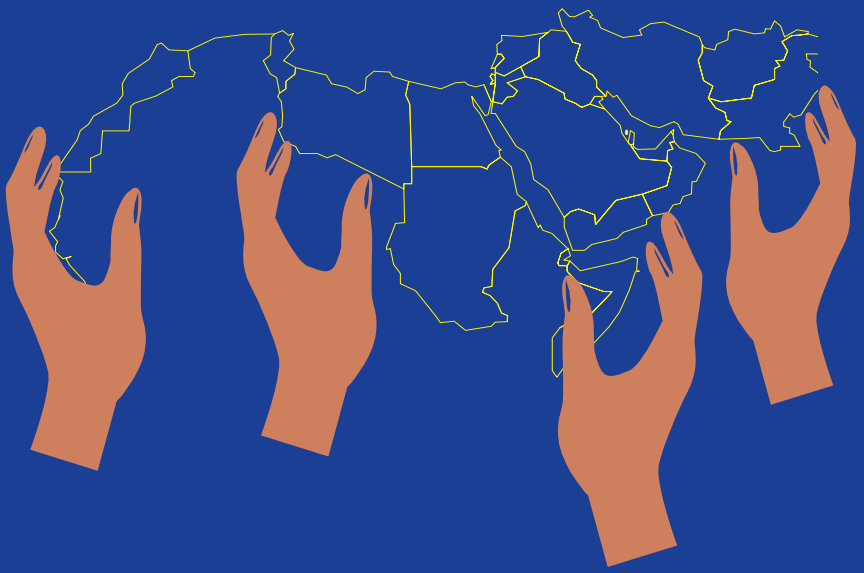
WHO-EM/HSG/030/E

A strategy for active, healthy ageing and old age care in the Eastern Mediterranean Region 2006–2015



World Health Organization
Regional Office for the Eastern Mediterranean

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Foreword

Population ageing or rapid increase in the number of older people is a global phenomenon. Nations are greying as the elderly population is growing much faster than the overall population due to decreasing fertility and increasing life expectancy. In most of the industrialized world, population ageing has been a gradual process following steady socioeconomic growth over several decades and generations. In the developing countries, the process is being compressed into two or three decades over a single generation. In 2050, there will be two billion people over the age of 60 years; 80% of them will be living in developing countries. Rapid ageing in developing countries is accompanied by dramatic changes in family structure and roles, as well as in labour patterns and migration. It is expected that, very soon, most institutions of civil society in many developing countries will be overwhelmed by the social, economic and health needs of this ever-increasing segment of the population.

The provision of affordable and quality health care to older people is a major concern for health systems in most countries. It is important that older people remain as independent, autonomous and active as possible so that they are able to contribute productively to society. Given these factors, the WHO Regional Office for the Eastern Mediterranean has made health care for the elderly a priority programme, with the principal objective of "adding life to years and not only years to life".

The Regional Office, in collaboration with its Member States, adopted a regional strategy for the ten-year period 1992–2001, with specific country and intercountry activities, and plans of action for its implementation. In an intercountry workshop held in Beirut, Lebanon, in April 2001, the achievements and pitfalls in the implementation of the strategy were reviewed. A recommendation was made for the preparation of a new strategy for a further decade. In its 50th session, the WHO Regional Committee for the Eastern

Mediterranean adopted resolution EM/RC50/R.10 which requested an update of the Regional Strategy for Health Care of the Elderly in the Eastern Mediterranean Region.

As a result, an updated strategy was drafted and presented for deliberation at the Regional Consultation on Active Ageing and Promotion of Health of Older Persons in the Eastern Mediterranean Region, held in Manama, Bahrain in April 2005. The draft strategy was adopted after incorporating comments and suggestions from representatives of Member States of the Region, international nongovernmental organizations and external experts.

The strategy for active, healthy ageing and old age care in the Eastern Mediterranean Region 2006–2015 outlines strategic directions for Member States and delineates the role of the Regional Office in supporting the Member States in achieving the stated objectives. The strategy is expected to enable senior administrators, policy-makers and decision-makers to face the challenge of population ageing.

Hussein A. Gezairy MD FRCS
Regional Director for the Eastern Mediterranean

Preface

Throughout the world, human beings are living longer than ever before. It is thus natural that national health systems should review their approach to the ever-increasing population of older people from time to time.

There is an urgent need for the implementation of national policy for the care of the elderly in each Member State. Although national policies for the care of the elderly exist in a majority of the Member States, in most instances the national policy has meant a national coordinating committee for the care of the elderly, usually administered by the Ministry of Social Affairs or the Ministry of Health. Most of these committees were established immediately after the release of the first regional strategy in the mid-1990s. The effectiveness of existing policies and the role of national committees need to be evaluated in order to revive and mobilize the resources available in countries. Older people, as stakeholders, are expected to participate in the implementation of the national policy through all its phases of planning, intervention and evaluation.

The WHO Regional Office for the Eastern Mediterranean has accepted the challenge of guiding the Member States in caring for their elderly populations since the 1980s. The first Regional Strategy for Health Care of the Elderly was prepared in 1994, which covered the ten-year period from 1992 to 2001. After a decade, the implementation of the regional strategy was reviewed at the Intercountry Workshop on the Protection of the Health of Elderly People in the Eastern Mediterranean Region held in Beirut, Lebanon in April 2001.

This document developed out of the recommendations of that workshop and Resolution EM/RC50/R.10 of the Regional Committee. The draft strategy was approved by representatives of the countries of the Region, international nongovernmental organizations and external experts at the Regional Consultation on Active Ageing and Promotion of Health of Older Persons in the Eastern Mediterranean

Region held in Manama, Bahrain, in April 2005. It outlines the present demographic situation, the health status of the population in the Member States, and the country and intercountry collaborative activities proposed to be undertaken by the Regional Office in order to realize the objectives. The strategy also incorporates measurable indicators for assessment of its impact in the Region and individual countries. The strategy document also incorporates the spirit of the Fifty-eighth World Health Assembly resolution in 2005 on strengthening active and healthy ageing in policy and planning of health care for older people.

The number of WHO collaborative programmes in the health care of the elderly is expected to increase every biennium in the Region. By the end of this decade, most countries are likely to have created an effective system to provide care for their older people and to prepare the younger generation to enter old age in good health and fitness.

The WHO Eastern Mediterranean Region, with its wide variations in the economic and demographic profiles of its Member States, provides great opportunity for innovation to health planners. Attempting to develop a fixed model that is applicable to every Member State will encounter many difficulties. However, the basic principles of the strategy, such as raising awareness, research and training of health professionals, remain the same for all Member States irrespective of their social, economic and political status.

1. Background

An unprecedented increase in human longevity was one of the most spectacular events of the 20th century. The resultant population ageing, with all its ramifications, is today evident in most parts of the world, including countries in the Eastern Mediterranean Region. The WHO Regional Office for the Eastern Mediterranean realized the need for developing suitable programmes for the growing elderly population as far back as the mid-1980s. Data on the status of older people was collected in 1987 in five countries: Bahrain, Egypt, Jordan, Pakistan and Tunisia. The Regional Office decided to bring the matter of the health care of the elderly to the attention of the WHO Regional Committee for the Eastern Mediterranean at its 38th session in 1991 through a technical discussion session on health care of the elderly and the elderly handicapped, following an intercountry consultation in the same year at Larnaca, Cyprus.

The Regional Committee passed resolution EM/RC38/R.7, which urged both the Member States and WHO to take urgent measures to promote and protect the health of older people so that they can lead healthy and active lives. This event was a major step towards creating awareness about population ageing and its implications among decision-makers and senior administrators in the health sector of the Member States of the Region.

With active intervention by the Regional Office, many of the Member States had, by the early 1990s, established focal points in the Ministry of Health for the health care of the elderly. Furthermore, a rapid questionnaire survey was conducted in 11 Member States to determine the health and socioeconomic status of the older population. These developments made it possible to develop programmes for the care of the elderly in many Member States.

The Regional Advisory Panel on Health Care of the Elderly was established in the Region in 1992. The panel adopted a regional strategy for WHO programmes on the health care of the elderly for the decade covering the period 1992–2001, specifying intercountry

and country activities for five biennia starting with the 1992–1993 biennium.

On 18–21 October 1999, the International Conference on the Rights of Aged People: An Islamic Perspective was held in Kuwait. This important seminar was organized by the Islamic Organization of Medical Sciences (IOMS) in close cooperation with the Regional Office, the Islamic Education, Science and Culture Organization (ISESCO), the Islamic Fiqh Council, Jedda (Saudi Arabia) and the Confederation of International Organizations of Medical Sciences. A comprehensive set of recommendations were developed and agreed upon by participants. The recommendations of the conference, known as the Kuwait Declaration on Elderly Rights, is a comprehensive document which can provide valuable inputs to any programme.

In April 2001, the last year of the decade for which the regional strategy was adopted, an intercountry workshop was held in Beirut, Lebanon. The workshop looked holistically at all aspects of the health of the elderly and reviewed the achievements of the strategy adopted in 1992. It recommended that new programmes should be developed where there were gaps in services and that a more holistic approach to older people be conceptualized to ensure that both the public and private sectors meet their needs. A comprehensive set of recommendations was developed.

At the 50th session of the WHO Regional Committee for the Eastern Mediterranean in 2003, a technical paper, "Health care of the elderly in the Eastern Mediterranean Region: challenges and perspectives", was presented and discussed. It was noted that there was rapid increase in both the absolute number and proportion of the older population in most countries, but that this was not widely seen as a cause for alarm in the Region. After detailed deliberation, the Regional Committee adopted resolution EM/RC50/R.10 regarding health care for the elderly in the Region and resolved to update the regional strategy. The Regional Committee advised Member States to undertake a comprehensive review of their national policies and strategies for care of older people to improve the integration and

coordination of health and welfare programmes and services in addressing their needs and to improve the primary health care systems for the promotion of healthy lifestyles throughout the life-course.

On 26–28 April 2005, the Regional Consultation on Active Ageing and Promotion of the Health of Older Persons in the Eastern Mediterranean Region was held in Manama, Bahrain. Prepared with the above guidelines, a draft updated strategy, providing a general framework for action to promote the health of older populations was adopted. It was anticipated that every Member State would adapt the elements of the strategy according to its own conditions and situation to achieve active and healthy ageing for its population.

