis, dementia and depression and cancer (risk increases as a function of age). Women presenting to their medical providers during the menopausal transition provide a unique opportunity for risk assessment, counselling and the institution of various preventive measures. Preventive strategies at menopausal stage include screening and assessment of risk



factors for NCDs, varied tools for risk assessment for different diseases which can vary according to ethnicity, lifestyle and prevalence in different regions of the world. In case of a need for personalized risk assessment, molecular tools and pharmacogenics may help.

Evidenced-based prevention at menopause after identification of risks is focused on lifestyle changes such as the cessation of smoking, curtailing excessive alcohol consumption, healthy diet, moderate exercise and encouraging mentally stimulating activities. Another preventive measure is estrogen therapy. There had been controversies as to the use of estrogen in women but scientific evidence shows that estrogen therapy may be included in healthy women aged 50–59 years as it reduces the risk of coronary heart disease and reduces all causes of mortality (consistent with randomized controlled trials and observational studies).

In the Women's Health Initiative (WHI) study, a critical analysis of women below 60 years was done. Those on estrogen therapy were compared with those on placebo. It was found that for every 10 000 women treated annually, there was a decrease in coronary artery disease by 11%, strokes by 2% diabetes by 14%, fractures by 56%, breast cancer diagnosis by 8%, breast cancer death by 10% and deep vein thrombosis by 4%.

The age at natural menopause of women in developed countries is 50–52 years and it is 47–49 years in less developed countries. Early menopause can increase the risk of cardiovascular disease and osteoporosis while delayed menopause can increase the risk of dependent tumors, breast and endometrial cancers (Gold et al., 2001; Dratva et al., 2009).

Cardiovascular disease accounts for the largest number of deaths in women above 50 years. Approximately 18% of women aged 45–64 years develop heart failure within five years versus 8% men after the first heart attack. There is a greater risk of heart failure for women who experience menopause at an older age while menopause before the age of 45 years is associated with increased risk of cardiovascular disease.

The relationship of reproductive hormones and cardiovascular risk was also explored. In the prospective, multiethnic Study of Women Across the Nation (SWAN) enrolling 3297 pre-and perimenopausal women, results



showed that after controlling for BMI, decrease in sex hormone-binding globulin (SHBG) and FA1 were strongly associated with increased CV risk factors (insulin, glucose, haemostatic & inflammatory markers), and adverse lipids. SHBG also increased body mass index as manifested by an increased waist circumference, increased waist to hip ratio and increased risk for metabolic syndrome. There is an increased prevalence of diabetes globally. Women have three times more risk compared to men. Incidence of diabetes is rising in Asia.

One factor associated with coronary heart disease is abdominal obesity. Waist circumference has been shown to be independently associated with increased age-adjusted risk of CHD, even after adjusting for BMI and other cardiovascular risk factors. When it comes to osteoporosis, the risk for fractures increases as a woman ages. Approximately 70% of women have osteoporosis of the hip, lumbar spine or distal forearm at 80 years. Low body mass index and use of tobacco are some of the factors that increase the risk of fractures. Among all types, osteoporotic fractures are more common in women than in men, as women lose bone density rapidly after menopause. Since the number of osteoporotic fractures of hip and spine rises alarmingly, it creates a massive impact on the quality of life of individuals.

To prevent osteoporosis, estrogen is found to be effective in preventing bone loss associated with menopause or with secondary amenorrhea. It decreases the incidence of all osteoporosis-related fractures, including vertebral and hip fractures, even in populations of women not at high risk of fracture.

Another health concern in elderly women is cancer. All cancers increase with ageing. For women, the most important cancers are breast, colon, endometrial, ovarian, cervix and lung. To prevent cancer, it is important to have appropriate screening and lifestyle changes especially after menopause. Among all types, breast cancer is a more common cause of death than CVD in women before menopause. However, the treatment for cancer accelerates the menopause with subsequent impact on quality of life, chronic disease and reproductive function. Dementia and cognitive decline is also another concern for women above 60 years. Around 36 million people suffer from Alzheimer's disease and it is projected to



double by 2030. This is the most common cause of dementia and could be genetically inherited.

As life expectancy increases globally more women will experience longer lives after menopause. Thus, improving the quality of women's lives after menopause should be a goal. Moreover, chronic diseases or noncommunicable diseases begin to occur around 60 years of age. An important window of opportunity exists at menopause to assess risk factors for NCDs to make a significant impact on quality of life after 60 years. Good evidence exists to support lifestyle changes to decrease the incidence of these diseases.





3 Country reports

Bangladesh

Yeasmin Jahan, Deputy Programme Manager Emergency Obstetric Care & Gender, Hospital Service Management and Focal Point of Gender Issues, DGHS

Bangladesh has a population of around 151.41 million (BBS-2010) with total annual births of about 3 million. The country's Honourable Prime Minister Sheikh Hasina received the Global Health and Children's Award and the South-South Award for her great contribution to poverty reduction in the country.

Currently, women in Bangladesh face a number of major challenges such as early marriage, teen-age pregnancy, poverty, malnutrition, illiteracy, ignorance, unscientific traditional beliefs, and home delivery by unskilled birth attendants leading to maternal morbidity and mortality. These major challenges lead to several health-related problems such as genital prolapse, cervical cancer, under-nutrition, osteoporosis, osteoarthritis, depression, hearing and visual problems, dementia, cognitive loss, memory loss, widowhood, divorce, lack of caregivers for older women, post-menopausal difficulties, absence of geriatric medicine and healthcare. In older women the leading causes of morbidity and mortality are hypertension and cerebrovascular diseases; osteoporosis and fractures; diabetic complications, cancer and incontinence; and anxiety disorders and depression.

To address these issues, the Women-Friendly Hospital Initiative and Women-Friendly Social Management were established to promote and protect the health of women in the country. The Women-Friendly Hospital Initiative addresses four dimensions: quality of care (represents the dignity, honour & respect of women); mother-baby package for the improvement of maternal and child health; management of violence against women;



and gender equity. In relation to this is the good health, good awareness campaign aimed at women's empowerment.

Under the Women-Friendly Social Management initiative, the government of Bangladesh adopted a new social protection mechanism to benefit poor older women. This is the old age allowance also called "Boyosko Vata". This programme has already demonstrated improvement in the economic condition of older women. Issuance of voter identification cards for all adults including older men and women has generated a sense of security in old age. In a culturally and traditionally close social system and family bondage, older members of the family are highly respected. Elder abuse or negligence is not a major issue in Bangladesh. But gender discrimination prevails strongly. There is a religious compulsion to take care of parents. The position of the mother is on the top. Older women avail of needed interventions and services through the Ministry of Health & Family Welfare; Ministry of Social Welfare; and the Ministry of Women and Children's Affairs.

There is a 'Probin Hitoyshi Songho' in the districts and at sub-districts level. This institution is for the wellbeing of senior citizens. They have a lot of practical knowledge and experience. From the community level to the central level the different levels of health facilities provide good services to the elderly. Health workers also provide health information, medicine and treatment.

Though there are good laws and policies in the country the implementation is not proper because of the lack of cultural competence. There have, however, been many positive developments e.g. old age allowance, women-friendly hospital initiative, free education for women, increasing the age of retirement from 57 to 59 years, and pension savings scheme. Many plans and policies have been initiated under the national Women Development Policies 2011 e.g. Women and the Law. A number of existing laws have been amended and new legislation enacted to prevent abuse of women, especially old women, and children. Numerous programmes have been included in the national strategy for accelerated poverty reduction including widowhood or old women's allowances. The programme for distribution of an allowance for widows and distressed women began in 1998. Presently it covers 920000 such women. They get 300 BDT per month. Maternity allowance is given at the rate of 350 BDT.



It covers 88 000 poor mothers. Under the food security programme for women without living means, they get 30 kg rice or 25 kg 'Pushti Ata' (flour) per month. It covers 750 000 women.

