MSI

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AGEING & HEALTH

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MSI on Ageing and Health

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Message from the president

An Urgent Need of a New Paradigm

The population pyramid of developed countries like Japan has become a cylinder. In few decades, it will be an side-down pyramid with its base upwards. Contrary to the general belief, this scenario is not going to be confined to the developed world, but is a global phenomenon. Today more than two thirds of the world's 600 million people above 60 years of age live in developing countries.

Sadly, worldwide policy has not kept up with the changing demography. Worse still, most of the countries still associate old age with sickness, dependence, retirement and lack of productivity. Their policies and programs are stuck in this out-dated paradigm.

The biggest challenge before us is to change the outdated paradigms and replace them with the ones that view older people as active participants in society.

I am proud of the fact that for years now, IFMSA has tried to address this issue. The aim of this publication is to raise awareness and provide advocacy for active ageing to the youth and policy makers alike.

IFMSA is the biggest and the oldest student's organization which has been officially recognized within the UN system. The federation has long identified the opportunities and challenges of population ageing. It is advocating policies that provide social inclusion, promote economic protection and social equities of older people.

I wish to acknowledge our debt to Dr. Alexander Kalache, co-coordinator of Ageing and Life Course Unit of World Health Organization, whose support to the Federation's endeavors in ageing remains as valuable as ever. IFMSA fully supports the life course approach to health, which requires young people to act *NOW* if they want to enjoy health and well being in their old age.

IFMSA has recently established a network especially committed to address this issue. This network is ISNAH (International Student Network on Ageing and Health). This network is inspired by the United Nations' principles of old age: Independence, Participation, Care, Self-fulfillment and Dignity. In its recent General Assembly, the IFMSA plenary passed a plan of action where ageing is very high on the agenda.

As the IFMSA president, I want to thank all the experts on ageing who have contributed to the MSI.

I would like to thank Ahmad Halwani, the chief editor, and his team for the massive effort put into the entire process: article collection, editing, lay out and design, publication and distribution.

Let us all promote active ageing…!

Sanjeeb Sapkota
President,
International Federation of Medical Students Associations.

Editorial

Ageing- A medical student's perspective

Ahmad Halwani

Can you imagine yourself 70 years old in the world of today? A bit hard, but the effort is well worth it. I'll try to help. Being 70 years old today means that you were born sometime in the 1930s. Back then, Antibiotics where a novelty. You were 10 years old when World War II was raging. You witnessed the birth of the United Nations, the cold war, and the opening up of space- you still remember that night when they broadcasted LIVE all night, as man walked on the moon. If you were a physician, you would have seen medicine undergo a revolution, allowing one to see inside the human body, as well as come up with cures based on solid knowledge that was un-imaginable when you first went to medical school. And if that was not enough, when you were sixty years old, the world decided to enter what it chose to call the information age, with instant communication made feasible, whole databases of knowledge made instantly accessible. If you were still practicing, and you probably were, patients would have started to come to the clinic with the latest downloaded articles from the internet. Now you are at 70- let us say you are retired. How would you imagine your life? Would you feel at ease with all the new technological advances your grandchildren have made an integral part of their lives? Can you play with your youngest grandchild on his new console? Can you carry out a conversation with another teen age grandchild who is so keen to tell you his latest hobby, his latest book, his latest fad? How much effort would it take to just KEEP UP? Can you imagine what kind of effort? You do need to squint at those flickering screens, use those miscalled joysticks with what may well be rheumatic hands, and exert an effort to come to terms with that infernal, ever crashing machine they call a computer- "O, it crashed grandpa, but that is all right!" Is it worth it? Would you do it? Wouldn't it be much easier to just let go? To go quietly away? The answers to these questions are not straight forward, and would depend on you as much as they would on your surroundings.

That is only one possibility in the almost infinite ways we can grow up. For growing up is truly as unique as each of us is. We all grow up with a lifetime baggage of experience, prejudice, memories, all in context of where we lived and where we are living. Imagine the grandfather who is working to raise up his granddaughter, the latter having lost her parents in the rampant AIDS epidemic. Imagine the old lady who stays at home with her cats, her family coming to visit on the holidays or not at all. Imagine the 60 year old ex-manager who starts an online store and manages a thriving business from the comfort of her home. Welcome to the world of Ageing and Health.

In shaping this issue of MSI, we tried as much as possible to give a glimpse of the intricate world of ageing, how it's evolving, and how it effects us as (future) health professionals. Students from all around volunteered to write and tell us about ageing in their countries. Experts in various fields wrote about ageing from several unique perspectives.

A word of caution is in order. In the articles that follow, you will read a lot about how there are so many old people around, especially in the opening paragraphs. Now that may have an impact on the health care systems, on economics, on medical curricula, to name a few. However as physicians, or future physicians, we have to think from the humanitarian perspective, where it really does not matter if we have a 100 or a thousand old people; we took an oath to provide health to all people. If we neglect to care for that group- personally or on a public scale, then shame on us- it is a mistake that needs to be rectified, irrespective of the percent of those above 60 in our population.

But it really goes beyond medicine. Old people, irrespective of how diverse they are, are at a disadvantage in some aspects, perhaps the most important of which is that younger folks like us tend to think that they are at a disadvantage in all aspects, that they are slow, and can't keep up with us, or that they don't BELONG, are too different, or not interesting… We physicians ought to know better. We should be the ones telling young people that old people are not frail. They don't have to be, and we have the medical knowledge to prove it. It is never too late to start gaining back those precious capacities, the capacity to breath, to exercise, to LIVE.

Consider this: We, the young of today, by our own acts, prejudices, and behavior, are shaping the old people of tomorrow… ourselves. By thinking that old people are ill, or need to be so, we are more likely to ignore those behavior patterns that we need to adhere to today if we are to maintain our health. We need to stop smoking today, so that thirty or forty years down the line, we don't get COPD, and we wouldn't wheeze every time we took a breath. We need to keep our diet, and our blood pressure, in check today, so that we can run with our grandchildren, and not pant pathetically as they run around us "Oh grandma is so slow". We need to get our Calcium deposits in shape before the fracture that puts us in bed makes us dependant. We need to do our screening physicals on time, to catch those tumors from spreading. When we speak of old people threatening to over-burden our economies, the message is not for the old people of today, it is really for the old people of tomorrow, none other than ourselves. And it may be a dark tomorrow for us indeed, if we fail to listen.

I do hope you try to enjoy this issue. Wherever you picked it up, in an IFMSA GA, in a conference… Don't just stuff it in your bag, carry it home, then put it on the shelf, picking up dust as a memento of the good times you had in the GA (and I do know how good they can be). Do try to READ this magazine. It is the result of a year's work by a small number of medical students probably just like yourself, who were as busy as you are, and yet they managed to write about ageing in their countries, or to presume on a number of kind experts who devoted some of their time to give us a glimpse into what ageing is today,

what it could become, and what it ought to be. And after you read it, give it to someone else who is interested. Better still, photocopy an article and post it outside your classroom, in your ward, or outside your office. Go online, visit WHO's Ageing site, write an article, help plan a Global Embrace event in your city. And write us and tell us what you're doing. Join our email group, throw ideas up, tear them down, but most of all share your ideas and work with others. Together, we can do what none of us can accomplish alone.

Right now, it is 11:20 pm, on a cold December night. I sit alone in my hospital's ward. The nursing station is brightly lit, but the rest of the ward is dark. The old laptop click eerily as I type. The medical charts look strangely inviting, bright blue box files in an otherwise sterile environment. I flip through the charts I know so well from my rounds. Most are for patients who are over 60. One patient is on his third cycle of chemotherapy for small cell carcinoma, a cancer that occurs only in smokers. My eye darts to another chart, a case of metastatic breast cancer. The list goes on. Now I may lack the resources, and the medical knowledge to cure many of these patients, but I sure can work to ensure that come the next decade, there will be less of these cases in this ward. I hope this issue of MSI will play a role towards that end. Just how big that role will be, rests on you.

Good Luck.

Acknowledgements

It is rare to meet someone as kindhearted, insightful, and inspiring as Dr Alex Kalache, who indeed embodies those qualities we should aspire to in our profession. Needless to say, without his support and guidance, this issue of MSI, as well as other IFMSA endeavors in the field of ageing, may have been nothing more than wishful thinking.

I would also like to acknowledge our gratitude to Ms Ingrid Keller, whose valuable advice was sought and generously given on almost every step in planning and executing this project.

From IFMSA, I would like to thank Barbara Schimmer for starting it all, Emilie Martinoni for organizing one of the most enjoyable workshops I have ever attended, Kenneth Hansen for his ability to put things to perspective, "Chuks" for most enjoyable 1 am discussions of project planning, and last but not least, Sanjeeb Sapkotas for his unwavering support of this project.

A great thank you to all those who helped in editing, layout, and publishing this issue.

Ahmad Halwani

Editor-in-chief

Foreword

Dr. Alex Kalache

In 1953 Sauvy, the French Demographer, stated that:

"The least debated of all the phenomena of our day, the surest in its progress, the easiest to foresee for ahead and perhaps the most pregnant with consequence is the ageing of the population".

Nearly fifty years later, his statement still holds true – with one exception: what was then an observation that largely applied only to France and other few already ageing societies, has now become virtually universal.

"The least debated of all the phenomena of our day, the surest in its progress, the easiest to foresee for ahead and perhaps the most pregnant with consequence is the ageing of the population"

However, progress is being made as the recent WHO-IFMSA partnership testifies. It is only two years ago that the World Health Organization first introduced to the IFMSA Executive Committee the importance of bringing **ageing** into the agenda. These preliminary discussions during the World Health Assembly in Geneva, May 1999, triggered a series of joint activities.

WHO was invited to address the subsequent annual meeting in Monterey where a workshop on ageing and health was held. On the same occasion, both the medical education and the public health committees embraced enthusiastically ageing and health as priority areas of work. Still in 1999, a joint project on the status of teaching geriatric medicine worldwide was initiated (preliminary findings reported in this MSI issue). A conference on ageing and health – counting as speakers some of the leading international experts in the field – was held in the context of IFMSA 2000 annual conference in Oporto. The IFMSA network on this issue, ISNAH, was established. Furthermore, over the last two years, affiliated national associations in many countries were active contributors to the "Global Embrace on Active Ageing" – a WHO-led event in celebration of the **International Day of Older Persons,** as also described in this issue.

The enthusiasm has not waned– and the best proof of that is this current MSI issue dedicated to ageing and the insertion of a workshop on "Ethics and Old Age" into the programme of the IMFSA 50th anniversary conference in Denmark

And so be it, as there is no doubt that the demographic imperative of the 21st century is population ageing.

The implication of ageing for today's medical students for the whole of their professional lives cannot be underestimated. With no exception, whatever the specialty they come to embrace, ageing will feature highly. For those who will deal mostly with adults through their clinical or surgical practices, an increasingly higher proportion of their patients will be ageing patients.

For those in Public Health branches, ageing will be a dominant

feature of policy development and resource allocation. As to those who will direct their talents and abilities to research, they will need to acquire a clear understanding of the ageing processes – to include response to different forms of therapy and mechanisms related to ageing-associated physiological changes.

Ageing individuals will no longer be the bulk of Primary Health practice in developed countries only – the proportions are already rapidly increasing in the developing world. And for those who might think that they can avoid "ageing" by electing Paediatrics or Obstetrics, a clear warning: the life-course perspective is increasing its importance in relation to the determinants of health or illness later in life. Action – or failing to act – early in life could have most positive or devastating influences to one's health, fifty or sixty years later.

