Health interventions for older people in emergencies

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EUROPEAN COMMISSION
Humanitarian Aid and Civil Protection

Gina Branucci/HelpAge International

HelpAge International helps older people claim their rights, challenge discrimination and overcome poverty, so that they can lead dignified, secure, active and healthy lives.

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Contents

The background

This document aims to provide general guidance for the implementation of health activities for older people in emergency situations. Its primary target is humanitarian workers working in the field. No specific knowledge of health is assumed. At both global and field level, this guidance can also be used to highlight and advocate for the health needs of older people in humanitarian crises.

Older people constitute a significant and growing number of those affected by humanitarian crises. About 12.5 per cent of the world's population is aged 60 or over; 17 per cent are aged 55 or over; more than 22 per cent are aged 50 or over.[1] The unprecedented growth in the number of older people worldwide has significantly changed the demographic and epidemiological profile of disaster-affected populations.[2] Yet, there are very few specific health interventions that target older people's health in emergencies, aiming at reducing their morbidity and mortality.

When asked about their needs in emergencies, older people prioritise health, food and shelter. Health is indeed a critical determinant for survival in a disaster, and older people are particularly vulnerable to the consequences of the disruption of health services. They need to have regular access to curative and preventive services, particularly if they are affected by a chronic disease. Their mobility and other physical abilities might be impaired, and it is important to help them with walking aids, glasses and other supportive devices.

In emergencies, minor health conditions (a cold, a minor wound) can quickly become debilitating and have serious consequences for an older person. Untreated chronic diseases often lead to severe complications (stroke, coma, diabetic foot with gangrene) and increased levels of mortality.

At the heart of humanitarian action are the principles of humanity and impartiality. All people have equal value and dignity, and the exclusion of an individual or a group on grounds of nationality, religion, or politics is contrary to the humanitarian ethos. Humanitarian principles affirm that everyone has the right to humanitarian assistance: "…no one should be discriminated against on any grounds of status, including age, gender…" (The Sphere Project 2011)[3]. For humanitarians as for health professionals, care and assistance must be provided according to need for the most vulnerable, and without discrimination. This means that the health needs of older people must specifically be taken into account.

The commitments

The United Nations defines older people as those who are above 60 years of age. However, the definition should be adapted to local contexts. For example, in many developing countries, people aged 50 years are considered to be old due to cultural and social factors which contribute to the perception of someone as being "old".

The right to health is a fundamental human right and part of our understanding of a dignified life. The right to "the enjoyment of the highest attainable standard of physical and mental health" was first articulated in the 1946 Constitution of the World Health Organization[4] (WHO). The preamble defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" and further states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." We should add age to this list.

Article 25 of the Universal Declaration of Human Rights 1948 states that "Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family."

1. United Nations, Department of Economic and Social Affairs Population Division, *"World Population Prospects: The 2010 Revision, Highlights and Advance Tables"*, Working Paper No. ESA/P/WP.220, New York 2011

2. Furtade C and Teklu M, *"The Sphere Project Handbook: Standards for Humanitarian Response Address Growing Problem of Chronic Diseases"*, Presentation to the Geneva Health Forum 2012

3. *The Sphere Project, Humanitarian charter and minimum standards in humanitarian response,* The Sphere Project, UK, 2011, www.spherehandbook.org/

4. Constitution of the World Health Organization, *Basic Documents*, 45th edition, Supplement, October 2006

The right to health includes a wide range of factors for a healthy life. The Committee on Economic, Social and Cultural Rights, the body responsible for monitoring the International Covenant on Economic, Social and Cultural Rights, calls these the "underlying determinants of health". They include:

- Safe drinking water and adequate sanitation;
- Safe food;
- Adequate nutrition and housing;
- Healthy working and environmental conditions;
- Health-related education and information;
- Gender equality.

Definitions: levels of health care

Health services comprise primary, secondary and tertiary levels:

Primary health care (PHC) services[5] aim to provide an integrated basic package of curative and preventive health services to the population.

PHC services include education in health and nutrition (healthy living), adequate supply of safe drinking water and basic sanitation, preventive activities (eg immunisation, prevention of communicable and chronic diseases), diagnosis and treatment of common diseases or injuries, and provision of essential drugs. For a patient, they are the entry point to the health system.

Secondary health care: when PHC services can not cope with a health problem, the patient has to be referred to a secondary health care facility (hospital), where the following services are available:

- In-patient and out-patient services;
- Diagnosis and treatment of complex cases, including medical consultation, surgery, X-ray services, more elaborate laboratory tests, and the availability of specialist drugs.

Secondary health care provides specialist medical care or surgery, in a hospital, either as an inpatient or outpatient service.

Tertiary level care provides patients with highly specialised health care. In some countries, only the national hospital qualifies as a tertiary health care facility.

Basic principles of emergency health interventions

The basis of emergency health interventions is to ensure that older people have access to essential health services, and that these services are adapted to their needs and are of good quality.

Effective, safe and quality health service delivery depends on having some key resources: motivated and trained staff, equipment, information, finance, and adequate drugs. Improved access, coverage and quality of health services also depend on the way services are organised and managed, and on the incentives influencing providers and users.

5. PHC was defined by the Alma Ata Declaration in 1978. Thirty years later, the World Health Report called for a renewal of PHC (Primary Health Care: Now More Than Ever, WHO, 2008)

Accessibility

Accessible health services for older people require:

Physical accessibility: health facilities should not be located too far away for an older person to attend. Older people's access should be facilitated by organising transport. The infrastructure of the facility should be "age-friendly", for example, it should not have too many stairs, or should be accessible by ramps.

Financial accessibility: in an emergency situation, health services should be free or subsidised for older people.

Availability of good quality essential drugs: in particular drugs for chronic diseases as continuity of treatment is very important.

Gender equality[6]

- Services should be designed to meet the needs of older women and men equally;
- Ensure older women and men participate equally in the design, implementation, monitoring and evaluation of health projects, programmes and strategies. Particular attention may be needed to ensure that older women are in decision-making positions;
- Ensure that older women and men benefit equally from training or other capacity-building initiatives, and are targeted with specific actions when appropriate (eg communications activities).

Health needs of older people

Age has an important impact on health. Older people have limited regenerative abilities and have health risks and needs that differ from younger age groups. The specific vulnerability of older people relates to multi-morbidity combined with physiological, sensory and cognitive changes experienced as part of ageing and, sometimes, isolation.

Chronic diseases

The scope of chronic diseases is large and growing. According to WHO, the global prevalence of high blood pressure in adults is 27 per cent (more than 35 per cent in Africa). The global prevalence of diabetes is around 10 per cent,[7] and more than 80 per cent of diabetes deaths occur in low- and middle-income countries.

