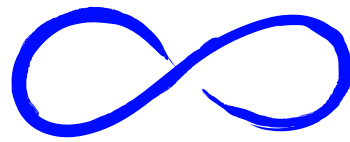




GLOBAL
CAMPAIGN
TO COMBAT
AGEISM

GLOBAL REPORT ON
AGEISM





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Global report on ageism

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MESSAGE BY THE UNITED NATIONS SECRETARY-GENERAL

Ageism is widespread in institutions, laws and policies across the world. It damages individual health and dignity as well as economies and societies writ large. It denies people their human rights and their ability to reach their full potential.

Despite its pervasive nature and harmful impacts, ageism still lacks a solid knowledge base of dedicated research, information, disaggregated data and systematic trends analysis. This new *Global report on ageism* fills this gap and underscores the need to adopt a forward-thinking, rights-based approach that addresses the underlying societal, legislative and policy structures that support long-standing assumptions about 'age' across the life course.

The COVID-19 pandemic has had a devastating impact on older persons. Intergenerational solidarity must be a touchstone in our efforts to recover. Older persons have also made important contributions to the crisis response, as health workers and caregivers. Women, for instance, are over-represented among both older persons and among the paid and unpaid care workers who look after them.

My policy brief on older persons and COVID-19, released in May 2020, highlights the need to recognize the multiple roles that older persons have in society – as caregivers, volunteers and community leaders – and underscores the importance of listening to the voices of people of all ages, valuing their contributions and ensuring their meaningful participation in decision-making.

Addressing ageism is critical for creating a more equal world in which the dignity and rights of every human being are respected and protected. This is at the heart of the 2030 Agenda for Sustainable Development, the world's agreed blueprint for building a future of peace and prosperity for all on a healthy planet. In that spirit, I commend this report to a wide global audience and look forward to working with all partners to uphold the promise to leave no one behind.

PREFACE

COVID-19 has affected people of all ages, in different ways. But beyond the impacts of the virus itself, some of the narratives about different age groups have exposed a deep and older malady: ageism. Older people have been often seen as uniformly frail and vulnerable, while younger people have been portrayed as invincible, or as reckless and irresponsible. Stereotyping (how we think), prejudice (how we feel) and discrimination (how we act) based on age, are not new; COVID-19 has amplified these harmful attitudes.

This global report on ageism could not be timelier. Its main message is that we can and must prevent ageism and that even small shifts in how we think, feel and act towards age and ageing will reap benefits for individuals and societies.

This report shows that ageism is prevalent, ubiquitous and insidious because it goes largely unrecognised and unchallenged. Ageism has serious and far-reaching consequences for people's health, well-being and human rights and costs society billions of dollars. Among older people, ageism is associated with poorer physical and mental health, increased social isolation and loneliness, greater financial insecurity and decreased quality of life and premature death. Ageism, in younger people has been less well explored in the literature but reported by younger people in a range of areas including employment, health and housing. Across the life course, ageism interacts with ableism, sexism and racism compounding disadvantage.

To achieve the long-lasting, vastly better development prospects that lie at the heart of the Sustainable Development Goals, we must change the narrative around age and ageing. We must raise visibility of and pay closer attention to ageist attitudes and behaviors, adopt strategies to counter them, and create comprehensive policy responses that support every stage of life.

In 2016, the World Health Assembly called on the World Health Organization to lead a global campaign to combat ageism in collaboration with partners. The Global Report on Ageism, developed by WHO in collaboration with the Office of the High Commissioner for Human Rights, the United Nations Department of Economic and Social Affairs and the United Nations Population Fund, informs the campaign by providing the evidence on what works to prevent and respond to ageism.

We all have a role to play in preventing and responding to ageism. The report suggests steps for all stakeholders – including governments, civil society organizations, academic and research institutions and business – to enforce new and existing policies and legislation, provide education and foster intergenerational contact for the benefits of people of all ages.

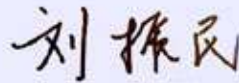
As countries seek to recover from the pandemic, people of all ages will continue to face different forms of ageism. Younger workers may be even less likely to get jobs. Older workers may become a target for workforce reduction. Triage in health care based solely on age will limit older people's right to health. We will have to tackle ageism in and after this crisis if we are to secure the health, wellbeing and dignity of people everywhere. As countries

build back better from the pandemic and to accelerate progress towards the Sustainable Development Goals, all must adopt measures that combat ageism. Our driving vision is a world for all ages, one in which age-based stereotypes, prejudice and discrimination do not limit our opportunities, health, wellbeing and dignity. We invite you to use the evidence in this report to help this vision become a reality.



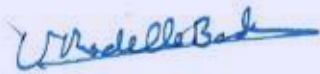
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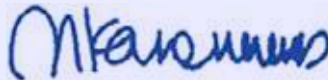
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The lead authors on the report were Vânia de la Fuente-Núñez (Chapters 1, 2, 4, 5, 6, 10) and Christopher Mikton (Chapters 2, 3, 5, 7, 8, 9, 10). The report benefited from the rich inputs of many experts and academics. It was also informed by a series of systematic and scoping reviews and qualitative research conducted in collaboration with WHO. The names of the experts and authors are listed under Contributors.

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- *Ageism, healthy life expectancy and population ageing: how are they related?* Alana Officer, Jotheeswaran Amuthavalli Thiyagarajan, Mira Leonie Schneiders, Paul Nash and Vânia de la Fuente-Núñez.

- *Campaigning to tackle ageism? Move with the evidence tide* – Cassandra Phoenix and Vânia de la Fuente-Núñez.
- *Determinants of ageism against older adults: a systematic review* – Sibila Marques, João Mariano, Joana Mendonça, Wouter De Tavernier, Moritz Hess, Laura Naegele, Filomena Peixeiro and Daniel Martins.
- *Global reach of ageism on older persons' health: a systematic review* – E-Shien Chang, Sneha Kannoth, Samantha Levy, Shi-Yi Wang, John E. Lee and Becca R. Levy.
- *Interventions to reduce ageism against older adults: a systematic review and meta-analysis* – David Burnes, Christine Sheppard, Charles R. Henderson, Monica Wassel, Richenda Cope, Chantal Barber and Karl Pillemer.
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CONFLICTS OF INTEREST

None of the experts involved in the development of this report declared any conflicts of interest.

ABBREVIATIONS

COVID-19	Novel coronavirus 2019 (also known as SARS-CoV-2)
GRADE	Grading of Recommendations Assessment, Development and Evaluation
MIPAA	Madrid International Plan of Action on Ageing
PEACE	Positive Education about Ageing and Contact Experiences
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
STDs	Sexually transmitted diseases
UN	United Nations
WHO	World Health Organization

EXECUTIVE SUMMARY

Age is one of the first things we notice about other people. Ageism arises when age is used to categorize and divide people in ways that lead to harm, disadvantage and injustice and erode solidarity across generations. Ageism takes on different forms across the life course. A teenager might, for instance, be ridiculed for starting a political movement; both older and younger people might be denied a job because of their age; or an older person might be accused of witchcraft and driven out of their home and village.

Ageism damages our health and well-being and is a major barrier to enacting effective policies and taking action on healthy ageing, as recognized by World Health Organization (WHO) Member States in the *Global strategy and action plan on ageing and health* and through the Decade of Healthy Ageing: 2021–2030. In response, WHO was asked to start, with partners, a global campaign to combat ageism.

The *Global report on ageism* was developed for the campaign by WHO, Office of the High Commissioner for Human Rights, the United Nations (UN) Department of Economic and Social Affairs and the United Nations Population Fund. It is directed at policy-makers, practitioners, researchers, development agencies and members of the private sector and civil society. This report, after defining the nature of ageism, summarizes the best evidence about the scale, the impacts and the determinants of ageism and the most effective strategies to reduce it. It concludes with three recommendations for action, informed by the evidence, to create a world for all ages.

THE NATURE OF AGEISM

Ageism refers to the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) directed towards people on the basis of their age. It can be institutional, interpersonal or self-directed. Institutional ageism refers to the laws, rules, social norms, policies and practices of institutions that unfairly restrict opportunities and systematically disadvantage individuals because of their age. Interpersonal ageism arises in interactions between two or more individuals, while self-directed ageism occurs when ageism is internalized and turned against oneself.

Ageism starts in childhood and is reinforced over time. From an early age, children pick up cues from those around them about their culture's stereotypes and prejudices, which are soon internalized. People then use these stereotypes to make inferences and to guide their feelings and behaviour towards people of different ages and towards themselves.

Ageism often intersects and interacts with other forms of stereotypes, prejudice and discrimination, including ableism, sexism and racism. Multiple intersecting forms of bias compound disadvantage and make the effects of ageism on individuals' health and well-being even worse.

THE SCALE OF AGEISM

Ageism pervades many institutions and sectors of society, including those providing health and social care, the workplace, the media and the legal system. Health-care rationing on the basis of age is widespread, and older adults tend to be excluded from research and data collection efforts. Older and younger adults are often disadvantaged in the workplace. People get angrier about crimes committed by younger offenders, rather than older, and see these crimes as more serious transgressions. Ageism also shapes how statistics and data, on which policies are based, are collected.

Globally, one in two people are ageist against older people. In Europe, the only region for which we have data, one in three report having been a target of ageism, and younger people report more perceived age discrimination than other age groups.

THE IMPACT OF AGEISM

Ageism has serious and far-reaching consequences for people's health, well-being and human rights. For older people, ageism is associated with a shorter lifespan, poorer physical and mental health, slower recovery from disability and cognitive decline. Ageism reduces older people's quality of life, increases their social isolation and loneliness (both of which are associated with serious health problems), restricts their ability to express their sexuality and may increase the risk of violence and abuse against older people. Ageism can also reduce younger people's commitment to the organization they work for.

For individuals, ageism contributes to poverty and financial insecurity in older age, and one recent estimate shows that ageism costs society billions of dollars.

THE DETERMINANTS OF AGEISM

Factors that increase the risk of perpetrating ageism against older people are being younger, male, anxious about death and less educated. Factors that reduce the risk of perpetrating ageism against both younger and older people are having certain personality traits and more intergenerational contact.

Factors that increase the risk of being a target of ageism are being older, being care-dependent, having a lower healthy life expectancy in the country and working in certain professions or occupational sectors, such as high-tech or the hospitality sector. A risk factor for being a target of ageism against younger people is being female.

THREE STRATEGIES TO REDUCE AGEISM

Three strategies to reduce ageism have been shown to work: policy and law, educational activities and intergenerational contact interventions.

- **Strategy 1: Policy and law** – Policies and laws can be used to reduce ageism towards any age group. They can include, for example, policies and legislation that address age discrimination and inequality and human rights laws. Strengthening policies and laws against ageism can be achieved by adopting new instruments at the local, national or international level and by modifying existing instruments that permit age discrimination. This strategy requires enforcement mechanisms and monitoring bodies at the national and international levels to ensure effective implementation of the policies and laws addressing discrimination, inequality and human rights.
- **Strategy 2: Educational interventions** – Educational interventions to reduce ageism should be included across all levels and types of education, from primary school to university, and in formal and non-formal educational contexts. Educational activities help enhance empathy, dispel misconceptions about different age groups and reduce prejudice and discrimination by providing accurate information and counter-stereotypical examples.
- **Strategy 3: Intergenerational contact interventions** – Investments should also be made in intergenerational contact interventions, which aim to foster interaction between people of different generations. Such contact can reduce intergroup prejudice and stereotypes. Intergenerational contact interventions are among the most effective interventions to reduce ageism against older people, and they also show promise for reducing ageism against younger people.

THREE RECOMMENDATIONS FOR ACTION

These recommendations aim to help stakeholders reduce ageism. Implementing them requires political commitment, the engagement of different sectors and actors and context-specific adaptations. When possible, they should be implemented together to maximize their impact on ageism.

- **Recommendation 1: Invest in evidence-based strategies to prevent and tackle ageism.** Priority should be given to the three strategies supported by the best evidence: enacting policies and laws, and implementing educational and intergenerational contact interventions. To make a difference at the level of populations, these strategies must be scaled up. Where such interventions have not been implemented before, they should be adapted and tested, and then scaled up once they have been shown to work in the new context.
- **Recommendation 2: Improve data and research to gain a better understanding of ageism and how to reduce it.** Improving our understanding of all aspects of ageism – its scale, impacts and determinants – is a prerequisite for reducing ageism against both younger and older people. Data should be collected across countries, particularly in low- and middle- income countries, using valid and reliable measurement scales of ageism. But the top-most priority should be developing strategies to reduce ageism. The evidence base for the effectiveness of strategies

is developing, but it still falls short of what is needed. Existing strategies should be optimized, their cost and cost-effectiveness estimated and then they should be scaled up. Promising strategies, such as campaigns to reduce ageism, need to be further developed and evaluated.

- **Recommendation 3: Build a movement to change the narrative around age and ageing.** We all have a role to play in challenging and eliminating ageism. Governments, civil society organizations, UN agencies, development organizations, academic and research institutions, businesses and people of all ages can join the movement to reduce ageism. By coming together as a broad coalition, we can improve collaboration and communication between the different stakeholders engaged in combating ageism.

CONCLUSIONS

It is time to say no to ageism. This *Global report on ageism* outlines how to combat ageism and, hence, contribute to improving health, increasing opportunities, reducing costs and enabling people to flourish at any age. If governments, UN agencies, development organizations, civil society organizations and academic and research institutions implement strategies that are effective and invest in further research, and if individuals and communities join the movement and challenge every instance of ageism, then together we will create a world for all ages.

INTRODUCTION

Ageing is a natural and lifelong process that, while universal, is not uniform. How we age is shaped by the relationships we have with the social and physical environments we have lived in throughout our lives. How we age also varies according to personal characteristics including the family we were born into, our sex and our ethnicity (1). The longer we live, the more different from each other we become, making diversity a hallmark of older age.

Our age reflects the number of years we have been alive. But what is considered young or old partly depends on context, purpose and culture. At age 18 you may be considered too old to learn to be a competitive gymnast, but too young to run for high political office. Cultures also vary as to what constitutes older age, middle age and youth. A century ago in western Europe and North America, old age started much earlier than it does today.

How we each think, feel and act towards age and ageing – our own and that of others – can either help us thrive or limit the lives we lead and the freedoms we enjoy. When age-based biases permeate our institutions (e.g. legal, health, educational), they can create and perpetuate disparities between groups so that individual-level change alone cannot address ageism, as research on sexism (2) and racism (3) has shown.

Box 0.1

The word ageism

The term ageism was coined in 1969 by Robert Butler, an American gerontologist and the first director of the National Institute on Aging in the United States. While ageism has existed across centuries, countries, contexts and cultures, the concept is relatively new and does not – yet – exist in every language. This can make it challenging to raise awareness about this social phenomenon and to advocate for change. Those languages that lack a specific term for ageism tend to use a proxy, such as *Altersdiskriminierung* in German, which captures only the dimension of discrimination. Other languages that have a specific term, such as Spanish (*edadismo* or *edaismo*) and French (*âgisme*), are only now starting to use it more widely. Identifying a word for ageism in every language would be one way to start generating awareness and change across countries. Although ageism covers any stereotypes, prejudice and discrimination based on age, other terms have also been used to refer to ageism directed against children and youth, including the concepts of adultism (4-6) and childism (7, 8). Ageism will be the only term used in this report to refer to age-based stereotyping, prejudice and discrimination.

Ageism refers to the stereotypes, prejudice and discrimination directed towards others or oneself based on age. Ageism affects people of all ages and will be the only term used in this report to refer to age-based stereotypes, prejudice and discrimination (see [Box 0.1](#)).

Ageism is prevalent, deeply ingrained and more socially accepted than other forms of bias. Age-related bias is often seen as humorous or at the least harmless. People fail to see that how age and ageing are framed (e.g. having a senior moment, grey tsunami, the problem of ageing populations, "young people think they know everything") and the language that is used (see [Box 0.2](#)) perpetuate misconceptions and influence the policies we develop and the opportunities we create – or don't. Ageism, as shown in this report, can change how we view ourselves, can pit one generation against another, can devalue or limit our ability to benefit from what younger and older populations can contribute and can reduce opportunities for health, longevity and well-being while also having far-reaching economic consequences.

Box 0.2

Language

Language conveys meaning and can fuel misconceptions that can lead to ageism. Words such as elderly, old or senior elicit stereotypes of older people as universally frail and dependent, and they are frequently used in a pejorative sense. Similarly, the word juvenile elicits a stereotype of younger people as immature. This report uses neutral language when referring to individuals and groups, including the terms older person, younger person or older people, older populations and younger people.

WHY A GLOBAL REPORT ON AGEISM?

The *Global strategy and action plan on ageing and health* (2016–2030) (9) and the related World Health Assembly resolution WHA69.3 (10) identified combating ageism as a prerequisite to developing good public policy on healthy ageing and to improving the day-to-day lives of older people. In response, the World Health Organization (WHO) was called on to develop, in cooperation with other partners, a global campaign to combat ageism. While developing the vision and principles of the Global campaign to combat ageism, it became evident that to prevent harm, reduce injustice and foster intergenerational solidarity we need to reduce ageism against people of all ages.

To prevent harm, reduce injustice and foster intergenerational solidarity we need to reduce ageism against people of all ages.

The Decade of Healthy Ageing: 2021–2030, an action plan for the last 10 years of both the *Global strategy and action plan on ageing and health* and the 2030 Agenda for Sustainable Development, was endorsed in August 2020 by the World Health Assembly and in December 2020 by the United Nations General Assembly (11, 12, 13). Combating ageism – that is, changing how we think, feel and act towards age and ageing, our own and that of others, is one of the four action areas prioritized by the Decade of Healthy Ageing. Combating ageism

is also integral to achieving progress in the other three actions areas: developing communities in ways that foster the abilities of older people, delivering person-centred integrated care and primary health services that are responsive to the needs of older people and providing older people who need it with access to long-term care.

Ageism, as shown in this report, can change how we view ourselves, can pit one generation against another, can devalue or limit our ability to benefit from what younger and older populations can contribute and can reduce opportunities for health, longevity and well-being while also having far-reaching economic consequences.

While ageism has been identified as an important problem, scientific information on ageism is lacking. There is limited agreement on definitions and little internationally comparable information on the scale of the problem and a paucity of evidence on the strategies that work to reduce it.

This report, directed at policy-makers, practitioners, researchers, development agencies, the private sector and civil society, compiles the best evidence on ageism.

AIMS

The central themes of this report are the heavy burden that ageism places on individuals and society and the urgent need for action from governments, civil society, the private sector and individuals of all ages.

The goals of the report are to:

- raise awareness about the global nature, scale, impact and determinants of ageism directed against both younger and older people;
- draw attention to the need to prevent ageism, to promote and protect the realization and enjoyment of all human rights for all persons and to present effective intervention strategies;
- call for action across sectors and stakeholders.

The scope of the report supports these goals, and the report is divided into 10 chapters. The first explains what ageism is and how it operates towards both younger and older people. There is much less evidence on ageism against younger people than on ageism against older people, and it is of poorer quality. As a result, the report presents evidence separately about ageism towards

younger and older people. Chapters 2–4 relate only to older people and detail the scale of the problem (Chapter 2), its impact (Chapter 3) and the determinants of ageism (Chapter 4). The fifth chapter compiles all of the evidence about the scale, impact, and determinants of ageism against younger people. The three subsequent chapters (Chapters 6–8) focus on strategies that work to reduce ageism against older and younger people, including policies and laws, and educational and intergenerational activities. Chapter 9 highlights strategies that are promising, but whose effectiveness is not yet proven. Each chapter explains the relevant strategy and how it works; provides an overview of the evidence on effectiveness; identifies the costs and factors that can potentially make the strategy more effective, where such evidence exists; and provides examples. Evidence relevant to younger people is included in boxes.

Because the way that research is conducted is important (see [Box 0.3](#)), each chapter has a box evaluating available evidence and suggesting opportunities for future research. Each chapter also offers conclusions and suggestions for future directions, which are drawn together in Chapter 10 to provide broad recommendations for policy and practice.

Box 0.3

How research is conducted on ageism matters

How well we understand ageism depends on how the research on ageism was conducted and how ageism was measured. If our definitions and measures are inaccurate, if the picture that our research produces of its scale and distribution and of the drivers and the impacts of ageism are inaccurate, our efforts to reduce ageism will be less effective. We are more likely to waste time and money. And ageism that could have been averted will persist, with the serious consequences outlined in this report.

The discussion of research in each chapter builds, to an extent, on the previous one. If definitions of ageism (Chapter 1) are not clear, ageism cannot be measured accurately and its scale and distribution (Chapters 2 and 5) cannot be established with confidence. If ageism cannot be measured accurately, it will be more difficult to ascertain the impact of ageism (Chapters 3 and 5). If the determinants of ageism (Chapters 4 and 5) are not identified correctly, strategies to reduce ageism (Chapter 6–9) are unlikely to be effective because the strategies are designed to target these determinants. In addition, without accurate measures of ageism, the effect of the strategies on ageism cannot be evaluated precisely.

PROCESS

The conceptual framework for ageism was developed in collaboration with the core group working on the Global campaign to combat ageism. In alignment with that framework, several steps were taken to compile or collect evidence to inform this report including:

- a review of the global prevalence of ageism towards older people, broadly understood as people aged 50 and older;
- a series of systematic reviews of research about ageism against older people in English, French and Spanish that was carried out by experts that assessed determinants, health impacts, intervention strategies and measurement;
- a scoping review on ageism directed towards younger people, which included evidence on people younger than 50, from peer-reviewed literature in English, Spanish and French;
- targeted searches to identify other forms of published quantitative and qualitative evidence that were conducted in response to gaps identified in the research, including ageism in low- and middle-income countries, ageism towards younger people and the intersections between ageism and other "-isms";
- a review of global, national and local campaigns to tackle ageism; and
- personal testimonies from younger and older people.

This Global report on ageism charts the steps that are required to combat ageism and, hence, contribute to improving health, increasing opportunities, reducing costs and enabling people to flourish at any age.

While there are many perceptions and opinions about the scale, impact and determinants of ageism and the most effective strategies to reduce it, this report has made every effort to base its findings on solid evidence. When deciding on what evidence to report, findings from systematic reviews – which aim to rigorously identify, evaluate and summarize the findings of all relevant individual studies on a topic – have been prioritized over single studies. When no evidence was available, the report points this out and calls for the gap to be filled. Ageism research, like about 90% of the research on psychology and health, is predominantly carried out in high-income countries, which account for some 15% of the global population.

It is anticipated that the policy and practice considerations outlined in this report will be periodically reviewed and revised by the Department of Social Determinants of Health at WHO, in collaboration with partners.

MOVING FORWARD

This *Global report on ageism* charts the steps that are required to combat ageism and, hence, contribute to improving health, increasing opportunities, reducing costs and enabling people to flourish at any age. The aspiration of those who contributed to this report is that it results in concrete actions that will be taken by all stakeholders, at all levels and across all sectors, and that these actions promote social and economic development, the achievement of human rights across the world and the development of a world for all ages.

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FERNANDO, 64,
PLURINATIONAL
STATE OF BOLIVIA

SAUMYA, 24,
INDIA

01

THE NATURE
OF AGEISM

“ Discrimination against older people is a serious issue. I was widowed seven months ago and since my wife died, the people, my own family has discriminated against me for being older and widowed. My brothers, my father-in-law no longer listen to me. They don't take any notice of what I say and I feel hurt. Some of my children support me, they tell me to take no notice but it is sad that your own family discriminates against you. ”

Fernando, 64, The Plurinational State of Bolivia
©Sebastian Ormachea / HelpAge International

“ Young people based on their age are discriminated and often not included in the decision-making spaces. Their presence and voices are often heard or included just to tick mark the box of youth inclusion but their recommendations are not included. Young people of age group 18-29 years are either considered perpetrators of violence whom we need to stop or victims who need to be supported but young people are peacebuilders and agents to build positive peace within their communities. ”

Saumya, 24, India
©Saumya Aggarwal / UN Major Group
for Children and Youth

Chapter

01

Section 1.1 of this chapter defines ageism and its three main dimensions: stereotypes, prejudice and discrimination. A clear and common understanding of ageism is crucial to raise awareness and ensure consistency in research, policy and practice (1-2). The definitions presented here underpin the rest of the report. Section 1.2 describes how ageism works and how it arises. Section 1.3 describes intersections between ageism and other “-isms”, such as sexism and ableism, illustrating their cumulative impacts.

Ageism refers to the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) directed towards others or oneself based on age.

Ageism can manifest at the institutional or the interpersonal level or it can be self-directed.

Ageism can be implicit or explicit depending on our level of awareness of being ageist.

Ageism starts in childhood and is reinforced over time.

Ageism intersects with other “-isms” and can result in compounded disadvantage.

1.1 DEFINING AGEISM

Age is one of the first characteristics – along with sex and race – that we notice about other people when we interact with them (see [Box 1.1](#)) (3). Ageism arises when age is used to categorize and divide people in ways that lead to harm, disadvantage and injustice and erode solidarity across generations.

Ageism takes many forms throughout our lifetime. Imagine being systematically ignored by colleagues and supervisors in the workplace, patronized by your family at home, denied a loan at the bank, insulted or avoided in the street, accused of witchcraft, denied access to your property or land, or not being offered treatment at a clinic, all simply because of your age. These are all examples of how ageism penetrates our lives, from younger age into older age.

Ageism is a multifaceted social phenomenon that the World Health Organization (WHO) defines as the stereotypes, prejudice and discrimination directed towards others or oneself based on age (9). Ageism has several interrelated aspects:

- three dimensions – stereotypes (thoughts), prejudice (feelings) and discrimination (actions or behaviour) (Section 1.1.1);

Box 1.1**Age and stage of life are partly socially determined**

Age, although correlated with biological processes, is also socially shaped. Who is considered young or old partly depends on context, purpose and culture (4-6). At age 18 you may be viewed as too old to become a competitive pianist, but too young to coach a professional soccer team. Cultures vary in how they demarcate old age, middle age and youth and in the norms and expectations they have for each of these life stages, which can change over time (7).

Environments also shape how we age. Inequalities linked, for instance, to sex, ethnicity and income determine our access to health care and education across the life course, and they influence how we are at age 50, 60, 70 or 80. A large part of the diversity we see in older age results from the cumulative impact of these health inequities across the life course (8).

- three levels of manifestation – institutional, interpersonal and self-directed (Section 1.1.2);
- two forms of expression – explicit (conscious) and implicit (unconscious) (Section 1.1.3).

1.1.1 Ageism as stereotypes, prejudice and discrimination

The three dimensions of ageism – stereotypes, prejudice and discrimination – each relate to a distinct psychological faculty: thoughts (stereotypes), feelings (prejudices) and actions or behaviours (discrimination).

Stereotypes are cognitive structures that store our beliefs and expectations about the characteristics of members of social groups, and stereotyping is the process of applying stereotypic information (10). Stereotypes guide our social behaviour and often govern what information we seek and remember (11-14).

In ageism, the stereotypes that people hold about age can guide the inferences that they make about other people based on

their age, including their physical and mental capacities, social competencies and political and religious beliefs. These inferences can lead to overgeneralizations that consider every person within a given age group to be the same. For example, a common overgeneralization is that older people are frail, incompetent and friendly (15) or that younger adults are materialistic, lazy and impatient (16).

Age stereotypes can range from positive to negative (17-19), but, being by definition overgeneralizations, both so-called positive and negative stereotypes are inaccurate and potentially harmful. Some age stereotypes cut across regions and cultures (20, 21). For example, older adults tend to be stereotyped as a mixture of warmth (positive) and incompetence (negative) across different countries in Europe, Asia and North and South America, while younger adults are stereotyped as highly competent (positive) but low in warmth (negative) (20, 22-24).

Other age stereotypes tend to differ by contexts and culture (17, 21, 25-28). **Table 1.1** provides a catalogue of stereotypes identified in different institutional settings across the world. Which stereotypes

Table 1.1. A catalogue of stereotypes identified in different institutional settings and countries

INSTITUTION OR SECTOR	STEREOTYPES	
	YOUNGER PEOPLE ARE...	OLDER PEOPLE ARE...
Health and social care^a		
POSITIVE	Healthy Physically active Strong and energetic	Warm Likeable
NEGATIVE	Risk-takers Drug-users Stressed and anxious	Rigid Irritable and frustrating Lonely and isolated Frail and weak Asexual Easily confused Depressed and depressing Needy Disabled
Work^b		
POSITIVE	Energetic Ambitious Tech-savvy Hard-working (middle-aged)	Reliable Committed Experienced Hard-working Socially skilled Good mentors and leaders Able to deal with change
NEGATIVE	Narcissistic Disloyal Entitled Lazy Unmotivated Easily distracted	Incompetent and unproductive Unmotivated Resistant to change Harder to train and unable to learn Not flexible Not technologically competent
Media^c		
POSITIVE	Attractive	Healthy Engaged Productive Self-reliant
NEGATIVE	Troublesome Violent criminals	Unattractive Unhappy Senile Badly dressed Inactive Dependent Unhealthy Disempowered and poor Vulnerable Diabolical

^a For additional information, see references 16 and 33-40.^b For additional information, see references 16 and 41-48.^c For additional information, see references 32 and 49-51.

predominate in a given situation depend largely on the age of the person being ageist (29) and the context, such as the place where the older or younger person is encountered (30, 31). Social and economic changes and shifts in values within a society can lead to stereotypes evolving over time (32).

Prejudice is an emotional reaction or feeling, either positive or negative, that is directed towards a person based on their perceived group membership (1, 52). Prejudice contributes to creating or maintaining hierarchical status relations between groups (53). In the case of ageism, prejudice is directed towards an individual or a group based on perceptions of their age.

Feelings of pity or sympathy are two common forms of prejudice towards older adults (15), and they can generate a desire to exclude oneself from the company of older people (54). In turn, younger people may provoke feelings of fear or aversion, often based on the presumption that they are delinquents or criminals.

Discrimination consists of actions, practices or policies that are applied to people on account of their perceived or real membership in some socially salient group and that impose some form of disadvantage (negative discrimination) or advantage (positive discrimination) on them (55).

In relation to ageism, discrimination relates to behaviours – including actions, practices and policies – that are directed towards people based on their age. Employers who refuse to allow a person to lead a discussion because they consider the person to be too young or who do not allow an employee to attend a training session because they consider the person to be too old to benefit from it are examples of, respectively, negative discrimination towards younger

and older people. Examples of positive actions include offering discounts to younger or older adults who are unlikely to have a regular income.

In short, ageism involves how we think (stereotypes), feel (prejudice) and act (discrimination) in relation to others and ourselves based on age (see [Fig. 1.1](#)).