The World Health Organization in the 58th World Health Assembly on 25th May 2005 in Geneva deliberated on strategies for strengthening active and healthy ageing in the light of the recommendations of the United Nations Second World Assembly on Ageing at Madrid in 2002. The World Health Assembly, after considering the various approaches adopted by WHO in preceding years, placed its focus on the development of age-friendly primary health care. It urged the Member States, the Commission on Social Determinants of Health and the Director-General to undertake measures to fulfil the commitments made at the Second World Assembly on Ageing to promote active and healthy ageing through primary health care, the life-course approach to development and the participation of older people in the developmental process.

2. Conceptual framework for the new strategy

The conceptual framework for the regional strategy for 2006–2015 is based on the paper presented at the 50th session of the WHO Regional Committee for the Eastern Mediterranean Region in October 2003. The plan of action for the health care of the elderly needs to be built upon three fundamental principles:

- participation of older people in the process of development
- advancing health and well-being into old age
- ensuring an enabling and supportive environment.

It needs to be acknowledged that every Member State in the Region is facing the challenge of population ageing, with minor variations in magnitude and pace, and that there is an urgent need for review of national policy for the care of the elderly.

The existing national policies for the care of the elderly and national coordinating committees for the care of the elderly are usually administered by the Ministry of Social Affairs or the Ministry of Health. Most of these committees were established immediately after the release of the first regional strategy in the mid-1990s. The effectiveness of existing policies and the role of national committees need to be evaluated in order to revive and mobilize the resources available in countries. Older people, as stakeholders, should be encouraged to participate in the implementation of the national policy through all its phases of planning, intervention and evaluation.

Health should ideally be the individual's responsibility, while the state should have the responsibility of facilitating the individual's effort in achieving and maintaining health throughout life and providing an environment in which such efforts can succeed. However, in many countries in the Region such ideal conditions may not exist. In such situations, apart from individuals and the state, there will be other players, namely, nongovernmental organizations, communities and families that have a role to play in providing support to individuals in attaining and maintaining health.

The shift in the burden of illness from acute life-threatening infectious diseases to chronic disabling noncommunicable diseases throughout the world has affected the health care delivery system. However, with the emergence of new infections and re-emergence of old communicable diseases, developing countries, including those in the Eastern Mediterranean Region, face the double burden of both communicable and noncommunicable diseases in an ageing population. This poses new challenges, especially in the context of care of the elderly population.

While emphasizing the need for continuous resource allocation for the control and eradication of infectious diseases, it is critical to note that there is a greater need for policies, programmes and intersectoral partnerships that can help to halt the massive expansion of chronic noncommunicable diseases. Although not necessarily easy to implement, the programmes that focus on community development, health promotion, disease prevention and increasing public participation are often the most effective in controlling the burden of noncommunicable diseases. Long-term policies that target malnutrition and poverty can help to reduce both communicable and noncommunicable diseases. Support for relevant research is urgently needed on all these issues in developing countries.

As older people in the Region are becoming a more visible proportion of the general population, better statistical information on the demography of ageing, its causes and consequences, and specific regional aspects, is urgently needed to guide policies and programmes. Due to continuous urbanization and the disintegration of the system of extended families, the conventional assumption that the elderly are largely supported by the traditional extended family in terms of care, shelter and useful roles, should be reviewed.

All these changes will lead to changing demands on the health systems in the countries of the Region. Health care systems are expected to include care for older adults along with care for other groups. The growing need for the treatment and care of an ageing population requires adequate projection and allocation of funds. In the absence of adequate policies, major cost increases are to be

expected. Another challenge is the level of economic support needed for this fast-growing elderly population.

In the past decade, the WHO has accepted active ageing as an achievable goal. This is a radical shift in focus from a clinical model to a health promotion model of care. The goal of active ageing should be the cornerstone of all state policies for older people as well as the individual. Active ageing applies to both individuals and specific population groups.

Policies that promote lifelong health, including health promotion and disease prevention, assistive technology, rehabilitative care, mental health services, and promotion of healthy lifestyles and a supportive environment, can reduce disability levels associated with old age and lead to budgetary savings.

Creation of a supportive environment for the elderly requires action in a variety of sectors in addition to health and social services, including education, employment and labour, finance, social security, housing, transport, justice, and rural and urban development. These sectors can formulate "age-friendly" policies and enabling programmes for older persons, including those with disabilities.

The mandate for the new regional strategy derives from the 50th session of the Regional Committee of October 2003. It formulated the six main strategic directions for the health care of the elderly:

1. Continuous review and updating of the regional strategy to suggest appropriate ways of health and socioeconomic support to the elderly population within the context of the prevailing social and cultural norms and values in the Region.

2. Creation and maintenance of an up-to-date database for an evidence-based decision-making process regarding comprehensive care for the elderly at country level.

3. Creation of multidisciplinary regional and national networks among agencies, organizations, academic institutions and individuals concerned with and interested in the health of the elderly.

4. Incorporation of health care of older persons in the primary health care system and in the curriculum for training of primary health care and community care workers.
5. Provision of appropriate knowledge and skills needed for self-care and health protection and promotion for older persons, their families and community at large.
6. Support of research and training in the field of health of elderly people and community care.

3. Regional strategy for active, healthy ageing and old age care: general features

3.1 Period covered

The strategy will cover the ten-year period from 2006 to 2015. Within the WHO programme structure, this covers the Eleventh General Programme of Work (the biennia 2006–2007, 2008–2009, 2010–2011, 2012–2013 and 2014–2015).

3.2 Components of the regional strategy

The regional strategy will comprise two types of activities: country activities and intercountry activities.

Country activities are those provided directly to countries who request assistance from the Regional Office. These activities can be of various types, but in most cases technical support is provided by WHO consultants in countries that have WHO collaborative programmes in the health care of older people.

In several countries, the WHO collaborative programme does not specify the need for consultancy assistance, but financial and technical support is required for convening national seminars, conducting training courses or designating nationals for WHO fellowships for specialized training in the health care of the elderly.

Intercountry activities are those designed by the Regional Office to collectively support all or most countries in certain selected areas of the programme for the health care of the elderly.

3.3 Determinants of the regional strategy

The Regional Office initiated programmes for the health care of the elderly during the 1988–1989 biennium. Since then, several collaborative activities have been undertaken by WHO and Member States. These include cross-national surveys, a quick questionnaire survey, intercountry workshops and meetings, an interregional consultation, establishment of a regional advisory panel,

development of a manual for primary health care workers in English and its translation into the different languages of the Region, establishment of nodal offices in the ministries of health of Member States, and formulation of national policy and establishment of national coordination committees.

While these initiatives of the Regional Office and Member States have achieved some of the objectives set out in the first regional strategy, a lot more still remains to be done. An objective assessment at this point needs to be carried out to define the future strategy.

Demography of ageing in the Eastern Mediterranean Region

The Region is witnessing an increase in the number and percentage of the population aged 60 and over. The number of persons aged 60 and older in the Region was around 26.8 million (5.8% of the total population) in 2000. It is projected that in 2025, older persons will make up nearly 8.7%, and by 2050 nearly 15% of the population.

The decline in fertility rates, combined with steady improvements in life expectancy over recent decades, is producing visible growth in population ageing. The total fertility rate in the Region is currently 4.2 children per woman. In 2025, it will have decreased to 2.8, and in 2050 to 2.2. Significant differences in fertility rates currently exist among Member States.

Over the last five decades, life expectancy at birth in the Region increased by almost 23.1 years, from 43.6 in 1950–1955 to 66.7 years in 2000–2005. In some countries of the Region such as Bahrain, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Oman, Palestine, Qatar, Saudi Arabia, United Arab Emirates, Syrian Arab Republic and Tunisia, life expectancy at birth is above 70 years. In Afghanistan, Djibouti, Somalia, Sudan and Yemen, it is still under 50 years. Demographic data from the Region shows that there is great variation in the proportion of older people among the different countries in the Region, as there is for life expectancy, per capita health expenditure

and number of physicians per thousand population (see tables in Annex 1).

Many countries of the Region with low proportions of people aged 60 and over have very high life expectancy at birth. This is possibly due to the presence of large numbers of expatriate workers who are usually young. Thus, a classification of countries on the basis of the proportion of the aged 60 and over population does not correctly reflect the ageing situation of the indigenous population. Thus, the countries of the Region can be grouped on the basis of life expectancy at birth, i.e. above 70 years, between 60 and 69 years and less than 60 years.

- Group I: Bahrain, Egypt, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia, United Arab Emirates.
- Group II: Islamic Republic of Iran, Iraq, Libyan Arab Jamahiriya, Morocco, Pakistan, Yemen.
- Group III: Afghanistan, Djibouti, Somalia, Sudan.

Such a classification is realistic as the proportion of the aged 60 and over population in projected population figures for the years 2025 and 2050 are much higher in Group I countries compared to Group III countries.

Population ageing imposes greater burden on most social services including health services. Thus, it is important to consider the economic parameters such as the per capita health expenditure and the number of health professionals (e.g. physicians) per thousand population, while considering activities for the care of the elderly. This is because health systems with poor resources (human and financial) may not give due priority to the care of the elderly at the expense of other programmes.

Awareness of ageing issues

Though most individuals are aware of issues related to old age, the views are often either extremely positive or extremely negative. As a result, a rational view of the challenges population ageing poses is lacking among policy-makers, planners and opinion-makers in

particular and society in general. Mass awareness programmes on active ageing are conducted globally on 1 October each year. However, there is need for continuous activity in this direction. In addition to the message on active ageing, information on the ageing process, adapting to retirement and disability, precautions to meet the vulnerabilities of old age, and on healthy ageing, needs to be passed on to older people and their carers. More importantly, policy-makers and planners also need to have information on best practices, the cost-effective management of resources while planning health care, and the utilization of older people as an available resource in society for self-care and the care of chronically ill family members.

Database

Data on health, disease and disability of the elderly are still scant in the Region. Some information was collected in the mid-1980s–1990s through cross-national surveys in four countries and questionnaire surveys in 11 countries. In 2002, four countries (Bahrain, Egypt, Islamic Republic of Iran and Lebanon) developed comprehensive country profiles on elderly issues. The INTRA (Integrated Response of Health Care Systems to Rapid Population Ageing) Project, initiated by WHO headquarters provided an excellent opportunity for Lebanon (in Phase I), Syrian Arab Republic (in Phase II) and Pakistan (in Phase III) to develop reliable databases on ageing issues.

In the past two decades, substantial improvements have taken place in the understanding of disease and disability in old age. In general, researchers, unless otherwise advised, tend to exclude older patients from drug and other intervention trials. Thus, there is a need to collect epidemiological data on this population group regarding health status, disease and disability, health behaviour, and the availability of services and service utilization. This would help in planning interventions of consequence.