In order to mitigate the negative impact of illiteracy and ignorance and improve the health of older women, the following measures have been undertaken:

- ◆ Gender sensitive workshops and programmes that highlight the needs of old women in the form of gender equity in different hospitals.
- ◆ Proper implementation of property rights of old women.
- ◆ Prevention of different forms of disability of old women by arranging light employment and strengthening empowerment.
- ◆ Developing a special park, gymnasium for light, old-age-friendly exercise and sports.
- ◆ To change the attitude towards old age among the young and the elderly. To organize meetings among them about health, hygiene and current social needs and environment.
- ◆ To prepare a place or institution for old women like a day care centre, whose family members are working outside the home.
- ◆ Improvement of home delivery service to cater to the need of old women.

Bhutan

Tashi Phuntsho, Senior Programme Officer, Department of Medical Services, Ministry of Health

Bhutan is a small landlocked country with a population of 683 407. The country's population growth rate is 1.3 with life expectancy at birth of 66.1 years (PHCB, 2005) – 7% of the population is above 60 years. The total fertility rate is estimated at 3.59%. (Annual Health Bulletin, 2013).

Diabetes, hypertension, cardiovascular diseases, cancers and chronic lung diseases are some of the major health problems affecting elderly people in the country. Limited qualified man-power and resources for



health, limited research-based evidence and limited public policies and multisectoral action to address social and other determinants of health are some of the major gaps in the health care delivery system of the country. Sustaining free universal health coverage is a current concern in the face of escalating health care costs and decreased external funding from traditional partners and international funding initiatives, as Bhutan transitions to lower-middle-income status.

Although Bhutan does not have any specific law directly linked to elderly women, there are several laws and acts that promote and protect women in general. These are guided by the Constitution and other international conventions like; Convention on Elimination of All Forms of Discrimination Against Women (CEDAW); and SAARC Convention on Prevention and Combating Trafficking in Women and Children for Prostitution. The following are some acts and laws aimed at the promotion and protection of women in Bhutan:

- (i) The Marriage Act of Bhutan enacted in 1980 and amended in 1996.
- (ii) The Bhutan Citizenship Acts in 1958, 1977 and 1985.
- (iii) The Inheritance Act in 1980. Penal Code of Bhutan enacted in 2004.

Further, to protect and empower women and also to protect child rights there are nongovernmental organizations like the National Commission for Women and Children (NCWC) established through a special Government order in 2004, National Women's Association of Bhutan (NWAB), RENEW (Respect, Educate, Nurture and Empower Women), Tarayana Foundation, and the Youth Development Fund.

The development of a National Health Promotion Plan and Strategy- "Health in All Policies"- health promotion activities both within the health sector and across other government and private sectors and civil society organizations is under way. For strengthening the national policy on healthy ageing in the MOH, Bhutan will focus on developing a coherent, comprehensive and integrated approach to promote healthy ageing in the 11th Five-year plan period (2013–2018).



The Ministry of Health has established the Community-Based Elderly Care Programme in five Districts to address the need of the elderly population in the country and promote resourcefulness, productivity, vitality and happiness. Further, the remaining 15 districts are yet to be covered by 2018 (five districts annually).

To improve the situation of older people, the Ministry of Health will be initiating the following activities:

- (i) Annual screening of all elderly above 65 years.
- (ii) Follow-up of chronic illnesses.
- (iii) House visits for the elderly people who cannot come to the health facility.
- (iv) Promote existing culture of children caring for their ageing parents.
- (v) Develop capacities among the elderly to care for themselves.
- (vi) Train Voluntary Health Workers on elderly care and also involve them in elderly care in their community.
- (vii) Use volunteers from schools and also the community for creating awareness on care of the elderly.
- (viii) Formulate national and international alliances for promoting healthy ageing.
- (ix) Capacity building for health care providers and care givers of the elderly.

Democratic People's Republic of Korea

O Ryong Chol, Director, Department of Labour, Ministry of Public Health

Like many countries in the South-East Asia Region, the Democratic People's Republic of Korea is also witnessing an increasing population of the elderly. According to the 2008 census report issued by the Central Bureau of Statistics (CBS), the percentage of women aged 60 years and above among the total female population (52.6% of the total population) was 16 % in 2008. The population aged 60 years and above was 13.1% of the total population in 2008, but it increased to 13.4% in 2012. In 2012, life



expectancy at birth was about 72.3 years for the total population (about 66.9 years and 73.7 years respectively for male and female).

In the country, the rights of the elderly including women and improvement of their health are guaranteed legally. An article in the Constitution of Democratic People's Republic of Korea states, "A citizen is entitled to the health care service free of charge and the people who lost their working capability due to old age or disease or disability, the elderly and children with no caregiver have a right to receive social support. These rights are ensured by a free medical service system, increasing hospitals and health facilities including sanatoria and social insurance and security system by state." In several laws, for example, "Law of the Democratic People's Republic of Korea on the Care for the Elderly" (adopted in 2007), "Law of the Democratic People's Republic of Korea on the Social Security" (adopted in 2008) and "Law of the Democratic People's Republic of Korea on the Protection of the Disabled" (adopted in 2003), various measures for promoting health and social welfare of the elderly are ensured and equal rights for both sexes are ensured by "Law on Sex Equality" (adopted in 1946).

Under the existing social security system, pension and subsidy are provided by the State to all women aged 55 years and above (for men, 60 years and above) on the basis of their service years. There is no distinction on the basis of sex in the provision of pension and subsidy. All rights of the elderly for possession and disposal of their property are protected by laws.

Table 1: *Economic activity situation of older women, 2008*

| Age | In service | In social security | In pension | Housing | Others | Total |
|-------|------------|--------------------|------------|---------|--------|--------|
| 50–59 | 57.1% | 1.1% | 29.7% | 12.0% | 0.1% | 100.0% |
| 60–69 | 3.7% | 0.0% | 90.1% | 6.1% | 0.1% | 100.0% |
| 70–79 | 0.7% | 0.0% | 94.3% | 4.8% | 0.2% | 100.0% |
| 80+ | 0.3% | 0.0% | 94.0% | 5.0% | 0.7% | 100.0% |

(2008 census)



The government is responsible for care of the elderly population, particularly those who have no immediate caregivers. There are 24 facilities for the elderly who have no immediate caregivers and immediate family members countrywide. According to data issued by CBS, these facilities had about 1400 staff including about 380 health care providers for about 7200 older persons including about 4800 older women in 2010. A programme to enhance nutrition by including seafood for the elderly in the facilities is progressing very well.

In 2007, a survey was conducted by the Population Centre to collect data on the health condition of the elderly in the country in cooperation with UNFPA and the result was disseminated to decision-makers and stakeholders.

Table 2: *Percentage of older women with disorder by age and kind of disorder, 2008*

| Age | Eyesight disorder | Hearing disorder | Walking difficulties | Memory failure |
|-------|-------------------|------------------|----------------------|----------------|
| 50–59 | 4.9% | 2.3% | 4.1% | 2.3% |
| 60–69 | 8.4% | 6.6% | 9.6% | 6.2% |
| 70–79 | 11.8% | 12.2% | 15.4% | 10.8% |
| 80+ | 13.9% | 16.6% | 19.4% | 14.5% |

(2008 census)

All health facilities provide health care and recuperation services to the elderly on the basis of universal free medical care system and household doctor system. For those over 90 years, additional care services are provided by the State.

In Democratic People's Republic of Korea, the elderly population is regarded as those who had devoted their lives to the younger generation and to the formation of a stable State and society along with economic and cultural wealth. Several campaigns to enhance the welfare and the health care of the elderly have been launched, for example, sports, games and mass rhythmic physical exercise for the elderly are promoted and Taekwondo for the elderly is televised at prime time more than once a week.



India

R C Danday, Director (RCH), Ministry of Health and Family Welfare

It is widely known that India is the second most populous country in the world. The elderly population is increasing in its 36 states and 660 districts. The sex ratio is 940 females for every 1000 males and TFR is 2.4. The total literacy rate is 74.04% (female 65.46%, male 82.14%). In terms of ageing, it is the second country with the largest aged population in the world. At present, the proportion of the elderly is around 8% which translates to 100 million people. By 2020, it is expected to rise to 11%, and by 2026, India is expected to have 198 million aged people. Life expectancy is 64 years; for females it is 67. India is projected to have a change in its population pyramid when comparing 2000 census and in 2025 when the country is expected to have a population of at least 10 billion.

