



AGEING

Learning from the Global South

Population Policy Series 2

Editor: Joe Thomas



Partners in Population and Development (PPD)

An Inter-Governmental Organisation
for Promoting South-South Cooperation

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These reports have been prepared mainly based on the secondary data from Government sectoral-ministry data and reports, demographic and health surveys, and development partner reports. The authors also utilised contents of various published and unpublished documents, including information gathered from websites.

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Acronyms

DSW	:	Department of Social Welfare
DWELE	:	Development Work in Education, Livelihoods and Environment
EXCOM	:	Executive Committee
GCADC	:	Global Commission on Ageing in Developing Countries
GSGDA	:	Ghana Shared Growth and Development Agenda
ICPD POA	:	International Conference on Population and Development Programme of Action
INAPAM	:	National Institute of Protection of the Elderly
KAIS	:	Kenya AIDS Indicator Survey
KIHBS	:	Kenya Integrated Household and Budget Survey
LEAP	:	Livelihood Empowerment Against Poverty
LMICs	:	Low and Middle Income Countries
MC	:	Member Country
MIPAA	:	Madrid International Plan of Action on Ageing
MoGCSP	:	Ministry of Gender, Children and Social Protection
NCD	:	Non-Communicable Diseases
NHIF	:	National Health Insurance Fund
NPOPA	:	National Policy on Older Persons and Aging
NSSF	:	National Social Security Fund

PCC	:	Partners Country Coordinator
PHC	:	Population and Housing Census
PPD	:	Partners in Population and Development
PWD	:	Persons with Disability
SDGs	:	Sustainable Development Goals
SSC	:	South South Cooperation
SSNIT	:	Social Security and National Insurance Trust
TFR	:	Total Fertility Rate
TCM	:	Traditional Chinese Medicine
WHO	:	World Health Organization

Preface

It is evident that rapid population ageing and a steady increase in human longevity present one of the hitherto unexplored social, economic and political challenges and opportunities of our time.

Many developing countries use the phrase ‘getting old before getting rich’ to summarise the challenges of a rapidly ageing population. The demographic phenomenon of increase in AGEING population is a product of several factors such as access to better health care, subsequent increase in life expectancy and reducing fertility levels. The discourse around ‘AGEING’ presents it as, ‘although an inevitable process yet an undesirable phenomenon’. In such a context the opportunities and possibilities provided by the ‘AGEING’ is greatly ignored or disregarded. Though, the trajectory and experience of ‘ageing’ in developed economy and developing economy varies vastly, the policy formulation towards ‘ageing’ is greatly influenced by the data and evidence from the developed economies.

It is becoming increasingly evident that responsible and fair ageing policy making in developing countries is possible and there is a need to carefully identify, learn, nurture this and share it among the developing countries. With right policy making, developing economies can continue to develop, navigate and promote health and active AGEING.

Governments and societies have a responsibility to ensure people everywhere age with dignity and security, enjoying life through its full realisation. Many of the governments, particularly in developing country’s need to address the needs of older persons, by developing adequate policies, strategies and laws to ensure their well-being.

Exploring ‘ageing’ from a social and health equity perspective may provide a useful frame work to explore the potential and opportunities provided by ageing population. Equity perspective also may present critique of dominant discourse on ageing as a ‘burden’ and ‘dependency’.

The ageing-demographic shift will affect all aspects of our social structure, every community, family and Individual. This social phenomenon will force us to rethink how individuals and societies organise our lives and work.

Principles and policies of social protection and social security, labour relationships, intergenerational transfer of knowledge and resource, gender relations, a regulatory framework to promote health and active ageing are to be re-examined in the context of ageing.

While an equitable healthcare, social security and pension scheme may contribute to the mitigation of the impact of ageing, addressing gender inequity may be the biggest mitigating factor of the social impact of AGEING. Raising female equity in the labour market, through providing greater child-care facilities and employer incentives to become more family-friendly may contribute substantially to address the impact of ageing on societies

Many older persons all over the world face continued discrimination, abuse and violence, and underscore the need for policies and programmes to end these destructive practices and invest in older people.

Ageing is a lifelong process that does not start at age 60. Today's young people will be part of the two billion-strong population of older persons in 2050 and majority of them are from developing countries. With proactive policies and programmes we can benefit from the 'longevity dividend' a second demographic dividend in the developing world.

The Global Commission on Ageing in Developing Countries (GCADC) was initiated to assist the developing countries, particularly the member countries of Partners in Population and Development (PPD) to navigate the AGEING related policy making. Promoting health ageing is one of the 6-point priorities of PPD. The assessment reports from seven PPD member countries are presented in this compendium aiming to document the ageing situation, health and well-being and policies for enabling and supportive environments in their own countries.

This book is the second volume of PPD Population Policy Series (first one is Population Trends and Policy Options in Selected Developing Countries, 2012). With the kind of response we have received, we also expect to publish another volume of other PPD Member Countries' assessment reports that we hope to receive soon.

A great deal of collective effort of experts working in the area of population ageing in PPD member countries has gone into this volume. It is a pleasure to acknowledge indebtedness to several individuals for completing this book and particularly here, I would like to take note of the authors who contributed to this volume.

Ms. Chen Xueping, Professor and President, Nursing Branch of Qianjiang College, Hangzhou Normal University, China; Ms. Huang Huijuan, Director General, Nanjing International Training Centre for Population Programmes, National Health and Family Planning Commission of China; Dr. Stephen Owusu Kwankye, Associate Professor at the Regional Institute for Population Studies (RIPS), University of Ghana; Ms. Esther Cofie, Head of Population and Development Unit, National Population Council, Ghana and PCC of PPD; Mr. George Alusa Kichamu, Formerly Director, Technical Services, National Council of Population and Development, Kenya; Dr. Roberto Ham Chande, Professor of the Department of Population Studies, El Colegio de la Frontera Norte, Mexico; Dr. Timothy Ndubisi Menakaya, Formerly Minister of Health of the Federal Republic Nigeria; Dr. Sanjo Oladepo Faniran, PCC and Director, United Nations System, National Planning Commission, Nigeria; Dr. Omokharo, Consultant, Nigeria; Prof. Monde Makiwane, Chief Research Specialist in the Human and Social Development (HSD) research programme of the Human Sciences Research Council (HSRC) in Pretoria, and Research Associate at Nelson Mandela Metropolitan University; Mr. Pham Vu Hoang, Deputy Director of the Centre for Population Research, Information and Documentation, the General Office for Population and Family Planning (GOPFP), Vietnam. All of them have contributed as authors of the chapters presented in this book.

I would like to express my deepest thanks to all the PPD Board Members and PPD Partners Country Coordinators for their guidance, immense cooperation and support. I thank each one of the Board Members and PCCs of PPD for considering population ageing as one of the 6-point priority areas of PPD.

I am happy to express my gratitude to Dr. Hu Hongtao, Advisor to National Health and Family Planning Commission for South South Cooperation, Government of China and Senior Advisor to PPD for South South Cooperation who has provided his immense support towards this effort.

With great pleasure, I would like to acknowledge PPD staff members' contribution for providing continued support throughout the entire process – from documentation to finalisation of publication of this ageing book. In particular, Dr. Nazrul Islam, Director Program and Ms. Tahrira Khan, Program Officer.

We are indebted to Gillespie Foundation for its continued contribution to PPD. We are very thankful to Dr. Bob Gillespie, the Founder of Gillespie Foundation for his generous support towards preparation and printing of this book.

We deeply acknowledge the meticulous editorial support made by Ms. Shoba Ramachandran, Creative Editorial Consultant of Moving Lines and her capable team to finalise all these reports, to design and format the work towards finally printing the book.

Dr. Joe Thomas

Executive Director

Partners in Population and Development (PPD)

Introduction

The articles presented in this edited volume are part of an outcome of the Global Commission on Ageing in Developing Countries. ‘The Commission’ was established to inform, discuss and formulate action plans that promote healthy and active ageing in developing countries.

Active ageing is the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age.(WHO 2002). An active ageing framework provides a useful tool for developing ageing related policies. However, promoting active ageing is fraught with complexities, and challenges as well as opportunities. It is also becoming evident that the trajectories of ageing and ageing related response in developing and developed countries are distinct and different. Collecting data, evidence and experience of ageing in developing countries is essential for proactive policy and programme development for promoting active and meaningful ageing in developing countries.

The Active Ageing Model, originally proposed by WHO (2002) is based on three concepts mentioned in the definition: participation, health, and security. The proposed model encompasses six groups of determinants of active ageing, each one including several sub components:

1. Adequate Health and social services (promoting health and preventing disease; functional health services; access to continuous care; access to mental health services),
2. Behavioural determinants of active ageing (smoking; physical activity; food intake; oral health; abuse of alcohol; adherence and access to medication)
3. Personal determinants (biology and genetics and psychological factors);
4. Physical environment (friendly environment; safety houses; falls; absence of pollution);
5. Social dominants of active ageing (social support; violence and abuse; education);

6. Economic determinants of active ageing (opportunities for economic engagements; access to social security; access to meaningful work), embedded in cultural and gender context.

The context of ageing in developing countries

It is known that the process of demographic transition reshapes the age structure of the population and results in growth of the ageing population in most of the regions. In this transition, the mortality and fertility decline from higher to lower levels and extends the life expectancy. Total fertility rate (TFR) 5.0 halved globally to 2.7 children per woman during the last 50 years, and it is expected that within the same time the replacement level of 2.1 children per women will be achieved. However, it was observed that this reduction has occurred in the developing regions during the last 3 decades of the 20th century. Similarly, over the last 50 years period, the life expectancy at birth increased by almost 20 years worldwide. The least developing countries mainly gained on average 23.1 years in life expectancy at birth (UNDESA 2001: *World Population Ageing 1950–2050*)

Ageing is taking place all over the world, but at a different pace in different regions. There were 901 million people aged 60 or over that comprise 12 per cent of the global population in 2015. However, it is projected to reach 1.4 billion by 2030 and 2.1 billion by 2050 and further it will rise to 3.2 billion by 2100. It is alarming that nearly a quarter or more of the population will be aged or 60 over in all the major areas by 2050, except Africa (UNDESA, *World Population Prospects: the 2015 revision*). Further, the number of people aged 80 or over is projected to triple by 2050, from 137 million in 2017 to 425 million in 2015. It is expected to increase to 909 million by 2100 and this is nearly 7 times its value in 2017 (UNDESA, *World Population Prospects: the 2017 revision*).

Population ageing will have a profound effect on societies. Developing countries will face more challenges as the most rapid increase of ageing population will take place in developing countries. About 80% of the ageing people of the world will live in developing countries. Not only healthcare, old-age pension and social protection systems but also labour market, housing and transportation of many countries are likely to face challenges in the coming decades. The elderly

people are at high risk for disease and disability. Financial barriers often make it almost impossible for older persons to obtain essential medical and other health-related care, especially when chronic health conditions and disabilities become more prevalent with advancing age. When age discrimination is prevalent for older men and women, older women face cumulative effects of gender discrimination contributing to more vulnerability in their old age. On the other hand, older men, once retired, become vulnerable because of their weaker social support networks and are subject to financial abuse.

1.1 Demographic Transition and Policy Lag

The Madrid International Plan of Action on Ageing (MIPAA) adopted during the Second World Assembly on Ageing in 2002 highlights the need for the involvement of the older persons in development planning, so that older persons should be able to participate in and benefit equitably from the development to advance their health and well-being, and that societies should provide enabling environments for them to do so. Later the sustainable development goals (SDGs) recognise the importance of the elderly population as it particularly focuses on the SDG3 which says, “ensure healthy lives and promote well-being for all at all ages”.

Given the current demographic shifts, the mainstreaming of ageing issues into the national development plans makes little progress in developing countries.

It is with this backdrop, PPD has taken a leadership role to establish a Global Commission on Ageing to address the issues related to ageing focusing on the developing countries. The Commission is aiming to:

1. Enable gender, equity and rights based policies and programming that would improve the quality of life of the ageing populations in developing countries.
2. Evidence to inform policy development in developing countries.
3. Identify opportunities for South-South Cooperation and exchange towards addressing the issues in developing countries.

PPD, through the Global Commission on Ageing conducted a rapid assessment to know the situation and best practices of ageing in 7 countries of PPD

members. Seven countries ageing reports are in this edited volume titled *Ageing: Learning from the Global South*. The countries are China, Ghana, Kenya, Mexico, Nigeria, South Africa and Vietnam.

The reports were made based on a rapid assessment, desk reviews, literature reviews and consultations with experts and practitioners. It is an effort of quantitative and qualitative analyses of the situation, policies and programs of population ageing in PPD member countries. The rapid assessment highlights the following aspects:

Background of ageing: include demographic, health, and social transitions in the country, projection of elderly population by 2030 and 2050; nature of problems faced by the elderly population; challenges faced by elderly population towards healthy ageing; what are the priorities; existing policy in the country; enforcement and Impact of policy; challenges towards policy implementation.

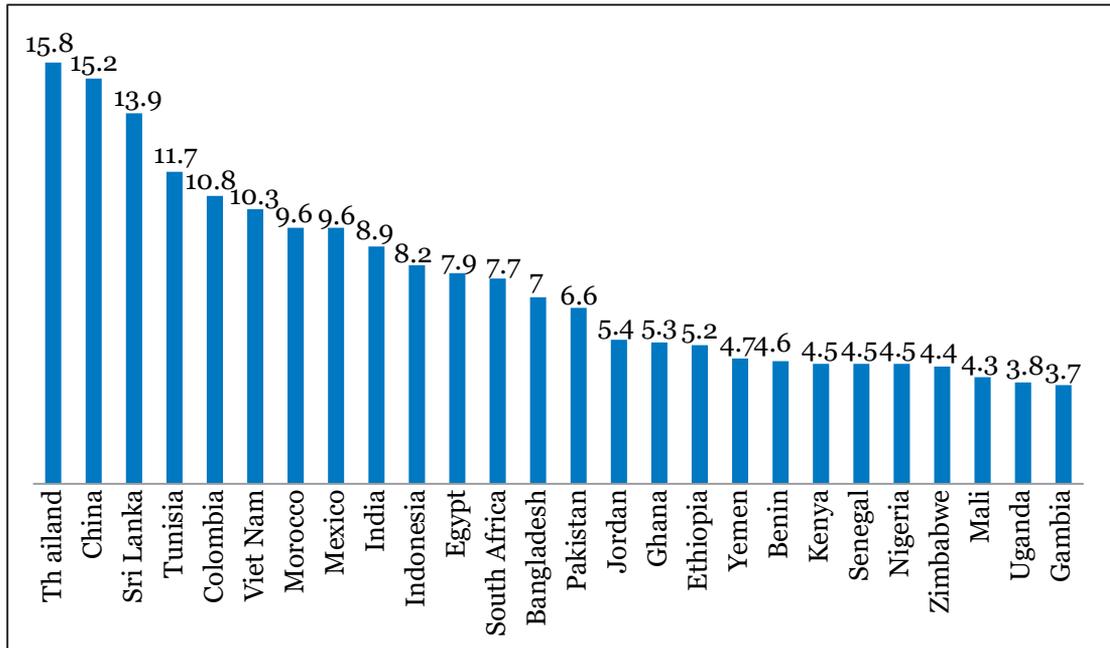
Programmes implementation: include integrated older person-centred care; creating a long-term care programme to take care of dependent older people and family caregivers; creating aged friendly environment where everyone can grow healthy and contribute to overall development; lessons learned and opportunity for scaling, explicability and sustainability; role of NGOs/civil society organisations in addressing healthy ageing; financing for healthy ageing.

In this introductory chapter we have summarised the ageing situation in PPD member countries followed by a brief introduction about the findings of the 7 selected countries.

1.2 Ageing Situation in PPD Member Countries

The 26 member countries of PPD constituted 442 million population aged 60 and above which is 49% of the total aged population of the world and it is projected to increase to 752 million in 2030 (53.38%) and 1.2 billion in 2050 (57.6%). Seventeen member countries of PPD namely Bangladesh, China, India, Indonesia, Pakistan, Sri Lanka, Thailand, Vietnam, Ethiopia, South Africa, Zimbabwe, Egypt, Jordan, Morocco, Tunisia, Colombia, and Mexico will have more than 10% of their total population aged 60 and above by 2050.

Graph1: Percentage of ageing of total population in PPD Member Countries in 2015

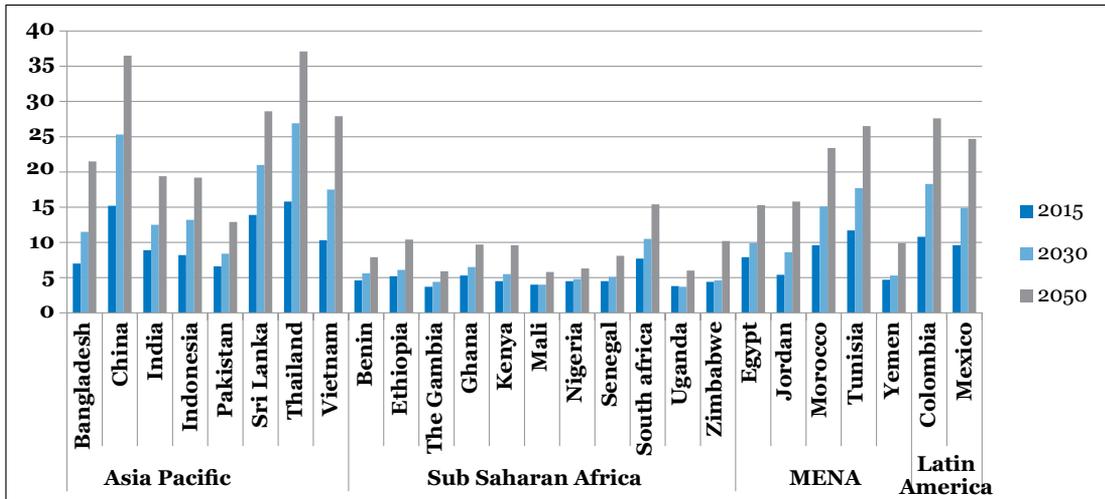


Source: “World Population Ageing 2015” (ST/ESA/SER.A/390). United Nations, Department of Economic and Social Affairs, Population Division. 2015. pp.123–133

Graph 1 shows in 2015, the highest percentage which is 15.8% of aged 60 and above population among PPD member countries in Thailand and the lowest rate is 3.7% in The Gambia. Among the eight member countries of PPD in the Asia-Pacific region, the rate of population aged 60 and above ranged from 6.6% in Pakistan to 15.8% in Thailand. Graph 1 shows the corresponding rate is 7% in Bangladesh, 8.9% in India, 8.2% in Indonesia, 10.3% in Vietnam, 13.9 % in Sri Lanka and 15.2% in China.

Graph 2 shows the projected rates of population aged 60 and above in 2050 are on an average 2.5 times more than the rates of 2015 in PPD member countries of the Asia-Pacific region. The increase rate will be more than 3 times in Bangladesh, Indonesia and Vietnam. The projected rates will be more than 30% in China, Thailand and Vietnam by 2050.

Graph 2: Percentage of aged 60 or above population in year 2015, 2030 and 2050 in PPD Member Countries



Source: “World Population Ageing 2015” (ST/ESA/SER.A/390). United Nations, Department of Economic and Social Affairs, Population Division. 2015. pp.123–133

In 2015, among the five member countries of PPD in the Middle East and North Africa Region, the rates of population aged 60 and above ranged from 4.7% in Yemen to 11.7% in Tunisia (Graph 1). But by 2050, these rates will increase to about 2 to 3 times as seen in Graph 2. The projected rate will range from 9.9% in Yemen to 26.5 % in Tunisia.

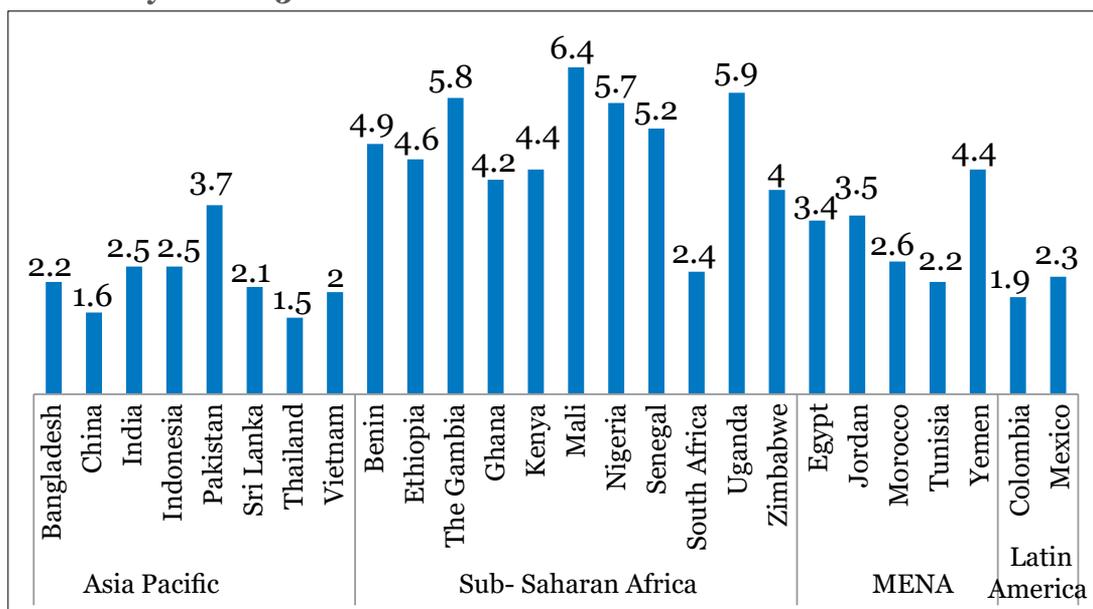
However, among the 2 of PPD member countries in Latin America, the population rate at 60 and above is in Mexico 10.8% and in Colombia 9.6% in 2015 (Graph 1). It is projected that by 2050 these 2 countries rate will increase about 2 fold.

Graph 1 shows among the 11 member countries of PPD in Sub-Saharan Africa, the rates of population aged 60 and above ranged from 3.7% in the Gambia to 7.7% in South Africa in 2015. However, the projected rates of population aged 60 and above by 2050 will increase on an average 2 times compared to the rates of 2015 (Graph 2). Population over 60 in South Africa will increase to 15% in 2050.

1.3 Demographic Determination of Ageing Process in PPD Member Countries

Among 26 of PPD MCs, the lowest Total Fertility Rate (TFR) is in Thailand which is 1.5 and highest TFR 6.4 in Mali in 2015 (Graph 3). Three of 26 PPD member countries namely, Thailand (1.5), China (1.6) and Colombia (1.9) have experienced below replacement level. Nine of 26 countries of PPD namely Bangladesh, India, Indonesia, Sri Lanka, Vietnam, South Africa, Morocco, Tunisia and Mexico have experienced TFR ranged 2 to 3. TFR in Pakistan, Egypt and Jordan is around 3 to 4. However, TFR in Sub-Saharan African region is very high compared to Asia, MENA and Latin America. Among the Sub-Saharan African countries the lowest TFR is in South Africa that is 2.4 in 2015 and the highest is 6.4 in Mali.

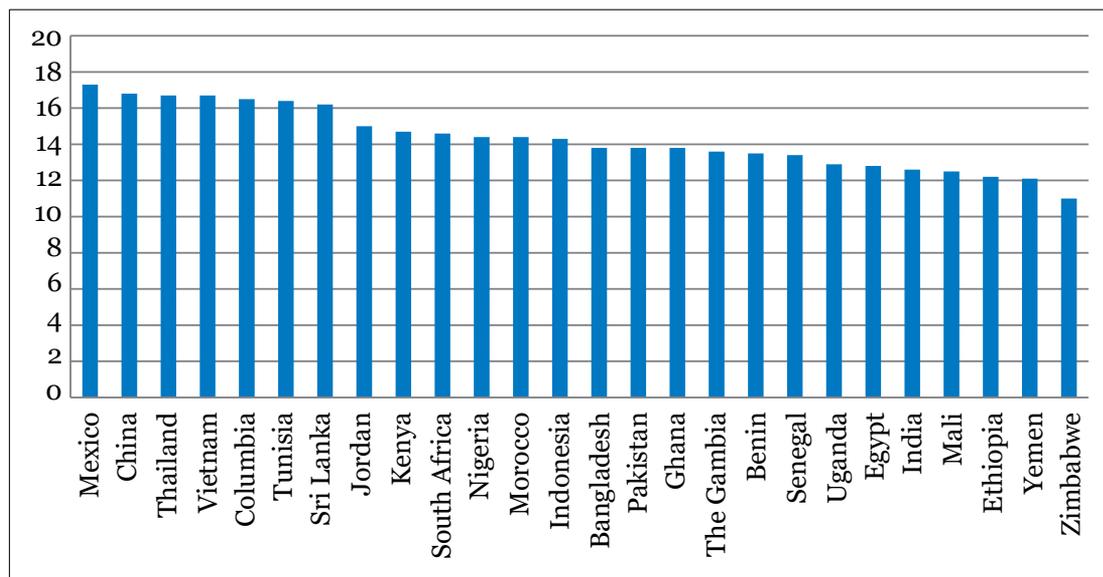
Graph 3: Total fertility rate (children per woman) of PPD MCs in the year 2015



Source: Data from “World Population Ageing 2015” (ST/ESA/SER.A/390).
United Nations, Department of Economic and Social Affairs, Population Division (2015)

Graph 4 shows among PPD member countries, Mexico has experienced the highest life expectancy at birth (male 74.0 and female 78.9) followed by China (male 74.0 and female 77.0) in 2015. Life expectancy at birth is lowest in Nigeria, that is (male 52 and female 52.6). Average female life expectancy at birth is higher than the male in PPD countries. Healthy life expectancy at age 60 is very indicative of ageing. Mexico has experienced 17.3 years and this is the highest, while Zimbabwe is the lowest with 11 years among PPD countries.

Graph 4: Healthy life expectancy at age 60 of PPD MCs



Source: Data from “World Population Ageing 2015” (ST/ESA/SER.A/390).
United Nations, Department of Economic and Social Affairs, Population Division (2015)

1.4 Country Situation in Ageing, policies and interventions

The following sections will summarise the findings of the selected PPD countries ageing situations or best practices in ageing:

1.4.1 CHINA

China report mainly focuses on the best practices on ageing since the Government of China has been attached with many innovative initiatives to offer

best services to the ageing population in China. This report presents findings of an experimental research program on Constructing Care Service Standards for the Elderly in Zhejiang Province in China. The research programme conducted by 2 prominent experts of ageing in China: Professor Chen Xueping and Ms Huang Huijuan.

China alone constitutes 1.37 billion population in the world. It has 230 million people aged 60 and above (16.7% of the total Chinese population) and 150 million aged 65 and above (10.8%). Nearly 150 million elderly suffer from chronic diseases, 40 million are disabled or partially disabled and about 10 million completely disabled among the total elderly population.

This report captured the different departments of the government of China's active involvement and experimental works in constructing the integrated medical care and nursing care system – home-based, community-supported and institution-supplemented – for the elderly since 2013. There has been notable progress made in the care system, facility level and programme implementation level. Emphasis has been given in two aspects: Promotion of the construction and development of extended medical institutions; developing standards and improving service capacities of various institutions.

It is suggested to extend the elderly's self-care ability as long as possible, and provide them with quality care when they lose the basic self-care ability that enables them to enjoy their old age in peace. Importance has been given in 3 areas: (i) build elderly care quality supervision agencies, set up a normal care quality management model, promote the implementation and constant improvement of care standards and raise the quality of elderly care quality; (ii) establish a sustainable learning model for improving the ability to care for the elderly. With the help of new information technology, the construction of existing video courses will be further improved to set up remote communication platforms that would make the courses available for the elderly and other service providers throughout the country and even to other countries; (iii) establish a set of new care methods with local characteristics that can play a role in functional exercise and physical and mental rehabilitation of the elderly, and improve the quality of life of the elderly.

1.4.2 GHANA

Ghana report was developed by Dr. Stephen O. Kwankye who is an expert in demography and development in Ghana. The report mainly highlights the situation of ageing and the opportunities for the elderly in Ghana.

With an estimation of 27 million total population, Ghana has the aged 60 and older at a total of 1.64 million that is 6.7% in 2015. Life expectancy at birth has improved from an estimated 45.5 years in 1960 to 52.7 years in 1984 but a larger number of the female population than the male attains the age of 65 years and above in Ghana. Elderly people in Ghana contend with many socio-economic challenges such as poverty, loneliness, neglect, cultural discrimination (e.g., accusation of witchcraft), etc. Old People's Home is slowly emerging as a result of the pressures of urban elderly people. The elderly population is economically active mainly in the fields of skilled agriculture and forestry (63.1%), service and sales (13.3%) and craft and related trades (8.4%), although their economic participation decreased with time. The government of Ghana adopted several ageing-related policies under the theme of "Ageing with Security and Dignity" to promote the social well-being of older people in Ghana.

There are several initiatives for the well being of elderly people like the National Health Insurance Act (Act 650) that make provision for exemption for persons who are more than 70 years and non-contributors to the Social Security and National Insurance Trust; exemption is provided for older persons who are 65 years and above, and registered under the Livelihood Empowerment Against Poverty, Cash Transfer Programme, upgraded pension scheme, lump sum payment on retirement and premium to access health services etc. NGOs and CSOs are also engaged in providing care and support towards realising healthy ageing in Ghana. However, still there is need to ensure healthy ageing and to guarantee comfortable and dignified life for the ageing population in Ghana.

1.4.3 KENYA

This report mainly captured evidence related to policies and programmes on elderly people from Kenya. Mr. Kichamu George Alusa, Commissioner of Global Commission on Ageing in Kenya has contributed to this report.

Kenya constituted about 1.9 million elderly populations who are about 5 per cent of the total population (2009). Among the elderly, over half are married and about one-third are widowed. About 1% elderly are divorced or separated and 2% have never married. Nine in every 10 elderly people mainly live in rural areas. Unlike other developing countries, elderly people in Kenya also face an increasing number of health difficulties as they grow older by communicable disease like Malaria/Fever (37%) and Flu (16%) and other non-communicable disease e.g. Backache (18%), Diabetes (4%), and Blood Pressure (5%) eye problem and 17% reported respiratory problems. HIV/AIDS is also afflicting older persons in Kenya. The educational achievement among elderly persons was generally low. Half of the older persons in Kenya live in absolute poverty and slightly under one-fourth of them are experiencing hard-core poverty.

The elderly population in Kenya is facing a number of challenges with the breakdown of societal structures and other support mechanisms that had been traditionally been in place to take care of their needs including protection of their human rights and dignity. The situation is aggravated by the fact that majority of the younger population who used to take care of them is also facing harsh economic difficulties and other challenges that increasingly make it difficult for them to attend to the needs of their ageing parents and relatives.

The Government of Kenya has adopted national policies on older person and ageing to provide an environment that recognises, empowers, and facilitates older persons to participate in the society and enjoy their rights, freedoms and live in dignity. It has also taken initiative to implement national programmes aiming to improve the wellbeing of older persons. These are the National Health Insurance Fund (NHIF), National Social Security Fund (NSSF), pension scheme, cash transfer, adult education, creating aged friendly environment for healthy ageing. It is recommended that there is need for progressive realisation of universal pension for older people. Initiative may be made to establish a geriatric and ageing units in all public hospitals. There is also need to have exchange of evidence based knowledge to better inform policy and programmes.

1.4.4 MEXICO

Professor Dr. Roberto Ham Chande, an expert in population studies contributed to this report. The report addresses the ageing situation within the social and economic context in Mexico. The total population of Mexico was 117.9 million with 6.0% at 65 or above. It is projected that aged 65 and over population will be 11.3% by 2030 and 20.2% will be at 65 or above of the total population of 156 million by 2050 in Mexico. Aged 62 and above mainly suffered serious health problems like, diabetes or hypertension, suffering sensorial impairments, having trouble performing daily life activities, and also the use of medical services. There are several programs dealing with the elderly population, but most of them are limited and narrowed in scopes. However, there is one very promising programme mainly focusing on health and aging in the National Institute of Geriatrics.