National policy

A clear policy for older people does exist in a few countries. However, in countries where policies are in place, their implementation has been slow due to lack of awareness at different levels, lack of coordination between different sectors and lack of interest from the national committees and focal points responsible for implementation. Above all, the single most important drawback in policy implementation has been the lack of a clear definition of the tasks and roles of different ministries in caring for older people. There is an urgent need for all the countries of the Region to adapt principles of active ageing into their policy frameworks and to formulate clear programmes for implementation.

Social care

As mentioned earlier, irrespective of state of development and pre-retirement economic status, many elderly people see a sharp decline in their financial situation in most countries. In addition, urbanization and large-scale migration have disrupted the traditional family and community support systems for the elderly, leading to their social isolation. Furthermore, with the increase in the gap between demand and supply of services and resources, an element of inequality based on economic status exists in most societies. Several countries in the Region have provision for assistance to the elderly population in terms of pensions, financial support to their families, subsidies in food, medicine, transport and housing, and the provision of aids and appliances for disability. A trend towards user-charges is occurring in the social support systems of most countries in the Region. This will necessitate a system for testing the means of people and for cost sharing on a continuous basis.

Health services

Health systems in the countries of the Region provide quality health care to most of their populations. However, care of the elderly as a special group has not attracted enough attention in most countries. In general, elderly patients in most hospitals do not have

special care systems, e.g. special units, separate wards and dedicated outpatient facilities in hospitals. Similarly, no outreach services exist for the elderly in the community.

Geriatricians or physicians with specialist training in the care of the elderly are rare among medical practitioners in both the public and private sectors. Health professionals in medical, nursing and paramedical streams do not receive training in the health care of the elderly. Furthermore, not many in-service training programmes for health workers are currently available. However, some countries have translated and/or adapted the training manual for primary health care workers, developed by the Regional Office in the 1990s, and could successfully conduct several national training courses. Research in most clinical and operational aspects of geriatric medicine is rare or non-existent in the countries of the Region.

Institutions for the elderly

In the traditional societies of the Region, institutionalization of the elderly is not approved of culturally or accepted socially. Having acknowledged this fundamental aspect of the complex system of the care of the elderly, it is realistic to accept that old-age homes and similar long-term care facilities have a role to play in present-day societies. In many countries of the Region, institutions for the elderly do exist. These are of two types: expensive institutions in the private sector and free or nominally charged institutions run by the state or charitable organizations. However, mechanisms for certification and maintenance of standards of old-age homes and nursing homes are poorly developed in the Region.

4. Components of the strategy

4.1 Introduction

The principal objective of the regional strategy is to guide and provide technical support to the Member States in developing and implementing a programme for the health care of the elderly. Although the support is provided to the Ministry of Health of the Member States as per the mandate of the World Health Organization, the role of other government agencies and nongovernmental organizations in the care of the elderly needs to be appreciated and incorporated into the strategy.

The framework of the strategy needs to have "active ageing" as the goal for old age. The main pillars of the strategy are: research and database, human resource development, provision of quality services at an affordable cost and participation of the targeted population in all phases of the strategy. As most elderly people in the countries of the Region will live and age in their community, the primary health care system, the most visible state apparatus in the community, requires to be identified as the major carrier of the strategy. Therefore, the strategy needs to be blended into the health policy framework of all countries.

The components of the regional strategy are the following:

- The iterative process of policy and strategy formulation
- Primary health care as the cornerstone of active ageing
- Strong participation of the older population in society
- Development of human resources for quality health care
- Creation and maintenance of multidisciplinary networks to facilitate care of the elderly
- Research, surveys and studies for establishment of a database for evidence-based care
- Raising the awareness of the population to active ageing

4.2 The iterative process of policy and strategy formulation

Formulation of national policy for countries who do not have one, and modification of existing policies adopted in the mid-1990s in some countries in line with changes in technology and thinking, should be the first step.

The Regional Office can play a facilitating role in the formulation of national policies in countries of the Region by providing technical assistance. It must be realized that care of the elderly is not the sole responsibility of the Ministry of Health. Other ministries such as Finance, Law, Transport, Communication, Social Welfare, Internal Security, Education, etc., as well as nongovernmental organizations and religious organizations, also have an important role to play in building a society for all age groups.

A good national policy and its implementation require political will, clear planning and role-defining. A model national policy is presented in Annex 3. Each country needs to modify and adapt this framework to its own system, taking cultural, social and economic realities into consideration. The Regional Office can guide Member States to develop or strengthen their national policy in the 2006–2007 biennium in Group I countries (Bahrain, Egypt, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia, United Arab Emirates) and in the 2008–2009 biennium in Group II countries (Islamic Republic of Iran, Iraq, Libyan Arab Jamahiriya, Morocco, Pakistan, Yemen). The countries not included in the programme in these two biennia would be covered in the 2010–2011 biennium. A review of the working of the policy would be carried out in the 2012–2013 biennium.

National policies need to be implemented through a strategy. Member States need to be guided in formulating the strategy at the same time as they are making the policy. Some degree of prioritization is essential to show short-term results in order to attract public attention. To this end, awareness campaigns, improvement of clinical care of the elderly through short-term training of health workers and other community programmes in collaboration with nongovernmental organizations are visible initiatives.

4.3 Primary health care as the cornerstone of active ageing

Good health is imperative for older people to remain independent and continue to contribute to their families and communities. The Madrid International Plan of Action on Ageing 2002, the outcome of the Second World Assembly on Ageing, prioritizes access to primary health care and, accordingly, that has also become WHO's focus in order to provide the regular, continuing contact and care that older people need to prevent or delay the onset of chronic, often disabling diseases, and to enable them to be vital resources to their families, societies and economies.

In 2002, WHO initiated a related age-friendly primary health care project in order to sensitize and educate primary health care workers and build capacity in primary health care centres to provide for the specific needs of their older users. Despite the vital role of such centres in older people's health and well-being, there are many barriers to care that may result in older people not changing behaviour detrimental to health or becoming discouraged from seeking or continuing treatment. The project provides a set of age-friendly principles for primary health care centres[1], and training and information materials for primary health care workers on how to overcome these barriers.

Older people in most parts of the Region live in the community where they have spent the best part of their lives. An effective strategy to keep the elderly active and help them age with dignity is to provide most of their care in a community setting. Primary health care needs to be strengthened to become the centre for all care provision, including that unrelated to the health sector. The credibility of primary health care services is directly dependent on the efficacy of the clinical care they provides, which in turn will influence their role in providing promotive and preventive care.

The role of WHO in the development of primary health care of the elderly is to:

1 *Towards age-friendly primary health care*. Geneva, World Health Organization, 2004.

- define the composition and responsibility of the team of carers in primary health care;
- provide clear guidelines for a health promotion and prevention strategy;
- define and advocate for maintaining minimum standards of care in the primary care setting.

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

Strengthening of primary health care should be completed in the 2006–2007 and 2008–2009 biennia in Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Morocco, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen. The rest of the countries will be covered during 2010–2011.

4.4 Strong participation of older people in society

One of the important pillars of healthy active ageing consists in the strong participation of the older people in society. This involvement recognizes and enables the active participation of people in economic development activities, formal and informal work and voluntary activities as they age, according to their individual needs, preferences and capacities. This participation may involve several activities that may vary from country to country according to its level of socioeconomic development. These activities may include any of the following:

- inclusion of older people in the planning, implementation and evaluation of social development initiatives and efforts to reduce poverty;
- elimination of age discrimination by enactment of labour market and employment policies and programmes that enable the participation of people in meaningful work as they grow older, according to their individual needs, preferences and capacities;

- pension reforms that encourage productivity, a diverse system of pension schemes and more flexible retirement options (e.g. gradual or partial retirement);
- enactment of policies and programmes that recognize and support the contribution that older women and men make in unpaid work in the informal sector and in care giving in the home;
- recognition of the value of volunteering and expansion of opportunities to participate in meaningful volunteer activities as people age, especially for those who want to volunteer but cannot because of health, income or transportation restrictions.

Such activities are likely to encourage the greater participation of older people in family and community life. This encouragement may be facilitated further by the following actions:

- provision of accessible and affordable public transport services in rural and urban areas so that older people (including those with disabilities) can participate fully in community life;
- involvement of older people in political processes that affect their rights;
- inclusion of older people in the planning, implementation and evaluation of locally-based health, social service and recreation programmes, including programmes for prevention of HIV/AIDS;
- involvement of older people in efforts to develop research agendas on active ageing, both as advisors and as investigators;
- provision of greater flexibility in periods devoted to education, work and care-giving responsibilities throughout the life-course;
- development of housing options for older people that eliminate barriers to independence or to interdependence with family members, and encourage full participation in community and family life;
- provision of intergenerational activities in schools and communities that encourage older people to become role models for active ageing and to mentor young people;

- fostering collaboration among nongovernmental organizations that work with children, youth and older people;
- recognition and support of the important role and responsibilities of grandparents;
- creation of realistic and positive images of active ageing in the media in popular literature and through removal of negative stereotypes and ageism;
- recognition of the important contribution that older women make to families and communities through care-giving and participation in the informal economy;
- support of older women to enable them to participate in political and decision-making processes as they age;
- provision of education and lifelong learning opportunities to women as they age, in the same way that they are provided to men;
- provision of a social safety net for older people who are poor and alone, as well as social security initiatives that provide a steady and adequate stream of income during old age;
- encouragement of young adults to prepare for old age in the domains of health, social relationships and financial situation;
- protection of older consumers from unsafe medications and treatments; and unscrupulous marketing practices;
- protection of the rights of older people to maintain independence and autonomy for as long as possible as enshrined in the UN Principles for Older Persons;
- upholding older people's rights;
- recognition of older people's right to and need for secure, appropriate shelter, especially in times of conflict and crisis;
- provision of housing assistance for older people and their families when required (paying special attention to the circumstances of those who live alone) through rent subsidies, cooperative housing initiatives, support for housing renovations, etc.;

- recognition of the relief and rehabilitation needs of older people during conflicts and emergency situations and also their contributions to recovery efforts;
- recognition and prevention of elder abuse in all forms, including sensitization of law enforcement officers, health and social service providers, spiritual leaders, advocacy organizations and groups of older people, through public information and awareness campaigns in the media for young as well as older people.

