



International Year
of Older Persons

Ageing



Exploding the myths



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Foreword

The ageing of the global population is one of the biggest challenges facing the world in the next century. It is also potentially a great opportunity. Older people have a lot to contribute.

Older people are often viewed as a homogeneous group from mainly industrialised countries, who no longer contribute to their families and societies, and may even be a burden. The truth could not be more different. The majority of older people prove these notions wrong every day, and it is an example that has inspired the WHO to focus on ageing.

The theme of World Health Day 1999, in the International Year of Older Persons, “Active Ageing makes the difference” recognises that it is key for older people to go on playing a part in society. Active Ageing involves every dimension of our lives: physical, mental, social and spiritual.

There is much the individual can do to remain active and healthy in later life. The right life style, involvement in family and society and a supportive environment for older age all preserve well-being. Policies that reduce social inequalities and poverty are essential to complement individual efforts towards Active Ageing.

Maintaining health and quality of life across the lifespan will do much towards building fulfilled lives, a harmonious, intergenerational community and a dynamic economy. WHO is committed to promoting Active Ageing as an indispensable component of all development programmes.

Gro Harlem Brundtland, MD, MPH
Director-General
World Health Organization



Ageing: Exploding the myths

We are all ageing – every day of our life. John H. Glenn, Jr. was 77 years old when he went into space for a second time as part of a scientific experiment to explore the secrets of ageing. Every one of us started to age before we were born and we continue to do so throughout our entire life course. Ageing is a natural process and should be welcomed, because the alternative would be premature death.

Life expectancy has risen sharply this century, and is expected to continue to rise, in virtually all populations throughout the world. The number of people reaching old age is therefore increasing. There are currently 580 million people in the world who are aged 60 years or older. This figure is expected to rise to 1,000 million by 2020 – a 75% increase compared with 50% for the population as a whole.

Health is vital to maintain well-being and quality of life in older age, and is essential if older citizens are to continue making active contributions to society. The vast majority of older people enjoy sound health, lead very active and fulfilling lives, and can muster intellectual, emotional and social reserves often unavailable to younger people.

This brochure outlines how the principles of Active Ageing help maintain health and creativity throughout the lifespan and especially into the later years. It explodes some common myths about ageing and older people, and suggests ways that individuals and policy makers can turn principles into practice to make Active Ageing a global reality.



Myth No. 1: Most older people live in developed countries

In fact the reverse is true. Most older people, over 60% of them, live in developing countries. There are currently about 580 million older people in the world, with 355 million in developing countries. By 2020, there will be 1,000 million, with over 700 million in the developing world.

Life expectancy has risen and is expected to go on rising in almost every part of the world. The reason for this is the sharp decline in premature mortality from many infectious and chronic diseases during this century. Improvements in sanitation, housing, nutrition and medical innovations, including vaccinations and the discovery of antibiotics have all contributed to the steep increase in the number of people reaching older age.

Sharp increases in life expectancy have been accompanied by substantial falls in fertility all over the world, mainly due to modern contraceptive methods. In India, for example, total fertility rates (that is, the total number of children a woman is expected to have) have decreased from 5.9 in 1970 to 3.1 in 1998. In Brazil, fertility rates dropped from 5.1 in 1970 to 2.2 in 1998. This decline is even more

Living in an ageing world requires:

- ▶ *acknowledging older people as a valuable resource and combating 'ageism'*
- ▶ *enabling older people to be active participants in the development process*
- ▶ *providing adequate health care and health promotion for older people*
- ▶ *promoting intergenerational solidarity*

pronounced in China, where the 'one-child-per-family' policy was officially introduced in 1979. Total fertility rates fell from 5.5 in 1970 to the current 1.8, which is below the 2.1 replacement level.

This trend by which more people live to reach older age while fewer children are born is referred to as 'population ageing'. It has been particularly rapid in developing countries. While it has taken France 115 years for the proportion of older people to double from 7 to 14%, it will take China only 27 years to achieve the same increase, between 2000 and 2027.

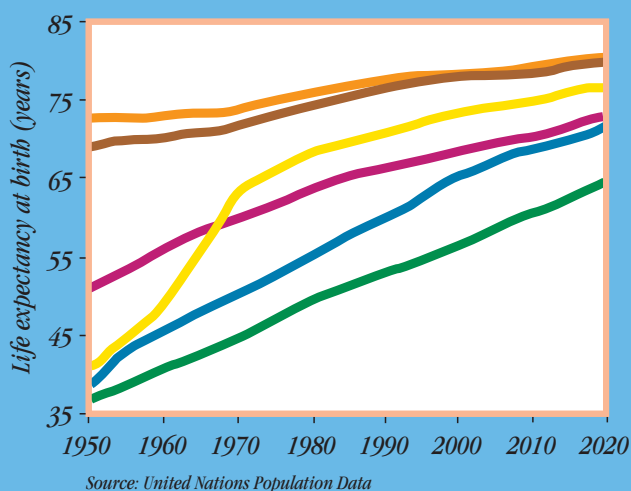
Living in an ageing world

As more people reach a 'ripe old age', they also enter a period in their lives when they are at higher risk of developing chronic diseases, which in turn may result in disability. In fact, chronic diseases including cardiovascular diseases, diabetes

