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ETHICAL ISSUES IN AGEING

FREDERICK F. FENECH

ABSTRACT - Population ageing, in both the developed and developing world, has put increasing demands on health resources; this has brought to the fore various ethical issues related to ageing. This paper examines moral issues that confront people as they grow old as well as those who are involved with them. The concepts of autonomy, dignity, justice and intergenerational solidarity are explored. Living wills and the role of a proxy could help to deal with the common ethical dilemmas related to death and dying. Positive action by governments to overcome ageism is recommended. The need to establish ethical guidelines, which take into consideration differences in religion, culture, ethnicity and race, is highlighted.

KEY WORDS: ageing, ethics of ageing, living wills, population ageing, proxy

The Second World Assembly on Ageing organised by the United Nations (UN) in Madrid on 8 -12 April 2002, was convened on the twentieth anniversary of the First World Assembly held in Vienna in 1982. The purpose of the Madrid Conference was to review progress achieved since 1982 and to consider priorities for future action. It set out a blueprint for an international response to the opportunities and the challenges of population ageing in the twenty-first century and for the promotion of a "Society of All Ages". This century has been termed the Age of Ageing; it is estimated that around one million people reach the age of 60 years every year and the number of people aged over 60 is expected to rise from 600 million to 2,000 million by the year 2050 when they would make up to 21 % of the world population.

An outcome of the First World Assembly was the establishment in 1988 of the International Institute in Ageing (INIA), United Nations in Malta. Its main mandate was to set up training and education programmes in the various fields of ageing particularly for developing countries, as well as to carry out research and consultancy work. In the last 14 years, INIA has trained more than 2,000 participants from 124 different countries in its programme dealing with the various aspects of ageing.

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Ethics of ageing

The pace of population ageing in both the developed and the developing world has, over the last 20 years, stimulated a growing interest in the ethics of ageing. These demographic changes are occurring at a time when major changes are taking place in information technology, globalisation and the ever-present introduction of new technologies. Moreover, the increasing demands on health resources have also brought to the fore issues of resource allocation between generations and of justice between generations. Several ethical issues have arisen, not all susceptible to judicial and public treatment, that call for deeper moral reflection and commitment by public authorities, non- governmental organisations and by individual human beings. As ethical issues in ageing are a prime interest of INIA, the Institute set up a study group made up of professionals and academics with expertise in medicine, law, economics, philosophy, bioethics and sociology to examine issues of a moral nature that typically confront people as they grow older or as they become involved in one way or another with people who are growing old. The following views reflect the deliberations of the study group.

Autonomy and dignity

A major concept, central to ethical practice, is autonomy. The capacity for autonomous decision-taking is regarded as the basis of human dignity. A primary moral difficulty is the preservation of such

a dignity at a time when there is a declining capacity for autonomous decision-taking. This decline may not be simply a consequence of ageing; it may be affected by such factors as increasing physical disability, intellectual disability such as illiteracy, and by psychological conditions that often lead to social isolation and depression. These disabilities call for different moral responses. The most difficult moral question is whether the principle of the maximum exercise of autonomy extends to authorisation of self-destruction. Moralists like G Dworkin₁, P Singer₂ and J Harris₃ hold that there may be conditions of life so bad as to make life worthless, whilst there are other just as worthy moralists like J Keown₄, L Kass₅, G Grisez₆ and others who hold that even the greatest debilitation cannot destroy the worth of human life. On this issue depends the moral legitimacy or otherwise of euthanasia.

Persons over the age of 80 are the fastest growing age group in developed societies; this is the group where physical frailty and diminished mental capacity are common, rendering them most vulnerable to abuse and where ethical dilemmas related to death and dying are frequent. This decline in functional capacity may lead to inability to take responsible decisions. This might require another person to act as proxy with all the attendant moral responsibility. The most critical cases of proxy decision-making arise when withdrawal of life support is being contemplated. The overriding principle is for the proxy decision-maker to show the maximum possible respect for the known or likely wishes of the patient. The formulation of so-called living wills may be of great help in the exercise of proxy decision-making.

The reduced autonomy of the older person needs to be exercised according to the group within which s/he lives, whether in a family or in an institution or alone. In all these cases, elderly people are morally obliged to keep making the most productive use of their talents, not only out of self-interest but also as their personal contribution to the common good of mankind. A specific danger threatening the proper autonomy of the elderly in the family setting is filialism (i.e. limiting the freedom and responsibility of older people by the well meant actions of sons

and daughters). However, the psychological contribution of family members to the sense of autonomous well-being of the elderly is irreplaceable by that of other carers, whether paid or voluntary. The family is the only institution that can ensure recognition of every elderly person's unique value.

Autonomy is not one sided. It implies responsibilities as well as rights. The individual should take a share of responsibility for his/her future, but this does not exempt the state and other corporate institutions from providing assistance. Indeed, there are many social provisions that can be made to enable the elderly to retain as much autonomy as possible.

Sustaining a growing older population is the responsibility of everyone society, government, the family and the individuals themselves. In general, there should not be any discrimination on the basis of age, any more than there should be on the basis of gender and race. This raises the issue of the morality of compulsory retirement; however, this should be viewed in terms of inter-generational equity with younger persons. As people are living longer and also remaining healthier, supporting so many healthy but economically unproductive people may render the concept of retirement obsolete. Also, in an age where globalisation is increasing, it is important that the elderly do not feel marginalised.

Justice and moral obligation

Justice is the other major concept, central to ethical practice. Justice includes notions of equity for all parties, especially if there is status denigration because of age, sex, race, ethnicity or social economic status. Justice would be done if society attempted in its laws to make up for the disadvantages suffered by people because of advanced age. One of the major moral issues is whether the elderly, being the category of persons in greatest need, should have priority in resource allocation. This raises the issue of justice between generations and how scarce resources can only be settled after realistic consideration in terms of relative need. Among the needs of the elderly, a paramount one is income security, though there is no general agreement as to the most moral way of guaranteeing it.

Ethics requires that human relations, even between generations, go beyond strict justice. Thus those elderly people who could assume responsibility for their own future should do so not only for their own sake, but also as an act of solidarity with the whole human community. These particular moral obligations both of and towards the elderly stem from the fact that all human beings share responsibility for the well being of all other human beings.

Respect for the elderly has always been thought to be a common heritage of mankind. The negative image of ageing with its discriminative practices characterised by the concept of ageism must be overcome through positive action by governments through the application of ethical concepts which are relevant different religions, ethnic, racial and social classes, as the practice of ethics is grounded in one's everyday life, whether personal and professional, whether public or private.

An international approach

Though different countries have different cultural, family and societal values as well as different economic realities, this should not hinder international moves to establish ethical guidelines. All human beings share responsibility for the well-being of all, so governments should be encouraged to formulate laws to make up for the disadvantages suffered by people because of advanced age in order to enable the elderly to retain as much autonomy as possible. Although ethical issues transcend national frontiers, the policies and the practices adopted have to be congruent with the country's culture. In view of the universality of the subject, in the run-up to the Madrid meeting, INIA prepared a Declaration on Ethical Issues in Ageing, which was circulated by the Malta Government during the conference. The declaration highlighted the need for an international task force of experts to prepare a comprehensive report in which they would examine the moral questions that face human beings concerning ageing, and propose answers that may be helpful to those who have to take the relevant decisions.

References

1. Dworkin R. *Life's dominion*. London: Collins, 1993.
2. Singer P. *Rethinking life and death*. Oxford: Oxford University Press, 1994
3. Harris J. *The value of human life*. Oxford: Oxford University Press, 1990
4. Keown J. *Euthanasia examined: ethical, clinical and legal perspectives*. Cambridge: Cambridge University Press, 1995.
5. Grisez G. Should nutrition and hydration be provided to permanently comatose and other mentally disabled persons? *Linacre Q* 1990;57(2):30-43.
6. Kass L. I will give no deadly drug. Why doctors must not kill. *Am Coil Surg Bull* 1992;77(6):6-17

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HEALTH, WEALTH AND THE ELDERLY

An Indian Perspective

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"The achievement we celebrate today is but a step, an opening of opportunity, to the greater triumphs and achievement that await us. Are we brave enough and wise enough to grasp this opportunity and accept the challenge of the future"?

- Jawaharlal Nehru
(The First Prime Minister of India)

Introduction:

The question, whether health creates wealth may be appropriate for a developed country. For a developing country like India the question has to be reworded as "Will health reduce poverty?" Good health will retain the elderly in the labour market and ensure their income for a longer period. In view of this, the proper questions will be: Can health reduce poverty? And Will it result in creation of wealth?

Presently poverty is defined in terms of "dolors and scents"! The value of money and its purchasing power is different in every country. Therefore it is an inadequate measure. The question about the relationship between poverty and happiness is crucial.

The real definition of poverty is in terms of loss of developmental opportunities. A family may be rich but, if the children are not able to enrol in a primary school or if children do not have any access to health, we will have to treat these families as poor. A definition of poverty is "absence of developmental opportunities". If this hypothesis is true, many of the statistical tables may be irrelevant. The poverty situations are cruel. This may be more acute & intense, in case of population ageing.

Development defined:

The World Bank has defined development as upgrading of the quality of life of millions of people who are denied the opportunities and qualifications. In the case of the elderly, many of them have the qualifications but they do not have the opportunities.

To achieve this, three factors are necessary:

- 1) A political system that ensures participation and empowerment
- 2) An economic system that is conducive to generate wealth.
- 3) A social system which can provide development with justice.