The World Health Organization "Ageing and Life Course" Programme is proud of the progress so far. It pledges its continuing support to IFMSA so that **ageing** will continue to be a major concern for the Federation. The Second UN Assembly on Ageing – which will take place in Madrid, April 2002 – will revise the International Plan of Action on Ageing. It is highly expected that their revised plan will strengthen the international resolve to put ageing high on the agenda of governments, NGOs and multiple sectors. IFMSA will no doubt respond to the call. Only together will we be able to build societies in which old age will be a positive experience for the great majority of us – yesterday's children, today' adults, tomorrow's older citizens.

Ageing

And

Health

Population ageing – a Global Perspective

Alexandre Kalache, Ingrid Keller

In 2000, for the first time, there were more people over the age of 60 than children under 14 in a number of developed countries (UN, 1999). The total number of older people (defined as 60 years of age and over) worldwide is expected to increase from 605 million in 2000 to 1.2 billion by the year 2025; 75% of them will be living in the developing countries (UN, 1999). Ageing is a privilege and a societal achievement. It is a challenge, too, which will impact on all aspects of 21st century's society.

The process of population ageing is driven by two major factors: increased life expectancy and declining fertility rates. This process is commonly referred to as the "*demographic transition*".

Rapid Process In Developing Countries

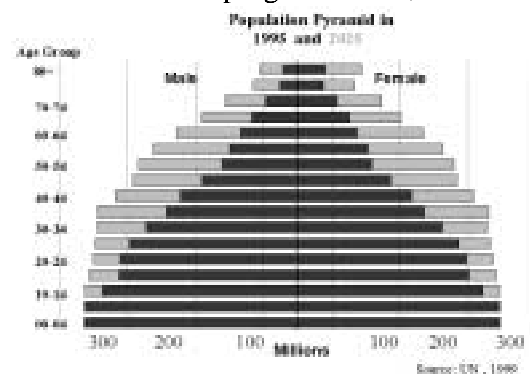
It is often assumed, that most of the aged population live in developed countries. The reverse is true. Currently around 60% of old people live in developing countries. Furthermore, those countries will have the steepest increase in the number of people over sixty within the foreseeable future. In China for example the population 60 years and over will increase from 128 million in 2000 to 288 million in 2025. Respective figures for Brazil are 13 and 32 million and for Nigeria 5.5 and 10 million. Other countries, such as Indonesia, Colombia, Kenya and Thailand, will experience even higher increases – between 300% and 400% -. i.e. up to eight times higher than the increases in societies such as Western European countries, where population ageing occurred over a much longer period of time. Important increases in the proportions of older people within the general population are expected in virtually all countries of the world, except Sub-Saharan Africa. Throughout the world (except in some countries in South Asia) women outnumber men in old age. For example, in Japan by 2020, very old women aged 80 plus will be the largest subgroup in the whole population at the top of an inverted population pyramid.

High life expectancy is no longer a privilege of wealthy societies.

The bottom of the population pyramid will remain at the current levels reflecting declines in fertility rates, which all other subgroups will experience – particularly over the age of 30 years. In most countries fertility decreased significantly over the last 25 years. Indeed, it is estimated that by 2020, 121 countries will have reached or will have rates below the 2.1 replacement level (average total number of 2.1 children per woman). This is a substantial increase compared to 1975, when just 22 countries had a total fertility rate below or equal to the replacement level – or the current figure, 68.

Shift in death causes doubles burden

In developing countries, causes



of death and morbidity are changing. In 1990, about 40 percent of all deaths in the developing world were attributed to communicable diseases, around 50 percent to non-communicable diseases (NCDs), and the remaining were due to external causes of death (mostly accidents). By 2020, a very different picture will have emerged. According to WHO estimates NCD may become responsible for over three-quarters of the deaths in developing countries. That does not mean that infectious diseases will disappear in the foreseeable future. Their role, however, in causing death is expected to decrease. At the same time, NCD will increase in prevalence and become a major cause of death in most of the developing world. Hence the "double burden of disease" for developing countries. In addition, new emerging diseases – such as AIDS and Ebola - will also pose challenges, requiring additional resources. Infectious diseases will persist and bind money and capacities in order to keep them at bay, while NCD will escalate to unprecedented levels.

With increasing proportions of older persons in the population, the demands to health care systems in developing countries will change. Health care systems will be expected to accommodate care of older adults alongside with, for example, child and maternal care.

This is quite different from the picture in the North. For instance, cardiovascular diseases rates in most of the developed countries have gone down, especially since the 1960's. In the developed world health indicators are substantially improving. However, even advanced health care systems will also have to adapt to the shifting needs due to population ageing. This does not imply that ageing is in itself a disease and old age should not be seen as equal to frailty, sickness and a high demand of health care services. Never the prospects of ageing have been so good for those that can afford all the wonders of biotechnology. And the rich world, the North, will be able to do so. For the third world, it's going to be a much bigger challenge.

A culture of ageing is a culture of solidarity and this solidarity is between countries, as well as generations. If we don't revise the kind of world that we want, the kind of world that we aspire for us in old age, if we don't reflect on this now, we are going to regret that we have become old.

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The focus on gender in health: why?

Trudy Van Ommeren

Gender may have little to do with the biological facts; both women's and men's behavior are socially and culturally defined. For women's and men's illnesses that is equally true: many are (partly) biologically defined, but differently presented. Even the same illnesses are differently diagnosed, treated and perceived by the health workers and society at large. Gender differences are reflected in all sectors of society, including health care policies and services.

Even the same illnesses are differently diagnosed, treated and perceived by the health workers and society at large. Gender differences are reflected in all sectors of society, including health care policies and services.

When looking into the health education in most countries, it is fair to state that the future doctors, or health workers in general, obtain little, if any, specific gender sensitive training. They learn a lot about the biological differences in men and women's health issues and problems. They learn very little about the political and socio-economic context in which these diseases occur. They learn very little about the men and the women 'behind' the disease. The medicine taught today is still largely gender neutral. This puts women in a disadvantaged position. Why is that?

The life-cycle

Specific care for women during all the phases of life is more or less virgin territory. Looking at daily realities in many Southern countries, already early in life, girls are discriminated, because parents have 'son preference '. This is especially the case in some Asian countries, such as Bangladesh and India.

However, in many more countries there is a general 'silent or hidden' under-valuation of females, in terms of less access to food and untreated diseases and in some cases even leading to early mortality. Quite commonly, young girls develop health problems which are the result of traditional beliefs reflecting the lower value of women, and which may have a lifelong effect, such as genital surgeries, clitoridectomy and excision of labia.

During the reproductive years, many women suffer from a series of health problems relating to lack of treatment, discrimination and violence, which they have been subjected to in their early years. More often than not, these problems lead to high mortality rates during pregnancy or delivery.

During the reproductive years, many women suffer from a series of health problems relating to lack of treatment, discrimination and violence, which they have been subjected to in their early years

The continued under nutrition in combination with multiple pregnancies leads to chronic anemia. The food taboos and eating customs, which favor males, add to these problems. Looking at women's lives in the years after

reproduction, one would assume that these should be the better ones.

However, the lower socio-cultural status of women, being subordinate to men and the multiple roles that they fulfill at home, caring for the children and participating at the community level, result in chronic overwork for many women.

The women who are older, are confronted with rules and regulations in society that prevent them from owning property and certain businesses and from employment. Female poverty exceeds male poverty throughout life. Despite all these negative experiences, women live longer than men do in nearly every country in the world. In many cases, women become widows, which again is accompanied with discrimination and social marginalization.

Health is a political issue

Health at the level of the WHO is defined as a complete state of physical, mental and social well being and not merely the absence of illnesses. This definition does not specifically refer to the political context of illness, which Wemos emphasizes.

The Wemos vision is that most illnesses do not need any medical solution, they rather ask for political and social changes: health is a fundamental human right indispensable for the exercise of other human rights. This right is reflected in many international documents. Also article 12 of the International Covenant on Economic, Social and Cultural Rights, refers to the right of the highest attainable standard of health.

In many international meetings the health rights of women have been formulated by them and confirmed by their governments. This led to important policy documents such as the ICPD (1994) and the Beijing's Platforms for Action (1995) The latter states that 'Women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men. The prevalence among women of poverty and economic dependence, their experience of violence, and the negative attitudes towards women and girls in many societies, racial and other forms of discrimination are in many countries common elements of women's lives affecting their health. In addition the limited power many women have over their sexual and reproductive lives and lack of influence in decision-making are social realities which have an adverse impact on their health."

A recent meeting with thousands of health activists, held in Bangladesh formulated in the People Health Charter (PHA, Bangladesh 2000) this right as prevailing over economic and political concerns'. 'Health is a reflection of a society's commitment to equity and justice’, the Charter states.

Central values

Health and illness should therefore be seen within their social context. In other words, all actors within the health care system should work on the basis of the vision that health and illness are closely intertwined and are influenced by individual and collective physical, psychological and social factors.

The self-determination of health care users should have a central place within the care system. The clients' own responsibility over their body and life is a fundamental right.

The health care system is dealing with individuals, not with entities or groups of people. A client should always be viewed as an individual person and not as an average member of a patient group.

Enhancing the ability for self-determination

Many of the necessities for a healthy life go beyond the scope of health care. In large parts of the world there is a lack of even the basic necessities, resulting in women being put at a disadvantage. Health problems experienced by women are related to their social position and socialization. Self-determination assumes that the basic necessities for healthy living have been met and is expressed at all different levels of personal well being and translated in political terms.

Self-determination is independent of the question whether each wish or need should be granted. The acceptance or otherwise of different conflicting or competing needs occurs on the basis of weighing up interests. It is all too clear that at present the interests of women are not sufficiently represented and that by the weighing up of interests the scales very rarely swing in their favor.

Start with women themselves!

If a society takes its fight for gender equality and equity serious at all levels, the starting point is empowering women. This will have direct benefits for their health and overall quality of life, but it will also enable them to choose their own directions. The priorities of women may differ from those of the doctors and the policy setters', and they may have a different direction than that of the donor community or even the mainstream in society. The socialization and living conditions should be systematically included within the care provision. A first step is to create an enabling environment. This is necessary for the women to be able to ask for help.

Health cannot be separated from other issues such as poverty and from the socio-cultural context, political power, nor can health in one stage be separated from the other stages. Health involves many gender issues in which girls and women are disadvantaged compared to boys and men, but in the long run what benefits women's health, will also benefit men's health.

This article highlighted some of the elements contributing to women's health and concludes that more radical changes are needed, to view health as a fundamental human right and address it as a political issue. Actions are needed to do justice to the concept of women's health from their own perspective.

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Ageing and Gender-Facts and Figures

By Manju Karki

By 2025, out of the total population of older persons, there will be around 650 million older women compared to 334 million today. In the very old age group the proportion of women increases sharply with a ratio for those over 80 of 2:1 in most countries. This is due to the fact that women live longer than men in most countries as shown in the table. However, longer life among women does not necessarily imply that they live healthier lives. In fact, women's longevity makes them more vulnerable to suffering from chronic diseases associated with age. In countries such as Nepal, Pakistan and Zambia, where girls and women have experienced discrimination with regards to access to health care, proper nutrition, material resources, education and social support, the natural advantage of women's life expectancy is reduced.