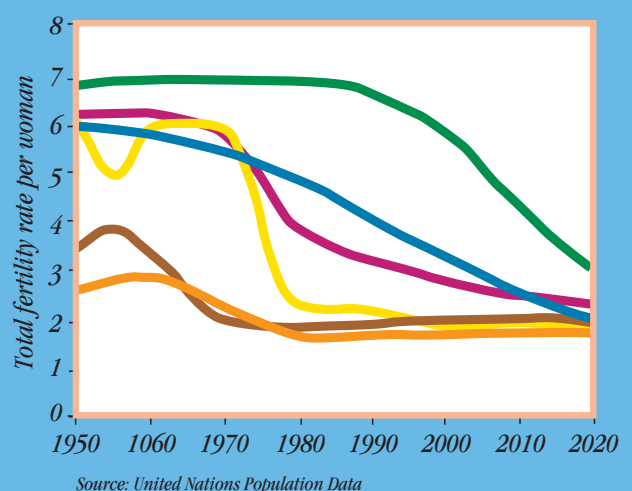
and cancer are predicted to be the main contributors to the burden of disease in developing countries by 2020. Infectious diseases – although declining – will continue to add to the burden of disease in those regions.

It is projected that in many countries with fertility rates below replacement level, the proportion of older people is expected to exceed the proportion of the very young (aged up to 19 years) by 2050. However, there is mounting evidence from developed countries that people are maintaining better health in later life than ever before. It is estimated that in 1996, there were 1.4 million fewer disabled older persons in the USA, than would have been expected if the health status of older people had not improved since the early 1980s.

Life expectancy at birth is increasing



Total fertility rates are decreasing

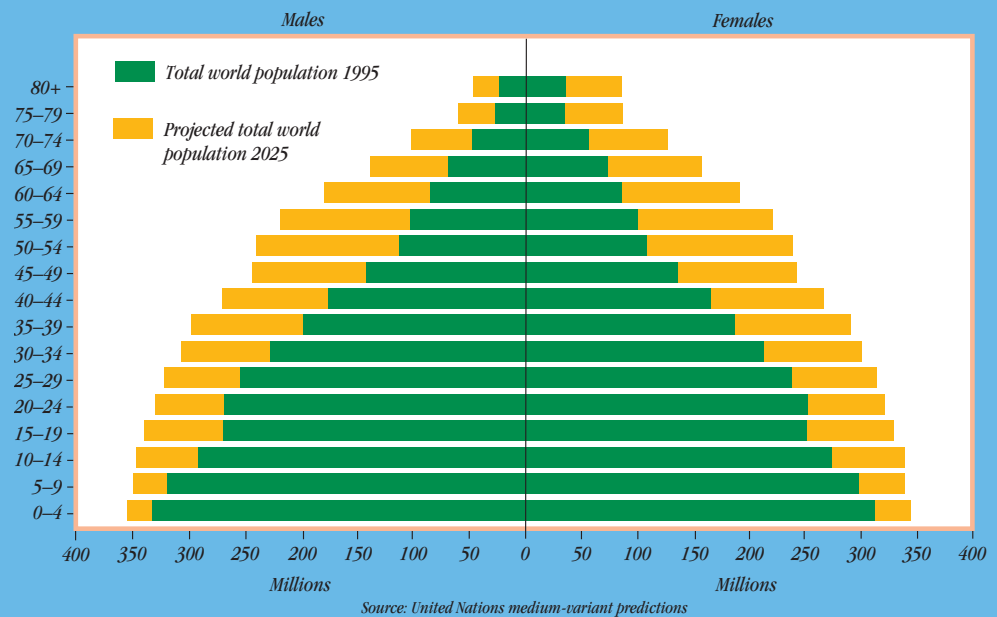


■ Nigeria
■ India
■ Brazil
■ China
■ USA
■ Norway

Valuing older age

Social perceptions of the value and benefits of old age vary in different cultures. In many African and Asian countries, words which describe older people characterise them as ‘someone with knowledge’. However, in some cultures these traditional values are in danger of being eroded. It is important to recognise that ageing is not an affliction but a great opportunity to make use of resources acquired over the life course, and that older people can be a tremendous asset to families and the community.