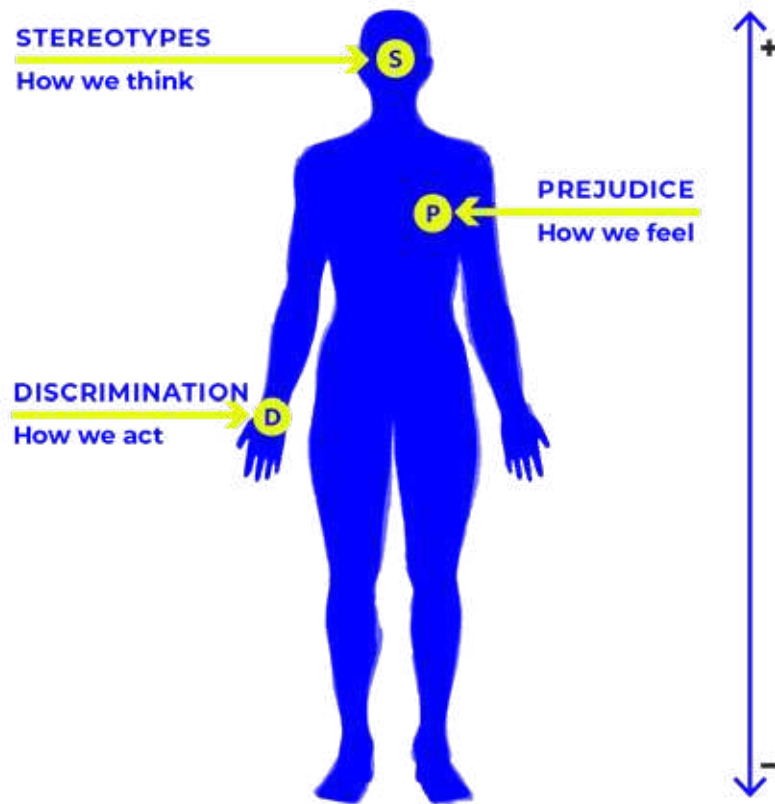
This report focuses on the negative implications of age-based stereotypes, prejudice and discrimination, regardless of whether the specific thoughts, feelings or actions are perceived to be positive or negative.

1.1.2 Institutional, interpersonal and self-directed ageism

Institutional ageism refers to the laws, rules, social norms, policies and practices of institutions that unfairly restrict opportunities and systematically disadvantage individuals on the basis of their age (1, 53, 56). It also refers to the ideologies that institutions foster to justify their ageism.

While institutional ageism can result from conscious and overt efforts made by individuals in an institution (in which case it overlaps with interpersonal ageism), it does not necessarily require the intentional support of the individuals in an institution or any awareness of bias towards younger or older people. Often people fail to recognize the existence of such institutional ageism because the rules, norms and practices of the institution are of long-standing, have become ritualized and are seen as normal. Moreover, institutional ideologies – often tacit – offer justifications for "the way things are done" (1, 53). Thus, while not always intentional, institutional ageism can legitimize the exclusion of people from power and influence, reinforcing an

Fig. 1.1. The three dimensions of ageism include stereotypes, prejudice and discrimination. These dimensions may be perceived as positive or negative



asymmetric power structure that is based on age and age-associated assumptions (57).

Because institutional ageism – like institutional racism or sexism – is not always the result of overt bias on the part of individuals, it often must be inferred from the disparate outcomes occurring between age groups. For instance, in health care, decisions regarding whether or not to withhold life sustaining therapies (e.g. ventilator support, surgery or dialysis) often vary by age contributing to different outcomes for different age groups. These disparate outcomes can then be traced back and attributed, at least in part, to the laws, policies or practices of an institution, which is then considered institutionally ageist.

Thus, a key consideration in institutional ageism is not so much the intention, but the disparate outcomes (55, 57, 58).

Examples of institutional ageism include:

- policies in the health sector that allow care to be rationed by age (59); and
- in the labour sector, discriminatory hiring practices or mandatory retirement ages (42, 43, 60).

Interpersonal ageism refers to ageism occurring during interactions between two or more individuals.

In interpersonal ageism, the perpetrator is distinguished from the target of ageism.

Examples of interpersonal ageism include:

- disrespecting or patronizing older and younger adults, ignoring their points of view in decision-making or avoiding contact and interactions;
- using an overly accommodating tone and simple vocabulary and sentence structure when interacting with older adults (known as elderspeak). This type of speech, by assuming that older adults are less capable, infantilizes them and increases the likelihood that others will view them as incompetent and incapable, and treat them disrespectfully and impolitely (61, 62);
- insulting older people by saying that they are worthless because of their age, or younger people by saying that they are thoughtless, selfish or criminals because of their age.

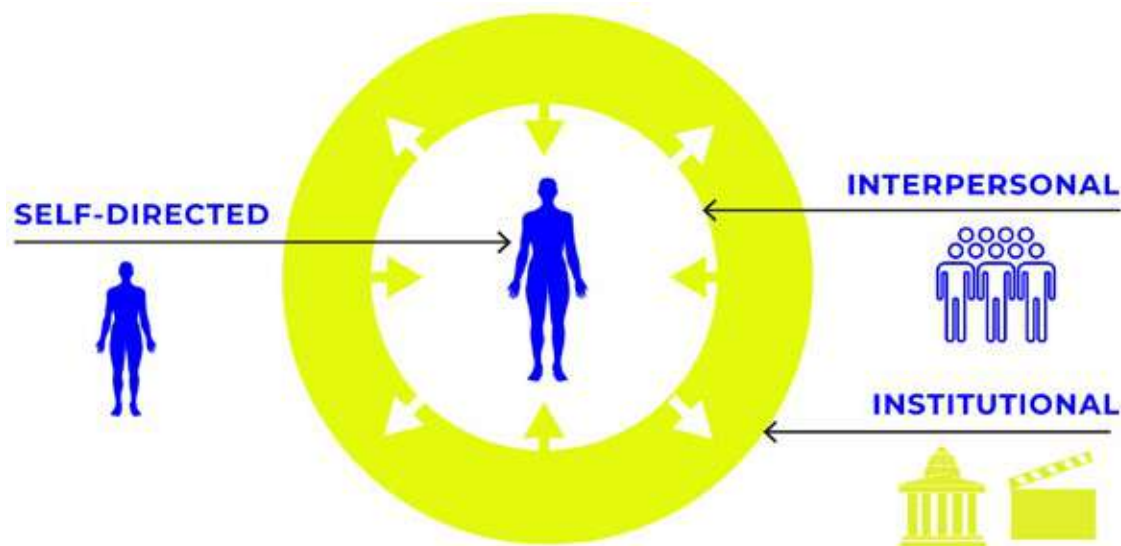
Self-directed ageism refers to ageism turned against oneself. People internalize age-based biases from the surrounding culture after being repeatedly exposed to those biases, and they then apply those biases to themselves (63).

Examples of self-directed ageism include:

- people in their twenties who think that they are too young for a job and may be reluctant to apply;
- older individuals who do not believe it is possible to learn new skills later in life and hesitate to enrol at university or take up a new hobby.

The three levels at which ageism manifests itself are intertwined and mutually reinforcing (see [Fig. 1.2](#)).

Fig. 1.2. Interpersonal, institutional and self-directed ageism are intertwined and mutually reinforcing



Ageist institutional rules, norms and practices, and the ageist ideologies they foster, can shape, and be shaped by, the attitudes of individuals – which underlie interpersonal ageism – who are members of these institutions and wider society.

At the same time, institutional and interpersonal ageism can be internalized and lead to self-directed ageism. And self-directed ageism can result in people conforming to their society's age stereotypes, which in turn reinforces interpersonal and institutional ageism.

1.1.3 Explicit and implicit ageism

People may not always be aware that they are being ageist. Ageism can be either explicit or implicit, depending on a person's level of consciousness or awareness of being ageist. In explicit ageism, a person's ageist thoughts, feelings and actions towards others or themselves are conscious and intentional – that is, within their awareness and control.

In implicit ageism, however, a person's ageist thoughts, feelings and actions towards others or themselves operate without conscious awareness and are largely unintentional and beyond their control (64). In implicit ageism, individuals do not recognize the thoughts, feelings and actions that are triggered by age stereotypes, and they may rationalize such behaviour by attributing it to other factors.

For example, rather than employers acknowledging that they prefer to hire a younger person, they might invoke an older candidate's personality or lack of specific training. When a culture's ageist attitudes are internalized and the ageism within its main institutions has become so routine and normalized that it is no

longer recognized by its members, ageism has become part of the subconscious framework of society, which can be expressed through implicit ageism (65).

1.2 HOW AGEISM WORKS AND HOW IT ARISES

1.2.1 Interactions between stereotypes, prejudice and discrimination

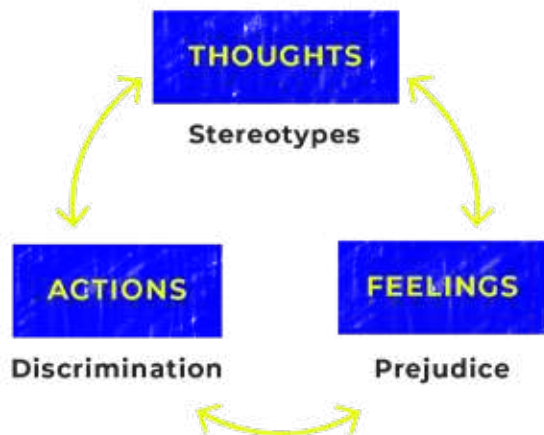
Because our thoughts, feelings and actions influence each other, the relation between stereotypes, prejudice and discrimination is multidirectional (see [Fig. 1.3](#)). Stereotypes can influence prejudice and discrimination; discrimination can influence stereotypes and prejudice; and prejudice can influence discrimination and stereotypes. For example, in English, using terms such as elderly to refer to older adults has been shown to evoke negative stereotypes of older people as frail and dependent (stereotypes) (66).

A study found that young adults with negative attitudes towards older adults showed less compassion towards them and wanted to keep their distance from them rather than show them empathy (prejudice) (67). Another study showed that employers who held negative stereotypes about older employees were also more punitive towards them (discrimination) (68).

These relationships between stereotypes, prejudice and discrimination are not automatic. The mere activation of a stereotype does not imply that people will inevitably have negative feelings and act in

discriminatory ways (69). These relationships are influenced by contexts, including laws and culture (70).

Fig. 1.3. Stereotypes, prejudice and discrimination interact with and influence each other in multidirectional relationships



1.2.2 Ageism starts early in life and is reinforced over time

Ageism starts in early childhood. From the age of 4 years, children become aware of their culture's age stereotypes through the cues they pick up from people around them (71, 72). They begin to internalize and use these stereotypes to make inferences and to guide their feelings and behaviour towards people of different ages (12, 73). For instance, children in preschool and primary school were shown drawings that depicted a man at four stages of life, and two thirds of the children viewed the oldest man as being "helpless, incapable of caring for himself, and generally passive" (63, 74).

We also draw on our culture's age stereotypes to perceive and understand ourselves and to guide our behaviour as members of a given age group, which can

result in self-directed ageism at any age. For example, when individuals reach old age, the ageing stereotypes internalized in childhood and then reinforced for decades can become self-stereotypes (63). Indeed, research has shown that older people express attitudes towards their own group that are as negative as those expressed by younger people towards older people (75). For instance, older people in the United States of America were more likely than younger people to oppose federal programmes that benefit them, and their opposition to these programmes was predicted by the stereotypes about ageing that they held (63).

Stereotype-consistent behaviour can also be triggered through what is known as stereotype threat. Stereotype threat arises when people underperform on a task due to worries about confirming a negative stereotype about their group (76, 77). For instance, an older person may do less well on a driving test or cognitive test due to anxiety about confirming stereotypes about older people being bad drivers or mentally slower. Furthermore, by behaving in a stereotype-consistent manner, older adults can help to reinforce prevailing attitudes, which can give rise to further age prejudice and discrimination.

1.3 AGEISM AND OTHER "-ISMS"

Ageism is, to an extent, different from other "-isms", such as racism or sexism. Whereas other "-isms" involve bias against relatively stable subpopulations that do not vary across the life course, ageism involves bias against a moving target. People belong to different age groups at different points

in their lives and, thus, will be more or less likely to perpetrate or be a target of ageism at different times. Another difference between ageism and the other "-isms" is that everyone is susceptible to experiencing it. Ageism also tends to be more accepted and challenged less often than other "-isms" (1, 78), and it has been shown to be more pervasive than sexism and racism across 28 countries in Europe (79).

Ageism can interact with other forms of bias, such as sexism and ableism, and exacerbate disadvantage, which may compound the impact on individuals' health and well-being (80-82). A growing number of studies have explored the interactions and intersections between different "-isms". Ageism and ableism and ageism and sexism are two forms of intersection that have been explored in some detail.

1.3.1 Ageism and ableism

Ableism refers to the stereotypes, prejudice and discrimination directed against people with disabilities or those who are perceived to have a disability. Ageism and ableism are closely intertwined in ways that can often result in mutual reinforcement (4).

For instance, given that stereotypes commonly associated with older people (i.e. they are warm yet incompetent) are the same as those associated with people with disabilities, they may reinforce each other and prevent people from recognizing the diversity seen among older adults with a disability (20). It is also often assumed that disability is the norm in older age (83, 84), which may stem from the fact that most people with disabilities are older (85). Still, this does not mean that most older people live with some form of disability. The discourse around successful ageing, with its emphasis on maintaining able-bodiedness and ablemindedness in older age, may have

further reinforced ageism and ableism (86).

In younger people, physical impairment may be particularly undermining, as it challenges people's expectations regarding active, independent and able-bodied young adults (87). Younger adults with a disability may be treated with disdain or disrespect because they are violating the cultural norm of able-bodiedness, whereas their older counterparts may be treated with support and empathy. For example, a study in the United States found that the link between disability and perceived discrimination is more pronounced among working-age adults relative to persons aged 65 and older (88).

People with disabilities are also treated as if they are either significantly older or younger than people of the same age without disability. Often they are viewed either as an older person in a stereotypical state of decline or as a child with limited competence and autonomy (89). At the same time, there is evidence that programmes, expenditures, and goals for people with disabilities differ substantially across age groups in ways that suggest ageism (90). For example, in the United States, government expenditures per recipient are substantially higher for younger individuals with disabilities, and care options rejected by younger people with disabilities (e.g. institutional care) are often considered acceptable for older adults (90). In Sweden, disability policies have been found to serve children and young adults better than older persons with disabilities (91). This is particularly problematic if we consider that older people are disproportionately represented in disability populations (85).

1.3.2 Ageism and sexism

Research on the combined impact of sexism and ageism in older age has concluded that older women – relative to older and younger

men and younger women – bear the brunt of multiple forms of discrimination.

The term "gendered ageism" has been coined to cover the intersection of age and gender, and it refers to differences in ageism faced by women compared with men (92, 93). Women are often in a situation of double jeopardy in which patriarchal norms and a preoccupation with youth result in a faster deterioration of older women's status compared with that of men (94). This double jeopardy also explains why the physical appearance of older women is judged differently than that of older men (95-99). Men with grey hair and wrinkles are seen as distinguished, wise and experienced, whereas grey hair and wrinkles are considered to make women look unattractive in many cultures. Women also face greater pressure than men to hide signs of ageing through the use of hair dye and anti-ageing products (100-102), and they are targeted by an ever-growing anti-ageing beauty industry (103).

Two other ways in which the intersection between ageism and sexism manifest are through accusations of witchcraft and discrimination directed against older widows. In parts of sub-Saharan Africa, accusations of witchcraft are widespread, with older women being persecuted and accused of causing ill luck, disease or death (104). In many parts of the world, older widows are socially ostracized or discriminated against. For instance, they are denied the right to inherit the property they shared with their husbands (105, 106) (see Section 2.2 of Chapter 2).

The interaction between ageism and sexism can manifest in many different institutions. For example, in health care, disparities have been documented in terms of older women's access to preventive care and treatment. Multiple studies conducted in the United States have reported that older men

generally receive more thorough medical examinations, more follow-up and more evidence-based medical care than women do, and men are also more likely to receive preventive care (107-110).

In employment, the disadvantages of being too young or too old impact women more than men. This suggests that in these age ranges, being a woman intensifies age prejudice (60, 101), which not only has an effect on a woman's career but also on her ability to access a pension in older age (92). Compared with older men, older women typically have had fewer years in the workforce, have earned less and are less likely to have pensions or substantial retirement savings.

1.3.3 Other “-isms”

Although research has mainly focused on the intersections of ageism with ableism and sexism, there may be as many intersections as there are forms of stereotypes, prejudice and discrimination, including with racism, classism, heterosexism, homophobia and transphobia.

An important intersection that has not been sufficiently explored is that between ageism and racism, but this field of research is growing. For example, in Canada there is evidence that stigma acts as a barrier to black female youth accessing mental health services and support (111). In the United States minority women were more likely to report unfair treatment based on age than other respondents, including white men (112).

Another intersection that is being increasingly explored is that of ageism and heterosexism and sexuality (113-115). A growing body of cross-cultural research recognizes the importance of examining how age, gender and sexuality work together and with other forms of exclusion, including those based

on ethnicity and class, to form a range of inequalities (or opportunities) for people as they age. Qualitative studies revealed that older lesbians report frequent experiences of homophobia, heterosexism and ageism in the health care system and elsewhere (116), and that older black gay men and lesbian women feel alienated from the black community, deliberately conceal their sexual identity and orientation, and feel isolated (117). These findings suggest that how these identities are managed may have an impact on an individual's adjustment to the ageing process.

Ageism can also interact and intersect with other "-isms", such as sexism, ableism and racism, thus exacerbating disadvantage.

Despite these advances in research, further research is needed to explore the intersections between ageism and these other "-isms" and the multiple and compounding forms of discrimination that they elicit.

1.4 CONCLUSIONS AND FUTURE DIRECTIONS

This chapter described what ageism is and how it works. It provides the conceptual basis for the rest of the report. Ageism refers to the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) directed towards people based on their age. It manifests itself at three levels – institutional, interpersonal and self-directed – and can be either explicit or

implicit. Age-based stereotypes, prejudice and discrimination interact and mutually reinforce each other. Ageism tends to start early in life and be reinforced over time through interactions between individuals and their social environments. Ageism can also interact and intersect with other "-isms", such as sexism, ableism and racism, thus exacerbating disadvantage.

The definition of ageism proposed in this report is the result of a decades-long process of refinement, and it enjoys considerable consensus among ageism researchers.

Future priorities for understanding the nature of ageism should include:

- promoting the use of the definition proposed in this report to enable cross-cultural comparisons of research and practice;
- improving our understanding of the way in which different languages and cultures refer to ageism to improve translatability;
- increasing awareness among all key stakeholders of what ageism is, particularly in low- and middle-income countries, to foster a shared understanding of the issue and stimulate action;
- conducting further research on the ways in which ageism intersects with other "-isms", which will have important implications for the actions taken to tackle ageism and other forms of stereotypes, prejudice and discrimination.

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A close-up portrait of an elderly woman with short, wavy grey hair. She has a serious expression and is looking slightly to the left. She is wearing a patterned garment with a mix of red, white, and black. The background is a vibrant, textured blue with a diagonal ribbed pattern.

VERA, 82,
KYRGYZSTAN

02

THE SCALE
OF AGEISM
AGAINST
OLDER PEOPLE

“ There are cases in the hospitals when we have to wait in long queues to see a doctor and when we are seen, some doctors don't bother to listen to everything we have to say, let alone examine us properly. When we start telling the doctors what our health problems are, they often say that these problems are due to our age and that they are natural changes. I feel very unwanted and helpless but there are no places to go and complain about this. Even if we did complain, I doubt they would listen to us. ”

Vera, 82, Kyrgyzstan

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Chapter

02

This chapter presents evidence on the scale of institutional ageism, interpersonal ageism and self-directed ageism. Section 2.1 describes the reach of institutional ageism by examining how it manifests itself in a variety of institutions. Section 2.2 surveys the evidence on the prevalence of interpersonal ageism around the world. Section 2.3 presents an overview of what little is known about the magnitude of self-directed ageism. Having an accurate understanding of the scale of ageism against older people is a critical first step for efforts to reduce it.

Ageism against older people is widespread across institutions, including those providing health and social care, and in workplaces, the media and others.

Ageism is pervasive across populations:

- 1 in 2 people worldwide are ageist;
- in Europe, 1 in 3 older people report having been a target of ageism.

Ageism is more prevalent in low- and middle-income countries.

2.1 INSTITUTIONAL AGEISM

Institutional ageism can manifest itself across different institutions, such as those providing health and social care, and in the workplace, the media and the legal system.

2.1.1 Ageism in health and social care

Health care rationing by age is widespread. A systematic review in 2020 showed that in 85% (127) of 149 studies, age determined who received certain medical procedures or treatments (1). One study of five medical centres in the United States examined how age affected the decisions of medical staff to withhold life-sustaining therapies in 9000 patients who had illnesses with high mortality rates. Medical staff were more likely to withhold ventilator support, surgery and dialysis as the patient's age increased. For ventilator support, the rate of decisions to withhold therapy increased 15% with each decade of age; for surgery, the increase per decade was 19%; and for dialysis, it was 12% (2).

Older adults tend to be excluded from health research even though they account for a

disproportionate share of the total burden of disease and the use of prescription medicines and therapies. A systematic review found evidence of ageism in all 49 studies that investigated the link between age and exclusion from different types of health research (1). These studies showed that older persons were systematically excluded from clinical trials in cardiology, internal medicine, nephrology, neurology, preventive medicine, psychiatry, rheumatology, oncology and urology, even though many of the conditions under study are more prevalent in older age.

Thus, the patients enrolled in many clinical trials are not representative of the actual distribution of patients in the general population, and the findings of such research – on the safety and efficacy of treatments – may not apply to older populations (1). Research into Parkinson's disease, which mainly affects older populations, clearly highlights this exclusion. A systematic analysis of 206 research studies recruiting patients with Parkinson's disease found that almost 50% of them excluded patients who were older than 79.3 years (3).

The extent to which health and social care workers hold ageist attitudes towards patients, while perceived to be high, is uncertain (4, 5). A review of 12 literature reviews of ageism among health-care workers (e.g. nurses, health-care providers in general, medical and nursing students) concluded that the evidence is contradictory and inconclusive, and that many of the studies were of poor quality.

This review highlights the urgent need for high-quality studies on ageism among health and social care workers, given that ageism is linked to reduced health care access (5). A 2017 review of nurses' attitudes towards the care of older people concluded that there was a paucity of

research on the topic and that the limited evidence indicated that nurses' attitudes are complex and contradictory (6).

Several studies also show that mental health professionals are not adequately trained to work with older patients, lack the clinical skills needed to diagnose and work with older patients who have mental health problems, hold negative attitudes towards this population and are less willing to work with them (7).

Although the demand for social care, including long-term care, has risen and is expected to rise further in response to population ageing (8), research on the manifestations of ageism in social care, including long-term care, is limited, particularly in lower-resource settings (4). Nonetheless, the few studies that exist report clear manifestations of ageism in long-term care. For example, a study in Canada found that most older residents in long-term care institutions perceived communication with caregivers as ageist. Caregivers used controlling language and infantile and patronizing patterns of communication (9). In long-term care institutions in Israel, ageism was evident through the lack of accurate medical diagnoses, the objectification of older residents, the routine neglect of their needs and attempts to save money at their expense (10).

In Australia, several inquiries and reviews revealed the presence of ageism in the long-term care sector, for instance, in the types of services available to older people, the language used when interacting with older people and in assumptions about older people's preferences and capabilities. In response, the Australian Human Rights Commission made a submission to the Royal Commission into Aged Care Quality and Safety that included a series of

recommendations about how to address ageism in long-term care by adopting a human rights perspective (11).

Age bias may affect the type of information that health-care workers seek during their interactions with patients. For example, a study found that psychiatrists in the United Kingdom take a sexual history much more frequently from middle-aged men than from older men (12), which could have

implications for the early detection and treatment of sexually transmitted diseases (STDs) or other conditions (see Chapter 3, Section 3.1).

A further example of the insidious presence of ageism in health and social care has been evidenced during the novel coronavirus 2019 (COVID-19) pandemic that has affected societies and economies to their core (see [Box 2.1](#)).

Box 2.1

Ageism and COVID-19

WHO declared the outbreak of novel coronavirus disease 2019 (COVID-19) a pandemic on 11 March 2020 (13). Global evidence has shown that older people face a significantly higher case-fatality rate from this disease than people in younger age groups (14, 15). The case-fatality rate is also increased in those with underlying conditions that affect the immune, cardiovascular and respiratory systems, and these conditions are common in older age (16, 17). In many countries, evidence shows that more than 40% of deaths related to COVID-19 have been linked to long-term care facilities, with figures being as high as 80% in these facilities in some high-income countries (14).

This pandemic has not only taken a devastating toll on the lives of many older people around the world but also has exposed ageist stereotypes, prejudice and discrimination against older adults. There have been reports of discriminatory practices in access to health services and other critical resources in several countries, especially among older people living in long-term care facilities (18, 19). For example, in some contexts scarce resources, such as ventilators or access to intensive care units, have been allocated according only to chronological age (20). This can be considered unethical and ageist in the context of this pandemic, given that chronological age is only moderately correlated with biological age or short-term prognosis, and that older people have been most affected in terms of severe outcomes in this pandemic (21, 22).

Chronological age has also been used to determine physical isolation measures in different countries. For example, in the United Kingdom, adults aged 70 and older were initially instructed to self-isolate for 4 months (23); in Bosnia and Herzegovina, older adults were not allowed to leave their homes for several weeks during the outbreak (24); and in Colombia (25) and Serbia (26), lockdown measures targeted only older adults. Strategies for lifting lockdown measures in many countries also made distinctions by chronological age. For example, in several cities in the United Arab Emirates, people older than 60 years were not allowed to enter shopping malls or restaurants once they reopened following the period of population confinement

(27). Similarly, in the Philippines, people older than 60 years were not allowed to take Metro Manila's four railway systems once these resumed operations with the lifting of community confinement (28).

Using chronological age as the sole criterion for physical isolation measures and for extending periods of confinement is discriminatory because it fails to account for the very diverse capacities and needs of older populations. Such measures can increase the risks of social isolation and loneliness, limit older people's ability to engage in self-care behaviours and challenge the ability of health and social care systems to respond to older peoples' pre-existing medical and social needs, which can ultimately have a detrimental impact on older people's health and well-being (29-31). The physical isolation of older people from their traditional social network (i.e. family, friends, care professionals) in the midst of the pandemic has also put them at greater risk for discrimination and abuse, be it in long-term care settings or at home (32-34). In addition, portraying the disease as an "older person's illness", by requiring only older adults to physically isolate or recommending that younger people stay home to protect their grandparents, may discourage younger people and others from following public health guidelines (35).

Ageism has also manifested in news and media coverage of the pandemic, with older adults being generally portrayed as a homogeneous, vulnerable group that is substantially different from other age groups (36). Portraying older adults as frail, vulnerable and in need of protection ignores the great diversity that is evidenced in older age. Such messaging can also have serious impacts on the health and well-being of older adults. Although it is necessary to identify and inform the populations who are most at risk, the ageist narrative around younger and older people runs the risk of pitting generations against each other, as illustrated by the rapid spread of the hashtag "boomer remover" in reference to the virus severely affecting older adults. In fact, nearly a quarter of all Twitter communication concerning older adults and COVID-19 has been classified as ageist (37). A comparable study based on the Chinese Weibo platform (which is similar to Twitter) found that the most popular themes related to COVID-19 and older persons concerned their contributions to society, but the themes of vulnerability and the need to protect older adults were also present (38). In Spain, an analysis of 501 headlines across two national newspapers found that 358 of these (71%) portrayed older people in a negative way (39).

The mathematical models of COVID-19 that have been used to guide the response to the pandemic have also often failed to consider populations in long-term care, an omission which is a form of ageism in statistics and data, given that the risk of spread of COVID-19 is higher in these facilities than in the general population (40).

The COVID-19 pandemic has not only exposed ageism in different settings but it has also presented the opportunity for many positive initiatives, reflective of solidarity and cohesion. For example, online information has been specifically developed for older adults (41), campaigns about older people's mental health have been conducted (42), and digital technologies and support for their use have

also been developed to help older people communicate during confinement (43). Older persons have also taken part in many solidarity initiatives by responding to helplines, remotely helping children with their homework and by returning to work, in the case of retired front-line health-care workers.

The content of this box is based on a rapid review of the literature conducted in May 2020 and repeated in August 2020 using the search terms "ageism" and "COVID-19" or "corona" in Google Scholar. The initial review was supplemented by a search using the functions "cited by" and "related to" in Google Scholar to identify additional articles once a relevant article was found. More specific search terms were also used to identify any missing articles, including "media", "policy", "lockdown", "triage", "long-term care", "nursing homes", "residential care" and "COVID-19" or "corona". The same search strategy was used in Google search. As this was not a systematic review of the evidence, it is possible that relevant literature was missed, including that on other possible manifestations of ageism against younger or older people.

2.1.2 Ageism in the workplace

Several reviews have demonstrated that ageism in the workplace occurs throughout the work cycle: during recruitment, once someone is employed and during dismissal or retirement processes (1, 44-47). Ageism in the workplace can limit older people's income, as explained in Chapter 3.

For example, a systematic review of 60 studies found that employers were less likely to hire older applicants than younger applicants; that once employed, older workers had less access to training; and that those who faced ageism in the workplace were more likely to retire early (1).

A meta-analysis, which quantitatively summarized the effect of ageism on older workers in the workplace, found that the process of hiring older workers, their career advancement, performance appraisals and evaluations of interpersonal skills were all affected by ageism (44). The specific examples provided below illustrate the manifestations of ageism occurring during different phases of the work cycle.

Across a range of sectors (e.g. hospitality, sales, accountancy), younger workers are more likely to be interviewed and hired relative to both middle-aged and older adults (48). For example, in Spain, when employers were presented with the curriculum vitae of an older and a younger candidate who had equivalent characteristics, younger candidates were favoured over middle-aged candidates across six occupations (49). In this research, candidates aged 28 years had a call-back rate for an interview that was 77% above that of the 38-year-old candidates. The disadvantage experienced by older applicants may increase with jobs that require specialized training or in workplaces affected by technological change (50, 51). These research findings are echoed in a 2015 survey of public perception that found more than half of Europeans believed that age was a disadvantage for job applicants who were 55 years and older, but only 16% believed it was a disadvantage for jobseekers younger than 30 years (52).

Ageism, for those in employment, affects access to training opportunities, with older workers being most affected. A study in

Switzerland found that 53% of employees of all ages believed older workers are harder to train, and 52% believed older workers are less interested in challenging jobs (53). The Survey of Health, Ageing and Retirement in Europe found that nearly half of all employed people older than 50 in Greece, Hungary, Poland and Spain reported not having had training opportunities (54).

Ageism may also contribute to older workers retiring prematurely. In an experimental study involving older white-collar workers in Belgium, those presented with negative information about older workers' abilities were then more likely to express intentions to retire early than those presented with positive information (55).

2.1.3 Ageism and the media

Ageism is widespread in the media (56-59). Representations on television and social media and in print are crucial because they influence our everyday perceptions and interactions, including how we relate to older people, and they shape how we each see ourselves growing old (58).

A review of 25 empirical studies, conducted from 1982 to 2020, that analysed the visual representations of older people in print and television advertisements and programmes in Europe and North America found that until the 1990s, older adults were underrepresented and portrayed negatively. In the 1990s, although older adults continued to be underrepresented, there was a shift from negative stereotypes of older adults as unattractive, unhappy, unhealthy, lonely and dependent to a new stereotype of older adults as active, enjoying life and maintaining a healthy lifestyle (58). Implicit in this shift to a portrayal of positive ageing may lurk a more subtle form of ageism: that good health in later life is the choice and responsibility of

the individual and that inequalities in access to resources have little influence (58).

Two studies illustrate the underrepresentation of older people in the media. The first found that only 1.5% of characters on television in the United States were older people, and most of them had minor roles and were often portrayed for comic effect, drawing on stereotypes of physical, cognitive and sexual ineffectiveness (60). The second, an analysis of prime time television series in Germany, found that only 8.5% of main characters were older adults (61).