Projected Life Expectancy in Selected Countries for 2000-2005

Country	Life Expectancy at birth		Life Expectancy at age 60	
	Women	Men	Women	Men
Japan	85	77.8	27	21.4
France	82.8	75.2	30	20
Canada	81.8	76.2	24.5	20.4
Germany	81.1	75	23.7	18.9
United Kingdom	80.7	75.7	23.3	19.4
Rep of Korea	79.1	71.8	22.3	17.3
Kuwait	79	74.9	22.1	18.7
Cuba	78.7	74.8	22.5	20.3
USA	77.7	74.6	23.9	19.5
Argentina	77.7	70.6	22	17.6
Mexico	76.4	70.4	22	19.6
Latvia	76.2	65.7	21.3	14.8
Bulgaria	74.8	67.1	19.4	15.4
China	73.5	69.1	20.1	16.3
Russian Federation	72.5	60	18.7	13.5
Pakistan	60.9	61.1	16.6	16.1
Nepal	59.6	60.0	16.3	15.2
Zambia	41.7	42.6	16.4	14.7

Source: UN World Population Prospect, 2000

Gender is a social construct, which means that men and women live their lives in culturally prescribed roles. As a result, it is an important determinant of health. The concept of gender recognizes that women and men have different needs and power relationships and that these differences must be identified and addressed, if possible in such a manner that the imbalance between the sexes is rectified. While some of the discrepancy in the health of men and women can be explained by biological differences, much can be attributed to cultural and social determinants. More often, gender is used primarily to explain disadvantages in the status of women. This notion evolved after the successful advocacy of the women's movements in the 1970s and 1980s.

Equally important however, is to address men’s health in the context of gender in order to fully understand the impact of gender roles on health and ageing.

With this regard, men’s behavior, often defined by society, is just as significant determinant of health as women’s. Men generally seek health care at an early age, at the end of their lives or when a health condition gets critical. Men’s shorter life expectancy is also due to a disadvantage imposed by gender roles, characterized by several risk taking behaviors such as alcohol and tobacco consumption as well as accidents and suicide- which explains why for instance in Russia men have such a shorter life expectancy at birth than women.

In an attempt to enhance our understanding on ageing and gender, the WHO Ageing and Life Course programme recognizes the need to develop a gender perspective throughout the lifespan in order to generate evidence-based guidance for policy development towards healthy ageing.

Ageing and the health care sector

Preparedness of the health care sector to include medical education with focus on PHC

Shah Ebrahim

The Demographic change

The most remarkable phenomenon of the 20th century has been the increased life expectancy of most populations in the world, which has resulted in dramatic ageing of populations. Currently, the oldest old – those aged 85 years and over – are growing at the most rapid rates in post-industrialized countries. But in the next two decades the post-war baby boom generation will become the young pensioners in 2020 and the numbers of both young and very elderly people will increase substantially from current levels. [1] Developing countries are ageing more rapidly than the post-industrialized parts of the world, which has implications for the medical training in these places. The growing globalization of employment for many health professionals, particularly nurses, means that demographic shifts have implications for training of health professionals worldwide.

…good health care for elderly people requires inter-disciplinary teamwork

With an ageing population come increases in chronic and degenerative diseases and the problems of multiple pathology. It is this latter fact that makes current medical training so vulnerable to inappropriate and poor quality care. Increasing specialization carries the danger of a failure to see the whole patient. Demands to keep up to date in ever-smaller areas of medical care drive out time for developing and maintaining more general skills. The ageing population is placing all doctors – except pediatricians – in the front line of geriatric medicine. Ageing and sickness go together and the consequence is that hospitals are filled with elderly people who require a very different approach from the traditional in-patient or primary care services.

Undergraduate medical education

Elderly patients have served as efficient vehicles for learning the examination of common physical signs – their histories were too long for the attention span of the average medic – for a generation of doctors. But good health care for elderly people requires inter-disciplinary teamwork as no one member of the team is capable of providing all the skills and expertise many elderly patients need. We know only too well what is required and have done for a very long time [2]. In 1970 the British Medical Students Association called for a joint core curriculum for all health professionals, which would foster better understanding of and respect for each others roles. Our elders knew better then and it never happened. Deans and Vice-Chancellors have failed to realize

that the pursuit of “excellence” through a retreat into basic science is more likely to result in stagnation of education and more grossly ill-trained doctors than ever before.

Reforms for undergraduate medical education have been extensive over the last two decades – integration of basic science and clinical practice, community-orientated training, problem-based learning, evidence-based care. Common threads running through these reforms throughout the world are to use small-group learning, have a focus on community and primary care, and to attempt to make the patient a whole being rather than a set of organs and systems.[3] These reforms should help students to achieve a comprehensive understanding of their patients' problems: physical, mental, social and spiritual – and elderly patients should benefit from being better assessed and ultimately better treated. We now need to ensure that current doctors know how to assess elderly patients and what to do about the common problems of incontinence, immobility, instability, insanity, and iatrogenesis. Specialists in health care for elderly people know how do to this. [4-6]

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Teaching Geriatrics

An example from the Medical Faculty of Geneva, Switzerland

Emilie Martinoni

Introduction

According to the United Nations, it is estimated that in the year 2000, 7% of the world population is composed of older people. This percentage is more than double in Europe, where 15% of the population is aged 65 or above. The UN projects that by 2050, these percentages will be 16.4 % for the world and 27.6% for Europe.

Every practitioner, and not only geriatricians, is asked to work with a population of old patients every day.

As future healthcare professionals, medical students need the appropriate knowledge and skills to ensure that older people of today and tomorrow, living in the community or in institutions, in good health or frail, can look forward to improvements in their function and care in the years to come.

As future healthcare professionals, medical students need the appropriate knowledge and skills to ensure that older people of today and tomorrow (…) can look forward to improvements in their function and care in the years to come.

Structure of the Curriculum

Undergraduate medical education at the "Faculté de Medicine" of Geneva consists of a six year program, structured as a one-year basic science curriculum, followed by a two-year pre-clinical program, followed by a three-year clinical program. Small-group, problem-based learning is the most common method of teaching at this time.

Until 1994, only 8 hours were allocated to the undergraduate geriatrics program at the "Faculté de Médecine" of the University of Geneva. This program was not mandatory and was not evaluated.

A new curriculum was instituted in 1995, and is now being fully implemented. The University of Geneva now offers a developed geriatrics undergraduate education. This presentation does not intend to expose a model, but an example of integration of geriatrics teaching throughout the medical curriculum.

The curriculum emphasizes the acquisition of active learning skills with emphasis on scientific knowledge, clinical and communication skills, and attitudes training.

The first year curriculum consists of basic science courses (lecture and laboratory), in chemistry, biochemistry, physics, biology and others. This year is not integrated in the new curriculum, due to the large and variable number of students.

The second year curriculum consists of medical basic science courses. Students are scheduled for teaching mostly in small groups (defined as about 8 students), with a Problem Based Learning format. Learning blocks integrate the basic sciences and provide exposure to clinical cases and training in clinical skills. Most of the blocks are directed at an organ system and are 4 weeks long. However,

practical labs, interactive forums, and question/answer sessions are also included. Students have large blocks of time for active learning and independent study activities. The Clinical Community Practice Skills course is used to teach clinical skills and expose the student to community medicine. They follow one or two patients in a doctor's practice.

Geriatric training is integrated in the blocks in the following way:

Introduction:

- Influenza epidemic in a nursing home: concept of frailty, host defenses against infections

Cell growth and ageing:

- Theories of biological ageing, Cellular mechanisms of ageing, free radicals, non-enzymatic glycosylation, telomeres
- Cataract, free radicals, non-enzymatic glycosylation, Evaluation of older drivers

The third year of undergraduate medical education continues the same structure seen in the second year.

Case studies related to the health of older patients are:

Perception and motor Control

- Pathophysiology of Parkinson's disease

Behaviour and Communication

- Memory and cognitive functions, Pathophysiology of Alzheimer's disease and other dementia

The learning of Clinical Skills and Community Oriented Skills is integrated into these two blocks. These are the related seminars: cognitive functions examination and decisional capacity.

Further in the third year two modules on

Locomotion

- A bad fall: Osteoporosis, Hip fracture, Factors increasing risk for falls

Infections

- Intoxication with a Tiramisu, host defenses against infection, immune system in old age

The hot point in this year is the final four-week block, the Community-Based Experience when students investigate a community health issue and present their findings as part of the course. 3 workshops and 3 lunch-meetings allow the students to meet older people in the community: physical and mental health of the elderly, independence and autonomy, multidisciplinary approach, role of the elderly in society, community resources for the care of the elderly.

Years 4 and 5 include the required clinical rotations. These years are divided in AMC (Apprentissage en Milieu Clinique) units of clinical learning per discipline and in Integration units.

The first integration unit addresses the basic principles of clinical care. Its main objectives are to help students to further integrate basic science concepts, and to develop their clinical knowledge and their problem-solving abilities. In the first integration unit, a 3- week block coordinated by geriatricians, neurologists, and psychiatrists suggests the following themes: TIA and stroke, dizziness and falls, dementia, malnutrition, nutritional assessment, end-of-life issues, delirium. Related seminars emphasize the acquisition of important aspects of the geriatric assessment, such as functional assessment, evaluation of the social network, mental examination, and assessment of the nutritional status; end-of-life issues

and principles of gerontopharmacology are also discussed in this multidisciplinary block.

Further concepts are integrated in the surgery and internal medicine preclinical blocks: pre-operative assessment, osteoporosis : screening, prevention

An "ageing game" seminar, organized in collaboration with physiotherapists and ergotherapists, allows the students to be faced with physical impairment, and its evaluation through different questionnaires: Activity of Daily Living, Instrumental Activities of Daily Living.

All students are exposed for a short period to the home care of frail elderly during a one-week rotation in a geriatric outpatient clinic, as part of a four-week Community medicine rotation. One case study focuses on palliative care, pain assessment and treatment.

…despite what is commonly thought, the vast majority of older people remain physically fit well into later life: they are able to carry out daily life activities, they continue to play an active role in community life.

One third of the students are more exposed to inpatient care of older persons: they spend their eight-week Internal Medicine clerkship at the University Geriatric Hospital of Geneva, where they participate in patient care and in most activities of the postgraduate training in geriatrics offered to the residents. Therefore these students are more intensively exposed to the care of hospitalized very old persons, and they interact with other health professional composing the network of care to older people.

Eight seminars on legal and bioethical topics are integrated in the Internal Medicine clerkship. Other related important topics are also addressed in Surgery, Obstetric-Gynaecology (Urinary Incontinence), Psychiatry (Depression vs. mild dementia, desafferentation and psychotic disorders, Advanced directives, Guardianship), Ophthalmology (Diabetic retinopathy, glaucoma, Macular degeneration, cataract, Evaluation of older drivers) and Neurology (Wernicke aphasia, Stroke, Parkinson, Mental examination) clerkships.

The 6th year is a clinical elective year, which students can spend at placements in Geneva or elsewhere. The University Geriatrics Unit offers a 2-3-month program titled "University Geriatrics at hospital and in the Community". The aim of the clerkship is to teach students the medical knowledge on internal medicine and geriatrics, in the hospital and in the community. A growing interest has been showed by students for this program.

Conclusion

In a United Nations projection for 2050, Switzerland will be one of the 14 countries with 10% of the global older population. Swiss geriatricians have submitted a project to have common learning objectives for geriatrics in the 5 Medical Schools of the country.

Fortunately, and despite what is commonly thought, the vast majority of older people remain physically fit well into later life: they are able to carry out daily life activities, they continue to play an active role in community life: older people are both the receivers and the providers of care.

A minority of older people, mostly the oldest old, become disabled to the point that they need care and assistance with the tasks of daily living.