* *Presentation at the UNESCO ILC Colloquium in Paris on 8th November 2005*

In the last decade of the last century the major thrust was on the debate as to how could we provide income security to millions of workers in the informal, unorganized and rural sector. Then the focus shifted to health research. Since then we have come a long way to include research in spirituality.

Now it is realized that while the brain is an organ which can be seen and studied, the human mind is something which is experienced in reality. This reflects the psycho-somatic relationship of human behaviour.

Indian Demographics

The Population of India aged 60 and over numbered 82 million in 2004, and it will be 177 million by 2025. India has gained about 30 years of life expectancy since independence. Presently India is passing through the last phase of demographic transition i.e. low mortality & low fertility.

Growth Rate of total population in India is 1.93 while growth rate of the elderly is 3.01. An important aspect is the rapid "feminization" of ageing. The other factors include rural poverty, inadequate health insurance and social security. In India 52 million older people live on less than a dollar a day. 80% of older persons have no regular income and they are living in rural areas. 90% are from the unorganized sector. Of the ageing population in India 55% are women. A staggering 20 million elderly women are widows. In the rural areas, 70% of older women work as agricultural labour and their work is not mechanised. Another disability that women face is that of loss of status due to widowhood.

As reported by the former governor of the Reserve Bank of India Dr. Bimal Jalan, "India is one of the fastest growing economies, and there is an emerging consensus that if India follows the right policies, by 2020 or 2025 it will be the third largest economy in the World. India's balance of payments position is stronger than at any time and it has one of the highest levels of foreign exchange reserves in the world, amounting to \$ 130 billion at the end of 2004."

Health and the Elderly in India

Ageing is a set of biological processes that are genetically determined. Ageing is progressive generalised impairment of function resulting from adaptative responses to stress and age associated functional loss, disease and disablement. (WHO.)

The World Health Organization defines health as: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This definition has three implications: they are - physical, mental and social and they cannot be separated from each other."

The World Health Organization has come out with a new approach called "A life course approach to Ageing" This approach emphasises the social perspective and looking back across an individuals or the cohort's life experience and across generations for clues to current patterns of health and disease.

Health problems in India include cardiac diseases, disorders related to bones and joints, Cancer and Tuberculosis. The incidence of Alzheimer disease and dementia is now being recognized. However, these diseases are neither a natural nor an inevitable part of ageing.

Science and Technology in Health Services:

The battle against ageing is being waged on two fronts. On the first, scientists are searching for disease - specific therapies aimed at curing, controlling, or preventing a particular disease. On a second front, researchers

are seeking answers to a more fundamental mystery that has the potential to unleash therapies for a vast array of diseases. Researchers are developing less invasive techniques.

Unfortunately, sometimes serious research in medicine, including in Ayurveda, is being mistaken for "anti-ageing" medicine; it is claimed that appropriate interventions can slow, stop or even reverse the ageing process. This is only partially true. As Dr. Robert Butler says, let us adopt the term "Longevity Medicine".

In recent times in India, research in the area of, genetics, stem cells research, biochemistry of ageing, brain cells and DNA is being pursued. Towards this, the Government of India has set up an organization called Ayush under Dr. R.A. Mashelkar, the Director General of the Council of Scientific Research of India.

Laboratories and more than 20 universities together, are trying to see what we can learn from each other and get new clues for discovery and development of drugs. It is amazing how new breakthroughs are taking place. The results are truly encouraging.

What is our target group?

Among the Elderly it is the poor, scheduled castes and tribes, rural women especially the destitute and widows and frail old persons who live alone should really be treated as a priority.

Experience shows that health services, if delivered well, can improve outcomes for even the poorest groups. A health programme in the Gadchiroli district in India reduced neonatal mortality rates by 62%. But those who need the most often get the least. Illness pushes households into poverty, through lost wages, high spending for catastrophic illness, and repeated treatment for other illness.

Consequently, the social safety - net and support provided by family structures are increasingly unavailable to many older persons. Therefore the challenge is to strengthen the family and community support. Strengthening the primary health centres is now a priority.

National Policy in India (NCOP) states:

"Health care needs of older persons will be given high priority. The goal should be good affordable health services, very highly subsidized for the poor and a graded system of user charges for others."

"The primary health care system will be strengthened and oriented to be able to meet the health care needs of older persons. The development of health insurance will be given high priority."

"Facilities for specialization in geriatric medicine will be provided in the medical colleges. The issue of trained geriatrician and health care personnel has been an area of concern. People trained in geriatric care are very few."

The majority of older persons who live below the poverty line depend exclusively on the public health system.

Wealth and Poverty:

To understand the significance of poverty we may have to use a number of indicators including the participation of the elderly in the labour market. While the dependency ratios are low among the relatively poor, they are

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very low among the landless wage earners. This may be attributed to the higher participation of females in employment and income earning activities among these vulnerable population groups.

Work Participation by the elderly as an indicator of poverty

Age	Male	Female	Total
60+	56.2	54.7	55.6
70+	37.3	29.7	33.6
80+	20.1	12.7	16.3

Fully dependent elderly in India as an indicator of poverty

NSS 52nd	Male	Female	Total
Rural	45.0	58.2	51.4
Urban	45.5	64.2	55.0
Total	45.2	60.6	52.8

No assets for elderly persons

Rural Male	Rural Female	Urban Male	Urban Female
28.3	56.9	27.4	59.6

The above information clearly indicates that the services are more needed in the rural area for poor elderly, destitute women and who belong to scheduled caste scheduled tribes.

Pension and social assistance:

The Reserve Bank of India indicates that pension liabilities will constitute a large potential claim on the states' resource in the future.

The incidence of poverty has declined from over 50% in the 1950s to less than 30% in the late 199s. According to the recent Human Development Reports of the United Nations Development Programme, India moved from the category of 'low' human development to that of 'medium' human development and its present ranking is 115.

Economic Security:

Basic features are: 1) Social assistance and social allowances come from public revenues and there are

entitlement criteria. 2) Social insurance is for members only. 3) Contribution is from both employer and employees. 4) Employer liability charges are paid by the employer based on the employment criteria.

Basic facts about social security in India.

Civil pensioners	7.6 millions in India
Pension expenditure	440 corers
Coverage	10% of population

Social Assistance for the Elderly in India

Eligibility	Age 65+; Destitute and have no regular means of subsistence
Rate of assistance	Rs. 75 per month
Sponsor:	Fully sponsored by the Centre
Assistance:	Twice in a year
Objectives:	50% of population below the poverty line in the age group 65+

Who gets the benefit

6.5 million elderly persons benefit from the scheme
Schedule Caste: 31%
Scheduled Tribe: 14
Other Caste: 55%
Women: 37%
Total close to 10% of population

Critical Assessment:

The crucial questions are:

- 1) For whom to provide a pension?
- 2) Can social assistance based on criteria such as poverty, widowhood, and dependency and being without children, help eliminate poverty?
- 3) Whether there can be a uniform rate of social assistance?
- 4) Is the “means test” an effective criterion?

A New Pension scheme

There have been four kinds of pension schemes:

- 1) The scheme run by the EPFO;

- 2) The pension for state and central government employees
- 3) A pension for employees of the public sector banks, and
- 4) Pensions "sold" in the market by mutual funds, insurance companies or superannuation funds. Only about 10% of the population has been able to access any of these schemes.

The New Pension Scheme is based on a defined contribution by the individual. In this system every individual has his own account. Government contributes the same amount. This contribution would be accumulated for the period of working and at the time of retirement a part of the accumulated fund would be annualised. The annuity would serve as a monthly pension. This will indicate that a good state of health during the entire service period is likely to benefit every individual in public sector employment which directly relates to creation of wealth.

Thus, all these groups are adversely affected by poverty viz.

- 1) dalits (scheduled caste and tribes)
- 2) destitute women in rural areas
- 3) frail elderly persons without any family support (because of poor health they cannot work and continue to remain poor).

To break this vicious circle we have to fight on three fronts: 1) Create health services and make them accessible and affordable. 2) Provide income security through pensions to the organized sector. 3) Provide universal social assistance for all those in the informal and rural sectors.

Conclusion

The Indian Perspective

We should hope to prolong enjoyable life and not mere existence. Ageing is an opportunity to look inwards and be useful to society, to discard selfish ambition but retain motivation of life. One of the terrible temptations that we face is of thinking that the problem of ageing is so great that nothing can possibly have any effect on the rate of ageing, therefore we must leave it either to Government or God.

Spirituality is not the flight from ethical responsibility of the material world but a rhythm of withdrawal, harmony in action and at the same time keeping oneself aloof from it.

In conclusion one can safely say that ageing becomes a celebration and an experience of happiness if one comes to the realisation that the true meaning of life lies in "Karma - fala - Tyaga" or doing your duty without being attached to it. This will make us divinely happy. Thus spiritualism is the key to cope with ageing. Spirituality is to be experienced and not treated as mere knowledge. The great wise man of China, Confucius says "To know that you do not know, is the beginning of knowledge." In this spirit if we take the first step it will lift us up to the experience of spiritual ecstasy and that is our first step in the long pilgrimage of light.

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AGE-FRIENDLY PRIMARY HEALTH CARE: in Thailand

DUANGPORN HOONTRAKUL

Abstract

The qualitative study reported here was designed to describe the meaning of agefriendly primary health care from the perspective of older people. The data were collected by participatory observation, natural interviews, focus groups, and in-depth interviews with 42 northeastern elderly persons living in the community to which the university hospital provides health services, in Khon Kaen Province, Thailand. The data were analysed using content analysis. Elderly persons describe age-friendly primary health care as emphasising socio-cultural aspects of service rather than bio-medical components of care. Age-friendly primary health care providers should respect elders, deliver a direct service within the community, focus on service equity, provide care to the elders' family, facilitate a good death, and ensure an age-friendly environment within the primary care unit. Results of this study provide an understanding of elders' needs. The study also indicates that primary health care for older people must integrate socio-cultural considerations with biomedical care in order to develop age-friendly primary health care.