The other one is a combination of programs and actions on the crucial question of social security and retirement pensions. In Mexico, the modality of providing elderly support is through family support, social security, and public institutions. The main source of support for the elderly population always is family and kinship networks, particularly spouses, offspring and eventually grandchildren. The next source of support for elderly is social security, mainly retirement pensions. There are some public programs for aid and support of the elderly population, although they are limited. There is a non-contributory basic pension for people 65 and over in poverty. There is also the National Institute of Protection of the Elderly (INAPAM), dedicated to grant some benefits, such as discounts on purchase of basic goods and services.

It is recommended that considering the Mexican context, the elderly community required long-term care support – a pension for their economic security. It is necessary to have practical ideas on how to achieve “healthy ageing” that includes the well being in all. Building social and economic sustainability for the elderly population is another initiative to be considered by the government itself.

Further it is suggested that a computer tool could be used for projections within the south south collaboration on ageing. A population projections and scenarios building software is being elaborated by El Colegio de la Frontera Norte which follows the demographic components method and technically it is similar to other existing tools. It is being designed to admit projections parameters that are closer to middle-income countries. In its demographics those refer mainly to survival rates and mortality models that can be adjusted to assumptions on future life expectancies after age 60. To use the software it will be necessary to discuss how to define and quantify such variables in an interdisciplinary collaboration.

1.4.5 NIGERIA

The Nigeria report presented a general situation of elderly population in Nigeria. This paper contributed by Dr. Timothy Menakaya, Dr. Sanjo O. Faniran and Dr. Emem Omokaro.

In Nigeria, the population of the aged 60 and above reached 7 million in 2006 and projected to reach 9.7 million by 2020 and about 29 million by 2050. Aging is relatively a new field in Nigeria hence there is no available data on ageing. Initiative has been made for ensuring social security and income security of the elderly in Nigeria, such as, contributory pension, non-contributory pension etc. Till today about 7.8 million elderly people have been covered by contributory pension in Nigeria under the Pension Reform Act-2004. Three (Ekiti, Osun, Anambra) out of 36 states have acted independently to ensure income security for the elderly. It has revised its National Health Policy that regulates rights to health standard for all vulnerable groups, including the elderly. It is also mandatory that every Teaching Hospital in the country opens a Geriatric Centre.

There is insufficient trained workforce in the field of ageing for research, education, and patient care in Nigeria. The Government has not yet made any structural support dedicated to elderly care. However, traditionally the

family members extend their full hearted support to the elderly. The informal means of social protection are prevalent among individuals, households and communities. There are many social protection intervention schemes that provide a conducive environment to the caregivers and community. But there is no age-specific health programmes designed to provide health care for older persons among the respective Federal and State Ministry of Health.

Policy and law makers are not much aware about the older people's problem as it is rapidly growing in Nigeria. With ominous lack of comprehensive, high quality evidence of the magnitude, nature and implications of the population ageing challenge, policy makers are reluctant to address ageing issues effectively. It is recommended to given priority on public policy for the next five to ten years to enable policy environment, resources allocation, partnerships and disaggregated data on ageing and older persons.

1.4.6 SOUTH AFRICA

Dr. Monde Makiwane, an expert on demography has contributed to the South African report on ageing. This report highlights the current situation, policies and programmes as well as challenges related to ageing in South Africa. Unlike other developing countries, population of elderly in South Africa is facing a number of social, economic and health challenges.

The population aged 60 and above in South Africa is 7.7% million in 2015 and projected to increase 10.5 in 2030 and 15.5 in 2050. The rate of ageing in South Africa has differed according to race. Life expectancy was estimated at 62.5 years for the overall population of South Africa with female life expectancy being 64.3 and males being 60.6. The proportion of older women is significantly higher than that of older men and this is a significant feature of population transition in South Africa. The elderly people having severed difficulties in all functional domains as increase with age like seeing, hearing, communication, walking or climbing stairs, remembering or concentrating, and self-care. The specific causes of death among older persons are ischemic heart diseases, stroke, hypertensive heart disease, chronic obstructive pulmonary disease and diabetes mellitus. The quality of life of elderly differed according to race and

class and geographical disparities. Circular migration also determines the type of life that which older persons live. Majority of the older people in South Africa either live in multigenerational families or in skipped generational families. Changing nature of intergenerational relations has an impact in the ability of younger generation to dispense their obligations to the previous generation.

Since 1994, the Government of South Africa has taken different initiatives to extend the socio-economic and political support for the older persons. The Older Persons Act 13 of 2006 provides a comprehensive framework for the promotion of welfare of old people, protection of their rights, combating of abuse, and the provision of services and programmes. The National Department of Social Development has the central responsibility of overseeing the development of older persons. An independent alliance of organisations of older persons called “Older Persons’ Forum” was constituted in 2005 aiming to co-ordinate, mobilise and represent the collective voice of older persons. The Forum continued to lobby the government on issues that pertain to older persons up to this moment.

The government has introduced and strengthened an “Old Age Grant” that is paid monthly to all men and women who are 60 and above. This grant is the primary source of income for the majority of the elderly in South Africa. Apart from the government, NGOs and CSOs are contributing to establish and managing residential care for older persons in South Africa. It is evident that adult education is required since many older persons take care of the younger generations. The report recommends encouraging the support role of media and technology; supporting for voluntary and flexible economic and social participation of retired persons through recognising the value of older workers’ experience and designing sustainable health and care systems.

1.4.7 VIETNAM

Mr. Pham Vu Hoang, the author of the report, very meticulously presented the Vietnam situation in ageing including policy and programmes and challenges faced by the elderly. The total population of aged 60 and above reached 9.9%;

with this demographic transition, Vietnam has officially shifted into an ageing society in 2011. It is a leading country in Asia and one of the top countries in the world where ageing is increasing at speedily compared to even some developed countries like French, Canada, Australia, Sweden etc. The proportion of aged 60 and above of Vietnam is 10.3 in 2015. It is projected to reach 17.5% in 2030 and 27.9 in 2050. Life expectancy is 73.3 years of Vietnamese – that is equal to those of countries with much higher income but the healthy life expectancy is quite low (64 years). One of the prominent demographic characters of Vietnamese elderly population is people aged 80 and above will increase to the highest number by 2049.

Most of older people in Vietnam suffer from common diseases, such as: Stroke, hypertension, Type-II diabetes, chronic obstructive pulmonary disease, heart failure, vestibular disease, Parkinson's disease and osteoporosis. The knowledge level in taking care of and self-care for older people is still low and a large number of older people are unable to have adequate treatment.

Since 2000, the Government of Vietnam has taken remarkable action to face the elderly population burden. It has issued the Ordinance on Elderly People and along with it has implemented the National Action Program 2012–2020. The National Assembly of Vietnam issued the Law on Elderly People in 2009. Further, it has continued to strengthen its policies and programmes for the benefit of the different categories of elderly people. The Government has also established a National Institute of Gerontology, geriatric centres, and sport activities for older people.

It is recommended to increase awareness and knowledge of managers, policy-planners as well as the community on challenges of population ageing and older persons' life; to improve social security to ensure income for the elderly and extend different insurance schemes appropriate to older persons. It is also recommended to develop and maintain long-term health care models for older persons.

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CHINA



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1. Background

The size of the global ageing population is increasing at a rapid rate. Developing countries are facing challenges with the increased number of the elderly and the rapid population ageing. As the elderly grow older, their physical functions inevitably undergo a physiological decline. Most elderly people suffer from various chronic diseases or accidental injuries, and the number of elderly people with different degrees of disability and dementia is increasing.

Healthy ageing is the goal pursued by countries all over the world, especially developing countries while the construction of the care service standards for the elderly is a key to realise healthy ageing. In developed countries, care services for the elderly are mainly nurse-oriented. One of the important factors for healthy ageing is to improve the level of care services for the elderly and maintain the self-care ability of the elderly as long as possible. Developed countries have better healthcare service systems in which the main care-service providers are nurses.

The issue of quality of ageing life becomes important to nursing practitioners and nursing educators. Due to lack of quality nurses, the developing countries face different challenges when determining the construction of the care service standards for the elderly.

With an underdeveloped economy, the society does not have a well-established and nurse-oriented elderly care service system. The elderly care issue is becoming a serious challenge due to low literacy, lack of skill professional and lack of effective care quality supervision. It is clearly an issue that demands urgent attention.

China is a developing country with the largest population in the world. Its total population has reached 1.37 billion at present, and this includes the 230 million people aged 60 and above, accounting for 16.7% of the total population, and 150 million aged 65 and above, accounting for 10.8%. Of the 230 million elderly in China, nearly 150 million suffer from chronic diseases, 40 million are disabled or partially disabled and about 10 million completely disabled.

Compared to the number of elderly people, the number of registered nurses for the ageing care is very low in China. The total number of registered nurses in China is only over 3.5 million, the licensed nursing staff for the elderly is about 100,000, which indicates that there is huge scarcity of direct elderly care workforce in the sector.

The Chinese government has attached great importance to the care of the elderly people. The respective departments of the government have actively constructed the integrated medical care and nursing care system – home-based, community-supported and institution-supplemented – for the elderly since 2013. There has been notable progress made in the care system, facility level and programme implementation level. Emphasis has been given in two aspects:

- ❖ **Promotion of the construction and development of extended medical institutions.** The government has attempted to promote the construction and development of extended medical institutions such as nursing homes, rehabilitation of hospitals, encouraging the investment of social capital, building labor division and strengthening coordination mechanisms between different levels of health and medical institutions such as general hospitals, healthcare centres, rehabilitation hospitals, nursing homes, hospice care institutions as well as integrated-medical and nursing care institutions. The government has also attempted to improve the medical treatment– rehabilitation–long-term care service chains to cater to the multi-level and diversified healthcare service needs of the elderly people.
- ❖ **Developing standards and improving service capacities of various institutions** Importance has been given on developing standards and improving service capacities of various institutions. A number of construction standards and service guidelines of various institutions have been successively issued. Some of these are Basic Standards of Nursing Homes, Basic Standards of Clinics in the Pension Institutions (Trial), Basic Standards of Nursing Centres in the Pension Institutions (Trial), Basic Standards of Rehabilitation Hospitals, and Basic Standards of Hospice

Centres, as well as various other management standards, service manuals and training programmes so as to guide the orderly construction and development of pension service institutions throughout the country.

Shejiang, a coastal province of China, has a total population of over 54 million, in which the registered the elderly people aged 60 and above is 10.31 million, accounting for 20.96% of the total registered population.

Considering the above mentioned facts, School of Nursing, Qianjiang College, Hangzhou Normal University in close cooperation with the related local government departments has conducted an experimental research programme on care services for the elderly in Shejiang Province.

This programme has been succeeded to develop a series of “standards on care services” that fit into the Chinese social context. They have established a knowledge supporting system that correlates with the “standards” and adapts to the level of caregivers, and innovated technologies of care services. Efforts have also been made to integrate the implementation of the “standards” with the dissemination of knowledge, improvement of care services and promotion of mutual assistance services in communities. The experiment has yielded very encouraging results.

2. Research, Development and Implementation of the Elderly Care Service Standards

2.1. Living Conditions and Care Status of the Elderly

A systematic investigation, using various types of subject research, carried out in terms of the elderly care service institutions, the elderly living at home and the caregivers has arrived at the status and needs of both sides of the care services as follows:

2.1.1. Higher needs of healthcare and nursing care among the elderly

The demand for effective healthcare services is of vital importance for the elderly. They have a higher prevalence of chronic diseases, ranging from hypertension, osteoarthritis, coronary heart disease, diabetes, urinary incontinence to cognitive impairment successively. In addition, 6–19% of the elderly suffer from instrumental impairment of daily living ability, and 2–6% suffer from impaired basic living ability, with a higher proportion of impaired vision and hearing, all of which demand for greater care services in their daily life.

A total of 603 elderly people in urban communities were selected in cluster sampling survey: elderly with chronic diseases account for 79.1%, including 61.3% hypertension patients, 21.1% osteoarticular patients, 15.8% CHD patients, 14.9% diabetes patients, 11.3% patients of urinary incontinence, and 10.6% patients of cognitive impairment. The proportion of the elderly with vision and hearing loss influencing their daily life reach 62.4% and 36.5 %.

2.1.2. Lack of professional skills of care providers with improper care

There is a shortage of nurses in the elderly care service facilities and the elderly nursing providers are old with lack of profession skills. The national professional standards for the elderly care stipulate that the practitioners should at least be a graduate from the junior high school. However, in reality, 50% care providers are with a low level of education generally – primary schooling or even illiterate. Care is basically a type of functional replacement service, without the knowledge of rehabilitation nursing, health promotion or psychological caring, or practical care service standards. For instance, a general standard of care service may state that “it’s necessary to ensure there is enough drinking water for an elderly person”, but the caregivers know little about the importance of drinking water and do not have such micro-operation specifications as “how much water to drink” and “how to arrange the drinking”. The disabled elderly persons, especially those with urinary incontinence, generally cannot get enough drinking water, and this is a serious issue.

2.1.3. Spouse and children are the main caregivers for the elderly living at home and they lack care knowledge, awareness and approaches to seeking help

Currently, the total number of beds in pension care service facilities in China is about 4% of the total number of elderly people; 96% of the elderly need to be staying at home. Spouse and children are the main caregivers for the elderly people living at home with an average age of over 60 years. Most of the caregivers are female and they lack care knowledge and awareness for seeking help. More than 50% caregivers give a wrong answer or fail to answer such questions as to why the body has to

be regularly turned over for the paralysed elderly, the frequency of the turning over, hazards of forced defecation, the quantity of drinking water every day, and prevention of orthostatic hypotension. Only 15.3% and 17.1% caregivers give right answers for emergency treatment for an elderly person who has had a fall and the temperature of the warm water bags for the elderly respectively. Lack of such knowledge may have negative impacts on the daily care of the elderly resulting in further serious negative impacts such as pressure sores, scalds, orthostatic hypotension, and cardiovascular and cerebrovascular accidents. More seriously, under the influence of traditional ideas, almost all of the elderly believe that it is not necessary to learn additional skills on how to take special nursing care of their disabled spouse. At the same time, there is a lack of specific nursing care trainings and sufficient social support systems for caregivers of the elderly living at home.

Caregivers of the Disabled Elderly

The fourth survey on the status of elderly population in urban and rural areas reported 9,600 older people in Shejiang province, among whom for 826 disabled elderly, the average age of caregivers is 62.93 years old; the caregivers are spouses (46.1%), children (33.0%), daughters-in-law (7.6%), housekeepers (8.7%), grandchildren (0.7%) and others (3.9%).

2.1.4. Lack of care service standard and quality supervision system

There is no national uniform standard for the elderly care service sector. Instead, there are varied grades ranging from 1 to 11, resulting in the disunity of care grading – inconsistent names of grading such as Special Care, Rehabilitation Care, Fourth Grade Care and Rescue; different standards for care grading. Most pension institutions grade the care by medical care habits, in which the elderly persons with Grade III care are fully able to take care of themselves, while some others are completely opposite, for which the elderly persons with Grade I care are fully able to take care of themselves.

With different grading procedure, some care service facilities even grade the care by the wishes of the elderly, while others grade by the economic situation or self-care ability of the elderly. It was found that the standards of fees for various care services differ from place to place. Additionally, without standardised admission-for-hospitalisation assessment, the elderly with dementia and mental disorders fail to receive attention and good management, resulting in more accidents of loss or injuries. There is widespread practice that does not follow the care service standards, such as sharing towels and nail clippers, and the use of 95% alcohol for disinfection. The models for supervision system – be it quality and performance – have not been put in place, resulting in failure to establish good quality standards and supervision agencies.

2.2. Development of Care Service Standards, Construction of Care Knowledge Supporting System and Innovations in Care Delivery Technologies

Based on the detailed understanding of the current status, and systematic studies on the elderly care system of some developed countries such as Japan, Germany, Australia, and the United Kingdom as well as China's Hong Kong and Taiwan regions, the experimental research team has been carrying out the ten years' exploration on "the standardisation of elderly care service provision" under various policy and system environments. These could come under the following:

2.2.1. Setting standards for care services

China currently does not have sufficient number of high-quality nurses working in the field of pension care services, or nurse-oriented care service system. Therefore, it is necessary to establish service standards and evaluation criteria suitable for the current situation of the care service providers, guiding and promoting service level with the construction of the “standards”. For this, we systematically studied the national professional standards of the elderly nursing care, explicit and implicit care service needs of the elderly and current situation of pension care services, listed the items of the care services for the elderly, established service standards and revised them along with the experiment and expert consultations. As an outcome of the experiment, a set of elderly care service standards have been published and implemented, such as the *Procedures for the Elderly Care Delivery, Standards and Evaluation Criteria of the Elderly Care Services of Pension Care Institutions and Standards of Pension Care Services for the Elderly Living at Home*.

The *Procedures for the Elderly Care Delivery* lists 52 technical service requirements, considerations and service processes for the care. The service processes are illustrated in diagrams, and some are popular science pictures suitable for caregivers with different educational background. At same time, we have established a set of care service assessment standards, and made the commonly used service delivery methods into videos that can be checked and learned at any time for the delivery of elderly care services.

Following this idea, *Standards of Pension Services for the Elderly Persons Living at Home* lists 131 items of services in 16 sections according to needs, status and development trend of the services for the elderly persons living at home, specifying the standards of the services one by one. According to the current situation of pension service institutions, the *Standards and Evaluation Criteria of the Elderly Care Services of Pension Institutions* provide normative service requirements such as life care, disease care, psychological care, recreational and safety protection from the perspective of structure, responsibility, system and service scope in the care service institutions.

The main features of the above standards include:

- ❖ **Matching with the educational background of caregivers:** Different from the approach of focusing on the nurses in developed countries, here the low educational background of the caregivers is given priority. The presentation of the standards is more concise, process-oriented, image-oriented and video-oriented, and it is easy and convenient to learn and implement by caregivers.
- ❖ **Connection to reality:** As most of the elderly persons in China are living at home with the care given by family members, basic knowledge and skills of care services should be transmitted to communities and families. The “norms” tend to be combined with daily life.
- ❖ **Integration of information and technology development:** The new development of modern information and technologies – network platform appointment making, e-platform communication, and e-technowledge applications – is integrated into the services, enabling quality care services.
- ❖ **Emphasis on the integration of prevention and rehabilitation:** Emphasis is given on the maintenance of the elderly person’s own abilities and the prevention of accidents such as falls, cardiovascular and cerebrovascular accidents, choking over food, aspiration, orthostatic hypotension and loss, and integrating the concept of maintaining the elderly person’s self-care abilities into each item of services.

2.2.2. Establish a care knowledge supporting system

At present, caregivers’ educational level and professional quality are not high, while homebased care services are mainly provided by family members who lack caring knowledge. The popularisation of basic knowledge and skills of care to caregivers and community population comprise the basis for good application and implementation of the “standards”. It has been systematically sorted out the basic knowledge and skills of care, developed video-oriented knowledge carriers, established distant learning courses, carried out online and offline combination of knowledge dissemination, and set up the following knowledge supporting system that matches with the standards:

- ❖ **Innovating knowledge carriers:** In the practice of popular science education and from the perspective of healthcare and nursing care for the elderly, we found that learning knowledge in a visualised, skills-oriented and life-oriented style is more suitable for the memory and thinking ability of the elderly, and it becomes easier to inspire the elderly to learn. Special attention is paid to video orientation and operability of the knowledge points. For instance: The elderly tend to suffer from orthostatic hypotension when waking up in the morning and most books generally claim that the elderly persons should get up slowly. For the sake of memorising with ease, we have developed standards where the elderly persons are told to get up in three 30-seconds, that is the first is 30-seconds for waking up, the second is 30-seconds for sitting up in bed and the third is 30-seconds for sitting on the side of the bed with legs dropping downwards, and finally they should stand up slowly. All of this is composed in the ‘Getting up Exercise’. But in reality, the elderly persons cannot perform it well. Therefore, we further have developed the ‘Health Getting-up Exercise’ in combination with TCM and Western medicine principles. We have prepared videos for these that could be attached via QR code to the cubic book, Handbook of Elderly Volunteer Services that covers 88 micro videos to be read with the Smartphone and TV.
- ❖ **Establishing distance learning courses:** These videos are loaded in APP to establish distance courses (<http://medulive.com/>), and the elderly, caregivers and volunteers may use the Smartphone and Smart TV to study and inquire at anytime and in any place.
- ❖ **Setting up knowledge dissemination models with the combination of online and offline learning courses:** In combination with online courses, offline training rooms are established in two pilot communities, and are equipped with necessary training aids for carrying out two kinds of Training Models for Trainers:
 - i) Community nurses should be trained first, then they in turn can train the elderly persons, caregivers and volunteers in communities in combination with online learning courses;
 - ii) Volunteers in communities should be trained first. Then they can train others in the communities, in combination with online learning courses.

After a couple of years' attempts, both models have received very good training results.

2.2.3. Care technology innovation

Innovations are the important connotations of “Standardisation”. Nursing care for the elderly is not simply functional substitution, but a professional job that can sustain the elderly self-care ability as long as possible. However, due to the lack of professional quality in China's elderly care service sector, it becomes difficult to carry out innovative work in preventing disability, self-care ability rehabilitation and health promotion. Therefore, we try to promote the functional maintenance and quality of life of the elderly through the design of a series of practical daily care techniques.

For instance, Listening Exercises is one such technique we designed:

- ❖ Change of pressure of the external auditory canal leads to the movement of the tympanic membrane and the ossicular chain of the middle ear, stimulating the circulation of blood;
- ❖ Point massage promotes blood circulation of the inner ear, delays ageing and improves hearing through the meridian principle of Chinese medicine. The scheme is designed on the basis of previous studies, and then experiments are carried out in the community. 70 hearing-impaired older people are divided into the experimental group and control group. The experimental group keeps listening to exercises twice a day for 18 weeks, and it is found that the subjective hearing and speech recognition rate of the elderly improve, but there is no effect on high frequency hearing loss. After that, the listening exercises are converted into a video and disseminated through the Smart community pension service platform. This has been well received by the elderly in the community. According to this idea, we have successively designed: an active finger-movement exercise that can improve hand grip strength in elderly patients; passive finger massage exercise that can improve the symptoms of dementia; and the rehabilitation exercise that can improve the function of the upper limb. The subsequent serial care techniques about “Healthcare for the Elderly” are in the process of development as planned.

2.3. Implementation of the Standards

2.3.1. Promoting the policy development

In the study of the current situation and the “standardisation”, a series of policy recommendations have been made to the relevant government departments on various aspects such as graded nursing, respite care, evaluation system, training of care service providers, etc. Active participation was ensured in the formulation of relevant policies of the local governments, the drafting of local standards for pension services in Zhejiang Province, and the master training programmes for service providers. The local governments have offered great support and assistance in successful application and implementation of the standards.

2.3.2. Establishing on a demonstration pilot basis for implementation of the standards

Two pension service institutions and two communities were selected to implement the standards by jointly building the demonstration pilot bases. Initially, we worked with the pension service agencies to promote the implementation of the standards with the following methods:

- ❖ Establish a “Care Centre” in each of the pension service institutions and set up the goals of joint cooperation: establishing a care quality management system under which care assistants are trained by nurses and nurses play the main role.
- ❖ Set up a working group: 3 experts in elderly nursing acted as instructors, and 13 nurses from the institutions selected as the main members of the working group.
- ❖ Set up the objectives of the working group: Nurses in the working group undertake the orientation training and further education of caregivers. The nursing management system in the care service institution is rebuilt and implemented.
- ❖ Establish communication platform and incentive mechanism: With mentor guidance and group discussion, the group decides the task of each nurse every week. Set aside half a day for training and discussion every week for a year. The training of nurses, the development of management systems

and other tasks are evaluated by the mentor, and the performance of the outstanding staff is the basis for the promotion and post appointment of the institution.

Focused on the approach of Nurses Training Caregivers and Reconstruction of Pension Service Management Process, we guide the development of service standards consistent with the current status of the institution, and advance the training capacity and management capacity of the nurses. After a year's efforts, the evidence shows that the nurses' subjective initiative has much better developed. The abilities of nurses have strengthened, and their knowledge and skills have improved in the process of training the caregivers. The management abilities of nurses have also improved in the process of the elderly care management, and in the revision, implementation and assessment of service standards. A system for elderly care quality management, and the model for nurses training care assistants have been established in the care service institution under which the nurses are the main actors.

The other experiment conducted in cooperation with selected communities is to promote the implementation of the standards in combination with exploring the approach for mutual support pension services. The specific methods are as follows:

- ❖ Signing a joint cooperation agreement: This was between the experimental research team, the communities and the home care service agencies to establish “a mutual support pension service base”.
- ❖ Organising volunteers for mutual support pension services: The communities have organised the elderly volunteers, and the experimental research team has organised nursing volunteers. Home care service agencies are responsible for the publicity and management of the community mutual support pension services. Offering training and certification to volunteers for mutual support pension: The offline training rooms were set up in the community. These are combined with the online distance learning courses, providing training to volunteers who participate in mutual support pension service, issuing certificates to qualified volunteers, and organising community mutual supporting services.

- ❖ Drawing up the catalogue of mutual support pension services and standards of service for the elderly: According to the current home care services demand and mutual service ability, 10 common services are selected as service items of this mutual support exploration – assistance in climbing stairs, assistance in wheelchair, home visits, assistance in participating in community activities, washing hair in bed, accompanying during hospital visits, training on finger exercises and hearing exercises, training on food choking prevention and first aid, and psychological counseling. The standards for mutual support are applied in training.
- ❖ Managing mutual service information and establishing incentive mechanisms: Supported by the China Population Welfare Foundation Project, the mutual support information management system was designed by the National Population and Health Science Data Sharing Platform/the Population and Reproductive Health Science Data Centre (http://101.200.179.2/yanglao_jy/index.php), holders of training certificates provide services for the elderly and their service information is recorded in the Service Time Bank of the information platform as the service savings.

2.3.3. Promoting academic exchanges

During the drafting, discussing, implementing and modifications of the standards, we have not only invited the participation of the experts on the elderly care from the Gerontological Society in Shejiang Province, but also the participation of the frontline caregivers. And great attention has been paid on the international exchanges also.

2.3.4. Disseminating concepts, providing methods and promoting the implementation of standards in the process of education and training

Following the series of pension service policies issued in Shejiang Province, Shejiang Provincial Civil Affairs Department and Hangzhou Normal University, Shejiang Provincial Elderly Service Management and Education Training Centre with the mandate to carry out training on elderly care and old-age service management for the personnel across the Province, and set up a new Bachelor's major on Elderly Care Services and Management.

At the same time, we developed professional appraisal manuals of caregivers, undertook the construction of a professional examination bank for medical care providers, and organised the skills competition of the care providers across the province. In the courses of education and training, we have disseminated concepts, provided innovative technologies, and pictures of popular science and standards as teaching materials to trainees so as to promote the implementation of the standards.

3. Main Results

3.1. Developed a Set of Standards for the Care Services in Accordance with the National Realities

Since China does not have a well-established nurse-oriented care service system, on the basis of a thorough understanding of the status quo and with reference to domestic and international experience, we have developed a set of operational standards of care services and a set of standards on institution-based and home-based care services with Chinese characteristics, and improved them in practice as much as possible. The ways of presenting the standards are based on the caregivers, integrating the concepts of prevention, rehabilitation and innovation. At the same time, in combination with the status of traditional home care in China, we pay high attention to carrying forward the care and rehabilitation function of Traditional Chinese Medicine TCM care in the elderly care services by closely connecting to daily life and matching to the traditional culture.

3.2. Established a Knowledge Supporting System that is Connected with the Standards

Based on the present situation and characteristics of the care-givers, we innovated knowledge carriers, making the basic knowledge and basic operation on care services into videos, publishing cubic books, and establishing remote training courses and community training rooms, promoting knowledge dissemination with combination of online and offline approaches.

Personnel Training in the Past Five Years

(1) Offline training: we have trained more than 2,000 caregivers at various levels; over 500 management in pension agencies; over 500 trainers on the elderly care in Shejiang Province; over 200 personnel in the elderly care service and management; over 5,000 young elderly, elderly service volunteers and others.

(2) Online learning: we have had more than 400,000 visits of distance courses and cubic books.

3.3. Achieved Good Results in Implementing the Standards and Knowledge Dissemination

The standards have been well implemented in the four pilot bases cooperatively built, and nearly 30 nurses of two pension agencies have received one-year long training on capacity building and subsequent consultancy services. More than 500 home caregivers, volunteers and the young elderly persons have received training in the two communities. The mutual support services have been offered according to the standards. The total amount of mutual support service of one community in a year reached 15,314 minutes. We disseminate the concepts and promote the application of standards via various trainings and skills competitions.

3.4. Promoted the Issuance of Related Policies

During the construction of the standards, we have made a series of policy recommendations, and promoted the release of such policies as: Respite care, evaluation system, personnel training and the popularisation of popular science on elderly care service, participated in the development of Shejiang Provincial Standards of Service and Management of Pension Institutions, and the implementation of graded care standards. At the same time, entrusted by the relevant government departments, we have carried out personnel training, developed and implemented the academic education programmes on Elderly Care Service and Management (Junior College) and teachers' training programme on elderly care in Shejiang Province.

3.5. Promoted the Health for the Elderly by Advancing Innovations in Care Technologies

The researches on innovation of care technologies have combined with traditional Chinese medicine care methods and the elderly care and rehabilitation measures. In the experimental validation study, hearing exercises have improved the subjective hearing and speech recognition rate in the elderly, finger movement exercises have improved the holding power in the elderly, passive finger exercises have improved the mental symptoms of the elderly with dementia, and somatosensory play has raised the cognitive function of the elderly with dementia to a certain extent. On this basis, the relevant technologies are taken into video and loaded into the Smart pension service platform to widely promote and apply in the community and pension institutions those that play a better role in the elderly healthcare and rehabilitation.

4. Main experience

4.1. Integrating the Implementation of Standards with Knowledge Dissemination and Capacity Improvement

With China's family care culture for thousands of years having affected people's identification on care services, the standardisation and professionalism of care services for the elderly have been neglected. The implementation of the standards is also a process of popularising the knowledge. We have innovated the knowledge carriers in formulating the standards, making cubic books and video courses connected to standards as the carriers of spreading basic knowledge. We have implanted the idea of standard services, provided specific methods and trained abilities in education and training, and we have disseminated the importance and professionalism of care in improving the quality of the care teams that mutually benefit.

4.2. Integrating the Implementation of Standards with Innovations in Care Technologies

Innovations in care technologies may provide new methods for care, improve the level of care and promote the physical and mental health of the elderly. At the same time, it can improve people's awareness of the professionalism of care, and also enhance the professional confidence of knowledge dissemination and the implementation of the standards.

4.3. Integrating the Construction of Pilot Bases with the Promotion of Policies

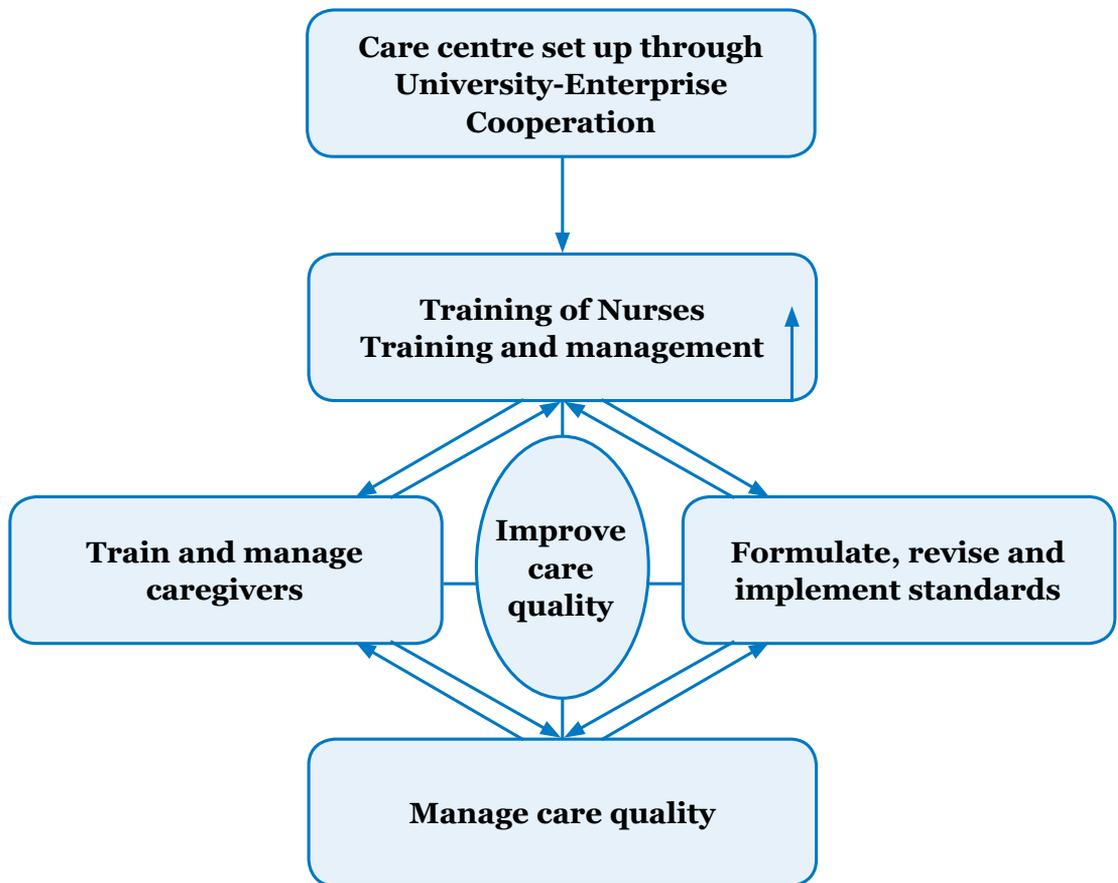
We enhanced the academic status of the team through the standard formulation, policy research and academic exchanges, and, while relying on the influence of the care service sector and the cooperation with pension institutions and communities, jointly built a demonstration base, promoting the implementation of standards in the base in different forms and accumulating experience.