The major causes of morbidity are hypertension, cataract, osteoarthritis, chronic obstructive pulmonary disease, coronary heart disease, diabetes, and depression. The common causes of mortality are bronchitis, pneumonia, ischemic heart disease, stroke, cancers (cervical) and tuberculosis. To address these health issues, currently the country has noncommunicable disease control programmes such as the National Programme for Prevention and Control of Cancer, diabetes, Cardiovascular Disease and stroke (NPCDCS); National Programme for Control of Blindness (NPCB); National Mental Health Programme (NHMP); National Tobacco Control Programme (NTCP); National Programme for Health care of the Elderly (NPHCE); National Programme for Prevention and Control of Deafness; National Programme for Prevention and Control of Diabetes; and the National Oral Health Programme.

Keeping in view the recommendations made in the “National Policy on Older Persons” (NPOP) adopted by the government in 1999 as well as the state’s obligation under the “Maintenance & Welfare of Parents & Senior Citizens Act 2007”, dealing with provisions for medical care of senior citizens, the government launched the NPHCE during 2010–11, in the 11th plan period, to address various health-related problems of elderly people. It envisions to provide accessible, affordable, and high-quality long-term, comprehensive and dedicated care services to an ageing population; creating a new “architecture” for ageing; to build a framework to create



an enabling environment for “a society for all ages”; and to promote the concept of active and healthy ageing.

Included in the benefits of the programme are free specialized health care facilities exclusively for the elderly through the state health delivery system; viz: district hospitals with geriatric clinic (OPD) and 10-bedded geriatric ward; bi-weekly geriatric clinic at community health centres; weekly geriatric clinic at public health centres; domiciliary visits to the elderly persons by ANM/male health workers posted under sub-centres and provision of calipers and supportive devices to make them ambulatory.

At the sub-centres, services provided in the form of packages include health education in relation to healthy ageing; domiciliary visits for attention and care of home-bound/bed-ridden elderly persons and provide training to the family care providers in looking after the disabled elderly persons; arrange for suitable calipers and supportive devices from the PHC to the elderly disabled persons to make them ambulatory; and linkage with other support groups and day-care centres operational in the area. On the other hand the package of services in the primary health centre include: weekly geriatric clinic run by a trained medical officer; maintaining a record of the elderly using standard format during their first visit; conducting a routine health assessment of the elderly persons based on simple clinical examination relating to eye, BP, blood sugar, etc.; provision of medicines and proper advice on chronic ailments; public awareness on promotional, preventive and rehabilitative aspects of geriatrics during health and village sanitation day/camps; and referral for diseases needing further investigation and treatment, to community health centre or the district hospital as per need.

At the regional geriatric centre level, there are geriatric clinics (specialized in OPD for the elderly). There is also an established 30-bedded geriatric ward for in-patient care and dedicated beds for elderly patients in various specialties viz. surgery, orthopaedics, psychiatry, urology, ophthalmology, neurology etc. Laboratory investigation required for the elderly with a special sample collection centre in the OPD block is also offered. Moreover, services on tertiary health care to the cases referred from medical colleges, district hospitals and below as well as cancer



(breast, cervix) screening facilities for elderly women and chemotherapy in district hospitals are available.

To date, a total of 100 districts in 21 states and eight regional geriatric centres have been covered under the NPHCE. Nearly Rs 18257.48 Lakhs (US\$ 30.02 million) have been released to states and the regional geriatric centres. During the XIIth Plan, the programme will be expanded to include an additional 12 regional geriatric centres and 225 districts and two national institutes of ageing. In the 12th Plan period Rs 1710.13 crores have been allocated for NPHCE. Under the Criminal Procedure Code (CrPC) 1973, section 125 provides that if a person having sufficient means neglects or refuses to maintain his parents who are unable to maintain themselves; the law provides monthly maintenance allowance decided by the court. The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 also provides remedy to parents and grandparents against one or more of their major children who are entitled to inherit their property to get maintenance through the tribunal/court.

Indonesia

RM Nugroho Abikusno, Member of Expert Group, National Commission of Elderly

Indonesia, a country with 17 500 islands has a current estimated population of over 250 000 000. Major challenges affecting women, specifically older women, are rapid growth of older population—currently, they make up 8.4% of the total population; and the accessibility of quality geriatric services in villages located in remote, isolated and border areas due to the country's geography and the limited human resources in geriatrics.

In the 2013 basic health survey, the top causes of morbidity are hypertension, arthritis, stroke, oral health, COPD and DM; while the five major causes of mortality based on the Ministry of Health report in 2011 are stroke, heart disease, COPD, tuberculosis and liver disease. A series of policy interventions have been enacted namely: Law no 13 on Older Person's Welfare in 1998; Law no. 39 in 1999 on Human Rights; Law no. 11 in 2008 on Social Welfare; Law no. 36 in 2009 on Health; Law no. 40 in 2004 on National Social Security System; Government Reg. No. 43 in 2004 on the Implementation of Efforts to Improve Older Person's



Social Welfare; and Presidential Decree RI No. 52 year 2004 on National Commission for Older Persons. A ministry of population and national planning is also being considered.

In Indonesia, the elderly are called “older persons”. The main programmes for the older persons are focused on the promotion and protection of the right of older persons to protect them against exploitation, violence and abuse, and discrimination; promote social, economic and political rights on strengthening the family and community first, then community and state as the last resort (welfare society model); and on the promotion of the establishment of commissions on older persons at national level and local government units. Available interventions and services accessible and available to older women include health services in primary care facilities (age-friendly health centres and integrated primary health services based on the life-course approach and integrated programmes), geriatric referral services (integrated geriatric unit in hospitals), geriatric nursing for elderly in hospitals and home care (public health nurse home visits), increasing community empowerment through elderly clubs, and the development of elderly care institutions (older care homes).

However, the country faces gaps in the health care delivery system due to the limitations on a) the number of health professionals trained in gerontology and geriatrics; b) age-friendly primary health centres; and c) geriatric units in referral hospitals. These gaps affect older women’s quality of life. Older women are brought to the hospitals in an advanced stage of the disease and gerio-psychiatric disorders are not detected early; thus, elder abuse and family violence are high and not easily identified in the community.

In response to these gaps, major national policies, legislation and acts related to the promotion of gender and rights issues of women, specifically older women, were created. Laws, regulation and programmes on social protection and promotion of gender rights by Ministry of Women Empowerment & Child Protection (WE&CP) were established and the National Committee for Elderly with members involved from across sectors, professionals and community was formed. To improve the present situation, outlined below are the plans of the national government:



Regarding the Regional Strategic Plan for Healthy Ageing: Development of a National Action Plan for Healthy Ageing, 2015–2019 in order to improve access to comprehensive health care services for a healthy, active and independent elderly person.

- ◆ Development of a Strategic Plan on Control and Prevention of Alzheimer's and other dementia disorders.
- ◆ Development of national standard for age-friendly PHC.
- ◆ Development of a national standard for integrated geriatric services in hospitals.
- ◆ Establishment of a working group within the MOH to coordinate various provisions of programmes in health services.

The implementation of healthy ageing policy using the life-course approach covers antenatal care, birth delivery and neonatal health, infant to toddler health, health of under-five children and adolescent health. The services provided for the older people is an integration of basic health, referral and mental health services, noncommunicable disease interventions, nursing, community nutrition, health intelligence, traditional medicine (acupressure) and health promotion. Currently, a brain stimulating activity for cognitive stimulation is being implemented in the country.

Maldives

Mariyam Sidhmeen, Director, Ministry of Law and Gender

Maldives is situated in the Indian Ocean. It consists of 1192 islands of which 194 islands are inhabited. These small islands are spread over 800 km from north to south covering a total area of 90 000 square kilometers.

According to the 2006 census, the population was 298 842 of which 19000 was above 60 during the time. It has been estimated that by 2025, the population 65 years and above will be 6.15% and by 2025 it will be 12.7%. The literacy rate is 98.4% (census 2006). Schooling for both girls and boys is universal, but more girls prefer to go for higher studies from master's degree to doctorate level. However, women who enter the labour force is 45%, among 38% of women are working in the formal



sector. Civil service jobs are occupied by 53% of women and only 15% of them earn above US\$1000. Many women do small-scale business that is run without loans. Tourism is one of the major occupations with fewer women, only 4%, working in the sector.