Keywords: Age-friendly, elder, primary health care, Thailand

Introduction

In 2004, the World Health Organisation (WHO) recognised the critical role primary health care centres play in the health of older people worldwide, and drew attention to the need for these centres to be accessible and adapted to the needs of the elderly. To develop primary health care (PHC), the WHO recommends the use of age-friendly primary health care principles. It is important to remember that while age-friendly services benefit older populations, they also enable people with temporary or permanent functional limitations to access care and to maintain health and independence. An age-friendly programme does not favour the elderly, but instead benefits all people in line with the slogan of the United Nations International Year of Older Persons "Towards a Society for All Ages" (WHO, 2004).

Age-friendly primary health care consists of two key principles, primary health care centre objectives and age-friendly principles. The primary health care

centre objectives include eight specific objectives: availability, accessibility, comprehensiveness, quality, efficiency, non-discrimination, and gender and age responsiveness. The age-friendly principles incorporate the principles of information, education and training, a community-based health care management system, and an accessible physical environment. The WHO believes that the integration of these principles will lead to age-friendly primary health care.

In Thailand, no studies have been conducted to support the idea that the integration of these two principles will lead to age-friendly primary health care in practice (Sombat, 1997; Charoenchai. et al., 2004; Sritanyarat. et al., 2004). This present study was undertaken to identify how age-friendly primary health care principles might be adapted for development in the Thai context.

Significance of the study

Over the past twenty years, the population of older

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people in Thailand has grown substantially, from 5.6% in 1980 to 9% in 2000 (Thailand National Statistics Office [NSO], 2003). It is expected that the population of people > 60 years will rise to 16.8% by the year 2020 (Thailand National Economic and Social Development Board, 2003), which means that the society is rapidly aging. This implies not only changes in the distribution of the population by age, but also to social, economic, and health problems exacerbated by other social changes, for example, in family structure and patterns of care.

The proportion of older people with illnesses is growing, from 30.65% in 1998 to 35.5% in 2001 (NSO, 2003). One-fifth of Thai elders are chronically ill and live with disabilities, and all need continuing care. In addition, they become more ill as they get older: almost 70% of people 60-69 years of age have chronic illnesses but the rate increases to 83.3% among those 90 years and older (Chooprapawan, 2000). Health problems are exacerbated by economic problems. Most Thai elders are poor, one quarter with incomes less than 5,000 baht per annum (NSO, 1998). As a result, it is crucial to prepare strategies to accommodate problems associated with aging, particularly in the area of health care and socio-economic services.

A primary health care system tailored to the elders' way of life and aging is a strategy specifically for older people with health problems, delivered within the community and therefore convenient for elders who present for health services. It also adopts a holistic focus, with continuing care that responds to both psychosocial and medical dimensions (Cooney, 1994; Hughes, 1995). If this type of service is improved to be age-friendly and responds to both the health and social needs of the elders, their quality of life will be enhanced. This will delay dependence upon others (Courtney, 1997; Kamponsiri, 1998; Sritanyarat, 2002; WHO, 2004). However, there is no evidence-base to define appropriate age-friendly primary health care for elders in Thailand. Most previous research on primary health care in Thailand has investigated the health problems of all people, not only the elderly (Sritanyarat. et al., 2004). Furthermore, most studies concerning elders focus on their health problems, self-care, and factors

related to self-care behaviours (Petchurai & Viriyavejakul, 1995; Sombat, 1997; Petchurai, Anaprayot & Jeampempon, 2002), but do not explore the components, development, and delivery of health care.

Individuals have the capability to create and adjust their society for the benefit of their health. Elders from each community, including those in Thailand, have their unique cultures, traditions, beliefs and ways of life. It is important to gain a better understanding of the thoughts and needs of the elderly, especially regarding what age-friendly primary health care is like and how they perceive it should be, before attempting to develop Thai age-friendly primary health care (Gubrium & Sankar, 1994; Leininger, 1996).

Methodology

This article draws on a qualitative study, designed to establish the meaning of agefriendly primary health care as perceived by north-eastern Thai elders. Information was gathered among older people residing in a suburban community within the service area of Khon Kaen University's primary care unit (PCU), Khon Kaen Province, Thailand. The PCU covers 2,827 households or 12,874 persons, of whom elders constituted 9.88 % of the population.

The data were collected by the first author through participatory observation, natural interviews, four focus groups (8 elders/group), and twelve in-depth interviews. The quality of data generated largely depends on the skills and expertise of the researcher (Guba & Lincoln, 1981). Therefore, to gain experience in the necessary skills, the researcher conducted a pilot study with two urban elders, two health care providers, and two rural elders. In the final study, in total, there were 42 Thai elders, 24 males and 18 females. Thirty-four participants were Buddhist and eight were Christian.

Content analyses were conducted of all data (Holloway & Wheeler, 1996; Rice & Ezzy, 1999; Streubert & Carpenter, 1999). The process of data analysis took place from the beginning of the observations and interviews. All audio-tapes of

interviews were transcribed verbatim. The first author read all transcripts carefully to develop a deep understanding of the text and to develop preliminary categories. The first author then shared the implicit categories contained in the data with the participants for clarification, explained the patterns and illustrated the relationships of categories to each other. The draft description of the meaning of age-friendly primary health care among Thai elders was consequently shared with participants to ensure accuracy.

FINDINGS

From the perspective of older people, an age-friendly primary health care service should be a service that ensures respect, direct service, equity, family caring, a good death, and an age-friendly environment.

Respect

Older people need health providers to treat them with respect, interacting with them as though they were older relatives, not just clients. Respect to older people as perceived by the elders in this study is comparable with other patterns of respect for elders in the region, and is considered a foundational value in Asia (Sung, 2001). Although the present study did not uncover the whole fourteen patterns of elder respect as did Sung (2001), a similar pattern of respect for elders was observed.

Thai culture dictates that young people be courteous and respectful to their parents and other older people (Wongtes, 2000; Kiengsiri, Bhinyoying & Promathatavedi, 2004). In addition, Thai people including elders should show respect to health personnel because they are thought to be capable and knowledgeable. Since almost all health personnel in the PCUs in Thailand are government officials who are highly regarded in society, while most elders participating in this study were villagers with no government employment history or other status, the treatment of elders with respect by health providers is a way to express warmth and care. It signifies the acceptance by providers of the elders, and has great value to such persons. Health care patterns that are respectful to Thai elders can be characterized as follows:

Recognition. Older people are appreciative and happy when health providers recognise who they are, remember their names, and greet them every time they meet both inside and outside the PCU. Elders are disappointed when they are not greeted by providers of care. For example, one female elderly reproaches nurses (and the first author) when she is not greeted: "You didn't say hello to me the other day. Didn't you see me?"

Respect also includes its non-verbal expression. Elders need providers to be enthusiastic about providing care. They prefer expressions of informality and caring from providers with whom they are well acquainted. Because they can ask for the service that they want, elders often choose to receive services from providers with whom they are acquainted, regardless of distance. This is probably because it makes them feel *krai jai* (closer at heart) than going to a PCU with which they are not familiar and do not know any providers. Elders explained: "I like to come here better. I could tell the providers and they listen. In other places I wouldn't dare to request anything, but I would here. Things will be arranged for me in no time." (Male, 72) "They hurry to come to see me every time. I didn't need to wait long." (M, 78) "I went there; they asked me why I came. I said I needed a wound dressing and they did a great job for me. It (the dressing) was not painful at all." (M, 65) "I'm not going to move. I went to this place many times, I know my way around even though I can't read. The providers and I are used to each other." (Female 72)

Actions indicating respect. These include listening, believing, and being sensitive to what elders say. Disbelief in elders' accounts leads elders to feel ignored and, on some occasions, it affects the timing of diagnosis such that treatment may be too late to help them. One female elderly who went to the PCU every week for two months with stomach ache, was eventually attended by a nurse who organized emergency admission to hospital for surgery for a gut obstruction. She explained: "Only (name...) believed me...she helped me when I was there. I told her I had a stomach ache (so bad) that I couldn't even sleep. I couldn't eat and she gave me an injection. Others (providers) were not like that, they

only gave me para(cetamol), I couldn't take it. Even if I did, it wouldn't work. (I) vomited."

Respect for older people needs to encompass the expression of understanding of older people's problems, and not to imply that their problems are a laughing matter or insignificant. For example, one woman was experiencing frequent falls. Providers greeted her as usual, without acknowledging her concern about her frequent falls:

"Oh, you fall again?" When I heard them greet me like this, I didn't want to go back, and I never did. I don't want to go, I feel ashamed. I'm afraid they'll say ... "You fall again?"

Respectful manners when providing care. This includes paying respect to older people according to Thai culture, with the *wai* when seeing them or when they come in for services. It also includes verbal gestures. Elders prefer to be called by a kinship term, e.g. calling female elders *mae* (mother, mom) or *mae-yai* (grandma) and male elders *por* (father, dad) or *por-yai* (grandpa). They do not like to be called *konkae* (old man/woman). When talking to providers, elders refer to themselves *por* or *Mae*, as they do when talking with family members in a context of love and respect.