Living in an ageing world





Myth No. 2: Older people are all the same

'Older people' constitute a very diverse group. Many older people lead active and healthy lives, while some much younger 'older people' have a poorer quality of life. People age in unique ways, depending on a large variety of factors, including their gender, ethnic and cultural backgrounds, and whether they live in industrialised or developing countries, in urban or rural settings. Climate, geographical location, family size, life skills and experience are all factors that make people less and less alike as they advance in age.

Individual variations in biological characteristics (e.g. blood pressure or physical strength) tend to be greater between older people than between young ones: the characteristics of two ten-year-olds would be more similar than those of two eighty-year-olds. Such diversity leads to considerable difficulties in interpreting results from scientific studies on ageing, which are often conducted on particular, well defined groups of older people: the findings may not apply to a large proportion, or even the majority of older people.

The differences are further increased by disease experiences throughout life which may accelerate the ageing process. Many studies have shown that there are wide variations in patterns of disease in people from different ethnic and cultural communities which remain largely unexplained. For example, immigrants and their descendants who move from the Indian subcontinent to countries across the globe have higher rates of coronary heart disease than the population of the countries to which they moved.

Why such difference?

A genetic component may contribute to how *long* we live. However, health and activity in older age are largely a summary of the experiences, exposures and actions of an individual during the whole span of life.

Our life course begins before birth. Research has suggested that foetuses undernourished in the womb grow up to be adults more likely to suffer from a variety of diseases, including coronary heart disease and diabetes; they also seem to age faster than people who receive good nutrition during early life. Malnutrition in childhood, particularly during the first year of life, childhood infections such as polio and rheumatic fever, and exposure to accidents and injuries all make chronic and sometimes disabling diseases more likely in adult life. Life style factors in adolescence and adulthood, such as smoking, excessive alcohol consumption, lack of exercise, inadequate nutrition or obesity, greatly add to disease and disability at any age in adulthood.

Differences in education level, income, and in social roles and expectations during all stages of a person's life increase the diversity of ageing. Throughout the world, the average education of older people is below that of younger people. Such

differences are important because higher levels of education are associated with better health. It is well known that children's health is directly linked to their mothers' education levels. Women with more education have fewer and healthier children. People with higher education levels at all ages tend to adopt and maintain healthier life styles, and have better access to health care and health information.



Life style choices for Active Ageing should start early in life and include:

- ▶ *participating in family and community life*
- ▶ *eating a balanced, healthy diet*
- ▶ *maintaining adequate physical activity*
- ▶ *avoiding smoking*
- ▶ *avoiding excessive alcohol consumption*

Poverty is clearly linked to a shorter life span and poorer health in older age. Less well-off people tend to live in more harmful environments where they are more likely to be exposed to higher levels of indoor air pollution and to the risk of diseases such as diarrhoea and respiratory infections. Poor housing structure and overcrowding increase the risks of accidents and transmission of infectious diseases; in many developing countries, the home may be used as a workplace where hazardous substances are stored.

Social isolation, because of widowhood or divorce for example, has adverse effects on health. Playing a part in family life, and being a member of a community or religious organisation have beneficial effects on health,

improve a person's self-worth and enable older people to make a greater contribution to society.

For older people living in poverty, access to adequate nutrition is often in jeopardy. Malnutrition is still one of the major contributors to disease and disability in the developing world. Although the percentage of malnourished people has declined worldwide, WHO figures indicate that 840 million people were still below the nutrition threshold (representing the minimum dietary requirements) in the early 1990s. Older people are particularly vulnerable. Studies in the developing world suggest that older women, for example, are likely to deprive themselves of food in favour of the young in times of shortage.

Promoting Active Ageing

Although the individual may not have control over early life experiences and other factors such as poverty or low education, actions taken during the remaining life course greatly affect health in later life. Information about healthy life styles needs to be promoted, including the importance of a balanced, healthy diet, adequate exercise, the avoidance of smoking and excessive alcohol consumption. In addition, policy decisions to encourage healthy, active ageing must include the creation of supportive social and environmental conditions throughout life. Equity, provision of efficient basic services and participation by all in society are essential concepts if the opportunities and potential of a rapidly ageing world are to be realised.





Myth No. 3: Men and women age the same way

Women and men age differently. First of all, women live longer than men. Part of women's advantage with respect to life expectancy is biological. Far from being the weaker sex they seem to be more resilient than men at all ages, but particularly during early infancy. In adult life too, women may have a biological advantage, at least until menopause, as hormones protect them from ischaemic heart disease, for example.