At the same time, we submitted policy recommendations to the related government departments to promote the construction of relevant systems and the implementation of local standards, and made better promotion at the policy level. For instance, the preliminary research found a lack of knowledge of family caregivers, and we submitted recommendations: The humanistic Respite Service System should be established to relieve the stress of care by improving the ability of family caregivers. Relevant government departments promulgated the policy of "Knowledge and skills of care for the elderly to go into the communities and into the families", we then undertook the elderly care training of master trainers across the province, in which we spread the concepts and methods of standard services and further promote the application of standards that are mutually promoted.

4.4. Strengthening Nursing Training and Improving the Care Quality of Medical Care Institutions

Vigorously promoted by the National Health and Family Planning Commission, integrated medical care and nursing care institutions have developed rapidly. Such institutions have a certain number of nurses and it is better to improve the care quality by strengthening the trainings and management for nurses and promote the implementation of standards on care services. We provide the practical mode of promoting the quality of care through the cooperation between universities and enterprises that can be referred to in Figure 1.

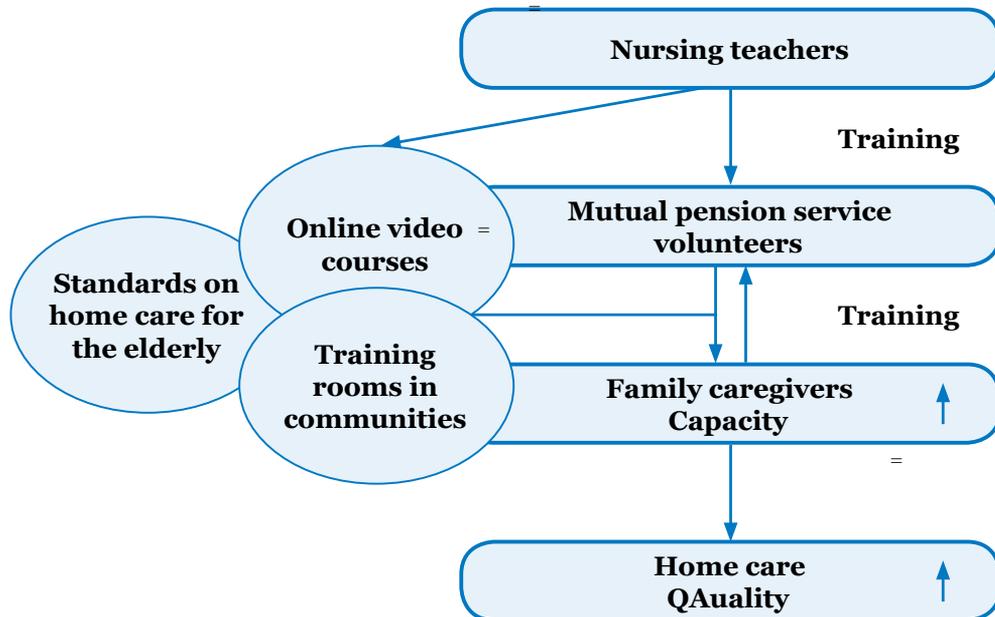
Figure 1. Mode of improving care quality



4.5. Promoting the Establishment of Knowledge Supporting system of Family Caregivers with Community Mutual Services

Home care for the elderly is the basis of care services and mainly assumed by family members. Family caregivers are important components of the whole care team, and improving their care provision abilities is social responsibility as well as government function. The National Health and Family Planning Commission initiated the pilot of the New Family Plan in 2014, and carried out the practical exploration of Family Care and Family Health Capacity Building, both of which are similar to such initiatives as “Knowledge and skills of care for the elderly going into the communities and into the families” being implemented in Zhejiang Province. Under the support of these policies, we combined the experience of promoting this project, set up and managed mutual care services, used mutual service teams to provide guidance and assistance to family caregivers, established the knowledge support system and raised the family care capacity in combination with online and offline resources. This is shown in Figure 2.

Figure 2. Training mode of trainers improves the quality of home



5. Problems and Countermeasures

5.1. The Unified Care Service Standards in the Pension Service Sector should be Established

From pension services, different regions have different standards such as grading care and that is the most basic work but difficult to implement in a unified standard. The key is lack of awareness of professional care and under the influence of traditional culture, the care provision focuses on the emotional inputs instead of professional and scientific management. It is expected that the relevant government departments strengthen the coordinated management and establish the unified standards.

5.2. The Community Nurses should Play Bigger Roles in Promoting the Combination of Medical Care and Nursing Care, and in Building care Quality Supervision System

Currently, there are limited nurses and they only provide medical care services. Over the past two decades, the Chinese government has attached importance to the development of community nurses, and are training community nurses to become better in both quantity and quality. They should be empowered in the training of caregivers and in the management of care services. The community nurses' original functions include community elderly care, chronic disease management, family care, community rehabilitation and health education, based on which, this increases the guidance and care supervision to caregivers provided by community nurses and can better integrate the care with nursing and improve the care quality.

5.3. A Care Quality Supervision System should be Established

The implementation of the standards is the basis of service quality. Quality supervision may promote the protection of implementing standards that can

guide and advance the constant improvement of care quality. Supervision is not only to supervise and more importantly to guide the development. Learning from the experience from foreign countries, it is necessary for China to enable professional academic institutions to play a bigger role, set up quality supervision agencies, improve the care service standards, and constantly improve quality through academic exchanges and training.

6. Replicability and Generalisation

Different from the nurse-oriented description in developed countries, the care standards we have formulated start from the role of caregivers with focus on detailed standards under nonmedical conditions, and are applicable to families, care service institutions and other places as well as to care services for old patients in hospitals. They are basic technique standards on the elderly care and general standards. The outcome of experimental project proves that innovative care technologies that carry forward the theories of traditional Chinese medical care can promote the functional exercise with physical methods, facilitate the physical and mental restoration of the elderly and reduce their discomforts. The distance courses connected with the standards, and video-oriented and practical knowledge carriers of basic knowledge and skills are particularly applicable for the elderly and caregivers to learn and spread among communities. This can be introduced in other countries, especially developing countries in combination with their national conditions and cultural background.

7. Future Expectations and Challenges

The goal of the elderly care is to extend the elderly's self-care ability as long as possible, and It is the goal of the elderly care to extend the elderly's self-care ability as long as possible, and provide them with quality care when they lose the basic self-care ability that enables them to enjoy their old age in peace. Continued efforts will be made in the following three areas and look forward to more supports.

1. It is necessary to build elderly care quality supervision agencies, set up a normal care quality management model, promote the implementation and constant improvement of care standards and raise the quality of elderly care quality.
2. It is essential to establish a sustainable learning model for improving the ability to care for the elderly. With the help of new information technology, the construction of existing video learning courses will be further improved to set up remote communication platforms that would make the courses available for the elderly and other service providers throughout the country and even to other countries.
3. New technologies on care for the elderly have been developed continuously to establish a set of new care methods with Chinese characteristics that can play a role in functional exercise and physical and mental rehabilitation of the elderly, and improve the quality of life of the elderly.

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GHANA



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Esther Cofie



1. Background

Ghana has a rapidly growing population that is youthful, but is gradually ageing. The working age population is also expanding similar to many developing countries. In addition, several other sectors of the country have expanded over the past few decades. In 2010, the country attained lower middle-income status. Ghana recorded significant expansion of the economy though it remains largely agricultural and extractive with a small industrial and manufacturing sector and an emerging oil and gas industry. Poverty levels have since 2005 declined from 31.9 per cent to 24.2 per cent in 2013 (Ghana Statistical Service, 2014). Cultural and religious beliefs are still strong in many Ghanaian communities. Yet, the strong extended family system that provides support for its members is gradually weakening in the face of rapid urbanisation, migration and economic hardships. In addition, the population is confronted with a double burden of diseases since non-communicable diseases (NCDs) appear to be on the rise alongside communicable diseases. It is within this context that this article attempts to ensure healthy ageing for all persons in Ghana while undertaking an assessment of ageing and health in Ghana to guide policy formulation and programming in the country.

An assessment of the situation of ageing will help in identifying relevant gaps towards achieving a process of healthy ageing in the country for policy attention. The article provides background information on the demographic, social and health transitions in the country to help place the discussions in context. Additionally, to determine their impact, it assesses policy and programme interventions targeted at the elderly population.

2. Demographic, Health and Social Transitions

2.1. Demographic

Ghana's population is estimated at 27 million at the end of 2015 based on the average annual growth rate of 2.5 per cent between 2000 and 2010. The proportion of urban population as of 2010 was 50.9 per cent. Ghana's

population is characterised by a youthful structure with a broad base that has, since the last two decades, been reducing due to steady decline in fertility while the number of elderly persons has been increasing. As of 2010, the proportion of the population aged less than 15 years was recorded at 38.3 per cent, having declined from about 47 per cent in 1970. The population of adolescents (15–19 years) and young adults (20–24 years) accounted for about 20 per cent of Ghana's population while persons 60 years and older were 6.7 per cent compared to 5.2 per cent in 1970. Similarly, the proportion of the population 65 years and above was 4.7 per cent in 2010 compared to 3.6 per cent in 1970 (Ghana Statistical Service, 2013).

2.2. Socio-Economic Situation

Ghana attained a lower middle-income status in 2010 and recorded an expansion of the economy with GDP per capita income standing at US\$1,838 in 2013 (GSS, 2014). The economically active population increased from 5.6 million in 1984 to 10.9 million in 2010. Analysis of the 2010 Population and Housing Census (PHC) indicates that the proportion of workers in the informal sector continued to rise, reaching 86.2 per cent in 2010 (i.e., about 8 in every 10 self-employed persons were in the private informal sector). The formal sector, whether private or public, engaged less than 10 per cent of the workforce in the country (GSS, 2013).

Ghana has since 1993 enjoyed stable democratic governance with respect for human rights, the rule of law, independence of the judiciary and a free and vibrant media. Literacy rates are higher among males (80.2%) than females (68.5%) and among residents in urban areas (84.1%) than in rural areas (62.8%). Although the extended family support system continues to be relevant, it is gradually being eroded with rapid movement towards the nuclear household organisation. Persons with Disability (PWD) accounted for three per cent of the total population of Ghana in 2010 and numbered 737,743. Disability varies by age, with sight and physical disabilities being highest among the elderly population.

Life expectancy at birth in Ghana has improved from an estimated 45.5 years in 1960 to 52.7 years in 1984 (NPC, 2014). Results of the 2010 PHC show that the life expectancies at birth for males and females were 60.2 years and 63.4 years respectively. Thus, a larger number of the female population than the male's attains the age of 65 years and above (GSS, 2013). However, Ghana, like other Low and Middle Income Countries (LMICs) faces a double burden of high levels of both communicable and non-communicable diseases (NCDs), with the majority of older people dying of NCDs than from infectious and parasitic diseases. Childhood mortality rates have declined in the past 26 years with infant mortality declining from 77 deaths per 1,000 live births in 1988 to 41 in 2014. During the same time period, under-5 mortality has sharply decreased from 155 to 60 deaths per 1,000 live births (GSS, GHS, ICF International, 2015). Maternal mortality, however, is still high at about 380 per 100,000 live births.

2.3. Elderly Population

Globally, the population aged 60 years and over is expected to almost triple, from 841 million in 2013 to two billion in 2050. These older cohorts will outnumber all children under the age of 15 by 2050, thus exceeding the number of young people in the world for the first time in history.

In Ghana, the elderly population is projected to represent 14 per cent of the total national population by 2050. This will be more than twice the figure 6.7 per cent that was recorded in the 2010 PHC Report. The total national population is projected to be about 33 million by 2030 and more than 40 million by the year 2050 (GSS, 2013). As is shown in Table 1, the population aged 60 years and above is projected to reach 2.8 million by 2030 and 5.8 million by 2050 (GSS, 2012). The elderly female population is expected to continue to be higher in proportion than males, even as life expectancy continues to increase.

Table 1. Population of the elderly in Ghana, 1960–2050

Age	1960	1970	1984	2000	2010	2015*	2020*	2030*	2040*	2050*
60–64	118,039	146,378	225,776	366,351	475,849	570,616	676,001	985,345	1,391,701	1,869,982
65–69	60,958	94,218	145,309	258,709	293,871	419,501	508,187	744,489	1,080,084	1,506,527
70–74	56,529	82,392	128,866	225,158	351,330	313,254	348,799	511,214	765,469	1,111,907
75–79	30,961	42,262	71,813	144,830	205,953	223,087	231,082	321,277	489,003	738,709
80+	61,107	205,164	341,533	370,243	316,378	274,290	244,651	256,692	370,210	587,274
Total	327,594	570,414	913,297	1,365,291	1,643,381	1,800,748	2,008,720	2,819,017	4,096,467	5,814,399

Source: *Ghana Statistical Service, National, Regional and District Population Prospects 2010–2050*

3. Ageing Situation in Ghana

A total of 1,643,381 persons were recorded to be 60 years and over in Ghana in 2010 and represented 6.7 per cent of the total national population. It must be noted that although this population represented a decline from 7.2 per cent in 2000, in terms of absolute numbers it showed a seven-fold increase from 213,477 in 1960 to 1,643,978 in 2010. Over two-thirds (68.2%) of the elderly population is classified as young-old (60–74 years) and approximately one in ten (9.6%) is very old (85 years and over). Females outnumber males in the elderly population that is consistent with the higher life expectancy of females than males in Ghana.

The rural population in Ghana is more elderly than the urban: 54 per cent of the rural population and 46 per cent of the urban population were recorded to be elderly in 2010. Rural-dwelling older persons are faced with greater challenges due to the disadvantage they suffer from on account of inadequate provision of basic infrastructure and amenities, sanitation facilities and safe drinking water compared to their counterparts in urban areas. This may create extra burden on caregivers of elderly people to provide support for them to access alternative means of basic amenities and facilities. It must be noted, however, that there

may be available more caregivers in rural settings than in urban areas where the demands of the labour market and poor human inter-relationships may make it difficult for even close family members to provide adequate care for the vulnerable, including the elderly, children and the sick. Indeed, an emerging phenomenon in urban areas is the Old People's Home that was unheard of a few years ago in Ghana, but is slowly emerging as a result of the pressures of urban life. According to the 2010 PHC, the elderly population is economically active mainly in the fields of skilled agriculture and forestry (63.1%), service and sales (13.3%), and craft and related trades (8.4%) although their economic participation decreased with time (GSS, 2013).

Depending on the kind of care giving and social support that may be available to the elderly population, the number of years of healthy life elderly people who survive to age 60 years would live, may vary. The Ghana Statistical Service (2013:190) developed empirical life tables for males and females based on the 2010 Population and Housing Census data. Information from these life tables suggests a life expectancy at birth of 60.24 years for males compared to

63.4 years for the females in the general population in Ghana. It also shows that females who survive to age 60 have a higher probability of living more years (23.02 years) compared to their male counterparts (18.42 years).

In Table 2, the United Nations (2015) World Population Ageing Report indicates life expectancy at birth during 2010–2015 at 60.1 and 62 respectively for males and females in Ghana; life expectancy at age 60 is estimated at 15 and 16 respectively during the same period with a total fertility rate of 4.2. The report further shows that healthy life expectancy as of 2013 in Ghana was 53 years and 55 years respectively for males and females while the potential support ratio relative to persons aged 20–24 per person aged 65 or more was at 14 in 2015 and is projected to reduce to 12.7 in 2030.

From the information presented in Table 2, we estimate that 11.8 per cent and 11.3 per cent of the estimated life expectancy at birth of males and females respectively would be lived as unhealthy, most likely in conditions of disability

due to non-communicable diseases associated with ageing. This compares with an estimated 12.2 per cent and 12.0 per cent of the life expectancies respectively for males and females estimated as unhealthy livelihood at the global level.

Table 2. Ghana's life expectancies – at birth, and age 60, healthy life expectancy and potential support ratio compared with global averages

Country	Total Fertility Rate	Life expectancy at birth, 2010–2015		Life expectancy at age 60, 2010–2015		Healthy life expectancy (years), 2013		Potential support ratio (persons aged 20–24 per person aged 65 or over)	
		Males	Females	Males	Females	Males	Females	2015	2030
Ghana	4.2	60.1	62.0	15.0	16.0	53.0	55.0	14.0	12.7
World	2.5	68.3	72.7	18.7	21.5	60.0	64	7.0	4.9

Source: *Extracted from United Nations, 2015. World Population Ageing Report, pp.127–28 & 132–33*

3.1. Problems Facing the Elderly

The World Population Report 2013 acknowledges that the socio-economic status of the aged worldwide is not favourable considering the fact that poverty is predominantly high among the aged, particularly in countries with ineffective social security systems. This is especially true in sub-Saharan African countries where economic progress has not preceded population ageing. Additionally, the process of ageing is taking place in an era in which traditional care and support systems for the elderly are rapidly undergoing transformation through the processes of modernisation and globalisation, and in the absence of public welfare systems (World Health Organization, 2014).

According to the Ghana Statistical Service (2013), more than one-tenth of the elderly in Ghana have sight, physical, emotional, intellectual and hearing disabilities. Furthermore, many elderly people in Ghana have to contend with socio-economic challenges in the form of poverty, loneliness, neglect, and cultural discrimination (e.g., accusation of witchcraft) among others. These factors sometimes act in concert to aggravate the problems the elderly face especially in developing countries including Ghana. While ageing is not

necessarily dependency, in Ghana dependency among older people is almost the norm. Most of the elderly people, particularly in the rural areas were previously engaged in the informal economic sector where, apart from the low incomes earned, they have no social security benefits to depend on after exiting from active work.

Ageing affects women and men differently, physiologically, emotionally, psychologically and socially. Women in Ghana suffer more from extreme poverty, discrimination and abuse because of their lower levels of education and high cultural restrictions society imposes on them. They suffer from exclusion and vulnerability and face barriers to assets acquisition and have limited access to economic opportunities. For example, some old women who lose their husbands or those who did not remarry may be ejected from houses they previously resided in with their deceased husbands (Ministry of Employment and Social Welfare, 2012).

3.2. Challenges of Healthy Ageing

The WHO Report 2014 identified several factors that had implications for healthy ageing in Ghana. These factors include socio-environmental circumstances such as the organisation of families and households, water and sanitation, housing, transport, and income security. The others are non-communicable diseases such as hypertension, cancer and diabetes that may be due to lifestyle, nutrition, physical activities and risky behaviour such as alcohol and tobacco consumption. The report also cites disability, especially visual and hearing impairments, violence against older people, dementia and depression.

Family and household arrangements have implications for the wealth of the household as well as the health and well-being of its members. Analysis of data from a study in Ghana on factors affecting mortality in older people showed that socio-economic status is not a determinant of death among older adults. However, living without a spouse, being male and old are strongly associated with mortality of older people. The results indicate that companionship, along with social and family ties, are more important in determining the health of

older adults than the socio-economic status of the household (Sammy, 2009). In Ghana, only 13 per cent of households live in separate self-contained housing units and 44.4 per cent live in often overcrowded compound housing facilities with limited access to sanitation facilities. Poor transport is also a barrier that could impede access to healthcare and also a major reason why some older people curtail their interaction with friends and other social networks. Changes in the Ghanaian society negatively affect older people whose early lives were shaped by traditional norms that ensured respect, support and reciprocity. These older people often find their expectations unmet, leaving many of them, especially women, isolated, weakened, and they become victims of illness and violence (Oppong, 2006). Inadequate health facilities and healthcare providers with specialisation for the care of the elderly are also barriers to healthy ageing as the elderly often fail to receive the necessary understanding and attention they expect.

4. Ageing-related Policies and Programmes

Ghana has adopted several ageing-related policies based on global and regional commitments such as the Madrid International Plan of Action on Ageing (MIPAA, 2002), the International Conference on Population and Development Programme of Action (ICPD PoA) and the African Union (AU) Policy Framework and Plan of Action on Ageing as well as national goals and targets. These commitments have been incorporated into national legal and policy frameworks. The 1992 Fourth Republican Constitution of Ghana provides a broad framework that promotes the social well-being of older people in Ghana. Specifically, Article 37(2)(b) states that the “State shall enact appropriate laws to assure the protection and promotion of all other basic human rights and freedom, including the rights of the disabled, the aged, children and other vulnerable groups in development processes”. Furthermore, Article 37(6)(b), provides that the “State shall provide social assistance to the aged such as will enable them to maintain a decent standard of living”. This means that healthy ageing is guaranteed under Ghana’s Constitution. In 2010, the Constitutional Review Commission that reviewed sections of Ghana’s

1992 Republican Constitution recommended the incorporation of “the right of the Aged to live in dignity, free from abuse should be guaranteed in the Constitution” (Government White Paper, CRC, 2012), (MESW, 2012).

The National Health Insurance Act (Act 650) of 2003 also makes provision for exemption for persons who are more than 70 years and non-contributors to the Social Security and National Insurance Trust (Non-SSNIT). Additionally, exemption is provided for older persons who are 65 years and above, and registered under the Livelihood Empowerment Against Poverty (LEAP) Cash Transfer Programme from the payment of registration fees and premium to access health services provided under the NHIS.

The Persons with Disability Act, 2008 (Act 715) provides a comprehensive policy framework for addressing the needs of persons with disability. Although this Act and its accompanying strategic plan are not restricted to disability issues of older persons in Ghana, it is undeniable that a significant proportion of Ghanaians who benefit from these direct interventions are older people.

The Social Security and National Insurance Trust (SSNIT) Pension Scheme has been upgraded under the new National Pension Act, 2008 (Act 766). This Act provides for the creation of two more separate tiers to the existing scheme. The Second Tier pays a lumpsum on retirement and is mandatory for all SSNIT contributors. The Third, however, is voluntary for both formal and informal sector workers to make contributions to registered trustees of their choice towards their pension in their old age. This new reform was intended to reduce old age income poverty and vulnerability.

The Medium Term National Development Policy Framework, the Ghana Shared Growth and Development Agenda (GSGDA II, 2014–2017) has key policy objectives aimed at ensuring adequate social protection and long-term care for the aged. They include enhancing national capacity for protection of the aged; accelerating the implementation of health and other social interventions targeting the aged; and strengthening the family and the provision of care for elderly people. One of the key strategies GSGDA II adopts to guide the implementation of interventions to achieve these objectives is

the establishment of the National Council on the Aged to enhance national capacity for the protection of older people in Ghana.

Furthermore, as part of efforts towards addressing issues pertaining to ageing, the Government of Ghana adopted the National Ageing Policy in July, 2010 under the theme “Ageing with Security and Dignity”. The Policy Document and its Implementation Action Plan were launched in 2011. The National Population Policy, Revised Edition, 1994 also recognises older persons as an important segment of the population of Ghana and outlines actions to promote their full integration into all aspects of national life through advocacy, enactment of laws, and collaboration among all stakeholders. In addition, social protection interventions including the Livelihood Empowerment Against Poverty (LEAP), EBAN Welfare, and the National Household Registry aim to make life more comfortable for the vulnerable, the poor and the aged in the country.

In terms of institutional framework for ageing policy implementation, the Ministry of Gender, Children and Social Protection (MoGCSP) has since 2013 been designated with an expanded three-fold mandate to ensure gender equality through mainstreaming gender considerations; promote the welfare and protection of children; and empower the vulnerable, the excluded, the aged and persons with disabilities through the use of social protection interventions to achieve national development (MoGCSP, 2014). The MoGCSP is, therefore, mandated to create an enabling environment and coordinate all interventions on the aged in the country. A National Advisory Council on Ageing is to be established to provide technical advice to stakeholders on the implementation of the National Ageing Policy of 2010 that is yet to be done. To cater to this gap, the MoGCSP in 2014 established an Advisory Committee on Ageing (drawn from the public sector, NGOs and academia such as Ministry of Health, Social Security and National Insurance Trust, HelpAge Ghana and National Population Council) to provide interim support for the implementation of the National Ageing Policy and guidance for the development of a legislative instrument on ageing in Ghana. The Ministry has also established an Ageing Desk to deal specifically with issues on ageing. In addition, development partners provide technical support and funding to implement interventions.

5. Assessment of Policy Implementation

This section attempts to identify the ageing-related policies and programmes that have been implemented in Ghana with the objective of assessing their effectiveness in addressing health and other related issues that are associated with ageing. Tawiah (2011) has noted that the adoption of the National Ageing Policy in 2010 was a policy response and an indication of the Government of Ghana's commitment to addressing ageing issues in the country. He, however, questions whether the government is committed to allocating adequate financial resources needed to promote security and dignity among the aged due to other competing demands on the national budget. He, therefore, argues that it is unlikely that the zeal with which the Policy document was developed will be applied at the level of implementation.

Thus, even though several legal and policy frameworks and programmes exist to promote the well-being of the aged, the enforcement and impact of these interventions are yet to be realised. The Ghana Shared Growth and Development Agenda (2014) reports that in spite of several interventions made to integrate the needs of the aged into the national development process, including the introduction of the three-tier pension scheme, improving institutional care for the aged, and the introduction of the National Health Insurance Scheme that exempts indigenes and the aged from paying premium, the interventions have not achieved the desired outcomes as a result of weak institutional coordination and lack of adequate funding to support the implementation of interventions. Some interventions such as LEAP does not solely target the aged, but, it is reported to have made some positive impact.

Furthermore, the creation of the MoGCSP appears to have contributed immensely to creating an enabling environment and intensified and strengthened interventions aimed at improving conditions for the aged. The Ghana Statistical Service (2013) has also indicated that the present socio-economic conditions in many sub-Saharan African countries would militate against the political will required to implement the policy. The WHO (2014) has endorsed this by asserting that very little has happened towards implementing

the National Ageing Policy and Implementation Action Plan. This may largely be the case because in many countries in Africa, the growth in the ageing population is progressing at a time when there is still a large population of young people requiring investments especially in health, education and employment.

5.1. Livelihood Empowerment Against Poverty (LEAP)

LEAP is a cash grant transfer programme that provides conditional and unconditional cash grants to the extreme poor people in Ghana. Specifically, the programme targets poor older persons

65 years and above, orphans and vulnerable children and persons with severe disability. It facilitates access to healthcare for older persons 65 years and above by exempting them from paying registration fees and premium under the NHIS. It is the flagship programme of Ghana's National Social Protection Strategy implemented by the Department of Social Welfare (DSW) in the MoGCSP. It seeks to provide financial support (cash grants), as well as access to complementary services such as the National Health Insurance Scheme to extreme poor families including the elderly (LEAP Operations Report, 2015). A total of 200,000 beneficiaries are targeted under the LEAP by 2016 with cash payments ranging from a low of GHC64.00 for one-member household to a high of GHC106.00 for a four-member household.

An Impact Evaluation undertaken by the University of North Carolina and the Institute of Statistical, Social and Economic Research (ISSER), University of Ghana in 2013 noted that the programme has had significant impact both on beneficiaries and their families, especially in relation to food security and nutrition, health, education, savings and investments, as well as on their wider communities particularly in terms of community development and economic growth.

The impact of the programme has, however, been limited primarily as a result of irregular payments due to delayed receipt of funds at the central level; the relatively small number of targeted families in each community; and a weak linkage to other pro-poor interventions. There is, therefore, an urgent need to

take steps to ensure that the impacts already achieved are not only deepened but also expanded.

5.2. National Health Insurance Scheme

According to the MoGCSP, more than 5,400 elderly women and men (65 years and above) have, since 2014, been freely registered for the biometric Identity (ID) card under the National Health Insurance Scheme (NHIS). The registration was conducted across the country and several communities in the country have benefitted from the programme. The Ministry also reports of partnership with development partners and the Ghana Health Service (GHS) to support the training of geriatric professionals to attend to the health needs of the aged in society.

There have, however, been some criticisms by some stakeholders to the effect that the NHIS has disregarded the special needs of the elderly (GNA, 2013). According to HelpAge Ghana, the NHIS prescribes the same basic healthcare without taking into consideration the tertiary healthcare needs of older people especially in the area of non-communicable diseases such as prostate-related health problems and colon cancers. HelpAge Ghana has, therefore, called on health authorities to adopt appropriate policies and programmes to address the critical issues confronting accessibility of the aged to healthcare. Again, although the United Nations defines older people as those 60 years and above, the NHIS restricts the minimum age of exemption from payment of premium to 70 years and above. Consequently, many old people, especially those not on Social Security and National Insurance Trust (SSNIT) Pension Scheme are unable to access healthcare. Furthermore, Ghana Health Service is yet to either train or incorporate geriatrics as a specialised area of healthcare in the health delivery system takes disadvantages many older people seeking appropriate healthcare at public health facilities. There is, therefore, the need to mainstream geriatrics into the syllabi of health training institutions and the expansion of Community Health Nursing to include house-to-house health information services and treatment for older people at homes, especially those who are bed-ridden.

The WHO (2014) also acknowledges that despite the emerging and recognised burden of NCDs, health systems in Ghana are designed mainly to identify

and treat acute communicable diseases. As a result, equity in terms of access to healthcare is constrained by patients with NCDs that make significant demands on already scarce health resources. This is particularly acute for older people with other barriers relating to their age, such as dementia, functional decline and socio-economic circumstances. Additionally, the country has an inadequate healthcare infrastructure, insufficient supply of medicines, and inadequate number of healthcare providers. At facility level, there are contextual, clinical and systems challenges to the delivery of healthcare for older people. These are the result of factors including poor patient attendance at health clinics, short consultation time with physicians/health workers that result in little or no time for patient education, limited staff training on the issues of older people, and almost non-existent formal patient education. Rural settings pose an even greater challenge where apart from the few providers that serve the population, distance to facilities constitutes a huge barrier towards healthcare accessibility.

It is partly in response to these challenges that the MoGCSP launched the African Health Markets for Equity in November 2015 aimed at increasing coverage of quality care within the private provider system and addressing priority issues that mostly affect the poor as well as the socially and economically vulnerable in Ghana. It is a five-year programme implemented by a consortium of partners that include International Finance Cooperation/World Bank, Health in Africa Initiative, Marie Stopes International and Pharm Access Foundation (MGCSP, 2015). Similarly, a Memorandum of Understanding (MOU) has been signed between Ghana and the Aarhus Social Healthcare College of Denmark to support the introduction and mainstreaming of geriatrics at the various health training schools in Ghana as well as within the healthcare delivery system.

5.3. EBAN Welfare Card

The EBAN Welfare Card was launched by the Ministry of Gender, Children and Social Protection in 2015 to protect the aged (65+) and safeguard their access to social facilities such as hospitals and banks. It includes a 50 per cent rebate on bus fare for EBAN Card holders on the Metro Mass Transit Buses to any destination in Ghana. The Government of Ghana has set aside GHC25,000.00

for the roll out of the EBAN Welfare Card targeting 25,000 elderly people in all the ten regions of Ghana. A total of 1,039 elderly people have been issued with the EBAN Cards on a pilot basis at Chorkor, Nima, La, Nungua and Ashaiman, all suburbs of Accra. Furthermore, in September 2015, MoGCSP registered 600 elderly people in Akwakwaa in the Agona East District in the Central Region of Ghana. Initially, all registration centres were in Accra, but it is planned to expand to cover the whole country.