Young people in developed countries are often brought up in nuclear families, and they might see only extremely frail older patients during their training. It is therefore important to emphasize the role of older citizens in the community, and to facilitate the contacts of medical students with older people who have successfully aged.

Multi-disciplinary and community-based training are certainly ways to equip future generation of health professional with skills and knowledge to work with a positive attitude for the care and caring of older patients.

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Abuse of Older people

A View from South Africa

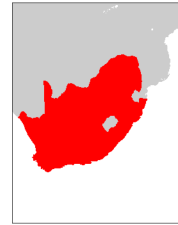
Will Brian

The fact that abuse of the elderly has received very little publicity in the past does not mean it did not occur. In fact, consensus has been reached in literature that the iniquity of abuse of the elderly has been in existence for a very long time. In South Africa elderly persons, especially the poor and those living in disadvantaged communities and deep rural areas, are subjected to the most appalling abuse, neglect and ill-treatment.

The lack of reliable data on abuse of the elderly in South Africa prompted the Council to undertake a survey amongst the elderly in KwaZulu-Natal, Eastern and Western Provinces in co-operation with the Medical Research Council. The findings highlighted several issues.

Financial Abuse

Many elderly, particularly in the black communities, receive their pension as a cash payment at a specific payout point. The problems associated with this method of payment are numerous and serious in nature, including: Having to travel a long distance to payout point with no provision for transport. Also noted was absence of adequate shelters, insufficient seating, no toilet facilities, food or water, and lack of provision of special services to assist the very frail. Another finding was ill treatment by officials, who often withheld part of the money, in the case of innumerate or illiterate elderly. Theft and robberies were also noted due to lack of security at the payout point. Financial abuse was also caused through intimidation by hawkers, moneylenders and family members, who all demanded part of the pension, leaving the elderly with little or nothing. If demands for payments are not met, the elderly are often subjected to physical abuse or even torture. Finally, in areas of high unemployment, communities - not just the elderly - now await the pension day.



Sexual Abuse

Rape of the elderly and sexual assaults are on the increase, both within the family and by outsiders, fueled by the belief that intercourse with a sexually inactive person can cure HIV and AIDS.

Through rape and sexual assaults, the number of elderly contracting this terminal disease is growing.

Witch Craft

In some provinces in South Africa, the elderly, particularly women, are labeled witches. At best, this can lead to ostracism- at worst, eviction from their home.

Systematic Abuse

This abuse was perceived as government's marginalization of older persons and lack of commitment to provide adequate services by in relevant state departments, including those involved in health care, housing, safety and security, and legislation.

Health Care

Health care and geriatric services are inadequate. Personnel are often not interested in older patients who end up being last in queue or even get sent away without being attended to. Inadequacy also includes superficial examinations as well as improper explanation of medication. Problems are exacerbated by inaccessibility of clinics, and lack of transport and supportive devices

Housing

The majority of older persons live in overcrowded accommodations, which is not suitable for adequate care and protection, hence a high level of abuse and neglect occurs when families are faced with the problem of nursing a mentally or physically frail person.

Safety and Security

Disturbingly high incidences of assault / rapes / robberies and murder cases have been reported and confirm that elderly, specifically women, are a soft target for criminals. However, older persons have lost faith in the Police and justice system to protect them from criminals.

Legislation

The present Aged Persons Act is the only legislation targeting the elderly but falls far short of protection for the elderly against abuse. Even the amendments to the Act in 1998 deal mainly with abuse in institutions. New legislation to protect the rights of old people, both within residential care and communities, is still awaited.

The Domestic Violence Act of 1990 is the only other legislation which provides a mechanism for intervention by the Police in a case of suspected abuse. However, the implementation of this Act has been slow due to a lack of awareness and understanding of the application of this Act both by the Police, the judiciary and the public.

Halt Elder Abuse Line - HEAL

In an attempt to assist older persons in accessing information and services, the Council for the Aged opened a national toll free help line for victims of abuse in March 1999. In the past two years, the line has handled nearly 3000 calls providing advice, counseling or referrals for professional intervention to service organisations at grassroots level thus enabling a support network for both the victim and the perpetrator.

Conclusion

Following a shocking TV broadcast on the treatment of elderly, the Minister for Social Development instituted a Committee of Enquiry in April 2000, enabling older persons to give evidence of the abuse in all its manifestations. Their report, published last month, confirms most of the above findings and includes a wide range of recommendations, which will ensure a better deal for older persons in South Africa.

Elder Abuse

Silvia Perel Levin

Elder abuse is the mistreatment of older people. Though a timeless phenomenon reflecting inter-personal violence, it is now achieving due recognition within ageing-specific contexts. Prevalence studies concerning abuse of older persons have been restricted to developed nations. Although there is no systematic collection of statistics and in the absence of prevalence studies, the extent of the problem in the developing world can be gleaned from crime records, journalistic reports, social welfare records and small-scale studies.

A definition developed by the UK's *Action on Elder Abuse* and adopted by the International Network for the Prevention of Elder Abuse states: "Elder abuse is a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person". The World Health Organization (WHO) recognized the need to develop a global strategy concerning the abuse of older people. This strategy is the product of a working partnership between the Ageing and Life Course unit of the Department of Noncommunicable Disease Prevention and Health Promotion and the Injury and Violence Prevention Department at WHO; the International Network for the Prevention of Elder Abuse (INPEA); HelpAge International and academic partners in a range of institutions. This partnership organized a study on elder abuse based on the conduction of focus groups (with older people living in the community and primary health workers) in eight countries, with emphasis on the developing world.

The research identified components of elder abuse as identified by older people themselves and by those forming the primary health care teams. The primary health care context was identified from the beginning of the study as it is within this context that elder abuse can first be identified (or not). Making primary health care workers aware of the problem is an important step in preventing and/or managing elder abuse.

The study was carried out in Brazil, Argentina, India, Lebanon, Kenya, Canada, Austria and Sweden. Reports from each country written by the local expert were reviewed and analysed at a meeting that took place at WHO in Geneva on 11-13 October 2001. The actions recommended by the participants of the meeting are:

- To develop a screening and assessment tool for use in primary health care settings in developing countries
- To develop an education pack on elder abuse for primary health care professionals
- To develop and disseminate a research methodology 'kit' to study elder abuse
- To develop a Minimum Data Set concerning violence and older people
- To ensure dissemination of the research through scientific journals
- To conduct intergenerational pilot studies of older and younger people in their organisations
- To develop a global inventory of good practice

Some of the above mentioned actions are already being implemented and the remaining ones will follow in the near future. WHO and INPEA are

looking forward to working with IFMSA on the strategy, which we call A *Global Response to Elder Abuse Together (GREAT)*

For more information, please visit http://www.who.int/hpr/ageing/elderabuse or contact activeageing@who.int

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Ageing and Mental Health

Pallab K.Maulik, Shekhar Saxena

As medical science advances further, an increasing number of diseases are conquered. Consequently people live longer and the number of our elderly population (above 65 years) increases. It is projected that by 2025, there will be 1.2 billion elderly people with 72% of those living in developing countries (Levkoff et al 1995). With increase of age, newer mental health problems are added to the existing ones. The prevalence of psychiatric symptoms among the elderly is estimated to be around 25%. There were an estimated 9 million elderly individuals with mental disorders in 2000 and this will increase to about 20 million in 2050 (Jarvik et al, 2000). Though the prevalence of certain psychiatric illnesses like neurotic disorders and schizophrenia is less in the elderly than in the younger age group, the prevalence of depression and organic disorders like dementia is quite high (see inset). Other organic disorders like delirium, dementia due to other causes besides Alzheimer's, and psychiatric disorders associated with physical illnesses are other prominent psychiatric problems of the elderly population.

The elderly are also faced with a multitude of stressors in the form of physical illnesses, retirement and loss of ability to support oneself, poor family support, widowhood, homelessness and the inevitability of death. These issues themselves or in combination with other social, political or economic factors can trigger mental health problems. Chronic and debilitating illnesses like diabetes, multiple sclerosis, cancer, cardiac problems, arthritis, etc, not only cause severe distress and dysfunction by themselves but are also causes of associated psychiatric illnesses like depression and anxiety. With retirement and loss of ability to support oneself economically the elderly become increasingly dependent on their children and find themselves unsupported and helpless leading to depression and other psychiatric illnesses.

Uwakwe (2000) found that 23.1% of the surveyed population of a rural community in Nigeria suffered from some mental disorder. In a recent community based study the prevalence of depression was found to be 4.4% in women and 2.7% in men (Steffens et al , 200 .(0The prevalence of depression was found to be 3.86% in a recent study in China, with the prevalence in the rural community being 5.07% and that in the urban community being 2.61% (Chen et al , 1999) . The prevalence of Alzheimer's in recent community based studies using standardized tools have found prevalence rates between 1.07% and 5 % (Prencipe et al, 1996; Chandra et al,1998; Wang et al, 2000;). Suicides have also been found to be high among the elderly population and suicide rates peak around 65 - 7 5years for males in industrialized countries and a decade earlier for females (Sainsbury,1987)

Mental health services are poorly and unevenly distributed across countries. Specific programmes for the elderly are available in less than 50% of countries (WHO, 2001). Whereas in developed countries, the problem is of poor family support with adequate facilities for care, the problem in poorer nations is of inadequate care facilities. However, programmes geared to look into the specific problems of the elderly and its management are present but these are very few and only available in an organized way in some developed countries. Primary or community psychiatric care facilities for this population group is almost non-existent. Even psychiatrists trained specially in geriatric psychiatry are few in number.

In conclusion, the magnitude of the mental health problems in the elderly is huge. As time progresses more will be learnt about the biology of mental illnesses in general and those in the elderly, but as of now the facilities to treat our elderly population is hopelessly inadequate and a lot needs to be done based on existing models of care. Along with development of community based care facilities for the elderly, efforts should be made to educate the public on this issue and its importance to society. More mental health professionals should be trained to tackle geriatric psychiatry cases. Some information about geriatric psychiatry should be incorporated into the undergraduate level training of doctors nurses so that they are able to identify mental health problems in the elderly in their communities and help accordingly.

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Ageing Around the World

Older People In An Ageing World

Peter Bujari

Ageing of the population is one of the major important developments in the 21st century and presents a major challenge in the near future both to the developing and developed countries. The effort to reduce the child mortality rate, infectious and parasitic diseases has led to a considerably longer lifespan.

Presently there are about 590 million people aged 60 years and above. It is projected that there will be 1.2 billion by the year 2025. Although the African continent remains relatively young, the myth that older people do not exist in Africa is certainly not true. The fact is that those who survive the diseases of childhood often become grandparents.

The demographic survey in Africa shows that the population aged 60 years and above will grow from 22.9 million in 1980 to 101.9 million in the next 25 years. In Tanzania where the population is estimated to be about 30 million, there are about 1.2 million aged 60 years and above. While the number is expected to rise exponentially, their roles in the community have changed significantly. The role of being guardian and advising the younger generation has now diminished and they are now being forced to make money in order to survive on their own or to pay for care. This has been partly due to the rapid change in the socio-economic situation in Tanzania. What we learn from the elderly is that they feel that they are much less respected than in the past.

The fact that aged women outnumber out number males in Tanzania is noticed at the ratio of 1.1:1. Like in many other rural areas women work harder and enjoy fewer benefits. Many more women than men have been widowed and are now struggling alone and bringing up dependent grandchildren, while many of those who have not been widowed, have been supplanted by a younger wife. In some parts of the country elder women are being accused of being witches, which is resulting in violence.