Ageism in social media is receiving increased research attention. A study focusing on the representation of ageing and older people on Twitter based on 1200 tweets found that the language used in tweets often reinforces negative stereotypes of older adults as a disempowered, vulnerable and homogeneous group, and ageing as something to be resisted, slowed or disguised (62). Another study of 354 tweets found that 12% (43) contained ageist language (63). An analysis of 84 Facebook groups that focused on older individuals found that ageism was rife within the groups. An analysis of the descriptions that introduced the groups showed that all but one focused on negative age stereotypes: 74% (62/84) excoriated older individuals, 27% (23/84) infantilized them and 37% (31/84) advocated banning them from public activities, such as shopping (64).

Media portrayals of older people vary around the world. A review of 25 studies from a range of countries across the WHO Regions of the Americas, Europe, South-East Asia and Western Pacific, which examined how older people are portrayed in the mass media, found important differences between these societies, as well as among Asian countries (57). For example, in the print media in China, Hong Kong Special

Administrative Region, vulnerability was a dominant theme (65), while in the Chinese mass media, filial respect for older people was prominent (66, 67). A comparison of how older people were portrayed in prime time television advertisements in the Republic of Korea and the United States found that older people were more likely to play major roles and be positively portrayed in the Republic of Korea (68).

In Japan, an analysis of some 3000 television advertisements broadcast on the five major commercial television stations found that older people were portrayed in more favourable ways, appeared more often and in more important roles in 2007 than in 1997. Still, older people continued to be underrepresented (69). A study in which Nigerian students were asked to describe how older people were represented in Nigerian films showed that they believed older people were portrayed as "wicked", "weak", "poor" and "diabolical" (70).

Ageism and sexism interact in the media. An analysis of 2000 Hollywood films found that women are given less dialogue the older they get: 38% of dialogue was spoken by women aged 22–31 years and 20% by those aged 42–65 years. In contrast, male actors get more lines as they age, up until age 65. At the age of 65, they begin to be viewed as old. At that point, men speak just 5% of the dialogue and women speak 3% (71). The fact that women are far less likely to be represented in media than men has been reported from around the world (61, 68, 72, 73).

2.1.4 Ageism and the legal system

Ageism against older people in the legal system has been studied with regard to the use of arbitrary age limits in legislation, and in court proceedings and their outcomes.

Examples of arbitrary limits include legislation that specifies upper age limits for organ transplantation regardless of the intrinsic capacity of the patient (74), and legislation that mandates retirement from work based solely on chronological age (75, 76).

Studies of court proceedings and their outcomes have also identified the presence of ageism. A study conducted in Israel asked older women about their legal experience during divorce proceedings in later life. These women reported that they experienced ageism in the way that lawyers and judges treated them (77). Another study in Israel, which examined the knowledge and attitudes of lawyers toward ageing and older persons, found that lawyers expressed low levels of knowledge about ageing, but had mostly neutral and non-ageist attitudes towards their older clients (78).

Another study disentangled the effects of age and sex on witness credibility (79). Some 1300 undergraduate students read a case summary and witness statement in which the sex and age (49, 69, 79 or 89 years) of the witness were varied. The study found that older witnesses were not perceived to be less credible than younger witnesses, and the study also found that older men, but not older women, were regarded as more credible than middle-aged witnesses.

2.1.5 Other institutional settings

Ageism manifests across a range of other institutions and sectors, including housing, technology, finance, responses to emergencies and in the way statistics and data are collected and compiled, all of which have received less attention in research.

Housing

In housing, age-based discrimination can occur during the screening of potential tenants, in the terms and conditions that apply to tenants and in the way people are required to leave (80). For instance, in Japan a study revealed that discrimination against older tenants was associated with several factors including fear that older tenants would get into disputes with other tenants; worries about negligence and safety problems, such as fires; and concerns that older tenants would stay a long time, making it difficult to raise their rent (81). Ageism can also manifest itself in the lack of accessibility, safety and quality in housing for older people (82).

Technology

While technology holds promise to improve the lives of older people, a digital divide has opened up between older and younger people that is partly due to ageism (83-85). For example, older adults who internalize the stereotype that older people cannot master technology may not even try to adopt new technologies (85). Ageist stereotypes may also explain why older adults are seldom included in focus groups assessing the design of new digital technologies (84).

Financial institutions

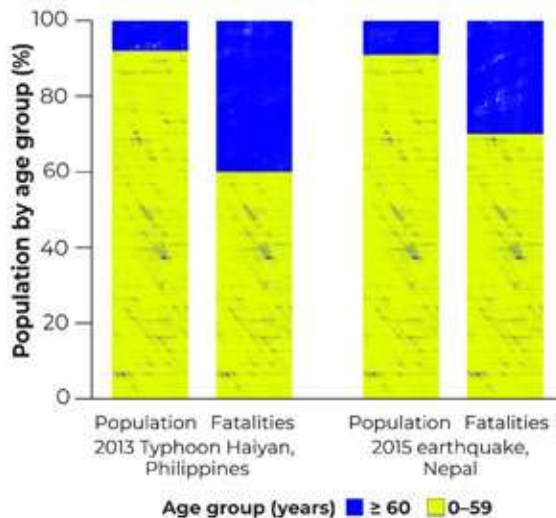
Many credit and loan schemes, particularly in low- and middle-income countries, have been found to discriminate against older people, often making it impossible for them to join. Women are particularly disadvantaged – a further example of how ageism and sexism interact – as they often have no independent income, no control over fixed assets such as land that could act as collateral and limited exposure to business or the formal employment sector (86, 87).

Financial institutions in high-income countries acknowledge that ageism is widespread (88, 89). Yet studies on ageism in the financial services are exceedingly rare. A report by the United Kingdom's Financial Conduct Authority stated that older people are likely to find themselves victims of age discrimination in financial services because age – but not gender or race – can be used as a risk factor in pricing financial products, and financial institutions can refuse to provide products to certain age groups. For instance, because insurance risks are not distributed uniformly across age bands, upper age limits are set for most new travel insurance policies, and mortgages and private health insurance premiums are higher for older people (90, 91).

Natural disasters and conflict-related emergencies

The neglect of older people during natural disasters and conflict-related emergencies has become more visible in recent years (92-97). Older people make up a large and increasing number of those affected by emergencies (92), including natural disasters and conflicts. For example, [Fig. 2.1](#) illustrates the disproportionate impact natural disasters can have on older people (93). Older people are also neglected in funding allocated for humanitarian responses. A 2016 report examined humanitarian funding delivered through the UN consolidated appeals process, using it as a proxy indicator for the degree to which the specific needs of older people are reflected in humanitarian programming (94). It found that of the 16 221 projects implemented between 2010 and 2014, only 6% (1009) included one or more activities that either targeted older people or that included older people alongside other vulnerable groups. Only 51% (513) of these projects were funded.

Fig. 2.1. Comparison of populations affected by and fatalities during natural disasters in Nepal and the Philippines, by age



Source: reproduced with permission from the International Federation of Red Cross and Red Crescent Societies (93).

Statistics and data

Ageism also manifests itself in the way statistics and data are collected and compiled. Examples include data simply not being collected about older people or when such data are collected, they are not disaggregated. For instance, many public health data sets focus on women aged 15-49 years or lump all data into a single age group of >60 years or >65 years, thus hiding the vast diversity among older people.

The use of the dependency ratio (the number of older people [aged > 60 or > 65]/ the number of working-age adults [aged 15-64]) is another instance of ageism as, in effect, it assumes that all older people are dependent. Many older people continue to contribute to the economy. Older adults

offer in-kind or financial support to their children or grandchildren. They volunteer. Many – especially those in countries with no or limited retirement benefits – continue to work in formal or informal employment as long as they can (98). The dependency ratio fails to reflect this.

A third example often pointed to is the indicator of premature mortality, defined as the percentage of 30-year-old people who will die before their 70th birthday from a range of diseases, including cardiovascular disease, cancer, diabetes or chronic respiratory disease. This indicator is used by WHO and included in the Sustainable Development Goals and has been interpreted as "a strong signal in favour of discriminating against older people in the allocation of health resources and the collection of data" (99).

Education

Education is a key institution in which ageism is only starting to receive attention. In the United States, for instance, in 2014, nearly 300 000 adults aged 55 years or older were enrolled in higher education, and 21.5% of the population aged 70 years or older was enrolled in some form of lifelong learning or adult education (100).

Ageism in higher education in the United States takes different forms, facilitated by the historically age-segregated structure of higher education. It can manifest itself in attitudes directed against older people on the part of staff and students and as negative attitudes on the part of older people themselves about returning to their studies. Ageist structural barriers, such as a lack of funding and support services (e.g. to help with technology), also often stand in the way of older people studying (101). Very little evidence on ageism in education is available from the rest of the world.

2.2 INTERPERSONAL AGEISM

This section provides an overview of the prevalence of interpersonal ageism, focusing both on the prevalence of ageist attitudes across countries and cultures, and reported experiences of ageism.

2.2.1 Holding ageist attitudes

An estimate of the prevalence of interpersonal ageism based on a survey of more than 83 000 people from 57 countries covering all six WHO Regions of the world, conducted between 2010 and 2014, showed that at least one in every two people held moderately or

highly ageist attitudes (i.e. stereotypes and prejudice) (102).

This study also classified countries as low, moderate, or high in ageist attitudes and found that 34 of the 57 countries were classified as moderate or high (see [Fig. 2.2](#)). The highest prevalence of ageism was in low-income and lower-middle-income countries (e.g. India, Nigeria, and Yemen): 39% of survey participants from low-income and lower-middle-income countries were high in ageist attitudes. This is concerning, given that about half (48.3%) of the world's population lives in low-income and lower-middle-income countries: 9.3% in low-income countries and 39% in lower-middle-income countries (103).

Lower prevalence rates were found in higher-income countries (e.g. Australia,

Box 2.2

The quality of the scales used to measure ageism

A systematic review of the scales used to measure ageism directed against older people was carried out to evaluate their reliability and validity (i.e. their quality) (106). It identified 11 different scales used to measure ageism, but only the Expectations Regarding Aging scale met the three minimum standards for reliability and validity. This scale assesses only the stereotype dimension of ageism, both towards other people and towards oneself. Thus, it does not evaluate the other two dimensions of ageism: prejudice and discrimination. No scale had high cross-cultural validity, a serious limitation for conducting any cross-national or cross-cultural studies. The review also found that of the many different measures of implicit ageism, none had been assessed in the minimum of three studies needed to be included in the review. To our knowledge, even less is known about the quality of scales used to measure ageism as it affects other age groups or to measure institutional ageism.

An unavoidable conclusion of the review is that existing estimates of the prevalence of ageism, given they were carried out using instruments often lacking reliability and validity, may not be accurate. There is urgent need to develop and validate a scale that can accurately measure the true magnitude and distribution of all the different dimensions of ageism (106). Given the fundamental importance of having a reliable and valid measure of ageism, WHO and its collaborators are developing such a scale as a matter of priority.

Japan and Poland): 69% of participants from high-income countries were low in ageist attitudes compared with 18% from low-income and lower-middle-income countries.

Regarding distribution across sociodemographic characteristics, analyses of these data showed that the prevalence of highly ageist attitudes was slightly higher among younger people and males, and it was markedly higher among people who had less education (102). Importantly, this study used a more comprehensive measure of ageism than many previous studies (see [Box 2.2](#)). The WHO African and South-East Asia Regions were the two regions where the largest proportion of the population held moderately or highly ageist attitudes (85.2% and 86.4%, respectively), whereas the Western Pacific Region had the lowest proportion of the population – 36.6% – holding moderately or highly ageist attitudes (see [Fig. 2.3](#)). A further analysis of the data showed that there were no marked differences in ageist attitudes between men and women in any WHO region (102).

Ageism across countries and cultures

Variations in the rates of ageism across countries and cultures and the factors that may account for these variations are just beginning to be explored. The analysis from WHO presented above, based on data from 57 countries, clearly showed that rates of ageism vary across the world, with low- and lower-middle-income countries having the highest rates.

A 2015 review of 37 papers explored the issue of cross-cultural variation in ageism in greater depth (104). The starting point was the prevailing belief that cultures in the WHO South-East Asia and Western Pacific Regions (e.g. China, India, Japan, Philippines and Viet Nam) hold older adults in higher esteem than in anglophone cultures (i.e.

Australia, Canada, New Zealand, United Kingdom and the United States) and cultures in the WHO European Region (e.g. Austria, Denmark, Greece and Sweden) owing to the stronger collectivist traditions of filial piety.

The analysis found evidence for the opposite pattern: anglophone cultures and those in the WHO European region appear to hold older adults in higher esteem than cultures in the WHO South-East Asia and Western Pacific Regions do. On closer inspection, however, the picture is more complex.

For instance, the review found that people in China, Japan and the Republic of Korea exhibited the greatest negativity towards older people within the WHO South-East Asia and Western Pacific Regions. Non-anglophone Europeans had the greatest negativity towards older people compared with North American and other anglophone countries. Additionally, people in two countries (France and Switzerland) had more negative perceptions of older people than people in the WHO South-East Asia and Western Pacific Regions. This analysis also found that negative views of older people appear to be driven by recent, rapid demographic changes in population ageing (see Chapter 5).

These and other findings highlight the inadequacy of using broad, geographical generalizations to understand contemporary attitudes towards older adults (104, 105).

A 2019 review of attitudes towards ageing and older people in Arab cultures identified seven empirical studies (107). The review paints an inconclusive and heterogeneous picture and calls for more and better research. Some of the studies pointed to more positive perceptions of ageing in Arab cultures than in the other countries studied

Fig. 2.2. Map of countries showing countries classified as low, moderate or high in ageist attitudes

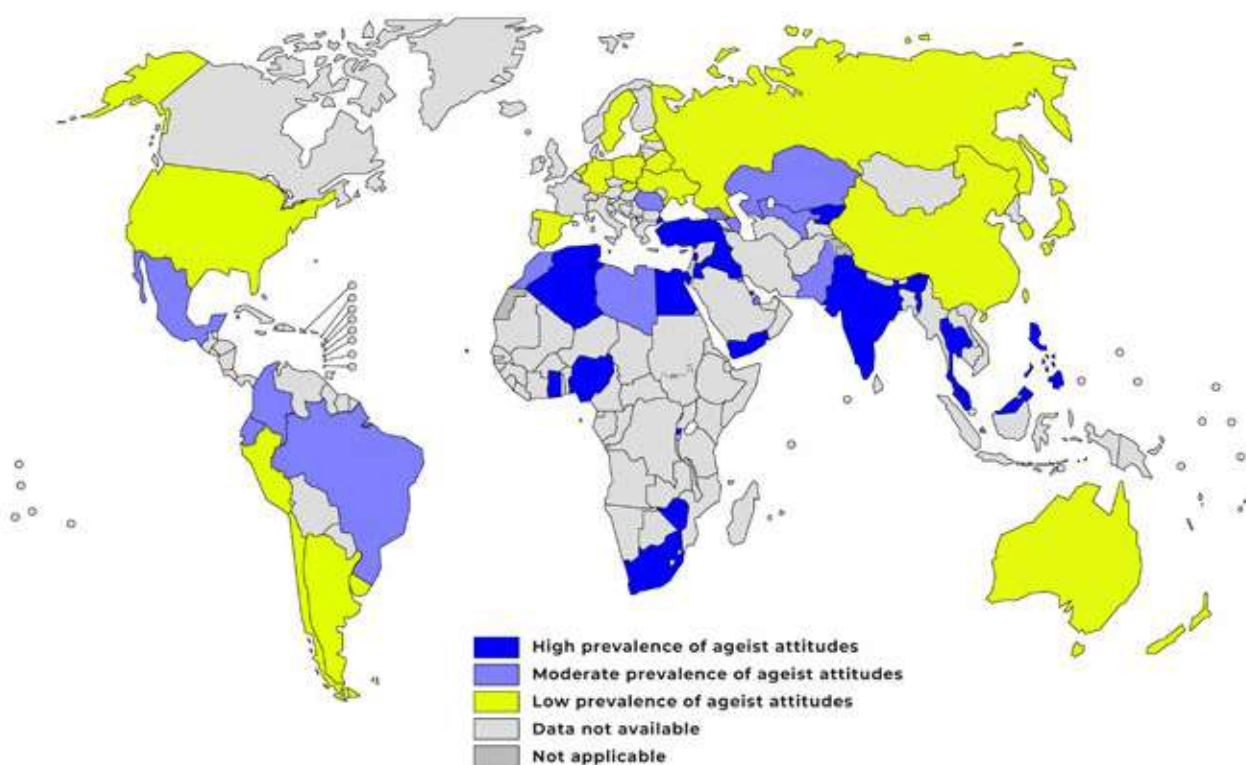
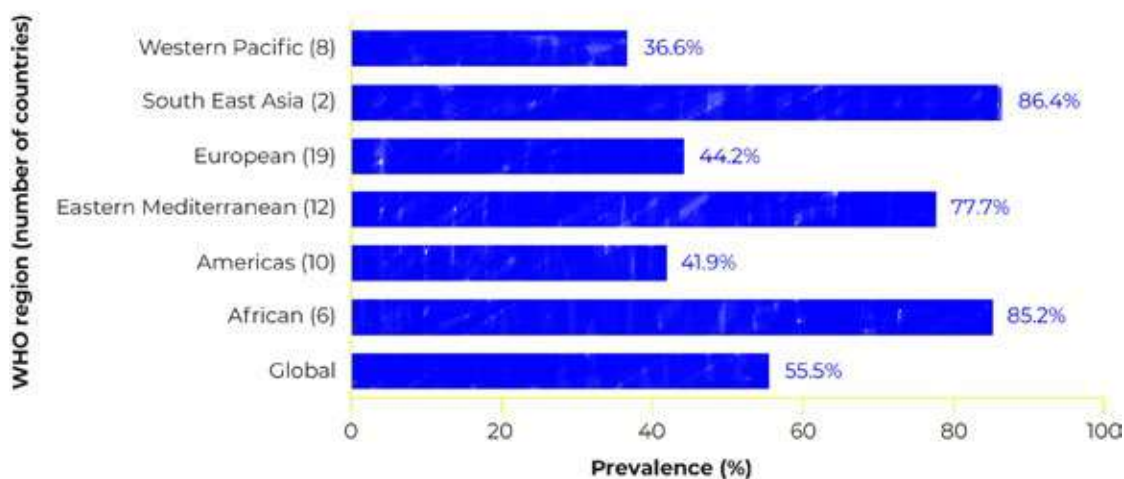


Fig. 2.3. Prevalence of population holding moderately or highly ageist attitudes by WHO region, from a further analysis of data in reference 102



Note: The percentages apply only to the pooled data of the countries included in the analysis for each region (e.g. the 12 countries in the WHO Eastern Mediterranean Region).

(e.g. France, the Netherlands), such as more tolerance of older people, a stronger perception of older people as contributing to society and a greater sense of filial piety. But in other studies, sometimes conducted within the same country, a more negative view prevailed. The inconclusive findings may be related to differences among the respondents in terms of gender, age, urban or rural residence and education level. The authors speculate that the differences may also partly be due to the pressure of social norms that prescribe reverence for older people. This may lead respondents to feel reluctant to express negative views about individual older people, but freer to be critical of older people in general.

Ageism across time

Age stereotypes related to older adults may have become more negative over time, as suggested by limited evidence from the English-speaking world (108, 109). However, global data on historical trends in prevalence are lacking. A study based on an analysis of the 400 million word Corpus of Historical American English (1810–2009) found that age stereotypes have become more negative – in a linear way – during the past 200 years and that age stereotypes switched from being positive to negative around 1880. Two main factors were associated with this switch: the medicalization of ageing and the proportion of the population older than 65 years (108).

Another study, using Google Books' Ngram Viewer search engine, which charts word frequencies in more than 5 million fiction and non-fiction books published between 1800 and 2000, found that from the early 1900s there was a shift from more positive to fewer positive terms about older adults, which may reflect a change in attitudes towards them (109). The analyses also

revealed that young and old women have been underrepresented in literature for the past 200 years, with the greatest difference appearing in 1900 when the term "old man" occurred more than three times more often than did "old woman".

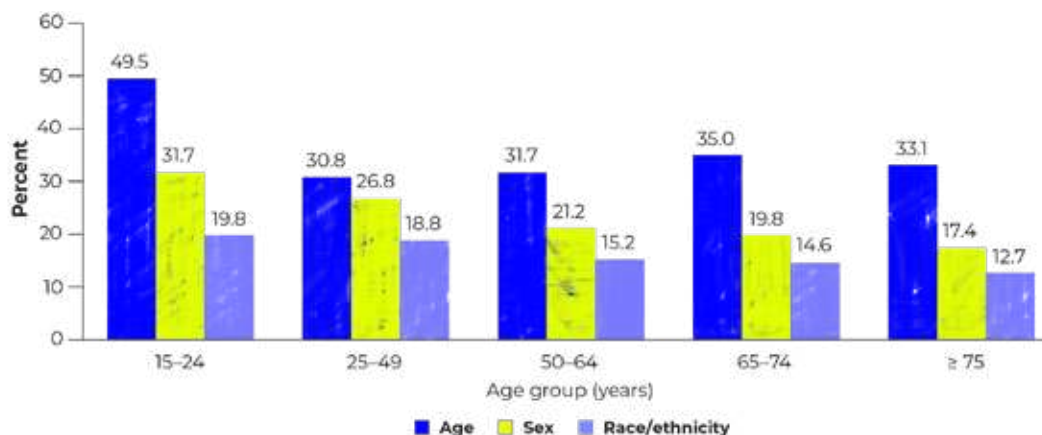
2.2.2 Experiences and perceptions of interpersonal ageism

Knowing the proportion of people who hold ageist attitudes is important; however, these figures are incomplete and are likely to be underestimations. Data on attitudes are likely to be underestimations, given people's tendency to provide socially acceptable responses instead of choosing responses that reflect their true attitudes and behaviours (110). In addition to data on attitudes, information on the number of people who report experiencing ageism is essential; however, cross-national data on age-based discrimination derive predominantly from European countries and focus only on perceived age discrimination.

Across 28 countries in Europe, more than one in three people aged 65 years or older reported being a target of ageism (i.e. insulted, abused or denied services because of their age). The only age group to report higher rates of ageism were those aged 15–24 years (see Chapter 5).

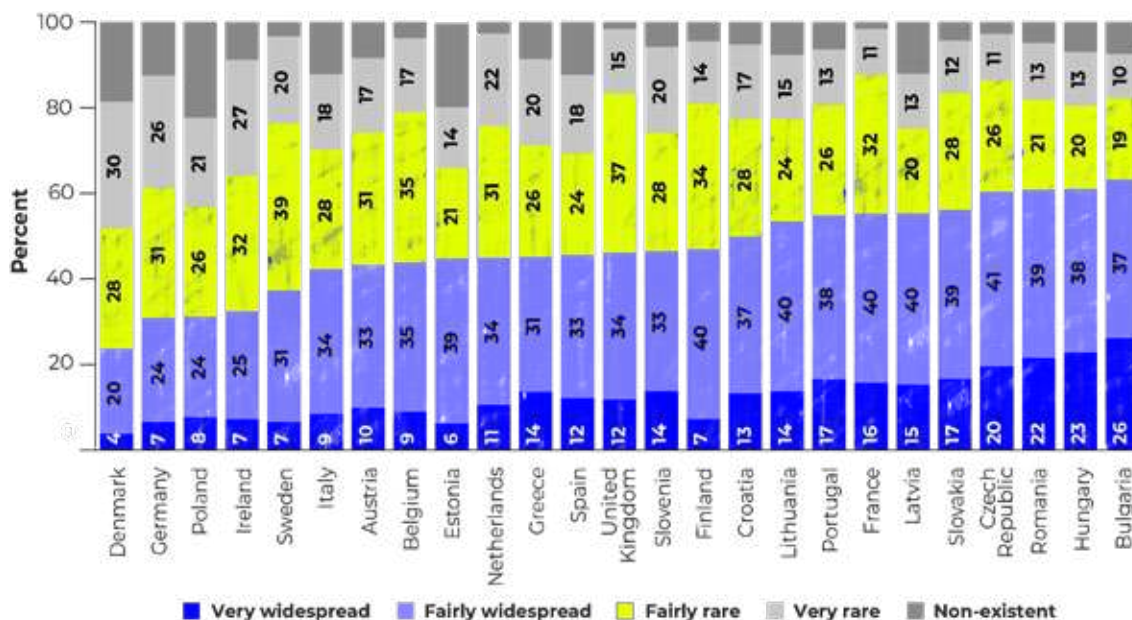
Older people, along with all other age groups, also reported experiencing more discrimination based on age than discrimination based on sex, race or ethnic background (see Fig. 2.4) (111). More recent comparable data are available about the proportion of people who perceive that discrimination against people aged 55 or older is very or fairly widespread in the European Union. Findings vary from a high of two out of three people in Bulgaria (63.1%) to a low of one out of four people in Denmark (23.6%) (see Fig. 2.5) (112).

Fig. 2.4. Percentage of people responding to the European Social Survey who reported experiencing unfair treatment because of their age, sex or race or ethnic background, by age group, 2008–2009 (includes only individuals who did not rate their experience as 0 on a scale that ranged from 0, indicating they had never experienced unfair treatment, to 4, indicating it was experienced very often)



Source: reproduced with permission from Abrams et al. (111).

Fig. 2.5. Comparison of perceptions of discrimination against people aged ≥ 55 years in 25 European Union countries



Source: reproduced with permission from Rychtaříková (112).

Although comparable cross-national data from other parts of the world about experiences and perceptions of ageism are lacking, some country-specific studies are available. For instance, in a nationally representative sample of people aged 50 years and older in Brazil, 16.8% of the population surveyed reported feeling that they had been the victim of some type of discrimination during the past year. This proportion was higher among urban dwellers than rural dwellers, most likely to occur in health care settings, and least likely to occur at work (113).

Discrimination against widows and accusations of witchcraft are examples of how ageism interacts with sexism and puts older women in a situation of double jeopardy.

Discrimination against widows – of which there are some 250 million in the world – and accusations of witchcraft, both of which often target older women, are examples of how ageism interacts with sexism and puts older women in a situation of double jeopardy (114-116). Although quantitative data about the exact scale of discrimination against widows and accusations of witchcraft are scarce, these phenomena are widely reported to occur, particularly, but not exclusively, in sub-Saharan Africa (115, 117, 118). The forms of injustice that widows are subjected to – based on the intersection of their status as a widow, their gender, and often their age – are manifold, with some being widespread and others more culturally specific.

One example is the theft of widows' property and the denial of their inheritance, which is reported to occur in sub-Saharan Africa, South America, South Asia and

the Middle East (118). Another example includes traditional widowhood customs, such as the social ostracism of widows, bans on remarriage and so-called cleansing rituals. These so-called cleansing rituals, which occur in parts of sub-Saharan Africa, sometimes require the widow to have sexual intercourse with a brother-in-law or another man to remove evil spirits (115, 118).

Accusations of witchcraft, most of which are directed at older women, are reported to occur frequently in countries in sub-Saharan Africa. Such accusations may result in the older woman being ostracized and neglected, driven out and banished from her community, or burned, stoned, chained up and, in some instances, killed (115, 118). In the United Republic of Tanzania, for instance, some 2500 older women were reportedly killed between 2004 and 2009 after being accused of witchcraft (119). In Burkina Faso, hundreds of older women accused of witchcraft (and called *les mangeuses d'âmes*, or soul eaters) have been either killed or banished (120). In northern Ghana, more than 1000 older women who were alleged to be witches have been driven out of their homes and are living in makeshift camps (121).

2.3 SELF-DIRECTED AGEISM

Self-directed ageism can have a serious impact on people's health, as shown in Chapter 3. But cross-national population-based studies of the prevalence of self-directed ageism are rare. In Panama, a study found that almost half (46.3%) of respondents aged 18–65 years recalled having engaged in self-directed ageism at least once, usually in response to a personal physical deficit (122).

Several studies have explored self-perceptions of ageing (i.e. people's perceptions of themselves as they age), sometimes viewed as a proxy for self-directed ageism. For instance, studies have explored the distribution of self-perceptions of ageing according to different sociodemographic characteristics, including gender, race, ethnicity and education. A study in Germany found that positive self-perceptions of ageing increase in midlife but then decrease in later life (123). Findings about the relation between gender and self-perception have been inconsistent (124-126). People with higher incomes and education appear to have more positive self-perceptions of ageing than people with lower incomes and education (123, 127).

2.4 CONCLUSIONS AND FUTURE DIRECTIONS

Ageism against older people is pervasive globally. It manifests itself in all key institutions in society. For example, in health and social care, where health care is sometimes rationed based on age; in the workplace during recruitment, employment and processes of retirement and dismissal; and in the media, where older people are often underrepresented.

Globally, at least one in two people hold ageist attitudes towards older adults. Across the countries in the European Social Survey, one in three older people has experienced ageism. Thus, ageism affects billions of people globally – and its spread may be increasing. Ageism constitutes both a serious and widespread human rights problem and a far-reaching public health problem, as both this chapter and Chapter 3, which discusses the impact of ageism, demonstrate.

Future priorities for understanding the scale of the problem should include:

- monitoring and tracking ageism in a range of key institutions, particularly among health and social care workers, in the housing sector, in the legal system and during emergencies, as well as in low- and middle-income countries more generally;
- using the instruments being developed to measure all of the different types and dimensions of ageism (see [Box 2.2](#));
- conducting population-based surveys of ageism using these newly developed instruments to better estimate the global prevalence and distribution of, and trends in, ageism, including self-directed ageism;
- conducting studies on the intersection between ageism and other "isms", including on situations of discrimination against widows and accusations of witchcraft.

Ageism affects billions of people globally and constitutes both a serious and widespread human rights problem and a far-reaching public health problem.

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GERTRUDE, 60,
KENYA

03

THE IMPACT OF AGEISM AGAINST OLDER PEOPLE

“Teaching is in my blood. It is no surprise I felt devastated when the Government told me at the age of 50 that I must stop working. They told me I was old and that I should allow young people to do the teaching. I felt bitter and angry.”

Gertrude, 60, Kenya

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Chapter

03

This chapter details the serious impacts of ageism against older people (see Fig.3.1). Section 3.1 describes the dramatic impact ageism has on health (including on well-being), leading, for instance, to preventable death and serious physical and mental health problems. Section 3.2 explores the heavy economic toll ageism takes on older people and on national economies. Overall, the impact of ageism is so serious and its costs appear to be so high that an intervention with only a modest effect has the potential to improve lives substantially and cut the economic costs of ageism significantly.

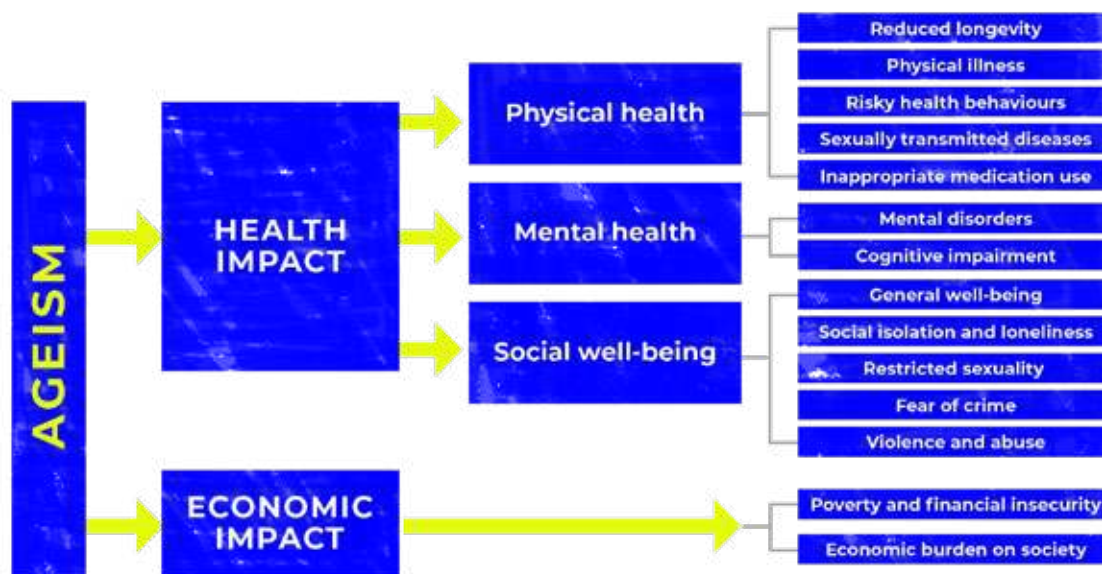
Ageism shortens lives; leads to poorer physical health and worse health behaviours; impedes recovery from disability; results in poorer mental health; exacerbates social isolation and loneliness; and reduces quality of life.