5.4. National Pension Scheme

Ghana's Pension Scheme until 2008 had largely targeted public sector workers with no formal arrangement put in place to cater for the retirement needs of workers in the informal sector even though they form over 80 per cent of the working population in Ghana. The new National Pension Act (Act 766, 2008), however, is aimed at targeting the informal sector as well as the formal sector. The pension scheme aims at improving living standards and guaranteeing income security; reducing anxiety, self-exclusion, and dependency; and other hardships associated with unplanned retirement. Table 3 presents the age distribution of pensioners on the SSNIT Pension Scheme by age and sex as on June 2015. It shows clearly that for the two broad age groups, beneficiaries under the SSNIT Pension Scheme are skewed to the disadvantage of females due mainly to their dominance in the informal sector that often attracts no pension benefits although many of them may be willing to contribute to a pension scheme when given the opportunity.

Table 3. Age distribution of pensioners (72 to 90+), June 2015

Age	Male		Female		Total	
	Number	%	Number	%	Number	%
72–89	27,532	87.8	3,827	12.2	31,359	100.0
90+	240	95.2	12	4.8	252	100.0
Total	27,772	87.9	3,839	12.1	31,611	100.0

Source: SSNIT Monthly News Sheet, July 2015

Adwala et al (2015) found that the majority of informal sector workers were willing to contribute to the SSNIT Scheme. They also found that age, marital status, education, number of dependents, and income were significant in determining the probability of a worker joining the pension scheme, with older workers having a higher probability of joining the scheme than the younger ones. They also found that reasons for non-contribution to the scheme by informal sector workers include low income and non-awareness of the existence of such a scheme not being a salaried worker, and others simply did not have the time to go through the process. Other constraints included difficulty in accessing one's contribution, difficulty in accessing the offices of the Scheme and lack of knowledge about and low confidence in the scheme.

5.5. Awareness Creation on Issues and Rights of the Elderly

The MoGCSP has been working with key stakeholders to organise workshops, seminars and other public fora to create awareness on the human rights of older persons in Ghana. HelpAge Ghana plays a very important role in the celebration of the International Day of Older Persons. Together with the Ministry, HelpAge uses the celebration to organise television and radio discussions, durbars and press releases on relevant subjects on healthy ageing in the country.

In addition, in furtherance of the rights of older persons, a “Witches Camp” that had 70 per cent of its inmates being older women 70 years and above who have been accused of witchcraft by their communities and have been ostracised has been closed down and the inmates reintegrated into society. This is an effort in dealing with abuse and discrimination against older persons and older women in particular, and to protect their rights as Ghanaians.

5.6. Challenges for Policy Implementation

Strengthening and coordination of social protection programmes in Ghana has been a key issue in the nation's quest to effectively implement social protection policies particularly for the elderly population. The Ministry of Gender, Children and Social Protection (MoGCSP) is the lead agency for coordinating

social protection programmes in Ghana. The challenge is how to work with all relevant stakeholder agencies to avoid duplication.

Effective targeting of intervention programmes has also been a challenge. In a study by ISSER on LEAP, it was found that some beneficiaries were not even aware of the LEAP Programme.

The absence of a National Social Protection Policy to guide the implementation of programmes is another challenge. However, the Policy is being developed to foster coherence in approach and ensure that all social protection interventions are operating within certain set national guidelines and standards. The policy will also ensure sustainability of interventions. Coordination of programmes is affected by challenges of inadequate resources from both national budgetary allocation and donor support in the face of other pressing challenges. Furthermore, there are inadequate health facilities and skilled health providers specially trained to take care of the needs of the aged.

6. Role of NGOs/Civil Society Organisation in Addressing Healthy Ageing

There are several NGOs and CSOs that are engaged in providing care and support towards realising healthy ageing in Ghana. Notable among these organisations are HelpAge Ghana, Christian Association of Ghana (CHAG), Sight Savers, Ripples, Akrowa Aged Life Foundation and National Insurance Trust Pensioners Association. HelpAge Ghana is the main organisation that promotes the prospects of older people in Ghana. Its mission is to advance the interests and welfare of older people in the country regardless of their sex, creed or colour. It is involved in the creation of public awareness on ageing-related problems facing older persons. It also assists organisations working with and for older persons in Ghana to develop appropriate community-based services through research for the development and implementation of national policies/laws and programmes. Its activities involve the provision of

healthcare such as community clinic/health screening, ophthalmic/eye care, purchase of prescribed drugs for poor older persons. HelpAge Ghana also runs a health post and a day care centre in Accra.

CHAG has a goal to improve the health status of Ghanaians, especially the marginalised and the most vulnerable. It is a network of 183 health facilities and health training institutions owned by 21 different Christian Church denominations. CHAG is the second largest provider of health services in the country and provides services in all 10 regions of Ghana, particularly in the most remote areas.

Akrowa Aged Life Foundation is dedicated to the welfare of older people and its objectives are to combat poverty, reduce isolation among older people, reduce neglect, secure the delivery of consistently accessible good-quality care, and promote equality and human rights of disadvantaged older people. The Foundation supports over 400 vulnerable older people in six communities. It offers 24 hours a day, 7 days a week home care assistance including door to door medical assistance, transportation to meet doctors' appointments and medication reminders for their clients.

There is also the National Social Security and National Insurance Trust Pensioners Association that brings together pensioners under the SSNIT Scheme to pursue common goals and interest. For example, the Brong Ahafo Branch of the National Pensioners Association in 2014 initiated a programme to ensure pensioners enjoyed uninterrupted health services delivery.

7. Recommendations

This report has shown that Ghana's population is gradually ageing and hence steps must be taken to address issues concerning the aged such as poverty, access to healthcare services and disability. Of great priority is the issue of health as ageing progresses with several health challenges and complications especially with respect to non-communicable diseases. While the government has taken some steps to address these issues through policy and programming,

a lot more is needed, including strengthening legal and policy reforms and programme interventions.

Stakeholders have advocated reduction in the minimum age for accessing the free benefits under the NHIS. The LEAP Programme has been found to be very beneficial to participants as it addresses poverty, health, nutrition and other related needs. However, it has limited coverage. Similarly, there are opportunities to improve access of the informal sector that constitutes the largest proportion of the economically active population in the country to enable them enjoy retirement benefits to the Pension Scheme. The New Pension Scheme provides for this opportunity for persons working in the informal sector to take advantage of. However, there is the urgent need to step up efforts towards effective education of the population in the informal sector, in particular regarding the benefits of this scheme and how they can take advantage of reducing their economic vulnerability when they become old.

In addition, the “EBAN Welfare Card” should be expanded to all parts of the country and made to operate practically in the interest of older people everywhere in Ghana. Furthermore, the government should hasten the process of mainstreaming geriatrics into the syllabi of health training institutions and expand Community Health Nursing to include house-to-house health information services and treatment for older people at home especially those who are bed-ridden.

There is also the need for effective targeting, coordination and harmonisation of interventions to ensure smooth implementation and efficient utilisation of limited resources. Consequently, there is the need to create a conducive environment and expansion of partnerships among stakeholders at all levels especially between government and NGOs and CSOs working at the community level. Additionally, there is need for the government to commit resources to the implementation of intervention programmes to ensure healthy ageing in the country and to guarantee comfortable and dignified life for the ageing population in Ghana

KENYA

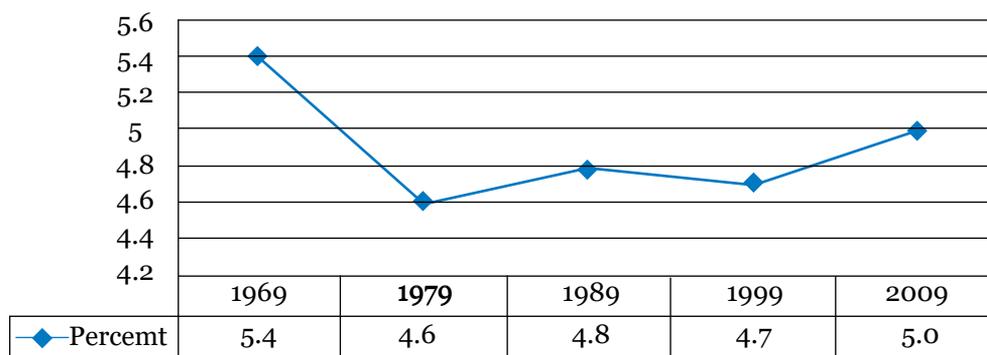
George Alusa Kichamu

1. Background

1.1 Demographic, Health, and Social Transitions in Kenya

The number of older persons in Kenya has increased by slightly over three times in a period of 40 years between 1969 and 2009. In 1969, the number of older persons in Kenya was about 591,000. Ten years later, in 1989, this figure had increased to slightly over 1 million. In 2009, the number of older persons had increased to about 1.9 million. Generally, among the older persons, females are more than males. Graph 1 shows the trend in the proportion of older persons as a percentage of the country's population between 1969 and 2009. In 1969 the proportion of older persons in Kenya was 5.4 per cent. This dropped to 4.6 per cent in 1979 before rising steadily to reach 5 per cent in 2009. These statistics indicate that though the proportion of older persons in Kenya has remained at almost the same level, the numbers have increased substantially. This can be ascribed to the increase in the overall population of Kenya from about 10 million in 1969 to 38.6 million in 2009 as well as the increase in life expectancy at birth from below 50 years in 1969 to about 60 years in 2009.

Graph1: Proportion of older persons in kenya from 1969 to 2009 (per cent)



Source: Kenya Population Situation Analysis (2013)

According to the 2006 Kenya Integrated Household and Budget Survey (KIHBS), over half of the older persons in Kenya are married while about one-third are widowed. It is only about 1 per cent of older persons who are divorced/separated and 2 per cent that have never married.

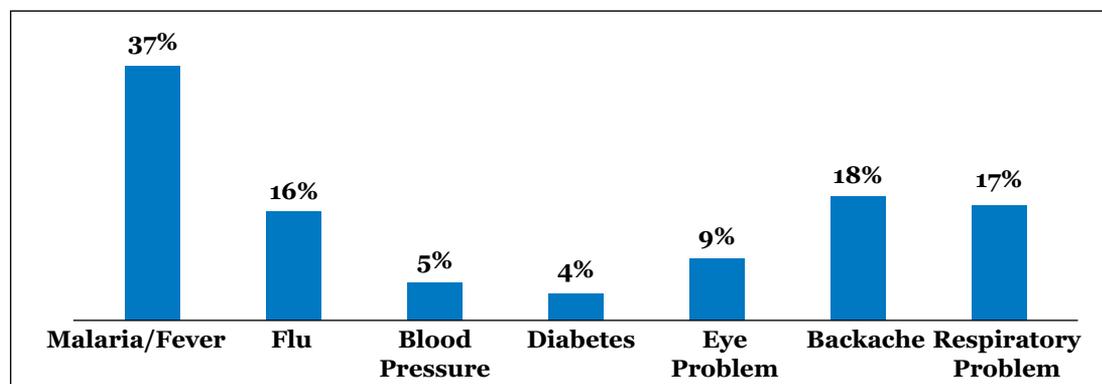
Older persons in Kenya mainly live in rural areas with 9 in every 10 of them found in these areas. The KIHBS also found that 7 in every 10 older persons live in households that have at least four members, including the older person. Only about 8 per cent of older persons live alone, 13 per cent live with one other person, and 10 per cent live with two other people.

1.1.1 Socio-economic situation of older persons

Health

Old age is associated with declining health and therefore older persons in society have to deal with an increasing number of health difficulties as they grow older. The main objective being to establish the level of wellbeing of Kenyans, results from the 2006 KIHBS found that about half of the older persons reported an illness in the month preceding the survey. Graph 2 shows the main illnesses that were reported to have afflicted the older persons. Malaria/Fever (37 per cent) and Flu (16 per cent) were the main communicable diseases that afflicted older persons while Backache (18 per cent), Diabetes (4 per cent), and Blood Pressure (5 per cent) were the main non-communicable diseases reported. About 9 per cent of the older persons who reported an illness indicated that they had an eye problem and 17 per cent reported a respiratory system related illness. When asked who diagnosed the reported illness, about half of the older persons who were ill during the same period indicated that the illness was self-diagnosed while the remaining said that a health worker diagnosed the illness.

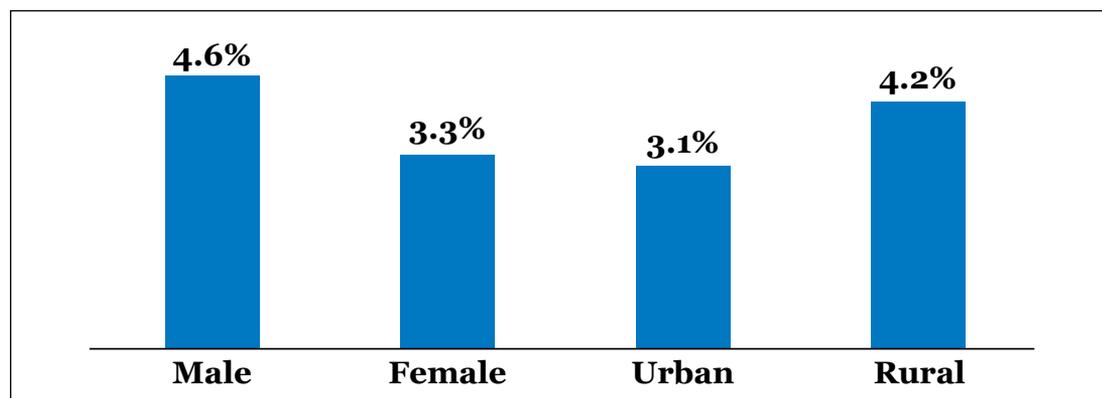
Graph 2: Prevalence of various diseases among older persons reporting illness (per cent)



Source: Kenya Integrated Household and Budget Survey (2006)

Graph 3 shows that HIV/AIDS is also afflicting older persons in Kenya. The 2012 Kenya AIDS Indicator Survey (KAIS) showed that men aged 60–64 years had a HIV prevalence of 4.6 per cent, which is higher than the 4.2 per cent among men aged 15–49 years. For the older women aged 60–64 years, the HIV prevalence was 3.3 per cent, which is less than half the prevalence level of 6.9 per cent among women aged 15–49 years. Older persons aged 60–64 years residing in urban areas have a HIV prevalence of 4.2 per cent. Their rural counterparts have a prevalence of 3.1 per cent.

Graph 3: HIV prevalence among older persons aged 60–64 years by sex and residence (percent)



Source: Kenya AIDS Indicator Survey (2012)

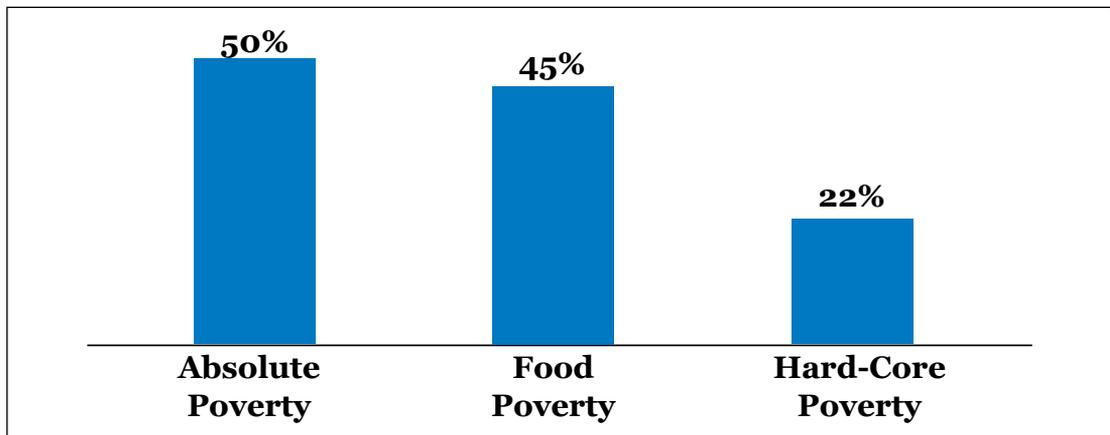
Education

In terms of education, the 2006 KIHBS reported that only 2 in every 5 older persons in Kenya had ever attended school. Out of the older persons who had ever attended school, 13 per cent had attained a primary school certificate, 10 per cent a secondary school certificate, 12 per cent a college certificate or diploma, and 2 per cent a degree certificate. This showed that the educational achievement among elderly persons was generally low with about 60 per cent of them having never attended school at all, while among those who ever attended school, about 60 per cent have no educational qualifications.

Poverty and Income

It is estimated that in 2015, about 46 per cent of Kenyans live below the poverty line. This situation is attributed to several factors including slow economic growth and high levels of unemployment in the general population. The 2006 KIHBS found that half of the older persons in Kenya live in absolute poverty and slightly under a quarter of them are experiencing hard-core poverty as shown in Graph 4. This situation coupled by the fact that older persons are susceptible to many illnesses implies that the wellbeing of majority of these people is wanting.

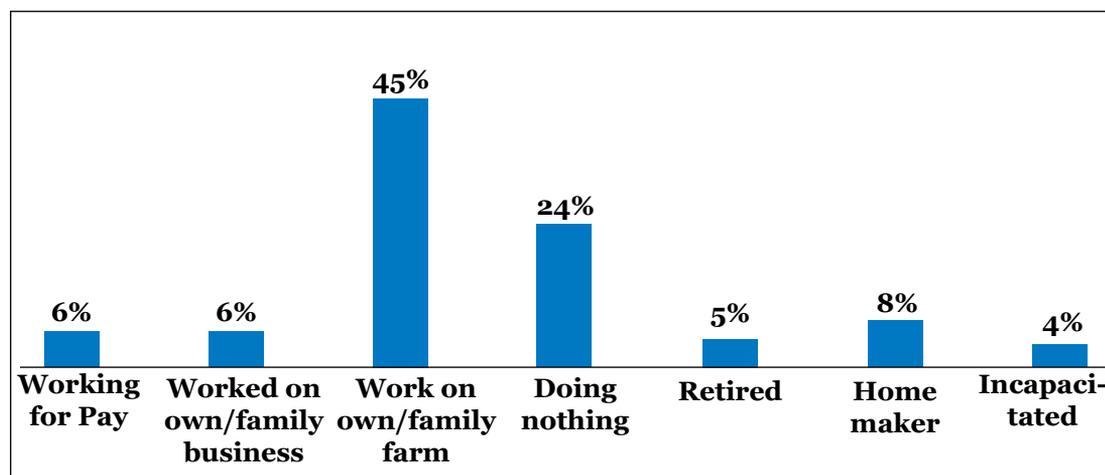
Graph 4: Prevalence of poverty by type among older persons (per cent)



Source: Kenya Integrated Household and Budget Survey (2006)

Graph 5 shows that over half of the older persons in Kenya work on their own or family agricultural holdings (45 per cent) or business (6 per cent). Slightly less than a quarter of the older persons are doing nothing while 6 per cent are reported to be working for pay. About 8 per cent of this segment of the population are homemakers and 4 per cent are incapacitated.

Graph 5: Activities being undertaken by older persons



Source: Kenya Integrated Household and Budget Survey (2006)

Housing, Water and Sanitation, and Energy

Housing, water and sanitation, and energy play a significant role in the health and living comfort of individuals. Reasonable quality and access to these facilities promote wellbeing. In 2006, the KIHBS found that almost all the older persons were living in households whose form of tenure was owner occupied. Only 5 per cent of the older persons were staying in households with other forms of tenure such as renting. Two-thirds of the older persons were staying in modern type of houses and slightly over a quarter were staying in traditional type of houses such as manyattas. About 2 in every 5 older persons were living in households where the main source of drinking water was a river, pond, stream, or unprotected well/spring. Forty per cent of older persons were staying in households where the main source of drinking water was a protected spring/well or a piped source. About half of the older persons were found to be using uncovered pit-latrines (33 per cent) or they had no access to toilets

(18 per cent). The remaining older persons were either using covered pit-latrines (43 per cent) or flush toilet (5 per cent).

Nine in every 10 older person stays in households where the main source of energy for cooking is firewood. Only about 4 per cent of older persons stay in households that use gas or paraffin as the main energy source for cooking. The main source of energy for lighting for 4 in every 5 older persons is paraffin. Those staying in households that use electricity or solar as the main source of lighting are 8 per cent.

1.2 Projection of Elderly Population by 2030 and 2050

The total population of Kenya increased from 10.9 million people in 1969 to 38.6 million recorded in the 2009 Kenya Population and Housing Census (KPHC). With an annual population growth of 2.9, this population is projected to increase to 59.5 million and further to 77.3 million people by the year 2050. Over the same period, the proportion of older persons (aged 60 years and above) reduced from 5.4 per cent in 1969 to 5.0 per cent in 2009. Although there was an observed decline in their proportion, indeed the absolute size of the population of older persons increased. Moreover, the proportion of this segment of the total population is projected to remain constant at about 5.0 per cent by 2030 but rapidly increase to about 10 per cent by the year 2050.

Table 1 shows the trends in the proportion of elderly population from 1969 to 2009 and projected population by 2030 and 2050 respectively. On the other hand, table 2 shows the trends in the population of elderly persons from 1969 to 2009 and projected population by 2030 and 2050 respectively.

**Table 1. Trends and projected proportion of elderly population
1969–2050**

Indicator	1969 (Census)	1979 (Census)	1989 (Census)	1999 (Census)	2009 (Census)	2030 (Projections)	2050 (Projections)
Proportion of elderly (%)	5.4	4.6	4.8	4.7	5.0	5.0	10.0

Source: Computed from 2009 KPHC

Table 2. Trends and projected population of elderly 1969–2050

Indicator	1969 (Census)	1979 (Census)	1989 (Census)	1999 (Census)	2009 (Census)	2030 (Projections)	2050 (Projections)
Proportion of elderly (%)	0.6	0.7	1.0	1.3	1.9	3.0	7.7

Source: Computed from 2009 KPHC

1.3 Natures of Problems and Challenges faced by Elderly Population

The elderly population in Kenya is facing a number of challenges resulting from the breakdown of societal structures and other support mechanisms that have traditionally been in place to take care of their needs including protection of their human rights and dignity. The situation is aggravated by the fact that majority of the younger population who used to take care of them is also facing harsh economic difficulties and other challenges that increasingly make it difficult for them to attend to the needs of their ageing parents and relatives.

With regard to seeking redress in the court of law, many elderly persons lack finances to cater to their legal fee and hence making it difficult for them to get justice. As a result the latter group of older persons either seeks redress from the local administration that includes local chiefs and village elders, or alternatively decides not to lodge any complaint.

In the absence of these support mechanisms, the resilience of older persons to difficulties associated with old age has reduced significantly. The vulnerability of this segment of the population has therefore increased over time. In the absence of a comprehensive social support programme that includes social security and health insurance schemes, the participation and contribution of older persons to the overall development of Kenya is limited.

In recognition of the plight of older persons in the country, the Government of Kenya and other stakeholders have developed and implemented policies and programmes that are aimed at improving the wellbeing of older persons. One key step in this regard is the adoption, in 2009, of the National Policy on

Older Persons and Aging (NPOPA). The overall goal of the policy is to provide an environment that recognises, empowers, and facilitates older persons to participate in the society and enjoy their rights, freedoms and live in dignity. The policy provides for a coherent and comprehensive framework for guiding the different sectors and agencies involved in development issues pertaining to older persons so that available resources and efforts are maximised for the benefit of older persons.

An important area of concern with regard to ageing in Kenya is the lack of comprehensive information on the state of older persons in the country. This situation has made it difficult to come up with policies and programmes that target and prioritise the needs of this segment of society. In the absence of this information, efforts to understand older persons in Kenya have mainly relied on national and sub-national studies that capture information on the general population. With the push to undertake a comprehensive study on ageing and older persons in Kenya, it is important to first take stock of the existing policies, programmes, and researches that relate to this subject.

2. Policies and Programmes on Ageing

2.1 Existing Policies

The Government of Kenya signed the International Plan of Action on Ageing that was adopted during the first World Assembly on Ageing held in Vienna, Austria in 1982. Over the years, the government has remained steadfast in recognition of the rights of older persons to independence, participation, care, self-fulfilment and dignity through formulation and implementation of legal instruments, policies and strategies that are geared towards addressing the plight of older persons. These policies provide an overall framework for implementation of the International Plan of Action on Ageing by ensuring that socio-economic support, protection and promotion of the dignity and rights of older persons are realised. Moreover, it is imperative that older person's protection and promotion of the human rights, health and dignity is guaranteed so as to enable them participation in the socio-economic development of the country.

Some of the key legal instruments, policies and programmes developed by the Government of Kenya that have specific provisions on the needs of older persons include: The Constitution of Kenya (2010), the Kenya Vision 2030, Social Assistance Bill (2012), National Policy on Older Persons and Aging (NPOPA), Population Policy for National Development (2012), National Housing Policy (2014), Gender Policy (2011), and Kenya National Social Protection Policy (2011). Here below is a brief overview of the provisions in the said documents that touch on the wellbeing of older persons;

2.1.1 Constitution of Kenya, 2010

Article 57 of the Constitution recognises older persons as members of the society. This article commits the State to take measures to ensure the rights of older persons with regard to full participation in the affairs of society, pursue their personal development, live in dignity and respect and be free from abuse, and receive reasonable care and assistance from their family and the state.

2.1.2 Kenya Vision 2030

The Vision 2030 document covers the following aspects with regard to older persons.

- i. **Vulnerability:** The social pillar of the Vision recognises that elderly persons are vulnerable and are faced with multiple challenges in their daily life such as high levels of poverty and various forms of deprivation. It also appreciates the fact that majority of orphans in the country, for instance, are under the care of the elderly who themselves are struggling to make ends meet.
- ii. **Consolidated Social Protection Fund:** This is a flagship project established under Kenya Vision 2030 for cash transfers to elderly persons aged 65 years and above. It aims to cushion them against economic difficulties. Is this a pilot project or conducted country wide, what is the amount given?
- iii. **The Bill of Rights:** Through its guiding principles, the implementation of Vision 2030 recognises the Bill of rights of older persons by covering their economic, social and, cultural rights and needs.

2.1.3 National Policy on Older Persons and Aging (NPOPA), 2014

Succeeding the National Policy on Older Persons and Aging of 2009, the NPOPA has the goal of providing an environment that recognises, empowers, and facilitates older persons to participate in the society and enjoy their rights, freedoms and live in dignity. The specific objectives of the policy are to:

- ❖ facilitate the provision of reasonable care and assistance to older persons by family and the state
- ❖ promote collaboration and partnerships among key stakeholders for its effective implementation
- ❖ promote the participation of older persons in development processes
- ❖ enhance and facilitate older persons to pursue their personal development
- ❖ create a favourable environment that enables older persons to live in dignity
- ❖ protect the Older Persons from abuse.

NPOPA has identified 10 thematic areas and issues that it seeks to address with regard to older persons. Briefly described herein are the issues facing older persons and also the policy objectives to address these issues.

- i. **Older Persons and the Law:** Despite the Constitution of Kenya (2010) recognising older persons as distinct rights holders, there is still no specific law at the national and county levels that comprehensively promotes and protects the rights of older persons. The objective here is to put legal measures in place to ensure that the rights of older persons are protected, promoted, and fulfilled.
- ii. **Poverty and Sustainable Livelihood:** The policy recognises that older persons constitute a sizeable percentage of the poor in the country. The specific objective of this thematic area is to promote the inclusion of older persons in poverty reduction policies, programmes, strategies and in national budgeting processes.
- iii. **Health:** Older persons' health is influenced by life-long experiences that include up-bringing, nutritional status, occupation in active life,

housing, access to health services, water, sanitation, income levels and the challenges of HIV and AIDS. The specific objective is to ensure access and the highest attainable standard of health for older persons.

- iv. **Family, Community and Culture:** The effectiveness of the traditional family and community structures to provide in-built support and care for older persons is increasingly under pressure. The policy objective is to strengthen the family and community support systems to appreciate ageing, respect and honour older persons, and to promote a positive culture that recognises diversity, protects and respects the dignity and worth of older persons in the society.
- v. **Food Security and Nutrition:** Older persons are most vulnerable to malnutrition, hunger and famine situations due to the fact that they are food insecure, consume foods with low nutrition value, are income poor, and lack means and resources for food production. The specific objective is to put in place measures to ensure availability of adequate food that is nutritious and safe for older persons.
- vi. **Infrastructure:** Older persons lack access to adequate and decent housing in a sustainable environment. They also lack access to clean and safe water besides limited accessibility for user-friendly transport, and built environments. Housing infrastructure and facilities are inadequate while the existing ones are not responsive to their needs. The policy objective is to review existing infrastructural policies and legislations to ensure they accommodate the rights and needs of Older Persons.
- vii. **Education, Training, and ICT:** The current education, training and ICT policies and programmes do not comprehensively address the potential and needs of older persons. However, the policy recognises the fact that there is an increasing number of older persons with skills and expertise in various sectors that can be tapped to enhance the knowledge and skills of their peers and other members of the society. The specific objective of the policy is to tap into the potential of these older persons for posterity and to promote active participation and involvement of older persons in education, training and ICT.

- viii. **Employment and Income Security:** Older persons' employment and income security capacities are constrained by inadequate skills, social support and access to credit. However, many older persons have skills resources and expertise that could be tapped and utilised for development. The objective here is to put in place measures that ensure older persons continue to provide their expertise, talents, experience, and abilities to their families, and community by accessing and creating employment.
- ix. **Social Protection and Services:** The introduction of the new economic order has disrupted the once functional traditional social systems thereby contributing to the marginalisation of older persons, especially those living in the rural areas. The aim is to strengthen the existing social and health insurance schemes to cover all workers in formal and informal sectors and also to upscale social assistance programmes to cover all vulnerable older persons.
- x. **Other Cross-cutting Issues:** These issues include gender, disability, conflict and disasters, and volunteerism. The objective is to take cognisance and mainstream these issues during the design, planning and implementation of development processes at both national and country levels and also to promote and reward voluntary work by older persons.

2.1.4 Social Assistance Bill, 2012

In this Bill the elderly are identified as a vulnerable group in the society that needs assistance. Clause 17 of the bill specifies that social assistance be provided to persons in need. This includes poor elderly persons. Further, Clause 21 also specifies that social assistance will be available to any person who has attained the age of 65, has been neglected or abandoned without any ascertainable means of support; or lives or begs on the street for a living.

2.1.5 Kenya National Social Protection Policy, 2011

In the year 2011, the government of Kenya developed a National Social Protection Policy. The overarching goal of this policy is to ensure that all Kenyans live in dignity and exploit their human capabilities for their own social

and economic development. As far as providing for older persons is concerned, the policy envisages social assistance as consisting of a benefit, grant, or pension payable to the older persons on either a targeted or universal basis and that, a compulsory contributory scheme, possibly provided by the National Social Security Fund (NSSF), occupational retirement schemes and voluntary social insurance/security schemes to provide pension benefits to their beneficiaries.

2.1.6 Population Policy for National Development

The Population Policy for National Development recognises the elderly as a very important but vulnerable segment of the entire population. The vulnerability of this segment is signified by the breakdown of the societal structures and support systems that used to take care of them and the absence of alternative comprehensive support programmes coupled with economic difficulties faced by majority of families. This policy proposes the implementation of the following policy measures:

- ❖ Support the implementation of the National Policy on Ageing including Article 47 of the Constitution of Kenya;
- ❖ Advocate for the establishment of social security and health insurance schemes;
- ❖ Advocate for formation of community-based support networks for the elderly people to undertake provision of population education in their respective communities.

2.1.7 National Housing Policy, 2014

This is a key policy document on housing that will succeed the National Housing Policy of 2004. The 2004 policy, aimed at facilitating the provision of adequate shelter and a healthy living environment at an affordable cost to all socio-economic groups in Kenya. The 2014 policy, currently under review, includes specific considerations for older persons. The policy advocates for the establishment and maintenance of older persons homes.