As a person gets older, health care becomes paramount due to increased vulnerability to both infectious and non-infectious diseases. In the ageing world, health care is becoming increasingly a problem because of reasons such as cost sharing, lack of commitment by health care delivery and poor perception towards old age. Older people therefore have to overcome prejudices from others including their families that their health is important. One

woman in Zanzibar, Tanzania resorted to telling her family that she was going to a funeral, instead of a cataract operation after she had been told that operating on her would not only be costly but also dangerous to her health.

While elders took care of young people to reach wherever they are, young people and their policies are not taking much care of several aspects of ageing; especially that of health. Some non-governmental organizations in Tanzania such as HAI and SAWATA (Need to know what SAWATA stands for!) under Help Age International funded by the British government, have managed to put elders together and train them to be paralegals to be able to demand their rights. The chairperson of one branch in the Kagera region in Tanzania says: "The fate of old people must lie in their own hands. It is important for older people to know their rights. If they know, they are not afraid of anything".

While this is important and true, the majority of old people are disadvantaged poor and have no formal education and therefore do not know their rights.

Young people should realize that it is because of these elders that they are what and who they are and that they- we need to take care of them.

OLD IS GOLD !

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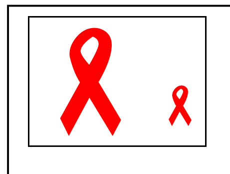
Voices of Older people: but are we listening?

Robert deGraft Agyarko

The HIV/AIDS pandemic has affected all aspects of human life and in all age categories. Findings from a WHO project "Developing and validating a methodology to examine the Impact of HIV/AIDS on older caregivers" in Zimbabwe, demonstrate the effect on older people. The study identified barriers that prevent older people from providing adequate care to their children dying from HIV/AIDS and, to their orphaned grandchildren.

In all, 810 household interviews and 32 key informants/focus group discussions were conducted through a mix method of qualitative and quantitative research application. Of those 79.3% were people above age 50 years. Two thirds of those are women. The majority of those older persons (52%) were peasant farmers, 22.9% were unemployed, 14.9% were self-employed and 6.3% were homemakers. The remaining 3.9% were farm workers, unskilled workers.

84% of the households of older persons indicated that the older person is the main care giver, either of the terminally ill or of the orphans whose parents (one or both) have died of AIDS, a burden that is borne more by the over 60 year group. 40 % of household members were children orphaned by AIDS and most of the orphans (80.6%) are the grandchildren of the older care giver.



The testimonies of older people across the country vividly capture the variety of experiences and the challenges faced as individuals and as a collective in the fight against AIDS:

"I am emotionally hurt when I look at the orphans, when the orphans cry, sometimes I cry along with them". (73 year old man, Bulawayo).

"Looking after orphans is like starting life all over again, because I have to work on the farm, clean the house, feed the children, buy school uniforms. I thought I would no longer do these things again. I am not sure if I have the energy to cope". (65 year old man, Makoni, Manicaland).

"The person with AIDS is very sick and at times loses his/her mind. When this happens it becomes impossible to provide effective care as the sick person may be abusive and violent" (59 year old woman, Mbare, Harare).

"The situation is very desperate, I am now forced to engage in selling illegal drugs to raise money to feed the orphans. I am no longer afraid of going to jail" (53 year old woman, Highfield, Harare).

"Hospital staff attitude towards us is very negative. They ignore and verbally abuse us. My child died on the stretcher while waiting for them to attend to us" (50 year old woman, Seke, Mashonaland East).

The findings further suggest that basic needs like food, blanket, clothing, high cost of medical fees, inability to pay school fees for orphans, loss of economic support and diminished livelihood opportunities are the main problems affecting older care-givers. In addition, Zimbabweans affected by AIDS were found to have limited access to and a low utilization of health services due to the high cost of health care, transport difficulties, stigmatization and a poor attitude of health-care staff. Most importantly, the health of the "older care giver" has taken a

big blow resulting in serious physical and emotional stress. There are also cases of physical violence, stigma and abuse resulting from witchcraft accusations as testified above.

As a result the Ageing and Life Course team (ALC) of WHO is collaboration with Governments departments, NGO's, academic institutions and other civil society organisations, to facilitate initiatives to improve institutional and community understanding of the plight of older people and to target policy, programme and projects initiatives that would strengthen the capacity of older people as care providers to their HIV/AIDS affected families.

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The Particular Afflictions of the Elderly Population in South Africa

Ntobeko Ntusi

South Africa is a country with a very complex and fascinating history. The four major racial groups historically had different access to resources and the consequent unequal development of these groups manifests itself in a multiplicity of ways in old age. Due to its historical legacy, the society is a very intricate mixture of both first and third world cultures that continually interact in a complicated fashion.

There are still many problems that are faced by the majority of elderly people in South Africa. These are particularly flagrant when one considers the background of abject and dire poverty against which the majority of South Africans age.

Poor education and poor literacy result in a lack of access to services and decreased knowledge about how to access them as well as decreased human and personal rights.

Limited access to healthcare is associated with poor mobility, high infirmity, an unclean and unhealthy environment, lack of a partner, a poor diet, poor finances, chronic illness and an unfriendly health system.

Changing family structure is impacting greatly on the process of ageing. Traditionally, the relationship of the elderly with their family was not one of simple dependency, but they played a series of very important roles. Now, for white South Africans, family support and socio-economic status have an inverse relationship. However, black, Asian and colored South Africans prefer to stay with family in multi-generational households. Some of the more significant demographic factors impacting on family structure include the HIV/AIDS pandemic, urbanization and modernization, as well as the decreasing prevalence and importance of the extended family.

Poverty of older people is common. While many qualify for a Welfare pension of R540 (US$ 67.50) per month, this is not enough. 90% of blacks receive it (with an average of 5-9 people dependent on a single older person's income) while 19% of whites receive the pension. Annually, 600 000 people are added to the list of recipients. In one household, there

Demographics of Population Ageing in South Africa

With a population of approximately 46 million people, the older people (aged 60 and over) are 2.3 million in number (5%) and are projected to increase to 7.3 million by 2050, when more than one in ten South Africans will be over 60. When one looks at the pattern of population ageing by race, the trends of ageing white South Africans resemble and approximate those of Western countries. With black South Africans, while there will be a significant increase in absolute numbers of older people, the percentage increase is significantly lower because the fertility rates amongst blacks are projected to remain high. The life expectancy at birth is 62 years for males and 68 years for females. Like in most other countries, the elderly are the fastest growing segment of the population in South Africa.

were 32 people dependent on an elderly woman's pension.

Abuse ranges from physical, emotional, financial, neglect, institutional abuse, as well as accusations of witchcraft.

HIV/AIDS is also significantly affecting the ageing process as well as changing the family structure. Due to HIV/AIDS, the lifespan of affected individuals is now decreased to 35-42 years. HIV/AIDS also has a significant impact on the economy. Besides the risk of being infected themselves, older people, especially the women, have to spend their time and meager resources caring for their dying children and orphaned grandchildren.

Cultural conflict is resulting in the dislocation of masses of older people by war and famine with the consequence of high numbers of traumatized elderly and older refugees.

Social exclusion and treatment at the level of government (and other institutions), the community, the family and closer relations is what we term 'ageism'. This is still common in South Africa and can only be changed through varying degrees of social integration of older people. There is also the phenomenon of rural ageing, where older people in rural communities are now living to very old age without the support of kin.

Housing and the living environment - is another critical factor for many elderly South Africans. The aged are excluded in infrastructure design and as a result have poor living environments and lack access to modern facilities.

Food and Nutrition is related to the high levels of poverty. Malnutrition of older people leads to poor health.

Income security is lacking as the majority of older South African only have the government pension as their source of income. Additional income-generation is required.

Gender Older women are vulnerable for a multiplicity of reasons. This occurs on a background of a lifetime of disadvantage.

Hence, it is clear that there is a big need to address the inequalities of the past as well as their consequences on the present conditions in order to uplift and maintain ***all*** older South Africans at a comfortable level of living and to address the afore-mentioned issues.

Quick View

Ageing in Chile

Borzutzky A., Barnett C.

At the beginning of the 21st century, Chile's elderly population numbered 1,500,000, which is more than 10% of the country's population. Therefore, our country can be defined as one that is finishing the demographical transition towards old age. Chile, as some other Latin American countries who have rapidly ageing populations, is still a developing country, in contrast to USA or European countries. This constitutes a greater challenge for our society and specially for health workers because we need to create a social and health infrastructure fit for the elderly's needs with lower funds and resources.

In the last few decades, Chile has succeeded in building a solid health system and developing effective public health campaigns. However, there is still much to accomplish about ageing policies and development of a health and social structure for the elderly. Some important actions have been undertaken towards improving the elderly's present situation, but still many of these initiatives lack financial backing from the government as well as from private institutions.

Ageing constitutes a social task for which a great fraction of Chile's society is still unprepared. Even though 80% of Chile's elders are literate, many of them grew up with a low level of education. This contributes to having a poorer intellectual background for developing activities to fill their time. Therefore it is important to develop educational and prevention campaigns, including old people and their caretakers, to ensure a healthier and more productive ageing process. At last, great efforts must be done in educating and training new generations of medical professionals and other health practitioners, on the main topics of Geriatrics and Gerontology. If we succeed in fulfilling these goals, we will be making very important advances in the care and health of our elderly.

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Quick View

Ageing in Indonesia

Nila Karmila Hartatiek

According to the Sex and Age Distribution of Population published by the United Nations in 1991, the number of persons aged 60 years or older in Indonesian in 2020 will consist of 28.8 million. In a 30-year period, the overall population aged 60-plus will become three times larger than it was in 1990. In fact, the increase in proportion of elderly people over the next decades in Indonesia is predicted to be the highest percentage among developing countries.

In reality, poverty rates have increased for the overall population. 44 million are at or below the poverty line. Nowadays, 4.1 million of 13.3 million elderly have lost confidence in social security. Without changes of policy, and if the socioeconomic context remains unchanged, the elderly are threatened by public pensions schemes.

Indonesians need to take the first step of recognizing ageing as an emerging issue. Drawing up a policy statement on welfare of an ageing population should follow. This will help administrators and others such as non-governmental organizations to look for options to meet the social service needs of the aged without jeopardizing the welfare of women and children, which is highly prioritized. In conclusion: there are priorities for actions. These are: preserving the health care system, social security, social care, and the promotion of participation and user involvement.

In Indonesia today, modernization and all aspects behind it

are seen as factors which undermine the traditional participatory role of ageing people in the community. However, persons aged over 60 continue to work for a living, thus elderly continue to contribute to the welfare of the community as a whole through their guidance work in social, economic, cultural and political activities. The challenge we face in Indonesia is not only providing care for the elderly, but also increasing participation to decrease dependency and keeping them involved in the development process of the family, community and nation.

Quick View

Older People And Humanitarian Disasters

Nandini Bura

As India was celebrating its 51st Republic day on January 26th 2001 a massive earthquake measuring 7.9 on the Richter scale occurred 20km north east of bhuj in Gujrat state at 08:46IST. The quake left approximately 20,000 dead, 166,812 injured and 600,000 homes were damaged or destroyed.

To combat this tragedy, the government, NGOs, corporations, volunteers and international agencies rushed rescue teams with heartening speed. The United Nations galvanized all its agencies into action in a massive rehabilitation effort for the victims of the earthquake. The World Bank and Asian Development Bank gave huge assistance. Offers of assistance also came from several other countries. However, all the help and goodwill could not make up for the absence of a coordinated Disaster management plan.