Ageism takes a heavy economic toll on individuals and society, contributing to financial insecurity and poverty and costing society billions of dollars.

3.1 THE IMPACT OF AGEISM ON HEALTH

Ageism has a serious impact on all aspects of health, which is defined by WHO as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (1) (see Fig. 3.1). Ageism thus constitutes an important, and hitherto neglected, social determinant of health. Its impact on health is on par with, if not greater than, that of racism, a form of prejudice and discrimination whose health consequences have been widely studied (2).

A global systematic review on the impacts of ageism on health commissioned for this report, which included 422 studies from 45 countries, found that in 405 (96%) studies, ageism was associated with worse outcomes in all of the health domains examined (2) (see Box 3.1). The association between ageism and health outcomes was strongest for self-directed ageism. The effects of ageism on health are seen in all parts of the world, have increased over time, and are most likely to impact disadvantaged groups. Furthermore, older people with lower levels of education are more likely to experience the health consequences of ageism. The review found there were health impacts from ageism in all 45 countries and across all areas (2). However, of

Fig. 3.1. The impacts of ageism on older people

the 422 studies included, 78.2% were conducted in North America or Europe, and only 1 study was conducted in Africa.

Consistent with other recent studies (3-5), many of the health consequences of ageism found in the systematic review appear to be increasing. This may be associated with financial downturns, as research has shown that economic crises lead to increases in prejudice and discrimination (2, 6, 7). Although the overall evidence of ageism among health-care workers is inconclusive, as shown in Chapter 2, it is possible that it may be increasing, perhaps because of the growing time pressure health workers are under (2).

3.1.1 The impact of ageism on physical health

Ageism is associated with earlier death (2). This finding was consistent across 10 studies that examined this ultimate end point in Australia, China, Germany and the United States (9-17). In China, researchers

found that older persons prone to self-directed ageism had an almost 20% higher likelihood of dying over the six-year study period than those with more positive self-perceptions (17).

Ageism is linked to poorer physical health, and it impedes recovery from disability. A total of 50 (96%) of the 52 studies that investigated the impact of ageism on physical illness found a link (2). Physical illness was measured by functional impairment, the presence of chronic conditions and the number of acute medical events and hospitalizations. For instance, in a study in Connecticut, United States, older persons who held positive age stereotypes were 44% more likely to fully recover from severe disability than those with negative age stereotypes (18).

Ageism increases risky health behaviours. In all 13 studies of this topic (2), people who had experienced ageism were more likely to adopt risky health behaviours, such as eating an unhealthy diet, not taking their medication as prescribed,

Box 3.1**Opportunities for research on the impact of ageism against older people**

The systematic review commissioned for this report on the impact of ageism against older people marks a major step forward in improving the quality of research in this area (2). It was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (8), based on a search of 14 electronic databases, included only studies that used appropriate designs and carefully assessed the quality of the studies. In addition, the review performed sensitivity – sometimes called "what if" – analyses and showed that the findings would have been the same if all of the studies had been of higher quality or included more participants.

This review was unable to estimate the strength of the association between ageism and its effects. To do this, studies would need to use more standardized and comparable definitions and measures of these effects. Estimating the strength of associations between ageism and its impacts, and more clearly demonstrating that ageism is indeed the cause of these impacts, rather than simply being associated with them, are areas where future studies and reviews should focus. The former would provide information on the relative importance of the different impacts of ageism, whereas the latter would increase our confidence that the relations between ageism and its putative effects are real. Future studies might also try to estimate the population attributable fraction for ageism at the level of countries, regions and the world. The population attributable fraction is the proportional reduction in population disease or mortality that would occur if exposure to a risk factor – ageism in this case – was reduced. For instance, it would allow us to say that if ageism was reduced by X%, longevity would be increased by Y%.

drinking excessively or smoking, or some combination of these. A study of older people in Ireland that examined the relation between self-directed ageism and cigarette and alcohol use, showed that greater awareness of, and stronger emotional reactions to, ageing increased the likelihood of smoking (19).

Ageism contributes to poor sexual and reproductive health and is associated with an increase in rates of Sexually transmitted diseases (STDs). Epidemiological research from around the world indicates that rates of STDs are increasing in older people, and ageism may have a part to play in this (20-22).

Older people may be at greater risk of STDs due at the lack of information and campaigns targeted at them. Older people are also less likely to seek diagnosis and treatment because there is limited information about STDs, a lack of sexual health services for older people and a fear of encountering ageist attitudes towards their sexuality (21).

The exclusion of older people from surveillance data and research studies on STDs may also have contributed to the increase in STDs in this population by reducing awareness of the risk of STDs among older people (21, 22).

For example, in China, 15.8% of all STD cases in men and 9.8% of all STD cases in women occurred in those aged 50 years and older, and people aged 65 years and older accounted for some 10% of newly reported cases in 2016 (23, 24).

In Botswana, the country with the second highest HIV prevalence in the world, rates of HIV prevalence in older men have increased from 17.2% in 2004 to 27.8% in 2013 and in older women from 16.3% in 2004 to 21.9% in 2013 (20).

Both interpersonal and institutional ageism can contribute to inappropriate medication use, including inappropriate prescribing, polypharmacy and medication nonadherence, all of which can have serious consequences.

Information is sometimes lacking about the efficacy and safety profiles of medications for older people because the necessary age-specific clinical trials have not been conducted: this is a form of institutional ageism that can result in inappropriate prescribing and polypharmacy (25-27). Poor coordination of care for older people, ineffective communication and inadequate education of older adults about medication are forms of institutional and interpersonal ageism that can lead to medication nonadherence (28-30).

Largely due to inappropriate prescribing, some 25% of patients aged 70–79 years suffer from adverse drug events compared with about 4% among those aged 20–29 years (25, 31, 32).

Polypharmacy, which is widespread among older people, results in a host of negative consequences: increased health care costs, adverse medication reactions, reduced intrinsic capacity and higher occurrence of geriatric syndromes, such as falls (28, 33).

More than 10% of older adults' admissions to acute care may be caused by nonadherence to medication regimens (34), and a quarter of admissions of older adults to nursing homes may be due to older people's inability to self-administer medication (35).

3.1.2 The impact of ageism on mental health

Ageism is also associated with poorer mental health. Some 96% (42/44) of the studies (2) that examined the relationship between ageism and mental health found evidence that ageism influenced psychiatric conditions. In 16 studies, ageism was associated with the onset of depression, increases in depressive symptoms over time and lifetime depression. When older American veterans resisted negative age stereotypes, they were found to be less likely to experience suicidal ideation, anxiety and post-traumatic stress disorder (36).

Based on figures for 2015, globally, about 6.33 million cases of depression are estimated to be attributable to ageism, with 831 041 cases occurring in more developed countries and 5.6 million cases in less developed countries (2).

Ageism accelerates cognitive impairment. Four of the five studies (80%) in the review that investigated a possible link between ageism and cognitive impairment found a relationship (2). One of the studies, in Germany, followed up 8000 people over several years and revealed that negative self-perceptions of ageing accelerated cognitive decline as measured by cognitive processing speed, whereas positive self-perceptions slowed it down (37).

These findings complement the large body of experimental studies on this topic summarized in several meta-analyses (38-40). These have shown that when

older people are exposed to negative stereotypes – regardless of whether they are conscious of it – their cognitive ability and memory decrease, a phenomenon known as stereotype threat (see Chapter 1, Section 1.2). An implication of these findings is that poorer results in clinical or workplace assessments of cognitive functioning in older adults may be partly due to exposure to negative stereotypes (39).

Ageism in the media negatively impacts health and cognitive performance. Ageist stereotypes in the media can have a negative impact on older people's self-esteem, health status, physical well-being and cognitive performance (12, 41, 42). Underrepresenting or misrepresenting older people in the media is not harmless, and Chapter 2 showed that it is widespread. A meta-analysis found that no more than brief exposure to stereotypes in the media had small, harmful effects on older people's performance on memory tasks (43).

Ageism in the workplace is associated with health problems. Workplace ageism predicted worse health in most of the 27 studies that evaluated its health impacts (2). For instance, a study of more than 6 000 employees in Finland revealed that perceived age discrimination at work led to subsequent long-term sick leave (44). This is probably due to a chain reaction in which work stress first increases the risk of health symptoms, which later increases long-term sickness absence (44).

3.1.3 The impact of ageism on social well-being

Ageism can have a far-reaching impact on older people's general quality of life and can also affect specific aspects of their social well-being. For instance, ageism can lead to social isolation and loneliness and restrict older people's sexuality. Ageism may also

be associated among older people with greater fear of crime and an increased risk of experiencing violence and abuse.

General quality of life

All 29 studies included in the 2020 systematic review that looked at ageism and quality of life found that ageism had a negative impact on quality of life (2). For instance, a study that evaluated the impact of attitudes towards ageing and quality of life among older people in 20 countries – including two middle-income countries, Brazil and Turkey – produced consistent findings across all of the countries: quality-of-life judgements made by people aged between 60 and 100 years were the product of older men's and women's perceptions of health-related circumstances and attitudes towards the physical and psychosocial aspects of the ageing self (45).

Social isolation and loneliness

Ageism contributes to social isolation and loneliness, which are widespread among older people. And social isolation and ageism have serious impacts on health and longevity.

Ageism increases social isolation and loneliness in three main ways. First, ageism can result in feelings of being undesired, unwanted, betrayed and socially rejected, which can lead to social withdrawal. Second, as in a self-fulfilling prophecy, older people can internalize ageist stereotypes – for instance, that old age is a time of social isolation and low social participation – and then act accordingly, by withdrawing from society. Third, ageist society-wide laws, norms and practices, such as mandatory retirement or design features of the living environment (e.g. inaccessible transport, cracked or uneven sidewalks), can act as barriers to older adults' participation in social activities, leading to social isolation and loneliness (46).

In a 2020 review, ageism was found to be a risk factor for poor social relationships in all 13 studies that examined this association (2). For instance, the negative self-perceptions of ageing held by older Chinese people were associated with their dissatisfaction in the social support provided by their children (47).

Rates of loneliness and social isolation are high among older people. In Finland and the United Kingdom, 40% of older adults living in the community reported experiencing some degree of loneliness (48, 49). In China, 24.8% of older adults living in the community reported that they sometimes felt lonely, and 8.3%, often or always felt lonely (50).

Multiple studies and reviews have shown that social isolation and loneliness have serious impacts on the mortality of older people, on their physical health and functioning (e.g. heart disease, diabetes, mobility, activities of daily living) and on their mental health (e.g. depression, anxiety and cognitive decline) (51-55).

Sexuality

Sexuality is another important aspect of older people's relationships that ageism can impact. Despite a recognition that sexuality is important to older people, ageist portrayals of sexuality in later life in the media, attitudes of health care and long-term care providers and of older people themselves often impede the free and full expression of older people's sexuality (56). Older people have a right to sexual health, defined by WHO as a state of physical, mental and social well-being in the sphere of sexuality (57).

Studies in multiple countries – including Algeria, Egypt, Indonesia, Mexico, Morocco, Nigeria and the Philippines – have consistently found that older people continue to engage in sexual activities

and view sexuality as a major component of their quality of life and well-being (54, 56, 58-61). Yet the topic of older people's sexuality often remains taboo. When it is addressed, it is often from a biomedical perspective that portrays older people as asexual and assumes decline in sexual function in later life. This assumption appears to be the result of too narrow a definition of sexual function (e.g. excluding solo, non-penetrative and same-sex sexual activity) and too great a focus on biological determinants of sexual function (e.g. declining levels of testosterone) to the exclusion of psychological and social determinants (e.g. depression, presence or absence of partners and characteristics of the relationship with a partner) (62).

Research shows that older people often internalize ageist stereotypes and myths regarding sexuality in later life. They are reluctant to express their sexuality and are often hesitant to discuss sexual issues with their doctors for fear of being met with disapproval. Older women have been found to internalize ageist cultural norms of beauty and to view themselves as unattractive (63, 64).

In many parts of the world, older women's sexuality may be exposed to the double jeopardy of ageism and sexism. A study in sub-Saharan Africa showed that myths, prejudices and misconceptions, rooted in religious and traditional customs and beliefs, often cause older women who show an interest in sex to be judged as behaving inappropriately and disrespectfully: a double standard that does not apply to men (65).

Health-care providers' education and training often does not prepare them to adequately address sexual health in older people, and many consider the topic

to be outside their scope of practice (66-68). In long-term care facilities, staff knowledge about sexuality among older people is often limited, and they are uncomfortable discussing sexuality with older people. The privacy required for sexual expression is rarely provided; clear policies regarding sexuality are often lacking; and prospective residents are seldom given information about how their sexual and intimacy needs will be respected (56, 68-70).

In many parts of the world, older women's sexuality may be exposed to the double jeopardy of ageism and sexism.

At the same time, the promotion of active and successful ageing may sometimes create unrealistic expectations concerning sexuality that may be at odds with the reality of some older people, a more subtle form of ageism that contributes to shame and loss of self-esteem (62, 71).

Fear of crime

Ageism may have a role in how police and policy-makers treat older people as being particularly vulnerable to crime, in sensationalistic media portrayals of – generally rare – attacks on older people and in depictions of them as prisoners of fear who are terrified to leave their homes. Such representations of older people may become internalized, lead to older people overestimating their vulnerability and fuel their fear of crime, resulting in the paradox of older people having a high fear of crime, but a low risk of victimization (72).

Violence and abuse

Ageism may increase the risk of violence being perpetrated against older people. According to a recent global review of the prevalence of violence against older people, some 15.7% of older people – or almost 1 in 6 – are victims of abuse. Some 11.6% of older people are victims of psychological abuse, 6.8% of financial abuse, 4.2% of neglect, 2.6% of physical abuse, and 0.9% of older people are victims of sexual abuse (73).

Although it is possible that ageism increases the risk of violence against older people, empirical evidence for the link between the two remains limited (74, 75). Negative stereotypes of older people (e.g. as dependent and burdensome), prejudices and discrimination dehumanize them and could contribute to making violence against older people more permissible (75-77).

Ageism may act as a risk factor for the financial abuse of older people by financial service institutions, defined as direct or indirect practices of these institutions that target or threaten the financial well-being of older people. An example might be selling inappropriate financial products to older people or pressuring them to invest their assets against their will (78).

3.2 THE ECONOMIC IMPACT OF AGEISM

Evidence of the economic impact of ageism is extremely limited, both for individuals and whole societies. What evidence exists, however, suggests that the economic costs of ageism may be high.

Estimates of the economic costs of health and social problems are important. They define the burden of the problem for society in financial terms. They can be used to justify intervention programmes and are required for assessing programmes' cost-effectiveness. Estimates can be used to help set policy and planning priorities and guide the allocation of research funds (79-81). They are also critical for understanding how health and social problems slow social and economic development. Finally, estimates of economic costs raise the visibility and, thus, the political and funding priorities of health and social problems.

Given the growth in the population of older people globally, but particularly in low- and middle-income countries, ending poverty in all its forms everywhere, as called for by the 2030 Agenda for Sustainable Development (82), depends on ending poverty among older people. And ending poverty among older people depends, at least partly, on tackling ageism.

3.2.1 Ageism, poverty and financial insecurity among older people

Ageism may increase the risk of poverty and financial insecurity in older age. The previous chapter of this report, on the scale of ageism, showed that ageism occurs throughout the employment cycle, from hiring and recruitment through to training, advancement opportunities and retention, and all the way to retirement. Although the cumulative financial impact of ageism over an employee's lifetime has not been estimated, there is no doubt that ageism leaves people less well off than they would have been otherwise.

There is some evidence from Australia that ageist discrimination in the labour market is associated with the unemployment

or underemployment of older people and dependency on social security, thus contributing to poverty among older adults (83).

Laws that mandate retirement age have sometimes been interpreted as being a form of institutional ageism that contributes to older people's financial insecurity. However, their impact on older people's financial status is not straightforward and continues to be a matter of debate, depending on, among other factors, the level of provision of state pensions in a country (84, 85).

Although the cumulative financial impact of ageism over an employee's lifetime has not been estimated, there is no doubt that ageism leaves people less well off than they would have been otherwise.

The loss of financial security and subsequent fall into poverty can have devastating impacts on an older person. They can result in a rapid decline in health, earlier mortality and dependency on state welfare systems, where such systems exist (86, 87). Yet studies looking at how ageism contributes to poverty remain rare. More research in this area should be carried out as a matter of priority in high-, middle- and low-income countries.

3.2.2 The economic burden of ageism on society

Ageism costs society billions of dollars, but, to date, few estimates of the economic costs of ageism to the wider society and economy, particularly at the level of countries, have been carried out. A study on ageism in the workplace found that in a company of 10 000 persons in the United States, disengagement

of workers due to age discrimination led to some 5000 unexcused days of absence and about US\$ 600 000 in lost salary payments per year (88). Estimates in Australia suggest that if 5% more people aged 55 or older were employed, there would be a positive impact of 48 billion Australian dollar on the national economy annually (89).

A study found that in the United States, annually one in every seven dollars spent on health care for the eight most-expensive conditions was due to ageism.

The first study of the economic burden of the health consequences of ageism on a national economy, conducted in the United States, was published in 2020 (90). The study calculated the costs of ageism to the United States over 1 year in relation to the eight most expensive health conditions for all persons aged 60 years or older. The eight health conditions were: cardiovascular disease, chronic respiratory disease, musculoskeletal disorders, injuries, diabetes mellitus, smoking-related diseases, mental disorders and noncommunicable diseases. Overall, the study found that in the United States, annually one in every seven dollars – or US\$ 63 billion in total – spent on health care for the eight most-expensive conditions was due to ageism. Negative self-perceptions of ageing cost US\$ 33.7 billion; negative age stereotypes, US\$ 28.5 billion; and age discrimination, US\$ 11.1 billion. These findings make a strong case for implementing interventions to reduce ageism (90). Even if an intervention only has a modest impact by, for example, reducing the number of cases of these serious health conditions by 5%, in the United States this would amount to a savings of US\$ 3.15 billion or 852 000 million fewer cases of these eight health conditions.

3.3 CONCLUSIONS AND FUTURE DIRECTIONS

As a public health problem, ageism is an important social determinant of health that has too long been neglected. But ageism is also a development and human rights issue with serious consequences.

Drawing on some 500 studies from more than 50 countries, this chapter has shown that the stereotypes, prejudice and discrimination associated with ageism take a heavy toll on the health and well-being of older people, that ageism costs countries billions of dollars a year and that it may be contributing to poverty among older people. These findings suggest that it is ageism – and not older people – that places a heavy burden on society.

Ageism increases risky health behaviours, negatively affects physical and mental health, accelerates cognitive decline, slows recovery from disability and reduces longevity. The impacts of ageism extend beyond the body, undermining social relationships and contributing to older people being socially isolated and lonely, and it may increase their fear of crime and risk of being a target of violence and abuse. Even if interventions to reduce ageism were to have only small effects, they could lead to big improvements in older people's lives and large savings for countries.

Future priorities to improve understanding and to direct actions on the impact of ageism as well as strengthen the case for combating it should include:

- raising public awareness of the far-reaching detrimental effects of ageism;

- filling the research gaps, including:
 - (i) demonstrating that the relationships between ageism and the impacts identified in this chapter are indeed causal and not simply associations (see [Box 3.1](#));
 - (ii) generating more research on the impacts of ageism in low- and middle-income countries; and
 - (iii) understanding if and how the impacts of ageism vary across individual characteristics (e.g. age, gender, race, disability, sexual identity), contexts and countries;
- producing estimates of the economic impacts of ageism and determining how ageism contributes to poverty among older people, its wider costs to national economies, and how ageism contributes to slowing social and economic development, particularly in low- and middle-income countries.

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ISABEL, 80,
THE PLURINATIONAL
STATE OF BOLIVIA

04

THE DETERMINANTS OF AGEISM AGAINST OLDER PEOPLE

“ Older people are discriminated against at home because the family don't understand them. The children, the daughter-in-law, the neighbours don't understand and this is how the discrimination and abuse begins. However public institutions are the worst perpetrators of age discrimination. ”

Isabel, 80, The Plurinational State of Bolivia
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Chapter

04

Identifying the determinants of ageism – both the risk and protective factors – is a prerequisite for developing effective strategies to reduce ageism. Risk factors are characteristics that increase the likelihood of ageism. Protective factors are characteristics that decrease the likelihood of ageism or provide a buffer against risk. To work, strategies to reduce ageism must target the determinants that cause ageism.

Section 4.1 of this chapter focuses on the determinants of interpersonal ageism. It examines individual characteristics associated with being a perpetrator and a target of interpersonal ageism and the contextual-level determinants of interpersonal ageism. Section 4.2 addresses the determinants of self-directed ageism. No evidence was found about the determinants of institutional ageism, a notable gap.

Individual characteristics associated with perpetrating interpersonal ageism against older people are age, sex, education, anxiety about or fear of death, certain personality traits, contact with older people and knowledge about ageing.

Individual characteristics associated with being a target of interpersonal ageism are older age, poorer health status and care dependence.

The main contextual determinants of interpersonal ageism are the healthy life expectancy of the country and working in certain professions and occupational sectors.

Individual characteristics associated with self-directed ageism are having poorer mental and physical health and lacking positive contact with grandchildren.

Findings in this chapter are primarily based on a comprehensive systematic review of the determinants of ageism against older adults (1). Only those determinants for which a clear association was found between a risk or protective factor and ageism are reported.

Dozens of other possible determinants – such as race and ethnicity, working or caring for older people, socioeconomic status, employment status, being part of a collectivist or traditional culture – were examined in the review, and either no association with ageism was found or the results were mixed. Several of these possible determinants, as well as others not examined – such as the presence of a social welfare system and universal health coverage – require further investigation. Furthermore, few of the studies included in the systematic review were conducted in low- and middle-income countries (1).

This chapter supplements the overview of the main determinants of ageism identified to date with a brief survey of three of the main theories of ageism for which there is considerable empirical support. Theories of ageism are explanations that specify the underlying causal mechanisms that produce ageism.

For strategies to reduce ageism to be effective, the causal mechanisms that are modifiable must be targeted (2-4). The specific programme theories or theories of change that underlie the development of effective strategies to reduce ageism draw on such broader, empirically supported theories of ageism (5-7).

4.1 DETERMINANTS OF INTERPERSONAL AGEISM

This section provides an overview of the main determinants of interpersonal ageism, including individual characteristics associated with being a perpetrator or target of ageism and contextual determinants of interpersonal ageism (see [Table 4.1](#)).

4.1.1 Individual characteristics associated with being a perpetrator of ageism

Age, sex or gender, and education

A recent study in 57 countries found that being younger, male and having a lower level of education increase the likelihood of a person being highly ageist. The effect of education was more marked than those of being younger or male, which increase the risk of ageism against older people only slightly (8). Having a lower level of education also increases the probability of an individual being moderately ageist (8). Previous smaller studies have shown similar results regarding sex or gender (9-13), age (14-16) and education (17, 18). However, these findings have not always been consistent (1).

Among health and social care professionals, however, age and sex/gender have not always been found to be determinants of ageism. A 2013 systematic review that included 25 studies found that age and gender were not consistent predictors of nurses' attitudes towards older patients (19). But among nursing students and registered nurses in Greece and Sweden, young age (< 25) and being male were found to be important risk factors for ageism towards older patients (20,21).

Physicians with more years of education were less likely to be ageist towards older patients (22). Being exposed to content about ageing in gerontological courses was also found to improve perceptions about and attitudes towards older adults in social care (23). This holds promise for future educational activities for health-care professionals that aim to increase knowledge about ageing and older age.

Anxiety about ageing and fear of death

Individuals with a higher level of anxiety about ageing or a fear of death display increased ageist attitudes (1). Although these findings come from a limited number of studies, they support the well-established theory of ageism known as terror management theory (see [Box 4.1](#)), which posits that older adults present an existential threat to younger people and generate death anxiety because they serve as a constant reminder of one's mortality and vulnerability (24).

Personality traits

A few studies have also found that individuals with the personality traits of agreeableness, extroversion, conscientiousness and personal collectivism are less likely to be ageist – that is, these characteristics act as protective factors against ageism (1).

Table 4.1. Determinants of ageism against older people

			TYPE OF DETERMINANT	TYPE OF ASSOCIATION	
INTERPERSONAL AGEISM	INDIVIDUAL-LEVEL DETERMINANTS	PERPETRATOR	Age	Younger	More ageism (risk factor)
			Sex/gender	Male	More ageism (risk factor)
			Education	Lower level	More ageism (risk factor)
			Anxiety about or fear of death	Higher	More ageism (risk factor)
			Personality traits	Agreeableness, extroversion, conscientiousness and a collectivistic orientation	Less ageism (protective factor)
			Contact with older age groups, particularly the quality of the contact, including grandparent–grandchild contact and intergenerational friendships	Higher quality contact	Less ageism (protective factor)
			Knowledge about ageing	Greater knowledge about ageing	Less ageism (protective factor)
	TARGET	Age	Older	More ageism (risk factor)	
		Health status and care dependence	Poorer health status and greater care dependence	More ageism (risk factor)	
	CONTEXTUAL-LEVEL DETERMINANTS	Proportion of older adults in country	Unclear		
		Healthy life expectancy of country	Lower	More ageism (risk factor)	
		Profession and occupational sector	Some professions and occupational sectors (e.g. high technology)	More ageism (risk factor)	
		Presentation of older people in experimental studies that simulate real-life settings	Positive presentation with more information	Less ageism (protective factor)	
			Comparison with younger people	More ageism (risk factor)	
SELF-DIRECTED AGEISM	INDIVIDUAL-LEVEL DETERMINANTS	Mental and physical health	Poorer	More ageism (risk factor)	
		Contact with grandchildren	More contact	Less ageism (protective factor)	

Box 4.1**Three theories of ageism that have empirical support**

Theories of ageism point to the underlying causal mechanisms that produce ageism. Specific programme theories or theories of change that underlie the development of effective strategies to reduce ageism draw on these broader, empirically supported theories of ageism.

Terror management theory: Terror management theory suggests that ageism results from our fear of death. It holds that humans' ubiquitous needs for meaning and self-esteem arise, in part, as efforts to secure ourselves psychologically from the awareness of mortality. Older individuals present an existential threat to younger people because they remind them that death is inescapable. Our fears of death, physical decay and loss of dignity and self-worth generate negative reactions towards, and a desire to distance ourselves from, older people, which manifest as stereotypes, prejudice and discrimination against older people. It is proposed that by learning to acknowledge and cope more directly with fears associated with our physical and mortal natures, we can counter these fears and reduce ageism (24, 32, 33).

Intergroup threat theory and intergroup contact theory: Intergroup threat theory holds that individuals react in hostile ways towards out-groups, particularly when out-groups are perceived as potentially harmful, posing either real or symbolic threats. Real threats refer to threats to a group's power, resources and welfare, whereas symbolic threats are threats to a group's world view, belief system and values (34). This theory can help explain why younger adults, who represent direct competition to middle-aged adults, may experience ageism in society. Even in cases in which individuals do not identify a specific threat from an out-group, they may choose to demonstrate biases that can help create a positive distinction between their group (in-group) and other groups (out-groups) (35).

Intergroup contact theory can be viewed as the flip side of intergroup threat theory. Intergroup contact theory holds that contact between groups under optimal conditions reduces intergroup threat and its concomitant stereotypes, prejudice and discrimination. The causal mechanisms through which it does this involve reducing anxiety about intergroup contact and increasing perspective-taking and empathy. Enhanced knowledge about the out-group also plays a role, albeit less strong. Optimal conditions are hypothesized to be having the groups share equal status and common goals; fostering situations that encourage intergroup cooperation; and having the support of authorities, law or custom (25, 36-38). The theory of intergroup contact has been extensively tested with different racial and ethnic groups, people with physical disabilities and mental health conditions, as well as with people of different age groups (37, 38). Intergenerational contact strategies are largely based on intergroup contact theory.

Stereotype embodiment theory: This theory proposes that members of stigmatized groups tend to assimilate stereotypes about themselves from society, leading to negative self-perceptions that can influence their health (39). Stereotype embodiment theory has four main components. First, it helps explain the process by which people internalize, from an early age, the age stereotypes that are salient in their culture. Second, it holds that stereotypes can operate unconsciously. Third, stereotypes gain salience as people reach certain milestones associated with a particular age, such as retirement. Fourth, stereotypes are embodied through three main pathways: physiological, behavioural and psychological. The physiological pathway is related to the physiological stress caused by considering that the negative perceptions of ageing are applicable to oneself. For instance, older individuals subliminally exposed to negative age stereotypes demonstrated a heightened cardiovascular response to stress (40). The behavioural pathway acts through changes in behaviours, such as people who view growing old negatively not attending medical examinations because they consider illness to be normal in older age. The psychological pathway involves the generation of expectations that act as self-fulfilling prophecies (39, 41). Each of these pathways offers potential targets for interventions. For instance, the psychological and behavioural pathways could be changed by educational interventions that alter what is considered normal in older age. Although this theory has been mainly used to explain self-directed ageism in older age, it is likely that the same mechanism operates in self-directed ageism at other ages since people are exposed to stereotypes about different age groups from childhood onwards.

Contact with older age groups

There is considerable evidence that having contact with people in older age groups, particularly higher quality contact, reduces the likelihood of ageism – that is, better quality contact acts as a protective factor against ageism.

A systematic review has shown that better quality contact, both with older people in general and with grandparents and other relatives in particular, reduced ageism (1). This confirms findings from previous reviews (25, 26). Studies examining the link between intergenerational friendships and ageism are rare (27). A study in 25 European Union countries found that those who reported cross-age friendships tended to be less ageist and that this applied to both younger

and older people (28). The rarity of such intergenerational friendships may partly explain the widespread ageism documented in Chapter 2 (28, 29). For instance, in 25 European Union countries some 18% of young people aged 18–30 years reported having friends who were aged 70 years or older. In this study, younger women were less likely than younger men to have cross-age friendships (28).

This is pertinent when considering possible interventions to reduce ageism because activities can be organized to bring different generations together. The influence of this risk factor on ageism can be explained through intergroup contact theory (see [Box 4.1](#)), which posits that greater exposure to older or younger people can help decrease prejudice towards them (30, 31).

Knowledge about ageing

Evidence suggests that having knowledge about ageing protects against ageism. In other words, the greater a person's knowledge about ageing, the less ageist they tend to be.

Of the studies included in a review conducted for this report that examined the relationship between knowledge about ageing and ageism, 18 found that having knowledge about ageing was associated with less ageism (42-59), and five studies found that there was either no association between the two or that it was mixed or inconsistent (60-64).

All but one of these studies used the same measure of knowledge of ageing, the Facts on Ageing Quiz, whose validity as a measure of knowledge of ageing has been questioned (65). Another limitation is that these studies do not generally specify which dimension or dimensions of ageism (i.e. stereotypes, prejudice or discrimination) this knowledge protects against.