4.5 Development of human resources for quality health care

Development of human resources is one of the constitutional mandates of WHO. Training of health professionals in providing good quality health care to the elderly at all levels of health care (primary, secondary, tertiary), at both the pre-qualification stage (in medical school, nursing school, etc.) and in-service (primary care physicians, community health workers, etc.) should be an important part of the strategy. Recognizing the importance of relevant training for future health workers, WHO has collaborated with the International Federation of Medical Students' Associations in a continuing effort to put ageing into the mainstream of medical curricula and to strengthen the teaching of geriatric medicine in 42 countries.

The health care of the elderly should be considered from several angles: for example, ambulatory care, home care, short-term institutional care and long-term institutional care. The training inputs for each of these are distinct and need to be developed at regional and national levels, taking cultural and social diversity into account.

The role of WHO will be as follows:

- Assistance to the regulatory bodies of different health professional courses in the Member States to modify the undergraduate curriculum through the Ministry of Health. Strengthening of pre-qualification training through inclusion in the appropriate sections of theoretical and practical teaching and assessment of content related to normative changes in

human anatomy and physiology, the pathophysiology of age-related changes and disease states, the pharmacotherapeutics of ageing, clinical geriatrics and preventive geriatrics.

- Sensitization of teachers in medical and nursing schools to geriatrics and gerontology, and the provision of short-term in-service training to health professionals.
- Short-term training in advanced centres through the WHO fellowship programme to help health professionals to become focal points for developing care of the elderly in Member States.
- Technical help to medical schools to develop collaborative centres in training and research in health care of the elderly. These centres will provide postgraduate courses in geriatrics and gerontology, producing specialists in the care of older patients in tertiary-care settings.

The above-mentioned steps are to be carried out throughout all the biennia covered by the regional strategy. In the first three biennia (2006–2007 and 2008–2009, 2010–1011) Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Morocco, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen will develop a strong base for in-service training. In the next two biennia (2012–2013 and 2014–2015), these countries will establish geriatrics training in medical and nursing schools. Those Member States not included in the list will be covered by the in-service training programme in the biennia 2010–2011 and 2012–2013.

At another level, training will be provided to informal carers in caring for the elderly in the family and for elderly people themselves in the principles and practice of self-care to achieve active ageing. This training will be given through developing and distributing information on care and related issues in simple and non-technical language, either through print or audiovisual media.

The materials for this awareness campaign will be completed in the 2006–2007 and 2008-2009 biennia, first in English, and then in Arabic and other dominant regional languages. The Regional Office will help in the preparation of the English language material.

Technical help to Member States will also be provided for translation into local languages.

4.6 Creation of multidisciplinary networks to facilitate care of the elderly

The formation of regional and national networks of organizations and individuals interested in the welfare of the elderly can be realized in the following manner:

- Formation of a national association of older persons in each Member State as a part of the national policy. The national committees/councils on ageing and elderly care can facilitate the formation of these associations as nongovernmental organizations. The Regional Office will facilitate the formation of a regional association of older people. These organizations will be important advocates for affirmative action for the elderly.
- Formation of national associations of health professionals caring for the elderly (physicians, nurses, etc.) with encouragement from the Ministry of Health. These national associations will form a regional forum to organize seminars and conferences at regular intervals. The Regional Office will facilitate the holding of these meetings, as well as networking among health professionals for the formulation of practice guidelines, management policies, etc.
- The Regional Office will coordinate with reputed international and regional nongovernmental organizations such as HelpAge International, Age Concern International, Alzheimer's Disease International and the Middle East Academy for Medicine of Ageing to strengthen cooperation at regional and country levels. These nongovernmental organizations will act as catalysts in creating networks of individuals and organizations working for the welfare of older people.

The Regional Office will initiate exploratory meetings in different countries in the 2006–2007 biennium. By the end of the 2008–2009 biennium, national associations of health professionals will

have a regional formation. By the end of the decade, a regional forum for older persons will be in place.

4.7 Establishment of a database for evidence-based care

For any strategy or policy to be successful, it must be supported by an authentic and strong evidence base. Cross-national and intracountry surveys need to be undertaken in the Region to generate data for this evidence. The components of this research will include:

- Demography: proportion and number of people above the age of 60 years, and for every five years as a sub-group thereafter; life expectancy at birth and at 60, 70, 80 years, etc.; the dependency ratio; and gender composition.
- Economic status: individual and family income; family size; living conditions; health expenditure; and source of income.
- Health status: morbidity and disease burden; cognitive status; fitness and activity levels; ability to pursue different levels of ADL (activities of daily living); and causes of health consultation, hospitalization, referral to specialist care and death.
- Health behaviour: attitude towards health, disease and disability; utilization of health services including preventive and promotive services; and perception of health services among users.
- Health service availability, utilization by users and quality of care.
- Predictors of good health, longevity and disability among both the institutionalized and community-based elderly.
- Health-related quality of life in relation to different types of intervention.

Data collected from these research studies will help to create models of care with regard to type of service, participation of the public and private sectors, and creation of good quality clinical services. The role of WHO in the creation of this database is manifold to provide technical support in research methodology and facilitation of collaboration between different countries, in addition to partial or

full funding of studies. Data collection of this magnitude in any country requires the active involvement of the Ministry of Health in funding, technical support and human resources.

Experience from other parts of the world shows that the involvement of medical schools in data collection helps in completing the task on schedule and in maintaining the accuracy and standard of data. National surveys and data collection will be initiated in the 2006–2007 biennium and completed by the end of the 2008–2009 biennium. The extent of data collection will depend on longevity and economic resources in the country.

All countries classified in Group I (Bahrain, Egypt, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia, United Arab Emirates) will complete the data collection process within the 2006–2007 biennium, while Group II countries (Islamic Republic of Iran, Iraq, Libyan Arab Jamahiriya, Morocco, Pakistan, Yemen) will complete the task by the end of the 2008–2009 biennium. The rest of the countries will complete by the end of the 2008–2009 biennium. A review of the database is required for future planning in the 2014–2015 biennium.

4.8 Raising the awareness of the population about active ageing

The full implications of an ageing population have yet to be sufficiently recognized by Member States or the general population. This has resulted in weak support for the care of this segment of the population, though there have been numerous measures undertaken by religious and charitable nongovernmental organizations supported by public donations.

The care of older people in the Eastern Mediterranean Region follows a long-standing cultural pattern. It is expected that older people will live and be taken care of within the homes of their families. However, with changing economic and social norms, families are finding it increasingly difficult to undertake these responsibilities without support. In order to provide this support, policy-makers, the mass media, civil society and the general population need to be made aware of this demographic transition, the

needs of older people and the measures that can be taken to respond to these needs.

National and regional strategies and policies need to highlight the importance of disseminating information regarding the socioeconomic and health needs of the rapidly increasing older population, and on how to respond to these needs through support from various sources. The senior administrators in the state, the community, the family, nongovernmental organizations and older people themselves should be the targets of awareness campaigns.

The information and broadcasting sectors of government need to be technically assisted by the health and social welfare sectors to develop national mass awareness programmes using audio-visual and printed media. Appropriate messages need to be developed that not only convey the needs of older people, but also highlight the actual and potential contributions of older people in the home and in society. Whenever possible, the contributions of outstanding elderly individuals in fields such as politics, literature, science, medicine and industry should be widely disseminated through the mass media to enhance the image of older people.

Mass media messages often lead to the formation of pressure groups in society that take up the cause of the elderly with the institutions of the state for provision of various types of support. Women's clubs, youth associations, and religious and charitable organizations, if properly motivated, can provide considerable support to economically underprivileged and disabled older people who have no one to take care of them.

National and regional associations of older people should be established for advocacy and information dissemination. Similarly, technical conferences for different disciplines (e.g. health and social workers) can be extremely effective in creating awareness among relevant professional bodies, thereby enlisting their support.

Reinforcing the cultural norm prevalent in the developing world of looking after older parents and relatives is an important component of national strategies. Strengthening these cultural norms among the youth is another important approach. The health sector

should assist the education sector in incorporating appropriate messages in the school curriculum to inculcate responsibility for taking care of elderly relatives. Strengthening these cultural norms, should also be done through messages from religious teachers, well-known philanthropists and respected individuals. National policies should therefore incorporate efforts to reach and motivate influential individuals.

5. Organization of the regional strategy

The implementation of the regional strategy requires proper planning, organization and prioritization by the Regional Office and Member States. The following steps need to be considered:

- adoption of the regional strategy by the Regional Committee and the Member States;
- adequate budget allocation for the implementation of the regional strategy by the Regional Office and the Member States;
- re-establishment of a regional panel for providing effective guidance and technical support in monitoring and implementing the regional strategy and for networking;
- availability of technical assistance to Member States in achieving the goals;
- monitoring of the implementation of the regional strategy by the Member States.

The Regional Office and Member States need to prioritize the implementation of these elements of the strategy:

- creation of a database through surveys and research
- formulation of national policies and national strategies
- awareness programmes in Member States
- preparation of training materials
- training of health professionals, informal carers and older people
- development of clinical geriatric units
- creation of networks of organizations and individuals.

6. Expected results at regional and country levels by the end of the decade (2006–2015)

The Regional Office, in cooperation and coordination with the Member States, will attempt to achieve the following measurable expected results.

- The Regional Strategy for Active, Healthy Ageing and Old Age Care in the Eastern Mediterranean Region will have been updated.
- A national strategy at country level will have been developed and/or updated in 17 (10 Group I, 5 Group II and 2 Group III) countries.
- A database for an evidence-based decision-making process regarding the epidemiological profile of health, living conditions and comprehensive care for the elderly at country level will have been created and updated in 17 (10 Group I, 5 Group II and 2 Group III) countries.
- Regional and national networks among agencies, organizations, academic institutions and individuals concerned with and interested in the health of the elderly will have been created in 17 (10 Group I, 5 Group II and 2 Group III) countries.
- Health care of older people will have been incorporated in the primary health care system and in the curriculum for the training of primary health care and community care workers in 17 (10 Group I, 5 Group II and 2 Group III) countries.
- A systematic awareness campaign and training opportunities for providing appropriate knowledge and skills on health protection and promotion issues will have been organized for older people, their families and community at large, at least on annual basis, in 17 (10 Group I, 5 Group II and 2 Group III) countries.
- A database on research related to various areas of the health of older people and their community care will have been created in at least seven (5 Group I and 2 Group II) countries.