After the quake, while the young and the middle aged are busy moving away or reconstructing, the old are at a special disadvantage. Many old are still in a state of shock and are facing the changes in their lives with a sense of helplessness and bewilderment. Others suffer unnecessary hardship, like waiting for hours together in long queues either at a hospital or to receive relief distribution. Although a lot of relief has come for women and children, many surviving old have lost their children or spouse and are lonely, dejected and suffering from insomnia. The quake will have a massive impact on old people for a long time to come.

Nursing the needs of old people, including the emotional ones, is important. There is need for rehabilitation; for rebuilding their confidence and removing their fears and insecurities. Special emphasis should be given to accessibility to healthcare, as well as to building suitable houses for the old while respecting their love for home and family atmosphere.

Donations for the rehabilitation of the elderly must be made exclusively in a transparent manner so that it does not deter potential donors from contributing more generously as people are worried about misappropriation and irregularities in utilizing donations. If a reputed international firm would audit the aid received from all over the world, it would clear lots of doubts from all the generous compassionate people who contributed in sharing solidarity with the victims.

The noble contribution of Taiwan's Buddhist master "Titung" should be an inspiring example to society. After the earthquake in Taiwan, he dedicated himself to caring for seniors .He set up "Bo–tree

evergreen village " in Puli (without government help) by the Buddha incense academy and made its mission to care for unsupported seniors.

Towards
A healthier
Tomorrow

Healthy Ageing

Alexandre Kalache, Ingrid Keller

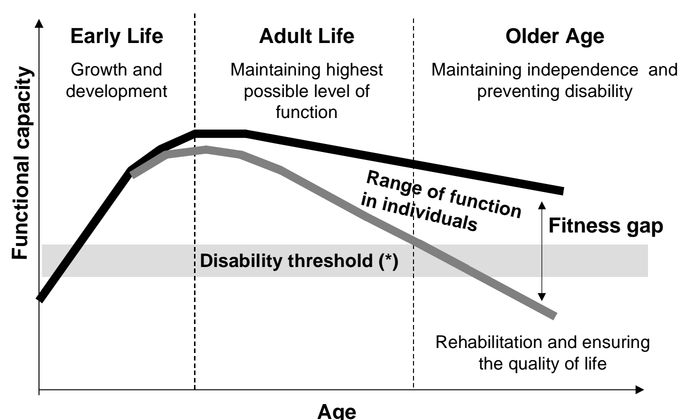
Older people are frail" is a common misconception related to ageing – as the reality is that the majority of older people remain physically fit well into old age. They continue to carry out activities of daily living and therefore to play an active part in their community. To ensure that this participation (and contribution!) to society is attained, WHO has been promoting the concept of healthy ageing across the life course. Such a concept is relevant both for the individual and, collectively, for societies and can be illustrated in the figure below.

Our capacity in relation to a number of functions (such as ventilatory capacity, muscular strength, cardio-vascular output) increases in childhood and peaks in early adulthood. This peak is eventually followed by a decline. How fast the decline is, however, is largely determined by factors related to adult life style – such as smoking, alcohol consumption and diet. The natural decline in cardiac function, for example, can be accelerated by smoking, leaving the individual with a functional capacity lower than would normally be expected for his/her age. The gradient of decline may become so steep as to result in premature disability. However, the acceleration in decline 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.

In addition to these factors others, conditioned by social class, 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 institutionalized, which in itself can lead to dependence, particularly for the small minority of older people who suffer from loss of mental function.
The slope of the decline can be influenced in any stage through individual as well as policy measures (see table below). For example smoking cessation at age 50 reduces the risk of dying within the next 15 years by 50%.

For those who become disabled, provision of rehabilitation and adaptations of the physical environment can greatly reduce the level of disability. Furthermore, specific interventions can help them to regain their functional capacity – for instance through a cataract operation or a hip replacement.

Quality of life should be a major consideration throughout the



Source: WHO/NMH/HPS, 2000

life-course, particularly for those whose functional capacity can no longer be maintained. For example changes in the living environment can vastly extend independence in later life. However, most of the gains are obtained by acting on the “care unit” – in most case the family and close friends. It is often by supporting the informal care giver (frequently an older women, in many cases in poor health herself) that the quality of life of the dependent older person can be most improved.

Finally, through appropriate environmental changes - such as adequate public transport in urban environments, the availability of lifts in apartment or office blocks, ramps, adapted kitchenware or a toilet seat with rails - the disability threshold can be lowered. Such changes can ensure a more independent life well into very old age and one of the major challenges is to ensure access to them for all older persons – including the poor and those who live in remote areas.

Action towards Active Ageing

In recent years, the World Health Organization’s Ageing and Life Course Programme has developed an "Active Ageing" conceptual framework for its activities which encapsulate the life course perspective. Active Ageing can be defined as *the process of optimizing opportunities for physical, social, and mental well-being throughout the life course, in order to*

FACTORS	INDIVIDUAL ACTION	POLICY ACTION
Diet	• Consume a diet high in fibre and low in animal fat and salt • Reduce body weight if overweight and maintain normal body weight	• Increase consumer awareness about direct links between good nutrition and health
Physical activity	• Exercise regularly from the earliest years through older ages	• Incorporate exercise into school curricula • Create workplaces which provide exercise facilities • Encourage sports for seniors
Smoking	• Smoking cessation is highly beneficial at any age • Educate children about the ill effects of smoking	• Ban tobacco advertising • Ban sale of tobacco to children • Provide health education in schools and workplaces • Inform adults and older persons that tobacco cessation is beneficial at every stage of the life course
Alcohol	• Maintain moderate drinking habits • Seek professional help if a problem is perceived	• Ban sale of alcohol to children • Target older persons with information campaigns
Social integration	• Stay involved in family and community life e.g. through a club or religious organisation • Be aware and speak out against ageism • Continue to educate ourselves, the family and the community	• Support activities that foster social cohesion • Provide access to life long learning • Promote solidarity among generations

extend healthy life expectancy, productivity and quality of life in older age. This process can be instrumental for the global challenge of ensuring that individuals grow older in good health and actively participate in society.

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Physical activity for older people

Katja Borodulin

By being physically active, older persons can enhance their health and maintain their independence and contribution to society. Evidence shows that exercise can protect older persons from disability, confinement and even premature death. Older persons represent a highly heterogeneous group, in which health status varies greatly. However, physical activity brings benefits to all older persons, whether healthy, sedentary, disabled or frail. Functional capacity declines with age. Being able to independently carry out daily activities, such as dressing up, bathing and eating means a lot to an individual and to society at large.

General practitioners should promote physical activity to older persons. Despite the beneficial role of exercise to health, rarely do people receive information from their doctor. Ideally, physical activity could even be prescribed instead of or along with medication. General practitioners can disseminate information on the local exercise facilities and potentially guide the patient to seek professional exercise counseling.

Each older person is an individual, a consideration which is often forgotten when designing exercise programmes.

Suitable forms of exercise

Due to declining functional ability, older persons need specially tailored exercise classes and services. One important issue is to educate instructors to understand the special needs and limitations related to physical activity of older persons. Each older person is an individual, a consideration which is often forgotten when designing exercise programmes.

Walking is recommended for older persons. By walking, cardiovascular health and aerobic endurance can be improved, as well as balance and flexibility. One essential factor in walking is the social well-being: older persons strengthen their social integration and form friendships. Walking suits everybody, as no special requirements, equipment or facilities are needed. People can walk practically everywhere and involve all members of their family, too. Each person can walk at their own preferred pace, rest when needed and use multiple devices, i.e. trolleys or weights.

Muscle strength declines dramatically with age. Strength can be increased and maintained through regular resistance training, which should be carried out at least once a week. Exercises should be tailored to the individual by using exercise machines. Maximal resistance training, i.e. using few repetitions at maximal load, has been found to be beneficial even to frail, bed-ridden patients. The ideal environment for strength training would be a fitness center designed especially for older people and with a full-time instructor.

Not all physical activities need to be planned and organized in a fitness center. Basic daily activities, such as cleaning the house, gardening

and walking to a shopping mall, are all excellent exercise. The recommendation for physical activity, regardless of age, is of 30 minutes physical activity on most days of the week. All household work and other such activities count towards the required daily 30 minutes. Taking the stairs instead of an elevator is a good example of making a more active choice.

Safety

Safety and comfort are essential issues in exercise for old people. Instructors need to carefully consider all safety issues in the planning of exercise classes. Also, doctors are to guide disabled patients on how to overcome barriers related to participation in physical activity. Often strenuous activities are not recommended and a correct performance of exercises is emphasized. Many older people have health problems like cardiovascular and blood circulation complications, diabetes, osteoporosis, joint complications, and poor vision and audition. One special group is the people recovering from surgeries or injuries, who need rehabilitation and encouragement to continue to carry out physical activity. Falling causes frustrations and fears that can be overcome by proper training and support.

All exercise, indoor or outdoor activities, has to be safe. What is more, safety issues are often related to traffic and transportation, too. Traffic (e.g. motor vehicles and bicycles) cause accidents that often could be prevented with proper planning of pedestrian ways and crossroads. When exercising outdoors, the route can be pre-arranged to maximize safety.

NGO in perspective

The role of voluntary organisations - families helping themselves

Nori Graham

Most older people remain bright and alert as they get older. All the same, a minority, as great as one in five over the age of 80, suffer with a memory loss and become increasingly confused. They are suffering from one of a number of dementias of which the most common is Alzheimer's disease.

This is a chronic and progressive disease which is usually irreversible and lasts for many years. The affected person deteriorates intellectually and becomes incapable of carrying out the most basic tasks of everyday life. People eventually require 24-hour care and ultimately die of natural causes.

The burden of looking after the person with dementia lies with the family. All over the world, because this is a worldwide problem, families struggle to look after their elderly relatives with dementia.

Alzheimer Associations are voluntary organisations which play a significant part in supporting these families. They do this in a number of ways. They organize support groups which bring together groups of carers of people with dementia who meet to talk, listen to each other and share problems. They provide core services of information, influencing policy decisions, development work, setting of standards, raising public awareness, training and fund-raising.

National Associations now exist in over 60 countries around the world and this number is increasing all the time. An international organization known as Alzheimer's Disease International (ADI), officially affiliated to the WHO, provides a global network to support these national associations. In many countries the idea of a voluntary organization is unfamiliar and poorly developed. People trying to set up national Associations in these countries need a great deal of help in organization and administration as well as in the provision of relevant material. ADI plays an important role here. ADI also runs an annual international conference in a different part of the world each year. These conferences are unique in bringing together carers, staff and volunteers of Alzheimer associations, scientists, professionals in the medical and para-medical fields, politicians and other interested people to hear the latest research and share experiences.

ADI is based in London with a staff of 5 people. ADI can only help in a limited way but it is impressive how much impact even a small organization can make. The underlying aim of ADI is to raise world awareness about this tragic disease and to impress on governments the urgent need to provide cost –effective resources for the care of people with dementia and their families, to improve the quality of training of care workers and, at the same time, to encourage research.

In their medical training students get very little information about voluntary organisations. Yet in practice, especially family practice, doctors discover that putting patients in contact with these organisations can be the single most important way they can help. Many doctors no longer ask themselves “Shall I refer this family to a voluntary organization?” but “ Which would be the most appropriate organization to refer this family to ?” Any experience that students can obtain working with a voluntary organisation during their medical studies will be found to be really worthwhile.