There are several legislations and acts which address women's protection and rights. In order to ensure non-discrimination in the country the Constitution of Maldives states in Article 17 (a) entitles rights and freedom without discrimination of any kind including gender and Article 17 (b) provides for special assistance or protection (e.g. temporary special measures, affirmative actions) to groups requiring special social assistance. Furthermore, Article 35 (c) states that elderly and disadvantaged persons are entitled to protection and special assistance from family, the community and the state. While the Pension Act came into force in 2009, the Domestic Violence Prevention Act and the Public Health Act were enacted in 2012. In addition, the Sexual Offences Act was ratified this year and ratification of the "Sexual Harassment Prevention Act" is due in November this year. The first draft of 'Gender Equality Law' is currently being prepared.

A Universal Health Scheme was launched in 2008 which benefits all citizens of the country. Provision of an allowance to all citizens of Maldives above 65 years, irrespective of their previous occupation and contribution to pension funds exists and this allowance has been increased from MVR 2000 to MVR 5000 by President Yameen Abdul Gayoom. There is also a mechanism to give an allowance to a person with disabilities and to single parents.

There are several policies and strategies focusing on health promotion and prevention of disease: The Health Master Plan, Mental Health Policy, National Reproductive Health Strategy, National Nutrition Strategic Plan, National Action Plan for Prevention of NCDs, Draft Policy and Strategy for Active and Healthy Ageing/Elderly Health Care in the Maldives (2012). Policies have also been implemented for preventing violence and to protect women from negative family consequences: One of them is 'Fast tracked "kharadh" cost for children' which will be received by divorced women who have children under 18 years. In addition, a review of the Pre-Nuptial Agreement is underway which will help ensure the right to property of women if couples are divorced. This is an important policy as the divorce



rate is quite high in Maldives. The country has also established safe homes in four different regions which function as shelters for women and children. They are called 'Aman Hiya' and are located in Villingili (Capital); H.Dh Kulhudhuffushi; Sh. Funadhu (North); Thaa Veymandoo (Central); GDh Thinadhoo (South).

There are several public health programmes to promote healthy and active ageing; tobacco control, adolescent health, nutrition and exercise, reproductive health, gender etc. NCD clinics have been established in almost all the atolls. In addition, there are programmes for mental health, cervical cancer screening, cancer and diabetes prevention and control. NGOs are also working in these specific areas. Observance of the International Day for Older Person every year is also an opportune time for advocacy and to create public awareness. Additionally, there are plans to address the international commitments such as CEDAW, Beijing plan for action, Millennium Development Goals etc.

In accordance with the NCD risk factor survey, the obesity rate is alarming and is higher among women than men — 42.3% and 32.0%, respectively. The most common morbidities are related to the circulatory system, respiratory system, neoplasms and certain conditions originating from the perinatal period. Morbidity from external causes and nutrition are not uncommon. Proportionally, the total number of deaths occurring due to these conditions is similar. It has been estimated that 80% of all deaths are due to NCDs.

Violence against women is the most serious difficulty women face in living a secure life. In the Maldives 1 in 3 women aged between 15–49 years is a victim of either physical or sexual violence at least once in her lifetime (Women's Health and Life Experiences Survey, 2007). There has been a 15% increase in cases of violence against women reported to Maldives Police Service since the enactment of the Domestic Violence Prevention Act (Maldives Police Service Statistics, 2012–2013).

Capacity building and public awareness on healthy and active ageing are conducted both by government institutions and civil society. There is only one NGO 'Age Care Maldives' which provides focused services to the elderly population. They provide nursing care for elderly people at home, promote active and healthy ageing, provide opportunities to



socialize and enjoy peer support. Health care facilities do not have units for elderly patients or specific geriatric units. However, often they are kept in the institution for several months giving time for the families to get ready to take them home. It has been noted that women in the Maldives are educated and the proportion of those who obtain a higher level of education is comparatively higher among women. However, areas of concern include the slow implementation of existing laws and policies due to inadequate budgeting and costing; ongoing major reformation of the health sector and the Ministry of Law & Gender (since 2008); no specific legislation for elderly rights; internal migration and rapid urbanization (one-third of the population live in the capital); socio-cultural transition, change of lifestyles; differences in political views even among families; no separate institutional care facility for elderly; no monitoring mechanism to ensure the utilization and benefits from the allowances for the elderly population; lack of capacity within government and civil society; inefficient data/lack of specific research; existing health service delivery issues; less attention to primary health care and more focus given to tertiary care; unhealthy behaviour among youth and adolescents; marketing and promotion of unhealthy foods and drinks.

Myanmar

Thuzar Chit Tin, Director (Health Promotion), Department of Health

The number of older people in Myanmar is increasing rapidly, having virtually quadrupled over the past 60 years. Currently older people account for about 9% of the country's population. According to the UN projections, by 2030 this proportion will rise to 15% and by 2050 older people will comprise a quarter of Myanmar's total population. The highest growth rate will be among those in their 70s and 80s.

Women tend to live longer than men. There are more women than men in the older population, particularly among the very old. Women already account for about 60% of people aged 80 years and above, and this share is expected to be higher by 2050. The majority of older women are widowed, while most of the men are still married. This difference is because men tend to die at a younger age and are often older than their wives.



Almost 40% of older people are widowed and only more than half are married. Over one-third of women have no formal education, compared to less than 10% of men. Only about half of older persons are fully literate with women particularly likely to lack literacy. The lack of education and literacy limit their ability to access information.

Older women in Myanmar face a number of socio-economic and health challenges. Common socio-economic challenges include: high reliance on their children; very few chances of getting a pension with men twice as likely to receive more; almost no welfare support from government or nongovernmental agencies; greater likelihood of living alone compared to men; among older couples, wives are often the primary caregivers for husbands, while husbands are less likely to provide similar care to their wives; they live in houses made of non-permanent materials; a third of older people live in homes without electricity and lack of running water is particularly common in rural areas.

Although noncommunicable diseases are major health challenges, reproductive health problems like cystocele, utero-vaginal prolapse and postmenopausal complications also cause physical and psychological trauma to older women. Functional limitation due to osteoporosis and osteoarthritis are common in older women and they are more prone to fall and easily suffer a fracture. With an increasing number of older women i.e. 80 years and above, they are more likely to suffer from dementia and chronic diseases, so long-term care for them is essential. They are more vulnerable to abuse and violence as well as more prone to disaster and emergencies. Visual impairment, hearing defect and dental problems are also common.

As to the leading causes of morbidity, there is no disaggregated data for older women. According to hospital statistics, leading causes of morbidity among older people are as follows: cataract, essential hypertension, cardiovascular diseases like chronic ischemic heart disease, infarct, heart failure etc., diarrhoea and gastroenteritis of presumed infectious origin, tuberculosis of lung, chronic obstructive pulmonary diseases; stroke; diabetes mellitus, mental and behavioural disorder, and malignancy. The leading causes of mortality are cardiovascular diseases, stroke, carcinoma bronchus and lung, tuberculosis, chronic obstructive pulmonary diseases, carcinoma liver, stomach, cervix and breast etc.



To address these concerns, a number of programmes have been introduced. For instance, the national policy and national plan of action for Older Persons are in the process of approval. Another is the healthy ageing programme which was first introduced in the 2nd National Health Plan (1993–1996). Aiming to achieve active and healthy ageing, this programme is implemented through the primary health care approach up to the rural areas but does not cover the whole country. Special interventions for health of older women are not being implemented yet. In the National Health Plan (2011–2016), maternal, newborn, child health and elderly health care is under the same strategic area using the concept of life-course approach. At present, older women can access routine health services but it is necessary to ensure quality of care. Availability of services like health screening and regular medical checkup are still limited.

Apart from the elderly health care programme, the following programmes are implemented by international NGOs, local NGOs and civil society in coordination with the Department of Social Welfare—Home for the Aged, ROK–ASEAN Home Care Programme, Older People Self Help Group, Rural Development on Ageing, Community-based Home Care for NCD, and Day Care Centre.