Direct services

Most elders in the community have mobility problems. They often have visual and/or hearing impairments or leg and joint pain. These limitations prevent elders from coming in for follow-up and receiving their medications. Sometimes they send someone else to renew their prescriptions, causing them to miss the health check up. A female elder explained: "I have so much leg pain that I can't ride on the back seat of the motorcycle. I need to have my daughter come in to renew my prescription for me." (F. 67)

In addition, their children must work outside the house during the day, leaving the elder at home alone or just with the spouse. Some elders also have to look after young grandchildren, keeping them busy and preventing them from presenting to the health

care service unless they are ill. Having to be at home alone, elders worry that if they become ill suddenly, they will not be able to let anyone know. They may die without getting help. Elders consequently agreed on the need for health checks within the community, telephone consultations, a way to communicate with health personnel when they have health problems, and a pick-up service in case of health emergencies. "Living alone, when you die, no one knows. Like Grandma (name), she fainted and died and no one knew. Her husband is old and he has bad hearing. I want the health check-up done within the community and give the telephone number of PCU for calling or consultation." (F 67) "I want someone to come and care for elders who live alone." (M, 65)

The situation is most serious for elders who stay alone in the day time and can not help themselves at all. Although sometimes neighbours stop by to feed them and give them a bath, they need a home visit when they are ill. When health providers come for a visit to take care of them, elders receive both physical care and emotional and moral support. For example, one female elder who had osteoporosis couldn't walk and help herself. She explained: "I want the provider to bring medicines for me or just to come by for a visit. Once a month is good enough." "I'm really glad that the provider visits me at home." (F. 72) "I like it when the nurse comes to visit, to talk with me. She (nurse) gives suggestions and sometimes even brings sand to kill mosquitoes." (F. 76)

Equity

Older people want to be accepted and to participate equally in society. They want to be recognised as being as important as anyone else. Equity must extend to elderly welfare socially as well as in the context of medical care.

The government pays 300 baht per month to elders who are poor, and have no children to take care of them. But only 16.6 % of Thai elders receive this welfare support. A number of older people proposed that the government provide living expenses for all elders, even though some of them receive money or are cared for by their children. Although they are happy to receive money from their children, it also

makes them feel dependent and a burden to their children. Receiving monetary assistance from the government gives elders' dignity, allowing them more independence from their children. In the focus group, elders argued that this was their privilege and recognised them as members of society: "It is better that the government distributes money to all elders." "Elders here are poor. We can not work so we must ask for money from our children." (M, 62) "They say being older is not poor. How can that be true? You can't do anything when you are old." (M, 68. "The money will pay for medications and food. I don't want to ask for money from my children." (M, 76) "We are old people, also disabled. Why not help us?." (F. 77) "They (sons/daughters) also have their own children to look after. I don't want to be their burden at all." (M, 72)

Therefore, even though the monetary value is small, elders want recognition, a symbol that older people are accepted and not ignored by society. For example, the community and PCU had a water blessing ceremony for elders in the community for Songkarn festival (Thai New Year). The water blessing was a celebration for elders. But there was not enough money to buy gifts for everyone, so the community committee determined that only those 65 years old or older should participate in the ceremony. When the community selected older people to be representatives, those who were not chosen felt disappointed and were critical of the selection process. One male elder explained: "I am an elder. I am 63, why didn't they choose me? What are the selection criteria?" Therefore, activities should be carried out for all elders without restrictions. This extends to equity in treatment. Elders need health care providers to care for them in the same manner; without discrimination: "I want the nurse to take care of elders in the same way as everyone else."

Family caring

In order for age-friendly primary health care to be delivered, sometimes it is necessary first to solve problems surrounding elders, especially when only family members provide care. On some occasions, primary health care can be directed to elder health

needs, but in many cases problems related to family members must be solved before any health service can be delivered to the elder. This is due, in part, to smaller family sizes and the fact that all members must work for a living. Some elders live in female-headed households, and tend to have both personal and financial problems, as illustrated in the following case studies.

Family case study 1 Uncle Mitr (alias), 76 years old, is paralysed and has lost all self-care abilities. He lives with his daughter in a rented single-room house. He has two school-age grandchildren. During the day he is left lying on a wooden bench alone at home. When he urinates, the urine flows all over the floor and the area smells bad. He does not have lunch because no one is available to feed him. Both health personnel and social workers come in to help by cleaning the house, giving hygiene care, arranging for donations of household supplies and providing advice for his care. However, these efforts are discontinued when the personnel leave. Uncle Mitr is still left alone at home without lunch until his daughter is back from work. Sometimes he goes 2-3 days without a bath. The health and social personnel and public health volunteers try to talk to his daughter, but on many occasions she refuses their requests and is often uncooperative with their suggestions. However, after a nurse and social worker helped the family to solve other family problems, such as finding a scholarship for uncle Mitr's granddaughter and getting her a part-time job to help pay for household expenses, the family's economic problems start to dissolve. His daughter is less stressed and the care for uncle Mitr is better. Both his daughter and other members of the family pay more attention to providing care and uncle Mitr is happier.

Family case study 2 Grandma Noi (alias), 78 years old, lives with her son because her husband passed away 5-6 years ago. The son living with her has drug related psychosis, and she has to work to support both herself and her son. She picks up trash and sells it for 100-200 Baht at a time. The money is used to pay for food and medications when she is ill. In addition, she receives an elderly welfare benefit of 3,600 Baht a year from the government. However,

the money takes 3-4 months to arrive. When she is in urgent need, sometimes Grandma Noi will go to beg for money at the Silk Festival (Red Cross annual festival) or at different temple fairs. When her vision became blurred and dark, and the health providers told her to have her eyes checked, it was found that she had cataracts that were beyond treatment and operation. Grandma Noi will inevitably lose her vision. Every afternoon, she returns home to prepare food for herself and her son. Sometimes neighbours drop by to give them food, help prepare the meal, and keep them company. After health providers take her son to receive treatment, bring the medications home for him, and invite a psychiatrist to visit him, his symptoms improve. A public health volunteer also comes to help with cleaning the house and doing laundry, as well as keep them company. Soon the son is well enough to start providing care for Grandma Noi. He cooks for her, takes her to the PCU for health checks, and closely watches her to prevent accidents because the house has steep staircases. Grandma Noi's once worrisome face is now full of happiness. Her meal is no longer mixed with dirt because of the instructions given by health providers and because her son's vision is much better than hers.

“Good death”

Thai elders who participated in the study did not fear death. But at the end of life, they want to leave peacefully. They want to receive good care from health providers and especially their family, without suffering and not extended, and they want to have the appropriate religious ceremonies because religion is a significant part of their daily lives. They do not want to be a burden to their children. Elders who are Buddhist usually donate food to the monks and pray each morning, or participate in religious activities, in Thai belief that gaining merit will lead them to a better life after death (Office of the National Culture Commission, 1996; Wongtes, 2000). Elders also hope that it will lessen the suffering when death actually comes.

Family case study 3 Grandma Yai (alias), 62 years old, lives with her grandchildren because her two daughters live in Bangkok. She has had hypertension for 10 years. She tries to control her blood pressure,

but it is still high (190-200/140 mmHg). She didn't want to be in a coma with her family members having to take care of her. She repeatedly spoke of this: "I try the treatment. I don't mind being dead, I just don't want to suffer too much because it will be burdensome for them (her daughters). It's all right if they want to do it, but if they don't, this will only inconvenience them, having to clean up after me. If they don't want to, I don't want them to. If I have to go, I want it to be like my mother. She got up to chew areca nuts, then died." "I pray, hands over my head, to the Buddha, the Dharma and the Sangha. If something happens, I pray that I would not be left with a disability. I pray to the Buddha's bone and my parents' greatness and also to all my teachers. With all the merits I have won until now, please don't let me be too sick and a burden to anyone (sobbing). If I am to die, I want it to happen at once. Please, no suffering."

In addition, older people try to comfort themselves about dying and not having their children to look after them: "It's good to live alone. When you die, no one is bothered with a smelly corpse." There are times when family needs compete with the needs of elders, as in the case of one male elder, who stayed with his family:

Family case study 4 Grandpa Mai (alias), 72 years old, lives with his son, daughter in-law, and two grandchildren. He had an intracerebral hemorrhage and remained unconscious. His son denied him medical treatment, and took his father home, reasoning that "staying in the hospital will only torture him. It's better to bring him home and let him pass away here." Twenty four hours after returning home, Grandpa Mai was still alive. Relatives couldn't do anything except clean up after him and give him a little water. Elderly neighbours living nearby perceived that the son was harming his father, so they came to ask the son to take his father back to the hospital. The son refused to do so. Other elders came to talk to the son because it seemed cruel to them that he was not being provided food and care. These elders verbalised their opinions of the son: "(He is) heartless, don't know why he did that." "It's not good torturing his dad like this. If he's going to die, don't make him suffer He shouldn't torture his dad like that."

Some elders came to the PCU and asked the nurse to talk to the son, to convince him at least to allow a nasogastric (NG) tube to be inserted for feeding. When the nurse came for a visit, the son would not allow her to insert the NG tube or to do any other interventions for his father. The nurse invited other elders to talk to the son with her, and eventually he allowed the NG tube insertion. Several elders then expressed their satisfaction: "I couldn't just let him die and do nothing. I couldn't live with that."

This case study illustrates how nurses in community settings have to work with tensions and divergent beliefs in the community, managing complexity and diversity. Sometimes elderly neighbours and elderly family members have a different perspective from trained nurses with the task of negotiation and compromise.