Global ageing is recognised to be a major factor in the increasing predominance of non-communicable diseases (NCDs) in developing countries. The prevalence of chronic illnesses increases significantly in old age. Older people in low- and middle-income countries are at especially high risk of cardiovascular disease, stroke, diabetes, and dementia.

Evidence from conflicts and natural disasters shows that much excess morbidity and mortality results from the exacerbation of existing non-infectious diseases such as hypertension, diabetes and cancer. The consequences of leaving these illnesses untreated can be severe: if diabetes is left untreated, it can lead to complications such as high blood pressure, blindness, amputation (due to extensive foot ulcers) and, in the long term, kidney failure.

Yet the management of non-communicable diseases is usually not included in humanitarian responses and currently there are virtually no guidelines for managing chronic medical conditions following disasters. The latest revision of the Sphere Handbook does however recognise the increasing evidence of acute complications from chronic diseases and has provided standards and guidance on addressing the growing burden of NCDs during disaster response.

6. See the gender markers for health at http://oneresponse.info/crosscutting/gender/publicdocuments/Health%20Gender%20Marker%20Tipsheet%20July%202011.pdf

7. World Health Statistics 2012, WHO

Communicable diseases

Older people can be at increased risk from communicable diseases as well. Infectious diseases have a specific presentation in older people. This is most obvious with respect to HIV and tuberculosis, but also applies to infections such as diarrhoea and pneumonia. With infections such as malaria, higher parasite loads, a higher proportion of severe forms, and an increase in fatal disease have been reported amongst older people. Yet infection control programmes usually do not consider specifics with respect to the older population.

The impact of disasters and displacement on older people's health: Hurricane Katrina, USA, 2005

A study conducted by the Johns Hopkins Bloomberg School of Public Health found that in the year following Hurricane Katrina, the health of survivors aged 65 and over declined by nearly four times that of a national sample of older adults not affected by the disaster; morbidity rates increased 12.6 per cent compared with 3.4 per cent nationwide.

Researchers found that for people over the age of 65, there was a significant increase in the prevalence of patients with cardiac diagnosis, congestive heart failure and sleep problems. Emergency department visits increased 100 per cent in the month following Katrina, and by 21 per cent over the next year compared to the pre-Katrina year. Hospitalization rates increased 66 per cent in the first month after Katrina and maintained an increase of 23 per cent over the ensuing year. Based on analysis of patients' locations, the researchers concluded that displacement had a major impact on declining health status.[8]

Lucy Blown/HelpAge International

The action points

These guidelines recommend five key action points for addressing the health needs of older people in emergencies. Action points 2 and 3 follow the minimum standards defined by the Sphere Project.[9] The key actions follow the two main sections of the Sphere chapter on Health Actions (health systems and essential health services), and the relevant standards within these sections have been adapted to capture older persons' specific needs.

These action points are not exhaustive: they provide guidance for essential minimum health interventions. Below you will find a summary of the points, with more detail provided in the main sections of the guidance.

8. Weiner J, *"Decline in health among older adults affected by Hurricane Katrina"*, Baltimore School of Public Health, John Hopkins University, 2006

9. The Sphere Project 2011, Minimum Standards in Health Actions

Key action points to address health interventions for older people in emergencies

Action point 1:
Assess the health needs of older people

- Identify existing gaps in the organisation of the health system by collecting data, meeting health officials and health partners at all levels of the system, and carrying out field visits to health facilities and communities.
- Undertake gender analysis and collect sex and age disaggregated data (SADD).
- Involve older people in the needs assessment through focus group discussions and individual meetings.

Action point 2:
Strengthen the health system so that it can cope with older people's health needs

- **Health service delivery:** ensure older people have access to effective, safe and quality health services that are standardised and follow accepted protocols and guidelines ("age-friendly" services).

  Organise access to health services at primary and secondary levels, as well as the referral system between the two levels. Make sure that a family member or a carer accompanies the referred older person.

  Mobile clinics might be useful as a temporary measure.

  Consult with older people when designing the response. Key mechanisms for consultation include meeting older people's associations, focus group discussions, and key informant interviews.

  Make information about health services available to older people in an appropriate form. Community services and health staff should take account of the visual, oral and literacy challenges faced by older people. Mechanisms to ensure accountability should be put in place.

- **Human resources:** ensure that health services for older people are provided by trained and competent health workers who have adequate knowledge and skills to meet the needs of older people.

  Provide basic training on the health needs of older people, and on how to communicate with older people.

  Train health workers at community, health facility and first referral levels, using appropriate curricula. Advocate for other agencies and health authorities to attend and provide such training.

  Evaluate the training and organise regular supervision and refresher courses.

- **Drugs and medical supplies:** ensure older people have access to a consistent supply of essential medicines and consumables, including medicines for chronic diseases.

  Ensure essential drugs for chronic diseases are available at primary and secondary levels. The quality of these drugs should be verified.

  Provide visual, hearing and mobility aids.

- **Health financing:** ensure older people (as well as the general population) have access to free primary health care services for the duration of the disaster.

If there is no national consensus to provide free primary services to older people, establish contracts with international or local organisations, or with public or private health facilities, to deliver PHC services free of charge to older people (see action point 4 about partnership).

- **Health information management:** the design and delivery of health services must be guided by the collection, analysis, interpretation and utilisation of relevant public health data.

  Ask partners to provide sex and age disaggregated data and advocate for SADD at cluster level.

  Analyse and discuss this data with the health teams and with older people in order to formulate recommendations for improving the health system and older people's health status.

Action point 3:
Provide integrated essential health services to older people

- **Prioritise health services:** provide essential health services to older people according to their needs.

  Depending on the context, the priority might be surgery, control of communicable diseases (eg cholera), specialised geriatric care, disability management (eg eye clinics) or nutrition.

- **Non-communicable diseases:** ensure older people have access to essential therapies to reduce morbidity and mortality due to acute complications or exacerbation of their chronic condition.

  Ensure the continuity of care by providing essential drugs for NCDs.

  Consider the possibility of making palliative care available for older people.

- **Mental health:** ensure older people have access to health services that prevent or reduce mental health problems and associated impaired functioning.

  Provide psychological first aid for people suffering from psychological distress.

  For people suffering from more severe conditions including dementia, provide or refer to mental health services.

  Analyse the needs of older people in care homes and institutions as they may need support during the emergency.

Action point 4:
Build partnerships

- Integrate care for older people in the general health system at primary and secondary levels by building partnerships with public or private health facilities and international or national non-governmental organisations.
- The partnership may include contracting the partner to deliver services. This may include providing funds, training for staff, or integrating your staff in their team.
- The partner must be accountable by providing regular activity and financial reports including SADD.

Action point 5:
Advocate for older people's right to health

- Present evidence and messages at coordination forums. Be an active member of the Health Cluster. Hold one-to-one meetings and build relationships with key decision-makers. Participate in the Consolidated Appeal Process.
- Share reliable SADD and make evidence-based recommendations to cluster partners and the relevant levels of the Ministry of Health.
- Coordinate with international and local partners who are working to address older people's health needs.