The following are the gaps in providing comprehensive health care and accessibility to elderly health care:

- ◆ Provider's side: insufficient health manpower.
 - Limitation of facilities, technology, drugs and equipment
 - Capacity building for health personnel is limited
 - Lack of funding and support
 - Heavy workload of health personnel
 - Low priority
- ◆ Client's side: poverty and unaffordable health care
 - Low awareness/lack of knowledge on active and healthy ageing concept
 - Low priority within the family



- ◆ Stakeholders' side: weak coordination and collaboration
 - Low community awareness
 - Political commitment is still necessary

The following is the country's plan of action to meet elderly women's needs:

- ◆ Assessment of the health of older women to identify their needs
- ◆ Advocate with the authorities concerned for committing and supporting the development of policy, legislation and acts for the promotion of gender and rights issues of women
- ◆ Capacity building of health professionals as well as caregivers
- ◆ Enhance national capacity to better understand the implications of ageing, including feminization of ageing and public health consequences
- ◆ Raise awareness among local authorities and civil societies for mobilization of resources
- ◆ Establish coordination network between INGOs and NGOs in the area of research and technology
- ◆ Develop and strengthen the health care services; hospital care, institutional care, home care, long-term care, preventive health services for chronic noncommunicable disease, communicable disease, and prevention of accidents including welfare services.

Nepal

Top Narayan Sharma, Joint Secretary, Ministry of Health and Population

Nepal has a total population of 26.5 million with more females than males (106:100) and the population growth rate is 1.35. Making up 8.1% of the total population are the elderly, 60 years old and above. The ageing population has a growth rate of 3.5%. See the table 3 for the sex ratio in urban and rural areas.



Table 3: Sex ratio of aging population in urban and rural areas by census year 1951–2011

| Area | Year | | | | | |
|-------|--------|------|--------|------|--------|------|
| | 1991 | | 2001 | | 2011 | |
| | Female | Male | Female | Male | Female | Male |
| Rural | 6.1 | 5.8 | 6.8 | 6.5 | 8.6 | 8.1 |
| Urban | 4.7 | 5.3 | 5.4 | 6.1 | 6.4 | 7.2 |

Major challenges affecting older women in the country are: economic dependency; low literacy rate among females; limited job opportunities; high household burden for elderly women due to the increasing migration rate of the younger generation; low access to health facilities in rural areas. Moreover, elderly women face major health issues such as reproductive health-related morbidities (uterine prolapse and fistulae); cancer, poor nutrition; poor personal hygiene in rural areas; mental health problems; social problems (loneliness due to separation with spouse); inadequate response from the government and the private sector; less social security; and absence of health insurance.

The five major causes of morbidity are: malnutrition, depression, reproductive problems such as uterine prolapse, chest infections and worm infestations. For mortality, the leading causes are heart disease, cerebrovascular accident, chest disease, cancer and renal disease. To address these problems, a number of policies and strategies have been proposed and implemented. These are: National Health Policy, 2014; Act for Elderly Citizens, 2006; Regulation for elderly citizens, 2008; National Population Policy (to be endorsed shortly), RH strategy; and Sectoral Nutritional Strategy; Geriatric wards establishment and Guidelines; and Social security allowance for older people and widows (Npr 500/Month).

To promote and protect the health of older women, the country has implemented the following: free basic health services for all including provision of essential drugs; free geriatric beds in seven (Patan hospital, Bharatpur hospital, Ayurveda teaching hospital, Kathmandu, Western Regional Hospital, Pokhara, BPKIHS, Dharan, Seti and Bheri zonal) hospitals; financial support to poor population for serious illness (cancer, heart disease, kidney disease, Alzheimer's, Parkinson's, head injuries,



spinal injuries, sickle cell anemia) up to Npr max. 100 000; long-term care of elderly is provided in “old age homes” only; and Initiation of health insurance for all citizens (pilot testing in three districts out of 75 districts) for people 60 years and above.

Nepal’s Constitution does not permit discrimination on the basis of sex and advocates special legal provisions to protect and advance the interests of women. The Interim Constitution of 2007 includes women’s rights, gender equality and the empowerment of women as important liabilities and responsibilities of the State in legal and moral terms. The country’s strategies, legal reforms, and institutional arrangements for service delivery to promote the health of elderly women are outlined below:

- ◆ Strategies:
 - Strengthening gender mainstreaming in development process and service delivery in all aspects of government system.
 - Strengthen gender budget system and expand up to local level.
 - Advocacy programme to prevent and control various forms of violence and discrimination against women.
 - Targeted, protective service-oriented and empowerment programmes for enhancing capacity and improving the living standards of the marginalized people including women.
- ◆ Legal reforms:
 - Country Code Act - enhances women’s right to property.
 - Under the Legal Aid Act - free legal aid is available in cases of abortion, trafficking, sexual exploitation and domestic violence.
 - The Civil Service Act, contains special provisions with regard to entry regulations, career development and conditions of service for women.
 - Establishment of National Commission on Women, gender focal points in all ministries, National Human Rights Commission, the National Dalit Commission and a national committee to monitor the implementation of the Conventions.



- ◆ Institutional arrangements for service delivery:
 - Focal Ministry: Ministry of Women, Children and Social Welfare
 - National Commission on Women
 - Gender-based violence Unit in Prime Minister's Office
 - One-stop crisis management centres for GBV survivors in 16 hospitals in the country
 - Social service units in eight secondary and tertiary level hospitals to provide free-of-cost services to senior citizens, GBV survivors, helpless, disabled people, female health service volunteers and the poor.

In order to improve the health of older women, strict implementation and monitoring of national plans/policies is encouraged. Further, more activities like health camps in rural areas and advocacy for spiritual health will be held regularly. Nepal is also establishing rehabilitation centres with training and entertainment facilities and to extend old age home care in other areas of the country in order to motivate/educate clients to undergo regular health check-ups.

Sri Lanka

Nethanjalie Mapitigama, Community Consultant Physician, Family Health Bureau

Sri Lanka's population is 20.45 m (2009) with an adult literacy rate of 93.2% for males and 90.8% for females (2006). The mean age at marriage of females is 23.3 years (2006/07) while the maternal mortality rate is 31.13/100 000 live births. Sri Lanka's life expectancy has increased by 77.9% from 1946–2001 as well as the literacy rate from 1881–1994. Identified causes of longevity are: advances in healthcare; better nutrition; improved sanitation; high literacy and educational level; economic prosperity; declining fertility rates; and lowered infant mortality. Noncommunicable diseases, specifically diabetes mellitus (10%) is more common in women in the urban areas than in the rural. Menopause, another health concern among women, is not a hindrance to longevity. After menopause, there is an average of 25 years of life.



According to the organizational structure, provision of health services is the responsibility of the Ministry of Health, as part of the maternal and childcare section. There is a well-organized healthcare system covering the nine provinces in the country which is further divided into 25 districts, 329 health districts and further into 6690 per hectare meter. Women face health issues in the post-reproductive period related to reproductive health, sexual health, gender violence and social issues. To address this is the Well Women Clinic programme (WWC). Specific to gender violence, the health sector responds by training staff, establishing care centres in curative health institutions and by collaborating with other service providers.

The objectives of the wellness clinic programme are to improve the health of women 35 years and above by providing screening services for common noncommunicable diseases through fully functional well women clinics. The rationale for establishing well women clinics is as follows: incorporation of reproductive health concept into the Family Health Programme after ICPD; increased incidence and mortality due to noncommunicable diseases (due to increased life expectancy and behavioural and lifestyle changes); possible modes for prevention, primary – secondary – tertiary; and the use of existing health infrastructure to provide services. WWCs offer services like care of noncommunicable diseases with general procedures like checking of BMI, PAP smear screening, health education, family planning services, and breast examination among others. The strategies to promote the health of women of reproductive age and post-reproductive age are: service delivery model to be developed; and Implementation through WWC.

The Ministry of Health has identified elderly care as a priority area in the Health Master Plan (HMP) under the project profile no 1.5.2- programme for vulnerable groups and the guidelines are very clear. Mahinda Chintana – policy document of the ruling political party, is a special hospital for elderly. This will cater only to the elderly. There is also a legislation on the protection of the rights of elders Act No.9. as elaborated in the National Charter for Senior citizens & National policy for senior citizens (2006) and the National Action Plan on Ageing (2012 – 2021). The health care system works on the preventive, promotive, curative, and rehabilitative aspects of health as outlined below:



Preventive care

- ◆ Awareness, advocacy
- ◆ Regional rehabilitation and long-stay hospitals, intermediate or half-way hospitals - curative and preventive
- ◆ Elderly day care centres at community level
- ◆ Coordinate grass-root-level elderly health care services with other services for elders: social services, community-based organizations, role of medical officer of health.