Physical Environment

PCUs all over Thailand have the same building plan from the Ministry of Public Health: a two-storey building with steep steps. It is common to see older people carefully climb the stairs with their hands gripping tightly onto the rail, while those who are acquainted with health providers and cannot climb the stairs wait for health providers to come down to see them at ground level. Although Thai elders do not consider such physical barriers to be as important as providers' attitudes and services, the physical environment and accessibility are a component of age-friendly primary health care principles of WHO. Health care buildings suitable for elders should not have steps too high, because many Thai elders have knee joint degeneration, leg pain, or visual impairments. When elderly health care services are offered at the ground level of the PCU, elders greatly appreciate the change: "Moving the services down here is great. Very, very good." "It's much better than upstairs. We don't have to trouble ourselves climbing the stairs anymore."

In terms of PCU surroundings, elders suggest that the walkway should be well paved with a rail to prevent falls. The pavement surface must not be slippery. It does not have to be a concrete pavement, just a smooth surface covered with well-cut grass

sufficient to prevent falls. When the surface is uneven, elders with trouble moving, or disabilities, have their own way to move around and often argue that they do not want to be bothered. They usually say, "I can climb. No need for concrete surface, just a grass-covered ground with a rail is good enough." For sloping walkways, the length should be long enough and not too steep so that the elders with wheelchairs can use the ramp themselves without assistance.

CONCLUSION

While the age-friendly primary health care principles of the World Health Organization focus on primary health care objectives and age-friendly principles (WHO, 2004), Thai elders focus on religion, culture, and their families. The results provide knowledge that can be synthesised into three principles: age-friendly behaviour, age-friendly primary health care services, and age-friendly environment.

Age-friendly behaviour is the performance of health care providers that conforms with need and socio-culture. The elders need to be accepted in terms of their values and rights, ensuring pride and dignity. An age-friendly primary health care service should ensure equality of access in social welfare and health services. In addition, age-friendly services should be proactive and continuous. Both active and inactive elders need to be looked after until the end of life. All Thai elders spoke of the need for a "good death". An age-friendly primary health care service should include family members care too. In addition, the safety and comfort of the PCU environment is part of an age-friendly primary health care.

For an age-friendly primary health care system, nurses or other providers must recognise diversity. This is particularly true for a community that has diverse religions, occupations, levels of education, and economic status. Nurses should realise the importance of surroundings on elders' health. Since the environment differs for each person, their health problems will vary and, as a result, they require different approaches. Community care for elders will have to adopt a different philosophy. Caring and problem solving must be elder-centered, utilizing

diverse methods and forms of care delivery, adjustable to suit each elder (Leininger, 1996; Nolan et al., 2004; Eliopoulos, 2005).

Caring for elders so they can die peacefully and without suffering at the end of their lives is an age-friendly health service. In order to provide suitable end-of-life care, nurses should make an effort to understand the elder's needs, including participation in gaining merit or other religious activities (Staab & Hodges, 1996; Eliopoulos, 2005). Nurses in the community not only provide care to individuals, but

also can promote co-operation within communities to build an age-friendly environment, especially in elders' homes (WHO, 2006).

The meaning of age-friendly primary health care from the perspective of elders is focused on socio-cultural rather than bio-medical components. It is necessary to integrate socio-cultural considerations with bio-medical care in order to develop agefriendly primary health care. How to apply this in an actual plan of intervention remains a challenge for community nurses and other health providers.

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References

- Charoenchai, A. et al. (2004) **The situation of public and private healthcare delivery system for the elderly with chronic illness in Northeast, Thailand.** Khon Kaen: Khon Kaen University Press. (in Thai)
- Chooprapawan, J. (2000) **The Health Status of Thai People.** Bangkok: AUSA Print. (in Thai)
- Cooney, C. (1994). **Primary health care: the way to the future.** New York: Prentice Hall.
- Courtney, M. et al. (1997). **Financial management in health services.** Sydney: MacLennan and Petty.
- Eliopoulos, C. (2005). **Gerontological Nursing.** 6th ed. Philadelphia: Lippincott Williams & Wilkins.
- Guba, E.G, & Lincoln, L.S. (1981). **Effective Evaluation.** San Francisco: JosseyBass.
- Gubrium, J.F., & Sankar, A. (Eds.). (1994). **Qualitative Methods in Aging Research.** Thousand Oaks: Sage Publications.
- Hughes, B. (1995). **Older people and community care: Critical theory and practice.** Buckingham: Biddies.
- Holloway, I., & Wheeler, S. (1996). **Qualitative Research for Nurses.** Oxford: Blackwell Science Ltd.
- Kamponsiri, T. (1998). **Healthcare Service for older people.** Nursing Newsletter. 25(3), 1 - 8. (in Thai)
- Kiangsiri, P., Bhinyoying, S. & Promathatavedi, M. (2004). **Thai Social Etiquette.** Bangkok: The Office of the Permanent Secretary for Culture, Ministry of Culture.
- Leininger, M.M. (1996). Culture Care Theory, Research, and Practice. **Nursing Science Quarterly**, 9(2), 71-78.
- National Statistical Office. (1998). **The Statistics of Thai Older Persons.** Bangkok: Ministry of Information and Communication Technology. (in Thai)
- National Statistical Office. (2001). **Working situation of Thai Elders**, year 2000.
- Retrieved December 12, 2003, from <http://www.nso.go.th/ageing/elderly43.htm>. (in Thai)

- National Economic and Social Development Board. (2003). **Thai Population 2000-2025**. Bangkok: Office of the Prime Minister.
- Nolan, M.R., Davies S., Brown, J., Keady, J., & Nolan, J. (2004). Beyond 'personcentred' care: a new vision for gerontological nursing. **International Journal of Older People Nursing** in association with Journal of Clinical Nursing, 13, 3a, 4553.
- Office of the National Culture Commission. (1996). **Understanding Thai Buddhism**. Bangkok: Office.
- Petchurai, R., & Viriyavejakul, A. (1995). **Research issues and research Bibliography related to Older people in Thailand**. Bangkok: Mahidol University Press., (in Thai)
- Petchurai, R., Anaprayot, P., & Jeampemphoon, D. (2001). **Elderly research in Thailand: A glossary' Supporting Organization and The Thesis data base on the Elderly**. Nakornpathum: Research Management Division, Mahidol University Press. (in Thai)
- Rice, P.L., & Ezzy, D. (1999). **Qualitative Research Methods**. Oxford: Oxford University Press.
- Sombat, P. (1997). **A Survey of Nursing Research related to the Elderly Population in Thailand**. Bangkok: Mahidol University Press. (in Thai)
- Sritanyarat, W. (2002). **Health services to strengthen equity in older persons**. Proceedings of Annual Conference 2002. Thai Society of Gerontology and Geriatric Medicine. November, 13-14 2003, Bangkok. (in Thai)
- Sritanyarat, W. et al. (2004). Health Service System and Health Insurance for the Elderly in Thailand: A **Knowledge Synthesis**. **Thai Journal of Nursing Research**, 8(2): 159-72.
- Staab, A.S., & Hodges, L.C. (1996). **Essentials of Gerontological Nursing Adaptation to the Aging Process**. Philadelphia: J.B Lippincott Company.
- Stanley, M., & Beare, P.G. (1999). **Gerontological Nursing**. 2nd ed. Philadelphia: F.A.Davis Company.
- Streubert, H.J., & Carpenter, D.R. (1999). **Qualitative Research in Nursing: Advancing the Humanistic Imperative**. 2nd ed. Philadelphia: Lippincott Williams & Wilkins.
- Sung Kyu-taik. (2001). **Elder respect: exploration of ideals and forms in East Asia**. Journal of Aging Studies, 15(1), 13-26.
- Wongtes, S. (2000). **The Thai People and Culture**. Bangkok: Paper House.
- World Health Organization. (2004). **Towards Age-friendly Primary Health Care**. Retrieved April 6, 2004, from http://www.who.int/hpr/ageing/af_report.pdf.
- World Health Organization. (2006). **Global Age-Friendly Cities Project**. Retrieved November 9, 2006, from http://www.who.int/ageing/projects/age_friendly_cities/en/index.html

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THE ELDERLY IN THE RUSSIAN FEDERATION

Implications for Socio-Economic Development

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INTRODUCTION

Russia: A Nation in Transition

The former Soviet Republics are often referred to as nations in transition (World Health Organization 2004). The World Bank (2004) describes the Russian Federation as a lower-middle income economy nation that is moderately indebted. Transition however, does not only refer to the economical state of the nation. The Commonwealth of Independent States (CIS) and the Russian Federation are also undergoing political and social transition from totalitarian government to democracy and privatization- a situation which distinguishes the Russian Federation and CIS from the category of developing nations. Russia's economic, political, and social structures have gone through major upheavals and reforms in the last fourteen years in an effort to achieve a westernized capitalistic and democratic society. Granted significant progress has been made, and the economy is currently on the rise. Nonetheless, the fast pace of change has left the majority of the Russian people struggling at the level of poverty. A clear lack and inadequacy of social services, especially health care, meagre salaries and pensions, high crime and corruption rates, restrictions on freedom of the press, and growing presidential control indicate that democracy and capitalism remain abstract concepts (Ortung 2004).

POPULATION TRENDS AND PATTERNS

Demographic Indicators

From 1959-1995 the proportion of people 60 years and older in the Russian population grew from 9% to 16.6% (Karioukhin 2002). In St. Petersburg, almost 25% of the population is over 60 years old. The elderly population in Volgograd rose from 23.3% in 1990 to 25.6% in 1993 (Karioukhin 2002). The same trend is true in other regions of Russia. The percentage of the population of working age has fallen from 38% to 22.4% while the percentage of pensioners has risen from 8.6% to 20.5%-making 1/5 of the population of pensionable age (Karioukhin 2002).