Currently, female life expectancy at birth ranges from just over 50 years in the least developed countries to well over 80 in many developed countries, where the typical female advantage in life expectancy ranges from five to eight years. As a result, the oldest old in most parts of the world are predominantly women. However, longer lives do not necessarily translate into healthier lives and patterns of health and illness in women and men show marked differences. Women's longevity makes them more likely to suffer from the chronic diseases commonly associated with old age. We know, for instance, that women are more likely to suffer from osteoporosis, diabetes, hypertension, incontinence, and arthritis than men. By reducing mobility, chronic disabling diseases such as arthritis have an impact on the capacity to maintain social contacts and thus on the quality of life. Men are more likely to suffer from heart disease and stroke, but as women age, these diseases become the major causes of death and disability for women too. The common view that heart disease and stroke are exclusively men's problems has obscured recognition of their significance for older women's health and more research is necessary in this area.

Gender and health in older age

While some of the differences between women and men are due to biological characteristics, others are due to socially determined roles and responsibilities, i.e. gender divisions and gender roles. Historically, women have not always lived longer than men. In Europe and North America, the gap only started to grow as economic development and social change removed some of the major risks to women's health. With greater control over the size of their families and improvements in living conditions and hygiene, women's risk of dying in childbirth decreased. At the same time, the gender division of labour meant that men were taking on more occupational risks as industrialisation spread to more countries. As a result, male deaths from occupational causes have historically always been higher than among females.

Men have also taken more risks when it comes to life styles. They have tended to smoke more than women, for example, resulting in higher levels of death from lung cancer. Recent figures from the Russian Federation show that, between 1987 and 1994, while life expectancy fell for both men and women, the steepest decline was

for men, with a fall of over seven years and in some parts of the country even more. A number of factors contributed to this fall, but research has suggested that many of the causes of death, such as accidents and violence, pneumonia and sudden cardiac death were linked with alcohol consumption. Life style factors combined with occupational risks have contributed to greater numbers of premature deaths among males, particularly in industrialised societies.



The impact of gender discrimination

In some societies, the biological advantage of women is reduced by their social disadvantage. The natural advantage in women's life expectancy is significantly reduced in societies where female infant mortality is higher and where girls face discrimination. Social and economic disadvantages also have important repercussions in many other areas. For example, in all countries, inequalities in income and wealth in earlier life mean that older women tend to be poorer than older men. Women everywhere still earn less than men and are often concentrated in lower-paid jobs. In industrialised countries, women's income from pensions and social security is still lower than that of older men. It is lower because women more often than men interrupt their careers to take care of children and other family members. In fact, in both developed and developing countries, women's entry into paid work only rarely frees them from responsibility for domestic labour, and this double burden on women often takes its toll on their health. In developing countries, where most people do not benefit from public income security schemes in old age, older women are almost always dependent on their families.

Because women live longer than men, they are also more likely to become widowed. This trend is compounded by the fact that most women marry men who are older than themselves. In fact most women can expect widowhood to be part of the later years of their adult life. In some societies, social norms of widowhood impose restrictions that have negative effects on the widow's well-being. Inheritance rights, in particular, are often not well established or non-existent in practice. While the vast majority of older women in developed countries cope with adjustments to widowhood, it remains one of the leading factors associated with poverty, loneliness and isolation.

International action plans developed at recent UN world conferences encourage countries to review their legal frameworks for eliminating discrimination between men and women. Issues covered include equal access to education for boys and

girls, combating all types of discrimination against girls and eliminating negative traditional practices, such as female genital mutilation. Many of these early interventions against inequality will set a life course trajectory that is more conducive to healthy and active ageing. In addition, NGOs and women's organizations in both developed and developing countries are giving more attention to the urgent issues faced by older women today. There are some encouraging examples of older women themselves forming advocacy groups and starting self-help projects that lead to empowerment and a better quality of life.

Gender analysis examines the origins of biological differences, disadvantage, and inequality between women and men. The objective of gender analysis is to improve the quality of life of both women and men as they age.

An improved quality of life for both women and men can be achieved through:

- ▶ *more equal distribution of work, caring and leisure activities between men and women throughout the life course*
- ▶ *educating boys and girls to understand and avoid gender stereotyping*
- ▶ *combating gender discrimination in all aspects of life, including jobs, pay, education and access to health care*
- ▶ *mainstreaming gender analysis in all areas of healthy ageing*



Myth No. 4: Older people are frail

Far from being frail, the vast majority of older people remain physically fit well into later life. As well as being able to carry out the tasks of daily living, they continue to play an active part in community life. In other words, they maintain high 'functional capacity'.

As in all aspects of ageing, there are differences in the way functional capacity is maintained in different groups of older people. Although women live longer than men, they tend to experience more disabling diseases as they grow older compared with men of the same age. There is also a wide variation in the perceived need for certain functional abilities among older people. In some societies, for example, fetching water and firewood are tasks traditionally carried out by women. Maintaining maximum functional capacity is as important for older people as freedom from disease.