However, for an active follow-up and evaluation of the health of older people programme in the Region, a set of minimum indicators should be used for making an assessment of its performance and impact:

- number of countries that have a documented national strategy and plan of action on the health of the elderly (target: 17);
- number of primary health care units/centres (or percentage) that offer health care services for older people, as well as outreach and home-care services (targets will vary from country to country: 50% for Group I, 30% for Group II and 15 % for Group III);
- number of health personnel specialized in gerontology and geriatric medicine in the country (target: 2–3 in each medical school/ tertiary care hospital);
- number of individuals trained per annum in providing social and health care for older people (target: 1.25%-5% of the primary care physicians);
- number of nongovernmental organizations providing social and health care for older people (target: minimum of 1 in every city/town with population of 50 000);
- number of countries that organize awareness campaigns and training opportunities regarding the health of older people (target: 17);
- number of countries that have a database on research related to the health of elderly people (target: 7).

The impact of implementation of the regional strategy at country level can be assessed and compared using the following indicators.

- Demographic and socioeconomic indicators: aging index, dependency ratio, life expectancy at birth, life expectancy at 60 years, healthy life expectancy at birth and at 60 years, median age, parent–support ratio, sex ratio, total fertility rate, urban/rural distribution, marital status, education level/literacy rate, employment, income level and living arrangements.

- Health and epidemiologic indicators: morbidity and mortality rates, causes of illness, causes of death, disability and disability adjusted life years (DALYs).
- Strategy and policy indicators: legislation, health policy, national commission/council, frequency of meetings and annual reports.
- Capacity-building indicators: trained providers, training courses, curricula, in-service training and refresher courses.
- Community participation indicators: community support services, facilities, day care and clubs.
- Coordination and cooperation: networks, referral arrangements, bylaws and steering committees.
- Health system performance indicators: age-friendly facilities, home services, quality of care indicators, accreditation schemes, research studies, reports, health promotion programmes, compliance and satisfaction.
- Utilization indicators: outpatient visits, hospitalization rates, average length of stay, medicine consumption and insurance status.

7. Plan of action of the regional strategy for the decade 2006–2015

7.1 Intercountry activities

Activity	Objective(s)	Implementing partners	Proposed time schedule
Organization of follow-up and technical meetings of the Regional Advisory Committee on Active Ageing and Health Care of the Elderly	To follow up on the implementation of the regional strategy To prepare training materials and manuals To conduct and analyze surveys and studies	Regional Office and experts from the Region	Once each biennium (five meetings in a decade)
Production of training materials	To provide Member States with materials to train community health workers in the care of the elderly	Regional Office and experts from the Region	At least one publication each biennium
Preparation of comprehensive data and effective tools for networking among organizations, institutions and individuals interested in the care of the elderly	To create a regional network on active ageing and health care of the elderly	Regional Office, Member States and experts from the Region	2006–2007 Ongoing

Activity	**Objective(s)**	**Implementing partners**	**Proposed time schedule**
Provision of technical assistance to Member-States in implementation of strategies, plans and programmes	To assist countries in organizing different programmes as part of national strategies and plans	Regional Office, Member States and experts from the Region	2006–2015
Organization of regional consultation for updating the regional strategy for the decade 2016–2025	To update the regional strategy according to demographic developments and the situation of care for the elderly	Regional Office, Member States and experts from the Region	2015

7.2. Country activities

Activity	Objective(s)	Implementing partners	Proposed time schedule
Conduct of transnational and intracountry surveys for collection of data for creation of evidence-based database	To create and update evidence-based data for policy-makers and programme managers	Regional Office, Member States, experts from the Region	2006–2007 (Group I) 2008–2009 (Group II and III) 2014–2015 (all groups)
Organization of national workshop for developing and updating national strategy and plan of action for active ageing and care of the elderly	To formulate/update national strategy and plan for active aging and care of the elderly	Regional Office, Member States, experts from the Region	2006–2007 (Group I) 2008–2009 (Group II and III) 2014–2015 (all groups)
Production of training materials	To prepare and produce training materials in local languages	Member States, national experts	At least one publication in each biennium
Training in care of the elderly under WHO fellowship programme	To strengthen national capacity in the care of the elderly	Regional Office, Member States	2006–2015
Establishment of national programme for training of health professionals in the care of the elderly	To sustain and develop national capacity	Regional Office, Member States	2006–2015

Activity	**Objective(s)**	**Implementing partners**	**Proposed time schedule**
Organization of national consultation on strengthening primary health care system in care of the elderly and developing quality health services for the elderly	To prepare and adopt national guidelines for strengthening the age-friendliness of the primary health care system To develop norms for quality health care	Regional Office, Member States	2008–2009 (Groups I and II) 2010–2011 (Group I)
Organization of national conference of associations of older people	To discuss and follow up on the inclusion and participation of older people in the development process in the country	Member States	2006–2015
Organization of national conference of the association of geriatricians and gerontologists	To discuss the practice of geriatrics and gerontology	Member States	2006 –2015

Annex One

Regional indicators on the older population

Table 1. Population of older people, life expectancy, per capita health expenditure and doctor–population ratio in the Eastern Mediterranean Region

Country	Life expectancy at birth (years)[1]	Per capita health expenditure (US$)[1]	Physicians per 1000[1]	Population aged 60+ (%) (2000) [2]	Population aged 60+ (%) (2025) [2]	Population aged 60+ (%) (2050) [2]
Afghanistan	44.7	8	1.9	4.7	5.2	7.7
Bahrain	73.8	565	18.5	4.7	20.4	24.9
Djibouti	44.1	41	1.6	5.5	6.2	5.8
Egypt	70.1	66	22.2	6.3	11.5	20.8
Iran, Islamic Republic of	69.0	259	11.9	5.2	10.5	21.7
Iraq	63.2	44	6.3	4.6	7.5	15.1
Jordan	71.5	163	22.6	4.5	7.0	15.6
Kuwait	78.4	630	16.0	4.4	15.7	25.6
Lebanon	71.3	12	28.1	8.5	13.5	25.4
Libyan Arab Jamahiriya	69.5	246	12.1	5.5	9.9	21.2
Morocco	69.5	56	5.2	6.3	11.2	20.6
Oman	73.8	218	13.9	4.2	6.6	10.5
Pakistan	63.6	18	7.3	5.7	7.3	12.4
Palestine	72.3	138	8.3	4.9	5.6	9.9
Qatar	74.7	672	23.5	3.1	21.8	20.7
Saudi Arabia	71.4	448	15.3	4.8	7.9	12.9
Somalia	47.0	4	0.4	3.9	4.0	5.7
Sudan	56.6	13	1.7	5.4	7.9	14.4
Syrian Arab Republic	71.5	59	14.3	4.8	7.7	18.0
Tunisia	73.0	132	8.1	8.4	13.4	24.6
United Arab Emirates	72.6	767	16.9	5.1	23.6	26.7
Yemen	62.9	21	2.2	3.5	3.6	5.3

Sources (Crude):

1. Demographic and health indicators for countries of the Eastern Mediterranean Region, Cairo, World Health Organization, 2004.

2. Population Division, Department of Economic and Social Affairs. *World Population Ageing*. New York, United Nations, 2001.

Table 2. Fertility rates for the Eastern Mediterranean Region (1950–2050)

Country	1950–1955	1975–1980	2000–2005	2025–2030	2045–2050
Afghanistan	7.7	7.4	6.8	4.7	2.8
Bahrain	7.0	5.2	2.3	2.1	2.1
Djibouti	7.1	6.7	5.8	3.9	2.1
Egypt	6.6	5.3	2.9	2.1	2.1
Iran, Islamic Republic of	7.0	6.0	2.8	2.1	2.1
Iraq	7.2	6.6	4.8	2.3	2.1
Jordan	7.4	7.4	4.3	2.4	2.1
Kuwait	7.2	5.9	2.7	2.1	2.1
Lebanon	5.7	4.3	2.2	1.9	1.9
Libyan Arab Jamahiriya	6.9	7.4	3.3	2.1	2.1
Morocco	7.2	5.9	3.0	2.1	2.1
Palestine	7.4	7.4	5.6	3.7	2.1
Oman	7.2	7.2	5.5	3.5	2.1
Pakistan	6.3	6.3	5.1	2.8	2.1
Qatar	7.0	6.1	3.3	2.1	2.1
Saudi Arabia	7.2	7.3	5.5	3.2	2.1
Somalia	7.3	7.3	7.3	5.1	3.3
Sudan	6.5	6.3	4.5	2.3	2.1
Syrian Arab Republic	7.1	7.4	3.7	2.1	2.1
Tunisia	6.9	5.7	2.1	2.1	2.1
United Arab Emirates	7.0	5.7	2.9	2.1	2.1
Yemen	7.6	7.6	7.6	5.4	3.4
Regional average	6.9	6.3	4.2	2.8	2.2

Source (Crude): Population Division, Department of Economic and Social Affairs. *World Population Ageing*. New York, United Nations, 2001.

Table 3. Life expectancy in the Eastern Mediterranean Region (1950–2050)

Country	1950–1955	1975–1980	2000–2005	2025–2030	2045–2050
Afghanistan	31.9	39.7	43.2	53.5	62.4
Bahrain	51.0	65.9	73.8	77.7	79.9
Djibouti	33.0	43.0	40.6	48.2	63.3
Egypt	42.4	54.1	68.3	74.7	77.8
Iran, Islamic Republic of	44.1	56.6	69.7	75.5	78.5
Iraq	44.0	61.1	64.9	74.3	77.6
Jordan	43.2	61.2	71.0	76.2	78.8
Kuwait	55.8	69.6	76.5	79.2	81.1
Lebanon	56.0	65.0	73.5	77.0	79.2
Libyan Arab Jamahiriya	42.9	57.7	70.9	76.6	79.1
Morocco	42.9	55.8	68.7	74.8	77.9
Palestine	43.2	60.8	72.4	76.4	79.0
Oman	36.4	54.8	71.5	75.5	78.5
Pakistan	41.0	51.0	61.0	69.7	73.7
Qatar	48.0	65.6	70.3	75.3	78.3
Saudi Arabia	39.9	58.8	72.2	76.9	79.4
Somalia	33.0	42.0	48.9	59.4	68.3
Sudan	37.7	46.6	57.0	67.1	72.9
Syrian Arab Republic	46.0	60.1	71.8	76.6	79.1
Tunisia	44.6	60.0	70.9	76.2	78.8
United Arab Emirates	48.0	66.8	75.4	78.4	80.5
Yemen	32.1	44.1	61.9	71.4	75.5
Regional average	43.6	57.1	66.7	72.7	76.6

Source (Crude): Population Division, Department of Economic and Social Affairs. *World Population Ageing*. New York, United Nations, 2001.