2.1.8 National Policy on Gender and Development, 2000

This policy was developed in the year 2000 and spells out an inclusive approach to gender mainstreaming by all public institutions. The policy advocates for

inclusion of persons of all genders, including older persons, in development processes.

2.2 Enforcement and Impact of Ageing Policies

Like many other policies in Kenya, enforcement and full implementation of the ageing policies have not been fully implemented. They include: weak institutional linkages; weak enforcement mechanisms; inadequate financing to fund implementation of these policies; inadequate institutional capacities addressing the elderly issues among others. In terms of their impact, a compressive survey to determine the impact of the policies implemented would be very ideal to give the actual situation of the elderly in Kenya.

2.3 Challenges Towards Policy Implementation

An assessment of these policies reveals a number of challenges with regard to policy implementation. Some of which include:

- ❖ Multiplicity of policies that is not well coordinated and or harmonised leading to duplication of activities;
- ❖ Weak institutional linkages and coordination which hampers the implementation and coordination of these policies;
- ❖ Lack of database for older persons;
- ❖ Social protection initiatives are not publicised to the citizens, therefore learning and information are limited to the institutions undertaking specific programmes;
- ❖ Identification of the targeted recipients has been a challenge in the implementation of the social protection policies

2.4 Programme Implementation

2.4.1 Integrated older person centred care

Besides the legal instruments and policies in place, the assessment identified key programmes and strategies adopted by the Government that directly or indirectly, have reference to or stipulations on older persons. These programmes although not explicitly integrated, the manner in which they were

developed and implemented ought to be integrated. It is envisaged that all these programmes and policies are implemented multi-sectorally with many actors so that each programme is integrated to the other for effective service delivery to the elderly. These programmes include:

- i. **National Health Insurance Fund (NHIF):** This is hospital insurance to which employees in the formal sector compulsorily contribute to, based on the salary scale, while those in the informal sector can also make voluntary contributions. It enables the contributor to access medical treatment on admission and older persons can continue contributing to the scheme even after retirement from active service.
- ii. **National Social Security Fund (NSSF):** This provides social security to workers in both the formal and informal sector based upon their contributions and interest accrued. The NSSF operates a provident fund scheme that covers workers in both sectors and is aimed at encouraging a saving culture. Older persons can access their contribution on retirement at the age of 60.
- iii. **Pension Schemes:** They are governed by the Pensions Act of Kenya 2004 where persons in formal employment receive their pension benefits on retirement. Such schemes assist older persons in their old age once they cease formal employment. It however is applicable only to persons in formal employment; hence other members in the informal sector have been forced to rely on support from family.
- iv. **Cash Transfer:** In 2009 the Government initiated a pilot cash transfer project targeting the very poor older persons in society. This process however is to be regulated by the National Social Protection Policy.
- v. **Adult Education:** Adult Education in Kenya, established under the Board of Adult Education Act of Kenya (Cap 223), is governed by the Board of Adult Education. The Board is tasked with among others the formulation of courses and syllabii for adult and continuous education as well as identification and assessment of the need for new developments in adult education. This initiative allows for older members in society

to access continuous education. Moreover, the Universal Free Primary education that started in 2003 also allows for entry of older persons into regular primary school education.

2.4.2 Creating Aged Friendly Environment for Healthy Ageing

A conducive socio-economic and political environment creates a friendly atmosphere for healthy ageing. In Kenya, the Government has been on the forefront in policy formulation to address the concerns of older persons. Moving forward, the Government is expected to offer a conducive environment in order to improve the life expectancy of her ageing population. Moreover, the government will continue to provide resources for the effective management and implementation of quality services to improve livelihood of the older persons.

An assessment on how a conducive environment has been created for the elderly has been demonstrated through a political, government administrative goodwill and support from charitable organisations. The enabling environment for older persons in Kenya can therefore, be looked at as being a government enabling environment with also support from non-state actors. Political commitment and administrative will on the older persons are provided for by the government as contained in the Laws and Rights of Kenya; Section 3 of the Constitution Act Cap 8 clearly states Kenya's "political commitment and administrative will". To further demonstrate the political goodwill, the national assembly has passed the following Acts:

- i. Widows' and Orphans' Act, Cap 192;
- ii. Provident Fund Act, Cap 191;
- iii. National Social Security Fund Act, Cap 258;
- iv. National Health Insurance Fund Act, Cap 255;
- v. Pensions Act, Cap 199.

As noted earlier, the elderly population in Kenya is facing a number of challenges resulting from the breakdown of societal structures and other

support mechanisms that have traditionally been in place to take care of their needs including protection of their human rights and dignity. The situation is aggravated by the fact that majority of the younger population who used to take care of them are also facing harsh economic difficulties and other challenges that increasingly make it difficult for them to attend to the needs of their ageing parents and relatives.

With the hard life caused by modernisation, a number of families and communities tend to ignore the long-standing tradition responsibility and leave only a few people to cater and take care of the older members of their families and communities. This has resulted in having old people being taken into old people's homes, home nursing services, foster homes and home help services amongst others for care. It is important to note that most of the elderly who are neglected cannot afford the high cost of home services, thereby increasing their vulnerability and suffering.

In Kenya, various communities differ in the role and manner the older persons are regarded and status they are accorded. Most communities respect the role older person's play in the community and are given much dignity among the population. Some communities however disregard their contribution and view them as both economic and social burden. In most instances, older people are not even being consulted for guidance on certain historical and cultural issues. Older persons need to be incorporated in guiding the family and the community in general and in the development process and decision-making because of their wide experience and wisdom in such issues.

Some organisations such as Help Age Kenya and Development Work in Education, Livelihoods and Environment (DWELE) have gone so far as even to ensure there is life after work for the elderly by providing/spearheading other initiatives that are instrumental in supporting individual needs of old people by providing assistance through community projects targeted at older persons. Most of these initiatives and others by government have helped to improve the lives of older persons in Kenya.

Moreover, the government of Kenya has put in place the Ministry of Labour.

2.5 Lessons learned and opportunity for scaling up, replication and sustainability

2.5.1 Lessons Learned

The following are summary of lessons learnt:

- i. A conducive policy and legal environment is key for implementation of policies and programmes on ageing;
- ii. Government commitment and taking lead in implementation of elderly policies and programmes are paramount to addressing elderly issues
- iii. Multi-sectoral and integrated programmes designed for the elderly population promotes healthy ageing in Kenya
- iv. A participatory approach in policy and programmes formulation with all the actors is necessary so that intended policy outcomes are realised
- v. Recognition and engaging elderly population make them feel part of the society and thus improve their life expectancy.

2.5.2 Opportunities for Scaling up and Sustainability

The existence of a conducive policy and legal environment and targeted programmes makes it easy for non-state actors and development partners to contribute in designing targeted programmes for the elderly. Devolved structure of government (County Governments) is an opportunity to ensure effective implementation of the elderly population in Kenya. There is considerable interest by majority of development partners who can work together with the government to implement Vision 2030.

2.6 Role of NGOs/civil society organisations in addressing healthy ageing

2.6.1 Help Age Programmes in Kenya

Help Age Kenya is a non-governmental organisation in Kenya that is affiliated to Help Age International. The organisation's focus is to help older people claim their rights, challenge discrimination and overcome poverty so that they can lead dignified, secure, active and healthy lives. Help Age Kenya has

implemented a number of programmes in the country that have gone a long way in addressing some of the issues affecting older persons in the society. The key activities undertaken by Help Age Kenya are:

- a. **Advocacy:** The organisation advocates for better health services for older people as well as sensitising the public on the rights of older people.
- b. **Livelihoods:** Under this activity, Help Age Kenya provides cash grants to older persons, orphans and vulnerable HIV affected households' children. Older people are also taught vocational skills.
- c. **Emergencies:** In collaboration with other stakeholders, the organisation provides emergency relief services to older persons especially those in the refugee camps and in drought prone areas.
- d. **Social protection:** Help Age Kenya provides capacity building to stakeholders on the cash transfer scheme rolled out by the government of Kenya.
- e. **Healthcare:** in collaboration with other stakeholders, Help Age Kenya offers the following health services:
 - ◆ Provide community training on HIV and AIDS and support to older people, orphans under their care and home-based carers.
 - ◆ Train older persons on HIV prevention education
 - ◆ Train older persons as peer educators in the society
 - ◆ Provide medical camps for people living with HIV
 - ◆ Provide food and nutritional training to older persons.

2.6.2 Development Work in Education, Livelihoods and Environment (DWELE)

Development Work in Education, Livelihoods and Environment (DWELE) is an NGO/Not-For-Profit International Organisation, registered by the NGOs Council of Kenya. DWELE exists to serve the disadvantaged population regardless of gender, race, religion and culture, through Education, Gender, Health and HIV&AIDS, Environment, Governance and Socio-economic

Empowerment Programmes. They have a special focus on Elderly concerns; Vulnerable Children; Women and Girls and their communities. We mainstream Gender, Economic Empowerment and HIV&AIDS as an integral part of all our interventions. They also foster Partnerships for expanded-reach in development; resource mobilisation; synergy and creation of sustainable linkages that Give Opportunities to the Disadvantaged persons to ensure Dignity for All People.

DWELE has an Elderly Support Resource Centre (ESRC) Project which employs integrated participatory strategies that ensures full participation of the elderly in decision making and management in the Elderly Support and Resource Centre Project as well as realisation of its benefits. Among the benefits the elderly benefit from ESRC include: socialisation and professional fulfillment; enabling the elderly continuously gain skills through learning and recreational activities; offering income generation; acting as rescue/drop-in centre for abused vulnerable children, including those from streets, and Gender-based Violence victims. In supporting the elderly issues in Kenya, the NGOs will be accorded a conducive environment to operate and perform the following roles:

- i. Mobilise resources to address issues relating to Older Person and Ageing;
- ii. Mobilise Older Persons to facilitate their participation and access to services at all levels of Government;
- iii. Advocate on issues of the Older Persons and Ageing.

2.7 Financing for healthy ageing

The government of Kenya remains and will continue being the principal player in developing and implementation of elderly care. The government will continue to fund the operation of the Ministry of Labour, Social Security and Services to effectively monitor the implementation of Kenya's NPOPA. The government shall also allocate funds to programmes and departments that address the issues of the elderly population. Additionally, the government has created an enabling environment for other non-state actors to develop and implement programmes that target the elderly.

Recommendations:

There is a need for:

- ❖ Progressive realisation of universal pension for older people
- ❖ Supporting the establishment of geriatric and ageing units in all public hospitals
- ❖ Intensifying data collection and collation about older people in order to better inform policy and programmes
- ❖ More coordinated efforts to protect older people against violence and abuse
- ❖ Supporting the implementation of the National Policy on older persons and Ageing
- ❖ Establishment of social security and health insurance schemes
- ❖ Support the formation of community based support networks for the elderly persons to provide needed services amenities
- ❖ The need for a participatory approach in policy and programmes formulation with all the actors is necessary so that intended policy outcomes are realised

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MEXICO



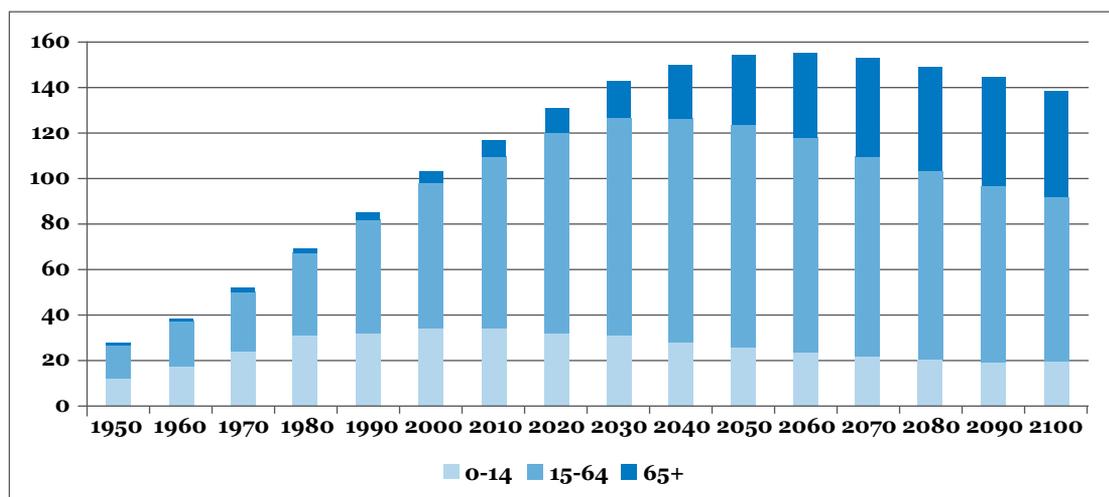
Roberto Ham Chande

1. BACKGROUND

1.1 Past and Projected Demographics

By the middle of the 20th century Mexico set off a remarkable demographic evolution, as depicted in Graph 1. From a 28.2 million population in 1950 it became 53.0 million in 1970. Such an increase was mainly due to advances in health and socioeconomic conditions that increased life expectancies while also boosting the already high fertility. Between 1950 and 1970 population 65 and over kept around a small 3.6% of total population. But under decreasing mortality and high fertility, demographic projections promised unsustainable population growth. Thus population policies aiming to decline fertility were implemented and population growth rate decreased, while population structures shifted to lesser presence of a young population and increased participation of an adult and elderly population. Beginning a fast demographic transition but still keeping a demographic growth momentum, by 2010 the total population was 117.9 million, with 6.0% in the bracket 65+. Projections in their intermediate scenarios estimate that the percentage of population of 65+ will be 11.3% by 2030, while the population 15–64 will reach the highest of 67.2%. By 2050 the total population will be around a maximum of 156 million of which 20.2% will be a population of 65+. Afterwards population might decline but the elderly increase will speed up. By 2050, percentage of population under 65 will start to decline and that of 65+ will increase. Although different projections may vary, all of them describe the overall picture of a rapid and unavoidable demographic ageing (CONAPO, 2012).

Graph 1. Population in wide brackets of age. 1950–2010 and projections to 2100



Data: *Proyecciones de Población. Consejo Nacional de Población, 2012*

1.2 Ageing and Health Transition

Mexico is now a middle-income country albeit marked by deep social and economic inequality. In 2014, 10% of the poorest households had as low as 1.9% of total income, while the richest 10% had 35.4%. These outrageous circumstances have promoted an uneven epidemiological transition that has been more rapid in contexts of high socio-economic status and slower in deprived social classes. In higher social groups the causes of death are mostly

non-communicable diseases while mortality from infections and parasites is still significant for groups in poverty. A straightforward explanation comes from inequality in access to medical services and differences in quality of health including prevention. Within this scenario the country now faces an accelerated demographic ageing when there are still unmet basic needs for largest parts of the population. However, for the overall population, life expectancies are increasing, prevalences of infectious diseases are falling and non-communicable diseases are becoming the main causes of death (Gutiérrez-Robledo).

Of all demographic and social issues about ageing, the most relevant are related to the epidemiological shift towards chronic diseases and disabilities. Following the concepts of WHO on health as a holistic concept, healthy ageing must go beyond the absence of disease or disability to encompass conditions of well-being including keeping physical mobility, mental awareness, and a pleasant mood.

Table 1 reports selected health conditions of population 62+ by age groups from the 2012 Survey on Health and Nutrition (INSP, 2014). It shows per cent distribution of people with recent health problems, diabetes or hypertension, suffering sensorial impairments, having trouble performing daily life activities, and also the use of medical services. Information is divided for three birth cohorts and by sex. The oldest are born before 1930, then there are those born between 1931 and 1940, and last are born between 1941 and 1950. Degree of urbanisation of the place of residence is used as a proxy to the socio-economic status. “Recent health problems” enquires if in the last two weeks there has been any adverse health condition. The prevalence of hypertension and diabetes is related to conditions diagnosed by a health professional. Sensory deficiencies for listening or sighting are considered if they are obviously interfering. And activities of daily living difficulties are those that require help. Healthcare is about recent use of outpatient services or hospitalisation. Finally there is a question on coverage by any healthcare system.

Table 1. Selected health conditions in three cohorts of elderly population

Birth cohort	Health conditions			Impairments			Healthcare		
	1941-1950	1931-1940	Before 1930	1941-1950	1931-1940	Before 1930	1941-1950	1931-1940	Before 1930
Age in 2012	62-71	72-81	82+	62-71	72-81	82+	62-71	72-81	82+
Men	17.0	19.3	20.4	5.8	11.7	22.7	11.8	12.9	14.6
Women	21.9	25.7	25.6	3.0	8.3	20.9	17.5	18.2	19.4
Rural	21.4	23.7	25.7	6.5	14.5	18.7	12.7	13.0	14.7
Less-urban	20.1	24.1	20.9	4.6	8.0	3.7	14.1	16.6	12.4
Urban	18.7	21.8	23.3	3.2	8.6	3.7	15.8	16.6	20.9

	Hypertension			Sighting			Hospitalisation		
Men	30.9	36.0	35.0	9.1	10.2	20.1	5.4	7.5	9.7
Women	45.2	48.7	49.6	7.8	12.7	18.2	5.8	7.6	10.7
Rural	30.2	36.2	39.1	11.4	16.5	25.8	4.8	6.8	6.8
Less-urban	36.0	38.6	34.0	10.6	10.1	20.5	6.2	8.9	10.4
Urban	42.8	46.7	48.4	6.3	10.0	15.7	5.7	7.4	11.8
	Diabetes			Activities of daily living			Lack of cover		
Men	25.3	19.9	19.6	27.4	42.8	65.4	17.4	16.5	21.7
Women	26.9	27.5	21.3	30.7	43.4	66.9	15.4	17.0	21.9
Rural	18.8	17.6	8.2	30.04	4.8	68.2	18.1	19.7	23.6
Less-urban	25.0	23.4	14.8	28.1	47.4	69.0	20.7	17.4	22.9
Urban	29.6	26.6	27.9	29.2	40.8	64.0	14.3	15.2	20.4

Sources: *National Survey on Health and Nutrition (ENSANUT) 2012* and *César Gonsáles-GonsálesHealth*

These estimates clearly indicate that for older generations health deterioration is higher, impairments are more prevalent and the use of medical services is more frequent. Figures also show that access to healthcare is lower. These trends and differences are expected but table 1 adds the statistical estimation of the above prevalences and the size of differences.

Table 2. Prevalence of dementia cognitive impairments without dementia

	Dementia	CIWD
Men	2.1	10.7
Women	3.1	14.4
Age		
60-69	1.1	11.8
70-79	1.9	9.3
80+	2.2	4.4

	Dementia	CIWD
Education		
0	2.4	10.4
1-6	2.3	11.9
7+	0.5	2.8

Data source: Mejía-Arango y Gutiérrez, 2011.

On mental conditions table 2 indicates the presence of dementia and cognitive deficiencies without dementia (PFWD) in the population 60+. Also here it is recognised that there is a higher prevalence of mental conditions in women than in men, they are increasing with age and they are lower when schooling is higher.

The depiction about ageing and health conditions (table 2) should be correlated with the available health system. Regrettably there is a lack of medical services with a heavy exclusion of those in the lower socio-economic status.

1.3 Social Context on Ageing

Mexico is a middle-income country undergoing serious problems consequential to a heterogeneous society heavily marked by social and economic inequality. Now it is also being struck by the rapid demographic aging as described previously and this will be critical for the 21st Century.

Individual aging is the last stage and by-product of all previous life-cycles in an approach outlined in the diagram below. The top part mentions just some of the many factors that affect each life cycle, influencing the following phases by carrying biological, social, economic and environmental consequences, ending with favorable or adverse outcomes in old age.

Factors as *nutrition* and *socio-economic status (SES)* are not mentioned in the chart, but they are quite important in each stage and main determinants for subsequent steps. In this scheme SES does appear in the last stage of old age because of its effects in old age allostatic condition (that is the accumulated inability to retrieve biological balance). This concept is important since social and economic inequalities are strongly linked characteristics of health and the functionality of the elderly.

In terms of the overall population these stages are discussed through the study of cohort survival, standing out historical circumstances that have determined social events, economic conditions and public health policies. The narrative is about how after the hostilities of the Mexican Revolution in the earlier decades of the 20th Century, pacification allowed improvements in public health programmes and education systems promoted social and economic development that translated into higher survival and longevity. However, there is no detailed historical data that might link quantifications of incidence and prevalence of morbidity as well as mortality to consequential social and economic development.

In any case, in the path of demographic and epidemiological transitions, literacy and schooling are key issues. Table 4 describes these elements for three cohorts of the elderly population. These are the population born between 1911 and 1930 that in 2010 was 80–99; then people who were born between 1931 and 1940 who are 70–79; and the cohort born in the period 1941 to 1950 thus aged 60–69 in 2010.

Table 3. Literacy and schooling profile of the elderly population by cohort. Mexico, 2010

		Cohort 1941–1950			Cohort 1931–1940			Cohort 1911–1930		
		M	W	Both	M	W	Both	M	W	Both
Literacy	Yes	86.4	77.9	81.9	77.6	70.3	73.7	61.9	58.2	59.9
	No	13.6	22.1	18.1	22.4	29.7	26.3	38.1	41.8	40.1
Schooling	None	14.9	21.8	18.6	26.6	30.9	28.9	43.7	44.2	44.0
	Primary	53.1	53.8	53.5	56.2	55.8	56.0	46.3	45.8	46.0
	Secondary	11.1	7.9	9.4	5.6	4.9	5.3	4.1	3.2	3.6
	High school	8.1	12.0	10.2	4.9	6.6	5.8	2.4	5.3	4.0
	College	12.8	4.4	8.3	6.8	1.8	4.1	3.5	1.5	2.4

Data source: ENIGH (2010) - INEGI

Figures show that by 2010 a significant per cent of the population of 60+ could not read or write. For both sexes illiteracy rates range from 40.1% in cohort 1911–1930 and fall to 18.1% in cohort 1941–1950. It is worse for older cohorts and for women. Statistics on schooling denote improvements for younger cohorts and preference for male education. “None” education fall from 44% in the eldest cohort to 16.6% in the youngest. All categories from Primary to College show higher participation of younger cohorts. A glance into the history of education shows that in the first decades of the 20th Century schooling was limited to urban areas, only for the well to do, with a curb on women. Later there have been steady improvements that will result in better educated future elderly cohorts.

About social conditions, ethnicity is always a key issue in Mexico and that remains the same about ageing. Using the 2015 inter-census figures, table 5 differentiates levels of schooling by age, sex and also between indigenous and non-indigenous populations of 60+. They appear the usual trends that the oldest cohorts are poorly educated, younger generations had better schooling, and the shortcomings for women. But belonging to the indigenous population is also an education handicap. Even non-indigenous women are more educated than indigenous men.

Table 4. Educations by age groups, sex and indigenous condition 2015

Education	Non-indigenous men						
	60-64	65-69	70-74	75-79	80-84	85-89	90+
None	10.9%	16.0%	22.2%	27.7%	32.4%	39.1%	46.0%
Elementary	44.8%	49.1%	50.5%	51.6%	50.1%	47.6%	42.3%
High school	24.8%	19.5%	14.8%	11.1%	9.0%	7.1%	6.0%
College	19.1%	15.1%	12.1%	9.1%	7.9%	5.6%	5.1%
n.a.	0.4%	0.4%	0.5%	0.5%	0.6%	0.6%	0.6%

Education	Non-indigenous women						
	60-64	65-69	70-74	75-79	80-84	85-89	90+
None	15.7%	21.7%	28.4%	32.8%	37.9%	44.5%	49.1%
Elementary	48.4%	50.2%	49.2%	49.7%	47.1%	43.6%	39.7%
High school	23.5%	18.7%	14.8%	11.7%	10.1%	8.2%	7.1%
College	12.1%	9.0%	7.0%	5.3%	4.3%	3.1%	3.5%
n.a.	0.4%	0.4%	0.5%	0.5%	0.5%	0.6%	0.7%
	Indigenous men						
	60-64	65-69	70-74	75-79	80-84	85-89	90+
None	17.3%	23.6%	31.8%	37.2%	42.4%	48.4%	56.9%
Elementary	52.0%	54.0%	52.4%	51.6%	48.1%	45.0%	37.4%
High school	19.3%	13.8%	9.3%	6.6%	5.5%	4.0%	2.9%
College	11.0%	8.2%	6.0%	4.0%	3.5%	2.0%	1.9%
n.a.	0.4%	0.4%	0.5%	0.6%	0.5%	0.6%	0.9%
	Indigenous women						
	60-64	65-69	70-74	75-79	80-84	85-89	90+
None	27.6%	35.5%	44.3%	49.1%	53.9%	61.3%	67.0%
Elementary	49.7%	48.7%	43.7%	42.3%	39.6%	33.7%	28.2%
High school	15.3%	11.0%	8.0%	5.5%	4.2%	3.2%	2.4%
College	6.9%	4.3%	3.3%	2.5%	1.8%	1.1%	1.6%
n.a.	0.5%	0.5%	0.6%	0.6%	0.6%	0.7%	0.8%

Data from: *Conteo intercensal 2015. INEGI*

1.4 Challenges Faced by Elderly Population

Due to the increasing demographic weight of the elderly population, ageing related problems are becoming more and more a relevant part of the national agenda. These problems have origin in the frailty correlated with older ages. These are conditions that damage health, wellbeing and functionality implying dependence with the burden falling on the adult population being able to work, having an income or being capable of providing care. Under this paradigm, the proposal is to regard dependency as the main mark to define and measure the ageing process.

It is not how many people of 65+ are for every 15–64 years but to include actual dependency. To substantiate concepts under this framework, dependency in old age can be classified into three categories of needs:

- ❖ **Healthcare.** Population ageing is the result of the concomitant action between demographic transition and epidemiological transition. Neither of those two transitions can be explained without the other. A gradually lowering in incidence and lethality of communicable diseases is occurring at early ages thus implying increasing survival to older ages. Once reaching older age, population is subject to incidence and prevalence of chronic diseases including disabilities associated with health conditions. These are conditions where lethality is not immediate. Rather, what becomes important is the long-term prevalence of adverse conditions that give rise to increasing longevity with worsening health outcomes.
- ❖ **Long term care.** Survival in conditions of illness and disabilities requires personal care beyond medical attention and therapeutics. This is particularly true when old people need help to carry out basic activities as well as instrumental activities of daily living. Those are unavoidable requirements for survival, wellbeing and maintaining important family and social relationships.
- ❖ **Everyday expenses.** Resources required to pay for at least the basic needs of life such as mainly housing, feeding, clothing and sundries comprise everyday expenses. Also basic entertainment like watching TV, enjoying social life and maintaining contact with family and friends can be included.

2. POLICIES AND PROGRAMMES OF AGEING

2.1 National Policies and Programmes

When ageing is the cause of health eroding, physical or mental functionality fading, work or usual activities having to stop, the main consequence is dependency. Projecting population, its age structures and potential levels of dependency show worrisome scenarios at the national, local, and family levels that deserve full consideration. The key issues are 1) Who is going to meet the burden of dependency? – Institutions, family, individuals? 2) What could be the responses? 3) Which will be the appropriate policy design and programmes to implement?

Trying to cope with dependency, the modalities of support are described as:

- a) **Family support.** In the Mexican context of incomplete development and high inequality, public institutions and public programmes for the elderly are few and limited in contrast with a growing requirement for such services. Thus, the main source of support for the elderly population has always been and will be from family and kinship networks – particularly spouses, offsprings and eventually grandchildren. They are the ones who take care of economic, material and moral needs, including personal care. It should be stressed that due to the higher female survival and longevity most recipients of care are mothers and grandmothers. This gender characteristic is also a matter for caregivers. Gender roles become evident and it is common that most personal effort comes from wives, daughters and granddaughters, while men are more prompted to provide financial support.
- b) **Social security.** The next source of support in importance comes from social security, mainly retirement pensions. From all options for economic security in old age, a pension is regarded by the elderly population as the best. In the case of Mexico, social security also includes healthcare. Limited

coverage and poor performance of retirement pensions are promoting the idea that individual savings during active life will accumulate enough resources for self-support during old age. It might seem that this is the ideal way, when each person uses his own savings during retirement. However, most of these schemes are restricted to financial savings that are especially risky in countries without a sound economy and lacking a proper financial system.

- c) **Public institutions.** There are some public programmes for aid and support of the elderly population, although they are limited. There is a non-contributory basic pension for people 65 and over in poverty. There is also the National Institute of Protection of the Elderly (INAPAM), dedicated to grant some benefits, such as discounts on purchase of basic goods and services. On the part of the healthcare has been recently instituted the so-called *Seguro Popular*, which provides basic medical services to the population not affiliated to the Social Security has recently been instituted as part of healthcare. It runs on very low fees or none at all, but its services are quite limited especially for the elderly (Laurel, 2013).

2.2 Challenges Towards Implementations

The priority of health

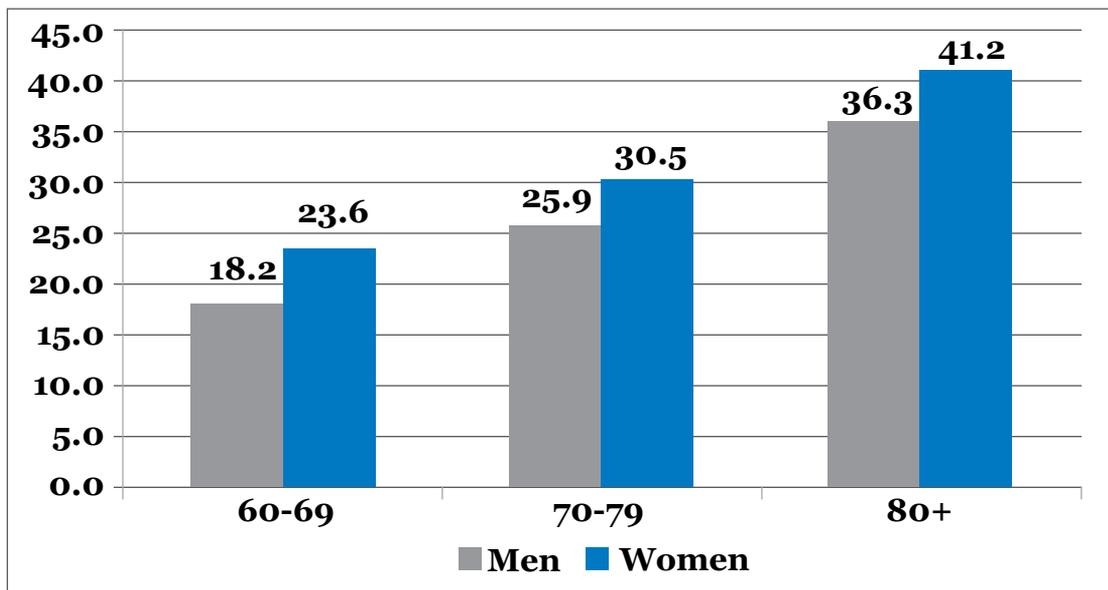
It should be stressed, again, that the social and economic importance of ageing is vulnerability and dependency. Thus, the source of all the weaknesses and risks in old age is in the realm of health. This means focusing on the non-lethal conditions of morbidity and disability correlated with advanced age. In the case of Mexico, as it is in all not fully developed countries, there is a clear trend towards non-communicable diseases and disabilities, notwithstanding the presence of communicable diseases due to social and economic lags and inequalities. Statistics distinguish that morbidity and the difficulty to perform activities of daily living have differences when considering birth cohorts, sex and size of the place of residence as proxy to the socio-economic status, including access to healthcare.

The accelerated ageing process expected in the next decades of higher life expectancies also foresees higher prevalence of chronic diseases and disabilities that will not be isolated but will come along with difficult economic and social conditions. This is leading to problematic scenarios on the demands for medical attention because of a socio-economic related lack of geriatric medical doctors, non-availability of pharmaceuticals, poor therapeutics services, and scarce clinic and hospitalisation facilities. The goals must be to optimise the investment of limited resources in prevention programmes as a main input for healthy ageing (Gonsales, Palloni, Wong, 2014).

Informal long term care

Long-term care refers to help and support needed by the elderly because of dependency from physical or mental limitations. While today a large number of the population 60+ lives independently, there are also those under increasing physical and mental fragility, becoming dependent and hence requiring support and adding a burden to the family, the society and the economy. Graph 2 points out statistics on how dependency increases with age and sex.