4.1.2 Individual characteristics associated with being a target of ageism

Age

As people age their likelihood of being a target of ageism increases: the older the person, the more likely they will be a target of ageism (1).

Health status and care dependence

Being in poor health or care dependent has been found in one study to be a risk factor for negative perceptions of older people (66). Another study found a possible bias against older adults who are ill or more care dependent (67). This suggests that how

older adults are perceived might depend on the health status associated with their age rather than on age itself (67).

4.1.3 Contextual determinants of interpersonal ageism

Proportion of older people in a country

A recent rigorous study conducted in 57 countries that had a sample of more than 80 000 participants found that the higher the proportion of older people in a country, the less ageism there was in the country – that is, having a high proportion of older people acts as a protective factor against ageism (8).

Previous studies had come to the opposite conclusion: that the higher the proportion of older people in a country, the greater the ageism against them (12, 68). A possible explanation for these inconsistent findings is that it may be the rate of change in the proportion of older people that matters and not the proportion itself. Countries whose population age structures are changing faster might be more prone to ageism (69).

Healthy life expectancy

The lower the healthy life expectancy in a country – that is, the average number of years that a newborn can expect to live in full health – the higher the likelihood of individuals holding highly or moderately ageist attitudes (8).

Countries with a lower expectancy for healthy life are more likely to have older adults in poor health, and increasing people's exposure to those who have poor health in older age is likely to reinforce negative attitudes towards getting older. In turn, ageist attitudes are likely to be internalized as one grows older, and are likely to be

applied to oneself in the form of self-directed ageism, which can decrease health and functioning, as explained in Chapter 3. This highlights the need to invest in policies that promote healthy ageing practices and allow individuals to live longer and healthier lives (70).

While having a lower proportion of older people in a country may be a risk factor for interpersonal ageism, and a lower expectancy for healthy life is likewise a risk factor for interpersonal ageism, a recent study in 57 countries found that in the aggregate these two risk factors also increase the likelihood of a country being highly or moderately ageist (8).

Profession and occupational sector

Ageism is reported to be widespread in certain types of professions and occupational sectors, such as computer programming, online marketing and hospitality, and in sectors such as new technologies and start-ups (71), with the term "Silicon Valley ageism" being used to describe this phenomenon (72).

Presentation of older people in experimental studies

In experimental studies that simulate real-life contexts (e.g. through the use of videos, vignettes, evaluation of curriculum vitae), how people are presented (i.e. whether negatively or generically described as an older person or whether they are described with more positive, detailed and specific information) influences their likelihood of being the target of ageist attitudes.

A positive presentation decreases ageism, and a negative presentation increases it (1). In studies that simulate employment contexts, whether individuals are compared with a younger or an older person can also

be a risk factor. Several studies found that older workers are given more negative evaluations when the same evaluator is also rating younger workers (73-75).

This direct comparison might influence ratings of the targets of ageism by creating a situation in which age becomes especially salient, even when all other characteristics are equal. This determinant has potential implications for strategies aiming to reduce ageism, in particular for educational interventions and campaigns.

Using an optimal presentation – e.g. positive and with enough individuating information, and avoiding comparison with younger people – when presenting an older person could potentially help reduce ageism.

4.2 DETERMINANTS OF SELF-DIRECTED AGEISM

This section provides an overview of the main determinants of self-directed ageism, including mental and physical health, contact with grandchildren and knowledge about ageing (see [Table 4.1](#)).

4.2.1 Mental and physical health

The few studies that have explored the factors that influence self-directed ageism in older people have found that individuals with poor mental and physical health are more likely to exhibit ageism towards themselves (1). This highlights again the need to invest in ageing-related policies and interventions that allow individuals to live both longer and healthier lives.

4.2.2 Contact with grandchildren

Older people who have positive contact with their grandchildren are less likely to be negatively affected by stereotype threat, a form of self-directed ageism (76). Stereotype threat refers to an older person's fear that they might confirm negative stereotypes about older people and, thus, perform more poorly on a task related to the stereotype, such as a test of mathematical or other cognitive ability.

4.2.3 Knowledge about ageing

One study in Australia and the United Kingdom that examined self-directed ageism seemed to indicate that participants who have greater knowledge about ageing may feel more positively about their own ageing, but the results were not conclusive (50).

Given that self-directed ageism appears to be widespread and has profound effects on health and well-being (see Chapter 3), it will be important to extend our knowledge of other determinants of self-directed ageism beyond the two identified so far.

4.3 CONCLUSIONS AND FUTURE DIRECTIONS

Considerable evidence is available about the determinants of interpersonal ageism, both for those who perpetrate ageism (i.e. age, sex, level of education, anxiety about or fear of death, personality, past contact with older people) and for those who are targets of it (i.e. age, health status and dependence on others for care). Some evidence is available about the contextual

determinants of ageism (i.e. the proportion of older adults in a country, the expectancy for healthy life in a country and being in certain professions and occupational sectors).

Limited evidence is available about the determinants of self-directed ageism (i.e. mental and physical health and contact with grandchildren). Strategies to reduce ageism are unlikely to work unless they target those determinants that (i) have been shown to be the main causes of ageism and (ii) are modifiable (see [Box 4.2](#)).

Future priorities for understanding the determinants of ageism are outlined below.

- Current research gaps in relation to those determinants of interpersonal ageism, for which evidence is currently lacking or inconclusive, should be addressed. These include socioeconomic status and the presence of a social welfare system. The determinants of self-directed and institutional ageism, for which little evidence is available, should also be investigated. It is essential that studies on the determinants of all forms of ageism are conducted across countries, including low- and middle-income countries, to assess whether they vary across cultures and contexts. It is equally important that studies are conducted to assess the relative importance and causal status of different determinants of ageism (see [Box 4.2](#)).
- Our improved understanding of the determinants of ageism should be used to inform the theories of change and programme theories that underpin the development of strategies to reduce ageism.

Box 4.2**Opportunities for research on the determinants of ageism against older people**

The systematic review on the determinants of ageism towards older people (1), on which much of this chapter is based, represents a significant step forward in research efforts seeking to identify the determinants of ageism. This review, which followed the PRISMA guidelines (77), was based on searches in 14 databases; included some 200 papers in English, French, and Spanish that identified 14 determinants of ageism categorized according to a multilevel framework; and carefully assessed the quality of the studies included.

However, this systematic review revealed several limitations in the underlying studies. Half of the studies were assessed as being of medium quality. Another limitation was that due to the heterogeneity of risk factors evaluated in the studies, it was not possible to use meta-analytic techniques that would have provided information about the strength of the association between each risk factor and ageism and, thus, an idea of their relative importance.

Future research should consider using more standardized definitions and measures of risk factors to increase comparability and allow findings to be subject to meta-analysis (1). A further limitation, which future studies should address, was that most studies were correlational in nature, and so the causal status of the determinants could not be assessed. Designing interventions to target risk factors that are not causally related to ageism increases the likelihood that the interventions will not work (78, 79).

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MRIDUL, 29,
INDIA



05

THE SCALE,
IMPACT AND
DETERMINANTS
OF AGEISM
AGAINST
YOUNGER PEOPLE

“As a youth, I just become another number of the ‘demographic dividend’ or an issue to be resolved, completely disregarding my political and social engagement. As a youth, if I want to do something for society, ‘volunteering and learning’ is suggested by people already earning very well, even if I have been doing that for more than a decade. With each dollar given to me, extra standards of accountability and transparency are also conveyed formally/ informally as if being young means incompetent, careless and/or corrupt.”

Mridul, 29, India

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for Children and Youth

Chapter

05

This chapter surveys what is known about ageism against younger people, that is, those aged < 50 years. Section 5.1 covers evidence on the scale of ageism against younger people; Section 5.2, its impact; and Section 5.3, the determinants of ageism against younger people.

Little is known about ageism against younger people (those aged < 50 years), with most of the evidence focusing on its prevalence and manifestations.

Ageism against younger populations occurs in institutions such as the workplace and the legal and political systems, and in Europe it appears to be more prevalent than ageism against older people.

The impact of ageism against younger people is still poorly understood.

The main determinants of ageism against younger populations include certain personality traits, whether there is contact with other age groups, health status and care dependence, and working in certain professions or sectors.

5.1 THE SCALE OF AGEISM AGAINST YOUNGER PEOPLE

Ageism against younger populations manifests across a range of institutions including the workplace, the legal system and politics. There is also growing evidence of interpersonal ageism directed against younger adults from population-based studies, which suggest that in Europe it may be more prevalent than interpersonal ageism against older people. No evidence is available on the magnitude of self-directed ageism in younger populations.

5.1.1 Institutional ageism

Ageism in the workplace

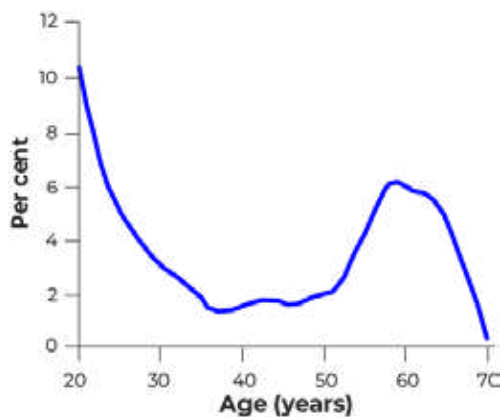
Although no reviews have systematically assessed how ageism affects younger populations in the workplace, a recent scoping review found increasing evidence that ageism towards this group manifests itself most markedly once they are employed, especially in terms of pay and benefits (1). This applies more to younger women than younger men, a case of ageism

intersecting with sexism. Younger workers also report not feeling valued, being subject to negative age stereotypes and belittling comments and being generally perceived as incompetent because they look young (1). Data from the European Working Conditions Survey 2015, which included nearly 44 000 workers in 35 countries, found that among those employed, age discrimination peaked at the ages of 20 years and again at 59 years (see Fig. 5.1) (2).

Ageism may also force younger workers out of employment. A study conducted in Australia between 2002 and 2005 that looked at the circumstances leading to the dismissal of 1259 employees aged 15 to 24 years, reported that about 8% of cases were due to age-based discrimination (3).

More research is needed to examine ageism against younger people occurring during hiring to determine if it is due to the age of the candidate or other factors, such as qualifications and work experience, fit between the position and the applicant, job level or workplace context (e.g. dynamic versus stable) (1).

Fig. 5.1. Percentage of employees experiencing age discrimination during the past 12 months by age, Europe, 2015



Source: reproduced with permission from Mullan et al. (2).

Ageism in the legal system

A scoping review of ageism directed towards younger populations found that crimes committed by younger offenders elicited greater anger, were perceived to be more serious transgressions and considered to deserve more severe punishment than those committed by older offenders. Findings are mixed when the age of the victim of crime is considered, with some studies showing that transgressions were evaluated more seriously and received recommendations for more severe punishment when the victim was an older adult and others showing no effect of age (1). A study in the United States found that employers were most likely to win a court case when the employee was younger rather than older (4).

Ageism and politics

An increasing number of studies have also explored how ageism manifests itself in politics, finding that there is a tendency to doubt, deny or dismiss the voices of youth and children; regulate their identities; and generally limit their efforts in political and advocacy movements (1), for example, by dismissing their input in political discussions or raising questions about the authenticity of youth organizers' perspectives.

Ageism towards younger people in politics interacts with sexism and racism. One study looked at the experiences of young women labour activists participating in youth programmes and found that the age of the women intersected with their gender and racial identity to create systemic disadvantage and unfavourable experiences (5).

Another study found that young women activists in Egypt often faced limitations due to their age and gender in filling political roles or engaging with formal institutions (6).

Studies simulating mayoral elections found that the age of the political candidate had more influence on voting behaviour than sex or gender or race, with middle-aged candidates preferred over younger candidates (7, 8).

Middle-aged adults, especially men, have the greatest status, wealth and power, according to studies that examined the level of status and power accorded to people based on their age. Younger adults were perceived to have the lowest status, wealth and power (1).

Other institutions

Little research has investigated if and how ageism against younger people manifests in other institutions, such as health care, the media and financial institutions. Regarding housing discrimination, a 2002 report in Canada found that younger applicants were sometimes rejected by landlords for being too young to live alone (9).

5.1.2 Interpersonal ageism

Ageist attitudes towards younger adults

While no comparable, global cross-national data are available about ageist attitudes towards younger adults, there appears to be a general tendency to report less positive feelings towards younger rather than older adults (10, 11).

In an analysis based on the fourth wave of the European Social Survey (2008–2009), which included a representative sample of some 55 000 participants aged 15 years or older in 28 European countries, younger adults received lower ratings than older adults across a range of positive stereotypes (10). As illustrated in Fig. 5.2, people in their twenties received lower ratings across the four characteristics examined in the survey, which included

being seen as friendly, competent and viewed with respect, and having high moral standards.

Reported experiences of interpersonal ageism

In the European Social Survey (2008–2009), those aged 15–24 years reported experiencing the most unfair treatment because of their age: 55% of them thought that someone had shown them a lack of respect or treated them badly (see Fig. 5.3). Also, like every other age group, those aged 15–24 years reported experiencing more discrimination based on age than discrimination based on gender, race or ethnic background (see Fig. 2.4) (10).

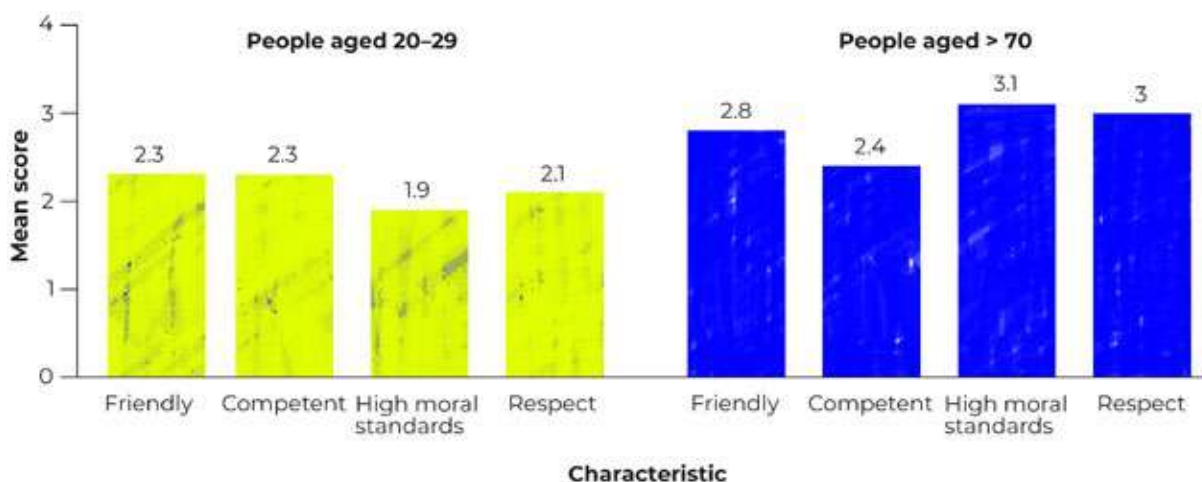
Thus, the evidence of institutional and interpersonal ageism directed against younger people is limited to the WHO European Region. Evidence on the scale of self-directed ageism against younger people is lacking.

5.2 THE IMPACT OF AGEISM AGAINST YOUNGER PEOPLE

Evidence for the impact of ageism on younger people is extremely limited – only 10 studies were identified – and has produced inconsistent findings (1).

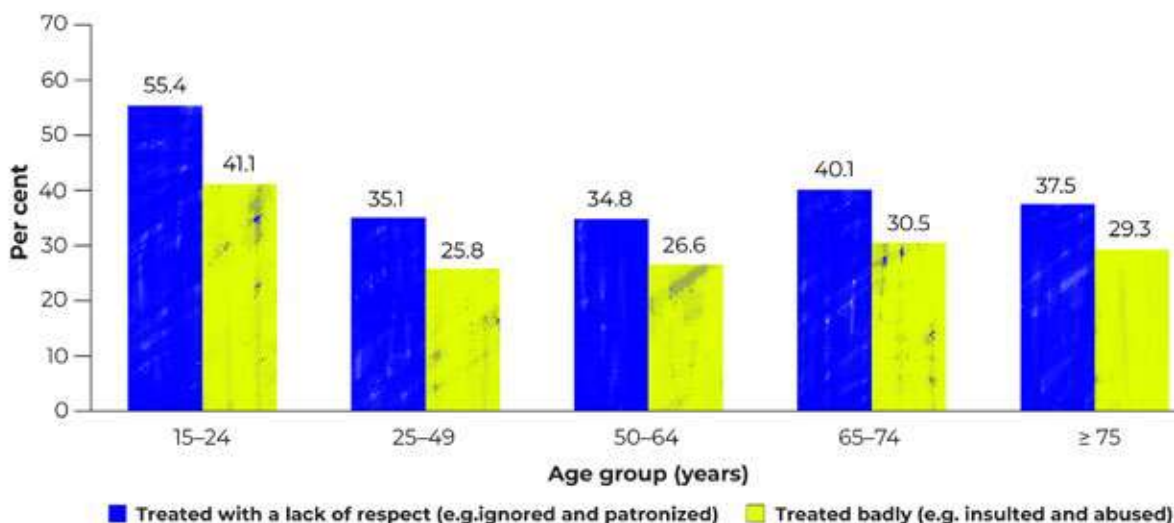
Ageism may affect health when it intersects with other “-isms”. One study in Brazil, which investigated the impact of different forms of discrimination on mental disorders, showed that ageism on its own was not associated with mental disorders, but it was associated when it co-occurred with racism or classism, or both (12).

Fig. 5.2. Likelihood that most people view those aged 20–29 and those older than 70 years as possessing certain characteristics (mean scores across European Social Survey countries, 2008–2009; scale ranged from 0, indicating not at all likely, to 4, indicating very likely)



Source: reproduced with permission from Abrams et al. (10).

Fig. 5.3. Percentage of people in countries in the European Social Survey (2008–2009) who thought someone showed a lack of respect or treated them badly because of their age, by age group (includes only individuals who did not rate their experience 0 on a scale that ranged from 0, indicating they had never experienced this treatment, to 4, indicating they had experienced it very often)



Source: reproduced with permission from Abrams et al. (10).

Evidence suggests that ageism has a limited impact on younger people's well-being and self-esteem. A study that included a large sample of Europeans revealed that perceived

age discrimination had the biggest impact on people's happiness and life satisfaction between the ages of 40 and 70 years and the smallest impact on those aged between

20 and 30 years and 70 years and older (13). In support of these findings, another study found that age discrimination had no impact on younger adults' well-being (14).

Two other studies showed that ageism had a limited impact on younger people. The first reported that the more self-conscious younger workers were about being stereotyped, the worse their mood and the less satisfied they were with older co-workers (15). The second concluded that age-biased communication behaviours had only a slightly negative impact on younger adults' self-esteem or life satisfaction relative to older adults. However, when older adults were perceived as adjusting their speech style to younger people, younger people's sense of collective self-esteem was enhanced (16).

Findings about the impact of ageism on cognitive performance are inconsistent. Two studies examined the impact of younger people's exposure to negative age stereotypes on their cognitive performance. One found that it had a negative impact (17), the other that it had a positive impact, but only when younger people saw themselves as under the control of powerful people; otherwise, it had no effect (18).

In the workplace, studies show that perceived age discrimination reduces both younger and older people's commitment to the organization (19, 20). A qualitative study also revealed that ageism affected the work identities of younger female workers and led them to consciously portray themselves as older and less feminine through their dress, speech and behaviour (21).

While this limited body of evidence has identified some negative effects of ageism against younger people, the findings are weak and inconsistent. Furthermore, important effects of ageism identified

among older people – such as serious health and economic effects – remain largely unexplored among younger people.

5.3 THE DETERMINANTS OF AGEISM AGAINST YOUNGER PEOPLE

Different individual characteristics associated with being a perpetrator of ageism or being a target of ageism have been identified in the literature, as have a series of contextual determinants of ageism directed towards younger populations (1).

5.3.1 Individual characteristics associated with being a perpetrator of interpersonal ageism

Several individual characteristics may be associated with becoming a perpetrator of ageism against younger people, including sex or gender, age, a lack of cross-generational friendships and certain personality traits (see [Table 5.1](#)).

The findings regarding sex or gender as a determinant for perpetrating ageism against younger people are inconsistent. Some studies suggest that women might be less ageist against younger people than men, while others found there was no difference (11, 22-24).

The overall picture is unclear about whether older or younger age is a risk factor for perpetrating ageism against younger people (1). For instance, in a study on the visual inspection of faces, older people spent more time examining the faces

Table 5.1. Determinants of ageism against younger people

			TYPE OF DETERMINANT	TYPE OF ASSOCIATION	
INTERPERSONAL AGEISM	INDIVIDUAL-LEVEL DETERMINANTS	PERPETRATOR	Sex	Unclear	
			Age	Unclear	
			Personality traits	Agreeableness Conscientiousness	Less ageism (protective factor) More ageism in workplace (risk factor)
			Contact with other age groups, including grandparent–grand-child contact and intergenerational friendships	More intergenerational friendships	Less ageism (protective factor)
	CONTEXTUAL-LEVEL DETERMINANTS	TARGET	Sex	Female	More ageism (in some professional contexts) (risk factor)
			Health status and care dependence	Poorer health	More ageism (risk factor)
			Profession and occupational sector	Some professions and occupational sectors (e.g. teaching)	More ageism (risk factor)
			Presentation of younger people in experimental studies that simulate real-life settings	More detailed information about the younger person	Less ageism (protective factor)

of people their own age than the faces of people of other ages, as did younger people (25). Other studies indicate that younger people may sometimes display more ageist attitudes towards people their own age rather than other age groups (26, 27).

The personality trait of agreeableness is associated with having less ageist attitudes towards younger people (26). Conscientiousness, however, appears

to predict more ageism towards the performance of younger workers (28).

A study in 25 European Union countries found that older people who reported having cross-age friendships tended to be less ageist against younger people than those who did not report such friendships. However, older people were still more ageist against younger people than younger people who reported having cross-age friendships were against older people (29).

5.3.2 Individual characteristics associated with being a target of interpersonal ageism

There is limited evidence about the individual characteristics that may be associated with becoming a target of ageism.

There is some evidence that being female may, in certain professional occupations, increase the likelihood of being a target of ageism directed against younger people. For instance, one study showed that students had lower expectations about the performance of young, unattractive female teachers than of young, unattractive male teachers or teachers of other ages (30).

Being in poor health or care dependent has also been found in one study to be a risk factor for negative perceptions of younger people (31)

5.3.3 Contextual determinants of interpersonal ageism

Profession and occupational sector has been identified as a possible contextual determinant of interpersonal ageism. In some professions, there is limited evidence of ageism against younger people. For instance, in an experimental study, preference was shown by participants for hiring a middle-aged applicant over a young applicant for a job as a tour guide, despite the candidates having the same qualifications (32). Another study suggests that younger teachers are held to higher standards of professional competence than older teachers (30).

The amount of information provided about a younger person has also been described as a possible contextual determinant of ageism. In experimental studies that

simulate real-life contexts, the more information that is presented about a younger person, the less likely it is that they will be subject to ageism (30, 33-35).

5.3.4 Institutional and self-directed ageism

There is no evidence about determinants of institutional ageism against younger people, nor is there any evidence about determinants of self-directed ageism among younger people.

5.4 CONCLUSIONS AND FUTURE DIRECTIONS

Too little is known about the scale, impact and determinants of ageism against younger people. However, there is some evidence that it occurs in the workplace and in legal and political systems. In Europe, the only region for which data are available, attitudes towards younger people are often more negative than they are towards older people; and younger people report experiencing more aged-based discrimination than any other age group.

The impact of ageism against younger people, particularly the cumulative impact over the life course, is not well understood. The main determinants of ageism against younger people include the personality traits of agreeableness (protective factor) and conscientiousness (risk factor), having contact with other age groups (protective factor), being care dependent or in poor health (risk factors) and working in certain professions or sectors (risk factors). Future priorities for increasing our understanding of ageism

directed against younger people should include:

- monitoring ageism in a range of institutional settings, including the workplace and legal and political institutions;
- improving our understanding of all aspects of the problem – its scale, impact and determinants – especially in low- and middle-income countries, where there is currently almost no research and

younger people often make up the bulk of the population (see [Box 5.1](#));

- ensuring that our improved understanding of the scale, impact and determinants of ageism against younger people informs the strategies that are adopted to address ageism against younger people.

Box 5.1

Opportunities for research on ageism against younger people

The findings about ageism directed against younger populations are mainly based on a scoping review commissioned for this report (1). This review used a comprehensive search strategy that included 13 different databases and three different languages (English, French and Spanish). It included 263 quantitative and qualitative studies and provided the first systematic effort to assemble evidence about ageism towards younger people, defined as those younger than 50 years. The scoping review was supplemented by an appraisal of the quality of the evidence on the impact and determinants of ageism against younger people.

One limitation of the studies identified was that many were cross-sectional in nature. This makes it difficult to establish whether the associations found – between ageism and impacts, on the one hand, and determinants and ageism, on the other – are, in fact, causal. Another limitation relates to the inconsistent terminology used to refer to ageism against younger people (e.g. adultism, kiddism), which makes comparability across studies complicated.

Future research should explore the determinants and prevalence of ageism against younger people across high-, middle- and low-income countries, including institutional, interpersonal and self-directed ageism. It is most important to investigate the impact of ageism on younger populations, including its health and economic impacts, both in the shorter term and cumulatively over the life course. If ageism against younger people turns out to be widespread but to have a limited impact, then perhaps addressing it should be less of a priority than reducing ageism against older people. It is possible, however, that cumulatively over the life course ageism against younger people takes a serious toll. We also encourage researchers to conduct more studies on ageism as it affects children, given that this is an area that is relatively underexplored.

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A close-up portrait of a man with dark hair and a beard, smiling warmly. He is wearing a patterned scarf over a dark shirt. The background is a bright, textured yellow.

KHALED, 26,
EGYPT

06

STRATEGY 1: POLICY AND LAW

“ As a young man interested in working in human rights, I started working in this field early by engaging in various activities and from then I faced a lot of discrimination due to my young age. ”

Khaled, 26, Egypt

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for Children and Youth

Chapter

06

This chapter provides information about the first strategy that can be used to eliminate or reduce ageism: policy and law. Section 6.1 describes this strategy and how it works in reducing ageism. Section 6.2 presents evidence on its effectiveness whilst Section 6.3 provides examples of this type of intervention from different countries and regions. Section 6.4 outlines the cost of this type of intervention and characteristics that can improve its effectiveness.

Policies and laws can be used to reduce or eliminate ageism against any age group.

Policies and laws to reduce or eliminate ageism include, for instance, legislation addressing age discrimination and inequality, policies to ensure respect for the dignity of all persons regardless of age and human rights laws.

Some direct evidence shows that policies and laws reduce ageism, and there is indirect evidence that policies and laws reduce other “-isms” (e.g. racism, sexism) and could, therefore, also work to reduce ageism.

6.1 WHAT THEY ARE AND HOW THEY WORK

The enactment of policies and laws constitutes an important strategy that can be used to reduce or eliminate ageism, especially discrimination on the grounds of age (1). Policies are plans, commitments or courses of action that are undertaken to affect a given issue within a society. Policies generally provide a framework against which proposals or activities can be tested or measured. Examples of policies include complaints mechanisms and plans for action in employment and health institutions that seek to eliminate age-based discrimination and to empower people to claim their rights to equal access and participation. Laws correspond to the system of rules that a particular country or community recognizes as regulating the actions of its members and that it may enforce by imposing penalties. Laws also help guarantee the protection of all human rights and enable individuals to hold their governments to account. A distinction can be made between international and national law. International law defines the legal responsibilities and obligations of signatory states in their conduct with each other and in their treatment of individuals within state boundaries. International conventions or treaties

and international custom are two important sources of international law. National law, which is often referred to as domestic law, refers to those laws that exist within a particular country. Although distinct, policies and laws are intimately linked; for example, policy can be translated into legislation, and legislation can include an obligation to formulate new policy.

The way in which policies and laws can reduce ageism is fourfold. First, according to deterrence theory, outlawing a given behaviour or practice can reduce that behaviour to the extent that sanctions are consistently imposed (2, 3). For example, employers are less likely to discriminate when anti-discrimination laws are in place, given that these create an expected cost of a magnitude that equals the cost of the violation if caught (e.g. attorney's fees, fines) times the probability of being caught (4).

Second, policies and laws can help reduce ageism by creating a clear social norm that ageism is socially unacceptable (2, 5-7). Being aware of the stance of one's community has been shown to impact the extent of prejudice one expresses, even when attitudes are stated privately and there is no possibility of criticism (7-12).

Third, according to the theory of cognitive dissonance (13), government-level policies and laws, by forcing people to change their behaviour, can eventually change most people's underlying attitudes too, as they will need to reconcile the dissonance between their attitudes and their behaviour. Fourth, laws and policies can increase diversity in the surrounding population (e.g. in the workplace) and shape the physical and sensory surroundings, which can, in turn, affect the degree of implicit bias that individuals exhibit (14, 15). For example, laws regulating discrimination in the workplace can increase the presence of representatives

of the protected groups, as well as prohibit the use of demeaning visual depictions of a particular group, which can lower implicit bias against members of that group (14).

The legal treatment of ageism, and age discrimination specifically, entails certain difficulties. There may be a range of circumstances in which age is considered a rational and legitimate reason for distinguishing between different groups of persons (16). For example, the use of an age-based distinction to determine who is entitled to pension benefits has been presented in the past as a rational reason for distinguishing between different age groups based on the argument that no other practical or fair way exists to decide who should qualify (17). Encouraging equal respect for the dignity of people of different ages may also, on occasion, require treating age groups differently (18). This means that not all forms of differential treatment on the basis of age may qualify as wrongful discrimination. The key question is whether differential treatment on the grounds of age undermines the human rights principles of dignity, autonomy and participation and whether the justification tests used to assess its legitimacy are contaminated by ageist stereotypes, assumptions and prejudice.

Policies and laws aimed at tackling ageism are quite varied and include anti-age discrimination and equality legislation and policies that define actions to ensure adequate respect for the dignity and equality of status of all persons irrespective of their age; policies that aim to change perceptions of older or younger people; and human rights law, which provides a system that codifies the human rights of older and younger persons and makes those rights enforceable. Different mechanisms are used to implement and monitor policies and laws, including human rights agencies, courts, ombudspersons and bodies working to uphold treaties and to ensure equality.

6.2

HOW WELL THEY WORK

Evaluating the effect of national laws and policies is a long-standing challenge, in part due to the difficulty of attributing observed changes to the implementation of laws or policies, especially when randomized controlled trials are not possible, affordable, ethical or feasible (19-22). Does the policy or law in question actually produce the effects observed, or are these effects caused by some other, confounding factor? (19, 20). The studies that do exist generally focus on the impact and effect of the use of the law, the measures put in place to enforce the law and their effectiveness, the contribution of the measures to the achievement of overall social policy goals, and the effect on the socioeconomic position of certain groups (23).

In the field of ageism, the few studies that have been carried out have focused on anti-discrimination laws in the field of employment in Australia, Canada, Europe and the United States. These studies have generally found positive effects of these laws (24-29). For example, the introduction of the Age Discrimination in Employment Act in the United States in 1967, which recognizes only bias against older workers, caused a small positive and significant effect on overall employment for older workers (24). It has prohibited employers from adopting and enforcing mandatory retirement policies on the basis of an employee's chronological age (with limited exceptions for employees in certain executive positions, as well as firefighters and law enforcement officers) (28, 29). Still, some studies have shown that when not adequately drafted and enforced, anti-age discrimination laws can have unintended consequences, such as when companies hire

fewer older workers as a means to avoid exposure to possible litigation (26).