Curative care

- ◆ Elderly patients treated in common with other age groups in all medical, surgical, gynaecology & specialty care units e.g.: cataract operation
- ◆ Establishment of elderly-friendly health units
- ◆ Age-friendly city – Wellawaya, Sri Lanka.

Supportive rehabilitation care providing cadres – physiotherapists, occupational therapists, speech and language therapists; establishment of stroke units in teaching hospitals, provincial general hospitals, district general hospitals; medical clinics/screening; healthy lifestyle clinics, under supervision of medical officer of health (MOH) & medical officer/NCD.

Thailand

Ekachai Piensriwatchara, Director, Elderly Health Division, Department of Health, Ministry of Public Health

A change in Thailand's demographic profile shows that the proportion of the elderly in the population has been growing since 2003 and increased to 15% this year. It is expected to rise to 30% in 2032. In other words, Thailand will truly become a super-aged society in the next 18 years. When considering the distribution of the elderly population by gender, it was found that the female elderly accounted for 55%. The number of very elderly females will increase rapidly, as females tend to live longer than males.



Because of advances in medical care, mortality is showing a downward trend across all segments of the population. The average life expectancy of Thai people is rising steadily. Thai women have an average life expectancy at birth of 78 years. The share of parliament seats held by women and men and the attainment of secondary and higher education by each gender has been used as measures of empowerment of women. As of 2011, women held 14% of parliament seats, which represents an improvement over the 9% held 10 years ago. With regard to education level, Thai women aged 25 years and above who attained at least secondary school education accounted for 25% of the Thai population, compared to 33.7% for men. According to economic activity, the position of Thai women in the labour market has improved a lot compared to the past as a result of modernization. In 2011, the labour force participation rate of Thai women was 65.5% compared to 80.7% for males.

The most common age-related health issues affecting the elderly are vision and hearing impairment, falls and bowel incontinence. These health issues are more common in women than in men. Almost 50% of older Thai women reportedly suffer from eye issues.

Mental health is another important aspect of elderly health status. As part of the Survey of Elderly in Thailand, a 15-item mental health test was conducted. The results showed that the male elderly scored higher than females. Elderly women and those living in rural areas are more likely than men to suffer depression. Older people with functional limitations in activities of daily living are usually classified as disabled. It is interesting to note that elderly women are more likely than men to experience difficulties in carrying out daily living activities. The married elderly tend to be in a better social and economic position, and have better physical and mental health compared with their unmarried counterparts. The proportion of female elderly who are never married, widowed, divorced, or separated is noticeably higher than male elderly. Only 1 out of 10 older persons has high school-level education or higher. More men than women have education above the high school level.

Approximately one-third of the Thai elderly contribute to the economy. The percentage of working elderly declines with age. In general, men are more likely to work than women. The three largest sources of income



for the elderly are children, employment, and government allowance. Work is a major source of income for 47% of elderly men, compared with only 26% in women. More elderly women are involved with housework, compared with men, probably in compliance with the social norm. Elderly men tend to be more involved in the labour force.

The Population Plan (2012–2016) has been developed under the 11th National Economic and Social Development Plan, with a vision that “every birth in Thailand is of high quality and is developed at full potential at every stage of life to become the driving force of the country”. The Second National Plan for Older Persons maintains the vision of “the Elderly are the pillar of the society.” It looks ahead to having “quality elderly men and women who are assets of the society, not a vulnerable group nor social burden”.

Recently, the Ministry of Public Health distributed the Health Record Book for the Elderly. This book is intended for the elderly to record their own health information by themselves, family or a volunteer. They can take this book with them when they receive treatment or seek advice from medical and health personnel or attend health service facilities. The book consists of various assessments, such as screening assessment of ability to perform activities of daily living, dementia, osteoarthritis of knee, falls assessment, dietary consumption, and health behaviour assessment etc.

With the policy on establishing income security to provide progressive monthly allowances for senior citizens, senior citizens aged between 60 and 69, 70 and 79, 80 and 89 and over 90 years will receive 600, 700, 800 and 1000 Baht per month, respectively.

Although the government’s Old Age Allowance scheme demonstrates the strongest implementation with most tangible results, the benefits are limited and inadequate. The income security system to guarantee for old age security needs to be extended to all sections of population. Old age savings, both voluntary and compulsory, must be encouraged. Formal education at all levels fails to inform the younger generations of the ageing process and the importance of preparation for quality old age.

Initiatives to promote employment and old age income security have not yielded concrete results. Employers in the private sector may not be



willing to hire older workers, perceiving that they deliver less profitability and productivity than younger workers. Many people feel that the elderly should rather engage themselves in recreations than being economically active, and that there is sufficient labour force in the market, making it unnecessary to retain older workers. Involvement in community activities suggests the capability and power of the older people. Most elderly men and women are found to have participated in community activities during the past year. Most often activities include funeral welfare service, and elderly club.

Monitoring and evaluation indicates that Thailand needs to make faster progress on elderly promotion, especially older women. Various factors impede success, including elderly policy fragmentation and programme discontinuation, lack of concrete transformation of policies into action, budget constraint, weakness in management of the elderly clubs, lack of personnel knowledgeable about geriatrics, and lack of enabling regulations on disbursements of budget for welfare of the elderly. All of these have been obstacles to the effectiveness of programmes for older persons.

Timor-Leste

Ines Teodora da Silva Almeida, Director of Disease Control,
Ministry of Health

Timor-Leste is a small country measuring around 15,874 km² with a population of 1.2 million in 2013; the population is expected to increase to 1.62 million in 2020 and to 2.2 million in 2030. Three-quarters of the population live in rural areas. Timor-Leste is divided into 13 administrative districts, subdivided into 65 sub-districts, 442 sucos (villages), and 2225 aldeias (hamlets).

From the population census of 2010, the population is currently growing at a rate of 2.4% per annum. The older population (60 years and over) is 87567 (8.2 %) of the total population, 51.7% of which is female (45 328) and 49.3% is male (42 239). The number of Timorese aged over 60 years is expected to increase from 52950 in 2005 to 119 150 in 2030. The life expectancy of men and women at birth is 65 and 68 years (2012), respectively. The adult literacy rate was about 58.7% in 2010. The Ministry of Health provides comprehensive health care services to



the entire population through: primary health care (226 health posts; 68 community health centres including 475 posts of *sisca*); secondary care (six referral hospitals); and tertiary care (one national hospital).

The major challenges affecting women are: (a) lack of understanding about health; (b) lack of understanding about human rights; (c) not a decision maker in the family; (d) not being able to inherit or own property; and (e) financial dependence. These challenges result in domestic violence, untreated chronic illness, late referral to the health facility due to treatment cost, hard work with less attention, and “bride price”, making it an obligation for women to serve throughout life. The main causes of mortality and morbidity among elderly women are tuberculosis, cerebrovascular and cardiovascular diseases, bronchopneumonia and COPD. Whereas, specific to morbidity is liver disease.

Currently, there is no separate policy/plan of action or strategy for healthy ageing in the country. However, the National Strategic Development Plan, 2011–2030, the National Health Sector Strategic Plan (NHSSP) 2011–2030, and the Fifth Constitutional Government of Timor-Leste (2012–2016) have considered the policy for elderly. The access to health services for those 60 years and above is through AFHCP (Age-Friendly Health Care Programme) in all health facilities and home visits by doctors and nurses in villages (HP) and through *sisca* activity. Older women may avail of these interventions or services. There is no special health and social support programme for elderly women and health services are provided through the regular health system and the AFHCP. Also, social subsidy support is through the monthly benefit of US\$ 30 to all citizens above 60 years in Timor-Leste.

The major gaps that affect health care delivery to women and particularly older women include the absence of long-term care institutions for the elderly, the lack of follow-up due to geographical issues, lack of community-based services for elderly people, and the lack of knowledge about the specific needs of elderly people.