Graph 2. Rates of dependency in population 60+ by age brackets and sex



Data from López-Ortega, Mariana (2014)

Care could be provided by paid formal health professionals, social workers, or rehabilitation technicians. However, the most common and reliable help comes from the informal support by kinship and friends donating their time, effort and even money. Informal caregiving by adult children is the most common form of care that supplements formal care or rather replaces it because of plain lack of affordability. The current epidemiological profile of the growing population of 60+, particularly those of 80+ will increase requirements of personal care and health services, either formal or informal.

Studies have also shown the indirect effects of the informal care as the loss of opportunities incurred by the caregiver, income lost due to the abandonment or reduction in work time or personal life. There is also an evident negative impact from the load and stress related to care activities. The aging process is also beginning to generate caregivers who themselves are of 60+ (López-Ortega, 2014).

Changes in size and family structure are announcing a future of reduced availability of relatives and other kinship to provide care to older persons. It is then essential to anticipate the expected needs in health and personal care of the ageing population in relation to the dynamics of family and households not just in regard to size and composition, but also considering economic conditions and social roles and their potentials for support.

Pensions and social security solvency

The most conspicuous political issues about ageing are retirement pensions just by the simple fact that they constitute a public debt impossible to be honored. This concern has an ongoing history that began at the very origin of modern retirement pensions, when they were devised as a partial income replacement to avoid extreme poverty when the ability to work is lost because of old age. It was meant as an act of justice for those who have delivered the efforts of a lifetime to build the social and economic infrastructure for the profit of the following generations. This basic conception has sustained the meaning of a pension as a settled well defined support, legally validated, accepted without reluctance, and claimed with the full feeling of a vested right. However, social

and political developments moved the pension system away from its solidarity and redistribution character. It became a scheme to reward non-deserving big unions and politically empowered groups, granting unjustified fringe benefits such as early retirement and excessive stipends in an exchange for political support and collaboration in election time. Thus, the pension system is fragmented, disordered, limited to salaried workers and urban workers, with outrageous perks for the few. The worst is that the rural and informal workforces have been forgotten, implicitly adding social security transfers from lower to higher SES populations.

Table 5 shows the distribution of population 65+ by the type of pension they have, adding the many that are excluded from the benefit. Almost 71.4% do not have a pension. It is 61% among men and 80.0% among women. Only 28.6% have some kind of pension. It is 39.0% of men and 20.0% of women.

Table 5

% distribution of population 65+ by pension categories			
	Both	Men	Women
No pension	71.4	61.0	80.0
Pensioners	28.6	39.0	20.0
Retirement	41.6	48.4	30.9
Disability, early retirement	34.4	44.0	19.4
Widowhood	17.8	0.1	45.7
Others	6.2	7.5	4.1

Data: ENSS-2013

All pensions are not the same. In the case of men most are for retirement (48.4%). Then there are those because of disability or early retirement (44.0%). In a lower fraction (7.5%) pensions are due to other causes, mainly surviving parents of a deceased worker who was the family provider. In the case of women most (45.7%) are because of widowhood, and the pension is granted to

a wife of a working husband who has died either in activity or already retired. Next come pensions for those women who have worked and retired (30.9%). The rest (4.1%) is from other causes (ENESS, 2015).

Since we are dealing with economic security for the elderly, figures in table 3 refer to pensions in population of 65+. But in the actual system, pensions are not exclusive for the elderly and there are pensioners at earlier ages. Before age 65, pensions should be solely granted because of disability, widowhood and orphanage. But it must be pointed out that there are pensions granted well before age 65 or 60 and sometimes even before 50. It has been established in work contracts and union bargaining that as low as 25 years of activity are enough to retire in public institutions. Another case is those who fake a disability to get a pension. The outrageous fact is that those unjustified pensions amount to such a large cost that they are jeopardising the social and economic sustainability of the pension system.

Table 6 below estimated that by 2013 there would be a total of 4 million 347 thousand pensioners, of which 3 million 188 thousand were affiliated to IMSS and 1 million 159 thousand belonged to various public institutions, including the IMSS as an employer. That is that 73.3% of pensions were granted to a retiring low profile working class. Public institutions have 26.7% of retirees.

Table 6

	Pensioners	% by type	% GDP	% ≤2mw	% >2mw
	4 346 973		120	67.6	32.4
IMSS	3 187 741	73.3	31	80.9	19.1
Public	1 159 232	26.7	69	25.6	74.4

Data: ENSS-2013

These figures reaffirm the poor and skewed coverage of social security. But the main issue is that numbers also point out that the present value of pension contingencies using a financial discount rate of 3.5% is equivalent to the shocking amount of 120% of GDP. That's why pensions are not affordable. But it is not the whole impact. It has to be realised that while 69% of the GDP is

the liability to confront the 26.7% of public pensions, the 73.3% of retirees of the IMSS require only 31% of GDP. The following two columns in table 4 provide the main part of the explanation. 80.9% of retirees of the IMSS receive a pension of up to two minimum wages, and that is insufficient to cover even the basics. On the other hand, in the public sector 74.4% have pensions on top of that amount. In fact, a good part of those pensions are many times above that cut.

2.3 Programme Implementation

There are several programmes dealing with the elderly population, but most of them are limited and narrowed in scopes. In this section there are references to one very promising programme mainly focusing on health and aging in the National Institute of Geriatrics. The other one is a combination of programmes and actions on the crucial question of social security and retirement pensions.

The National Institute of Geriatrics

The Institute of Geriatrics (INGER) was founded in 2008. It was one of the National Institutes of Health of the Ministry of Health in 2012 to respond to the challenges posed by the ageing of the Mexican population. INGER conducted research on geriatrics and related topics, education and training of specialised staff, development of models of care, and innovation of public policies aimed at the elderly.

Being a new-generation institute, INGER has a multidisciplinary and horizontal approach to the diversity of topics concerning ageing, and two of its main goals are: to concur the implementation of the models of care and education by both private and public sectors, and to establish a healthcare model for older persons based on morbidity and disability indicators, providing access to physical activity, proper nutrition and timely treatment of health conditions that may have negative consequences on their quality of life; as well as the extension of care in communities and homes.

Research, studies and training is conducted in the general themes of: 1. Biology of ageing; 2. Geriatric and epidemiology; 3. Development of healthcare and

prevention; 4. Demographic, social and economic determinants of ageing; 5. Gerontological technologies.

Social Security Reforms

In order to monitor financial performance and guarantee economic sustainability in the long-term, Social Security and retirement pensions are legally compelled to undertake periodic actuarial evaluations. Since the inception of Social Security in Mexico, this requirement has been accomplished. But their results were not taken into account in the management and design of policies related to long-term actuarial equivalence. Actuarial valuations actually warned a couple of decades earlier that the system would be of limited coverage, that most future retirees would receive inadequate benefits, while minority privileges would lead the system to economic and financial bankruptcy. It was just in the last decade of the last century that Social Security was forced to admit that this forecast had arrived as predicted.

The need for a social security reform thus emerged as a public issue. That was not because the largest fraction of the population was outside of Social Security. The triggering fact was the alarming tide wave of pensions to come and the intimidating cost even for the immediate short-term.

Despite sound considerations suggesting parametric changes aiming to a fair Social Security, reforms were carried out with the central principle of replacing pensions by a scheme of individual savings in private administration. Solidarity was disregarded in exchange of personal capacity for savings. It should be noted that these changes were not exclusive of Mexico but that they were carried out in some countries in Latin America, following the initial example of Chile at the behest of international agencies among which stands out the World Bank.

It should be stressed that these reforms have been adopted solely by 23 countries belonging to only two regions in the World. One region is Latin America and the other comprises countries in Eastern Europe. In addition, eleven of these countries have reversed the reforms for a total or partial return to Social Security (Ortis, 2015). The reasons for the low confidence in the reforms are due to:

1. Individual accounts cannot expand coverage because social security is linked to formal employment.
2. Resources collected for each individual depends on wage level and time of employment. In a labor environment of low salaries and unemployment, savings will be far from enough.
3. Social Security principles based on solidarity are discarded. It is now a matter of personal financial investment thus withstanding the entailed monetary risks that very few understand. It is particularly unfair for women and the population in poverty.
4. Administration costs are increased for two main reasons. One is the high cost of maintaining individual records that is particularly inefficient for low amount accounts. The other is intrinsic to private business whose primary objective is to make profits.
5. Investment of funds is done in a high percentage in government bonds. Resources are used in government current expenditure thus becoming a public debt to be paid by future generations. The burden on public finances will be very large and hard to pay.
6. The last step is to buy a life annuity from an insurance company with the accumulated lump sum. This implies a commission and administration expenses that will further erode retirement resources.

In addition to the these arguments, it would be better to ponder the concepts from M. Dawson and endorsed by actuaries and economists up to date (Dawson, 1912).

“There is a fundamental fallacy in the notion that any man is supported in old age out of his savings. He is obviously fed not by the grain which was grown by himself when he was a young man, but by the grain which is grown contemporaneously by those who are in their working days It may be that he has accumulated means by which he can compel his support by the new generation, [thus requiring] enforceable promises to pay or other forms of wealth and property which put him in such position that he can’t require the new generation to support him.”

This clearly concludes that there is a need to overhaul the pension system.

3. RECOMMENDATIONS

From what has been discussed about demographic ageing, health status of the elderly, their need of long-term care and what should be a pension for their economic security, it is now time to ask for practical ideas on how to achieve “healthy ageing” as a concept that includes the well-being in all concerns. Let us be very explicit recalling that recommendations and planning are always seeking the best of the possible futures.

3.1 Projecting Economic and Social Needs of the Elderly

Dealing with the future, let us examine it through *demographic projections*. They are the plausible scenarios of population dynamics not only in terms of population sizes, but also in expected sex and age structures, as described in Graph 1. Such projections suggest the expected size and age structure of the population. That it is how we have noted the conspicuous demographic ageing to come. Since the conditions and opportunities of the elderly are always related to the young and adult population, dependency ratios and other intergeneration relations can also be projected and used as indicators of what might occur.

It is necessary to recall the nature of demographic projections not as predictions of what actually is going to happen, but as indicators of what could be the demographic process to come under specific assumptions on fertility, mortality and migration. We can then evaluate which can be the dependency ratios if migration changes or if life expectancies at 65 rise or remain stable.

The next step is to assign values to variables of health and disability that can be attributed as prevalent in demographic projections to estimate the future population with such characteristics. A main application will be assuming hypothesis on incidence and prevalence of chronic diseases and disabilities to estimate the size of the burden to come and the cost that might be attached to such scenarios. This regarding of a demographic projection allows its use as a tool for planning and policy design in an attempt for a better future following two fundamental prospectives.

One is for the short-term using high likelihood hypothesis. This is really trying to predict the future as close as possible. The aim is to formulate immediate planning and budgeting for present administration and allocation of resources.

The other is for the middle and long-term. It is not to foresee the actual future to come, but to build scenarios seeking social and economic sustainability. It is a tool and device that does not imply concrete results and commitments. Rather it is a help to identify for the long run what could be the policy making path to a sustainable future. A main example for this approach is on the financing of Social Security. Although the big application will be in creating scenarios on epidemiology, dependency, health system changes, health professional training, prevention, the financing of all the above and the rest that have not been mentioned. A combination of short and long-term is required for the planning of healthcare. The inevitable transition to chronic diseases and the diminishing capacities make healthcare the most onerous aspect in old age.

3.2 A Computer Tool for Projections within the South-South Collaboration

A population projections and scenarios building software is being elaborated by El Colegio de la Frontera Norte. It follows the demographic components method and technically it is similar to other existing tools. Besides being user friendly, it is designed to admit projection parameters that are closer to middle-income countries. In its demographics, those refer mainly to survival rates and mortality models that can be adjusted to assumptions on future life expectancies after age 60.

The section that is providing a new aspect is a module allowing scenarios building on variables beyond the demographic parameters. They are mainly based on incidences and prevalence of chronic diseases and disabilities. But this can be extended to other concepts such as wellbeing or costs or the estimation of impacts from prevention plans and interventions. To use the software it will be necessary to discuss how to define and quantify such variables in an interdisciplinary collaboration. This collaborating project is now being implemented for Latin America.

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NIGERIA



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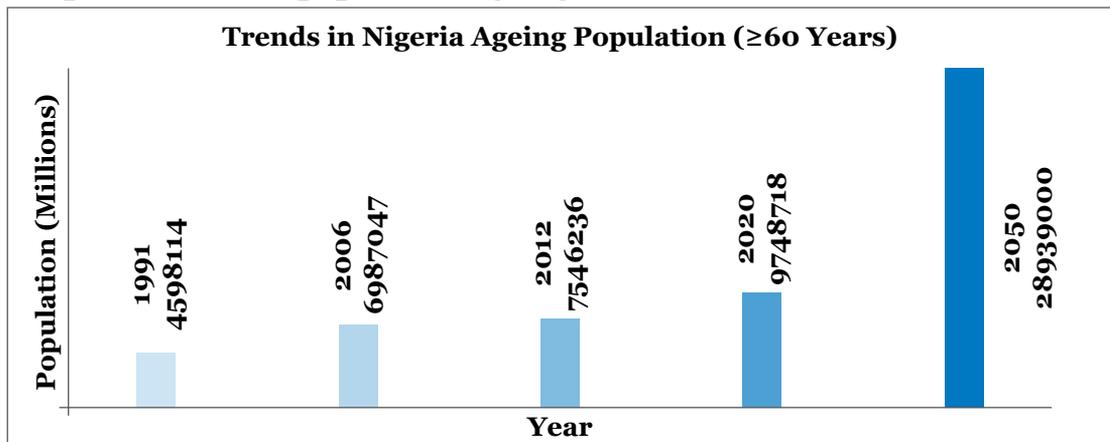
Emem Omokaro



1. Background

The wellbeing of the rapidly growing population of elderly (aged 60 year and above) is becoming a public health concern and a major challenge to sustainable development. In 1950, there were 205 million persons (aged 60 or over) in the world. By 2012, the number of older persons had almost quadrupled at almost 810 million. This number of older persons was projected to more than double by 2050, reaching 2 billion.¹

Graph 1: Trends in population ageing



Source: National Population Commission (NPoPC)

The 2006 census figure of older persons (aged 65+) was 6.99 million accounting for 3.2% of the 140.4 million people or almost the same as in the 1991 Census (3.3%), and this but there was an increase in absolute numbers from 4,598,114 million in 1991 to 6,987,047 million in 2006. The result of the 2006 census also revealed significant differences in the structural composition of population in the states and geo-political zones ranging from 2.9% in the NC, NE and NW geo-political zones to 3.3% in SW, 3.5% in SS and 4.2% in the SE geo-political zones (Table 1).² However, the population of the aged and older persons was estimated at 7.5 million in 2012, 9.7 million by 2020 and 28,939,000 by 2050, if the current inter-censal growth rate persists.³

¹ UNFPA Report: <https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA-Report-Chapter1.pdf>

² NPopC 2006 National Population and Housing Census Data

³ *ibid*

Table 1: Population of older persons in the six geo-political zones

S/N	Geopolitical Zone	Older Person's Pop.
1	South East	1,132,703
2	South South	1,157,181
3	South West	1, 417,401
4	North Central	896,118
5	North East	856,502
6	North West	1,618,144
	Total	7,078,049

Source: National Population Commission (NPC, 2006)

Issues of population ageing and older persons have played an important role in major international conferences during the past two decades. These include the 1992 Rio+10, the International Conference on Population and Development (ICPD) held in 1994,⁴ Rio+20, 2014 ICPD FoA and the 2015 SDGs, that recognised the socio-economic impact of population ageing in all societies. This is because ageing of the population presents vast societal challenges to ensuring that our infrastructures can support the needs of older people enabling them to live healthy, independent and productive lives. To meet these challenges, there is the need to rethink and conceptualise the programming, monitoring and evaluation of ageing issues and initiatives.

2. Ageing and Older Persons

Ageing is solitary in the country. Older persons are isolated, neglected and excluded from the benefits of socio-economic growth. The erosion of familial and communal support systems and the enabling environment and perception

⁴ Department of Economic and Social Affairs Population Division, World Population Ageing 2013

of this cohort of the population as homogenous in terms of frailty and disability have compromised their inclusion as social capital in the development process. From time immemorial, elderly persons in the country are cared for by their adult children, son's wife and the extended family members, particularly the women.⁵ This is however not unique to African countries since the European Study of Adult well-being found that the family provides the bulk of support for older people in most European countries. Non-formal support comes primarily from a spouse and from adult children in the absence of a spouse.⁶

In the country, the processes of modernisation including individualism, urbanisation and migration and the parallel process of the impact of HIV/AIDS have eroded traditional systems of intergenerational family and community support where many people living with HIV/AIDS become dependent on their parents for care rather than supporting them in old age. Shifts and change in domestic and personal circumstances of parents and children,⁷ financial responsibility of the adult children caregiver in respect of their income, family size and stage in family cycle; perceived needs of elderly, income/assets of elderly and residue of parent-child conflict especially witchcraft acquisition; as well as conflict of adult children with parents; childlessness and migration of children and young people have impacted on the care for the aged and older persons.

3. Social Security of the Elderly

Despite the increase in the overall wealth of Nigeria based on its classification as middle-income country by international institutions, the distribution of its wealth remains deeply inequitable. More than 60% of the population lives in poverty.

⁵ Anionwu, 1986; Adeokun, 1986; Ekpeyong 1995

⁶ Burholt *et al.*, 2003

⁷ Omokaro E .2014. Ageing in Nigeria : A keynote paper presented at the Centre of Ageing, University of Manitoba Annual Spring Symposium

3.1 Contributory Pension

Few of the 7.8 million older persons have pension in the form of contributory pension in Nigeria. Aimed exclusively at the formal sector according to recent estimates, this makes up only 10% of the workforce. Only 1.2% of the Nigeria workforce is currently covered by the contributory pension.

The new pension scheme (Pension Reform Act, 2004) is better administered than the old pension scheme. The segregation of duty between the National Pension Commission, Pension Fund Administrators (PFA) and Custodians has helped in the past 8 years to promote transparency and accountability and enabled easy access.

3.2 Non-contributory Pension, Social Assistance (social transfers) and Welfare

The issue of poverty has triggered the emergence of social protection as a policy framework. Increasingly, social protection interventions are based on a multidimensional perspective on poverty that is reflected in the widening scope of social assistance programmes, social insurance and public works schemes in Nigeria. However, welfare and social services targeted the indigent and other vulnerable groups, the Federal Government and most States through the MDG offices, NAPEP, SURE-P etc., and since they do not have an age specific category, they therefore excluded elder persons. This social transfer includes cash/in-kind transfers, and unconditional cash/in-kind transfers.

Workers who are engaged in private sectors that do not have retirement benefits suffer after their disengagement. Although national level attempts at a social protection strategy have stalled in Nigeria, three (Ekiti, Osun, Anambra) out of 36 states have acted independently to ensure income security for the elderly.

Table 2: State Social Welfare Scheme for the elderly in Ekiti, Osun and Anambra

State	Pop. of the elderly aged 65 years and above (NPC, 2006 Census)	Year of establishment of social pension scheme	Amount paid per month	Population of elderly aged 65 years and above who have benefitted	Social security scheme	Elderly persons covered
Ekiti	137,146	October 2011	N5000 (\$33)	20,000 older persons as of May 2012	Social pension	65+
Osun	201,480	July 2012	N10,000 (\$66)	1,602	Social pension and medical treatment	65+
Anambra	261,886		N5000 (\$33)		Social pension	75+

3.3 Employment in Old Age: Anticipation and Social Inclusiveness

Ways of engaging the growing youth population is of great concern to the government. Older generations are often unable to work except for those volunteering in community development projects.

The three tiers of government (Federal, State and Local) and the community however provide increasing social, political and cultural opportunities for older persons to participate in the normal activities of their society.

3.4 Enabling and Supporting Environment and the Elderly

Informal networks such as family, faith based organisations, association of artisans, cooperative societies, assistance from community solidarity, etc., support the elderly who have to cope with various shocks and deal with isolation, loneliness and long term poverty. The informal means of social protection are prevalent among individuals, households and communities. There are however, many social protection intervention schemes that provide a conducive environment to the caregivers and community to do more and be optimistic.

4. Health Status of the Elderly

Prior to the advent of the National Health Council Policy mandating all University Teaching Hospitals in the country to open a geriatric centre, the Government believes the health problems that manifest among women of reproductive age (15–49 years), children and youth need more attention than that of the elderly. Also, there are no age-specific health programmes designed to provide healthcare for older persons among the respective Federal and State Ministry of Health.

At retirement, “many elderly people who do not have their own houses in cities, are forced to relocate to the rural areas where there is inadequate access to good healthcare facilities and quality standard of living”. The poor health status of the elderly is further worsened by:

- ❖ Existing widespread lack of specialist services and personnel (Geriatrician) to serve the health needs of the growing number of older people.
- ❖ Lack of a health insurance scheme that covers the interests of the elderly. This implies that even if the aged people are aware of their health problems, they would probably be unable to afford treatment.

In a study among the institutionalised elderly in Nigeria, it was found that while the institutionalised elderly in Lagos are not deficient in energy their diet does not provide adequate amounts of vitamin B, especially B6, biotin, thiamin and riboflavin. In addition to a monotonous diet, the majority of the elderly do not engage in adequate amount of physical activities.⁸

A study on elderly persons aged 65–78 year from rural and urban areas of the south-western region of Nigeria reported that elderly male respondents were significantly taller than female.⁹ Therefore, the higher body weight among the elderly females could contribute to fat deposits rather than skeletal weight since the male were taller. The magnitude of decrease in the Body Mass Index was found to be relatively more before the age of 60 years and after 80 years. The study further revealed that from the age of 60–80 years the elderly demonstrate minimal change in their nutritional status.

A community-based study on the health status of the elderly in the Ijumu local government area, Kogi State, Nigeria revealed that arthritis was the most prevalent (16.9%) common chronic disease reported by the elderly in the study area, followed by hypertension (16.4%), Rheumatism (13.5%) and general body pain (9.4%). Other known chronic elderly disease conditions were less prominent.¹⁰

The National Health Council mandate has however led to the establishment of a Geriatric Unit at the University College Hospital Ibadan in Nigeria in 2012. A private initiative and first of its kind in the country, the Chief Tony Anenih Geriatric Centre runs five Community Geriatric Care outposts.

⁸ Olayiwola O.I et al., 2007. Nutritional assessment of some elderly farmers in rural areas of ogun state Nigeria. *International Journal of Agricultural sciences, Environmental and technology* 6 (1): 78 -87.

⁹ Oguntona and Kuku 2000

¹⁰ Ibitoye et al., 2014. The determinants of healthcare utilisation among the elderly in a rural community in Nigeria. *IOSR Journal of Humanities and Social Science (IOSR-JHSS)*, Vol 19, Issue 7, Ver III, Page 154-159.

5. Nigeria's Ranking on the Global Age Watch Index

The Global Age Watch Index published in 2013 by Help Age International in collaboration with UNFPA provides a global picture of how well countries are doing to support their ageing population using a unique set of internationally comparable indicators to assess older people's income status, health status, education and employment and enabling environment. Of the 91 countries selected globally, the participating African countries had poor ranking on both the overall and specific well-being domains. The maximum value (score) obtainable per wellbeing domain is 100.

Nigeria ranks poor with an overall domain ranking of 85th position compared with South Africa and Ghana that had an overall ranking of 65th & 69th positions respectively. It therefore becomes more and more important that governments and individuals in Nigeria and Africa as a whole be well guided about their perception and actions concerning healthy ageing and a dignified old age. Table 3 shows Nigeria ranking on the specific well-being domains as well as values and indicators used for measuring success per domain.

Table 3: Wellbeing of older persons

Wellbeing Domain	Ranking	Values	Indicators
Income security	87	14.2	Pension income coverage Poverty rate in old age Relative welfare of older people GDP per capita
Health Status	84	26.4	Life expectancy at 60 Healthy life expectancy at 60 Psychological wellbeing
Employment & Education	70	30.5	Employment of older people Educational status of older people
Enabling environment	76	53.6	Social connections Physical safety Civic freedom Access to public transport
Overall	85	24.0	All indicators stated above

Source: 2013 Global Age Watch Index Report

6. Policy Environment for Ageing

Efforts to address the challenges of ageing and older persons is implicit in the Constitution that states that as part of the economic objective, the country shall direct its policy towards ensuring that suitable and adequate shelter, food, old age care and pension, and unemployment, sick benefits and welfare of the disabled are provided for all citizens.¹¹ In response to the 1994 ICPD Programme of Action (PoA) and the 2001 MDGs, the country revised its 1988 National Policy on Population for Development, Unity, Progress and Self Reliance (NPPDUP&SR) in 2004 as the National Policy on Population for Sustainable Development (NPPSD) and put in place the Strategic Plan in 2008. This triggered the development of some sector-specific policies, programmes, strategic frameworks and plans on health, family planning, youth development, women empowerment, etc., to streamline interventions with a view to scale up progress towards achievement of the national and international development goals including ICPD PoA and the MDGs. Some of these policies and programmes include:

- ❖ National Gender Policy (2006)
- ❖ Midwifery Service Scheme.
- ❖ Subsidy Reinvestment programme (SURE-P)
- ❖ National Health Policy (revised) regulates rights to health standard for all vulnerable groups including the elderly and mandates every Teaching Hospital in the country to open a Geriatric Centre.

None the less, the country is yet to enact a National Policy on the Care and Welfare of the Aged and Older Persons. The National Social Protection Policy (February 2014) remains in draft form since March 2003. The government and

¹¹ Section 16(2)(d) of the 1999 Constitution of the Federal Republic of Nigeria (FRN) in *Protecting the Rights of Old People in Nigeria: Towards a Legal Reform* Araromi, Marcus Ayodeji, PhD. Department of Public Law, Faculty of Law, University of Ibadan.

political leaders believe that the provision of care for older people in the country is the responsibility of families. The Contributory Pension Scheme (Insurance) is mainly designed for those who work(ed) in the formal sector, and does not cover many older persons. It is yet to make appreciable impact on the lives of older people. At the moment, there is no law on elder abuse. Yet, the country is signatory to global and regional frameworks that guide country level responses to tackling the challenges of the ageing population and achieving improved well-being for older persons: i) The Madrid International Plan of Action on Ageing (MIPAA) – the global policy framework adopted by the United Nations General Assembly in 2002 and ii) The African Union Policy Framework and Plan of Action (AU PFPA)- the regional level policy instrument (2003). The creation of awareness of elderly abuse as a public health and social issue has been intensified since the first World Elder Abuse Awareness Day took place in most major cities in Nigeria in 2006.¹²

Overall, lack of political will and different priorities are the factors directly underlying Nigeria's failure to ratify, let alone implement the National Ageing Policy. Policy and lawmakers are not sufficiently sensitised to the scope, nature or seriousness of older people's problem nor to the broad economic and social development implications of leaving these problems unaddressed in the context of rapid population ageing. The key cause of the country's failure to act on ageing is thus the ominous lack of comprehensive, high quality evidence of the magnitude, nature and implications of the population ageing challenge that would serve to sensitise policy makers.¹³

The country does not have a dedicated policy addressing ageing and/or the needs of older persons (60+) that is currently being implemented. Further, the country does not have any main institution responsible for implementing

¹² Country Report: Ageing in Nigeria – Current state, social and economic implications: at <http://www.eldis.org/>

¹³ Protecting the Rights of Old People in Nigeria: Towards a Legal Reform Araromi, Marcus Ayodeji, PhD. Department of Public Law, Faculty of Law, University of Ibadan, Journal of Law, Policy and Globalisation www.iiste.org ISSN 2224-3240 (Paper) ISSN 2224-3259 (Online) Vol.40, 2015

the policy, programme and strategy on ageing and needs of older persons. Interventions on ageing are being addressed sectorally under the 2004 NPPSD, National Health Policy and National Gender Policy, but the country has not established any institutional entities to address issues regarding ageing and/or the needs of older persons (60+ years). The lack of a dedicated national policy on social protection and inadequate programmes on issues of ageing have led the low ranking of the country at 85th position compared with South Africa and Ghana that had an overall ranking of 65th & 69th positions respectively. The specific well-being domains are income security, health status, employment and education and enabling environment.¹⁴

7. On-Going Programmes for Ageing in Nigeria

On-going social security for the elderly include the ad-hoc interventions in relevant sectors including the National Population Commission, Federal Ministry of Health and Federal Ministry of Youth Development; Contributory Pension, Non-Contributory Pension in a few States, the activities of CSOs and NGOs and the Geriatric Centres in the Teaching Hospitals.

The ad-hoc interventions in the relevant Ministries are neither coordinated nor sustainable. There is also no synergy between these sectors in the process. Following the establishment of the Pension Reform (2004), about 7.8 million older persons have the contributory pension. This is aimed exclusively at the formal sector and according to recent estimate, makes up only 10% of the workforce. Only 1.2% of the Nigeria workforce is currently covered by the contributory pension. The new pension scheme (Pension Reform Act 2004) is better administered compared to the old pension scheme. The segregation of duty between the National Pension Commission, Pension Fund Administrators (PFA) and Custodian has helped over the past 8 years to promote transparency and accountability and enabled easy access. However, since attempts at a social

¹⁴ 2013 Global Age Watch Index Report

protection strategy have stalled at the national level since 2003, a few States [Ekiti (2011), Osun (2012) and Anambra (2013)] out of 36 states and the FCT Abuja have introduced the State Social Welfare Scheme for the elderly. One state (Cross Rivers) is currently drafting its social protection policy. However, in October 2014, the federal government announced plans to launch a National Policy on Ageing in the country to provide a suitable national framework for care of older persons.

In order to ensure that citizens live their fullest age and in good health, the National Health Council has mandated every Teaching Hospital to open a Geriatric Centre. This has led to the establishment of two Geriatric Centres in the country. The first of its kind in the country was the Chief Tony Anenih Geriatric Centre, University College Hospital, Ibadan and another one at University of Benin Teaching Hospital (UBTH).¹⁵

Informal networks such as family, Faith-Based Organisations, Association of Artisans, Cooperative Societies, assistance from community solidarity, etc., serve as key sources of support coping with various shocks and dealings with isolation and long term poverty. The informal means of social protection are prevalent among individuals, households and communities. Similarly, Civil societies and NGOs such as Dave Omokaro Foundation (DOF) are advocating governments to widen the social, political and cultural opportunities for older persons to participate in the normal activities of the society including income generating activities and encouragement of continuing engagement of retirees. Such NGOs have facilitated several National and International training workshops, conferences, symposiums and published proceedings and communiqué on ageing issues while also promoting research and inter-sectoral collaboration since 2011 to lay solid foundation for the emergence of Centres of Excellence in Gerontology and Geriatrics in the country's universities. These efforts have resulted in the NUC/DOF Partnership on Capacity Building on Ageing Studies that has led to the development of the Benchmark Statement and Minimum Academic Standard (BMAS) for pilot Post-Graduate Studies

¹⁵ Omokaro (2004)

(PGD, MSc, Ph.D.) and the training of Lecturers as Specialist in Ageing Certificate Programmes and Research in eleven (11) Nigerian Universities (since September, 2014).

8. ICPD Issues Regarding Ageing and the Needs of Older Persons in the National Context

Due to the absence of deliberate policy and lack of concrete programmes on ageing by the government, most of the ICPD issues regarding ageing and the needs of older persons have not been addressed in the national context. These ICPD issues include:

- ❖ Enabling older persons to live independently as long as possible
- ❖ Providing social services including long-term care
- ❖ Enabling older persons to make full use of their skills and abilities
- ❖ Extending or improving old age allowances/pensions and/or other income support schemes for older persons, including non-contributory pensions
- ❖ Providing affordable, appropriate and accessible healthcare to meet the needs of older persons
- ❖ Addressing neglect, abuse and violence against older persons
- ❖ Preventing discrimination against older persons, especially widows
- ❖ Promoting employment opportunities for older workers
- ❖ Providing support to families caring for older persons
- ❖ Collecting age and sex-disaggregated data on the socio-economic status and living conditions of older persons
- ❖ Instituting concrete procedures and mechanisms for older persons to participate in the planning, implementation and evaluation of development activities that have a direct impact on their lives
- ❖ Achievements in addressing issues related to ageing and/or the needs of older persons (60+).