Life style and ageing

The capacity of our biological systems (e.g. muscular strength, cardiac capacity) increases during the first years of life, reaches its peak in early adulthood and declines thereafter. How fast it declines, however, is largely determined by external factors relating to adult life style, including smoking, alcohol consumption, diet and social class. The natural decline in cardiac function, for example, can be accelerated by smoking, leaving the individual with lower functional capacity than would normally be expected for his/her age. The gradient of decline may become so steep as to result in disability.

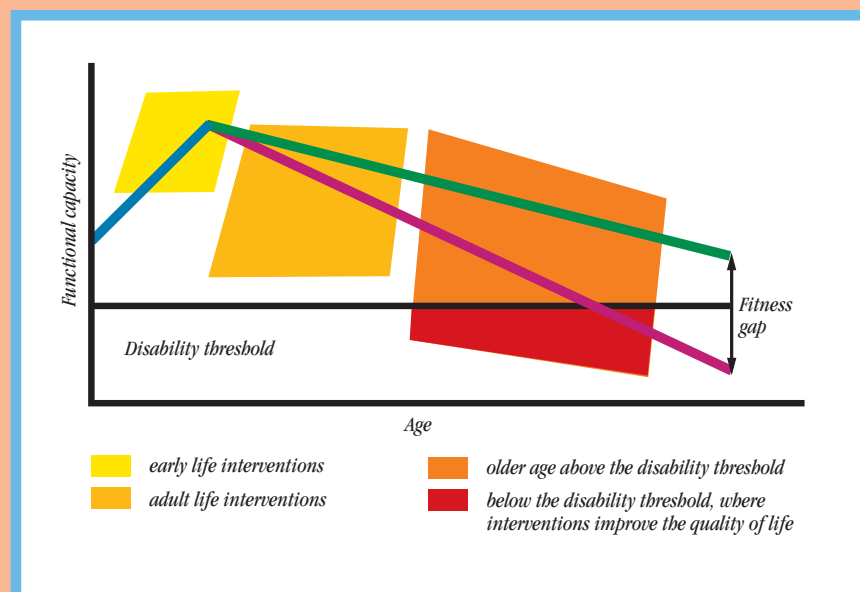
However, the acceleration in decline caused by external factors may be reversible at any age. Smoking cessation and small increases in the level of physical fitness, for example, reduce the risk of developing coronary heart disease including in later life. For those who are disabled, improvements in rehabilitation and adaptations of the physical environment can help reduce the progression of disability.

Many chronic diseases which reduce functional capacity are the result of an unhealthy life style. According to the 1996 'The Global Burden of Disease' Report, alcohol use is the leading cause of male disability in industrialised countries, and the fourth largest cause in men in developing regions. The report further states that non-communicable diseases, which are largely preventable, including cardiovascular diseases and cancers, are a major cause of disability in both industrialised and developing countries. Since many developing countries are still coping with infectious diseases and malnutrition, this sharp rise in non-communicable diseases is creating a double burden.

Social factors, which the individual can usually do little to change, also affect functional capacity. Poor education, poverty, and harmful living and working conditions all make reduced functional capacity more likely in later life. In some countries, people with poor functional ability are more likely to become institutionalised, which in itself can lead to dependence, particularly for the small minority of older people who suffer from loss of mental function and/or confusion.

Policy decision makers should, therefore, take social factor into account. Policies which benefit people who already have disabilities (e.g. public transport legislation, structural changes to buildings etc.) can do much to improve quality of life.

Functional capacity throughout life



Health policy measures for maintaining maximum health and activity in later life include:

- ▶ *promoting the benefits of healthy life styles*
- ▶ *legislation on sales and advertising of alcohol and tobacco*
- ▶ *ensuring access to health care and rehabilitation services for older people*
- ▶ *adapting physical environments to existing disabilities*

Older people who need care

The vast majority of people remain fit and able to care for themselves in later life. It is a minority of old people, mostly the very old, who become disabled to the point that they need care and assistance with the activities of daily living.

Various measures have been developed to forecast the care needs of an ageing population. One of the most commonly used projections is to estimate disability-free life expectancy. The most recent findings for developed countries show that severe disability is declining in older people at a rate of 1.5% per year. United States estimates, for example, predict the number of severely disabled older people will fall by half between the year 2000 and 2050 if current trends continue.

About one-fifth of older people in developed countries currently receive formal care, i.e. medical or social services. Only one-third of such formal care is provided in institutions while two-thirds is home-based. In fact, in recent years, many developed countries have moved away from providing care in institutions in favour of care that allows older people to remain in the community, in their own homes, for as long as possible.

Older people are both the receivers and the providers of care. As well as caring for grandchildren and their own children, many older people care for other family members, especially their spouses and sometimes their own, often very aged, parents. In fact, many of the 'young' old provide care for the very old. Such care is often provided out of affection, but also out of a sense of obligation and with the expectation of reciprocity. The demands of providing such care may be stressful and sometimes detrimental to the caregiver's own health. Recognising caregiver stress and assisting the informal family caregiver, who is most often a woman, should be an important policy objective in the design of caregiving strategies.