Like in many other developed countries, the population of people 80 and older in Russia is growing faster than the 60+ category. In the period of 1939-1994 the 80+ group grew from 0.5% of the total population to 2.2%. By 2055, the average age in the Russian Federation will be 57 years, and the percentage of pensioners in the population will rise to 55% or 75 million people (Karioukhin 2002).

The current situation in Russia is extremely paradoxical - while the proportion of elderly people in Russia is growing, the life expectancy is decreasing from 70.1 years in 1987 to 64.1 years in 1994. The decline in life expectancy, which is most drastic for males, is often attributed to the rise in alcoholism, homicide, narcotics, and AIDS.

Population aged 60 years or over												Sex ratio (men per 100 women), 2006)		Potential support ratio		Statutory retirement age		Life expectancy at age 60, 2005-2010	
Number (thousands)		Percentage of total population		Percentage 80 years or over		Percentage currently married		Percentage living alone		Percentage in labour force		60+	80+	2006	2050	Men	Women	Men	Women
2006	2050	2006	2050	2006	2050	Men	Women	Men	Women	Men	Women	(10)	(11)	(12)	(13)	(14)	(14)	(15)	(15)
(1)	(2)	(3)	(4)	(5)	(6)	(7)		(8)		(9)		(10)	(11)	(12)	(13)	(14)		(15)	
24282	34755	17	31	14	19	87	53	10	31	20	9	51	26	5	3	60	55	14	19

Indicator	Age	1950	1975	2000	2025	2050
Population (thousands)	(1)	(2)	(3)	(4)	(5)	(6)
Total	Total	102 702,5	134 232,5	145 491,2	125 687,2	104 258,5
	0 - 14	29 689,2	31 280,2	26 122,7	16 574,2	14 106,8
	15 - 59	63 573,4	84 699,7	92 444,7	76 413,4	51 378,4
	60 - 64	3 086,3	6 369,3	8 753,8	9 095,5	9 902,9
	65 - 69	2 421,9	4 886,8	5 974,9	8 786,5	9 005,1
	70 - 74	1 781,9	3 428,4	6 087,9	6 725,7	7 038,3
	75 - 79	1 183,1	1 904,1	3 167,6	4 091,8	5 255,6
	80 - 84			1 524,9	1 739,1	3 440,8
	85 - 89			1 038,3	1 605,9	2 484,7
	90 - 94	966,6	1 664,0	313,4	484,5	1 238,9
	95 - 99			58,5	154,1	356,1
100 +			4,7	16,4	50,8	
Female	Total	58 624,4	72 870,5	77 361,1	67 398,2	55 771,5
	0 - 14	14 608,8	15 368,7	12 765,7	8 093,2	6 879,0
	15 - 59	37 409,0	44 565,2	47 011,1	38 809,9	25 521,8
	60 - 64	2 027,6	4 245,6	5 121,5	5 149,8	5 285,1
	65 - 69	1 657,6	3 401,3	3 676,2	5 260,3	5 052,9
	70 - 74	1 272,3	2 550,1	4 035,7	4 281,1	4 187,9
	75 - 79	884,4	1 442,7	2 400,6	2 776,0	3 312,6
	80 - 84			1 196,2	1 266,9	2 339,0
	85 - 89			843,0	1 233,7	1 847,2
	90 - 94	764,6	1 296,8	259,2	387,0	996,4
	95 - 99			48,5	126,5	304,6
100 +			3,4	13,8	44,9	
Male	Total	44 078,1	61 362,0	68 130,1	58 289,0	48 487
	0 - 14	15 080,4	15 911,4	13 357,1	8 481,1	7 227,8
	15 - 59	26 164,4	40 134,4	45 433,6	37 603,5	25 856,6
	60 - 64	1 058,6	2 123,7	3 632,3	3 945,6	4 617,8
	65 - 69	764,3	1 485,6	2 298,6	3 526,2	3 952,1
	70 - 74	509,6	878,3	2 052,2	2 444,6	2 850,5
	75 - 79	298,7	461,4	767,0	1 315,8	1 943,0
	80 - 84			328,7	472,2	1 101,8
	85 - 89			195,3	372,2	637,5
	90 - 94	202,1	367,3	54,1	97,6	242,4
	95 - 99			10,0	27,6	51,5
100 +			1,2	2,6	5,9	
Percentage in older ages						
Total	60 +	9,2	13,6	18,5	26,0	37,2
	65 +	6,2	8,9	12,5	28,8	27,7
	80 +	0,9	1,2	2,0	3,2	7,3
Female	60 +	11,3	17,8	22,7	30,4	41,9
	65 +	7,8	11,9	16,1	22,8	32,4
	80 +	1,3	1,8	3,0	4,5	9,9
Male	60 +	6,4	8,7	13,7	20,9	31,8
	65 +	4,0	5,2	8,4	14,2	22,2
	80 +	0,5	0,6	0,9	1,7	4,2
Ageing index		31,8	58,4	103,1	197,3	274,9
Broad age groups (percentage)	0 - 14	28,9	23,3	18,0	13,2	13,5
	15 - 59	61,9	63,1	63,5	60,8	49,3
	60 +	9,2	13,6	18,5	26,0	37,2
Median age (years)		25,0	30,8	36,8	43,8	50,0

Dependency ratio	Total	54,1	47,4	43,8	47,0	70,1
	Youth	44,5	34,3	25,8	19,4	23,0
	Old age	9,5	13,0	18,0	27,6	47,1
Potential support ratio		10,5	7,7	5,6	3,6	2,1
Parent support ratio		3,5	3,6	6,1	8,6	17,8
Sex ratio (per 100 women)	60 +	42,9	41,1	53,1	59,5	65,9
	65 +	38,8	36,7	45,8	53,8	59,6
	80 +	26,4	28,3	25,1	32,1	36,9
Indicator	Age	1950 - 1955	1975 - 1980	2000 - 2005	2025 - 2030	2045 - 2050
Growth rate (percentage)	Total	1,6	0,6	-0,6	-0,7	-0,8
	60 +	1,5	0,5	-1,8	0,2	1,0
	65 +	2,1	3,5	1,6	1,5	1,3
	80 +	2,1	2,6	1,4	3,0	-0,8
Total fertility rate (per woman)		2,8	1,9	1,1	1,4	1,8
Life expectancy (years)						
Total	Birth	64,6	68,9	66,0	73,2	76,9
	60	..	..	16,5	19,2	21,0
	65	..	..	13,5	15,7	17,4
	80	..	..	6,6	7,7	8,6
Female	Birth	67,3	74,1	72,5	77,4	80,5
	60	..	..	18,7	21,4	23,5
	65	..	..	15,0	17,5	19,4
	80	..	..	6,8	8,2	9,4
Male	Birth	60,5	62,7	60,0	68,7	73,1
	60	..	..	13,5	16,2	18,0
	65	..	..	11,1	13,2	14,7
	80	..	..	5,8	6,5	7,0
Survival rate (percentage)						
Total	60	..	..	69,7	83,0	88,6
	65	..	..	60,9	75,8	82,6
	80	..	..	25,2	39,4	48,7
Female	60	..	..	83,6	89,8	92,6
	65	..	..	77,0	84,9	88,9
	80	..	..	38,0	51,5	60,4
Male	60	..	..	56,9	76,3	84,6
	65	..	..	46,1	66,5	76,4
	80	..	..	13,4	26,3	36,0
Labour force participation (percentage)		1950	1970	1990	2000	2010
Total	65 +	7,6	6,6	7,8	7,5	7,0
Female	65 +	2,4	2,7	5,9	5,4	5,0
Male	65 +	21,0	17,2	13,2	12,1	11,1
Illiteracy rate (percentage)		1980	1990	2000	2005	2010
Total	60 - 64	2,7	1,4	0,7	0,4	0,3
	65 - 69	3,5	2,3	1,1	0,7	0,4
	70 +	4,6	2,9	1,5	1,2	0,8
Female	60 - 64	3,4	1,8	0,9	0,5	0,3
	65 - 69	4,3	2,9	1,4	0,9	0,5
	70 +	5,4	3,4	1,8	1,4	0,9
Male	60 - 64	1,3	0,8	0,5	0,3	0,2
	65 - 69	1,6	1,0	0,7	0,5	0,3
	70 +	2,0	1,3	0,8	0,7	0,5

SOCIAL IMPLICATIONS ON AGEING:

a) The Family

Proportion of persons aged 60 years over living alone: total and unmarried population, by sex (percentage)

All				Unmarried			
Total	Male	Female	F-M	Total	Male	Female	F-M
24,8	10,1	31,3	21,3	47,3	56,2	46,3	-9,9

Proportion of persons aged 60 years over living alone: total and unmarried population, by age group (percentage)

All							Unmarried						
Total	60-64	65-69	70-74	75-79	80-84	85+	Total	60-64	65-69	70-74	75-79	80-84	85+
24.8	18.4	25.5	30.5	31.2	29.4	23.5	47.3	53.0	54.1	51.1	44.5	36.4	26.2

Proportion of older persons living alone at various dates by sex

Date	Age group	Percentage living alone				Source
		Total	Men	Women	Difference col. (5) - (4)	
(1)	(2)	(3)	(4)	(5)	(6)	
1989	60+	24.8	10.1	31.3	21.2	ECE/PAU

Proportion of women aged 60 years or over with zero children ever born, and proportion with zero living children

Percentage with zero children	
Ever born 13	Living 16

Proportion of the population aged 60 years or over living in an institution, by sex and age group (percentage)

Total					Male					Female				
60+	60-64	65-69	70-74	75+	60+	60-64	65-69	70-74	75+	60+	60-64	65-69	70-74	75+
0.7	0.4	0.5	0.7	1.1	0.5	0.4	0.5	0.5	0.7	0.7	0.4	0.6	0.7	1.2

b) Care-services for Older Persons

Legal Basis for Social Protection of Older People

The legal system of the Russian Federation consists of legal codes and rules which protect basic freedoms and interests of all the citizens of the country including older people.