Action point 1: Assess the health needs of older people

It is essential to develop health interventions according to the needs of older people. The needs assessment should allow the **identification of existing gaps** in:

- The structure of the health system: what is available and is it accessible?
- Service delivery: are the needs of the older people covered?
- The quality of the health services: do they have trained staff, good hygiene, and age friendly services?
- You should also be able to assess the health status of older people, and the major health problems affecting morbidity and mortality.

Include gender analysis in the health needs assessment: analyse the impact of the crisis on older women and older men. Assess whether the available services meet the needs of older women and men equally, and whether older men and women can access health services equally.

What data to collect?

Always collect sex and age disaggregated data (SADD). Find out the percentage of older people in the general population: the global average of people aged 60 and above is 12.5 per cent in 2012 but the proportion is context specific. HelpAge recommends that SADD is collected for the following age groups: 50-59; 60-69; 70-79 and 80 years and above.

See HelpAge International's recommendations on how to collect SADD in Annex 1.

If possible, calculate **mortality and morbidity** rates:[10]

- Crude and age specific mortality rates.
- Incidence of major diseases for the general population and for the age group 60 years and above compared with other age groups (children under 5, adults between 20 and 59 years). Include communicable diseases (eg malaria, diarrhoea, acute respiratory infections), and non-communicable diseases (eg diabetes, high blood pressure).

Your assessment should include:

- Type, number and location of health facilities (health posts, clinics, health centres, referral hospitals), and services actually available at each level (eg PHC, laboratory exams, surgery, X-ray). Map public and private health facilities, as well as those managed by international NGOs.
- Partners involved in the health sector including the various levels of health authorities, local and international NGOs and private providers.
- Number, gender and qualifications of health staff in each PHC facility (community health workers, home based carers, nurses, medical assistants, medical doctors). Are staff receiving a regular salary? (This helps to assess the motivation of the health staff, and the level of functioning of the services).
- Are there any community-based health activities? Do they target older people? Who is performing them? Volunteers? Do they receive any incentives? What is the proportion of male and female community health workers?

10. For guidance, see the Sphere Handbook 2011, p.346 www.spherehandbook.org/en/appendix-12/

- Is there any mental health support available (psychological support, mental health services) and does it include older people? Which staff are involved (their category and level of training)?
- Is the community involved in the health services? What parts of the process are they involved in, eg planning, design, monitoring, management?
- Are staff trained in geriatrics or older people's health needs and health care? Is geriatric care part of the national curriculum for medical doctors and nurses?
- What are the existing protocols and guidelines in use at health facility level (eg for the management and treatment of chronic diseases and communicable diseases)?
- Do older people have to pay for health services? What is the cost of consultations, laboratory exams, essential drugs, hospitalisation?
- When hospitalised, do patients receive food or do they have to bring their food with them? Do they have to be accompanied by a helper in order to receive proper care?
- Are essential drugs available? Is the supply regular? Where do the drugs come from (local market, national warehouse)? Is there any quality control of the drugs?
- Are essential drugs for chronic diseases available?
- Which data are routinely collected in the health facilities? Are they disaggregated by sex and age?
- Any available data about older people's health status before the crisis, especially for chronic diseases. Identify pre-existing health problems affecting the population prior to the crisis.

How to find the information?

There are many different sources of health information. It is useful to cross reference the information by using several sources. In general, you will need to:

- Meet officials at central and decentralised levels of the Ministry of Health to collect information about the structure of the health system, staff training, national protocols and guidelines on health financing, the national drug service and management of diseases.
- Meet with international and national agencies and NGOs (including the private sector and religious institutions), cluster leads (UNICEF and WHO) and OCHA. These sources are especially useful in cases where the authorities are not impartial (in conflict situations for example) or not available.
- Carry out field visits to get to know the health facilities and the communities, as well as the partners involved. It is important to at least visit the referral hospitals and several health facilities of each type (private, public, health posts, health centres). Meet with their managers (hospital medical director, head of centre) and talk to different members of staff (pharmacist, laboratory technician, medical doctor or health assistant, community based health workers).
- Meet the relevant community representatives and older people, as well as with the local or international organisations working in the area.

Older people's participation in the health needs assessment is essential. You can organise focus group discussions with groups of older people, making sure that men and women have equal opportunities to express their opinion. Some older people have key positions in the community, for example traditional birth attendants often are older women and it can be very useful to have their opinion of the health system, access to health care and community mechanisms.

Resources:

World Health Statistics 2012, WHO
WHO Global Health Observatory
NCD Country Profiles 2011, WHO

Health information

Institutional sources

- Ministry of Health
- International and national NGOs
- Clusters/UN Agencies
- Religious organisations

Primary sources

- National and local health authorities
- Health staff at various types of facilities
- Community health workers
- Traditional health attendants
- Community and religious leaders
- Older women and men

Action point 2: Strengthen the health system in order to cope with older people's health needs

Health service delivery

Ensure that older people have access to effective, safe and quality health services that are standardised ("age-friendly" health services) and follow accepted protocols and guidelines (Sphere health systems standard 1).[11]

Level of care: evidence shows that locating the health system entry point close to the population has measurable benefits in terms of relieving suffering, preventing illness and death, and improved health equity.

PHC services can be delivered at two levels:

- Home-based care, provided by home based carers or community based health workers, whether they are volunteers or paid;
- Health care provided in a health post, a health centre or a clinic (mobile clinic or fixed clinic) by a qualified nurse, a health assistant, or sometimes a medical doctor (general practitioner).

Referral system: home based carers and community health workers should be trained to identify older people in need of referral to a health facility. It is important to organise transportation, as well as somebody to accompany the sick older person, especially for those who are isolated and do not have a regular carer or family support. This may be done by organising access to a local ambulance service, taxis or donkey carts, depending on the context.

Make sure that secondary care is accessible as well. Work with the staff at the health facility in order to organise the referral system for older people and arrange for transportation to the nearest hospital. It is essential to ensure that older people are accompanied: organise for a family member or carer to accompany the referred older person to the hospital and to check every day whether s/he is receiving treatment, has access to food and medicines, and is properly cared for. An effective strategy to address gaps is to support a local NGO to provide food and other essential items, and to bathe and turn older patients.

Secondary care should include advice on physiotherapy, occupational therapy and discharge liaison officers. Assess the feasibility of providing these services, and identify potential partners who can provide them in order to have an agreement with them. In the referral budget, include provision for a carer and follow up by medical coordination staff.

Age-friendly services: check that there are special provisions at health facilities for older people. These should include dedicated consultation times or agreed shorter waiting periods, waiting areas with seating and shelter from the elements, and the availability of drinking water and toilets. Discuss with the health team the feasibility of establishing such rules, and plan with them how it can be done. You should also discuss these measures with the local health authorities and the broader community.