9. Key Achievements

Among the issues related to ageing and the needs of older persons (60+) that are most relevant in the national context are:

- ❖ Contributory Pensions
- ❖ Non-Contributory Pension in a few States
- ❖ Draft National Social Protection Policy
- ❖ Cross Rivers State Draft Social Protection Policy
- ❖ Increasing awareness on issues of ageing and the needs of older persons.
- ❖ Establishment of Pension Reform (2004).
- ❖ Introduction of State Social Welfare Scheme for the Elderly in Ekiti, Osun and Anambra.
- ❖ Establishment of Geriatric unit in tertiary teaching hospitals like the University College
- ❖ Development of the draft National Social Protection Policy (February, 2014).

The key facilitating factor for these achievements is the advocacy by donors and NGOs on issues of ageing and the needs of older persons. However, the barriers to achievements in the area of ageing and the needs of older persons are:

- ❖ Weak policy environment
- ❖ Low level of awareness
- ❖ Inadequate institutional entity for ageing
- ❖ Absence of disaggregated data. The country has not conducted any assessment or situation analysis of the needs of older persons at the national and/or subnational level in the last five (5) years.
- ❖ Weak sectoral and inter-sectoral synergy, collaboration and partnerships
- ❖ Low involvement of CSOs and private sectors.

10. Partnerships for Ageing and the Needs of Older Persons

- ❖ Dave Omokaro Foundation (DoF) a national NGO with the National University Commission (NUC) on research and data collection, advocacy and policy formulation, awareness raising and social mobilisation, and education and training.
- ❖ NUC research and data collection awareness raising and social mobilisation and education and training.
- ❖ UNFPA and WHO research and data collection, advocacy and policy formulation, awareness raising and social mobilisation and education and training.
- ❖ University of Indiana, USA to develop a curriculum for programmes of Studies in Gerontology and Geriatrics in Nigeria.

11. Recommendations

The most relevant issues regarding ageing require further public policy priority for the next five to ten years to enable policy environment, partnership and resources allocation, and disaggregated data on ageing and older persons. In order to achieve this, the Government of Nigeria needs to step up efforts towards the following:

- ❖ Advocacy and enabling environment – enact the national and state-level policies on ageing and older persons.
- ❖ Establish institutional entity – National Commission on Ageing and State-level Commission on Ageing.
- ❖ National and sub-national including sectoral and inter-sectoral data on the needs of older persons. Regular and timely collection, analysis and utilisation of accurate and reliable data on persons aged 50+ disaggregated by sex, geographical location, education and income, etc.; to inform policy and development interventions.

- ❖ Deliberate coordinated actions that are Enabling Environment, Income Security, Health Status, and Employment and Education in all sectors and at all levels in the wellbeing domain of older persons.
- ❖ Partnership and resource mobilisation for ageing programming.
- ❖ Inter- and intra-sectoral synergies in programming for ageing and needs of the older persons.
- ❖ Global observances: International Day of Older Persons and the World Elder Abuse Awareness Day to increase awareness on ageing and the needs of older persons.
- ❖ Relevant Ministries, Department and Agencies (MDAs) to address ageing in their annual budget.

SOUTH AFRICA



Monde Makiwane

1. Background

1.1. Demographic Information

The population of older persons is increasing at a rapid rate throughout the world. It is expected that the number of older persons will reach the 2 billion mark by 2050. Currently, Africa is demographically a young continent, but is currently experiencing demographic transition that has spurred a rapidly growing number of older persons. Thus, the elderly population in Africa is currently estimated to be slightly over 38 million, and projected to reach between 203 and 212 million by 2050 (Help Age International, 2012). In 2015, the South African life expectancy was estimated at 62.5 years for the overall population; with female life expectancy being 64.3, and males being 60.6 (StatsSA, 2016). The overall median age for South Africa is 25.7, 25.4 for males and 26 for females (World Factbook, 2014).

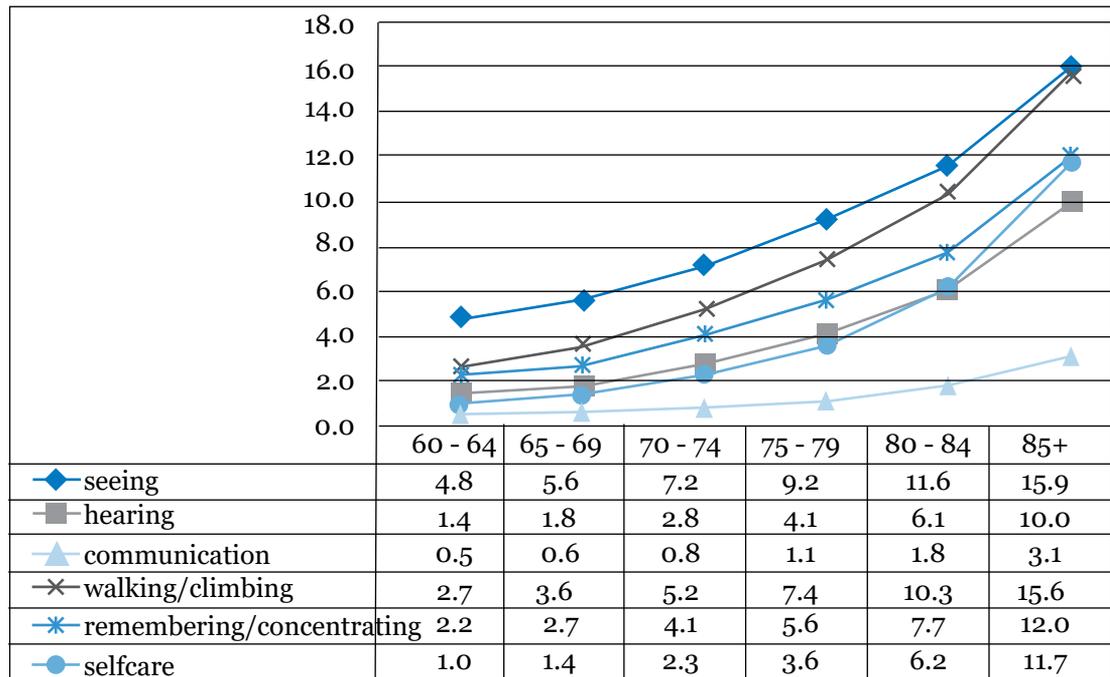
The demographic transition on the continent started in Northern Africa; followed closely is the Southern part of the continent. In South Africa, it is expected that by 2050 the population aged 60 and above will have increased from the current 3.7 million to 4.6 million and would constitute 13.7% of the total population. The ratio of older persons to the potentially economically active adult group will have increased to 14.9% of the total population. The rate of ageing in South Africa has differed according to race. The proportion of elderly Whites and Indian/Asians increased by 5.7 percentage points (from 14.4% in 1996 to 20.1% in 2011) and 4.8 percentage points (from 6.4% in 1996 to 11.2% in 2011), respectively over the period 1996–2011, while elderly Coloured and Black Africans grew by 1.9 percentage points (from 5.8% in 1996 to 7.7% in 2011) and 0.4 percentage points (from 6.2% in 1996 to 6.6% in 2011), respectively (Help Age International, 2012).

Another noteworthy feature of population transition in South Africa has been feminisation of ageing, as the proportion of older women is significantly higher than that of older men. This is a result of a higher male mortality in society. As women outlive men, many multigenerational households are headed by women. This is a shift from the traditional role of women in society.

1.2. Health Situation of Older Persons

One way of assessing the health of older persons is to evaluate the level of difficulty older persons find in carrying out basic functions. The difficulties older persons find in carrying out basic functions as years progress are shown below. Graph 1, describes the percentage of elderly persons aged 60 years and older with severe difficulties in selected functional domains by age.

Graph 1



Source: South African Census 2011

According to Graph 1, the proportion of elderly persons who reported having severe difficulty in all functional domains increases with age (such as seeing, hearing, communicating, walking or climbing stairs, remembering or concentrating, and self-care). As shown in Graph 1, older persons are most likely to start experiencing difficulty with seeing, followed by walking. As early as age 60–64, 4.8% experience difficulty with seeing and the difficulty increases with age. As the elderly age, particularly towards their eighties, walking a kilometre or climbing a flight of stairs as well as taking care of one’s

self, become more difficult tasks to perform. Despite the severe difficulty in hearing, seeing and remembering/concentrating, the level of difficulty in communicating among the elderly remains relatively low even among those aged 80–84 (3.1%). Another way of examining the health of older persons is to evaluate the burden of diseases as reflected by the causes of death. According to the South African Medical Council (2016), the specific causes of death among older persons are ischaemic heart diseases, stroke, hypertensive heart disease, chronic obstructive pulmonary disease and diabetes mellitus. Ischaemic heart disease and stroke ranked first and second respectively for men, whereas they ranked second and first for women.

1.3. Social Context on Ageing

Historical structural inequalities have a big impact on the quality of life of the elderly in South Africa. Most notably, racial and class disparities as a result of the legacy of Apartheid and aspects like geography (rural or urban) play a major role in the quality of life of the elderly. Circular migration also plays a big role in determining the type of life that older persons live. As a result of circular migration, many children and older people reside in rural areas while majority of the middle generation stay in the cities to be in proximity with work opportunities. This situation is not only found in South Africa, but is commonly experienced in many African countries, where workers move back to their rural homesteads after reaching pensionable age. As a result of this phenomenon, rural areas carry a disproportionate high burden of caring for both elderly and children. Thus, the majority of older people in South Africa either live in multigenerational families, or in skipped generational families. It has, in the past, been assumed that the elderly are the biggest beneficiaries in multigenerational households, both economically and as recipients of care, but emerging evidence shows that not only are older persons major economical benefactors of such families, they are also major givers of care (Makiwane et al., 2004).

1.4. Challenges Faced by Elderly Population towards Healthy Ageing

The change in the age structure of the world population towards older persons has resulted in a worldwide interest in the problem of ageing. Of special interest in developing countries has been a lack of a comprehensive social security system and sound pension schemes for the majority of the aged. This is a result of most labour in these countries being found in the informal economy that generally does not have pension provisions for its workers and the fact that majority of governments do not have a financial muscle to develop a sound social security system.

The extended family has always been seen as an alternative institution that cares for the elderly in African society. Over the twentieth century, a waning extended family system has resulted in crises of care for the elderly in many African countries. Traditionally, in Africa the extended family has been known for giving care to the majority of its elderly. Recently it has been noted that there has been a decline in this practice that is associated to many factors, including a drastic decline in fertility resulting in smaller families (Chimere-Dan 2015). Other factors include high mobility of younger generations (Hall et al., 2015) and thus many young people might not be available to take care of their ageing parents. Overall the changing nature of intergenerational relations has an impact on the ability of the younger generation to dispense their obligations to the previous generation (Makiwane et al. 2004).

2. Ageing Policies and Programmes

2.1. National Policies and programme

The democratic government came into existence in 1994 and has put issues related to ageing high on the agenda of the state. This has been demonstrated by including ageing in the Bill of Rights of the Constitution. Thus, Section 9 of the Bill of Rights of the Constitution of South Africa states that “The state may not unfairly discriminate directly or indirectly against anyone on one or more

grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth". "Age" is an attribute based on which no South African should ever be discriminated against. In addition to the Constitution, the South African government introduced the Older Persons Act 13 of 2006 that provides a comprehensive framework for the promotion of the welfare of old people, protection of their rights, combating of abuse, and the provision of services and programmes. The National Department of Social Development has the central responsibility of overseeing the development of older persons in conjunction with other non-governmental organisations. A South African Older Persons' Forum was also formed in 2005 as an independent alliance of organisations of older persons. The aim of the Forum is to co-ordinate, mobilise and represent the collective voice of older persons. The Forum has continued to lobby the government on issues that pertain to older persons up to this moment.

As a result of the government prioritising the interest of older persons, South Africa is one of the few Sub-Saharan countries that operate a non-contributory social pension system. The Old Age Grant is paid monthly to men and women who are 60 years and older, regardless of whether or not the person worked previously. In South Africa, the scheme is 'means tested', meaning that it is given to elderly persons who either do not have any other regular income, or the level of the regular income they receive is below a minimum living level standard. The Old Age Grant (OAG) is the primary source of income for the majority of the elderly in South Africa. Furthermore, in many cases the elderly are likely to use their old age grants to support the entire household that is usually multigenerational (Makiwane et al., 2004). This is stemming from high youth mortality and unemployment that forces many young people to be dependent on their ageing parents. Despite many development challenges, South Africa has shown commitment to the care of older persons by sustaining the Old Age Grant.

The Old Age Grant was introduced by the Apartheid government for the poor white elderly, but was later extended to the Black majority for a smaller amount than that given to their white counterparts. The social grants were equalised

at the end of Apartheid. In addition the child support grant was introduced by the post-apartheid state in order to alleviate poverty in poor households. Quite commonly, it is the grandparents as carers of grandchildren who make claims on behalf of these children (Makiwane, 2010). The older persons tend to live in poorer households. More importantly, the households headed by older persons with access to social security have become a refuge for members of other generations who have no source of income of their own.

2.2. Global Ageing Policies and their Adaptation into the National Policies

The United Nations Convention on Ageing has adopted a comprehensive and systematic framework for the protection and promotion of all the human rights of older people. It prohibits discrimination on the basis of old age in all aspects of people's lives, and advocates that the human rights framework must be articulated and specifically applied to older persons. In addition, the framework advocates for a strong implementation plan that has a well-articulated monitoring and accountability system.

The Older Persons' Act was passed in South Africa in 2006 in line with the United Nation's convention. The Act deals with comprehensive issues of older persons in South Africa. The main objectives of the legislation are to maintain and promote the status, well-being, safety and security of older persons; to maintain and protect their rights and to shift the emphasis from institutional care to community based care. In addition, the bill aims at regularising the services and facilities of older persons and combating the abuse of older persons. The legislation encourages establishments of community based care and support services and the delay of institutionalisation of older persons, for as long as possible. This home-based care is planned to go hand in hand with opportunities to develop the full potential of older persons. A provision has been made for the registration and setting of minimum standards for institutions caring for older persons. Prevention of domestic and public abuse of older persons has received prominent attention in the policy. Abuse has been defined broadly to include physical, sexual, psychological and economic abuse. In addition, the policy on older persons specifically mentions that older persons should be targeted for

community development programmes, including programmes aimed at poverty reduction and food security even in emergency situations, recreation, access to information and consumer protection. In addition, the policy promises reduced tariffs for government and municipal services that are used by older persons. A scheme to extend the employee social security to sectors that are not presently covered is also envisaged.

2.3. Challenges towards Implementation of Policies and Programmes

In spite of an impressive legislative framework alluded earlier, the majority of aged in South Africa remain in a disadvantaged position. Historical disadvantages according to race, gender and class weighs heavily on older people on many fronts. The generous grant given by the government to assist many older people, ends up not only assisting the entire extended families where older people reside, but in many cases attract poorer relatives. Secondly, the care needs of older persons are not well catered to because of limited assistive devices and residential care, and the fast changing structure of the extended family. As a result of the changes in the family structure, it has been noted that not only are many older persons lacking in care, but many cases they end up being the main caregivers of grandchildren and sick children. Thirdly, as shown above, there is an inadequate residential care for many frail older persons.

2.4. Role of NGOs and CSOs in Addressing Healthy Ageing

The major contribution of NGOs and CSOs was establishing and managing residential care for a significant section of older persons. Residential care is still not available to the majority of older persons who need them. Racial discrepancies in the availability of residential care facilities for older persons are one of the unique consequences of apartheid South Africa. In line with the British practice of the time, the provision of old age homes emerged in South Africa over a century ago. The number of homes expanded rapidly after World War II. They were all reserved for white people. By 1964, 120 such old age homes were subsidised by the government. Things did not change much in 2015. The distribution of old age residential facilities is still disproportionate

in the wealthier provinces of Gauteng and the Western Cape (17%), with a distinct lack of facilities in poorer provinces such as Limpopo. Voluntary, Non-Governmental Organisations (NGOs,) Faith Based Organisations (FBO') and Community-Based Organisations (CBOs) run a large number of these facilities. In addition to accommodation and assisted living facilities, such organisations provide home help and meals on wheels and they facilitate support groups and luncheon clubs.

The democratic government has invested considerable efforts to give access of residential facilities to the population that was denied opportunities in the past. In spite of this, there are glaring disparities among different race groups when it is related to access. For instance, the old age homes can be divided into three categories: (i) those wholly owned by the government and are predominantly black and poorly resourced; (ii) those that are subsidised, racially mixed old age homes that have a white majority and have better resources and (iii) those wholly privately owned, and are predominantly white and possess the best resources.

NGOs have also greatly assisted in the establishment of community based care services. This came after it was established that suitable institutions are not available for the majority of older persons, coupled with wide spread abuse and other problems that were found to be common in some South African institutions. As a result, focus started to shift toward community based care for older persons and on community care that assisted older persons in their care and in health needs. In 1995, the Discussion Group on Ageing estimated that 20% of older persons on social grants required community-based services in the form of multi-purpose community centres where there would be primary healthcare, food distribution and adult education services, as well as pre-school and after school centres. (Help Age, 2012)

In reality, few community centres were established. Most funding went to the establishment of old age clubs could be established with less financial resources. These clubs are mostly run in local churches and community halls and are mostly managed by elderly volunteers. They provide meals, companionship, home care and spiritual support. Age in Action has set up majority of the clubs, and found that only 25% of clubs receive government funding. Funding criteria

and minimum norms and standards for these services are yet to be developed. (Help Age, 2012).

3. Lessons learnt

Racial discrepancies in the availability of residential care facilities for older persons are one of the unique consequences of apartheid South Africa. The provision of old age homes emerged in South Africa over a century ago, in line with British practice at the time. The number of homes expanded rapidly after World War II. They were all reserved for white people. By 1964, 120 such old age homes were subsidised by the government. There were also homes for white older persons run for profit, over which the government had no control. In spite of the collapse of the Apartheid system in South Africa, it has proved to be extremely difficult to provide suitable residential care for the majority of poor Black older persons.

Another aspect is related to a need for improved literacy for older persons. Given that many older persons give care to younger generations, a need has been realised to prioritise adult education. A high proportion of older persons from poor urban and rural backgrounds never had the opportunity to attend school or dropped out at an early age. They are typically marginalised within an education system that favours youth and even within the adult basic education and training (ABET) sector. However, older persons have a variety of literacy needs, depending on their personal circumstances. For the urban and rural poor, these needs include form-filling in order to acquire identity documents and to access government services such as Old Age and Disability grants, reading books and newspapers, and assisting children with homework, since older persons are often also primary care-givers.

4. Recommendations for further policy advancements

What follows is the thrust of the suggested policy interventions suggested below is to encourage “age-friendly” families and communities. Some of the strategies have been listed below:

Some of the means could include:

(i) ***Technology and media that encourage better intergenerational relations***

The first policy option is to encourage the support role of medial and digital technology. It is common understanding that new technological innovations have played a divisive role among generations. This is due to the fact that young people who were born during the digital age, leave behind other generations who are digital “migrants”. New attempts are envisaged that would make digital communication to be more user-friendly to the older generation, and thus enable them to communicate and transfer knowledge and skills to the younger generation who might not be residing with them. In addition, the media should encourage a positive and integrative role between members of different generations. This could be done by harnessing the power of digital story telling methods that reflect the current state of intergenerational relations.

(ii) ***Support for voluntary and flexible economic and social participation of retired persons through recognising the value of older workers’ experience***

The government can facilitate participation by a number of considered incentives to the state and other private sector organisations that accommodate flexible participation of older persons. This would enhance skills and knowledge transfer across generations. Multipurpose centres where old people can receive healthcare, and entertainment but also where the old people, in turn, can provide a service to children and youth. People of different generations must share physical environment and

be encouraged to engage in formal and informal interactions. This can be done by recognising and making relevant the value of older workers' experiences. Some of the strategies that can be adopted are:

- ◆ Improve the measurement of productivity, especially of older workers, in order to adequately change working arrangements to accommodate them and keep them in the workplace.
- ◆ End implicit bias against older workers and all forms of ageism in the workforce.
- ◆ Encourage lifelong-learning to enable older workers to “up skill” and remain engaged in the workplace, and support the development of workforce networks that can enable people to ascend and reintegrate into their or other sectors and professions.
- ◆ Adapt innovative strategies to encourage employers to engage and retain older people, promoting multigenerational and age-friendly workplaces.
- ◆ Adopt employment policies that encourage “soft landings,” ensuring better transitions out of the workforce, enabling intergenerational skills and knowledge transfer, and maximising productivity.

iii) Designing sustainable health and care systems

Recognise historical disadvantage in dealing with health needs of older persons. This is the case in funding models and healthcare facilities.

Acknowledging that older people are not a homogenous group. Those that are relatively well and independent must be assisted to remain active as long as they can be. The second group is those living with chronic conditions who need some help with daily care but can get assistance from the family and community. Families and community must be given training and financial incentives so that they could be of better assistance to this group.

The third category of care is for those who need frail care which must be provided in institutions that are also accessible to the poor majority. The overall arching strategy should be to encourage self-care and community based care and thus change the disproportionate investment in institutional care.

A “culture of health” and that of saving must be encouraged to the entire population. The culture of health would lead to healthy ageing. On the other hand, lifetime savings would result in a majority of older people who are not dependent on meagre social grants from the government and giving greater priority to self-managed care options through the use of both technological innovations and low-tech and high-tech solutions.

Improve the image of care, making it attractive to potential workers across age groups and genders, as well as potential investors and innovators. Expand human resources for healthcare and training for elderly care across a broad spectrum.

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VIETNAM



PHAM VU HOANG

1. BACKGROUND

1.1. Vietnam's Economic and Social Backgrounds

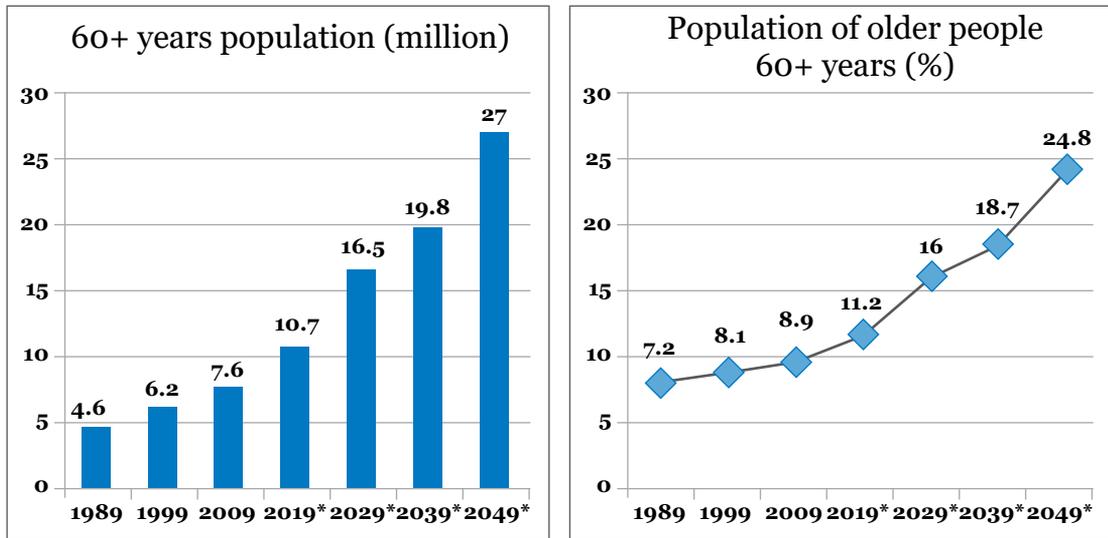
The Socialist Republic of Vietnam has an area of 330,967.3 km² with a population estimated in 2015 at 91.7 million, in which 50.7% are female (GSO, Statistical Yearbook 2015).

Economically speaking, since 1986 Vietnam has implemented economic reforms, expanding trade relationships with various countries and territories in the world; has actively participated in many organisations and forums, both regional and international, such as joining the Association of South-East Asian Nations (ASEAN) in 1995, becoming a member of the World Trade Organisation (WTO) in 2007 and participating in the Asia-Pacific Economic Cooperation forum (APEC); has signed over 90 bilateral trade agreements, most recently is the Trans-Pacific Partnership (TPP). During the last decade, Vietnam's economy has had steady growth and reached a high level compared to the region. Vietnam has transformed into a middle-income country since 2008. In 2011, Vietnam's GDP reached US\$2,052 (GSO, *Statistical Yearbook 2014*).

1.2. Population Ageing in Vietnam and Forecasts to 2029 and 2049

Vietnam is currently experiencing a great demographical shift. The median age in 2005 is 25.5 years, marking the end of Vietnam's "young population" period. The Vietnamese median age has reached 28.5 years (2010), and it's estimated to increase to 34.4 years in 2025 and 42.4 years in 2050 (UN, *World Population Prospects: The 2008 Revision*). The proportion of older people (60+ years) in the total population has increased from 6.9% (1979) to 7.2% (1989), 8.12% (1999) and 8.9% (2009). In 2011, Vietnam has officially shifted into the "ageing" population structure when the proportion of older people (60+ years) makes up 9.9% (8,655,324 people), especially with the proportion of older people (65+ years) being 7% (GSO, *The 1/4/2011 Population change and family planning survey: Major findings*).

Graph 1. Quantity and proportion of elderly population (60+ years), 1989-2049



Source: GSO, *Population and Housing Survey 1979, 1989, 1999, 2009*; GSO, *Vietnam Population Forecast 2009-2049*.

Thanks to significant achievements in healthcare and family planning, Vietnam's birth rate has steadily yet dramatically reduced from the average of 4.8 children (1979) down to 2.33 children (1999), 2.01 children (2009) and 2.1 children (2015). As a result, the proportion of children under 15 years constantly decreases; the average life expectancy increases from 68.6 years (1999) to 72.8 years (2009) and 73.2 years (2014), expected to be 75 years in 2020. Vietnam's population is in the ageing period with clear manifestations: Birth rate and mortality rate have been decreasing, the average life expectancy at birth is constantly increasing, leading to the proportion of older people (60 years and above) is getting bigger day by day.

According to UN's World Population Prospects: The 2008 Revision, the proportion of Vietnamese older people is expected to be 11.4% in 2020 and would reach 26.6% in 2050, ranked at a high level in the ASEAN group, only after Singapore (39.6%) and Thailand (26.4%).

Table 1. Population, proportion of older people 60+ years, 65+ years and under 15 years

Year	Total population (thousands of people)	Population of 60 years and above		Population of 65 years and above		Population of under 15 years	
		Quantity (thousand)	Proportion (%)	Quantity (thousand)	Proportion (%)	Quantity (thousand)	Proportion (%)
1989	64,376	4,600	7.1	3,034	4.7	25,223	39.2
1999	76,323	6,136	8.0	4,389	5.8	25,272	33.1
2009	85,847	7,454	8.7	5,515	6.4	20,993	24.5
2029	102,678	16,466	16.0	11,151	10.9	21,236	20.7
2039	106,887	21,817	20.4	16,001	15.0	19,133	17.9
2049	108,707	26,951	24.8	19,545	18.0	19,136	17.6

Source: Results from Population Census 1989, 1999 and 2009;
Results from Vietnam population forecast 200 – 2049

From 1999 to 2009, the proportion of older people 65+ years only increase by 0.6 percentage point, while it's estimated to increase by 4.5 percentage point during the period 2009–2029 and is expected to increase at a faster speed for years ahead. This makes Vietnam being the leading country in Asia and also one of the top countries in the world for speed of ageing. Developed countries have taken decades or even centuries to shift from ageing (older people 65+ years takes up 7% of total population) to aged population (older people 65+ years takes up 14% of total population) such as France: 115 years, Sweden: 85 years, Australia: 73 years, the USA: 70 years, Canada: 65 years and Japan: 26 years... Meanwhile Vietnam, as forecasted by national and foreign demographers, would only takes about 16-18 years for this change. If in 2009, there was only one older person in 10 people, this proportion would be 6:1 in 2029 and 4:1 in 2049.

Vietnam has officially stepped into the period of 'ageing population' since 2011. Demographically, older people in Vietnam have several characteristics as follows:

- ❖ *Older people group has the highest increase:* During the past two decades, Vietnam's population has undergone dramatical changes in both scope and age structure. Total population increased 1.53 times, the population of children (under 15 years) decreased, the population of people in working

age (15–59 years) increased 1.7 times, while the population of older people 60 years and above increased 2.1 times.

Table 2. Population size by age group (million), 1989–2015

Age group	1989	1999	2009	2013	2015
0–14	24.98	25.56	21.45	21.7	21.9
15–59	34.76	44.58	56.62	58.4	59.2
60+	4.64	6.19	7.72	9.4	10.5
Total	64.38	76.33	85.79	89.5	91.5

Source: GSO, Population and Housing Census 1989, 1999; 2009. Population Change and Family Planning Survey 2013.

- ❖ *The oldest age group increases the most in older population:* Vietnam is currently at the beginning of the population ageing period, but the speed would become more rapid in the near future with most of the increase in the oldest age group of 80 years and above. It is forecasted that in 2049, the proportion of older people 80 years and above would increase 5.4 times from 0.7% to 3.8% compared to 1989, while younger age groups would lower increase.

Table 3. Older people population structure by age group (million), 1989–2015

Age group	1989	2009	2013	2015
60–64	2.4	2.3	2.9	3.7
65–69	1.9	1.8	1.8	2.4
70–74	1.4	1.7	1.6	1.7
75–79	0.8	1.4	1.3	1.4
80+	0.7	1.5	1.8	2.1
Total	7.1	8.7	9.4	11.3

Source: GSO. Population and Housing Census 1989, 2009. Population Change and Family Planning Survey 2013.

- ❖ *There are big gaps among older age groups in different territories:* Older people in Vietnam mainly live in 3 regions: Red River Delta (28.6%), Northern Central Midlands and Central Coast (25.4%) and Cuu Long

River Delta (18.7%). Tay Nguyen has the lowest proportion of older people (3.7%). More than two-thirds (66.8%) of older people live in the countryside (GSO, 2014).

- ❖ *Women make up a large part in the older age group:* There is a big gap in gender structure of the older age group in Vietnam. The higher the age, the bigger the gap in gender structure. In 2015, in the age group 60–79, there is one male for every 1.3 female; in age group 80 and above, there is one male for every 1.8 female and in group 85 and above, there is one male for every 2.5 female. The main reason for this gap is that women’s life expectancy is higher than that of men.

Most of the Vietnamese older people are married. The proportion of older people separated, divorced or never married is extremely low (approximately 2%). 40% of Vietnamese older people have lost their spouses, in which the rate of being widower/widow increases as they get older: 19% in age group 60–69, 41% in age group 70–79, and 62% in age group 80 and above. Notably, the proportion of women being widow is always higher than that of men being widower, and the gap gets wider as the age increases. In 2011, only 14% older men were widowers while 50% women lost their husbands.

1.3. Challenges in Population Ageing

Organising older people’s lives: Informal care by families and at home still plays the main role all over the world. In Vietnam, older people generally live with their children and most of the older people wish to be taken care of at home. However, the family structure has changed. The average household size has decreased from 4.8 persons (1989) to 3.8 persons (2009) [1]. According to the Household Living Standard Surveys, the number of older people living with their children has declined from 79.7% (1992) down to 62.6% (2008), the number of older people living in families consist of only the elderly increasing from 9.5% to 21.5%, the number of older people living alone increasing from 3.5% to 6.1%. In particular, the number of older people living in ‘skip-generation’ families has doubled, from 0.7% (1992) to 1.4% (2008) [2]. The Vietnamese family structure has shifted from a traditional, multi-generation family into a 2-generation nuclear family.

Moreover, the flow of migration of people in the working age from rural areas to big cities for study and work has put a bigger burden on older people's lives in the countryside, who already have it difficult enough on their own. In particular, migration and urbanisation increase women's opportunities to find jobs outside of home. More women have joined the work force. The inter-generation supporting network will continue to undergo significant changes. There will be a large number of 'skip-generation' families that only consists of small children and older people, especially in the countryside due to migration of 'middle-generation' to the cities. The proportion of older people who lost their spouses is getting higher and higher, especially for older women, leading to 'feminisation' of the older population. This poses a lot of challenges for older people, older women in particular.

The social security system is still inadequate, has not adapted to the "population ageing" period: In developed countries, although the "population ageing" period happens at a slow pace, there are still challenges spouting from the relationship between the ever growing older population, decrease of the population in working age and balancing resources, and savings to insure old age through the social security system.