Table 4. Percentage of population aged 60+ in the Eastern Mediterranean Region (1950–2025)

Country	1950	1975	2000	2025	2050
Afghanistan	4.5	4.7	4.7	5.2	7.7
Bahrain	4.6	3.6	4.7	20.4	24.9
Djibouti	3.4	3.3	5.5	6.2	5.8
Egypt	5.1	6.5	6.3	11.5	20.8
Iran, Islamic Republic of	8.3	5.4	5.2	10.5	21.7
Iraq	4.3	4.1	4.6	7.5	15.1
Jordan	7.4	4.3	4.5	7.0	15.6
Kuwait	4.5	2.6	4.4	15.7	25.7
Lebanon	10.4	7.5	8.5	13.5	25.4
Libyan Arab Jamahiriya	7.3	3.7	5.5	9.9	21.1
Morocco	4.6	5.2	6.4	11.2	20.6
Oman	5.0	4.4	4.2	6.6	10.5
Pakistan	8.2	5.5	5.8	7.3	12.4
Palestine	7.4	4.9	4.9	5.6	9.9
Qatar	5.7	3.1	3.1	21.8	20.7
Saudi Arabia	5.6	4.8	4.8	7.9	12.9
Somalia	4.6	4.8	3.9	4.0	5.7
Sudan	5.4	4.6	5.5	7.9	14.4
Syrian Arab Republic	6.8	5.3	4.7	7.7	18.0
Tunisia	8.0	5.8	8.4	13.4	24.6
United Arab Emirates	5.7	3.4	5.1	23.6	26.7
Yemen	6.2	4.4	3.6	3.6	5.3
Regional average	6.7	5.3	5.8	8.7	15.0

Source (Crude): Population Division, Department of Economic and Social Affairs. *World Population Ageing*. New York, United Nations, 2001.

Annex Two

Milestones to the regional framework

1. The first steps

The WHO Regional Office for the Eastern Mediterranean realized the need for developing suitable programmes for the growing elderly population as far back as in the mid-1980s. Following data collection in five countries (Bahrain, Egypt, Jordan, Pakistan and Tunisia) in 1987, and an intercountry consultation at Larnaca, Cyprus, in 1991, the Regional Office decided to bring the matter of the health care of the elderly to the attention of the Regional Committee for the Eastern Mediterranean at its 38th Session in 1991 through a technical discussion session on "Health care of the elderly and the elderly handicapped".

As a consequence, the Regional Committee passed Resolution EM/RC38/R7, which urged both the Member States and WHO to take urgent measures to promote and protect the health of elderly populations so that they can lead a healthy and active life.

With active intervention by the Regional Office, many of the Member States had, by the early 1990s, established focal points in the Ministry of Health for the health care of the elderly. A rapid questionnaire survey based on a WHO protocol was conducted in 11 Member States to determine the health and socioeconomic status of the elderly population. These developments made it possible to develop programmes for the care of the elderly in many Member States.

2. Regional strategy for health care of the elderly 1992–2001

Against this background, a regional advisory panel on health care of the elderly was established in the Region in 1992. The panel adopted a regional strategy for WHO programmes on the health care of the elderly for the decade covering the period 1992–2001, specifying intercountry and country activities for five biennia, starting with the 1992–1993 biennium.

After its meeting in July 1993 in Limassol, Cyprus, the advisory panel announced the components of the regional strategy, which had the following salient features:

- to sensitize and technically assist the Member States in developing and implementing a programme for the health care of the elderly;
- to emphasize the importance of intersectoral coordination between different government agencies (other than health), nongovernmental organizations and WHO to develop a multifaceted approach at national level;
- to integrate the health care of the elderly with the national health care system designed for the health protection and promotion of the general population of the Member States, discouraging creation of separate vertical programmes;
- to encourage assimilation of the health care of the elderly into the overall developmental model with due recognition to the socioeconomic care of this population group;
- to recognize the role of primary health care in providing the major part of health care to the elderly population in the Member States, with an emphasis on the rural population.

The regional strategy recognized that great variations exist in the demographic profiles of the Member States with regard to their populations of the elderly. Some of the countries of the Gulf Cooperation Council have a large population of young expatriates. The ageing situation of the indigenous population was therefore incorrectly reflected in the demographic profile of these countries, despite appreciable gains in life expectancy at birth. However, even with a relatively lower proportion in the total population, the absolute number of older people requiring care in these countries was not so small as not to attract the notice of policy-makers.

Similarly, rural and urban differences, dissimilarity in socioeconomic status and the heterogeneity of the health status of the elderly in most Member States needs to be taken into consideration while planning for programmes for them. Like most countries in the developing world, countries in the Region have witnessed large-scale

migrations from rural areas to cities, adversely affecting the health care system in traditional societies.

The regional strategy therefore comprised of initiatives in:

- creation of mass awareness;
- formulation of national policy for the welfare of the ageing population;
- planning of governmental support for the elderly population through old-age pensions, subsidized public transport, housing, and access to subsidized health care and food;
- development of a health care system for the elderly with a focus on primary health care;
- support to old-age homes and similar institutions;
- social care.

The strategy recognized that:

- elderly patients in all hospitals were catered to in the same way as other patients with no special arrangements to meet their special needs;
- separate wards for elderly patients in most hospitals were nonexistent and only in a few hospitals were there geriatric units responsible for outpatient service;
- health care of the elderly was not featured in training courses for doctors, nurses or paramedical staff;
- primary health care workers were not trained to provide health care to elderly patients, and there was no health education in this area;
- research on health problems of the elderly was rare in countries in the Region;
- geriatric specialists were rare among medical practitioners in both the public and private sectors.

The regional strategy identified the following intercountry initiatives for the Member States:

- sponsorship of an initial fact-finding survey to generate data on the socioeconomic and health status of the elderly populations in four out of 22 countries;

- creating awareness among decision-makers in the health sector as well as in social welfare, legal affairs and information;
- establishment of a focal point in the Ministry of Health that would coordinate with the WHO Regional Office as well as with other relevant agencies in the country;
- development of a model national strategy which could be applicable in most Member States;
- sponsorship of WHO collaborative programmes in the health care of the elderly.

The regional strategy considered the following country activities in which it could have a role:

- establishment of special units in the Ministry of Health with responsibility for development of programmes for the health care of the elderly;
- conducting national surveys to collect data regarding demography, living conditions, dependency, morbidity, impairments, governmental and nongovernmental support;
- conducting national seminars at regular intervals to disseminate information on the needs of the elderly among policy- and decision-makers, administrators, nongovernmental organizations, political and religious leaders, and service providers;
- conducting national-level workshops for health professionals in creating awareness and providing state-of-the-art knowledge for management of the problems of old age;
- setting up of an intersectoral coordination committee in the Ministry of Health and other related sectors with technical expertise from WHO;
- developing a national strategy and policy for the elderly;
- developing a national mass awareness campaign;
- organizing the health sector to meet the needs of the elderly.

The regional strategy for 1992–2001 also provided a detailed programme of activities for the decade. The targets for country activities by 2001 included the following:

- all countries would have a responsible officer or a unit in the Ministry of Health for the health care of the elderly;
- all countries would have completed some form of situation analysis providing basic data necessary for the government to adopt ameliorative measures;
- all countries would have undertaken measures to create mass awareness regarding the needs of the elderly;
- at least 50% of the countries would have conducted national seminars on the health care of the elderly;
- at least 25% of the countries would have integrated measures for the health care of the elderly into primary health care;
- at least 10 countries would have oriented the national primary health care system to provide basic health care to the elderly and would have implemented training courses for intermediate- and peripheral-level health workers on the health care of the elderly.

3. Rights of Aged People – An Islamic Perspective

The International Conference on Rights of Aged People – An Islamic Perspective was held from 18–21 October 1999 in Kuwait. This important seminar was organized by the Islamic Organization for Medical Sciences (IOMS) in close cooperation with WHO, Islamic Education, Science and Culture Organization (ISESCO), Islamic Fiqh Council of Jedda, Saudi Arabia and the Confederation of International Organizations of Medical Sciences (CIOMS). The conference resulted in the Kuwait Declaration on the Rights of the Elderly. The following comprehensive set of recommendations were developed and agreed upon by participants.

1. To take all measures to maintain the elderly's health as from the foetus and childhood stages and continue the same for adolescents and adults; to promote social relations network in family, school, locality and community; to strengthen their submission to God and their commitment to the teachings of religion and protect them from harmful practices such as taking drugs and alcoholism; and to prevent environmental pollution.

2. To make the elderly aware of whatever ameliorates their health conditions, especially balanced nutrition, moderate physical exercises, suitable hobbies, preservation of social relations as much as possible and spiritual furtherance that supports faith, tranquillity and self-satisfaction.
3. To provide the elderly with suitable primary health care, clinical care and all levels of health care; to adapt health services so as to take into account the needs of the elderly; and to train physicians on discovery and treatment of physical and psychological illnesses which may have symptoms that are different from those in younger people.
4. To ensure justice and equality in providing health services to elderly men and women and to introduce an integrated health and social insurance system that covers all the segments of elderly including farmers, craftsmen and small wage earners who are not covered by the outstanding insurance systems.
5. To encourage the conduct and financing of topical and field research work on elderly physical and psychological health; collect data related to their activities and health problems, analyze the same and make them available to decision-makers to help them take proper decisions; and to pass appropriate laws to ensure elderly care.
6. To encourage mass media to highlight elderly health issues, sensitize them and their families, especially as related to their nutrition, physical activity, prevention against accidents and hazards, and to observe medication intake time; and to allocate special programmes for recreation and amusement.
7. To include elderly health, medicine and care in curricula of schools of medicine, nursing and other health disciplines; and to create geriatric medicine and nursing, and other health disciplines; and to create geriatric medicine and nursing departments in different health educational institutions.
8. To instil religious values and teachings that evoke benevolence to parents and high esteem of elderly, especially through curricula of various levels of education, which should include

subjects to enhance the awareness of the elderly, stress their position and rights in the family, showing faithfulness and good treatment to the elderly, paying visits to them in their gathering places and urge students to follow healthy behaviour which enables them to remain in good health as they become aged, make them avoid smoking, drugs and all other harmful habits, and make them aware of how to take care of the elderly.