Involve older people in the organisation of the health system: they might have a very clear opinion of which type of services they need, and how to organise the referral system. In any case, they will be able to clarify their needs and resources and so contribute substantially to planning discussions. Respect for the culture and health perceptions of members of the affected communities must be the focus of any health humanitarian action and/or service delivery.

11. The Sphere Project 2011, p.296 www.spherehandbook.org/en/health-systems-standard-1-health-service-delivery/

Age friendly health services in Darfur

From the outset of its emergency response programme in Darfur, HelpAge identified health care access as a pressing need for older people. To begin addressing these needs in 2004, the following steps were taken:

- **A network of community health workers was established in each of the camps in which HelpAge operates. They received on-going training in areas related to health, hygiene and care of older people and are responsible for referring sick older people to health clinics and for following up on them once the patients have returned home.**
- **HelpAge allotted specific times when older people are given priority for consultations and treatment in primary health care facilities.**
- **Medicines were provided for the treatment of chronic illnesses.**
- **A system of donkey-cart ambulances was established to assist medical referrals of older people.**
- **Treatment for ophthalmic problems such as cataracts was provided through regular eye camps to rectify debilitating but rectifiable eye problems.**

Within a few months of implementing these activities, a significant impact could be observed. Older people expressed a greater willingness to access health services and there was often a marked improvement in overall wellbeing as a result of medical attention.

Gina Bramucci/HelpAge International

In some cases, you can have written agreements with public or private health facilities to ensure that older people receive appropriate care and have free access to medical consultations, laboratory exams and essential drugs (see section on health financing on page 16).

Older people's participation: the need for immediate response is not incompatible with the concept of community participation. In fact, the community's involvement in assessing immediate needs and deciding response priorities is increasingly part of humanitarian response strategies. It is important to systematically engage with and involve older people. Organise focus group discussions with older people of both sexes, and consult with older people's groups and associations and older people involved in the community.

Mobile clinics are sometimes useful in order to access isolated parts of the population. This delivery system should always be temporary, and should be organised with the agreement of the health authorities when appropriate and possible. Mobile clinics can provide general primary health services or specialised services such as eye clinics.

The disadvantage of primary health care mobile clinics is the potential for a lack of continuity in the provision of preventive and curative care. It is particularly important to ensure that older people with chronic diseases are attended to through regular clinic schedules. Home based carers and community health workers should be made aware of the schedules and be able to mobilise older patients on the day and time of the mobile clinic. Ideally, you should advocate and plan for the mobile primary health care clinic to be taken over by a fixed health facility, and ensure that the relevant communities are involved in this process.

Including older people in health care delivery in Haiti and Chad

In Haiti, HelpAge initiated the creation of older people's associations (OPAs) in camps for displaced people. These associations are groups of older people who are directly involved in the design and delivery of programmes and the representation of older people. In Haiti they had a specific role with regard to health care including: monitoring the activities of home-based carers to ensure they provide agreed levels of assistance; disseminating health information (eg on cholera prevention) to older people and the community; and representing older people in the various coordination bodies involved in reconstruction and service delivery to ensure they receive the assistance they needed. With the resettlement of displaced people from camps to new accommodation, OPAs have been established at commune level where they continue to provide information and support to older people to meet their health needs and access services.

In Chad, older people, including traditional birth attendants who are mostly older women, are members of the health management committees that supervise and support health activities at health centre level. This engagement is key to ensuring older people's health needs are represented in discussions and decisions about health care delivery.

Ensure that information is available: train community health workers (or other community groups such as older people's associations), to provide older people as well as their families and caregivers with adequate education about older people's health and nutrition needs, and information on the type and availability of health services. This has to be done in cooperation with the staff in the health facilities. Ensure information is clear and easy for older people to understand and remember. Take account of the literacy level of the population (amongst older people in particular), and older people's eyesight and hearing challenges and adapt information dissemination methods accordingly.

Accountability: put in place accountability mechanisms at every level of the health system. Involve the community and the older people in programme planning, monitoring and evaluation. Organise a safe and reliable mechanism for complaints and redress.[12]

Resources:

WHO guidelines on age-friendly PHC[13]

Human resources

Ensure that health services for older people are provided by trained and competent health workers who have adequate knowledge and skills to meet the needs of older people (Sphere health systems standard 2).[14]

It is not necessary that health workers have a high level of geriatric care knowledge in order for them to care for older people at primary health care level. However you may need to organise training in order to ensure that health workers know about and understand the specific health needs of older people.

In order to ensure that health services are age-friendly, you may need to:

- Organise a training or refresher course to ensure that staff know about the health problems likely to affect older people;
- Ensure that staff are well aware that older people require special attention and an appropriate attitude when being interviewed and examined. An older person needs respect, politeness and a positive attitude; they should not be patronised.

12. For guidance on how to do this, see the Danish Refugee Council's Complaints Mechanism Handbook (2008)

13. Age-friendly Primary Health Care Centres Toolkit, WHO 2008

14. The Sphere Project 2011, p.301 www.spherehandbook.org/en/health-systems-standard-2-human-resources/

They may take time to explain their problems and they often present with multiple symptoms and complaints. It can therefore take longer to interview and examine an older person, and to explain the diagnosis and treatment to them.

The training should include: awareness of the consequences of ageing, skills for communicating with older people, and knowledge of assessing and caring for their health needs (assessing health status, being able to identify and prescribe basic treatment for chronic diseases, and promoting healthy ageing).

Your programme might include providing specific training to health staff at various levels of the health system (community health workers, health facility staff, hospital staff). Check that the curricula are consistent with the level of care and the qualification of the trainees.

You might also advocate to health authorities and other agencies to include this kind of training in their activities.

Evaluate the training: it is generally recommended to test the trainees before and after the training course, in order to assess their progress. Plan for regular supervision and refresher courses to ensure knowledge developed during training is being correctly applied, and to provide the opportunity to update and develop skills and knowledge.

Drugs and medical supplies

Make sure that older people have access to a consistent supply of essential medicines and consumables, including medicines for chronic diseases (Sphere health systems standard 3).[15]

Emergency drugs kits are designed to cope with health emergencies such as communicable diseases, as well as maternal and child care. As a consequence, they include very few essential drugs for the treatment of non-communicable diseases. The reference is the interagency emergency health kit (IEHK), which provides medicines and medical devices for primary health care for 10,000 persons for approximately three months.[16]

For an older person suffering from high blood pressure, cardiac failure or diabetes, it is essential to ensure continuous treatment. An interruption in the daily treatment can lead to severe complications and, ultimately, death.

It is therefore very important to ensure some essential drugs for chronic diseases are available at primary and secondary levels, and that older people have regular access to them (see Annex 2 for an example of essential generic drugs used to treat non communicable diseases).