The effect of national anti-discrimination legislation has been further studied in other areas (e.g. race, sex or gender and sexual orientation) in a range of high-income countries, and it has largely been found that it helps to reduce discrimination (7, 23, 30-32). The most systematic effort to assess the effects of national anti-discrimination laws looked at impact assessments of these laws, which addressed various grounds (e.g. age, sex or gender, and disability) in 12 different countries, including several in Europe as well as other high-income countries such as Australia, Canada and the United States (23).

Benefits resulting from the adoption of anti-discrimination laws were highlighted in all of the analysed studies and included higher participation of all individuals in society, including in employment and education. Additionally, the adoption of effective anti-discrimination laws helped narrow the pay gap between protected groups and the general population and increase educational attainment in these groups (23). The enforcement of anti-discrimination legislation can also reduce the acceptability of discrimination in the broader community and the extent of interpersonal discrimination (7).

Measuring the direct or indirect effects of international law is equally challenging, as it is often difficult to establish a conclusive causal link between a treaty system and legislative or policy reforms on the domestic level (33). Still, mounting evidence supports the assumption that the process of formulating and ratifying an international treaty and advocacy and monitoring of state performance can contribute to changes in law, policy and practice at the national level. This is illustrated in several case studies and in official UN reports and reviews

that assessed changes at the national level following countries' ratification of the Convention on the Rights of Persons with Disabilities (34, 35), the Convention on the Elimination of All Forms of Discrimination against Women (36, 37) and the International Convention on the Elimination of All Forms of Racial Discrimination (38). Another study that looked at the changes resulting from the ratification of six UN human rights treaties in 20 countries found that individual countries took tangible steps to incorporate treaty norms into their domestic legal structures and cultures (39). Importantly, a couple of studies have even reported that at least the Convention on the Elimination of All Forms of Discrimination Against Women had a small but statistically significant and positive effect on women's rights, even when other key factors were controlled for (40, 41).

At the regional level, there is evidence that the enforcement of the European Convention on Human Rights by the European Court of Human Rights has not only resulted in individual plaintiffs being awarded damages but also in European governments revising legislation on such matters as gay rights and age discrimination (33).

Other examples of human rights courts include the Inter-American Court of Human Rights, which rules under the American Convention on Human Rights, and the African Court on Human and People's Rights, which rules under the African Charter on Human and People's Rights and whose output is growing (33).

6.3 EXAMPLES

Six examples illustrate different types of policies and laws from different parts of the world that aim to tackle ageism against

older people. The first four examples relate to international and regional instruments, whereas the last two relate to national instruments. Examples on the use of policy and law to tackle ageism against younger populations are shown in [Box 6.1](#).

6.3.1 Political Declaration and Madrid International Plan of Action on Ageing

In 2002, the UN General Assembly endorsed the Political Declaration and Madrid International Plan of Action on Ageing (MIPAA) (42).

In Article 5, the declaration makes a commitment to eliminating all forms of discrimination, including age discrimination. Endorsed by 159 governments, MIPAA is not legally binding, and its implementation is voluntary.

Every five years, countries analyse the state of implementation of MIPAA and the actions required to make progress. The process involves a participatory element to engage civil society and older persons, and it is designed to assist countries in receiving feedback on the policies and programmes that they have implemented. Following review and appraisal at the national level, UN Regional Commissions consolidate the information. Reviews and appraisal processes culminate with a global review by the UN Commission for Social Development.

The progress made in developing policies to eliminate age discrimination at the country level following the adoption of this political declaration is reported through its monitoring processes as well as through dedicated studies that generally have found that governments have gradually developed and implemented legal and policy measures to prevent age discrimination (43-46).

Box 6.1**Policy and law to reduce or eliminate ageism against younger people**

As illustrated in the examples in this box, policies and laws have also been used as strategies to eliminate or prevent ageism against younger people, although there is limited research about their effectiveness. For example, the World Programme of Action for Youth to the Year 2000 and Beyond, adopted by the UN General Assembly in 1996, provides a policy framework and practical guidelines for national action and international support to improve the situation of young people around the world (59). It is intended to support the full enjoyment of all human rights and fundamental freedoms by young people, encourage governments to take action against violations of these rights and freedoms, and promote non-discrimination and tolerance, equality of opportunity, solidarity, security and the participation in society of all young women and men. Every 2 years, the UN General Assembly and the Commission for Social Development receive a report from the Secretary-General and adopt a resolution on policies and programmes involving youth.

The Iberoamerican region has also been a pioneer in promoting and protecting the rights of younger people through the Iberoamerican Convention on Rights of Youth, which entered into force in 2008. This Convention lays out specific rights for people aged between 15 and 24 years and recognizes them as strategic actors in development (60). It also has an additional protocol, adopted in 2016, which clarifies and strengthens some of the Convention's articles. For example, it allows for an extension of the upper age limit considered in the Convention, with a view to adapting the definition of youth to the legal and demographic realities of each country (61). The Convention does not have a monitoring system similar to international treaty monitoring bodies, but it has established a tracking system through which state parties are required to submit a report every two years to the Secretary-General of the Iberoamerican Youth Organization (62). A total of seven countries have ratified this treaty: The Plurinational State of Bolivia, Costa Rica, Dominican Republic, Ecuador, Honduras, Spain and Uruguay.

Another example is the African Youth Charter, which entered into force in August 2009 and underscores the rights, duties and freedoms of youths aged 15 to 35 years. It also paves the way for the development of national programmes and strategic plans for the empowerment of young people. It aims to ensure that youth are protected against all forms of discrimination and involved in decision-making in the region, including in the development agendas of African countries. It does not provide for a specific follow-up and monitoring mechanism, but Article 28 sets out the responsibilities of the African Union Commission to ensure that state parties respect their commitments and fulfil the duties outlined in the Charter (62, 63). A total of 39 countries in Africa have ratified the charter and, therefore, are bound by its provisions (64).

6.3.2 The employment equality framework directive of the European Union

A milestone in protection from age discrimination in the European Union was Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation, which implemented a structure for ensuring equality for individuals in employment and their occupation regardless of their age, among other protected characteristics (47). The Directive limits the circumstances under which national law in European Union Member States may permit employers to subject employees to different treatment on the grounds of age, thus establishing minimum requirements for protection against discrimination. Member States must ensure there are judicial or administrative procedures for those who believe they have been discriminated against and must provide guidance on sanctions, which may include compensation (27). The Directive also requires Member States to promote social dialogue with the aim of fostering equal treatment through "the monitoring of workplace practices, collective agreements, codes of conduct and through research" (47, 48).

The European Commission is responsible for assessing the national legislation of Member States to see if it correctly reflects the requirements of the Directive. If it does not, the Commission can launch infringement procedures against the Member State concerned. In turn, the Court of Justice of the European Union helps advance interpretation of the Directive in cases of uncertainty or lack of clarity in specific clauses (49).

All countries of the European Union have introduced this legislation, and it has achieved a number of important outcomes. It placed age alongside other grounds in the European

Union's anti-discrimination and equality agendas, was responsible for introducing anti-age discrimination laws in many Member States for the first time, increased the scope of protection in those few States that already had some legislation in place (27, 48) and set minimum standards throughout the European Union. It also helped to challenge structural inequalities in the labour market, such as the use of upper age limits in job advertisements (50).

Despite the advances achieved through this Directive, there are still areas for improvement. For example, the broad discretion afforded to national jurisdictions to set aside equal treatment has led to diverging national practices and levels of protection against age discrimination across the European Union (51). Also, the framework focuses only on employment and does not cover other important areas in which age discrimination might occur, such as education, housing and social protection (see Chapter 2).

In 2008, the European Commission proposed a new draft Directive to protect everyone living in the European Union against discrimination beyond the workplace (e.g. in access to goods and services) that is based on age, disability, sexual orientation and religion or belief. If adopted, this law would complete the European Union framework by affording age a similar level of protection as currently exists for race and gender under law (52).

6.3.3 The African Union Protocol on the rights of older persons

The African Union Protocol to the African Charter on Human and People's Rights on the Rights of Older Persons in Africa is another major development. Adopted in January 2016, this protocol is the product of many years of consultations, and it reinforces the commitments made in the 2002 African

Union Policy Framework and Plan of Action on Ageing (53). The Protocol prohibits all forms of discrimination against older persons (Article 3), and it covers a range of rights including access to health services, and the rights to employment, social protection and education, thus providing a framework for governments to protect those rights. Still, the Protocol does not explicitly prohibit discrimination on the basis of age, which may limit its interpretation at the national level.

The Protocol, if ratified and implemented, has the potential to improve older Africans' enjoyment of their rights. This Protocol has been ratified by two countries, Benin and Lesotho. Twelve additional countries have signed the Protocol, which indicates their willingness to ratify it (54).

6.3.4 The Inter-American Convention on Protecting the Human Rights of Older Persons

The Inter-American Convention on Protecting the Human Rights of Older Persons is the first regional treaty that fully safeguards older people's human rights. It explicitly prohibits discrimination on the grounds of age (Article 5); encourages positive attitudes towards and dignified, respectful and considerate treatment of older persons; and promotes the recognition of older people's experience, wisdom, productivity and contributions to the development of society (55).

Countries ratifying the Convention must adopt measures to prevent, sanction and eradicate violations of the rights of older persons. They must also adopt and implement affirmative measures to carry out the rights set forth in the Convention, including policies, plans and legislation. It is also the duty of states to establish and promote public institutions that specialize in protecting

and promoting the rights of older persons. As for the protected rights, the Convention establishes the rights to equality and non-discrimination on the grounds of age, to life and dignity, to independence and autonomy, to work and education, to physical and mental health and to give free and informed consent in the realm of health care, among others.

By adopting this Convention, countries across the region show their commitment to addressing ageism and the denial of human rights in older age, and they have recognized that explicit, legally binding human rights standards, and the accountability mechanisms that accompany them, are necessary to do this. The Convention entered into force in 2017, and seven countries have ratified the treaty: Argentina, the Plurinational State of Bolivia, Chile, Costa Rica, Ecuador, El Salvador and Uruguay. It is too soon to evaluate its effectiveness, but it is expected that its ratification will help establish minimum regional standards for protecting the rights of older persons and it will have strong potential to encourage countries to adopt new public policies and legislative frameworks (56).

6.3.5 Uruguay's legal and policy frameworks

The national legal and policy frameworks of Uruguay prohibit any discrimination on the basis of age and guarantee older and younger persons equal and effective legal protection against discrimination. The Constitution establishes that everyone is equal before the law (Article 8), and the country has taken a number of measures to counter age-based discrimination in specific sectors, including employment, by means of affirmative action policies and a specific ban on discriminating against any worker on the grounds of age.

The Institución Nacional de Derechos Humanos (National Institution of Human Rights) and the Oficina del Defensor del

Pueblo (Ombudsperson's Office) was formally established in 2012 to promote and protect human rights, as defined by Uruguayan law. Other mechanisms have also been established in the country to promote and protect human rights including the Defensor del Vecino de Montevideo (Office of the Public Defender of Montevideo), which promotes and defends the rights of all inhabitants of Montevideo, and the Secretaría de Derechos Humanos (Human Rights Secretariat), which is in charge of monitoring and evaluating the human rights situation. Also, Uruguay was the first state to deposit the instrument of ratification of the Inter-American Convention on Protecting the Human Rights of Older Persons, on 18 November 2016.

These existing legal and policy instruments could be further strengthened by providing adequate human, technical and financial resources (57) and ensuring greater coordination between the National Institution of Human Rights and the Ombudsperson's Office. There is also a need for studies to further evaluate the impact of these legal and policy frameworks in Uruguay.

6.3.6 Equal Opportunities Act of Mauritius

While the Constitution of Mauritius does not explicitly refer to discrimination based on age, specific enactments, such as the Equal Opportunities Act of 2012, do explicitly prohibit such discrimination in various spheres of activity, namely employment; education; the provision of goods, services or facilities; accommodation; access to premises and sports; and societies, registered associations and clubs. The Equal Opportunities Act established the Equal Opportunities Commission and the Equal Opportunities Tribunal, which consider complaints about the infringement of rights protected under the Act. The Equal Opportunities Commission is an independent

and autonomous institution that attempts to bring about conciliation between parties in a dispute. Cases in which conciliation cannot be reached may be referred to the Equal Opportunities Tribunal. In 2014, the Commission referred two cases related to age-based discrimination to the Tribunal (58). No comprehensive assessment of the Equal Opportunities Act has been conducted.

6.4 KEY CHARACTERISTICS AND COSTS

Few methodologically rigorous studies have sought to assess the factors that contribute to the effectiveness of laws and policies in tackling ageism. A few studies do, however, offer some indication about the potentially important characteristics of laws and policies that can increase their effectiveness, including one that comprehensively examined the factors contributing to the acceptance and effectiveness of national anti-discrimination laws in 12 countries that focus on grounds such as age and disability (23). Still, several studies included in this analysis had flawed designs or provided limited methodological information, which limits the conclusions that can be derived (23). Some of these potentially important characteristics are outlined below.

- Strong monitoring and enforcement mechanisms: several studies identified weak enforcement mechanisms as one important factor limiting the success of anti-discrimination laws (23, 27, 32, 65). Monitoring and enforcement mechanisms can take multiple forms, including the establishment of national councils or commissions, equality bodies or ombudspersons.

- Public awareness about the law or policy and clarity on its provisions: anti-discrimination legislation appears to be most effective if accompanied by awareness raising and dissemination of information about the policy or law at various levels (7, 23, 27, 48, 65, 66). For legislation and policy to have effects in a given community, at least some members of the public need to be aware of its existence. This is necessary to ensure that legislation has an instrumental effect on a given individual such that the individual aims to avoid the specific penalties in the law and also for individuals to be aware that they can file complaints if they experience violations of the law, in this case, age discrimination. It is equally important for the provisions of the law or policy to be clear and include information about who can file a case and under what conditions, and what the burden of proof is.
 - Strong civil society activism: domestic nongovernmental organizations can play an important role in the process of reform and can help enhance the impact of reporting about violations of laws or progress made in implementing treaties, conventions or policies (36, 40, 67).
 - Resource availability: a lack of resources, including funding for enforcement and monitoring bodies, can negatively affect the implementation of policies and laws (23, 40, 67-69).
 - Democracies: Evidence suggests that international laws may be most effective in stable or consolidating democracies (69, 70) because these may be more likely to adhere to treaty obligations, due to the presence of internal monitors that make it more difficult to conceal a dissonance between expressed and actual behaviours.
 - Existing social norms: the implementation and effectiveness of an anti-discrimination law are enhanced when the law builds on and formalizes a norm within the society that was already widely observed (23).
 - Public consultation: the meaningful engagement of the people whom the law or policy is likely to affect is essential to ensure that their needs and concerns are met (68, 71).
- The estimated costs of policies and laws vary widely and depend on factors such as the geographical coverage (e.g. international, regional or national), the provisions of the policy or legislation, the need for training to support implementation and the monitoring and enforcement mechanisms required (23). One study estimated the cost of the law-making component of a new public health law, and found that in high-income countries, such as New Zealand and the United States, the average cost of new public health legislation ranges between US\$ 382 000 and US\$ 980 000 (72). Still, these estimates did not factor in the costs of implementing the provisions of the law or those associated with monitoring and enforcement.

6.5 CONCLUSIONS AND FUTURE DIRECTIONS

Evidence shows that enacting policies and laws can be an important strategy to reduce or eliminate ageism, and it appears

Box 6.2**The UN Open-Ended Working Group on Ageing and the possibility of a new UN convention on the rights of older persons**

The UN General Assembly established the Open-Ended Working Group on Ageing in 2010 (78). Its purpose is to strengthen the protection of older people's rights by reviewing how existing instruments address these rights, identifying gaps in protection and exploring the feasibility of developing new instruments and measures. It is the first intergovernmental body outside of the UN Human Rights Council that annually brings together national human rights institutions (79) with UN Member States, nongovernmental organizations and UN agencies. Since its establishment, the Working Group has held discussions about key areas of older people's lives, including discrimination, health and long-term care, autonomy and independence, social exclusion, social security, violence and abuse, and end-of-life and palliative care. Since 2019, Member States have been able to present recommendations negotiated in Working Group sessions for consideration by the UN General Assembly (80). Based on the proposals made to improve the promotion of older people's rights, in 2014 the Human Rights Council appointed for the first time an Independent Expert on the Enjoyment of All Human Rights by Older Persons (81).

The Working Group is the primary forum for debate on the development of an international human rights treaty or convention regarding the rights of older persons. Indeed, in 2012, the UN General Assembly requested that the Working Group consider proposals for an international legal instrument to promote and protect the rights and dignity of older persons and present, at the earliest possible date, a proposal containing the main elements that should be included in such an instrument that are not addressed sufficiently by existing mechanisms (82). The UN Secretary-General has further highlighted the need to build stronger legal frameworks to protect the human rights of older persons, including by accelerating the efforts of the Working Group to develop proposals for an international legal instrument (83).

A UN convention is a legally binding document, which is enforceable by law, that outlines the rights of a specific group (e.g. women) or addresses a specific issue (e.g. torture). Any UN Member State can ratify a UN convention, thereby agreeing to abide by its rules. Once a country ratifies a convention, it must either adapt its national laws and policies or adopt new legislation to put into effect the rights included in that treaty. Thus, a convention can provide a framework based on rights, equity and social justice to guide policy responses to demographic ageing. It can encourage a paradigm shift from one in which older people are considered as passive recipients of welfare to one in which older people are seen as active rights holders.

UN Member States have expressed a variety of views on how to best promote and protect the human rights of older persons, including through enhancing the use of existing legal instruments or drafting a dedicated instrument. The Working Group continues to focus on more in-depth and open, substantive discussions to fully understand the issues, identifies elements that require further elaboration and considers appropriate solutions.

to be affordable. Policies and laws aimed at tackling ageism are quite varied and can include legislation addressing age discrimination and inequality, policies to ensure respect for the dignity of all persons regardless of age, and human rights laws. Along with educational interventions and intergenerational contact activities, policies and laws are among the most important strategies to include in any effort to combat ageism.

Future priorities in relation to policy and legislation interventions are detailed below.

- International policy and legislative guarantees against age discrimination should be increased. In international law, there is no specific legal instrument to dispel prejudice and discrimination against older people, and most international human rights instruments do not explicitly list age as a prohibited ground of discrimination. An international convention could turn aspirations into binding obligations and result in national legislation and policy, as has happened with other conventions such as the Convention on the Rights of Persons with Disabilities (34, 35), the International Convention on the Elimination of All Forms of Racial Discrimination (38) and the Convention on the Elimination of all Forms of Discrimination Against Women (36, 37). Support for the development of a new UN treaty on the human rights of older persons has increased recently, especially since the establishment of the UN Open-Ended Working Group on Ageing (see [Box 6.2](#)).
- It is critical to develop and enforce national anti-discrimination laws and policies, modify or repeal existing laws and policies that may be ageist and improve access to justice for those making complaints on the grounds of age discrimination or ageism more broadly. Although there has been steady progress in the adoption of national legal and policy provisions prohibiting discrimination on the basis of age (17), their scope and coverage are uneven compared with guarantees against discrimination on other grounds. Many inconsistencies and gaps also exist in terms of specificity, alignment with international law, legal and material scope, protection from both direct and indirect discrimination, differential treatment and exceptions, as well as in terms of monitoring and access to remedies (51). There is also a need to develop protections from intersectional and cumulative discrimination through policies and laws (e.g. discrimination based on both age and disability) (73-76).
- Public awareness about anti-discrimination and human rights laws and policies should be increased.
- It is important to conduct research to improve understanding of the effectiveness of existing and new anti-discrimination legislation and policies at the national and international levels (see [Box 6.3](#)).
- Estimates of the costs of policy and legislation interventions should be improved. Without accurate and comparable estimates of cost, the cost-effectiveness of interventions can neither be estimated nor compared. WHO's cost-effectiveness and strategic planning model (known as WHO-CHOICE) can be used for costing the implementation of new laws and policies (77).

Box 6.3**Opportunities for research on policy and law**

Although no systematic reviews are available about the effects of policies and laws on addressing ageism, evidence on the effectiveness of laws in tackling ageism and other "-isms" supports the use of this strategy to reduce or eliminate it. It will be important for future research to focus on conducting rigorous impact assessments of existing and new anti-discrimination laws and on policies aiming to eliminate ageism, as well as to assess the contributing factors to effectiveness (23). It is key that studies are conducted in low- and middle-income countries and that they also investigate the impact of these interventions on tackling ageism beyond the employment sector, given that most of the evidence has focused on employment-related outcomes in only a limited range of countries.

Given that randomized controlled trials are not always a possible or ethical design when evaluating policies and laws, future studies could use a range of techniques to address the challenges of attributing observed changes to the implementation of a given law or policy, for example, by using a statistical technique known as differences in differences, which aims to isolate the effect of a law on specific outcomes. Using this type of analysis, studies have compared, for example, the outcomes of older workers before and after a change in discrimination law (e.g. the introduction of the Age Discrimination in Employment Act in 1967 in the United States or changes in state laws) with those of an unaffected control group, such as younger workers or older workers in countries without legal changes, or both (24).

Additional methods have also been proposed to overcome other challenges encountered in evaluating laws and policies using observational designs, for example, by using regression discontinuity designs, instrumental variables or near-far matching approaches to address the issue of unobserved confounders (19). Or propensity score matching (i.e. a statistical matching technique that attempts to estimate the effect of a policy by accounting for the covariates that predict exposure to the policy) can be used to address the issue of constructing a comparison population when a well-matched comparator is not immediately available (19).

Qualitative comparative analysis is another method that has been increasingly used (84). This is a mixed quantitative and qualitative technique that is based on multiple case studies and that aims to determine which logical conclusions multiple case studies support and which can help explain why change happens in some cases but not others (85).

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CELIN, 61,
HAITI

07

STRATEGY 2: EDUCATIONAL INTERVENTIONS

“ I am not ashamed to be an old person; it is a stage in life which is inevitable. I think we need to teach people that stigmatizing people because of their age is wrong. ”

CELIN, 61, HAITI

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Chapter

07

Section 7.1 of this chapter describes educational interventions – the second strategy to address ageism. Section 7.2 reviews available evidence on their effectiveness, and Section 7.3 provides examples of this type of intervention from various countries. This chapter also presents, in Section 7.4, those characteristics that can make this intervention more effective, as well as its costs.

Educational interventions include instruction that transmits information, knowledge and skills, as well as activities to enhance empathy through role-playing, simulation and virtual reality.

Research shows that educational interventions are among the most effective strategies for reducing ageism against older people. Nothing is known about their effectiveness for reducing ageism against younger people.

These interventions are feasible and affordable.

Educational interventions have a central role to play in any effort to reduce ageism.

7.1 WHAT THEY ARE AND HOW THEY WORK

Educational interventions to reduce ageism refer to diverse activities, which are often combined. These include instruction that transmits information, knowledge, skills and competencies aimed at reducing ageist stereotypes, prejudice and discrimination. Educational interventions also include activities intended to enhance empathy through perspective-taking, using, for instance, role-playing, simulation and virtual reality. Many educational interventions also either include an element of intergenerational contact or are combined with fully fledged intergenerational contact interventions (see Section 7.2) (1, 2).

Educational interventions can be delivered either face-to-face or online. Face-to-face and online instruction may include lectures or modules on ageism that are integrated into specific courses (e.g. on geriatrics, gerontology or ageing and health) or whole courses addressing ageism that are integrated into curricula (e.g. in medical, nursing and social work schools). Face-to-face educational interventions can also take place during service learning (i.e. learning combined with community service to provide pragmatic instruction

and reflection while simultaneously meeting community needs), clinical rotations or attachments (e.g. students shadowing physicians) and mentoring (i.e. during which a more experienced or knowledgeable person helps to guide a less experienced person). Most interventions have taken place in formal educational settings (i.e. schools, colleges, universities), and only a few have taken place in non-formal learning settings (e.g. a workplace or community centre) (3, 4).

Educational interventions that seek primarily to transmit information and knowledge operate on the assumption that stereotypes, prejudices and discrimination are the result of ignorance, mistaken information, misconceptions and simplistic thinking. Providing accurate information and counter-stereotypic examples, dispelling misconceptions about a particular age group and teaching more complex thinking skills allow people to consciously reconsider and update their beliefs, feelings and behaviours and lead to a decrease in ageism (1, 5-9).

Empathy-enhancing activities are a type of educational intervention that is increasingly used to address ageism. Empathy refers to the ability to sense other people's emotions and to imagine what someone else might be thinking or feeling (10). Empathy-enhancing activities aim to generate identification with, and awareness of, another person's or group's suffering, generally through perspective-taking exercises used to counter stereotypes, prejudice and discrimination.

Such exercises seek to increase emotional engagement, compassion and the desire to help. Such interventions use, for example, role-play activities, simulation games and immersive virtual reality to allow participants to imagine or experience the world from a different perspective, thus challenging stereotypes and prejudices (11-13).

Most educational interventions – both those that seek primarily to transmit knowledge and those that aim to enhance empathy – have targeted interpersonal ageism, rather than self-directed or institutional ageism, and most of the interventions that have been evaluated were implemented in high-income countries.

7.2 HOW WELL THEY WORK

A 2019 systematic review of 23 educational interventions aimed at reducing ageism reached encouraging conclusions (1). It found that educational interventions had a small to medium effect on attitudes towards ageing and older people (a standardized mean difference of 0.34), including on stereotypes and prejudice. It also found a small to medium effect on knowledge of ageing (a standardized mean difference of 0.41), including effects on information and misconceptions about the ageing process (1, 14, 15).

Educational interventions to reduce ageism refer to diverse activities, which are often combined. These include instruction that transmits information, knowledge, skills and competencies aimed at reducing ageist stereotypes, prejudice and discrimination.

Twenty-one of the 23 educational interventions included in the review were from the United States, 1 was from Australia and 1 from Taiwan, China, all of which are high-income countries (1).

It is likely that educational interventions will also work to reduce ageism in low- and middle-income countries, but they need to be tested there. This systematic review confirms the findings of a previous review of educational interventions for addressing ageism among students, which suggested that educational interventions change both attitudes and knowledge related to ageism (2). The review also dispels the inconclusive findings of two older and less rigorous reviews of educational interventions, one of which assessed impacts on medical students and doctors (16) and the other on health-care providers (17).

It is likely that educational interventions will work to reduce ageism in low- and middle- income countries, but they need to be tested there.

7.3 EXAMPLES

Four examples illustrate different types of educational interventions from various parts of the world. The first, from Iran, is an educational intervention that includes an intergenerational element. The second and third, from the United States and Australia, concern interventions aimed at, respectively, high-school students and university students. All three primarily rely on classroom-based instruction. The last is an empathy-enhancing activity that used virtual reality to counter ageism among university students in the United Kingdom.

7.3.1 Workshops and conversations in Iran

In the Mazandaran Province in Iran, an educational intervention with an

intergenerational element was conducted among elementary, middle, high-school and university students.

The intervention consisted of 10 workshops about human development across the life course, and it included lectures, discussions, movies and pamphlets, all focusing on issues important to ageing. The intervention also included conversations with older adults.

Before the intervention, the elementary, middle and high-school students were found to be more ageist than their university counterparts. The intervention led to lower scores on the Fraboni Scale of Ageism, indicating less ageism, for all groups of students, with the largest decrease on the affective dimension of the scale. The study also found that ageism was more prominent among nursing and medical students than other types of university students (18).

7.3.2 Life-story documentaries in the United States

In a face-to-face educational intervention in the United States, students watched and then discussed life-story documentaries. For instance, one told the story of Sam Ballard and his four marriages; it included his reflections on finding love, losing love, and the meaning of love and relationships over his life.

Another told the story of Mary Starke Harper, an African American woman from Alabama, who became a psychologist, social scientist and a nurse; was awarded an honorary law degree; and advised six presidents on policy and research into mental health and ageing.

The intervention was found to strengthen students' sense of kinship and belonging with older people, their engagement with and interest in older people, and how enthusiastic they felt about and how

impressed they were with older adults. It also led to decreases in antagonism and antipathy towards older people and avoidance of older people. However, it did not lead to more positive feelings towards older people (e.g. "I like older people" or "I feel positively towards older people"), a greater sense of comfort with older people or to less discriminatory attitudes towards older people (19).

7.3.3 Curriculum-based intervention in Australia

A face-to-face educational intervention for high-school students in Australia consisted of four interactive weekly sessions, involving group discussions, games, role-plays and case studies. It was integrated into a health and society curriculum. The high-school students were also given homework during which they had to practice the new skills they had learned with older people in their lives. Almost all of the students were in contact with older people, such as grandparents, other relatives or family friends (20).

Session 1 encouraged students to discuss what it means to be an older person in today's society to help them consider older people's perspectives. The main question for this session was, "What might older individuals expect of me?"

Session 2 aimed to raise self-awareness of ageist attitudes and stereotypes. The main question for this session was, "What have older individuals done for or contributed to society?" Its goal was to challenge students' perceptions of older people and broaden their understanding of older people's lives to help students move beyond hasty judgements about whether older people deserve respect.

Session 3 promoted mutual respect through asking adolescents to reflect on what they

would like older people to understand about them. The main question for this session was, "What would I like back from older people (for a mutually respectful interaction)?"

Session 4 aimed to foster positive and respectful interactions between adolescents and older individuals by teaching interpersonal skills. The main question for this session was, "What can I do (i.e. how can I behave) to increase mutually respectful interactions?" This session was designed to overcome adolescents' tendency to avoid initiating interactions with older individuals for fear of negative reactions and uncertainty about how to cope.

This intervention led to greater knowledge and fewer misconceptions about older people, less negative bias, more positive attitudes (including stereotypes) and improved social skills related to older people.

7.3.4 Virtual reality in the United Kingdom

A research team in the United Kingdom used three virtual reality activities to foster empathy for older people among university students (11). In the first activity, students used an app to create a visual image of themselves as an older person. In the second, aimed to simulate the experience of social exclusion and isolation that many older adults experience, students wore a virtual reality headset that gave them the experience of taking part in a dinner during which they were not included in interactions. In the third activity, students were guided through an immersive experience of completing several everyday tasks in the home of an older person with moderate frailty (e.g. making a hot drink, answering the door). Through virtual reality, the speed of their movements and reactions was slowed, their hearing was dulled and their vision blurred. The students reported

becoming more aware of older adults' experiences and having increased empathy and respect for older people.

7.4 KEY CHARACTERISTICS AND COSTS

It is not known which subtype of educational intervention is more effective: instruction-based or empathy-enhancing. Nor is it known which characteristic of each subtype (e.g. online or classroom-based instruction; role-playing, simulation or virtual reality) is associated with greater effectiveness (see [Box 7.1](#)).

Presenting information in a positive light can help counteract pre-existing stereotypes and prejudices about older age.

A challenge to identifying which characteristics are associated with effectiveness is the heterogeneity of educational interventions. For example, while most of the studies in the systematic review relied primarily on courses and lectures to transmit information and knowledge, some also included an element of intergenerational contact, role-playing or simulation. Nevertheless, several studies provide some pointers to potentially important characteristics of educational interventions, and these are outlined below.

- Small doses over time may be better than a dedicated course. One study compared modes of instructional delivery and found that both receiving information in

the form of a dedicated course over one semester and infusing the same information over the whole of the curriculum led to improvements in attitudes towards older people, but infusion over time worked marginally better than a dedicated course (21).