In Vietnam, these challenges are even bigger due to the number and proportion of older people increasing rapidly; many older people were born and grew up in past wars, so they have little to protect their health and savings for old age. On the other hand, Vietnam as a lower middle income country has to, at the same time, to solve many problems relating to taking advantages of the period of "demographic window of opportunity" for economic development and adapting to "population ageing" in which there is the social security system. Older people's material lives still have many difficulties, 68.2% Vietnamese older people live at rural areas, are farmers and do agricultural work. 70% older people don't have material savings, 30% older people don't have health insurance, 18% live in poor households and 10% live in temporary houses.

The social security and social protection system is inadequate: Only about over 39% older people have pensions or benefits from the government's

budget; others depend on their children and grandchildren, as well as their own working capacity. At the moment Vietnam does not have any systems providing jobs for older people so as to promote the roles and ongoing contributions of older people. In addition, Vietnam is facing an increase in unemployment of the population in the working age group. Pension funds and death allowances also pose a big problem to the Vietnam Social Insurance Fund.

The healthcare system hasn't met the growing demand of older people: Vietnam's disease model in general and older people's specifically, are rapidly changing from the model of mainly infectious diseases to non-communicable diseases. Although Vietnamese's life expectancy is high, the number of years of the living sick is also not small. Naturally, our health deteriorates as we gets older, especially the oldest age group (80+ years). Therefore, the need for healthcare in older people gets higher, while older people often suffer from chronic diseases and have to face with the risks of disabilities due to ageing, threatening their capability to live independently. Besides, the treatment costs for older people are often very high.

Population ageing has been going on in Vietnam since 2011 with an increasingly fast speed; therefore the public healthcare system for civilians, especially for older people has not been able to keep up with this tremendous change. There is only one geriatric hospital at the central level, while lower levels such as provinces and districts as well as primary care have not been able to invest and build a system including human, material and financial resources to care for older people's health. Besides there is the difficulty in equal access to official healthcare system through social and medical services. At the moment poor older people, especially those older people living in the countryside and rural areas have limited access to necessary healthcare services. Vietnamese older people are mainly females, with a high rate of being widows while having more risks than males considering income, disability status and capability to access healthcare services and health insurance. Thus it poses a big challenge in healthcare for older people.

Challenges in planning and making policies: Each population age group has different behaviours with clear economic implications: The young age group asks for deep investment in health and education. This age group recently has stepped into the working age group and supplies labour force and increases accumulation; and the older age group asks for healthcare and income from pensions. When the scope of each age group changes due to demographic shifts, their economic behaviors also change accordingly. Policy makers should carefully consider these impacts of demographic change when making a decision for the country.

In Vietnam, taking care of older people's lives in order to ensure they have adequate physical and mental health has always been in the orientation from the Party and government in all development phases of the country. However, due to the increasingly fast speed of "population ageing," with a high number of older people, the increasing trend in the number of older people would put more burden on the socio-economy to maintain physical and mental health of the older age group. Despite the fact that the proportion of dependent children has reduced, it still can't compensate for the rising social costs, because the costs for taking care of older people are far higher than those for children. In order to adapt to "population ageing," preparing all necessary and sufficient conditions for meeting the needs of the "aging population" in the next 1–2 decades will be a big challenge to policy makers.

Civil society and social organisations haven't made the most of their roles: Population ageing is one of the most significant demographic changes in this era. Taking care of older people and promoting their roles are responsibilities of not only the government and elderly's associations but also individuals, families, civil societies... so as to share the burden with the government budget in building an elderly-friendly environment. Existing care models for older people are still superficial, mainly voluntary, and nursing homes or elderly care institutions are very few...

1.4. Healthy Ageing in Population Ageing: Challenges

Nowadays, one of the community's concerns is whether the increase in life expectancy accompanies good health and better living quality. Statistics show that living longer does not mean our health would improve or have a happy old age. From the older people's perspectives, the definition of being healthy doesn't simply mean the absence of diseases. It forms a close relationship with happiness and the capacity to adapt to challenges from external forces in their daily lives.

In the past recent years, thanks to the improvement in physical and mental lives along with a certain progress of the healthcare system, Vietnamese older people's health has shown improvements in general. However, challenges still exist.

First, Vietnamese life expectancy is 73.3 years (GSO, 2015), equal to those of countries with much higher income, but the healthy life expectancy is quite low (64 years), ranked 124/193 countries and territories in the world (WHO, World Health Statistic 2010). 56.3% older people self-assessed as having low health, 36.3% self-assessed as having normal health and only 7.6% thought they were very healthy [11]. Researches have shown that older people's health depends largely on their age, in which the higher the age, the bigger number of older people having low health, more diseases and longer treatments.

Second, the biggest challenge at the moment is the disease model and the causes for diseases in older people are changing rapidly. Vietnamese older people are carrying the burden of "double disease" due to the transition from infectious to non-infectious and chronic disease model, while new illnesses continuously appeared along with changes in lifestyle and have become more common, such as cancer, stress and depression [6].

Most of the older people in Vietnam suffer from illnesses, 90% contract at least one disease (in which 75.6% contract 1 disease, 14.1% contract 2 diseases, 1.1% contract 3 or more diseases, and the rate of being healthy is

very low with 9.17%) [5]. The most frequently seen diseases in older people are osteoarthritis, blood pressure, eye disease and dementia [5]. Older people having blood pressure diseases take the biggest proportion (38.4%), followed by osteoarthritis (31.9%). These are very dangerous diseases that can easily lead to death and are seen most often in the older group with good living condition. Heart disease is closely related to hypertension (1/2 death cases in older people are due to hypertension) and is extremely common in older people living in urban cities. Osteoarthritis is mainly caused by humid air, poor working condition and heavy lifting. Nevertheless, the rate of having osteoarthritis in older people tends to reduce when the economy develops.

According to the compilation of older patients' 10 most common diseases in the National Institute of Gerontology's research on older people's disease model in 2008, 10 out of 10 are non-infectious and mainly are chronic diseases such as: Stroke, hypertension, Type-II diabetes, chronic obstructive pulmonary disease, heart failure, vestibular disease, Parkinson's disease and osteoporosis. Meanwhile, diseases caused by changes in lifestyle such as dementia and depression tend to increase and the rate of older people having these escalate as the age gets higher.

Third, the implications for the disease model's change into non-communicable diseases have quickly become the leading cause for illnesses and disabilities in older people and this trend will continue for the next decades. Eye and ear diseases, vision and hearing loss are also common diseases in older people. These two diseases are related to the deterioration of body organs. They are also the cause for disability in older people, making a negative influence on older people's physical and mental lives as well as their ability for community integration (older people get nervous, lose confidence and become unsociable). Notably, partly or complete loss of vision is the most severe since it affects all aspects of the older patient's life and makes things difficult for caretakers in the family.

Fourth, the knowledge level on taking care of and self-care for older people is still low, despite a lot of health risks. Results from Tran Thi Mai Oanh's research (2010) shows that most of the older people donot know about the

signs of hypertension (66.5%), don't know what causes hypertension (84.1%) or how to prevent osteoarthritis (74.6%). Most Vietnamese elderly do not have the habit to go through periodical health checks, only 27.5% of the elderly got health checks in 2014 (Vietnam Association on the Elderly, 2015). Also a number of habits affect older persons' health.

Fifth, the capability and the rate of accessing healthcare services among older age groups are extremely varied, and this makes a large number of older people unable to have adequate treatment even when the diseases are discovered. The older age group living in the countryside, rural areas, near the borders or on islands – the group that takes up a large proportion in older population – have difficulties in accessing healthcare services. There are many reasons leading to this, but the main cause is due to the primary care system being still weak, lack of medicine and medical equipments for older people, and inappropriate distribution of health stations, especially in rural and mountainous areas.

Another primary cause is that the burden of healthcare costs tends to deviate over the poorer older age groups. Health expenditure of households which have older people is mainly self-paid and the reimbursement from social security only takes a small proportion. Although the average spending of a rural family is much lower than that of an urban one, but the proportion in expenditure between a rural family which has older people and an urban family taking care of older people isn't much varied, thus the burden of healthcare costs tends to shift over to older people in rural areas. The older age group in the population group which has the lowest income (or the poorest group) has the proportion of health expenditure in comparison with total expenditure equal to that of the older age group which has the highest income (or the richest group), but the average time taking periodical health exam of the poor is only half compared to the rich.

As for healthcare costs, a research from the National Institute of Gerontology shows that, the average cost for taking care of one older person is equal 7-8 times the cost for taking care one child. Therefore, if we can not control and prevent diseases and disabilities of older people, the heavy burden of resources to take care of older people would be inevitable.

Finally, although the proportion of older people is increasing, the healthcare network for the elderly in Vietnam is still very weak, the number of medical personnel serving in communities is scarce and they are still lacking in skills. At the moment, the speed of improving and reconstructing the healthcare system for the elderly is slow: there are just Gerontology Departments in 49 out of 63 provincial hospitals that can not meet older persons' need for healthcare; research on ageing issues are few.

One missing point that is vital in researches on elderly care in Vietnam now is that we have not had any researches analysing in depth about disease trends and costs relating to reproductive health for older people. The increasing trend of diseases such as cervical cancer, breast cancer and prostate cancer... asks for immediate response from research to policy and relating healthcare services.

1.5. Priorities for Population Ageing

The average life expectancy of Vietnamese people has had a major increase in the past decades, clearly reflecting achievements of socio-economic development. Population ageing is a pride but it also brings along big challenges in meeting the increasing needs for healthcare. After the 2009 population census, researchers forecasted that in 2017, Vietnam would step into the population ageing period. However, in 2011, when the proportion of people over 65 years old is 7%, Vietnam has officially stepped into the "population ageing" period, 6 years earlier. According to calculations, the transition time from "population ageing" to "aged population" in Vietnam is only about 18 years. Vietnamese older people's health in general has been improved, but the increase of "double disease" burden has negatively affected life quality and healthy life expectancy.

Therefore, the priority for pre-ageing in Vietnam is to improve quality of elderly care. This can be solved by building a geriatric system, counselling, providing guidance and knowledge on self-care for older people and their families. At the same time, we should build care models at homes and in communities, encourage the participation of individuals and social organisations in establishing nursing homes and providing primary care services for older people at their homes, etc. National strategies on developing healthcare and

primary care system should be integrated in developing elderly care models in communities. These models should also be adapted to the responding and expanding capabilities of the healthcare system and relating social networks at different levels.

2. POLICIES AND PROGRAMMES

In Vietnam, older people mostly live with their children and grandchildren in families. The main form of taking care of older people is still informal care from families, and family members (children/grandchildren) are responsible for this, the government and community provide forms of formal care to help families through social welfare policies, services and models for taking care of older people at home and in the community. As for homeless and poor older people and those having contributions to the revolution that receive benefits from policies, the Government would directly foster them in social protection centres and nursing homes for contributors of the revolution. All in all, the Government creates the legal structure on policies, supports families in taking care of older people and directly cares for specific individuals; the private sector and NGOs provide care with the encouragement from the Government.

2.1. Current Policies

Ever since the Socialist Republic of Vietnam was established in 1945, the Party and Vietnamese government have paid attention to older people, which clearly portrays in the 1946 Constitution, 1959 Constitution and 1992 Constitution. The Elderly Association was established in 1995 – this is the organisation that united all older people throughout the country.

In 2000, Vietnam issued the Ordinance on Elderly People. During the period 2000–2010, Vietnam implemented the National Action Programme on Vietnamese Older People for the period 2005–2010. In 2009, the National Assembly of Vietnam issued the Law on Elderly People. Currently, Vietnam is carrying out the National Action Programme on Vietnamese Older People for the period 2012–2020.

The ministries and departments have conducted a review and issue additional regulations and policies on caring and promoting the role of older people, guiding and urging provincial bodies to implement them. The provinces/cities have carried out many activities in programmes and policies for older people.

Policies on elderly people currently have the following contents:

- (1) Healthcare;
- (2) Care on material lives;
- (3) Care on mental lives, encouraging older people to actively participate in activities in order to promote the role of older people.

The government distributes annual budgets for implementing policies on elderly care, raising funds for taking care and promoting the role of older people, integrating the policies on older people into socio-economic development policies and determining responsibilities from families, government and communities in taking care of the older people.

2.2. Implementing Policies and Impacts

(a) *In material lives:* In order to support families in taking care of older people, the Government has issued policies specific for older people. However, the policies are mainly about offering economic support for a particular group of older people who are retired, and homeless older people through social security and social protection with a wider range than the past periods. The details are as follows:

- ◆ Retired older people: Policies on pensions and benefits offered by social security;
- ◆ Lonely older people without a source of income: Receive social benefits with 180,000 VND/person/month for older people 60–80 years; 270,000 VND/person/month for older people 80 years and above (in the past, it was 120,000 VND/month as in Decree No.67/2007/ND-CP and 65,000 VND/month as in Decree No.168/2004/ND-CP);
- ◆ Older people 80 years and above with neither pensions nor any social benefits are to receive 180,000 VND/person/month (before it was

90 years and above as in Decree No.168/2004/ND-CP and 85 years and above as in the Ordinance on Elderly People No. 23/2000/PL-UBTVQH10 and Circular No. 09/2007/TT-BLDTBXH on guiding the implementation of Decree No.67/2007/ND-CP);

- ◆ Older people qualified to live in social protection centres but are taken care of by care takers in communities are to receive 360,000 VND/person/month [9].
- ◆ Older people 60–85 years that are crippled, lonely and qualified to enjoy the benefits (Decree No.67/2007/ND-CP);

Moreover, the Government has a programme to provide homes for older people that is integrated into the national target programme to reduce poverty and gratitude programme. It indirectly takes care of older people through programmes to reduce poverty, employment programmes, programmes to protect environment and develop agriculture in rural areas. Besides, older people are given discounts on tickets and fees for various services: at least 15% off ticket price or service fee when transporting by ships, trains and airplanes; at least 20% off ticket price or service fee when visiting ancient relics, historical sites, museums and other famous tourism spots; doing exercise and sports in sports centres that require service fees. The economic support for the burial ceremony in case of older people's death is 3 million VND [9]. The Government also offers several benefits to older people such as: Older people have the right to decide whether to live with their children or live independently; Are exempted from the responsibility of contributing for social activities, except for voluntary contribution; Are prioritised to receive financial and material support, healthcare and accomodation to overcome difficulties caused by natural disasters or other force majeure risks.

As for lonely, homeless older people, the Government directly fosters and cares for them in social protection centres with monthly allowance of 360,000 VND/person/month [9].

(b) *In healthcare:* Older people are prioritised in healthcare services and are encouraged to contribute to society according to their health [7]. The

government and community takes care of older people through hospitals, geriatric hospitals, governmental and private health agencies... In order to support families in taking care of older people, the Government set up regulations in healthcare for older people in the national healthcare system as follows:

- ◆ In the last year before retirement, workers can shorten daily working time or work for less hours a day or week [8];
- ◆ Older people 90 years and above are provided social security card for free, equal to 50,000 VND/person/year [4] or receive free medical check-up following the reimbursement mechanism in healthcare centres [3]. The Government also issues health insurance in 2 forms: compulsory and voluntary to partly solve financial difficulties for patients, in which mainly are older people;
- ◆ Primary care at place of residence: Commune health stations are responsible for primary care and health for older people at their communities. In case of older people being crippled, lonely and homeless, are sick but don't go to the designated medical centre, the head of the commune health station would ask a health officer to go to where that person lives or report to the local People's Committee to help the person go to the designated medical centre [9].
- ◆ Medical treatment: Treating older people, 80 years and above, is prioritised [9].

The Ministry of Health issued Circular No. 02/2004/TT-BYT in 2004 and most recently was Circular No. 35/2011/TT-BYT on October 15th, 2011 on guiding the implementation of providing healthcare for older people. The Circular states clearly about managing healthcare and primary care for older people, organising health network for older people, the responsibilities of the National Institute of Gerontology, hospitals, health centres, commune health stations and relating agencies, etc. Moreover, the Government also establish the National Institute of Gerontology, geriatric centres, and sport activities for older people...

- (c) *Care for mental lives and encourage older people actively participate in activities to promote their roles:* Policies enhancing older people's mental lives are as follows:
- ◆ Celebrate older people's birthdays, in which 100-year-olds will receive wishes and birthday gifts from the President of the Socialist Republic of Vietnam; 90-year-olds will receive wishes and birthday gifts from the Chairman of the province/city's People's Committee [9];
 - ◆ Have the right to join the Vietnam's Association of the Elderly, according to the Association's regulations [9].

Furthermore, older people are encouraged in the following aspects: older people are encouraged to participate in cultural, educational, sports, tourism and recreational activities; they are encouraged to promote their talents, knowledge and good qualities in participating socio-cultural activities; they are encouraged to participate in economic activities such as: Teaching and restoring traditional crafts, agriculture, fishery and forestry, according to their specific conditions and capabilities; older people are encouraged to contribute feedbacks on making policies and laws, especially older people-related, professional and technical consulting, research and apply technologies, especially in medicine, education, science and technology; older people are encouraged to carry on study and give out socio-cultural, scientific and technological knowledge, job skills to younger generations, being the leader and the core in building a learning society, a learning clan and a learning family.

All in all, Vietnam's policy system on elderly people is improving through time. Since 2000, many policies on caring and promoting the roles of older people have been issued, adapting to the increasing trend in the number of older people in the total population.

2.3. Challenges in Implementing Policies

The system of legal texts on elderly people in Vietnam is considered to be fairly adequate, but its implementation is not timely and not adapted to the "population ageing" period, in details as follow:

- ❖ The laws and orders have been slow in implementation. The issuing of of guiding documents by relating departments has not been timely and specific, thus the grassroots level still face many difficulties in implementing policies.
- ❖ Several organisations and agencies' awareness on the orientation and policies on elderly people and law on elderly people is inadequate. Some local governments still consider implementation of policies on elderly people is the responsibility of families, the Association of the Elderly and society, not theirs.
- ❖ The budget for older people's healthcare activities is limited, especially at grassroots level. Expenditure norms for social activities are low and slow to change. The local government has total control on the national budget, but there is no sanctioned system to handle violations or inadequate implementation of policies.
- ❖ Intersectoral collaboration in guiding, coordinating activities that take care and promote the roles of older people is still limited and infrequent at both the central and local levels; the Association of the Elderly was established long ago but it still hasn't had a complete system of specialised officers for managing issues regarding older people at national level. Most of relating ministries and departments haven't had specialised officers for supervising implementation of policies on older people.

2.4. Implementation

Vietnam is currently implementing “The National Action Programme on Vietnamese Older People for the period 2012–2020.” It can be said that this action programme has realised the policies on older people with the help of ministries and departments at all levels, socio-political organisations, local and international organisations as well as many individuals.

Objectives of the Action Programme are to improve the quality of elderly care, to promote socialisation of care activities and promote the role of older people according to their potentials and the socio-economic development level.

The programme has several main activities as follow:

- ❖ *In material lives:* The Government finalises the policy on providing assistance with a wider range of receiving individuals and adjusts the monthly social allowances according to actual circumstances, supports for reducing poverty, helping older people living in temporary housing or dilapidated homes, standardises and improves the quality of activities in nursing homes. The Government encourages and supports organisations and individuals in taking care of lonely and poor older people, as well as activities to take care of older people in community. The goal for 2020 is that over 2 million older people would receive monthly social assistance or would be given access to nursing homes, 80% of older people without a caretaker would be fostered in nursing homes.
- ❖ *In healthcare:* Provide counselling, guidance and training on self-care and improving health for older people and families; Invest on infrastructure – technology of the health service system, establish geriatrics departments in provincial and district hospitals; develop the system of health service centres; establish and develop healthcare and rehabilitation network for older people living in communities; integrate elderly care into programmes on preventing, detecting and treating old age-related diseases early, research programmes on old age diseases and training programmes for social workers, contributors and volunteers working in counselling for older people and elderly care. The goals for 2020 is as follow: 100% older people, when sick, are examined at health centres and receive care; 90% of general hospitals, specialised hospitals (except for Pediatrics, Nursing and Rehabilitation hospitals) provide health services specially for older people and 100% general hospitals and specialised hospitals at provincial level have geriatrics department;
- ❖ *Care for mental lives and encourage older people actively participate in activities to promote their roles:* Encourage older people to participate in economic activities, especially in teaching and restoring traditional crafts; Support the establishment and activities of the Foundation for elderly care and promote the role of older people. The goals for 2020 are: Offer support

in capital investment, means of production, technology guidance, etc. for 50% of older people wanting to participate in economic activities; 80% of local communes establish a fund for older people.

The National Action Programme on Vietnamese Older People period 2012-2020 also promotes building and expanding community-based elderly care models, focusing on implementing pilot programmes and replicating good models, standardising elderly care facilities, investing and building social homes in communities for lonely and homeless older people. The goals for 2020 are: At least 50% local communes adapt community-based models for taking care and promoting the role of older people, in which more than 70% older residents join in and receive benefits from the models.

There is a variety of community-based elderly care models, although these models still lack a general assessment system and haven't been adapted widely. Nevertheless, an age-friendly environment is being created. The models are as follow:

❖ *Long-term care models with Government budget:*

Nursing homes for contributors in the revolution: The nursing homes for contributors in the revolution are managed and provided by the Government. Older people living in these homes are to receive high-quality care. The nursing homes are established in cities, with basic facilities (housing, recreational area, medical equipments...). There are trained caretakers, doctors and nurses [10].

Social protection centres: The Government also provides formal care models for lonely, homeless and poor older people through social protection centres. These centres are for many different individuals, including older people with special circumstances. The social protection centres are directly under the local Offices of Labour, Invalids and Social Affairs and the provinces/cities' Red Cross organisation. The centres are equipped with housing, recreational area, cafeteria, conference hall and operating area. The infrastructure overall is still lacking, the rooms are too small, care takers though being government officers but are weak in skills and low in number. Living in the centres, older

people are to be taken care of according to the government's regulations. In actuality, aside from government budget, social protection centres need funds from benefactors and local governments in order to operate. Older people living in these centres are to receive free healthcare; however, elderly care are facing many difficulties in human resources (doctors, nurses, physicians...). In abnormal circumstances, the medical capability of health stations in these centres has been rather limited and they often need to transfer to hospitals at higher levels [10]. Because of financial limitations, the centres' infrastructure has neither been adequate nor received timely upgrade; too many older people are given access to the centres, leading to overload; officers and employees in the centres are not fully qualified.

❖ *Elderly care models with collaboration between the Government/organisations/agencies and communities/benefactors*

Community-based care models for lonely and poor older people at home with community volunteers: This design model has proven to be successful in 10 South East Asian countries, providing care for lonely and poor older people at their own homes. In this model, community volunteers are local residents who volunteer to take care of lonely older people at home with enthusiasm and love. This model is regarded highly and has been implemented in many provinces in Vietnam. In order to take good care of lonely and poor older people at home, volunteers are to participate in a short course focussing on: Legal policies on elderly people, psychology of older people, life skills for taking care of older people, measuring blood pressure, treatment for regular diseases in older people, etc. One individual or a group of volunteers are responsible for taking care of lonely, poor older people for a long time period. Volunteers can support in healthcare like raising awareness about common diseases and providing guidance on how to be healthy for older people, and taking care of lonely older people when they are sick. Besides healthcare, volunteers also come to older people's homes to encourage and share their burdens, helping them feel safe, happy and trust in the community. The model has a lot of advantages, and it fits in the Vietnamese culture, suitable for older people living alone or older couples. The model fulfils the wish of most older people who are living in their

own homes, taken care of by volunteers that are also their neighbours and local residents; older people are cared for free of charge; the model is accessed easily and suitable for all individuals from cities to the countryside, can be adapted whether in mountainous areas or the plains. However, the model is still in pilot period and gradually expanding so there remains limitations. According to feedbacks in final review conferences, the quality of care reflected through volunteers' skills in taking care of older people has not been adequate. It is because the volunteers donot have basic training, only take very short courses and the occasional budget for training is still limited.

The elderly care and counselling model: This model only provides a part of healthcare and primary care for older people in communities. It is community-based, built to meet the increasing needs for health counselling of older people and this is necessary for a large part of residents, demonstrating the socialisation of elderly care in communities. Many individuals, organisations and agencies have invested in and contributed for the elderly care and counselling model. This model provides healthcare counselling for older people, diagnosis and specific direction for treatment before the patients go to hospitals. This model has been implemented in many regions. Older people are able to practice health exercises (Taichi and Qigong, meditation, yoga, group activities...) and even participate in group excursions. The model applies technological innovations and the media (TV, websites...) in publicising medical knowledge to older people, with consultations from local and international specialists. Counselling and healthcare activities are highly regarded by older people. However, the model's current capability in counselling can only serve a small number of older people due to limitations in financial budget for human resources, equipments and autonomy. To expand the model, investment from the government and benefactors as well as attention from authorities are much needed.

Nursing homes/elderly care centres organised by agencies/charity organisations: In order to practice socialisation in elderly care and surmount the subsidising status in governmental centres, agencies/charity organisations in the community provide their own nursing homes/elderly care centres. This model has just appeared recently. It is based on non-government agencies/

charity organisations so it has an independent financial budget and flexible management. These organisations establish and sponsor for a period, then the nursing homes have to raise their own funds by all means, such as asking for help from benefactors, older people and employees doing extra jobs to improve life quality without any support from the government. This model is implemented in a small scope for the needs of a small group of older people (lonely, have special circumstances; having the same profession or the same interests...) because of limitations in budget and infrastructure (only for healthy older people, the centre can't take care of sick ones), so the quality of care is lacking.

❖ *Self-paid elderly care models*

Home doctors: This model only provides healthcare and primary care for older people at their homes. It appears due to popular demand, older people/older people's families have to pay for the service. Home doctors are usually those working in private health clinics or registered individuals. Besides counselling about illnesses, they provide methods to keep good health for older people and their families. If any older individuals need frequent treatment such as injections, acupuncture and exercise guidance, home doctors will make a health record, creating treatment regimen and sending employees to homes for daily care. The costs for these services are rather high, depending on requirements and demands from older people and their families. This care model has several advantages: beside medical care, home doctors are also effective counselors (direct counselling, through phones and email...); saves time and shortens older patients' stay at hospitals, meeting immediate demands from older people; older people are taken care of at their own homes, family members feel secure since they can still visit and take care of their parents, as well as supervising how the doctors and health workers treat older people. However, this model has disadvantages in monitoring and service quality. It is only suitable for better-off families.

Private-owned elderly care centres: In this model, private companies or individuals invest to build and manage the elderly care centres, older people living in these centres have to pay for the service, and the fees are very high.

The private-owned elderly care centre model has just appeared recently in big cities such as Hanoi and Ho Chi Minh City. This type of model is a breakthrough in elderly care in both model and service quality. Following the market mechanism, these centres constantly strive to improve service quality in order to satisfy their customers and for their own development.

2.5. Lessons and Opportunities for Expansion and Sustainable Development

Vietnam is going through a significant demographic shift. 2005 was the year when Vietnam ended the “young population” period and officially moved to “population ageing” in 2011. Therefore, in order to adapt to population ageing and healthy ageing, Vietnam has had researches, organised cooperation programmes, learned from experiences of many countries around the world, especially South Korea, Japan, China, etc.

Aside from perfecting legal policies on older people, support older people and their families in taking care of older people at home, the implementation of elderly care models at home and in communities (relying on volunteers) is promoted in order to establish a long-term care programme for older people fitting their needs and in response to a part of lonely poor older people. In some regions of Vietnam, we are currently adapting the elderly care models from Japan and South Korea. The trend in general is community-based elderly care model relying on volunteers. These volunteers can be either members in organisations, relatives or people volunteering to go to lonely older people’s homes to help every week. Volunteers helping older people are completely voluntary and unpaid, but they need to commit to work in an organisation within a fixed period, conforming to regulations and plans, and are trained. At the same time, we should collect, compile and edit age-related documents, healthcare knowledge for older people from other countries so as to advocate to older people, improving knowledge of people and adapting to ageing. The community-based model responds to the wish of most older people to live in their own home, and/or be taken care of by friends and relatives without paying for healthcare services. Another advantage is accessibility. This model is suitable for any region in the current status of Vietnam.

2.6. The Role of NGO and Social Organisations in Healthcare for Older People

In 2004, the National Committee on Older People was established. The Committee is a multisectoral organisation with the function of assisting the Prime Minister in directing and coordinating activities for taking care of and promoting the role of older people, in which the Chairman is the Vice Prime Minister. Vietnamese older people have their own social organisation which is the Vietnam Association of Elderly People. This is a large organisation, spreading from central to local levels, even to villages and hamlets with 8 million members (90% of all older people in Vietnam). With a large scope and big amount of members, the Association often organise activities on advocating healthcare, medical check-ups at local communities, and also being the link between government agencies and older people in community activities. There are other organisations collaborating with the Association such as the Red Cross, the Association of Veterans, the Association of Women... These associations all spread from central to local levels and attract a large number of older people being their members. In these associations, older people have the chance to improve both in physical and mental health.

NGOs working in age-related issues in Vietnam are playing an active role. They provide financial support, methods and technology in implementing various activities towards healthcare for older people. They have close coordination with government agencies, age-related organisations and associations, and they also have very good cooperation with local regions for implementing care models and health services for older people. These organisations are the United Nations Fund for Population Activities (UNFPA), the World Health Organisation (WHO), Help Age International (HAI), programmes with government funds from other countries such as South Korea and Japan, etc.

2.7. Financial Issues for Healthy Ageing

Older people's issues are the responsibilities of many government agencies in various levels. Therefore, based on the roles of each agency and department with the issues, it is assigned to implement and manage the corresponding government budget, for example: care programmes and social security

programmes are managed by the Ministry of Labour, Invalids and Social Affairs; medical care and medical equipment provision are implemented by the Ministry of Health, etc. The government budget at the moment is very limited, unable to respond to all needs in healthcare for older people. However, this financial source can maintain for long-term with a national scope, in all provinces/cities for everyone in the older population.

There is also a financial source from international organisations, supporting healthcare programmes for older people. This source tends to be short-term, follows specific programmes or projects, and these projects are only implemented in selected regions. On the other hand, the financial source from communities and benefactors is always encouraged; this source is mobilised and used mainly at community level, portraying the tradition of caring for each other of the Vietnamese people.

Overall, Vietnam's financial budget for older people is still very limited; it has not been able to respond to all needs for social security in old age as well as the issues in healthcare services. Besides, Vietnamese older people's income is barely minimal. With almost 70% of the older population living in rural areas and having jobs in agriculture, most of them don't have pensions in old age (only about 22% older population have pensions); their primary source of income for daily expenses is from their children/grandchildren (32%) and from working (29%) [11]. Only more than 10% of older people have savings, which means approximately 90% don't have any savings. The older we've got, the more expenses for healthcare; it is clear that finance for older people is a challenge not only for the government, but also for families and older individuals. This is as well a difficult puzzle for a poor country which has already aged.

Limitations in finance is the main cause that affected the implementation of the National Action Programme for Older People, such as several regions only implemented free medical care for older people 80 years and above, those from 60 to 79 years old weren't able to receive regular check-ups; priority for older people in hospitals hasn't been adapted correctly. It's quite common that older people are sick but haven't been able to receive treatment since they have no money to pay for health services.

3. RECOMMENDATIONS

Older persons – the group that is increasing in number and will get the fastest growth, This is creating great pressure on policy issue in ensuring both material and spiritual life of the elderly. Like other countries, population ageing is resulted from social achievements, but Vietnam also needs to have appropriate strategies and policies to response.

- ❖ Improve awareaness and knowledge of managers, policy-planners as well as the community on challenges of population ageing and older persons' life. Create favourable conditions and community movements to involve in healthcare for the elderly.
- ❖ Improve social security to ensure income for the elderly. Reform and extend different insurrance schemes appropriate to older persons' contribution and affordability. Create opportunities for older persons to participate economic activities, especially those with high qualifications, older persons with priority, rural elderly and older women.
- ❖ Improve health of older persons through improving their knowledge and skills to take care of themselves; strengthening the PHC and healthcare system for the elderly through capacity building of commune health stations, gerontogoly departments of provincial hospitals, and other hospitals providing healthcare for the elderly; pay attention to detection and treatment of chronical diseases and ensure access to healthcare for disadvantaged elderly.
- ❖ Develop and maintain long-term healthcare models for older persons.
- ❖ Enhance roles of civil societies in developing, advocating and implementing policies on ageing and for older persons.

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