Quality of drugs: humanitarian health programmes sometimes provide partners with a budget to purchase essential drugs. It is the responsibility of programme managers to make sure that drugs purchased are of reliable quality. Generally, you should avoid purchasing drugs in local pharmacies. Ideally, drugs should be procured through the national (WHO-labelled) drug service when it is available. Some international NGOs have very reliable drug purchasing systems and ensure strict quality control of drugs used in their health facilities. If quality drugs are not available locally, you might be able to reach an agreement with those NGOs to import the necessary drugs.

Visual, hearing and mobility aids: it is important to enable older people to cope with their disabilities. They may have lost their walking aids, glasses or other assistive devices during displacement or a natural disaster and their quality of life and level of independence can be greatly improved by providing new ones (see Annex 3 for a list of various aids for older people). Identify a local or international partner to work within your programme to organise screening for older people (eye tests, hearing tests, assessing the level of disability), identify their needs, and provide the necessary aids. You can then organise the distribution according to their recommendations.

15. The Sphere Project 2011, p.302 www.spherehandbook.org/en/health-systems-standard-3-drugs-and-medical-supplies/

16. The Interagency Emergency Health Kit 2006 – Medicines and Medical Devices for 10,000 People for Approximately 3 Months – An Interagency Document, 2006

Resources:

The Interagency Emergency Health Kit 2006 – Medicines and Medical Devices for 10,000 People for Approximately 3 Months – An Interagency Document, 2006.

Health financing

Ensure that older people (as well as the general population) have access to free primary health care services for the duration of the disaster (Sphere health systems standard 4).[17]

In most countries, people attending a health facility have to pay a user fee. They often have to pay for drugs, laboratory exams and, in hospitals, for food, bedding and treatment.

In a disaster, people are generally struggling with meagre resources, and humanitarian health assistance is normally offered free of charge. However, after the initial phase of a crisis, national health services might revert to cost recovery.

In many developing countries, older men and women cannot afford to pay for health services and medicines. Health costs (including medication) are often greatest in the last years of a person's life, when, due to ill-health and frailty, they are unlikely to be able to work to make a living. HelpAge believes that older people should have free access to health services. There are various mechanisms by which you can support this:

- In some countries there is a national consensus that older people, as a vulnerable group, are exempt from paying users fees and other costs in the national health services. You should ensure that older people are provided with information and aware of their rights and entitlement to health care.
- In many countries the national consensus on free health care extends only to children under five and pregnant women. In this case you might advocate for free services to be extended to older people. Engage in advocacy at health coordination meetings, and especially health cluster meetings.
- Reach an agreement with one or several international NGOs that provide free health services so you can refer older people when they are sick.
- Reach an agreement with public or private health facilities to facilitate access for older people. You may have to make subsidies available to these facilities to meet the costs of users' fees, laboratory exams and drugs (to be adapted with the context). Sign a written agreement (or memorandum of understanding) with the other party.

Health information management

Make certain that the design and delivery of health services are guided by the collection, analysis, interpretation and utilisation of relevant public health data (Sphere health systems standard 5).[18]

When working with partner health services (including community based health workers, health centres and hospitals), ask them to provide you with data on attendance, diagnosis, number of referrals etc that is sex and age disaggregated. Use existing data sheet if they are appropriate, or create your own data reporting system if none is in place (eg for community health services). Analyse and discuss this data with the health teams and with older people in order to formulate recommendations for improving the health system and older people's health status. Share it with the health cluster or the relevant coordinating body to improve awareness of older people's specific needs.

At national level (especially in the health cluster meetings), you should advocate for the collection of SADD that includes older age groups to be standard in data collection and analysis.

17. The Sphere Project 2011, p.304
www.spherehandbook.org/en/health-systems-standard-4-health-financing/

18. The Sphere Project 2011, p.305
www.spherehandbook.org/en/health-systems-standard-5-health-information-management/

Action point 3: Provide integrated essential health services to older people

Prioritising health services

Provide essential health services to older people according to their needs (Sphere essential health services standard 1).[19]

Essential preventive and curative services: make sure these are available to older people at primary and secondary levels. An initial needs assessment should indicate which kind of services you need to prioritise. The following table shows the various patterns of mortality and morbidity according to different disasters:

	Complex emergencies	Earthquakes	High winds (without flooding)	Floods	Flash floods/ tsunamis
Deaths	Many	Many	Few	Few	Many
Severe injuries	Varies	Many	Moderate	Few	Few
Increased risk of communicable diseases	High	Varies*	Small	Varies*	Varies*
Food scarcity	Common	Rare	Rare	Varies	Common
Major population displacements	Common	Rare (may occur in heavily damaged urban areas)	Rare (may occur in heavily damaged urban areas)	Common	Varies

* *Depends on post disaster displacement and living conditions of the population (Source: The Sphere Project, 2011)*

Priority services might be surgical or orientated to communicable disease prevention (eg cholera, malaria) or secondary geriatric care.

Older people are sometimes particularly sensitive to **communicable diseases**. Respiratory chest infections or influenza can have devastating consequences for an older person.

When training health staff at community and facility level, ensure that they are aware of this sensitivity, and are able to diagnose and treat older people swiftly and efficiently.

19. The Sphere Project 2011, p.309 www.spherehandbook.org/en/health-systems-standard-1-health-service-delivery/

Hospital care for older people in Haiti

In Haiti, HelpAge initiated an emergency health response in the immediate aftermath of the earthquake in 2010. There was a pressing need for specialised geriatric care as many older people were in shock, wounded or had lost their usual medications, thus aggravating existing chronic diseases. As no other hospital was caring for this age group, HelpAge established a partnership with a private hospital to open a geriatric ward for a limited time, providing resources for staff, equipment and drugs.

Leah Gordon/HelpAge International

The impact of cholera on older people

HelpAge International, MSF and the Brighton & Sussex Medical School are carrying out research on older people and cholera. Preliminary results from MSF cholera treatment centres in Haiti indicate that people over 60 years old are more likely to present with severe dehydration as opposed to mild dehydration when compared with younger adults. In addition, individuals above 80 years of age have eleven times the mortality of younger adults in the cholera treatment centre.

The initial findings indicate the need to re-consider the way in which cholera treatment is provided to older people. The full study will be available end of 2012.

Disability: organise a needs assessment or a vulnerability assessment to identify whether older people are suffering from a disability and are in need of mobility aids (such as walking sticks or wheel chairs) or hearing aids. You might organise the distribution or provide these aids through partners (see the paragraph on visual, hearing and mobility aids, page 15).

Eye clinics: large numbers of older people suffer from vision problems such as presbyopia and cataract. Eye clinics are a very efficient way of having a major positive impact on older people's wellbeing. They can be organised with local or international partners in order to diagnose the various affections and identify those who are in need of spectacles or a cataract operation. The latter is a very simple surgery that can dramatically improve the quality of life and productive capacity of older people.