9. To benefit from the elderly's rich resources of knowledge and experience by involving them as much as possible in bringing up younger generations. In this respect, decision-makers may consult the elderly people experienced in public affairs.
10. To boost the family role in taking care of the elderly, to be keen to keep the elderly always in a familial atmosphere whether with their own families or with other families or in elderly houses that have to be in close relation with the family, provide the familial atmosphere and all conditions that preserve the elderly's dignity and provide their required physical, psychological, social and spiritual care. The elderly houses should be distributed all over localities so that every elderly house becomes a nucleus for participation in the locality's social, cultural and religious activities.
11. To encourage voluntary and nongovernmental organizations, and all the other civic society institutions, to perform their role in providing health and social care for the elderly men and women, especially for those whose share in the familial is diminished.
12. To make the authorities and decision-makers aware of the importance and special needs of the elderly in light of Islamic jurisdiction including raising retirement age, introducing a penalty for disobedience of parents, helping the needy to support their elderly and establishing a higher council for elderly care where all the concerned parties are represented, and which will have appropriate competence and sufficient resources.

13. To provide the elderly with the necessary privileges and facilities, particularly the priority in public places and allocation of seats for them in the means of public transportation, gardens, theatres, and social and cultural clubs, provision of means of mobility for the handicapped or disabled, and granting them suitable deductions in the fares of land, sea and air transport, and membership fees of clubs and all other institutions that provide social and recreational services, sports, etc.
14. To enable the elderly to define their own needs, give them opportunity to fully utilize their long experience and skills for their benefit and the benefit of their societies, to enhance their initiative-taking, to train them on self-reliance, to help them perform activities that suit their capacities and abilities, and to found associations to be managed by the elderly themselves through which they develop self-satisfaction by active participation in the society.
15. To conduct continuous governmental evaluation of the demographical changes and transformations, to take them into account in drawing comprehensive social development plans and to make special emphasis on the considerable projected increase of the elderly, especially women, and to take the necessary procedures to adapt to the projected situation.
16. To use words denoting respect while addressing or referring to the elderly.
17. To prepare the elderly psychologically before retirement in order to avoid the shock that may result from solitude and idleness.
18. To encourage caregivers to allocate endowments for the benefit of the elderly.
19. To call upon IOMS to publish a book on "the elderly ordinance" that includes the rules of rites, transactions and other juristic rules related to the elderly.

20. To appeal to OIC, ISESCO in cooperation with IOMS to issue, then declare, a document on elderly rights from an Islamic perspective.
21. To set up a committee to follow up the implementation of such recommendations; organizers of the Symposium shall be on the follow-up committee.
22. To adopt a declaration titled 'Kuwait Declaration on Elderly Rights'.

4. Protection and promotion of the health of elderly people in the Eastern Mediterranean Region: intercountry workshop, April 2001

In April 2001, the last year of the decade for which the regional strategy was adopted, an intercountry workshop was held in Beirut, Lebanon. The workshop looked holistically at all aspects of the health of the elderly and reviewed the achievements of the strategy adopted in 1992. It was recommended that new programmes should be developed where there were gaps in service and that a more holistic approach to older persons needs be developed to ensure that the public and private sectors meet their needs. The following comprehensive set of recommendations was produced.

To Member States

1. Introduce appropriate programmes for the protection and promotion of older persons where they do not exist and identify focal points.
2. Maintain existing programmes on health care for older persons, based upon national objectives with prioritized needs and with an intersectoral approach.
3. Promote the coordination of the health sector with the social welfare and other relevant sectors to provide services for older persons.
4. Encourage and enhance national policies and programmes to assist older persons to live independently in the community, for instance, through access to primary health care, provision of affordable essential drugs, subsidized public utility, education and information.

5. Examine carefully and systematically the interrelationships between religion, culture, society and economic status, as well as the social and physical dimensions of ageing, for the development of more effective programmes.
6. Make efforts to create national associations of older persons for the purpose of developing programmes and to generate awareness and advocacy for their needs and stimulate and strengthen inter-generational solidarity.
7. Encourage and enhance family support and empower care providers for older persons through social, economic, cultural, physical and spiritual means.
8. Encourage and promote policies, programmes and practices that will support older persons to live independently in the community and enjoy the highest quality of life.
9. Encourage and promote policies, programmes and practices that will assist dependent older persons to spend their remaining years in dignity.
10. Develop equitable practices for older widowed and divorced women through ensuring economic support and access to health care services which address their special health needs.

To WHO

1. Formalize a communication and information-gathering network to provide technical assistance, share country experiences and disseminate the information to a wider audience.
2. Integrate and involve nongovernmental and professional organizations concerned with the protection and promotion of older persons to capitalize on experience and exchange of information.
3. Develop a standard data collection format in order to create country and regional profiles.

To WHO/EMRO and Member States

1. Develop a standard set of indicators for the promotion and protection of older persons in older to develop, monitor and evaluate programmes.

With respect to revision of the primary health care manual

1. Develop a separate set of guidelines for primary health care workers and physicians.
2. Expand and revise existing chapters.
3. Incorporate newly emerging health issues.

5. Active ageing: the changing concept of health in old age

In the past decade, the WHO accepted active ageing as an achievable goal for the care of a sick and ageing population. This was a paradigm shift of focus from a clinical model to a health promotion model of care. A WHO discussion paper circulated at the Second United Nations World Assembly on Ageing in 2002 provided the conceptual basis of active ageing.

WHO defines active ageing as the process of optimizing opportunities for health, participation and security of older people in order to enhance quality of life as people age. The policy framework takes into account the determinants of health throughout the life-course, and has helped to shape ageing policies at national and regional levels, and to direct academic research on ageing; it has also influenced the practical application of policies at community level. Policy-makers at various levels have adopted the framework's conceptual approaches. Basic indicators for monitoring the implementation of active ageing policies are now being formulated and should be ready in 2005

The concept of "active ageing" considers that if ageing is to be a positive experience and longer life is to be accompanied by continuous opportunity for enjoyment and productivity, then ageing must be seen not as a state of "disease and disability" but as a state of "health and fitness".

The term "active ageing" was adopted by WHO in the late 1990s to convey a more inclusive message than "healthy ageing" in order to recognize the importance of other factors, in addition to health care, in maintaining an aged population. This concept has now been accepted by national organizations, as well as academicians, who support the idea of continued involvement of older people in socially productive and meaningful work. The phrase "active ageing" implies continuous involvement of older people in social, economic, spiritual, cultural and civic activities, and not just the ability of physical movement and survival. Thus, even older people with disease and disability can remain active and contribute to their families, communities and countries.

The determinants of active ageing include:

- gender and culture
- health and social service system
- economic factors: income, work and social protection
- physical environment
- personal factors: biology, genetics and adaptability
- behavioural factors: physical activity, healthy eating, tobacco and alcohol use
- social environment: social support, education, literacy, violence and abuse.

The policy initiatives required in the health sector to achieve active ageing include:

- reduction in the prevalence of risk factors of serious diseases and adoption of all those factors that protect health and well-being throughout the life-course;
- development of a health and social service system that emphasizes health promotion, disease prevention and provision of dignified long-term care at an affordable cost;
- reduction in the burden of illness and disability in marginalized population groups;
- active participation of older people in all aspects of society;
- improvement in health and enhancement of independence in difficult times by provision of protection to older people;

- stimulation of research and dissemination of knowledge about best practices;
- international dialogue.

The objective of WHO's INTRA project is to formulate an integrated response of health care systems to rapid population ageing in developing countries and to create a knowledge base to support countries in reorienting policies towards integrated health and social care systems serving older populations. The first two phases (now completed) of the project, conducted in 12 developing countries (Botswana, Chile, China, Ghana, Jamaica, Republic of Korea, Lebanon, Peru, Sri Lanka, Suriname, Syrian Arab Republic and Thailand), consisted of quantitative and qualitative research on: the care-seeking behaviours of older people at primary health care level; the roles, needs and attitudes of their service providers; and the types of services provided. Governments, academic institutions, and nongovernmental organizations contributed to this interdisciplinary research project, which resulted in the sharing of information and models of good practice among the participating countries and a series of specific policy recommendations.

The next phase, being implemented in collaboration with the WHO Centre for Health Development, Kobe, Japan, brings in six additional countries (Bolivia, India, Kenya, Malaysia, Pakistan, and Trinidad and Tobago) and focuses on older people who do not use primary health care. The project will lead to comprehensive policy recommendations on developing a continuum of care within the primary health care sector aiming towards integrated old-age care.

Thereafter, work will focus on step-wise implementation of the recommendations. The project was conceived as a model to stimulate exchanges of knowledge, experience and models of good practice between developing countries with rapidly ageing populations, and with the aim of building relevant research capabilities in developing countries.

6. Second United Nations World Assembly on Ageing

The United Nations Second World Assembly on Ageing (Madrid, 8–12 April 2002) unanimously adopted the Madrid Political Declaration and International Plan of Action on Ageing, 2002. WHO's contributions to the Assembly included the submission of a policy framework (*Active ageing: a policy framework*, Geneva, World Health Organization, 2002, WHO/NMH/NPH/02.8), and the formulation of regional action plans for implementing the International Plan, notably by the United Nations Economic Commission for Europe, the United Nations Economic and Social Commission for Asia and the Pacific, and the United Nations Economic Commission for Latin America and the Caribbean. Reports on the content of the policy framework and the outcomes of the Second World Assembly were submitted to the Fifty-fifth World Health Assembly (Documents A55/17 and A55/17 Add.).

The World Assembly followed wide-ranging discussions and consultations among Member States, governmental agencies, international organizations, researchers and academicians, and nongovernmental organizations around the world. At the end of the Assembly, a political declaration and an emergency international plan of action were released.

The recommendations of the action plan include three priority directions:

- older persons and development
- advancing health and well-being into old age
- ensuring an enabling and supportive environment.

Health professionals, researchers and nongovernmental organizations held wide-ranging discussions and arrived at a consensus for formulating issues and actions in the health care sector. The issues include:

- health promotion and well-being throughout the life-course
- universal and equal access to health care services
- older persons and disabilities
- training of caregivers, providers and health professionals
- mental health needs of older persons

- older persons and HIV/AIDS.

The recommended initiatives include:

1. effects of factors that increase the risk of disease and consequently the potential of dependence in old age;
2. development of policies to prevent ill-health among older persons;
3. access to food and adequate nutrition for older persons;
4. elimination of social and economic inequalities based on age, gender or any other ground, including linguistic barriers, to ensure that older persons have universal and equal access to health care;
5. development and strengthening of primary health care services to meet the special needs of older persons;
6. involvement of older persons in the development and strengthening of primary and long-term care services;
7. provision of adequate information and training for medical and paramedical personnel on the needs of older persons;
8. development of mental health care services, ranging from prevention to early intervention;
9. provision of treatment services and the management of mental health problems in older persons, and maintenance of mental capacity throughout life;
10. promotion of full participation of older persons with disabilities in all social activities;
11. improvement in the assessment of the impact of HIV/AIDS on the health of older persons, both for those who are infected and those who are caring for the infected or serving family members;
12. provision of adequate information, training in care giving skills and recognition of the contribution of older persons as sole caregivers of children of parents with chronic disease.