- Presenting information in a positive light can help counteract pre-existing stereotypes and prejudices about older age. A challenge in educational interventions is striking the right balance between, on the one hand, being honest and comprehensive about ageing and, on the other, not painting too negative a picture that ends up being counterproductive (22, 23). The risk is that when efforts are made to present both the positive and negative facets of ageing, participants may focus on and remember the experiences and information that reinforce their pre-existing negative stereotypes and prejudices. It is probably advisable to err on the side of positivity when developing educational interventions, as research on the presentation of older people in experimental studies suggests (reviewed in Chapter 4). The effects of interventions to reduce stereotypes and prejudice also tend to dissipate quickly when pre-existing stereotypes and prejudices are rekindled by the surrounding culture (6).
- Group discussions or skills training is required to reinforce education. Changes in attitudes towards older people brought about by information alone tend to fade quickly unless they are reinforced by subsequent activities, such as group

Box 7.1**Opportunities for research on educational, intergenerational, and combined educational and intergenerational interventions**

The findings on educational interventions, intergenerational contact interventions and combined educational and intergenerational contact interventions are based on a high-quality systematic review and meta-analysis commissioned for this report: the first such meta-analysis in the field (1). This review included 63 studies and was conducted in accordance with the PRISMA guidelines (29). A total of 14 electronic databases were searched, and the quality of individual studies was carefully appraised as well as the body of evidence across studies for each outcome.

However, the quality of the underlying studies was not high. Only six of the 63 studies were randomized controlled trials. More than half of the studies were rated as being at high risk of bias on four or more of the six dimensions assessed using the Cochrane Risk of Bias tool. The Grading of Recommendations Assessment, Development, and Evaluation (GRADE) tool was used to assess the quality of the body of evidence across studies for each of the ageism outcomes: the overall quality was rated as moderate for three of the outcomes and low and very low for the remaining two (30). In future, researchers should strive to conduct studies of higher quality with less risk of bias.

The essential characteristics of interventions should also be identified with greater rigour. This will (i) allow interventions to be optimized, (ii) help identify which characteristics contribute to effectiveness when two or more interventions are combined, and (iii) provide some guidance on the characteristics of a strategy that are key to its effectiveness, especially in a new context in which interventions cannot be retested. The Template for Intervention Description and Replication checklist and guide (31) was developed by an international team of experts to promote full and accurate descriptions of interventions. We encourage researchers to use this checklist and guide when they plan and report on evaluations of interventions to reduce ageism.

discussions or social skills training (9, 24, 25).

- The effects of role-playing can be enhanced by debriefing and by having students play the part of the older person. A systematic review of interventions that sought to enhance empathy in student health

professionals through role-play activities made two suggestions.

First, it is important for students to play not only the role of the health professional but also that of the older patient. Second, a debriefing session should be included to allow students to translate the experience of role-playing into empathic behaviours (26).

- The key characteristics of effective virtual reality interventions include ensuring that participants are fully immersed in a scene and experience what it is like to be in an older person's body. The more effectively virtual reality simulates being in the world of the other person and the greater the feeling one is really in that world (i.e. the greater the sense of immersion), the more empathy seems to be generated. And the more an individual has the impression of experiencing the world through another's body (i.e. the greater the sense of embodiment), the greater the empathy generated (12).
- A review of virtual reality-based simulations used to train health professionals about mental illness found that such interventions seem to have a larger impact on the empathy of those with a health-care background compared to those without (27). This review also highlights the lack of consensus on the optimal content of such interventions and on the protocols for their delivery, points that also are relevant to virtual reality interventions used to reduce ageism.

Evidence shows that educational interventions are effective in reducing ageism and appear to be affordable.

The Aging Game is one of the few educational interventions shown to be effective and whose cost has been estimated (23, 28). In the Aging Game, medical students experience simulated physical, sensory and cognitive deficits,

which tend to increase with age. The intervention takes half a day and involves some 30 students at a time. It is estimated to cost about US\$ 33 per workshop per student, which is relatively affordable. Knowing the cost of effective interventions is important. Without accurate and comparable estimates of cost, the cost-effectiveness of interventions cannot be estimated. Further accurate estimates of educational interventions are required.

7.5 CONCLUSIONS AND FUTURE DIRECTIONS

Evidence shows that educational interventions are effective in reducing ageism and appear to be affordable. Such interventions are, however, quite heterogeneous. They encompass disparate types of interventions, such as those that seek to transmit information and knowledge in a classroom setting or online and empathy-enhancing activities that include role-play, simulation games and immersive virtual reality. Educational interventions and intergenerational contact activities are among the most effective interventions for reducing ageism, and the two work well when combined (see Chapter 8).

Future priorities for educational interventions should include:

- developing, testing and scaling up educational interventions in all countries to reduce ageism against older people, but particularly in low- and middle-income countries where they are rare, across formal (e.g. school, colleges, universities) and non-formal (e.g. workplaces) educational settings;

- developing, testing and scaling up educational interventions that reduce self-directed and institutional ageism, few of which are available;
- describing the characteristics of the interventions in a standardized way, so the interventions can be replicated more easily and their essential characteristics be better identified (see [Box 7.1](#));
- estimating the cost and cost-effectiveness of educational interventions where such estimates are lacking.

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OLIPCIA, 74,
HAITI

08

STRATEGY 3: INTERGENERATIONAL CONTACT INTERVENTIONS

“ I think that it is important [that] the whole society and the government in particular focus on creating a mutual understanding between younger and older people. ”

Olipcia, 74, Haiti

©Joseph Jn-Florley / HelpAge International

Chapter

08

This chapter discusses another effective strategy to eliminate ageism: intergenerational contact interventions.

Section 8.1 describes this intervention and how it works in addressing ageism. Section 8.2 reviews the evidence on its effectiveness and Section 8.3 provides real-world examples of this type of intervention. Section 8.4 summarizes the evidence on the factors that can make this intervention more effective and its costs.

Intergenerational contact interventions aim to foster interaction between different generations.

Research shows that intergenerational contact and educational interventions are among the most effective interventions for reducing ageism against older people, and they are promising for reducing ageism against younger people.

Interventions that combine education and intergenerational contact also work to reduce ageism against older people and they have a slightly larger effect on attitudes than intergenerational contact interventions used alone, but they have little effect on knowledge about ageing.

Intergenerational contact interventions should be included in any comprehensive effort to reduce ageism, along with relevant policies, laws and educational interventions.

8.1

WHAT THEY ARE AND HOW THEY WORK

Intergenerational contact interventions aim to foster interaction between people of different generations, and they are an important strategy to tackle ageism. They typically involve bringing together older and younger people to work cooperatively on tasks to encourage cross-generational bonding and understanding (1).

Intergenerational contact activities are often divided into those that involve direct contact and those that involve indirect contact. Direct contact involves face-to-face interaction, which can occur in various contexts, such as older and younger people playing games, gardening, making art or engaging in music therapy together or teaching each other; younger people visiting nursing homes or doing service learning with older people; older people conducting extended interviews or holding discussions with younger people or vice versa; or older and younger people living together, sometimes

referred to as home-sharing. School-based programmes are among the most common direct intergenerational contact activities. These might involve older people meeting with students once a week for an hour or two, for instance, to share stories, paint together or share recipes and cook together.

Intergenerational friendships and contact between grandparents and grandchildren are also forms of direct intergenerational contact that can potentially reduce ageism (2). Thanks to increased longevity, more young people have living grandparents than ever before in history. Relationships with grandparents also provide many younger people with their first and most frequent contact with older adults (1). Skipped-generation households, in which grandchildren live with their grandparents, are common in some parts of the world (e.g. Africa, eastern Europe, Latin America and the Caribbean), either due to children being orphaned by parents who had AIDS or because their parents migrated for work (3).

While intergenerational friendships and contact between grandparents and grandchildren do not, strictly speaking, constitute interventions, and no study to date has examined the effect of grandchild–grandparent contact or intergenerational friendship on ageism as its main purpose, they are addressed in this section due to their importance.

Indirect intergenerational contact interventions entail participants being exposed to another age group without a direct or face-to-face encounter. Extended and imagined indirect contact are sometimes distinguished. Extended indirect contact occurs when, for instance, a friend of a similar age is known to have friends in another age group. It is based on the idea that a friend of yours is a friend of mine. Imagined indirect contact works by asking people to imagine having

a positive encounter with a person from another age group (2).

Intergroup contact theory explains how intergenerational contact interventions work in reducing ageism. Facilitating contact between groups under optimal conditions reduces intergroup prejudice and stereotypes, to a lesser extent, by reducing anxiety about intergroup contact and increasing perspective-taking and empathy (4, 5).

Optimal conditions occur when both groups have equal status and common goals, and when there is intergroup cooperation and the support of authorities, law or custom (2, 4–6) (see [Box 4.1](#) in Chapter 4). Evaluations of interventions based on this theory, which have included interventions to reduce ageism, demonstrate that the effects of intergroup contact can generalize beyond the immediate participants in the intervention to the entire out-group (4, 5).

8.2 HOW WELL THEY WORK

Intergenerational contact strategies are among the most effective interventions for reducing ageism against older people, along with educational interventions.

Evidence is increasing that interventions based on intergenerational contact work to reduce ageism against older people. A systematic review that included evaluations of 21 different intergenerational contact interventions aimed at reducing ageism against older people found that they had a small effect on attitudes (a standardized mean difference of 0.18), including on stereotypes and prejudice (7). It also showed that these interventions had a moderate effect on knowledge (a standardized mean

difference of 0.53), including on information and misconceptions about the ageing process (see Chapter 7, [Box 7.1](#)).

All of the studies in the review were from high-income countries, except for one from China, an upper-middle-income country (7). So although there are some grounds to assume that such interventions will also work in low- or middle-income countries, this is not certain (8-11). The systematic review also evaluated the effects of interventions that combined educational and intergenerational contact activities (see [Box 8.1](#)).

In the review, only two of the 40 intergenerational contact and combined intergenerational contact and educational interventions targeted anxiety about participants' own ageing, which is related to self-directed ageism. And none addressed institutional ageism (7).

The results of this systematic review confirm the findings of previous reviews. For instance, a systematic review of interventions testing intergroup contact theory that included 54 studies looking at prejudice against older people found that the interventions were effective (5), as did another review of intergenerational contact programmes (2).

While only limited evidence is available about the effectiveness of such interventions to reduce ageism against younger people, it is nevertheless promising ([Box 8.2](#)).

It is important to emphasize that intergenerational contact has other benefits in addition to reducing ageism. For older people, it can, for example, lead to improved health and psychosocial well-being, and increased self-esteem, and it can reduce distress, decrease loneliness, lead to a greater sense of social connectedness and strengthen intergenerational solidarity (2, 20, 21).

8.3 EXAMPLES

The first of the four examples of intergenerational contact interventions presented in this section involves older and younger people playing video games together in Singapore. The second example, from China, Hong Kong Special Administrative Region, describes a form of service learning for nursing and medical students. The third example discusses an intervention in Portugal in which students engaged in sustained intergenerational contact by sharing older people's homes. The last example involves only brief, imagined intergenerational contact among students in the United Kingdom.

8.3.1 Video games in Singapore

This intergenerational intervention in Singapore involved direct contact between older and younger people who paired up to play video games six times over two months. The older participants were recruited from activity centres in the local community and had a mean age of 76 years; the younger participants were recruited from local schools and had a mean age of 17 years.

Both younger and older participants who played video games together reported more positive changes in intergroup anxiety (e.g. they felt less awkward and self-conscious, and more confident when interacting with members of the other group) and attitudes (e.g. as measured along the dimensions of foolish–wise, boring–interesting and inactive–active) than participants in the control group, who did not play video games together. The results showed that enjoyment of the game had an important role in reducing intergenerational anxiety and improving attitudes among older people but not among the younger participants (16).

Box 8.1**Combined educational and intergenerational contact interventions**

Educational and intergenerational contact interventions are frequently implemented together. A total of 19 of the 63 studies included in a systematic review commissioned for this report consisted of such combined interventions (7).

Interventions that combined education and intergenerational contact had a slightly larger effect on attitudes towards older adults (a standardized mean difference of 0.43), including on both stereotypes and prejudice, than those that involved only intergenerational contact (a standardized mean difference of 0.18). But there was no difference in effects on attitudes between interventions that combined education and intergenerational contact and those that used only education. Nor were there any differences in effects on attitudes between education-only and intergenerational contact-only interventions. Also, combined interventions had no significant effect on knowledge, but education-only and intergenerational contact-only interventions had, respectively, small and moderate effects on knowledge (7, 12, 13).

Further analyses combined results from education-only, intergenerational contact-only, and combined education and intergenerational contact interventions and produced several noteworthy findings (7). The analyses found that although these interventions had a small effect on attitudes and knowledge in high-school and university-level age groups, they were not effective in improving attitudes in pre-primary and primary school-aged children. No studies examined their effect on knowledge in pre-primary and primary school students. The analyses also revealed that the dose of the intervention was not related to improvements in attitudes or knowledge. Finally, interventions also appeared to increase younger participants' level of comfort when interacting with adults, but seemed to have no effect on their prejudicial attitudes towards their own ageing (a proxy for self-directed ageism).

Eighteen of the 19 combined interventions included in the review were implemented in the United States and one was in Canada (7). So we cannot be completely sure whether these findings about combined interventions apply to low- or middle-income countries.

Example: Positive Education about Ageing and Contact Experiences from the United States

The Positive Education about Ageing and Contact Experiences (PEACE) programme is an example of a combined education and intergenerational contact intervention to reduce ageism that was aimed at younger people and delivered online (14). The intervention consisted of presenting a series of true/false statements about ageing and older people. For instance, participants had to decide whether the statement "depression is more frequent among older adults than among younger people" was true or false. For the educational component, the correct responses and accompanying explanations were provided after the participant had answered the questions.

The contact component was a form of indirect, extended contact and consisted of an additional response to the question about depression that described an intergenerational relationship in a positive way: "Max (aged 22 years) ... admires Charles' positive take on life and hopes to be more like him. ..."

When tested, this simple, easy to implement and presumably inexpensive online intervention improved attitudes towards older people and knowledge about ageing. Potentially, it could be developed into a more in-depth intervention and delivered widely online to reduce ageism. An evaluation of the PEACE programme found that the combined intervention was generally not any more effective at reducing ageism outcomes than either the educational or the intergenerational contact components alone (14).

8.3.2 Service learning in China, Hong Kong Special Administrative Region

This intervention for nursing and medical students in China, Hong Kong Special Administrative Region, consisted of three components: a half-day introductory workshop, a 10-week interaction period and a half-day intergenerational sharing session. During the interaction period, older adults and students were paired, and they identified mutual learning objectives (e.g. about age-related changes, the challenge of chronic illness in old age, or a healthy lifestyle in later life). Then the pairs met from one to two hours per week. They discussed topics such as age-related changes, the challenge of chronic illness in old age and having a healthy lifestyle in later life. The goal was for younger students to learn about the reality of ageing and how their older partners coped.

The intervention increased medical and nursing students' overall knowledge of ageing and their understanding of mental health needs in old age and reduced their negative attitudes toward older adults (22).

8.3.3 Home-sharing in Portugal

The Aconchego programme, which started in Portugal in 2004, encourages sustained,

direct intergenerational contact. In this programme, older people provide housing to university students and, in exchange, students help alleviate older people's loneliness and isolation.

This programme carefully matches older people who live on their own with students who need accommodation, paying close attention to mutual expectations, interests and personal histories. At first, demand for the programme came mainly from students looking for accommodation, but in time, as older people became more familiar with the programme and trusted it more, demand from older people increased. The programme started in Porto, a city with large populations of students and older people; it was then replicated in Lisbon and in Coimbra, two other cities with many students. Although the Aconchego programme has been carefully monitored, its impact on ageism has not been evaluated (23, 24).

This model has spread to some 16 countries, including Australia, Belgium, Canada and the Republic of Korea; sometimes it is known as home-sharing (25). While some qualitative evaluations of home-sharing programmes have been carried out in relation to outcomes other than ageism (26), no rigorous evaluation assessing their impact on ageism has been conducted.

Box 8.2**Intergenerational contact interventions to reduce ageism against younger people**

The evidence is promising for the effectiveness of using intergenerational contact strategies to reduce ageism against younger people. A rapid review conducted for this report identified five studies evaluating the effectiveness of these strategies that used a design with a comparison group (either randomized or not randomized) (15-19). All of these studies examined ageism against both younger and older people. Four of the studies found that such interventions work to reduce ageist attitudes towards younger people (15-17, 19), while one found they made no difference (18).

Example: The Young–Old Link and Growth Intergenerational Programme in China, Hong Kong Special Administrative Region

An example of one of these interventions is The Young–Old Link and Growth Intergenerational Programme in China, Hong Kong Special Administrative Region.

This programme aimed to combat age-related stereotypes and facilitate positive interactions between younger and older adults in China, Hong Kong Special Administrative Region (19). It comprised six sessions that brought together 167 older people from community social services and 179 younger people from secondary schools. The programme was run by social workers who specialized in working with younger and older people.

The first stage – the foundation stage – consisted of two rounds of training of the social workers selected to deliver the intervention. The second stage – known as the stimulation stage – provided information to the participants to help them get to know one another. This stage consisted of two 2-hour sessions, one for older people and one for younger people. Older people watched a video on youth development to better understand the needs of contemporary youth, and younger people engaged in exercises that simulated the impairments that older people may have (e.g. blurred vision). The third stage – known as the consolidation stage – consisted of two day-long sessions attended by both groups together. The first involved setting collective goals (i.e. identifying sightseeing locations suitable for both generations), and the second, achieving the goals (i.e. visiting the sites together). This was followed by two additional 2-hour sessions, in which older and younger people participated together, focused on preparing, rehearsing and delivering group presentations about the sites visited.

An evaluation found positive changes in intergenerational attitudes, an increased sense of comfort with participants of a different generation, and increased interactions on the parts of both the younger and older participants. However, the changes were generally larger for the younger participants than for the older participants (19).

8.3.4 Imagined contact in the United Kingdom

A brief intervention based on a form of indirect and imagined intergenerational contact was used with the aim of reducing both explicit and implicit negative attitudes towards older people among undergraduate students in the United Kingdom.

The students were instructed to spend two minutes imagining themselves meeting an older stranger for the first time. They were also asked to imagine that they found out some interesting and unexpected things about the person.

This simple and inexpensive intervention led to reductions both in explicit negative attitudes towards older people (e.g. the students felt less cold, less suspicious, less hostile) and in implicit bias in favour of young people over older people. The authors note, however, that imagined contact likely has less powerful and long-lasting effects than direct, face-to-face intergenerational contact (27).

8.4 KEY CHARACTERISTICS AND COSTS

Several studies provide some indication about which factors contribute to the effectiveness of intergenerational contact, including between grandparents and grandchildren and between friends of different generations.

- According to intergroup contact theory, one of the optimal conditions for intergenerational contact activities is to ensure that the groups are of equal status. A common feature of unsuccessful programmes to reduce ageism among younger people

against older people appears to be the unequal status between the younger and older participants. Unequal status can arise when tasks favour the skills of one group over the other, or there are unequal numbers in the different age groups or differing levels of familiarity with the environment. For instance, an intervention taking place in a school, which might be unfamiliar to older people, and that includes many younger people and only a few older people is likely to create unequal status. Having lower status in a contact situation may exacerbate pre-existing anxieties about participating in activities. If the status between groups is markedly unequal, intergenerational activities may actually increase prejudice (2, 4).

- The quality of the contact between groups in intergenerational activities (e.g. how well older and younger people get on or how emotionally close they feel) is another key factor that may be more important than the frequency of contact in reducing stereotypes and prejudice against older people (1). Better quality contact can be fostered by organizing tasks that build confidence, avoiding situations in which either party patronizes the other and encouraging self-disclosure during which participants share personal information with one another. However, encouraging self-disclosure requires careful design: research suggests that older adults telling stories about the past increases the closeness of contact, but if older adults divulge too much personal information, it can lead to poor communication and negative outcomes (2, 28, 29). Thus,

it is important to include balanced amounts of self-disclosure from both parties and for the stories of the past not to be too personal (2).

- Activities that increase cooperation through goal sharing and that reduce competition between age groups appear to be important, in keeping with the idea of optimal conditions in intergroup contact theory. Activities than foster cooperation include taking part in, for instance, arts and crafts projects, intergenerational choirs and orchestras and cooking. It is equally important to ensure that activities or tasks that confirm negative stereotypes about either group are avoided, as well as the presence of onlookers who are not participating in the programme and situations in which individuals can sidestep contact altogether (2).
- A review found that the more well structured and carefully designed the interventions were, the more effective they were (e.g. ensuring that instructors are well trained, clear instructions are given to participants, and intervention protocols are used) (20).
- One study points to the potential importance of how participants are grouped, whether in pairs or larger groups of mixed ages. It suggests that activities performed in child–older adult dyads (e.g. structured conversations and moving to music) had a more positive effect on stimulating interaction than activities occurring in a larger group (e.g. singing or playing an instrument) (15)

Several factors, which could potentially be manipulated in an intervention, appear

to enhance the positive impact on ageism that contact between grandparents and grandchildren and between friends of different generations can have. These factors partly overlap with the characteristics of the successful intergenerational contact interventions discussed above.

- A systematic review found that both the quality and frequency of contact with grandparents have robust and independent ageism-reducing effects (30). However, some research suggests that for good-quality contact to positively affect attitudes towards grandparents, it also needs to be relatively frequent (2, 31). High-quality contact seems to be characterized by increased self-disclosure and perspective-taking by both parties; younger people treating grandparents as individuals; younger people avoiding using overly accommodating speech, sometimes referred to as elderspeak (e.g. not using baby talk with older adults); and younger people having little anxiety about interacting with grandparents (2, 31). Although little research has examined the characteristics of intergenerational friendship that lead to a reduction in ageism, it appears that self-disclosure, perspective-taking and empathy by both parties play key roles (2).
- Parental encouragement and shared family identity also play roles in the impact that contact between grandchildren and grandparents has on ageism. Generally, grandchildren who identify more strongly with their family and whose parents encourage relationships with their grandparents have more favourable perceptions of older adults (29).

- Findings about the effect on ageism of living or having lived with an older person are inconclusive (32-35). More research is required to clarify the roles of factors such as the state of health of the older person, the type of relationship (e.g. grandparent, other relative, non-relative), the quality of the relationship and the cultural norms governing intergenerational living (29, 36, 37).

Little information is available about the costs of intergenerational contact interventions. However, several reviews emphasize that the costs of such interventions are likely to be low (particularly those based on imagined and extended indirect contact in which older people are not required to participate) and such interventions are easy to implement (1, 2, 7). For instance, the intervention in Singapore in which older and younger people played video games together is presumably affordable and straightforward to implement (16). Still, exact estimates of the costs of these interventions are needed.

8.5 CONCLUSIONS AND FUTURE DIRECTIONS

Evidence shows that interventions that foster intergenerational contact are among the most effective interventions for reducing ageism against older people. They also appear to be affordable and relatively easy to implement.

While interventions that combined education and intergenerational contact had a slightly larger effect on attitudes, including on prejudice and stereotypes, than those that involved intergenerational contact alone, they did not have a larger effect than

education-only interventions, and they had no effect on knowledge. Education-only and intergenerational education-only interventions had, respectively, small and moderate effects on knowledge.

Future priorities in relation to intergenerational contact interventions should include the following:

- It is essential to develop, test and scale up intergenerational contact-only and combined educational- and intergenerational-contact interventions to reduce ageism against both older and younger people in all countries, but especially in low- and middle-income countries.
- There is a need to identify the essential characteristics of intergenerational contact interventions and the right mix of intergenerational and educational-components in combined interventions (see [Box 8.2](#)).
- Interventions that aim to reduce self-directed and institutional ageism should be developed.
- It is important to estimate the costs of intergenerational contact-only and combined educational- and intergenerational-contact interventions.
- Equally important is the need for further research to determine the optimal conditions under which contact between grandparents and grandchildren and intergenerational friendships lead to reductions in ageism. This should be followed by the development and testing of interventions to foster these relationships and reduce ageism.

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BUAKHIAW, 84,
THAILAND

09

PROMISING STRATEGIES

“ We don’t have control over other people’s thoughts. What we can do is to control and shape our own thoughts and behaviour. ”

Buakhiaw, 84, Thailand

©Paiboon Yeelar / FOPDEV / HelpAge International

Chapter

09

This chapter discusses two strategies to address ageism that are supported by limited evidence, but which hold promise. Section 9.1 surveys the evidence for campaigns to reduce ageism, a strategy often used, but for which there is no direct evidence of effectiveness. That there is some evidence for the effectiveness of campaigns in other areas provides grounds to think they might also work to reduce ageism. Section 9.2 summarizes the evidence for strategies to mitigate the impact of ageism against older people after it has occurred; however, some of these are only potential strategies.

Based on some evidence for their effectiveness in other areas, campaigns may be a promising strategy to reduce ageism.

Research on strategies to mitigate the impact of ageism after it has occurred is still at an early stage. Nonetheless, some approaches may hold some promise for lessening the impact of negative stereotypes.

Both campaigns and strategies to mitigate the impact of ageism should be further developed and tested as rigorously as possible before they are scaled up.

Other strategies to mitigate the impacts of all dimensions of ageism – stereotypes, prejudice and discrimination – should be developed and tested.

9.1 CAMPAIGNS

9.1.1 What they are and how they work

Campaigns are purposive attempts to inform or influence behaviours in large audiences within a specified period by using an organized set of communication activities and featuring an array of mediated messages delivered through multiple channels to produce non-commercial benefits to individuals and society (1, 2).

Campaigns use either traditional media (e.g. television/cinema advertising, radio, billboards, the press, signs in buses, taxis, etc.) or new media (e.g. social media, targeted landing pages, pay-per-click advertising, digital banners and signage, Facebook, Twitter, YouTube advertisements, etc.) (3).

Campaigns generally seek to reduce ageism either directly, by changing individual behaviour, or indirectly, by changing laws and policies and shifting social norms. Often, they do both. When they operate indirectly, campaigns seek to influence policy-makers, civil

society, political and opinion leaders, the media and the general public to increase the visibility of an issue, alter perceptions of who is responsible for causing the issue and mobilize constituencies, all to create an environment conducive to changes in individual behaviour (1, 4, 5). In recent years, campaigns have increasingly been used to address ageism, as the examples in Section 9.1.3 illustrate.

9.1.2 How well they work

No high-quality studies demonstrate the effectiveness of campaigns to reduce ageism (6). Testing the effectiveness of campaigns is inherently challenging, which may explain why so few ageism campaigns have been evaluated (see [Box 9.1](#)) (7-9). Still, some evidence exists from campaigns addressing other health issues and other forms of stereotypes, prejudice and discrimination.

One of the most comprehensive reviews of the literature on the effectiveness of health campaigns includes a systematic review

of 36 other systematic reviews, as well as three new systematic reviews of primary studies (3). It summarized the evidence for mass media campaigns targeting six risk factors for noncommunicable diseases: alcohol use, diet, illicit drug use, physical activity level, sexual and reproductive health, and tobacco use (3).

The review found moderate evidence that mass media campaigns can reduce sedentary behaviour and influence sexual health-related behaviours and treatment-seeking behaviours (e.g. through the use of helplines to quit smoking and sexual health services). The evidence for an impact on tobacco use and level of physical activity was mixed. The evidence for an impact on alcohol use was limited, and there was no impact on illicit drug use. Campaigns appear to have less of an impact on behaviour change than on knowledge and awareness.

Overall the evidence suggests that health campaigns have a small beneficial effect, even if the findings are somewhat mixed (3, 10, 11).

Box 9.1

Opportunities for research on campaigns to reduce ageism

Campaigns are more difficult to evaluate using rigorous designs than many other types of interventions (7-9). It is difficult to use randomized controlled trials to evaluate most campaigns (9). Cluster-randomized trials are rigorous designs that are occasionally used instead, but they are also challenging (9, 12, 13).

In most cases, campaigns are evaluated using weaker designs that produce findings in which we have less confidence (7-9, 13). Indeed, when a weaker design is used to evaluate a campaign, the campaign often – misleadingly – appears to work twice as well as when the same campaign is evaluated using a more rigorous design (14).

The priority is to conduct the most rigorous evaluations possible of campaigns aiming to reduce ageism, and guidance is available (7, 9, 15, 16); once their effectiveness is demonstrated, the next step is to identify their essential characteristics.

A review of systematic reviews evaluating mass media campaigns for reducing prejudice and discrimination against people with mental health conditions found that campaigns had small to moderate positive impacts on stigma-related knowledge, attitudes and intended behaviour (i.e. desire for contact with people with a mental health condition) (17).

An earlier review found that mass media interventions had a small to moderate effect on reducing negative attitudes towards people with mental health conditions, but they had mixed effects on discrimination (18).

High-quality evidence is sparse about campaigns that work to reduce stereotypes, prejudice and discrimination based on race and ethnicity, and it shows a mixed picture (19-21).

Thus, campaigns may offer a promising strategy to tackle ageism. Even if campaigns have only a small effect, with sufficient reach and penetration at the population level they could nevertheless bring about significant change (18).

9.1.3 Examples

This section highlights a few international and local campaigns, including one run by a coalition of groups and another by a global network. The first example describes a worldwide campaign taking place in several low- and middle-income countries.

The second example is an ongoing, research-based, national campaign in Australia, while the third concerns an innovative city-based campaign in Canada. While the previous examples focus on campaigns to reduce ageism against older people, **Box 9.2** provides an example of a campaign to reduce ageism against younger people.

Take a Stand Against Ageism: an international campaign

Take a Stand Against Ageism is an ongoing campaign taking place in different regions of the world, and it is led by HelpAge International, a global network of organizations working with and for older people. The campaign takes its name from the theme for the 2016 International Day of Older Persons (6).

The aims of the campaign are to increase the awareness of ageism among HelpAge network members, campaigners and supporters and to increase the visibility of older people's lived experiences of ageism to ensure that older people are no longer denied their rights simply because of their age.

Campaign resources are available from HelpAge International and include guides to conducting consciousness-raising workshops and ageism role-plays (22).

This campaign comprises many ongoing campaigns, and the activities vary across countries. For instance, in Bangladesh more than 2000 older and younger people, development workers, students and journalists formed a human chain to demand government action to support a UN Convention on the rights of older people. Activities organized in Mozambique included a march in Maputo, two radio debates with representatives from the government and older people's associations, and a health fair.

The EveryAGE Counts campaign in Australia

EveryAGE Counts is an ongoing advocacy campaign in Australia that was launched in 2018 and is run by a coalition of organizations aimed at tackling ageism against older Australians. Its vision is "a society where every person is valued, connected and

Box 9.2**Not Too Young to Run: a campaign to reduce ageism against younger people in politics**

In November 2016, the global campaign Not Too Young to Run was launched by a partnership including the UN and several other international and nongovernmental organizations (25). It aims to address ageism against younger people in the political process by promoting their right to run for public office. In a fast-changing world where more than 50% of the population is younger than 30 years-old, but less than 2% of elected legislators are, the campaign highlights the fact that the active participation of young people in electoral politics is essential to ensure thriving and representative democracies worldwide (26).

The campaign seeks to (i) raise awareness of the lack of young people in public office by collating global statistics by country concerning youth and politics and also identifying barriers to participation; (ii) advocate for the rights of young people to run for public office and leadership positions, and for increased participation of young people in politics and government; and (iii) gather input and ideas from young people around the world with regards to their participation in political decision-making processes through an online public consultation. The campaign also highlights young leaders already in elected positions and tries to inspire young people to run for office.