Eye camps in Darfur, Sudan

Eye camps have had considerable success in supporting older displaced people in Darfur, and could be replicated in many other crisis-affected areas. Since 2004, HelpAge has been running eye camps. These are offered for all age groups but older people represent by far the highest proportion of beneficiaries needing operations for trachoma and cataracts (84 per cent) and treatment (51 per cent). Upon completion of eye surgery, three post-operative eye clinic follow-ups are undertaken (at 24 hours, two weeks and a month after surgery) to ensure there are no post-operative complications. Eye camps are cost-effective and do not involve the establishment of permanent structures or support.

Gina Bramucci/HelpAge International

Nutrition: older people have specific nutritional needs, and in situations of displacements, food crisis or famine, they are extremely vulnerable to undernutrition. Basic nutrition care includes making sure that older people have access to an adequate general food ration, that their nutrition status is assessed (using middle arm upper circumference – MUAC) and that they are included in selective feeding programmes if they are malnourished.

Resources:

HelpAge International is developing specific guidelines for nutrition interventions for older people in emergencies. These guidelines will be available in 2013.

HelpAge, NutritionWorks and the Global Nutrition Cluster have developed a training module on older people nutrition in emergencies (www.ennonline.net/htpversion2).

Non-communicable diseases

Ensure that older people have access to essential therapies to reduce morbidity and mortality due to acute complications or exacerbation of their chronic condition (Sphere essential health services – non-communicable diseases standard 1).[20]

Basic or essential care following disasters usually focuses on the treatment of acute conditions such as injuries, diarrhoea and respiratory infections, as well as more recently on psychosocial and mental health services, and HIV/AIDS.

The provision of care for chronic diseases is rarely seen as a priority, yet the biggest causes of death worldwide are cardiovascular diseases (including high blood pressure), cancers, chronic respiratory diseases and diabetes. In people aged 65 years and older, arthritis, hypertension, heart disease, diabetes, and respiratory disorders are some of the leading causes of activity limitation.

When to intervene: non-communicable diseases (NCDs) affect more and more older people in developing countries. They cannot be ignored when a disaster occurs. However, before planning to intervene in this field, you must have a good understanding of the pre-disaster situation: presence or absence of national guidelines and protocols that were used, global burden of diseases, as well as the attitudes, beliefs and practices of the local population towards these chronic diseases. Two rules have to be respected:

- Coordinate any intervention and have it approved by the local and/or national authorities. It is generally not recommended to provide new protocols or programmes for the management of chronic diseases, unless there is a national strategy allowing for innovation.
- It is not recommended to initiate involvement in chronic diseases management if there is no hope of ensuring the continuity of this intervention, either by securing long term funding, or by handing over the project to a partner such as a health authority or NGO. There has to be a consensus on the guidelines and protocols that will be used.

Many emergency situations continue for protracted periods of time and development actors may be involved. In these instances, you should be able to ensure that care for non-communicable illnesses and palliative support are available through partnership with longer-term providers or direct inputs (eg training, provision of specialised drugs).

How to intervene: management of chronic conditions involves a spectrum of services ranging from disease prevention to health promotion, diagnosis, treatment, rehabilitation ("tertiary prevention") and palliative care. Always incorporate advocacy for including chronic diseases in the humanitarian response as part of your programme.

In an emergency situation, you might chose to limit your intervention to ensuring the continuity of previously existing care: providing essential drugs (see Annex 2 for an example of essential generic drugs), training staff at primary level (including community level), and organising the referral of severely ill patients to specialist care.

20. The Sphere Project 2011, p.336 www.spherehandbook.org/en/2-6-essential-health-services-non-communicable-diseases/

The issue of **palliative care** poses a number of problems: it requires specific training of various staff in medical and psychological care (aiming at inter professional collaboration). It generally requires the use of drugs that are not commonly included in essential drugs lists (eg opioid analgesics). It is a long-term commitment, and it might be difficult to organise in the acute phase of an emergency.

Nevertheless, everybody deserves the right to die with dignity, and you should make end of life support available for patients, their family and carers. For people affected by lethal chronic diseases, ensure that a range of physical, emotional, spiritual and social support are on offer. This includes symptom control, nursing care of a dying patient, family support, psychosocial and spiritual care. It may be best delivered in partnership with specialist service providers.

Mental health

Make sure that older people have access to health services that prevent or reduce mental health problems and associated impaired functioning (Sphere essential health services – mental health standard 1).[21]

Mental health is an issue for older people in emergency situations. Often there are few or no mental health services available. In many cases this is because they did not exist before the emergency, or they may be provided at in-patient facilities, usually in the main town.

Mental services should be made available as early as possible after a disaster. We make the distinction between psychological first aid and mental health services, but both involve multi-sectoral support: social services, community and family support, non-specialised and specialised services. Strong community participation is essential. This could be facilitated through older people's associations.

21. The Sphere Project 2011, p.333 www.spherehandbook.org/en/2-5-essential-health-services-mental-health/

Kate Holt/HelpAge International

Older people's role in psychosocial support in Haiti and the Democratic Republic of Congo (DRC)

In response to both sudden onset crisis in Haiti and chronic crisis in DRC, HelpAge and its partners have involved older people in the delivery of psychosocial support.

In DRC, members of Older People's Associations were trained by a local partner to improve their understanding of older people's mental health issues, the physical and mental impact of ageing, counselling techniques, and psychosocial support for older people to enable them to provide care to older people living in displacement camps.

In Haiti, a group of home-based carers was trained by international experts in the psychological impact of disasters to recognise the psychological impacts of the earthquake. To support older people's recovery, the same carers were also given training to conduct group sessions in which older people could discuss their experiences and feelings, to help them come to terms with the impact of the disaster.

Psychological first aid: this is for people suffering from psychological distress. According to Sphere (2011) and IASC (2007), psychological first aid describes a humane, supportive response to a fellow human being who is suffering and who may need support. It involves the following themes:

- Providing distressed people with practical care and support, which does not intrude;
- Assessing needs and concerns;
- Helping people to address basic needs (for example food, water, and information);
- Listening to people, but not pressurising them to talk;
- Comforting people and helping them to feel calm;
- Helping people connect to information, services and social supports (including leisure activities);
- Protecting people from further harm.

There are a variety of methods for providing psychological first aid, such as self-resilience techniques or individual or group counselling. They are all based on communication and community support. (See the resources listed at the end of this section.)

Home-based care in the Gaza Strip

Home-based care has been a central element of HelpAge's activity since it began operations in the Gaza Strip. Designed to address the psycho-social needs of older people, the interventions were implemented in response to a number of factors including: the high level of need for psychosocial interventions for older people linked to exposure to chronic political violence, the poor economic situation and high levels of chronic diseases, the gap in health service provision for these services, and the change in family structures in Gaza which resulted in increasing numbers of older people living alone or with reduced support.