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Towards A New Global Plan of Action on Ageing

Irene Hoskins

While the process of rapid population ageing started half a century ago, 1982 was a banner year for advancing the issues of ageing. It was the year of the First World Assembly on Ageing in Vienna, an historic gathering of government policy makers and representatives of civil society who focused for the first time at the global level on issues relating to individual and global population ageing. They adopted the Vienna International Plan of Action on Ageing and since then many initiatives and policies at the national level have been inspired by the Plan.

But even though the 1982 Plan of Action was a remarkable achievement, the world has changed significantly since then. The 1982 recommendations suited the interests of the developed countries but not the new realities of the 21st century. Twenty years after the adoption of the Plan of Action, many new questions have arisen: Can countries, even those in the developed world, afford to grow old or are the growing numbers of older people going to bankrupt health and income security systems? How can the developing world cope with their rapidly growing numbers of older people when there are so many competing demands for scarce resources? How can we ensure that in countries in transition, older people are not further marginalized and that the downward trend in life expectancy, particularly among men, can be halted? What are the effects of a global economy on the health and well-being of older citizens, particularly in developing countries? How can we ensure that older people, who may have less access to training and for whom it may be more difficult to compete in the labor market, do not fall victim to a new generational divide? And finally, of most relevance to the next generation of health care professionals, how can we ensure that adequately trained human resources are available to provide appropriate care to growing numbers of older people?

On the positive side, there are now new and encouraging trends which must be strengthened. First among these is the recent decline in disability rates among older people in the developed world. How can we ensure that these trends continue and accelerate? How can we further encourage health-seeking behaviors and how can we eliminate some of the

risk factors which lead to disability and chronic disease at older ages?

To address these and other issues, the UN has decided to convene a Second World Assembly on Ageing from 8-12 April, 2002 in Madrid, Spain. The objective of this global UN conference is to revise the Plan of Action on Ageing and to design a long-term strategy on ageing. A number of international instruments, decisions and events in the field of ageing underpin the development of a revised Plan of Action on Ageing. Two stand out among them. First, the 18 United Nations Principles for Older Persons, promulgated in 1991, underpin policies and provide guidance in the areas of independence, participation, care, self-fulfillment and dignity. Second, the International Year of Older Persons 1999 with its theme "Towards a society for all ages", provided inspirations on how to mainstream ageing across different sectors and how to gain a clearer understanding of the importance of the life course perspective.

For the revised Plan of Action, three priority issues for policies have already been identified: Sustaining development in an ageing world; advancing heath and well-being into old age; and ensuring enabling and supportive environments for older people, including care both in and outside of institutions.

To understand the policy development leading to the revised Plan of Action on Ageing, one has to understand first of all that the World Assembly on Ageing is a governmental process. Governments will have to build a consensus around policy recommendations that they regard to be most effective when it comes to the three priority themes of the Assembly. In doing so, they will receive input from international organisations, such as the WHO and individual experts, but also from organisations of civil society, such as IFMSA. After receiving input and reaching a consensus, governments will subsequently be able to use the revised Plan of Action as a basis for elaborating their own national blueprints for ageing policies.

By representing future health care practitioners across the world, IFMSA has an important role to play in this process, particularly now that it has achieved consultative status with the Economic and Social Council. As an organization in consultative status, IFMSA can make its voice heard at the United Nations in the formulation of health care policies for ageing populations. Even more appropriately, it can speak with authority about the need for better training of primary health care workers in gerontology and geriatrics. There can be no better image of intergenerational solidarity than the concern expressed by today's young future health care practitioners for articulating equitable, fair, and sensitive principles for caring for the world's growing population of older people.

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The challenge for health systems – preparation of future medical professionals

Ingrid Keller, Ageing and Life Course Programme, WHO, Geneva

Thiago Monaco, *former* director of medical education, IFMSA

With increasing proportions of older persons in the population, the demands to health care systems in developing countries will gradually change. Health care systems will be expected to accommodate care of older adults alongside with, for example, child and maternal care. Also more advanced health care systems in the developed world will have to adapt to the shifting needs due to population ageing. This does not imply that ageing is in itself a disease and old age should not be seen as equal to frailty, sickness and a high demand of health care services. However, for this commonly held belief to be reversed it is crucial to train health professionals and to prepare health care systems for such fast ageing world.

Taking population ageing into account, the WHO Ageing and Life Course Programme has initiated a study to identify where and how geriatric medicine is taught globally in undergraduate medical education. The importance of education is clear: the vast majority of tomorrow's medical doctors will increasingly deal with older patients. Therefore, the basic principles of older age care should no longer be the exclusive concern of geriatric physicians.

A study entitled "Teaching Geriatrics in Medical Education" (TeGeME) was devised by the WHO Ageing and Life Course Programme (ALC) and has been carried out since December 1999 in close collaboration between ALC and the International Federation of Medical Students' Associations (IFMSA), including its regional associations.

Aim And Methodology

The TeGeME study aims to gain insight of how/if ageing is incorporated into the medical curriculum world-wide. The study has been carried out through an e-mail survey.

Two questionnaires have been developed. One including questions about the inclusion of geriatrics into the national curriculum/objectives (if existent) and the second asking about the inclusion of geriatrics into the curriculum of each medical school. Both questionnaires were available in English, French, Spanish and Portuguese.

Most IFMSA Member countries named a National Focal Point (NFP) for the TeGeME study. The NFP received the questionnaires from WHO, answered the one on the national level and passed the second on to the individual medical schools in the participating countries. The coded answered questionnaires were then sent back to WHO.

Focus: A Life Course Perspective In Geriatric Teaching

Special attention was paid to identify if geriatric medicine is taught from a life course perspective. Teaching geriatric medicine from a "life course perspective" is defined as regarding ageing over the whole life span, from birth to death as opposed to

A life-course perspective to health

A life course approach emphasises a temporal and social perspective, looking back across an individual's or a cohort's life experiences or across generations for clues to current patterns of health and disease. It also recognises that both past and present experiences are shaped by the wider social, economic and cultural context. In epidemiology, a life course approach is being used to study the physical and social factors during gestation, childhood, adolescence, young adulthood and midlife that raise - or decrease - chronic disease risk and health outcomes in later life; it aims to identify the underlying biological, behavioural and psychosocial processes that operate across the life span .

A life course approach incorporates, but is broader than, David Barker's idea of biological programming (the fetal origins hypothesis which links conditions in the intrauterine environment to the later development of adult chronic disease). Growing evidence suggests that there are critical periods of growth and development, not just in utero and early infancy but also during childhood and adolescence, when environmental exposures do more damage to health and long term health potential than they would at other times. There is also evidence of sensitive developmental stages in childhood and adolescence when social and cognitive skills, habits, coping strategies, attitudes and values are more easily acquired than at later ages. These abilities and skills strongly influence life course trajectories with implications for health in later life. Additionally, a life course approach considers the long term health consequences of biological and social experiences in early and mid adulthood, and whether these factors simply add additional risk or act interactively with early life biological and social factors to attenuate or exacerbate long term risks to health .

It is not yet known how powerful early life factors are relative to genetic and later life factors on adult health and ageing; explanations may be cohort and disease specific, factors may be additive in their cumulative effects or may interact synergistically and caution is needed in extrapolating from the past to the present and from one place to another. However, the questions being raised are fundamental. A life course approach provides an essentially optimistic approach to health and raises policy issues. It helps identify chains of risk that can be broken and times of intervention that may be particularly effective. Special emphasis is given to key life transitions, e.g. late adolescence to early adulthood, in order to identify not only safety nets but springboards which can alter life course trajectories with implications for subsequent health.

IF YOU WANT TO KNOW MORE ABOUT THE LIFE COURSE PERSPECTIVE, PLEASE READ THE HEALTHY AGEING ARTICLE OR DOWNLOAD THE WHO / INTERNATIONAL LONGEVITY CENTRE (ILC-UK) BROCHURE ON "THE IMPLICATIONS FOR TRAINING OF EMBRACING A LIFE COURSE APPROACH TO HEALTH": HTTP://WWW.WHO.INT/HPR/ALC/LIFECOURSETRAINING.PDF

as focus on "older persons" or "the elderly" only. That means in the medical curriculum that "ageing" and "older persons" are studied under many different disciplines and points

of view instead of an exclusive geriatric perspective.

A life course approach also emphasises a temporal and social perspective, looking back across an individual's or a cohort's life experiences or across generations for clues to current patterns of health and disease, whilst recognising that both past and present experiences are shaped by the wider social, economic and cultural context.

For more information about the life-course perspective, please see article "Healthy Ageing" and the box on the "Life – Course Perspective".

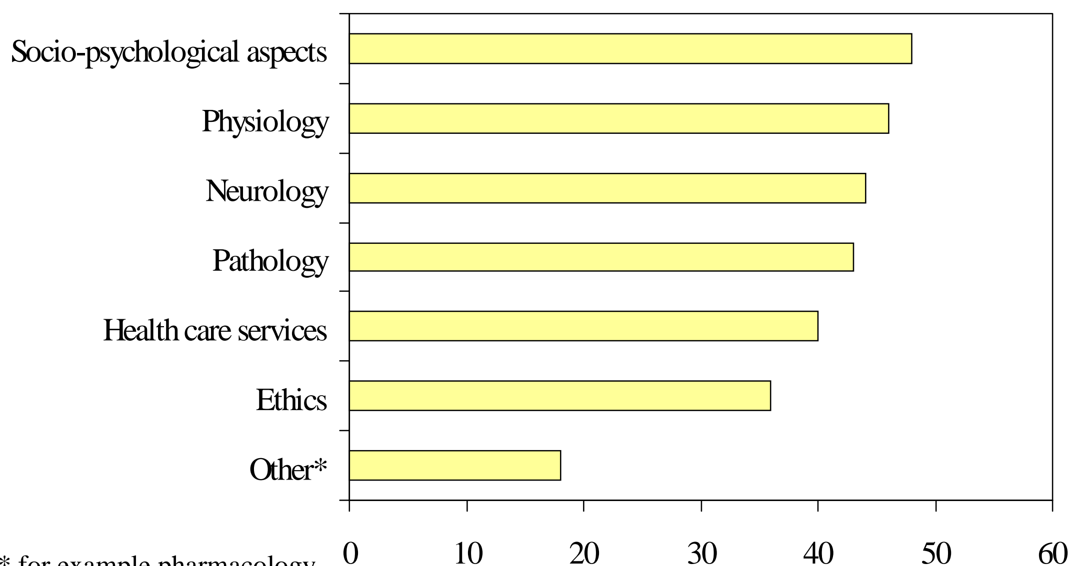
Selected Results Of The Tegeme Survey

282 questionnaires were received by e-mail or regular mail from medical schools in 71 countries. Of these, 5 questionnaires could not be coded since they were incomplete. Out of the 277 schools included in the data analysis, 52 schools were identified as teaching geriatric medicine (as a mandatory or as an optional course) from a life course perspective. These schools identified are located in 26 different countries, mainly in Europe, but also in Panama, Brazil, Malaysia, Indonesia and Zimbabwe. Of these 52 schools, 22 have a geriatric faculty and 32 have a separate geriatric ward, in 48 schools geriatric medicine is mandatory and 35 schools offer some kind of post-graduate studies in geriatric medicine.