Myth No. 5: Older people have nothing to contribute

The truth is that older people make innumerable contributions to their families, societies and economies. The conventional view that perpetuates this myth tends to focus on participation in the labour force and its decline with increasing age. It is widely assumed that the fall in numbers of older people in paid work is due to a decline in functional capacity associated with ageing. In fact, declining functional capacity does not by any means equate to inability to work. Indeed, the physical requirements of many jobs have been reduced by technological advances, permitting severely disabled people to be fully economically productive. In addition, the fact that there are fewer older people in paid work is more often due to disadvantages in education, training and particularly to 'ageism', than to older age *per se*.

The widely held belief that older people have nothing to contribute also relies on the notion that only paid occupations count. However, substantial contributions are made by older people in unpaid work including agriculture, the informal sector and in voluntary roles. Many economies worldwide depend to a large extent on these activities, but few of them are included in the assessment of national economic activities, leaving the contribution made by older citizens often unnoticed and undervalued.

Valuing what older people have to offer means:

- ▶ *recognising older people's roles in development*
- ▶ *enabling older people to participate in volunteer activities*
- ▶ *supporting the contributions that older people make to society, particularly their caring activities*
- ▶ *promoting lifelong learning opportunities*

Older people in paid and unpaid work

Due to financial insecurity, many older people, particularly in developing countries, work in agricultural production until very late in life. A large proportion of these are women, as many agricultural activities are inseparable from domestic tasks, including crop production and animal husbandry.

Work in the so-called informal sector is difficult to measure, as it is not part of the market economy and so often remains 'invisible'. The International Labour Organization defines this sector as consisting generally of 'small-scale, self-employed activities, with or without hired workers'. This includes usually low-wage occupations, like petty trading, selling street food and domestic work. Many

older people, especially in the developing world, support themselves and others through work in this sector. The informal sector also refers to caring activities within the family, including the provision of shelter, child care and health care. It is estimated that over 2 million children in the United States are being cared for by their grandparents, with 1.2 million of them living in their grandparents' home. Older people therefore provide shelter, food, education, and transmit cultural values to their grandchildren, while enabling mothers to enter the workforce. In developed and developing countries alike, many older people also provide financial help to their adult children or grandchildren. These transfers often involve substantial amounts of money.

Caring for ailing spouses or relatives is traditionally done by older women, but increasingly also by older men. In many developing countries with less established health-care systems, older women act informally as nurses and midwives within their communities. In some countries, where up to 30% of the adult population are infected with the AIDS virus, older people will have to care for their adult children, after whose death they will have to raise their orphaned grandchildren. Even in developed countries, care for the chronically ill is largely provided by informal family care-givers. Such care often remains 'invisible' because it has not been quantified and valued in national accounts.

In developed and developing countries alike, skilled older people often act as volunteer teachers and community leaders. In the United States alone, over three million people aged 65 and above are involved in voluntary activities in schools, religious institutions, health and political organizations. Another example is the senior executive service in which retired senior experts make themselves available for advice, business and training free of charge. Many voluntary organisations in many parts of the world would not function without the contribution made by older people.





Myth No. 6: Older people are an economic burden on society

Older people contribute in innumerable ways to the economic development of their societies. However, two concurrent developments have contributed to the myth that societies will not be able to afford to provide economic support and health care for older people in the years to come. One of these developments is the growing realisation of the sheer numbers of citizens who will be living to older ages in the next century. The second development is the greater emphasis on market forces in almost all parts of the world, and the related debate about the proper role of the state in providing income security and health care for its citizens.

There has been growing concern in many, particularly industrialised, countries about the levels of state expenditures for social protection and whether costs could be reduced by opening social protection to more private sector competition. This worldwide debate has unfortunately placed the entire emphasis on the cost to society of providing pensions and health care for older people rather than on the continuing and significant economic contributions that older citizens make to society. It has given rise to the widely held myth that older persons are generally economically dependent and thus a burden on society. The facts, however, demonstrate that this is not a true reflection of reality. Two important considerations – work and public pension protection – must be taken into account.

Older persons work

Most older persons around the world continue to work, in both paid and unpaid jobs, making a significant contribution to the economic prosperity of their communities. There is no economic or biological basis for retirement at a fixed age (often 60 to 65 in developed countries). In fact, in national economies which are dominated by agriculture, most older people, men and women, continue to work in farm production until they are physically unable to carry out their tasks, which is often very late in life. And in developed societies, there is a growing recognition that older people should be fully enabled to work as long as they desire. Age should in no way prevent or hinder a person from getting a job and indeed the benefits of age should be recognised and rewarded.