Home-based care activities include group and individual counselling sessions, training, family reunions, recreational trips and awareness raising with older people and their carers on older people's health and dietary needs. A local partner, in charge of training and supervising the home-based carers in their psychosocial practices, provides these services.

The approach has been welcomed by older people and resulted in positive outcomes and impacts. Isolation and dependence on family members have been reduced and psychosocial wellbeing has improved, reflected in reduced feelings of isolation, depression, restlessness, and increased self-confidence. Families and carers report increased awareness of the challenges older people face and how they can be supported. Intergenerational relations have improved, and family tensions have been reduced.

Sarah Marzouk/HelpAge International

Mental health services: for people suffering from more severe conditions than psychological distress, ie mental disorders such as psychotic or anxiety disorders (including post-traumatic stress disorders), there is a need for more specialised services. They should be multi-sectoral, but from a health perspective these interventions should include:

- Technical support for implementing specific mental health activities, including: individual psychotherapy sessions, mobile multi-disciplinary teams in the community (for psychiatric, psychological, medical, and social care), therapeutic discussion groups, community support groups, house visits and therapeutic education for the patients and their families;
- Inclusion of trained mental health workers at primary health care level;
- Partnership with mental health institutions for referral of older people;
- Technical support for health professionals: counselling, supervision and training on systems for supporting clinical practice.

Dementia: the word "dementia" describes a number of progressive brain diseases that affect a person's memory, thinking, behaviour and emotions. Because the global population is ageing, the number of people with dementia is rapidly growing, particularly in low and middle-income countries. It is a major cause of dependency in older people, and exposes them to abuse and discrimination. Yet it is rarely diagnosed and thus not taken care of, especially in emergency situations. You might train health staff to recognise the symptoms of dementia, and organise community-based support networks for affected people and their families and carers.

Older people in institutions: older people with dementia or other chronic mental diseases are sometimes institutionalised in psychiatric units or homes. In an emergency, they might be in need of basic support (shelter, water, food, sanitation, medical care) and protection, and the continuity of the medical and social care should be ensured: you might plan to have a partnership with such institutions, supporting them with staff salaries, and medical and non-medical equipment.

Resources:

Psychological first aid: Guide for field workers, WHO 2011.

Policy Paper: *Mental health in post-crisis and development contexts,* Handicap International, April 2011.

Psychosocial and mental health interventions in areas of mass violence, a community-based approach, guideline document, second edition, de Jong K, 2011.

Psychological First Aid Field Operations: Guide for Nursing Homes, Brown L M, Frahm K A, Hyer K, and Gibson M, second edition, March 2011.

About psychosocial support and mental health needs of sexual violence survivors in conflict affected settings:
www.who.int/reproductivehealth/publications/violence/rhr12_18/en/index.html

Action point 4: Build partnerships

Why?

An emergency health intervention for older people should be integrated with the global health response for the general population. HelpAge International does not recommend opening health clinics for older people only. Wherever possible, you should aim to integrate care for older people within the general health system at primary and secondary levels.

Exceptionally, when a needs assessment shows that there is no availability of a specific service, you might consider providing that service to older people specifically.

Who?

In most situations, you should work with partners in order to integrate health care for older people into the health system. The partnerships should aim at providing accessible and quality services to older people and can be established with:

- Public health authorities: at local, regional or facility level for primary health care services and referral;
- Private health facilities: often a hospital or a specialised institution (for mental health, rehabilitation, specific surgery or other specific needs);
- International or national NGOs for primary health care services and referral. (For example, HelpAge International has a memorandum of understanding with MERLIN and Handicap International to help establish programme-level partnerships).

How?

Country Health Clusters and coordinating health authorities have a role in identifying areas for cooperation and partnerships in an emergency, by identifying gaps and opportunities.

The partnership may take the form of:

- Providing funds to the partner in order to cover the cost for specific care to older people;
- Training the partner's staff in basic geriatric care;
- Integrating appropriately trained staff in health facilities in order to directly provide health care to older people, train staff and advocate for older people's participation.

There should be an agreement between the partners including a detailed description of the activities involved, the respective commitments in service delivery, supervision, monitoring and evaluation, as well as reporting (both financial and activity).

Vincent Gainey/HelpAge International

HelpAge International

Delivering age friendly health services through partnership – HelpAge and Merlin in Pakistan

Merlin and HelpAge began working together in Pakistan Administered Kashmir in 2006 following recognition of the lack of specialist health services for older people in the Kashmir earthquake response. Public health, psychosocial and protection specialists were seconded from HelpAge to Merlin's response programme. The HelpAge technical advisers supported the development of needs assessment approaches that were inclusive of older people, and staff capacity building in targeted health facilities to improve levels of care for older people, ensure continued access to essential health care in the rural remote communities during the recovery/reconstruction phase, and to work with communities to mitigate, prepare, and respond to future crisis. HelpAge also supported specific areas of service delivery including provision of mobility, visual and hearing aids, and later eye care. By drawing on the successful model of integration of older people into primary health care provision, HelpAge was able to work with three universities to include a geriatric care component into their teaching modules.

In 2008 and 2012, in response to conflict related displacement Merlin and HelpAge again worked together to deliver age appropriate health services. The close working relationship over the course of these responses has enabled Merlin to integrated older people into their health programmes in North Western Pakistan, with specific age focused services now provided in longer term programmes, without direct technical assistance from HelpAge at clinic level.

Action point 5: Advocate for older people's right to health

For the purpose of humanitarian response, advocacy can be defined as "the act or process of supporting a cause",[22] in this case, the rights of older men and women to receive effective, safe and quality health care that is age-friendly and appropriate to their needs.

Advocacy should be part of all interventions for older people in emergencies, with the goal of ensuring that older people are acknowledged as a vulnerable group and that their needs are met as part of the response.

How?

Advocacy can take the form of many different activities. In humanitarian response it often means presenting key messages and evidence at coordination forums, holding one-to-one meetings, and building relationships with key decision-makers.

In the health sector, advocacy includes:

- **Participating in the consolidated appeal process** and any subsequent appeals to ensure that the needs of older people are included in humanitarian planning and allocated financial resources. When appropriate, you should also include dedicated resources for coordination.
- **Active participation in health cluster meetings** or the national health sector coordination to promote the inclusion of older people in the humanitarian agenda.

  Active participation means more than just attending meetings. The cluster system is meant to improve the coordination between the health actors, thereby identifying gaps, improving accountability to beneficiaries, enhancing understanding of the situation through shared information and analysis, and more powerful advocacy on behalf of the affected populations. The system is only efficient if the partners are active. You will need to take initiative within the cluster, eg by volunteering to chair sub-working groups on specific issues that affect older people, or participating in joint assessments.