Characteristics Of The Geriatric Training

In nearly 50% of the schools teaching geriatric medicine from a life course perspective, the geriatric teaching comprises 20 – 40 hours. 6 schools offer a geriatric medicine course of 120 hours or more. 46 schools offer lectures, 38 schools offer bed-side teaching, 29 offer problem-based learning and 31 offer field visits. Out of the latter, 20 schools offer visits to nursing or older people's homes and 17 schools offer visits to community centres. In less than 50% of the schools

Content of the Geriatric Training



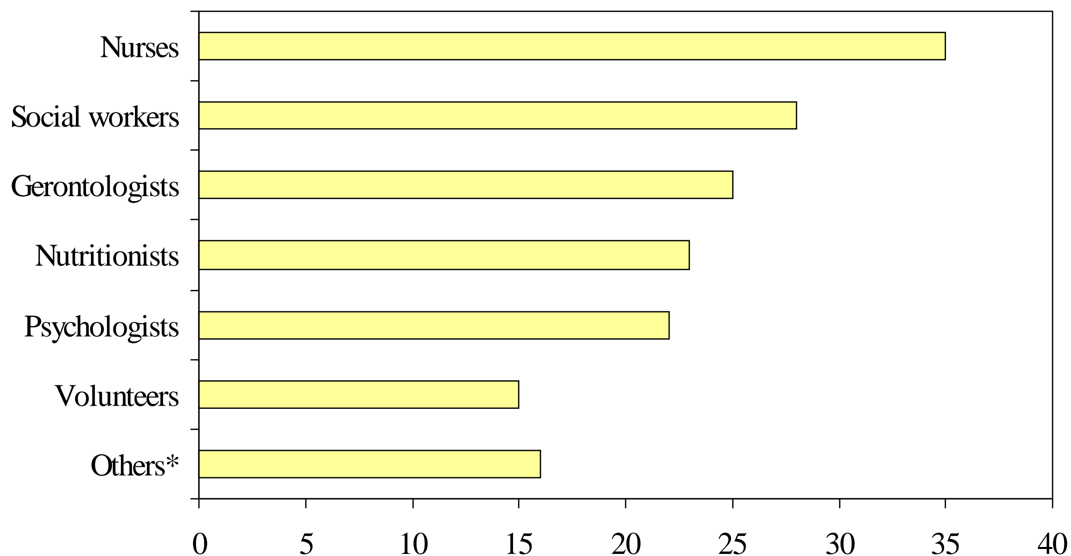
* for example pharmacology, nutrition, rehabilitation, cognitive and functional assessment

geriatric teaching includes work on the ward.

The content of the teaching is shown in Figure 3. Nearly all schools include socio-psychological aspects into the geriatric teaching, only somewhat more than half of the schools include ethical aspects.

Many schools offer interaction with other health care personnel and/or volunteers as shown in Figure 4. Interactions occur most frequently with nurses and social workers and gerontologists. In most cases the interaction with other health personnel is carried out through a multi-disciplinary teamwork.

With reference to the life course perspective, it was indicated that only a few schools teach all subjects from a life course perspective, however, for example in New Zealand a pre-clinical class is offered named “Reproduction, development and ageing” and the Universit Sains in Malaysia has some units on the “Woman’s life cycle”. Other universities take disease prevention into account e.g. by focusing on the effects of childhood diseases for health in adult hood as the Akdeniz University in Turkey or like at the University of Hong Kong in a class named “Paediatrics and Adult Medicine”.



* for example: speech-, occupational- and physiotherapists

Limitation Of The Data

Data collection was carried out through the IFMSA and other student networks. All data were collected by students with the support of faculty or publications from their university. The data were collected on a voluntary basis.

The total number of countries that participated in the study was 71 and altogether they counted with 1212 medical schools. However, we received results from only 282 of them. This was due to various circumstances such as unwillingness of the university to support the students in the data collection or low interest on both sides.

The selection of these 282 schools was not representative. Often the schools from where a filled questionnaire was received, is a school where the students are active in local or national medical student associations and activities.

In spite of this major shortfall, we believe that the results provide a snapshot on the status of the teaching of geriatric medicine world-wide. The data received have been verified through internet research in the web-sites of the medical schools.

Conclusion

Despite the limitation of the data, they shed some light on geriatric education world-wide. Even though about 64% of the schools included in the survey offer geriatric medicine to some extent (either through a course taught by staff from a geriatric faculty or by staff from other faculties; as elective or mandatory or as postgraduate studies), not enough information could be collected about the content and the quality of the teaching. Only for the 52 schools which teaching geriatric medicine from a life-course perspective a comparative analysis of the curricula was carried out and will be discussed elsewhere.

WHO promotes the inclusion of a life course perspective into the teaching of health professionals. A brochure to stimulate further discussion has been published in 2000 (WHO/ILC, 2000). The role of this brochure is to stimulate wider consideration of issues and ideas to bring the life course perspective into the curricula of health professionals.

A further conclusion from the WHO perspective is that the awareness of the importance of the training in geriatric medicine for the future cohorts of medical doctors is not yet satisfactory. Further activities are needed to increase the number of schools where geriatric medicine is taught by well-trained staff and from a life course perspective as a mandatory subject for undergraduate students.

WHO strongly argues that all future medical doctors need to be well trained in the care of older persons, since most of them will see older people in daily practice. Today's students need to acquire knowledge about how to treat older persons from an interdisciplinary point of view. This should apply to all levels of care and to all countries. First steps have been taken through this study and the formation of a strong partnership with IFMSA.

IFMSA has also gained knowledge on the subject. Having disregarded the challenges posed by population ageing in the past, it has turned to be fully committed to them now. This is an indirect achievement of the TeGeME survey that cannot be underestimated.

During all the process of survey its organizers faced the opportunity to educate hundreds of medical students all over the world by clearing doubts and talking about the importance of a more comprehensive medical education in what regards the needs of the Societies of the future. IFMSA officials, i.e., medical students elected to run the Federation, have also become very committed to change medical education and practice as regards ageing. These results started to appear even during the process of conducting the survey.

The 2000 annual pre-General Assembly Conference of IFMSA was devoted to the topic Ageing and Health and counted approximately 80 medical students from all over the world. One

of the main outcomes of the conference was the creation of ISNAH, the *International Student Network on Ageing and Health*. ISNAH is, as the name says, a network of students promoting follow-up activities to the past conference and seeking the involvement of other students, professionals and educators who may contribute to the field of Ageing and Health.

IFMSA has long advocated the constant reformulation of medical education as a process of keeping it up-to-date with social needs. Medicine is a social profession and should answer these needs as its first priority. Let us repeat: the world's population is ageing fast. This means that more of those who constructed the present world will be alive in the future and have the right to enjoy life to its full extent. This survey has consolidated IFMSA's belief that the doctors of the future must be prepared to serve them in their needs.

References:

WHO / International Longevity Centre (ILC-UK), The implications for training of embracing a life course approach to health, WHO/NMH/HPS/00.2, 2000 available from activeageing@who.int or to be downloaded under: http://www.who.int/hpr/alc/lifecoursetraining.pdf

Investigating the attitudes of Medical Students towards Older Persons

Jacco Veldhuyzen

Population ageing is a world-wide phenomenon. Due to increasing life expectancy and decreasing total fertility rates – people have fewer children and live much longer - the population ages. As a consequence, health care systems need to prepare their primary health care personnel as well as all other levels of health care staff for this social change. The various aspects of ageing need to be more fully incorporated into the training curriculum of all health professions. Disciplines like geriatrics and gerontology need to be further developed and regularly included into medical and health education.

The Teaching Geriatrics in Medical Education study (TeGeME – refer to *The challenge for health systems – preparation of future medical professionals*) evaluated the current status of geriatrics teaching around the world. To investigate the attitude of medical students towards older people, a follow up study was started by IFMSA and WHO under the name TeGeME 2. The study aims to assess medical students' attitudes on ageing / old age in general in selected countries.

The project team has selected five Sub-Saharan African countries to participate in this study, namely: Ghana, Kenya, Nigeria, South Africa and Tanzania. The selection has been based on the comparatively high level of ageing in these countries, the knowledge of English language among the medical students and the co-operation in the TeGeME 1 project.

In each country a national co-coordinator takes care of the data collection. The national cocoordinator administers, in collaboration with faculty concerned, the questionnaire to a random sample of medical students in clinical years at one medical school in his/her country. Depending on the number of clinical students at the medical school, the sample size will vary between 100 and 500.

A questionnaire to assess the attitudes of medical students toward older people has been developed, based on an extensive literature review . The questionnaire to be used is based on the semantic differential used by Rosencranz and colleagues. This questionnaire is a known method, which makes it possible to compare our study with the findings from other studies for example from the USA or the UK.

The questionnaire asks the students to give their opinion about older persons by evaluating statements (older persons are rich/poor, weak/strong, friendly/unfriendly). Furthermore the students are asked to provide some basic statistical data such as age, gender, year of study and whether they live(d) with older persons in the same house during childhood and/or adolescence. This makes it possible to determine some influences in the attitudes of medical students towards older persons.

Currently, data has been collected in most of the countries. This data will be analysed by IFMSA and WHO. In addition focus group discussions with selected groups of students in the selected countries might be carried out to create an even better

insight. It is planned to publish the results in Winter 2001.

References

Rosencranz H., Mc Nevin T., A factor analysis of Attitudes Toward the Aged, Gerontologist 9 (1): 55-59, 1969

NGO in perspective

Activities of the University of the Third Age (U3A) in Geneva

Raymonde Wagner

In front of one of the central buildings of the University - it is ten minutes past 4 o'clock in the afternoon; a big group of people, their hair white or grey, cross the street, ready for a cup of tea or a glass of beer, or else heading for home . . .

You may have guessed… They are U3A members leaving after one of the 50 conferences organised every year. This is the time of the week that the largest group of members meets. Like the top of an iceberg, these 350 to 600 people may be considered the visible part of the total of our members. The U3A was founded in 1975 with the following goals:

1. Maintaining and renewing the members' knowledge;
2. Encouraging human relationships
3. Developing links between elderly people and the University of Geneva,
4. Keeping the elderly active and present within the society

The U3As of Switzerland are open to people over 60, they are designed for pensioners and retired people, and they are run by them: by the end of the year 2000, the Geneva U3A had nearly 140 volunteers and 2,400 members, figures which prove that U3A is made **for and by its members**.

There are three types of activities, proposed and organised either by the Programme Committee or by anyone

or any group with a project:

Learning :

- Lectures (arts, economics and law, history and geography, literature, medicine, science, religion and philosophy),
- Guided visits of places of interest,
- Workshops: arts and history, memory training, discussion groups in foreign languages, recording memoirs, computer and internet classes . . .

Providing services

- To the U3A: programme and administration,
- To the society: research in social sciences, children – and – grandparents groups (teaching about nature, telling stories of days gone past), International networking, preparing the International Day of Older Persons, etc.,
- To the students of Geneva University: serving as "guinea-pigs" for certain research work.

Giving assistance:

- To former members (paying visits, organising day tours and Sunday Club activities for the lonely, etc.)

This short list gives you an idea of what is offered today. The type of activity is regular, though the content and number of activities may change

whenever called on by the members' wishes and expectations.
Working in a U3A is a very interesting experience, both joyful and challenging: welcoming new members but also taking leave of others whose friendship over the years had become precious; finding the right work for the right person; proposing new activities but accepting too to let go of programmes which no longer meet a need . . .

The International Association of Third Age Universities (AIUTA) is prepared to help setting up new U3A's: "He who has ears to hear . . . "

The next AIUTA Congress will be held in Geneva, from 2 to 5 October 2002: welcome!

Raymonde Wagner
U3A of Geneva
www.unige.ch/uta
AIUTA