Social protection of older people is based on the current legal acts and rules which can be divided into 3 groups:

1. Legal Codes which ensure rights of all the citizens independently of age. They are crucial for older people as for the other categories of population. (The Constitution of the Russian Federation, the Civil Code of RF, the Family Code of RF, the Labour Code, Legal Fundamentals on Health Care, Federal Laws on Housing Policy, on Social Service in Russian Federation, etc).

2. Legal rules which protect rights of older people and appropriate responsibilities of the State, nongovernmental organizations and family. (Pension

ADVERT

Code and Federal Law "On Social Services for Older and Disabled People").

3. Legal rules which guarantee rights and benefits of specific groups of older people (veterans of war and labour, Heroes of the Soviet Union, Heroes of Socialist Labour, citizens who were repressed and then rehabilitated, etc).

There are also municipal laws which are usually introduced by regional and local authorities. As a rule, they are addressed to those groups of older people whose rights are not included into the federal laws.

Both federal and local legal acts take into account the existing international legal rules devoted to older people and experience of some other countries (Great Britain, Germany, Sweden, etc).

Pensions in Russian Federation

The Pension System in the Russian Federation was previously based on a distributive principle. On the 1st of January, 2002 three new federal laws came into force - <<On the State Pension Providing System in Russian Federation", on the Compulsory Pension Security in Russian Federation" and "On Labour Pensions in Russian Federation". They were worked out in accordance with the Programme of Pension Reform in the Russian Federation. The transition from the distributive principle to the principle of accumulation and distribution of pensions.

The new structure of the Pension System in the Russian Federation includes:

1. State Pensions (to federal officials, military servicemen, participants of the Great Patriotic War, and to those citizens who suffered from technogenic and human-made disasters, to disabled people who cannot work etc.)
2. Compulsory pension security (insurance) (labour pensions to employees based on previous compulsory insurance fees);
3. additional pension insurance (additional payments

based on accumulated voluntary payments of employers and insured individuals themselves).

The new structure of pensions is being introduced:

- The basic part of labour pension will be of equal size for all recipients of state pensions who fulfill the minimal requirements on length of service,
- The insurance part of labour pension depends on the results of personal work and employer's payments for the person during all his labor activity;
- The accumulative part of labour pension is calculated as accumulated insurance fees plus investment profit.

Today the real income of pensioners in the Russian Federation is quite low (the average pension is equal to 1200 rubles per month, that is less than 40US\$). The size of average pension is equal to 28,5-34% of the average salary and even decreases in comparison with 1997. At the same time a pension is the only financial source for the great majority of older people in Russia. According to the official statistical data, only 18.5% of pensioners continue to work.

The System of Benefits and Allowances

Social protection of older people in the Russian Federation includes benefits and allowances. Almost two thirds of the whole population get various kinds of allowances and additional payments, a half of the recipients are older people. Allowances and benefits are based on the federal laws and on regional and municipal legal rules.

According to the Institute of Labour, in 2000 there were approximately 650 kinds of benefits, financial compensations and other social payments and 740 groups of population to whom they were addressed and 610 legal acts ensuring these payments. Such a system of benefits is rather complicated and ineffective because of the absence of a mechanism which would provide the delivery of money to the right, direct address. The other reason for its inefficacy is a constant budget deficit, so it must be reformed in the new social and economic situation

in Russia. The reform will be done in several steps. First of all, some ineffective, meaningless benefits will be eliminated. The responsibilities of the State will be dovetailed with its financial possibilities.

The recipients of pensions will be divided into 3 categories:

1. Citizens who have performed great services to their Motherland independently of their income (Heroes of the Soviet Union and Russian Federation, participants of the Great Patriotic War and some others who are predominantly older people). All investments are made from the federal budget.

2. Citizens who will receive benefits according to the size of their income in comparison to the subsistence minimal wage which is different in different regions of the country (veterans of labor, disabled people and some other groups, predominantly - pensioners).

3 Citizens who will be entitled to benefits dependently on their work and profession. They will receive special payments together with their earnings. The investments will be made by Ministries and Departments.

of the XX century. Now we have 4 kinds of social services: residential service; partially residential; care at home; urgent social services (they were organized during the last 10-15 years)

The residential network consists of 1314 institutions such as: 618 sheltered accommodations and special homes for older and more dependent disabled people (non-specialized); 440 psychoneurological departments; 64 charity homes for older and disabled people; 14 gerontological centres.

245,000 people live in these institutions of social care, 140,000 of them are older people. The number of older people in the institutions is permanent during the previous years but the number of institutions has significantly increased.

The living conditions were also improved in them.

During the last years we can see a trend to diminish the size of the institutions and organize group homes (average number of people in such a home was 151 in 2002 in comparison with 293 per institution in 1992). The other trend is to organize specialised residential care institutions for older people and

Development of the network of residential social care institutions in Russian Federation

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Total Number of institutions	896	909	954	1020	1030	1061	1165	1156	1136	1280	1314
Non specialized home and sheltered accomodation	297	305	352	406	425	457	484	500	533	501	618
Pyschoneurological departments	440	438	437	447	440	447	419	443	442	440	440

However the reform is impossible without radical amendments which will change the Russian Constitution and many federal laws and regional legal rules to ensure civil rights.

The System of Social Services

In Russia the modern state (municipal) system of social services for older people started in late eighties

gerontological centres which are mainly concentrated on medical care.

17,200 older people are now waiting for their turn to be admitted to these centres.

Partially residential care institutions include the Centres of Social Services which are booming during the last decade. The first Centre of Social Services

Development of CSS network in Russian Federation

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
CSS	86	321	565	999	1316	1435	1502	1680	1744	1825	1875
Day Care Units	No data					711	848	931	991	1060	1150
Respite Care Units	No data					294	342	376	426	596	696

(CSS) was founded in Cheliabinsk in 1987. Now we have 1875 CSSs in Russia.

In 2001 825,500 older and disabled people got help in day care units, 54,400 older and disabled people attended respite care units.

There are 99 institutions for people without permanent residence. In 2001 they provided services for 57,400 people, predominantly in 38 night shelters (23,100 people) and in 21 centres of social adaptation (15,600 people). 30% of them are older and disabled people. The health care network is also being developed. 52 centres of social and medical care provided services to 55,900 people in 2001. 21,700 people live in 701 specialized homes for lonely elderly. These institutions are not large, for less than 25 people. 21,8% of these homes provide social services and daily help for older people. Non-residential care (care at home) is characterised by high rates of development of specialised departments (15-20 times higher than non-specialised).

In 2001 these departments provided services for 1,255,300 older and disabled people, 12% (150,900) of them were served by specialised departments of social and medical care.

Urgent social care – is the most widespread and popular in Russian Federation. In 2001 more than 13 million people got single-time urgent social assistance. In some regions 92-93% of them are older and disabled people. On the whole, the welfare and living standards of Russian citizens constantly improve. Nevertheless urgent social care is booming and provides services for a great number of people.

Interaction between State institutions and Non-governmental Organisations

Social partnership in protecting older people is not well developed in Russia yet. On the one hand, there is a legal base for it, on the other hand, there is not mechanism for its functioning and conditions for effective work of the legal acts. So we can see a tendency to proclaim slogans instead of real work. For instance, in the sphere of social services we try to develop mainly state institutions which are invested from the state budget. Our state doesn't even notice all the attempts of some NGOs to cooperate and solve the problem.

According to the Federal Law on Social Care of Older and disabled people (1995) NGOs can be potentially developed in Russian Federation. But the

Development of network of domiciliary care departments

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Departments of domiciliary care	5910	7032	8629	9897	10710	11148	11274	11330	11444	11664	11061
Specialized departments at social and medical care at home	No data						632	649	1002	1192	1370

Development of the network of urgent social care departments

Years	Number of departments	Number of users
1992	59	250,300
1993	635	1,621,400
1994	1,050	2,005,400
1995	1,366	3,876,900
1996	1,585	5,282,100
1997	1,732	6,838,500
1998	1,719	7,128,100
1999	1,803	8,369,700
2000	1,838	10,344,200
2001	1,969	12,615,400
2002	1,994	13,171,900

NGO sector has no opportunity for development because of the lack of standards for social services, rules and mechanisms of getting license for their activities and absence of tax benefits. There is no stable and serious support of NGOs from the government. There is a lot of problems and barriers for charities and volunteering, thus they are not developed in this country. Unfortunately, the position of the State remains unclear even after the preparation of the Draft of the Declaration on State Social Policy dealing with support of older people for the current decade (till 2010)

Medical Situation

One of the main social problems of the elderly in Russia is loneliness. In 1987, there were more than 354,000 single elderly individuals in Russia. Data gathered by O.V. Belokon (1995) suggest that in 1995, there were 4.6 million single seniors of which 4 million were women (7.2 times more than men) (Karioukhin 2002). Ten per cent of the elderly population have some range of mobility (around their apartments) and 1.5% are totally bed-ridden-41.3% of this group are women. These individuals are / obviously the most in need of home care services but are often the most neglected and least likely to receive them. V.S. Preobrazhenskaya and N.H. Michnevich (1995) showed that 5.7% of elderly people do not have any close relatives and

therefore require special attention by both medical and social workers (Karioukhin 2002).