In periods of high unemployment, it has been easy to argue that older persons should be encouraged to leave paid employment to free up places for younger job seekers. Research has, however, demonstrated that the reality of the labour market is far more complex and that the early withdrawal by older workers from the labour force does not necessarily translate into jobs for the young. The unemployed job seeker may not have, for example, the necessary training or skills to take the place of the older worker. Indeed, experienced older workers are needed to ensure that productivity is maintained and that labour force stability can be counted on by employers and customers.

Pensions protect against poverty

Many older persons are now covered by both public and private pension schemes which protect them from poverty, particularly in the more developed economies. The worldwide growth of such schemes is related to the industrialisation of economies, to urbanisation, and the loosening of traditional family bonds. These pension programmes represent a collective approach to the sharing of resources between people of working age and those who have retired from the labour force.

Income security concerns not only older people, but also their children. In many developing countries, population ageing has added urgency to the problem of poverty among older people. While in the past, families were willing and able to care for their parents, they now find themselves in a changing world which severely limits their ability to assume these traditional roles.



Investing in an ageing population means:

- ▶ *life-long learning programmes to increase the possibilities of older people finding employment*
- ▶ *eliminating age discrimination in the workplace*
- ▶ *promoting income security policies to provide adequate income protection for older people through reliable public and private pension arrangements*
- ▶ *access to adequate health care to prevent poverty due to ill health.*
- ▶ *adapting pension policies to provide maximum individual choice and labour market flexibility*

The many decades of social security experience in Europe, North America, Australia, New Zealand and other countries has proved that a collective approach to ensuring income security and health care for older persons works. It is estimated that in many industrialised societies, more than half of the older population would fall into the poverty trap if they did not have public pension benefits. Recent experience has also demonstrated the constant need to adapt and adjust these programmes to changing economic and social conditions. Without adaptations (e.g. modifications in retirement ages, survivors benefits, flexible retirement), the capacity of the pension programmes to provide benefits in the future would be severely endangered.

The 20th century experience with social security protection also demonstrates the important link between income status and health. Poverty is closely associated with ill health. Ill health and incapacity are

major threats to income security in many developing countries where poor nutrition and living conditions leave many people too weak to produce enough to cover their subsistence needs. In the developed countries, it is far more rare for ill health alone to prevent people from earning their living. However, it is not uncommon for health problems and disabilities to coincide with unemployment, thereby throwing people into chronic situations of employment insecurity.

Access to health care is vital in order to help workers regain work capacity and to ensure that children grow up into healthy adults able to participate productively in society. Health policy must, therefore, adopt a life-cycle approach which tackles health problems from the very start, enabling people to grow older without disabilities and chronic diseases.

The growing number of older people who expect health care and old-age pensions should not be viewed as a threat or a crisis. It is an opportunity, rather, to develop policies that will ensure decent living standards for all members of society, young and old, in the future. Countries need to develop strategic frameworks for the coordination of health, social and economic reforms as well as to raise the level of public understanding of the policy choices to be made. It is the need to examine and make appropriate changes to health, social and economic policies, not the ageing of populations, that is the biggest challenge facing societies today.



Action towards Active Ageing

Factors	Individual action	Policy action
Foetal environment	▶ Ensure balanced nutrition in young girls and pregnant or lactating women ▶ Avoid smoking during pregnancy	▶ Focus health promotion activities on girls and women ▶ Increase awareness about importance of balanced nutrition for girls and women
Childhood environment	▶ Breastfeed babies for at least 4 months ▶ Ensure balanced nutrition & adequate physical exercise for your children ▶ Have your child immunised and observe good hand & food hygiene to prevent infection	▶ Promote breastfeeding, legislate against advertising for milk powder, and fortify foods/water in areas of malnutrition ▶ Ensure access to immunisation programmes ▶ Improve sanitation & housing and reduce domestic overcrowding
Smoking	▶ Stop smoking – cessation is beneficial at any age ▶ Educate your children about the ill effects of smoking	▶ Ban tobacco advertising ▶ Ban sale of tobacco to children ▶ Provide health education in schools and workplace
Alcohol	▶ Maintain moderate drinking limits ▶ Seek professional help if you think you may drink excessively	▶ Ban sale of alcohol to children
Physical activity	▶ Exercise regularly from the earliest years through to older ages; walking, climbing stairs, and housework are effective forms of exercise!	▶ Incorporate exercise into school curricula ▶ Create workplaces which provide exercise facilities ▶ Encourage sports for seniors
Diet	▶ Consume a diet high in fibre and low in animal fat and salt ▶ Reduce your weight if you are overweight and maintain normal body weight	▶ Increase consumer awareness about direct links between good nutrition and health
Adult Diseases	▶ Make above-listed life style adjustments ▶ Make use of available prevention programmes (screening and vaccination) ▶ See your doctor at regular intervals	▶ Implement evaluated prevention programmes ▶ Ensure access to safe maternity services ▶ Provide accessible and affordable health care for all and reduce environmental threats
Social integration	▶ Stay involved in your family, your community, a club, or a religious organisation ▶ Be aware of and speak out against ageism ▶ Continue to educate yourself and all your children	▶ Support activities that foster social cohesion ▶ Provide access to life-long learning ▶ Promote solidarity among the generations
Gender	▶ Be aware of and speak out against gender discrimination and prejudice ▶ Educate boys and girls to avoid gender stereotyping	▶ Implement legislation against gender discrimination in education, jobs, health care, property rights, marriage and inheritance laws ▶ Promote health education on the dangers of high risk life styles by targeting population groups that are particularly at risk ▶ Integrate gender analysis in health research and health care programmes
Income security	▶ Be informed about public and private measures intended to protect income security over the life course	▶ Provide income security and access to appropriate health care for older persons ▶ Fight age discrimination in the workplace