The campaign scales up the movement of the same name that was started by civil society groups in Nigeria in May 2016. This movement contributed to the Nigerian Government enacting legislation in 2018 that reduced the age limit for state legislators and those in the federal House of Representatives from 30 years to 25 years; for senators and governors, from 35 to 30 years; and for the president from 40 to 35 years (25, 26).

respected regardless of age and functional health" (23).

The overall goal is to build strong, new foundations to enable current and future generations to age well. The campaign seeks to shift entrenched negative social norms about ageing and older people and to reframe older age as a valid, positive and meaningful part of life.

EveryAGE Counts seeks to bring about social change by engaging in advocacy, political engagement and public campaigning for policy change; addressing specific structural

barriers to participation for older people (e.g. in the workplace and health care); and increasing the diversity and accuracy of representations of older people in the media, arts and public discussions.

Campaign activities have included pledge-signing events at Parliament House during which participants acknowledge that they "stand for a world without ageism" (23); hosting or participating in community-based events to build awareness of the campaign and increase membership; and developing and disseminating materials such as a quiz (*Am I ageist?*) and a magazine (*The real old*),

which encourages people to think about ageism and to speak out against it (23).

Research has played an important part in the development of the campaign. For instance, a research project looking at the drivers of ageism provided the foundational evidence that informed the campaign's strategy (23).

The Best Before Date campaign in Canada

The Best Before Date campaign in Peterborough, Canada, was a city-wide marketing campaign aiming to tackle ageism, that took place in 2013-2014. Launched as part of Seniors' Month, it sardonically showed people of all ages with a fake "best before" date tattooed on their forehead to highlight the stigma related to ageing.

The campaign included television spots, YouTube videos, print and radio ads, and an interactive website where users could take a quiz to find out their own best before date and upload a picture of themselves to have the date "tattooed" on their forehead. The campaign aimed to reduce ageism by changing perceptions in Peterborough that older adults are a drain on resources and a nuisance, old-fashioned and out of touch with new ways and technology and an impediment to people's busy everyday lives. It also aimed to emphasize the valuable knowledge and experience older people can offer the community. However, no findings about the impact of this campaign are available (6, 24).

9.1.4 Key characteristics

Based on research that evaluated campaigns addressing other areas and the limited evidence about anti-ageism campaigns (6), the following characteristics of campaigns against ageism may be associated with effectiveness.

- **Dose:** Generally, the longer the duration of and the greater the intensity or exposure to the campaign, the more effective it will be. However, consensus is lacking about the exact dose necessary for a successful campaign (3). The US Centers for Disease Control and Prevention has suggested that advertisements for tobacco prevention campaigns should be aired for at least six months to affect awareness, 12–18 months to establish the campaign's themes and have an impact on attitudes and 18–24 months to have an impact on behaviour (27).
- **Framing:** Framing can influence our perceptions, attitudes, actions and how ageing and other issues are perceived and responded to (28–30). Framing refers to how an issue is communicated, where the communication starts, what is emphasized, how it is explained and what is left unsaid.
- **Types of messaging and denormalizing behaviour:** In anti-ageism campaigns, it is preferable to present simple messages about achievable actions and images that avoid reinforcing the two extremes of ageing – the heroes of ageing and bodily decline (6). In general, campaign messages that denormalize a behaviour (i.e. increase its social unacceptability, thus reinforcing the perception that it is neither mainstream nor a normal activity in society) may be more effective than other types of messages (3).
- **Interactive and social media channels:** Health campaigns, particularly sexual health campaigns,

that have interactive components (e.g. personalized emails) and use social media appear to be more effective than those using static components (e.g. having someone watch an online video) (3, 31, 32).

- **Community engagement:** Engaging community representatives – including older and younger people – when developing campaigns is likely to be important. One way this can be done is by having community representatives help design the campaign and by using participatory action research. Community representatives can contribute by identifying experiences of ageism and helping to design communication tools (6).
- **Funding and partnerships:** Ensuring there is sustainable, long-term and flexible funding is likely to benefit campaigns. This often requires obtaining money from several sources (e.g. government departments, grant funding agencies). It also appears helpful to be associated with a larger programme (e.g. WHO's Age-Friendly Cities and Communities Programme) and to work in partnership (e.g. with health-care providers or media studios) (6).
- **Combining campaigns:** Effects may be enhanced when campaigns against ageism are combined with other strategies. There is some limited evidence that when mass media campaigns are used as awareness tools, compliance with laws and regulations may be increased (e.g. using seat belts, alcohol regulations) (11, 33). However, although combining strategies into multicomponent and multilevel

interventions may sometimes result in enhanced effects (e.g. smoking cessation), this is not always the case (e.g. for campaigns to increase physical activity, reduce childhood obesity and the risks of cancer) (34-37).

- **The role of culture:** Cultural appropriateness contributes to the effectiveness of health campaigns, particularly international campaigns and campaigns in multicultural societies. Guidance for ensuring cultural appropriateness is available (29, 38-41). Culture can also be an entry point for engaging in focused collective dialogue about ageism with local communities, opinion leaders, faith-based leaders, traditional elders and other agents of change. Such dialogues can become the starting point for culturally informed campaigns that are designed with local representatives and other communication activities (e.g. using digital media, video and storytelling) (42).

9.2 POTENTIAL STRATEGIES FOR MITIGATING THE IMPACT OF AGEISM

Very few studies have evaluated strategies – or potential strategies – for mitigating the impact of ageism after it has occurred.

A study using data from a national survey in Japan found that being subject to perceived

age discrimination negatively affected job satisfaction in older men. However, elevated levels of social support from managers and co-workers decreased the impact of the perceived discrimination (43).

An intervention in the United States with older participants of Chinese background protected them against the effects of stereotype threat. The intervention reminded participants of their Confucian values. It consisted of participants reading a script that, first, stated they should be proud of their ancient traditions that honour the role of older adults and, second, reassured them that these values had been successfully transmitted to the younger generation. The stereotype threat consisted of being told that they would be taking a memory test to see how ageing affects memory, and the results would be compared with those of younger people. The intervention did not, strictly speaking, mitigate the effects of ageism (i.e. the stereotype threat) after it occurred, but rather inoculated participants against the effects of ageism before it occurred. Nonetheless, one can hypothesize that it might also work to mitigate the effects of ageism after it has occurred (44).

Several other studies have shown in laboratory experiments that exposing participants to implicit, positive age stereotyping improved physical function (45, 46), memory performance (47, 48) and cardiovascular measurements (49).

The use of implicit or subliminal stereotypes refers to being exposed in a way that allows for perception but without full conscious awareness – for instance, through words being flashed on a screen at high speed.

It is possible that such exposure to implicit, positive age stereotypes may not only have the beneficial effects noted above but also may mitigate the effects of exposure to

negative ageist stereotypes and perhaps other forms of ageism, although this has not yet been demonstrated. If this were shown to be the case, such laboratory experiments might have the potential to be turned into interventions to mitigate the effects of ageism after it has occurred.

9.3 CONCLUSIONS AND FUTURE DIRECTIONS

Campaigns to reduce ageism and strategies for mitigating its impact are potentially important strategies to address ageism, but research on them is limited. Developing them further and generating more evidence of their effectiveness should be priorities.

9.3.1 Campaigns

No campaigns to reduce ageism have been evaluated for effectiveness. But based on evidence about the effectiveness of campaigns in other areas of health – such as sexual health – and in reducing stereotypes, prejudice and discrimination related to mental health conditions, campaigns represent a promising strategy to combat ageism.

Future priorities in relation to campaigns to reduce ageism are described below.

- There is a need to develop and test campaigns that address different forms of ageism (i.e. institutional, interpersonal and self-directed ageism) using the most rigorous designs possible (see [Box 9.1](#)).
- It is critical to develop, implement and evaluate campaigns in low- and middle-income countries. Only one

of the campaigns included in a recent review of anti-ageism campaigns – the global campaign organized by HelpAge International (6) (see Section 9.3.1) – took place in low- and middle-income countries.

- The cost and cost-effectiveness of anti-ageism campaigns should be estimated. Campaigns can be expensive. Hence, it is critical to ensure that they are cost-effective. Evidence for the cost-effectiveness of campaigns in all areas of health is extremely limited, other than for smoking, for which there is moderate evidence of cost-effectiveness (3).

9.3.2 Strategies for mitigating the impact of ageism

Research on strategies to mitigate the impact of ageism is still at an early stage. Only a handful of studies are available.

Some are laboratory experiments rather than fully developed interventions. Nonetheless, these strategies may hold some promise for lessening the impact of negative stereotypes.

Given the pervasiveness of ageism and its serious and far-reaching impacts – described in Chapters 2 and 3, respectively – future priorities in relation to mitigating the impact of ageism should include:

- investigating whether exposure to implicit positive stereotypes might help mitigate the effects of negative stereotypes and other forms of ageism and, if so, how this could be turned from laboratory findings into scalable interventions;
- developing, testing and scaling up strategies to mitigate the impact of all dimensions of ageism – that is, stereotypes, prejudice and discrimination.

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BERKEHAN, 21,
TURKEY

SISAY, 65,
ETHIOPIA

10

THE WAY FORWARD

“ We need to act now as youth and call the world to action for the future we are dreaming of, and capable of creating. ”

Berkehan, 21, Turkey

©Berkehan Erkılıç / UN Major Group for Children and Youth

“ The world should prohibit and discard all negative stereotypes and end the discrimination of older people. Once this is done, the world would be surprised of the things older men and women can contribute. A world without ageism would make every generation [...] positive in their outlook on life. ”

Sisay, 65, Ethiopia

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Chapter

10

The *Global report on ageism* has assembled the best scientific information about ageism to understand and help improve the lives of people of all ages. Building on the evidence in the preceding chapters, this chapter presents three recommendations to assist stakeholders in taking action to prevent and eliminate ageism across the world. These recommendations fall under the umbrella of the Global campaign to combat ageism that the United Nations is championing as part of the Decade of Healthy Ageing: 2021-2030.

To prevent and respond to ageism, priority should be given to the three strategies supported by the best evidence: policy and law, educational interventions and intergenerational contact interventions (Recommendation 1).

It is equally important for countries to improve data and research to gain a better understanding of ageism and how to reduce it (Recommendation 2).

Every stakeholder has a role to play in addressing ageism and should be part of the movement to change the narrative around age and ageing (Recommendation 3).

These recommendations should be implemented together where possible to maximize their impact.

Implementing these recommendations requires strong commitment and the involvement of different sectors (e.g. health and social care, education, work and employment, legal and media) and actors (e.g. governments, civil society organizations, UN agencies, development organizations, academic and research institutions, businesses and people of all ages). Each recommendation identifies key actions for these different stakeholder groups.

It is essential that countries tailor these recommendations to their specific contexts. Where possible, a multipronged approach that includes all key recommendations should be favoured, as it is through concerted and comprehensive action that transformative change is most likely to occur.

10.1

RECOMMENDATION 1: INVEST IN EVIDENCE-BASED STRATEGIES TO PREVENT AND RESPOND TO AGEISM

Governments, civil society organizations, UN agencies, development organizations and other stakeholders

should draw upon the evidence-based solutions presented in this report to effectively tackle ageism.

First, countries should implement policies and laws with adequate legal and material scope to prohibit age discrimination and to foster the equal rights of all persons regardless of their age. It is equally important that countries modify or repeal existing laws or policies that permit age discrimination and that they put in place enforcement mechanisms and monitoring bodies to ensure effective implementation.

International policy and legislative guarantees against age discrimination could also be increased. In international law, there is currently no specific legal instrument to protect the human rights of adults and to dispel prejudice and discrimination against people on the basis of their age, and most international human rights instruments do not explicitly list age as a prohibited ground of discrimination.

Second, national governments and other actors should design and deliver formal and non-formal educational activities because these are among the most effective strategies to tackle ageism and are also likely to be affordable. Educational activities can help to dispel misconceptions about different age groups and reduce prejudice and discrimination by transmitting information or enhancing empathy towards people of other ages through perspective-taking, for instance, by using role-playing, simulation and virtual reality to reduce ageism. These types of interventions can be implemented across all levels of education, from kindergarten to university and life-long learning platforms.

Third, investments should be made in intergenerational contact interventions, which aim to foster interaction and contact between people of different generations.

Under optimal conditions, contact between different age groups can reduce intergroup prejudice and stereotypes, and the effects may generalize beyond the immediate participants in the intervention to the entire out-group. Intergenerational contact interventions are among the most effective interventions to reduce ageism against older people, and they show promise for reducing ageism against younger people. In addition, they appear to be affordable and relatively easy to implement.

10.1.1 Specific actions by stakeholder group

Below is an overview of the specific actions that can be taken by different groups of stakeholders to implement evidence-based strategies to reduce or prevent ageism.

Governments can:

- build human and institutional capacities to develop and implement evidence-based strategies to tackle ageism;
- draft and implement laws and policies that prohibit discrimination on the grounds of age, and modify or repeal any existing laws or policies that directly or indirectly discriminate against people on the basis of their age; these actions should be taken in consultation with older and younger people;
- put in place enforcement mechanisms and monitoring bodies to enable the effective implementation of laws and policies addressing discrimination, human rights and inequality;
- ratify existing regional treaties that protect the rights of older or younger adults;

- support the development of further protections through international law and ratify any new instruments that may be developed;
- implement educational activities across formal and non-formal education sectors to tackle ageism aimed at different age groups;
- provide resources for the implementation of intergenerational contact interventions.

United Nations agencies and development organizations can:

- support countries in their implementation of evidence-based strategies to tackle ageism;
- contribute to the development of the Global campaign to combat ageism;
- build understanding within the UN system of ageism and the capacity to identify and address it using evidence-based strategies;
- identify and revise existing ageist policies and practices;
- fund civil society organizations working to address ageism in low- and middle-income countries.

Civil society organizations can:

- advocate for the development of laws addressing discrimination and inequality and their enforcement, and also help monitor the application of these laws;
- build the capacity of older and younger adults to advocate for and monitor the implementation

of laws addressing discrimination and inequality, and strengthen their participation in these activities;

- design and deliver evidence-based educational programmes and intergenerational activities to tackle ageism against different age groups and incorporate these activities into existing programmes, if possible;
- seek and establish collaboration between older people's organizations and youth organizations to encourage intergenerational activities and collaborations.

Academic and research institutions can:

- design and deliver evidence-based educational programmes and intergenerational activities to tackle ageism against different age groups;
- work with governments and civil society to identify the essential characteristics of the three evidence-based interventions that work to tackle ageism – making changes in policies and law and intervening through educational activities and intergenerational contact.

The private sector can:

- develop and implement policies and interventions in businesses to prevent and respond to instances of ageism (e.g. by developing intergenerational mentorship programmes);
- build the capacity of employees and employers to detect and respond to ageism;

- monitor the production of movies, television series, advertisements, magazine and newspaper articles, books and other forms of media to ensure that they are not ageist.

10.2

RECOMMENDATION 2: IMPROVE DATA AND RESEARCH TO GAIN A BETTER UNDERSTANDING OF AGEISM AND HOW TO REDUCE IT

Successfully addressing ageism will require improving our understanding of all aspects of it and how to reduce it. More and better quantitative and qualitative data should be collected, particularly in low- and middle-income countries, about the prevalence and distribution of all forms of ageism against older and younger people – that is, institutional, interpersonal and self-directed. It is equally important to obtain better estimates of the prevalence of ageism in specific institutions, such as health and long-term care, the workplace, the media and legal systems. These data should be collected using measurement scales for ageism that are reliable, valid, cross-culturally valid and comparable. WHO is initiating, in collaboration with other partners, the development of such a scale to measure ageism.

Measures, methodologies and data tools that are being used for policy and programme development and evaluation need to be

revised to reflect the latest scientific evidence in order to identify outdated concepts and biased approaches (e.g. the use of the dependency ratio).

A better understanding of the impacts of ageism against older and younger people and the costs of ageism – for individuals across their life course and for the wider society – is critical to persuade policy-makers and the public of the far-reaching impacts of ageism and to mobilize them to tackle it. Our lack of understanding of the impact of ageism against younger people is a gap that must be addressed. It is only by gaining a better understanding of the impacts of ageism against younger people across their life course that we will be able to establish how serious a problem it is and what priority it deserves.

Successfully addressing ageism will also require gaining a better understanding of the determinants of ageism against older and younger people, both risk and protective factors, their relative importance, their causal status and whether determinants are the same across countries and cultures.

Most importantly, successfully addressing ageism will require undertaking sustained and coordinated research efforts to refine existing effective strategies, including policy and law, educational and intergenerational contact interventions. It will also require further research into promising strategies (e.g. campaigns), improved estimates of the cost-effectiveness of each possible strategy and then the scale up of those strategies that have been shown to be both effective and cost-effective.

Implementation research will also be required to help identify the essential components of effective strategies; develop and test new strategies in multicentre and multi-country trials; adapt existing

strategies to new contexts; and explore the barriers to and facilitators of sustained, large-scale implementation of strategies to reduce ageism.

To help with these tasks, it will also be important for countries to carry out readiness and capacity assessments to pinpoint those areas that need to be strengthened to be able to successfully scale up strategies to reduce ageism; assessments will be needed of, for instance, human and institutional resources, funding, political will and support and coordination and governance.

Low- and middle-income countries must be a top-most priority across all areas of data collection and research, since the majority of data and research on all aspects of ageism comes from high-income countries where a minority of the world's population lives. These countries are also a priority because the highest prevalence of ageism, at least against older people, was seen in low- and lower-middle- income countries.

10.2.1 Specific actions by stakeholder group

Below is an overview of some of the specific actions that can be taken by different groups of stakeholders to improve the data and research about ageism.

Governments can:

- allocate resources to those aspects of ageism-related research judged to be a priority in the country and channel those resources through relevant national science-funding bodies and foundations;
- modify any national or local data collection approaches that may be age-biased;
- support testing of the measurement scale for ageism that WHO is developing with other partners;
- include modules on ageism against younger and older people in national social surveys and in national data collection exercises addressing ageing and health and other relevant topics, drawing on a validated scale for ageism, such as the one that is being developed by WHO and other collaborators.

United Nations agencies and development organizations can:

- include modules about ageism against younger and older people in international surveys that they help conduct, such as the Demographic and Health Survey;
- increase capacities for research and data collection, and fund researchers working on ageism, particularly in low- and middle-income countries;
- review statistical concepts, data collection instruments and methodological approaches used in policy development and assessment in order to identify and revise any that may be age-biased;
- support the collection and dissemination of age-disaggregated information about older and younger people;
- develop with WHO a valid measurement scale for ageism and encourage governments and research institutions to use it in stand-alone studies or ensure it is integrated into other data collection efforts.

Civil society organizations can:

- contribute to the evaluation and monitoring of strategies to reduce ageism and collaborate with researchers to support applied research on ageism;
- advocate for governments to revise age-biased data collection instruments and methodological approaches, to continue to build a strong evidence base about ageism and to use validated scales for ageism, such as the one that is being developed by WHO and collaborators;
- produce evidence, in collaboration with research institutions, of the lived experience of ageism from the perspectives of older and younger people and of the impact it has on their lives.

Academic and research institutions can:

- conduct high-quality research to address the gaps in data and research identified in this report and to develop and scale up effective and cost-effective strategies to reduce ageism, in consultation with people in the relevant age groups;
- support testing of the measurement scale for ageism that WHO is developing with other collaborators and encourage its uptake across research activities on ageism.

The private sector can:

- conduct comprehensive and rigorous evaluations of ageism in the workplace;

- financially support research on ageism through relevant national science-funding bodies and foundations.

10.3

RECOMMENDATION 3: BUILD A MOVEMENT TO CHANGE THE NARRATIVE AROUND AGE AND AGEING

Ageism is endemic and will continue to spread unless appropriate action is taken, both to prevent ageism and to respond to it. We all have a role to play. Countries (at all levels and across all institutions), international organizations (including UN agencies, nongovernmental organizations, multinational corporations), national organizations, communities and individuals can all join the movement to change the narrative around age and ageing.

A number of international agencies, regional institutions and UN bodies are either already working to address ageism or have mandates or activities highly relevant to reducing ageism, including those dealing with human rights, international law, economic matters and sustainable development. International nongovernmental organizations and the private sector can help raise awareness locally and globally as anti-ageist citizens, employers and corporate entities and act to reduce ageism within their own structures. Although there have been joint efforts, coordination across all these agencies and stakeholder groups is still insufficient. This should be remedied to avoid unnecessary duplication and to

benefit from the economies of pooling expertise, networks, funding and in-country resources and to take collective action to reduce ageism within these institutions.

Developing a global coalition to drive this movement and help change the narrative around age and ageing should be explored to improve cooperation and communication between different stakeholder groups working in this area. A coalition could achieve better sharing of knowledge, agreement on goals to prevent and respond to ageism, and coordination of action. For example, a network of researchers and practitioners could greatly enhance the world's knowledge base as well as help refine the intervention strategies, discuss methodologies and critically examine research results.

A broader exchange of information and ideas is crucial to future progress, alongside the work of government authorities, service providers and advocacy groups. Advocacy groups working on changing the narrative around age and ageing as well as those working on sexism, racism and ableism are important partners in combating ageism because they can mobilize resources, gather and convey information about important problems and mount campaigns that can impact decision-makers.

Therefore, much could be gained by developing a coalition that can facilitate the implementation of evidence-based strategies, the exchange of information, the development of joint research and advocacy work.

10.3.1 Specific actions by stakeholder group

Below is an overview of some of the specific actions that can be taken by different groups of stakeholders to build a movement to change the narrative around age and ageism.

Governments can:

- convene and coordinate national and local multisectoral and multi-stakeholder coalitions to prevent and respond to ageism;
- contribute to the global coalition aiming to change the narrative around age and ageing, including by sharing knowledge and experience.

United Nations agencies and development organizations can:

- develop and contribute to the global coalition aiming to combat ageism, particularly by bringing the organization's expertise to the coalition (e.g. the International Labour Organization could support policies and legislation in the workplace);
- support governments and civil society organizations seeking to build capacity to implement evidence-based strategies;
- develop technical guidance to help different stakeholders change the narrative around age and ageing;
- take steps to end ageism within the UN and within developmental organizations, including by reviewing existing policies and practices and developing new norms and standards as required.

Civil society organizations can:

- advocate to encourage governments to combat ageism, and also develop national coalitions to support advocacy efforts;

- identify systematic ageism and report it to the relevant authorities (e.g. equality bodies, ombudsperson, national human rights institutions);
- join and contribute to the global coalition and support the implementation of actions recommended by the coalition;
- raise awareness of and build understanding in communities about what ageism is and why we should all work to challenge it.

Academic and research institutions can:

- contribute knowledge and information to the global coalition;
- help monitor and evaluate programmes and activities aimed at tackling ageism.

The private sector can:

- contribute to the global coalition by implementing evidence-based interventions in businesses and sharing information about best practices.

10.4 CONCLUSIONS

It has taken more than 50 years since the word ageism was coined to build an evidence base that will allow transformative change in how we all think, feel and act towards age and ageing.

Today we can act. This report has identified three key strategies to tackle ageism across the world: making changes in policies and laws and intervening through educational activities and intergenerational contact. It has further outlined areas for research that should be pursued to advance our understanding of this phenomenon and how best to tackle it.

Everybody can and must do something to put an end to ageism. If governments, UN agencies, development organizations, civil society organizations and academic and research institutions implement those strategies that have been found to be effective, if they invest in further research and if individuals and communities challenge every instance of ageism that they encounter, we will together create a world for all ages.

GLOSSARY

Ableism refers to the stereotypes, prejudice and discrimination directed towards individuals with disabilities or those who are perceived to have a disability. Ableism assumes that people with a disability are defined by their disabilities and are inferior to individuals who do not have a disability.

Age is the time lived since birth. Although correlated with biological processes, age is also socially and culturally shaped.

Ageing is the process of becoming older and represents the accumulation of changes over time, encompassing physical, psychological and social changes. The changes that constitute and influence ageing are complex. At a biological level, ageing is associated with the gradual accumulation of a wide variety of molecular and cellular damage. Over time, this damage leads to a gradual decrease in physiological reserves, an increased risk of many diseases and a general decline in the capacity of the individual. Ultimately, it will result in death.

Ageism refers to the stereotypes, prejudice and discrimination directed towards others or oneself based on age.

Attitudes include both stereotypes and prejudice.

Campaign refers to purposive attempts to inform or influence behaviours in large audiences within a specified period by using an organized set of communication activities and featuring an array of mediated messages delivered through multiple channels to produce non-commercial benefits to individuals and society.

Care dependence arises when an individual's functional ability has fallen to a point where they are no longer able to undertake the basic tasks that are necessary for daily life without the assistance of others.

Denormalization refers to increasing the social unacceptability of a behaviour by reinforcing the perception that it is neither a mainstream nor a normal activity in the society in question.

Determinants refer to both risk and protective factors. Risk factors are characteristics that increase the likelihood of a particular outcome, ageism in the case of this report. Protective factors are characteristics that decrease the likelihood of an outcome or provide a buffer against risk. To be effective, interventions must target causal determinants that change the outcome – that is, reduce ageism – and not just determinants that are associated – perhaps spuriously – with the outcome.

Discrimination consists of any actions, practices, laws or policies that are applied to people based on their perceived or real membership in a socially salient group and that impose some form of direct or indirect disadvantage (negative discrimination) or advantage (positive discrimination) on them. In the case of age-based discrimination, these actions, practices and policies are directed at people perceived to belong to a specific age group.

Educational activities or programmes refer to any activities that provide instruction with the intention of improving knowledge, skills and competencies. Formal education refers to education or learning that takes place in a formal institution of learning, such as a school or university; follows a syllabus; has clear learning objectives; and is officially accredited. Non-formal education or learning is usually intentional and takes place in an institution such as a workplace or community centre. However, it does not necessarily follow a syllabus, nor is it necessarily accredited.

Effect size is a quantitative measure of the strength of a relationship between two variables that uses a standard metric. It is particularly useful for quantifying how effective one intervention is in relation to another.

Elder abuse is a single or repeated act or a lack of appropriate action occurring within any relationship in which there is an expectation of trust, that causes harm or distress to an older person. Elder abuse can take various forms, such as financial, physical, psychological and sexual. It can also be the result of neglect.

Elderspeak refers to the adjustments to speech patterns that are sometimes made by younger people when communicating with older adults, such as speaking more slowly or more loudly, shortening sentences or using limited or less complex vocabulary. These simplified speech patterns are implicitly based on the assumption that older adults are cognitively impaired or incapable of understanding normal speech.

Empathy refers to the ability to sense other people's emotions, coupled with the ability to imagine what someone else might be thinking or feeling.

Explicit ageism refers to ageism that is consciously and intentionally engaged in by a person. It is often contrasted with implicit ageism, which operates largely outside of conscious awareness.

Framing refers to how information on a given issue is packaged and presented. Through framing, issues can be highlighted and placed within a particular context to encourage or discourage certain interpretations. Framing thus exercises a selective influence over how people view reality.

Gendered ageism refers to the intersection between ageism and gender bias and may account for differences in the ageism faced by women and men.

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Human rights are the rights people are entitled to simply because they are human beings, irrespective of their age, citizenship, nationality, race, ethnicity, language, gender, sexuality or abilities. When these inherent rights are respected, people are able to live with dignity and equality, free from discrimination. The concept of human rights has its origins in a wide range of philosophical, moral, religious and political traditions, and it has evolved over time.

Impact refers to the consequence, effect or influence of one thing on another.

Implicit ageism is ageism that is engaged in by a person without conscious awareness and intention.

Institutional ageism refers to the laws, rules, norms, policies and practices of institutions – and the ideologies that are fostered to justify them – that unfairly restrict opportunities and systematically disadvantage individuals based on their age.

Intergenerational contact activities and interventions aim to foster interaction and contact between people of different generations or age groups, often to reduce ageism. They can either involve direct contact through face-to-face interactions or indirect contact through, for instance, virtual conversations or imagined contact.

Interpersonal ageism refers to ageism occurring during interactions between two or more individuals. In interpersonal ageism, the perpetrator is distinguished from the target of ageism.

Intersectionality is a theoretical framework for understanding how different aspects of a person's social and political identities combine (e.g. gender, sex, race, class, sexuality, religion, disability, physical appearance) and may potentiate each other to shape an individual's or group's experience and create unique modes of discrimination and privilege.

Law is the system of rules that a particular country or community recognizes as regulating the actions of its members and that may be enforced by imposing penalties. It includes international law and national law. International law defines the legal responsibilities of states in their conduct with each other and their treatment of individuals within state boundaries. National law or domestic law refers to those laws that exist within a particular country.

Older person is a person whose age has passed the median life expectancy at birth. In this report, persons above the age of 50 are considered older persons.

Policies refer to decisions, plans and actions that are undertaken to achieve specific goals within a society.

Prejudice is an affective reaction or feeling that is directed towards an individual who belongs to a specific social group. In the case of ageism, prejudice is directed towards individuals perceived to belong to a specific age group, regardless of whether they actually belong to that group.

Protective factors are characteristics that decrease the likelihood of an outcome (ageism in this report) or provide a buffer against risk.

Racism refers to the stereotypes, prejudice or discrimination directed against people based on their race, and it usually involves the belief that one's own race is superior to other races. There is now wide agreement that the concept of race is primarily a social construct without biological meaning, and it is only a very weak proxy for human genetic diversity.

Ratification defines the international act whereby a state indicates its consent to be bound to a treaty or convention.

Risk factors are characteristics that increase the likelihood of an outcome (ageism in this report).

Self-directed ageism refers to ageism turned against oneself. People internalize biases based on age from the surrounding culture after being repeatedly exposed to them, and they then apply the biases to themselves.

Sexism is prejudice, stereotyping or discrimination, typically against women and girls, on the basis of sex or gender.

Sexuality is a central aspect of being human, which encompasses sex, gender identities and roles, sexual orientation, eroticism, sexual pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.

Social care refers to assistance with the activities of daily living, such as personal care or maintaining a home.

Social norms are rules or expectations of behaviour that apply within a specific social or cultural group. Often unspoken, these norms offer social standards of appropriate and inappropriate behaviour, governing what is (and is not) acceptable and coordinating our interactions with others. A variety of external and internal pressures are thought to maintain cultural and social norms. Thus, individuals are discouraged from violating norms by the threat of social disapproval or punishment and the feelings of guilt and shame that result from the internalization of norms.

Standardized mean difference is used as a summary statistic in meta-analyses when the studies all assess the same outcome but measure it in different ways (e.g. if all of the studies measure depression, but they use different scales to measure it). In such a case, it is necessary to standardize the results of the studies to a uniform scale before they can be combined. The standardized mean difference expresses the size of the intervention effect in each study relative to the variability observed in that study.

Stereotype threat arises when people underperform on a task due to concerns about confirming a negative stereotype about their group. For instance, an older person may do less well on a driving test or cognitive test due to anxiety about confirming stereotypes about older people being bad drivers or mentally less capable.

Stereotypes are cognitive structures that store our thoughts, beliefs and expectations about the characteristics of members of social groups. In the case of ageism, age stereotypes are used to make inferences about, and guide behaviour towards, people of a given age group.

Stereotyping is the process of applying stereotypes, which can lead to overgeneralizations that consider every person within a given social group to be the same.

Younger person is a person who is younger than the median life expectancy at birth. In this report, people younger than the age of 50 are considered to be younger people.

Youth is a period of transition from childhood to adulthood. For statistical purposes, youth is often considered to encompass people between the ages of 15 and 24, although there is little consensus on the exact age range.

Well-being refers to the total universe of human life domains, including the physical, mental and social aspects, that make up what can be called a "good life". It includes domains such as happiness, satisfaction and fulfilment.

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