More than 60% of older persons have chronic diseases. Sixty-two percent of individuals who turn to home care services have chronic diseases (Karioukhin 2002). In 1994, 16.7% of the population was made up of individuals 60 years and over and were responsible for utilizing 33.2% of the medical services (Karioukhin 2002). In reality, less than 10% of elderly people with functional disturbances receive help from the government. Meanwhile, 75% of the elderly who live at home also lack help from the informal sector (family and friends).

Economic Situation

Economically, 32.4% of elderly people said they could not 'make ends meet' (Karioukhin 2002). Specifically, 62.4% rely solely on their pension for support, 28% receive help from their children, 2.8% from grandchildren, 1.8% from friends, 4.6% from social services, and 0.5% from charitable organizations. Only 23% of elderly people reported receiving free medications. U.M. Evsyukova (1995) acknowledges that the elderly were the first and hardest hit during the many economical crises following the collapse of the Soviet Union. The meagre pension allowance is not sufficient for the rapidly rising rent, electricity, and food costs. O.V.

Belokon (1995) showed that the number one problem facing old people in Russia is their material poverty.

RECOMMENDATIONS

Main Problems

At a glance, a variety of services for the elderly seem to exist: hospitals, geriatric centres, nursing homes, Centres of Social Services, health resorts, and private doctors. The government may also provide housing for single elderly individuals, subsidized apartments, public dining rooms, public stores and pharmacies where people are granted discounts (Vasilchikov 2002). The illusion, however, is not longlasting. Once one digs slightly below the surface, the gross reality becomes apparent.

The current situation of the elderly in the Russian Federation is obviously extremely complex with many interconnected factors and role players. Without succumbing to oversimplification, several key problems can be disentangled from the mess. The first, and probably the most significant obstacle, is the poverty of the elderly in Russia. As the number of free prescriptions in Centres of Social Services is limited, many pensioners can not afford to buy the medication they require (Karioukhin 2004). As a result, many older people cut back on other basic necessities such as food or reduce the dosage of their medication in order to make it last longer (Karioukhin 2004).

Secondly, specialized in-patient and out-patient services are exceedingly difficult to obtain. Bed space is limited and many times older individuals are turned away because of the common perception that old people "block" hospital beds; yet, the truth of the matter is that they have no where else to go for inpatient care (Karioukhin 2002). If a person is admitted to a hospital or geriatric centre, he will likely need to bring his own linen and food. The hospitals do not receive enough funding from the government to provide basic sanitary necessities not to mention to update the equipment, conduct renovations, or purchase supplies and medication. Among the geographical regions in Russia, the European part (Privolozhsky, Central, Southern, and

Ural) dominates in the number of public gerontological centres.

Furthermore, the waiting lists for nursing homes and health resorts are getting longer, especially in rural areas and eastern regions of the country. It is not surprising then, that the majority of the elderly in Russia prefer to receive public services through other forms such as: home care, day care, and urgent care (Vasilchikov 2002). Around 45% of the elderly population receive care from out-patient services (Vasilchikov 2002). In fact, the number of older persons living at home who receive various social services is 90 times more than the number of seniors in in-patient care (Vasilchikov 2002). This data suggests that most elders prefer to spend old age in the comfort of their homes and communities. Thus, a concentrated effort must be made by all sectors of society to develop and improve non-traditional out-patient care services.

The Centres of Social Services form the backbone of public out-patient care in Russia. Yet, as noted earlier, the development of social gerontological care is extremely unevenly distributed throughout the country. The Central (515), Southern (284), and Privolozhsky (511) regions have the most Centres of Social Services. Moscow, as the most prosperous and financially stable city in Russia, has the most centres (118) (Vasilchikov 2002). The Centres of Social Services, however, only cover about 20% to 60% of the elderly population in need (Karioukhin 2004). On average, an elderly person will spend 30 days in a temporary-stay residence, and Departments of Day Care are able to receive about 30 people at a time (Karioukhin 2004). In this way, due to limited capacity and resources an individual may visit Centres of Social Services only a few times a year.

Another setback is the general lack of trained specialists in social gerontology, geriatric professionals, and social workers. The initiative to pursue social professions is extremely low as often "a common retiree's pension is higher than the salary of the social worker who visits him" (Kachalova 1999). Tatiana Chubarova (2004) also notes that Russia does not have a history of health management as a speciality. In the Soviet Union and now, doctors may hold several positions and are responsible for

both managerial and medical tasks. More emphasis on degree programmes designed to specifically train people in health administration and management would allow hospitals, Centres of Social Services, and GNGO's to function more efficiently.

Thirdly, the laws and programmes of the government relating to the elderly have no practical effects. The Russian government does not have a comprehensive document stating its policy regarding the elderly population. The federal programme "Older Generation", which has been renewed several times, contains no specific guidelines or deadlines (Federal Review Committee 2003). Financial resources set aside for the actualization of the program either were never allotted or were pocketed by municipal authorities (Federal Review Committee 2003).

The elderly are often the target of abuse and neglect. Evictions and robberies are realistic threats for single, older people. Even worse, many seniors are not aware of their rights or of the services available to them. Having lived the majority of their lives under Soviet rule, seniors are less likely to take an active role in their own protection and well-being; they are used to relying passively on the government for public protection and services.

With the upheavals of economic, political, and social transition, many Russians have understood that an active non-governmental sector is necessary to support the people in times of drastic changes. A small network of GNGO's has developed in Russia. Nevertheless, as stated earlier, all NGO's in Russia must fight an uphill battle. The government does not provide any incentives such as tax benefits for the establishment of NGO's. No regulations, standards, methods for providing long-term care or

outside organs of control exist in reference to NGO's (Karioukhin 2004). Work with the elderly is considered a low-priority and is limited to a small circle of enthusiasts (Karioukhin 2004).

Prospective for the Future

If Russia hopes to deal effectively with the demographic ageing of its population, the federal government will need to play an active role. The Ministry of Labour and Health should:

- Provide a legal basis for a gerontological service system
- Formulate a national ageing strategy
- Provide measures to ensure the actualization of its programmes
- Encourage the growth and establishment of the non-governmental sector
- Acknowledge the need for specific services in different regions of the country
- Establish a standard for social services
- Acknowledge the need for specialists of different levels and qualifications
- Organize services for the elderly in rural villages
- Educate the public about the rights and services to which they are entitled

To meet the demands of The Madrid International Plan of Action on Ageing and to create a "society for all ages" (United Nations 2004), a partnership must be formed between all levels of government, the NGO sector, the commercial sector, and the people. The Russian Federal Government needs to raise the quality of life of a significant portion of its population by taking an official position and activating it.

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INIA'S ACTIVITIES 2007-8



19th - 26th August	1st Training Programme in Social & Economic Aspects of AGEing in collaboration with the Institute of Gerontology Universiti Putra – Malaysia.
27th August - 7th September	8th Asian Training Programme in Singapore.
October 2007 – June 2008	International POST GRADUATE DIPLOMA IN GERONTOLOGY AND GERIATRICS (Dip.Ger) European Centre of Gerontology and Geriatrics, (University of Malta), (MALTA)
5th – 16th November	International Short Training Programme in DEMOGRAPHIC ASPECTS OF POPULATION AGEING, POLICIES AND ITS IMPLICATIONS FOR SOCIO-ECONOMIC, POLICIES AND PLANS ,(MALTA).

INIA's 2008 Training Programme

18th - 29th February	International Training Programme in SOCIAL GERONTOLOGY.
3rd - 14th March	International Programme in Economic and Financial Aspects of Ageing.
14th – 25th April	International Programme in Medical Gerontology (Geriatrics)
13th – 24th October	International Programme in Policy Formulation, Planning, Implementation and Monitoring of the Madrid International Plan of Action on Ageing.
17th – 28th November	International Programme in Demographic Aspects of Population Ageing and its Implications for Socio-Economic Development, Policies and Plans.
October 2008 - June 2009	International Post-Graduate Diploma in Gerontology and Geriatrics (European Centre for Gerontology and Geriatrics, University of Malta)

INTERNATIONAL DIARY 2007/8

6th - 8th September 2007 – University of St. Gallen, Switzerland

The 3rd World Ageing & Generations Congress

9th - 15th September 2007 - Moscow, Russia

29th ISSA General Assembly - World Social Security Forum
E-mail: issa-ag2007@ilo.org

24th - 25th September 2007 – Greater Toronto Area – Mississauga, Ontario, Canada

2nd Canadian Coalition for Seniors' Mental Health Conference
Website: <http://www.ccsmh.ca>
Contact Person: Kim Wilson

2008

17th - 20th March 2008 – Washington D.C.

2008 Joint Conference of NCOA and the American Society on Aging.

6th - 8th April 2008 – Antalya, Turkey

Geriatrics Congress

Website: www.geriatrics2008.org

29th June – 2nd July 2008 – Seoul, Republic of Korea

Announcement of the XVIIth World Congress on Safety and Health at Work.

2009

16th – 19th March 2009 – Las Vegas N.V.

2009 Conference of NCOA and the American Society on Aging.

Geriatrics Society, Turkey is organizing Geriatrics 2008 Congress in April, 6th - 8th April 2008 in Antalya, which is one of the most fascinating cities of the Mediterranean shore and this congress is supported by International Association of Gerontology and Geriatrics – IAGG, European Union Geriatric Medicine Society – EUGMS and International Institute on Ageing – INIA.

Website of the congress: ww.geriatrics2008.org <http://www.geriatrics2008.org/>