7. The mandate for the new regional strategy: Resolution EM/RC50/R.10

The WHO Regional Committee for the Eastern Mediterranean, at its fiftieth session in October 2003, reviewed the challenge and perspective of health care of the elderly in the Region and passed the following resolution:

The Regional Committee,

Having reviewed the technical paper on health care of the elderly in the Eastern Mediterranean Region: challenges and perspectives;

Recalling resolution EM/RC38/R.7 on health of the elderly and problems of the handicapped elderly;

Noting with concern the challenges for health and socioeconomic development associated with the rapid increase in the number and percentage of persons of 60 years and above in all countries of the Region;

Acknowledging the increased awareness in the Member States of the Region of the consequences of population ageing and their efforts to formulate policies and to develop or strengthen programmes for the health of older persons;

Recognizing also the potential to increase the valuable contribution older persons make to society;

Urges Member States to:

1. Review national policies, strategies and plans of action to ensure the promotion of healthy lifestyles throughout the life-course and the comprehensive care of older persons;
2. Develop programmes that delay the onset of disability, ameliorate its trajectory and enhance older people's capacity to take better care of themselves, such as the active ageing approach;
3. Support and encourage family and community caregivers of older people and promote the retention of appropriate traditional care and positive social and cultural values and practices.

Requests the Regional Director to:

1. Support the development of multidisciplinary regional and national networks among agencies, organizations, academic institutions and individuals concerned with and interested in providing care for older persons;
2. Update the regional strategy on the health care of older persons;
3. Continue to support Member States in promoting quality of life and well-being of older persons through approaches such as active ageing and community-based programmes or services for older people;
4. Develop a computerized database on the status of the ageing population in the Region.
5. Develop appropriate health education materials to prepare people for the process of ageing.

8. Fifty-eighth World Health Assembly, Resolution WHA58.16 on Strengthening active and healthy ageing, Agenda item 13.15, 25 May 2005

The Fifty-eighth World Health Assembly,

Having considered the document on International Plan of Action on Ageing: report on Implementation;

Noting that more than 1000 million people will be over 60 years old by 2025, the vast majority in the developing world, and that this figure is expected to double by 2050 which will lead to increasing demands on health and social-service systems worldwide;

Recalling resolution WHA52.7 on active ageing that called upon all Member States to take appropriate steps to carry out measures that ensure the highest attainable standard of health and well-being for the growing numbers of their older citizens;

Recalling also United Nations General Assembly resolution 58/134 of 22 December 2003, which requested the organizations and bodies of the United Nations system and the specialized agencies to integrate ageing, including from a gender perspective, into their programmes of work;

Recalling further United Nations General Assembly resolution 59/150, which called on governments, the organizations of the United Nations system, nongovernmental organizations and the private sector to ensure that the challenges of population ageing and the concerns of older persons were adequately incorporated into their programmes and projects, especially at country level, and invited Member States to submit, whenever possible, information to the United Nations database on ageing;

Acknowledging the active ageing policy framework, WHO's contribution to the United Nations Second World Assembly on Ageing, and its vision for the framing of integrated intersectoral policies on ageing;

Mindful of the important role played by WHO in implementing the objectives of the Madrid International Plan of Action on Ageing, 2002, particularly Priority Direction II: Advancing health and well-being into old age;

Recognizing the contributions that older persons make to development, and the importance of lifelong education and active community involvement for older persons;

Stressing the important role of public-health policies and programmes in enabling the rapidly growing numbers of older persons in both developed and developing countries to remain in good health and maintain their many vital contributions to the well-being of their families, communities and societies;

Stressing also the importance of developing care services, including e-Health services, to enable older persons to remain in their homes for as long as possible;

Underlining the need for incorporating a gender perspective into policies and programmes relating to active and healthy ageing;

Welcoming WHO's focus on primary health care, such as the development of "age-friendly" primary health care,

Urges Member States:

1. to develop, implement and evaluate policies and programmes that promote healthy and active ageing and the highest attainable standard of health and well-being for their older citizens;
2. to consider the situation of older persons as an integral part of their efforts to achieve the internationally agreed development goals of the United Nations Millennium Declaration, and to mobilize political will and financial resources for that purpose;
3. to take measures to ensure that gender-sensitive health policies, plans and programmes recognize and address the rights and comprehensive health, social-service and development needs of older women and men, with special attention to the socially excluded, older persons with disabilities, and those unable to meet their basic needs;
4. to take steps and encourage measures to ensure that resources are made available for persons or legal entities who take care of older persons;
5. to pay special attention to the key role that older persons, especially older women, play as caregivers in their families and the community, and particularly the burdens placed on them by the HIV/AIDS pandemic;
6. to consider establishing an appropriate legal framework, to enforce legislation and to strengthen legal efforts and community initiatives designed to eliminate economic, physical and mental elder abuse;
7. to develop, use and maintain systems to provide data, throughout the life-course, disaggregated by age and sex, on intersectoral determinants of health and health status in order to underpin the planning, implementation, monitoring and evaluation of evidence-based health policy interventions relevant to older persons;
8. to undertake education and recruitment measures and incentives, taking into account the particular circumstances in

developing countries, in order to ensure sufficient health personnel to meet the needs of older persons;

9. to strengthen national action in order to ensure sufficient resources to fulfil commitments to implementing the Madrid International Plan of Action on Ageing, 2002, and related regional plans of action relating to the health and well-being of older persons;
10. to develop health care of older persons within primary care in the existing national health systems;
11. to provide progress reports on the status of older persons and on active and healthy ageing programmes when making country health reports;
12. to support WHO's advocacy for active and healthy ageing through new, multisectoral partnerships with intergovernmental, nongovernmental, private-sector and voluntary organizations.

Requests the Commission on Social Determinants of Health to consider including issues related to active and healthy ageing throughout the life-course among its policy recommendations;

Requests the Director-General:

1. to raise awareness of the challenge of the ageing of societies, the health and social needs of older persons, and the contributions of older persons to society, including by working with Member States and nongovernmental and private-sector employers;
2. to provide support to Member States in their efforts to fulfil their commitments to the goals and outcomes of relevant United Nations conferences and summits, particularly the Second World Assembly on Ageing, related to the health and social needs of older persons, in collaboration with relevant partners;
3. to continue to focus on primary health care, with an emphasis on existing community structures where applicable, that is age appropriate, accessible and available for older persons, thereby strengthening their capability to remain vital resources to their

families, the economy, the community and society for as long as possible;

4. to provide support to Member States, by promoting research and strengthening capacity for health promotion and disease prevention strategies, policies and interventions throughout the life-course, in their efforts to develop integrated care for older persons, including support for both formal and informal caregivers;
5. to undertake initiatives to improve the access of older persons to relevant information and health care and social services in order, particularly, to reduce their risk of HIV infection, to improve the quality of life and dignity of those living with HIV/AIDS, and to help them support family members affected by HIV/AIDS and their orphaned grandchildren;
6. to provide support to Member States, upon request, for compiling, using and maintaining systems to provide information, throughout the life-course, disaggregated by age and sex, health status and selected intersectoral information, on determinants of health, in order to underpin the planning, implementation, monitoring and evaluation of evidence-based health policy interventions relevant to older persons;
7. to strengthen WHO's capacity to incorporate work on ageing throughout its activities and programmes at all levels and to facilitate the role of WHO regional offices in the implementation of United Nations regional plans of action on ageing;
8. to cooperate with other agencies and organizations of the United Nations system in order to ensure intersectoral action towards active and healthy ageing;
9. to report to the Sixtieth World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

9. Emerging issues

The Madrid International Plan of Action on Ageing, 2002, identified two emerging areas requiring urgent action: older persons

and HIV/AIDS; and abuse of older people. Worldwide, particularly in sub-Saharan Africa, older people (mostly women) absorb enormous additional burdens placed on the family by the HIV/AIDS pandemic. In response, WHO has developed a method to assess the needs of older carers through pilot research in Zimbabwe. The project is intended to be replicated in other countries in order to provide evidence-based data for interventions.

In work towards the prevention of abuse of older people, WHO is conducting research in collaboration with the University of Geneva on reliable tools to facilitate detection of such abuse at the primary health-care level. Following a large study in Canada that validated one such tool, WHO would pilot the application in four other countries. The project builds on a qualitative study jointly conducted by WHO, the International Network for the Prevention of Elder Abuse, and HelpAge International.

That study's resulting publication on the views of older people on elder abuse has been widely disseminated (see International Network for the Prevention of Elder Abuse. *Missing voices: the views of older people on elder abuse*, Geneva, World Health Organization, 2002, WHO/NMH/VIP/02.1). WHO was one of the parties to the Toronto Declaration on the Global Prevention of Elder Abuse launched at the Ontario Elder Abuse Conference (Ontario, Canada, 18–20 November 2002).

Annex Three

Model national policy for the elderly

A national policy for the elderly needs to take into account the following factors: the country's demography, the impact of population ageing on various institutions of society, the existing status of the elderly in all spheres of life, the trend of change in the structure of the family, the state of the economy and the cultural moorings of the society.

The national policy must have a mandate which is in tune with the constitution of the country and its future vision. The national policy must be inclusive, i.e. it must help in building a society for all ages, with emphasis on affirmative action in favour of the elderly, rather than isolate them as a vulnerable group waiting for support.

The principal areas for policy development are as follows.

- Financial security in the form of an old-age pension contributed to during working years.
- Access to affordable and quality health care, which includes: primary health care oriented to the care of the elderly; ambulatory and institutional mental health care; subsidized specialist care; subsidized drugs, aids and appliances; availability of home care and long-term care; availability of affordable health insurance; and health education to enter old age in good health.
- Access to shelter in an elderly-friendly environment.
- Institutions for the destitute.
- Availability of scope for formal as well as non-formal education and training for those who still want to be economically productive.
- Protection of life and property.
- Social security for the vulnerable elderly provided by the state and emotional support from the institutions of civil society to strengthen coping capacity.
- Encouragement of organizations in the nongovernmental sector to support the state in caring for the elderly.

- Support to the family in caring for the elderly.
- Creation of a good database to plan interventions under the policy.
- Training of carers and managers in care of the elderly.
- Use of mass media in influencing society in favour of the elderly.
- Creation of a national association of older persons to give them the strength to influence policy and programmes meant for them.
- Creation of a mechanism to implement and monitor the impact of the policy.