For legislation and acts to support and care for elderly population and address these concerns, the decree-law no. 19/2008 of 19 June 2008 by the Ministry of Social Service (support allowance for the elderly and people with disability) was created. In addition, domestic violence Law 2010 and Gender Equity in article 17 of the Constitution were formulated.



To improve the health of older women, the Ministry of Health works with the Ministry of Social Solidarity to develop and implement community-based services for the elderly and people with disabilities, sensitize and educate all community-based workers and leaders about the specific needs of older clients, create opportunities and mechanisms for old age patients to participate and contribute to community activities, involve community members in the design, implementation and monitoring of services for the elderly.





4 Partners' forum

Community mobilization and support in caring for older women

Meredith Wyse, Strategic Development Manager, East Asia and Pacific
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Community care refers to care services delivered in the home or another location in the community (for example, a community centre), typically by individuals from within the wider community. The provider may include NGOs and CSOs (Community Support Organization) and local authorities working with para-professionals or volunteers from religious institutions and the private sector. In communities, there are organizations for older people also known as older people associations (OPA). These groups engage older people in leadership roles, are multi-functional, promote self-help and build on community resources. These groups also allow the elderly to have their own source of income.

Older persons set up community-based volunteer homecare for people with difficulties in ADLs (Assisted Daily Living) and IADLs (Independent Assisted Daily Living). They target poor older people who usually live alone and with multiple care needs. Activities include ADL assistance (personal hygiene, feeding); IADL (cleaning, going to the market, collecting water, accompanying them to the clinic, contacting families); be friendly; attend initial training and monthly meetings; and provide a minimum of two home visits per week (multiple volunteers recruited for one client if required).

In an OPA piloting paid homecare done in four countries involving paid home care, the roles of volunteers include monitoring health, providing basic nursing, referrals, and support to family caregivers and volunteers. The role of OPA management and its members includes:

- ◆ Assessment of care needs in the community and design of care plans
- ◆ Recruit and train homecare volunteers



- ◆ Monthly monitoring and regular review
- ◆ Identification of volunteers
- ◆ Basic care training for all OPA members, who are often family caregivers
- ◆ Provide holistic support: house repairs and modifications, financial support for transportation to a clinic, input to meet basic needs (in cash and in kind), disaster risk reduction and preparation.

OPAs can strengthen existing community resources and reciprocity in developing low-cost community care appropriate for both older men and women. Ensuring this is embedded in a strong community organization, such as an OPA, which facilitates ongoing management, sustainability and integration with other interventions. Older men and women themselves are one of the largest resources available within the family and in the community. However, resources and support mechanisms for the community are required.

To improve implementation and coverage, it is necessary to examine what role existing health care workers and health volunteers can play in supporting community care, and ensure integration of health and care systems. Policies should be developed and their implementation promoted with regard to OPAs, and community-care programmes. Provision should be made for technical and financial support for the establishment and strengthening of holistic older people's associations.

Partnerships and networking in promoting health and care of older women

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The UN principles for older persons adopted by the General Assembly resolution 46/91 of 16 December 1991 are independence: participation, care, self-fulfilment and dignity and the traits possessed are benevolence, dignity, humility, and serenity. According to the 2011 report on the Status of Elderly in Selected States of India, women have higher prevalence rates of chronic conditions than men on average, and are much more likely to suffer from arthritis, hypertension and osteoporosis specifically; more



women (66%) than men (33%) are fully dependent on others economically; a higher morbidity burden is seen for widowed elderly than those who are currently married; children are the major source of financial support for treatment of chronic ailments followed by self and spouse.

Signs of gender bias are seen early in life. For instance, a girl child is generally not wanted. They are married early and forced to conceive to prove their fertility leading to an increase in morbidity. Studies have also shown that women consume less food than required and hence are malnourished. Women have longer life expectancy so they mostly end up as widows. They experience social isolation brought about by caregiving responsibilities, class and caste prejudice, employment status, fragmentation of families leading to loss of family care, fragility and bedridden conditions. Malnutrition is another issue that leads to poor quality of life. Malnutrition may be due to economic reasons and the lack of availability of the desired food. Currently, one of the states in India, Tamil Nadu, makes available breakfast and meals for less than a dollar per day for those living below the poverty line.

To address these issues are projects like micro-financing and self-help groups (SHGs). Currently, there are 2.5 million SHGs in the country, 90% of which are women SHGs in order to attain a feeling of homogeneity. Meetings of self-help groups are held regularly and about 85% adopt small family norms. One hundred per cent of the children of SHG members had access to immunization services against the six diseases. The increase in income has been spent on better nutrition of children and on health care for the family. There have been improvements in school enrolment, attendance, toilet facilities and access to electricity and gas. This provides a huge potential and opportunity to improve the quality of lives of older women.

In terms of social networking, inadequate social support is associated not only with lower overall general health and wellbeing, but also with higher levels of emotional distress, more illness and higher mortality rates (WHO 2002). Positive social interactions protect against developing difficulties with physical functions in later life (Mavandadi, Rook & Newsom, 2007).



Association between the ability to undertake activities of daily living (ADLs), disability and social ties among people over 65 years in three European countries, found that social ties can help to maintain ADL abilities in old age and even to restore them after injury or trauma. (Zunzunegui, 2005). Hence, it is important to engage senior citizens in health promotion activities that increase physical activity, improve nutrition and improve mental health.

Networking opportunities:

- ◆ Establish more pressure groups and build their capacities (training of trainers)
- ◆ Devotional music singing (bhajan) or music clubs or dance clubs
- ◆ Family get-together
- ◆ Media (our partner) uses what is given (press notes must be positive)
- ◆ TV shows and talks besides films
- ◆ National programme for health care of the elderly (NPHCE)/ National Rural Health Mission (NRHM) –ASHA workers
- ◆ Religious associations
- ◆ Senior citizens clubs
- ◆ Social clubs – Rotary/Lion's
- ◆ Spiritual clubs – Brahmakumaris
- ◆ Use social media
- ◆ Walkers clubs
- ◆ Women's associations/clubs

National Strategy:

- ◆ Health – inculcate healthy habits early stages
- ◆ Wellness – e.g. diabetic clubs
- ◆ Education – self-care
- ◆ Income – old age pension is a major solution



- ◆ Promote networking amongst elderly women
- ◆ Involve communities – healthcare at door step e.g. mobile medical services at strategic locations
- ◆ Training healthcare personnel with focus on health of older women

The Maintenance and Welfare of Parents and Senior Citizens Act, 2007: The state governments shall ensure that government hospitals or hospitals funded fully or partially by the government shall provide beds for all senior citizens as far as possible; separate queues be arranged for senior citizens; facility for treatment of chronic, terminal and degenerative diseases is expanded for senior citizens; research activities for chronic diseases of the elderly and ageing is expanded and there are earmarked facilities for geriatric patients in every district hospital duly headed by a medical officer with experience in geriatric care.



5 Conclusions and recommendations

Conclusions:

- (i) As the proportion of older women increases, they continue to face poverty, social isolation, discrimination and violence. Chronic diseases remain the main cause of morbidity and mortality among older women. However, accurate sex-disaggregated data on the different causes of morbidity and mortality in older women and men were not available. Similarly, morbidity and mortality data categorized in different age groups [60–70 years, 70–80 years and 80 years onwards] were lacking. These information gaps were a constraint in identifying appropriate interventions to improve the health, gender equity and rights of older women.
- (ii) All Member States of WHO's South-East Asia Region have established plans of action and programmes to respond to the health needs of older women as well as relevant gender, equity and human rights issues. However, the extent of collaboration and coordination between the different sectors of the government delivering these services remained unclear in most Member States. Harmonization and consolidation of interventions were lacking in most Member States with a tendency for duplication of services in certain areas and insufficient coverage in others.
- (iii) A shift from the "disease concept" to a "functional approach" where wide-ranging environmental and personal factors such as gender, social engagement and healthy behaviours played key roles in enhancing resilience and functional capacity of older persons was discussed.
- (iv) Several innovative projects such as 'elderly clubs', 'self-help groups', 'friends-help-friends' have been introduced in Member States by nongovernmental organizations and civil society. It was noted that in most instances these were dependent on external



human and financial resources and not always in alignment with the services provided by the national authorities. As such, sustainability and expansion of such initiatives remained uncertain.