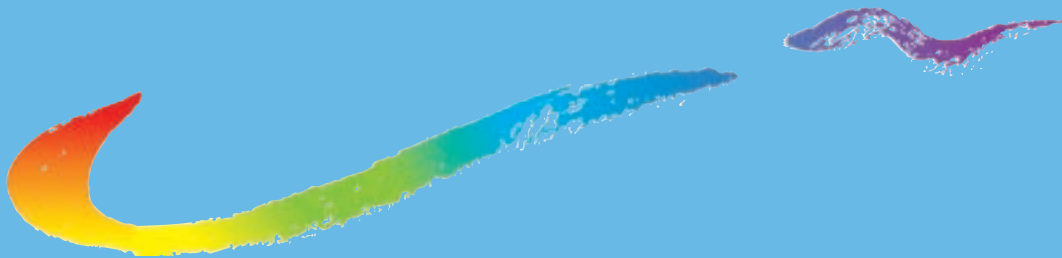
Ageing and Health at WHO

The major challenge facing the Ageing and Health Programme is to understand and promote the factors that keep people healthy into older ages. Since health and well-being in older age are largely a result of experiences throughout the lifespan, work on ageing and health takes a holistic approach, involving other WHO programmes, such as primary health care, gender analysis, non-communicable diseases, mental health and rehabilitation. The programme is extending the impact of its work by collaborating with a number of academic institutions and non-governmental organizations. WHO's Ageing and Health Programme must be a catalyst for action.

Active Ageing in the International Year of Older Persons 1999

The United Nations is marking 1999 as the International Year of Older Persons, with the theme 'Towards a Society for All Ages'. A key principle will be the concept of Active Ageing, whereby people of all ages are encouraged to take steps to ensure greater health and well being in the later years for themselves and for their communities.

WHO is taking a worldwide lead in promoting Active Ageing. During the International Year of Older Persons, the WHO Ageing and Health Programme is initiating the Global Movement for Active Ageing. This is a network for all those who are interested in moving policies and practice towards Active Ageing. The Global Movement will be inaugurated by a global walk event, the Global Embrace, on Saturday, 2 October 1999. In time zone after time zone, ageing will be celebrated in cities around the world through individual walk events. The Global Embrace is therefore an around-the-clock-around-the-world party to which all countries are invited. It was conceived to inspire, to inform, to promote health and to provide enjoyment and good company. It will link local projects to a global community of similar concerns and to people all over the world.



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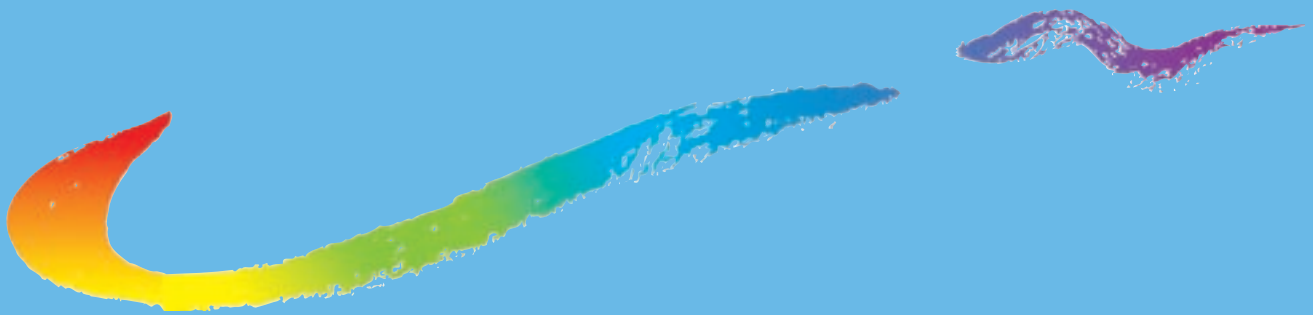
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