- (v) Appropriate research on health, gender equity and human rights issues affecting older women was inadequate in most Member States. This resulted in limited understanding of the magnitude of problems encountered by older women and in the identification of relevant interventions and generation of sufficient political commitment.
- (vi) The development of a national framework of action for improving the health and related gender equity and human rights issues affecting older women was an important activity. The key actions identified in the framework would provide a way forward into issues requiring urgent attention and a comprehensive approach.

Recommendations:

- (i) A positive attitude towards older women has to be established in all quarters of society and the government will take the necessary initiative, in view of the fact that ageing was a natural process and an aged person is an asset and a repository of knowledge and wisdom rather than a liability when ageing of the population, particularly older women, is concerned.
- (ii) Member States should examine the existing morbidity and mortality data for older persons with the possibility of disaggregating information into sex and age categories. Coordination between sectors dealing with reproductive health, disease surveillance, health information management and ageing to deliver a comprehensive data-set and information-base would be required. International partner agencies and stakeholders could provide the necessary technical support.
- (iii) A multisectoral programme for improving the health of older women should take into account the emotional, cognitive, physical and functional issues that may affect older women. Such a programme should identify a nodal agency along with partnering sectors within and outside the government. The nodal agency and partnering sectors should have clear roles and areas



of responsibility, thereby avoiding any programmatic conflicts or inadequacies.

- (iv) Health services should be built around the age-friendly approach while universal health coverage should ensure that older women have optimum accessibility and availability of preventive, promotive, curative and rehabilitative health services.
- (v) Establishing programmatic linkages among the government, nongovernmental, academia, professional organizations and the private sector for activities addressing the psychosocial and health issues of older women should be explored.
- (vi) Awareness and advocacy activities highlighting the ageing of society and special needs of older women should form part of any activity promoting the health, gender equity and human rights issues concerning older women. Such activities would go a long way to garner political commitment and resources.
- (vii) There is an urgent need for evidence-based policies on the health and related gender equity and rights issues affecting older women in most Member States. Member States could mobilize resources for research and promoting engagement of relevant sectors such as the government, academia, professional organizations and interested nongovernmental/civil society agencies.
- (viii) Legislation and law enforcement as required by Member States should focus on the health, gender, equity and human rights of older women.





Annex 1: Agenda

- ◆ Inaugural session
- ◆ Objectives and mechanics of the regional meeting
- ◆ Global overview of ageing and health: priorities and future direction
- ◆ Economic and social support issues affecting older women in Asia
- ◆ Health of women beyond reproductive years: key issues and concerns
- ◆ Health of older women in post-2016 agenda
- ◆ Gender, equity and rights issues in the South-East Asia Region
- ◆ Overview of legislation, laws and acts for improving the health and care of older women in the countries of South-East Asia
- ◆ Management of chronic diseases in older women
- ◆ Country reports
- ◆ Partners' forum
- ◆ Group work
- ◆ Conclusions and recommendations





Annex 2: Group work and national frameworks

Developing a national framework and action points for promoting the health of older women

Participants were requested to select at least one and up to five priority areas for addressing the health of older women in their country and to describe what can be done in the next two years to address the selected priorities or areas of work. Member States were asked to describe activities and potential short-term results based on current resources. The priority areas are outlined below:

- ◆ Promoting active and healthy ageing
- ◆ Management of chronic diseases in older age (hypertension, diabetes, geriatric conditions, sensory impairment, urinary incontinence, arthritis, dementia, end of life care, cancer, respiratory problems, medications: promoting rational use of drugs and access to medicine).
- ◆ Avoid dependency by preventing and managing frailty, dementia, and sensory impairment at primary health care level.
- ◆ Building systems to provide and support long-term care.
- ◆ Promote gender equality, support and protection for older women.

Participants were divided into three groups with each group having three to four Member States and several resource persons. Each group was required to prepare a report on the outcome of the group work and present it during the plenary session. This information will be used to revise the (draft) regional strategy.

Framework for addressing older women's health

Participants were divided into three groups and were asked to provide inputs to the following areas:



- (i) Promoting active and healthy ageing
- (ii) Management of chronic diseases in older age
 - Hypertension
 - Diabetes
 - Geriatric conditions
 - Sensory impairment
 - Urinary incontinence
 - Arthritis
 - Dementia
 - End of life care
 - Cancer
 - Respiratory problems
 - Medications – promoting rational use of drugs and access to medicine
- (iii) Avoid dependency by preventing and managing frailty, dementia and sensory impairment at primary health care level
- (iv) Building systems to provide and support long-term care
- (v) Promote gender equality, support and protection for older women

Consolidated inputs from group work

- (i) Promoting active and healthy ageing:
 - Adoption of a national policy/plan of action/strategy for older women
 - Health interventions for older persons and particularly older women would have to be integrated in the primary health care programme
 - Universal health coverage to include health care of the elderly and the concept of age-friendly primary health care
 - Observing the 'International Day for Older Persons'
 - Sensitization and training of family members



- Establishing and promoting 'Senior Citizens' Clubs/Associations' where older men and women participate in increasing numbers utilizing their skills, knowledge and experiences
- (ii) Management of chronic diseases in old age:
- Community and facility-based health services addressing geriatrics needs of older persons
 - Improved information-base on the morbidity and mortality patterns of older women
 - Standard operating procedures for the identification, treatment and management of chronic/noncommunicable diseases of older persons with particular attention to chronic health problems of older women
 - Clinics targeted to women for screening of cervical and breast cancer
 - Awareness building about available facilities and services for older women
 - Training of informal and formal caregivers including family members
 - Strong referral systems and capacity building of secondary and tertiary care health facilities to respond to the health needs of older women
 - Provision of essential medicines for the treatment of older women
- (iii) Avoid dependency by preventing and managing frailty, dementia and sensory impairment at primary health care level
- National programmes for the prevention of blindness, deafness, physical disability for older persons and organization of annual screenings of sight, hearing, oral health and physical performance and activities
 - Programmes to promote mental health of older persons with emphasis on the prevention and/or limitation of dementia in older persons and particularly older women



- Establishing age-friendly infrastructure at public places, community centres and homes
 - Training of family and community-based caregivers to recognize the early signs and symptoms of dementia and in introducing preventive measures
 - Development of appropriate training manuals and tools for use of family and community-based caregivers and health staff working at the primary health care level
 - Dissemination of essential information to older women
- (iv) Building systems to provide and support long-term care
- Strong health promotion activities and establishing a strong continuum of care encompassing preventive, curative and rehabilitative services for older persons.
 - Establishing community and institution-based services including old age homes and long-term care
 - Establishing volunteer groups to provide home-based care for older persons
 - Promote involvement of older women in income-generating activities and decision-making process
- (v) Promote gender equality, support and protection for older women
- Laws and legislation for protecting the rights of older women
 - Establishing social and financial support for older women
 - Involvement of all relevant sectors for providing health, social and economic care to older women
 - Primary health care staff to be trained in providing psychosocial support to older women and in advocating the importance of gender equality and care of older persons to family and community members
 - Developing national capacity to respond effectively to gender-based violence particularly affecting older women including the full utilization of 'Gender-based Violence Care Centres' in hospitals and other health facilities.





Annex 3: List of participants

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Available information indicates that a large proportion of older women in Member States of the South-East Asia Region are marginalized and vulnerable to many health problems due not only to old age, but also because of low socio-economic and cultural status. Longevity with poor health, inadequate support from family members and the community do not contribute positively toward well-being and quality of life of older women. Older women are more likely to be widowed, have low economic security, less involvement in the labour force and more care-giving responsibilities than elderly men.

A regional meeting on Health of Older Women: Policy, Gender and Delivery of Service Issues, was organized by the World Health Organization's Regional Office for South-East Asia in collaboration with the Department of Ageing and Life-Course, WHO headquarters, and the Elderly Health Division, Department of Health, Ministry of Public Health, Royal Thai Government. The general objective of the meeting was to promote the health of older women in countries of the South-East Asia Region, examining the health status and care available to older women, examining different successful policies and practices including a framework of action, related to the health of older women. The framework for action will have two overarching priority areas – to strengthen health systems to better respond to the health needs of older women and in expanding human rights commitments and standards to promote women's health through a life-course approach by taking into account the gender perspective.



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