  You should also attend inter-cluster meetings and meet with communications staff to ensure that appropriate and accurate information about the services available to older people are included in humanitarian information services.
- **Gathering and sharing reliable sex and age disaggregated data and making evidence-based recommendations** to the cluster partners and with the various relevant levels of the Ministry of Health to raise awareness of the numbers and vulnerabilities of older people. Distributing edited monthly reports and case studies of successful approaches for addressing older people's health needs is also a useful strategy.
- **Coordinating with international and local partners who share a similar goal:** identify partners who work with older people and form strategic alliances to deliver harmonised or joint messages at key national and humanitarian coordination forums.
- **Working with the media:** sometimes the best way to draw attention to and gain support for a cause is to organise national and international media stories about the issue. You can meet with journalists to draw their attention to the issues affecting older people in a crisis and facilitate interviews and field visits for them, in coordination with your media and security colleagues.

22. Webster-Merriam dictionary

Strategies for successful advocacy

Successful advocacy depends on convincing the right people (ie decision-makers) that your cause is valid and requires their action and support. Some strategies to help make advocacy more successful include:

- **Be prepared:** with compelling arguments, evidence and examples that support your messages;
- **Adapt to your audience:** different people (eg cluster leaders, national health authorities, community leaders) will be convinced in different ways. Successful advocacy depends on correctly identifying your target audiences and adapting your strategies and messages to them. Identify ahead of time the specific motivations and concerns of your audience and adjust your information and communication strategies accordingly;
- **Use examples:** familiarise yourself with case studies or examples, preferably from similar contexts;
- **Work with partners:** messages are always stronger when they are delivered jointly;
- **Identify "champions":** individuals in the right places can play a critical role in bringing about change. Build relationships and partnerships with people in target organisations who share your ideas.

If advocacy is a big component of your programme, you should begin by creating an advocacy plan to clearly define your goals, objectives, and audiences, and then identify what messages, strategies and materials or media you will use. An advocacy plan template is provided in Annex 4.

Messages

Your advocacy goals, targets and messages must be drawn from the local context and adapted to your key audiences. For some general guidance, here is a summary of key messages drawn from the action points in this paper.

Inclusion in the humanitarian agenda

- Older people should be recognised as a vulnerable group and their health needs must be prioritised in humanitarian relief and recovery plans;
- Health assessment data should be sex and age disaggregated, and should identify the specific health needs of older people.

Availability of health services

Older people should have access to primary health services, including:

- In their communities: home visits/home-based care, health education and referral, and community-based activities, carried out by trained home-based carers or community health workers;
- At health facilities: trained staff, availability of essential drugs, and referral to secondary level and follow up.

Older people should have access to secondary health services, including:

- An organised system of referral and follow up; and
- The availability of a carer to accompany them.

Vincent Gainey/HelpAge International

Access to essential health services

- Access to preventive and curative care for chronic diseases is a priority to reduce morbidity and mortality among older people in a crisis. This includes access to essential drugs for managing these diseases;
- Older people are at higher risk from many communicable diseases and must be diagnosed and treated quickly and efficiently;
- Older people are especially vulnerable to undernutrition; they should be included in assessment/screening, and be a priority target group for receiving basic nutrition care;
- Older people with disabilities should have access to mobility and visual aids;
- Older people need to have access to psychological care and mental health services, including at community level.

Availability of age-friendly health services

- Health facilities should have special provisions for meeting the needs of older patients including:
  - Physical accessibility;
  - Reduced waiting times;
  - Waiting areas with seating and protection from the elements;
  - Access to drinking water and toilet facilities;
- Health staff must be aware of the specific health needs of older people and have the skills to communicate, assess and care for their needs;
- Health services must meet the needs of older men and women equally.

Health Policy

- Older people should have access to free health services;
- Health services for older people must be integrated in primary health care;
- Essential drugs for chronic diseases should be included in emergency kits;
- Older people should participate in assessing, designing, planning and organising the health system;
- Health systems should be accountable to older people, and mechanisms should be put in place to ensure this accountability.

Annex 1: HelpAge International's Sex and Age Disaggregated Data Methodology

The use of Sex and Age Disaggregated Data (SADD) is essential for humanitarian programmes, advocacy and learning. The application of the following SADD methodology will enable response teams to understand the demographic composition, profile and number of the older population that may be affected by conflict or natural disaster.

How/where to collect SADD

It is unlikely that you will find accurate nationally produced SADD in many countries or regions so we must make demographic projections through estimations that will be close to real figures.

You can use data produced by the National Institute or Bureau of Statistics if the census provides detailed information by sex, age and administrative boundaries, and is no more than five years old. Unfortunately a lot of national statistical information is neither updated nor accurate, and in some contexts can even be influenced by political considerations. In an emergency, when time may be very limited, two alternative sources of information may be used to produce quality demographic projections.

1. Data provided by the UN Department of Economics and Social Affairs (UNDESA) – Population Division

How to use UNDESA data to produce national SADD estimations

Follow this link: http://esa.un.org/unpd/wpp/Excel-Data/population.htm

It will lead you to the UNDESA World Population Prospects where you will find updated population estimations disaggregated by country, sex, age, population density and dependency ratios. Open the relevant Excel files, search for the relevant country and find the estimates on older age groups.

How to estimate SADD

Having found the relevant country and the most recent year's data, you can calculate the percentage of older people from the total population and fill in the table below.

You will see that some countries in the UNDESA database have estimations for the 80+ and 90+ age range. In these cases, we recommend using 80+ as the cut-off.

How to estimate SADD for specific geographical/administrative areas

Once you have a nationwide estimate, you can estimate the percentage of older people in the population in specific areas of the country. All you need is an estimation of the total population for the area of interest, and apply the national percentages you have used in the table below.

2. Data provided by *The World Gazetteer*

If you cannot obtain reliable population estimates from country-based information sources, you can use *The World Gazetteer*, by following this link: www.world-gazetteer.com/

The World Gazetteer provides a breakdown of population data for countries and offers related statistics for different administrative divisions, areas, cities, towns and maps in English, French, Spanish and German. It will provide you with quality estimates that you can disaggregate later.

Always remember

You should make both a lower and higher estimation of the numbers of older people (60+) potentially affected by the crisis.

You can establish estimates based on the initial reports issued by the media, UN, INGOs etc of the numbers of people affected by the crisis. Estimations will vary depending on the crisis; for example your lower estimation may show 30-50 per cent of the older population has been affected by a crisis and 60-80 per cent affected as the higher estimation. In some cases these estimations may equal 100 per cent, for example when assessing refugee or IDP camps with defined populations.

Estimating the size of the older population affected by a crisis is not an exact science. However it can form very important messages to share with humanitarian actors and decision makers in the initial stages of an emergency response.

Age	Male	Female
60-69 years	Total sum (% of total population)	Total sum (% of total population)
70-79 years	Total sum (% of total population)	Total sum (% of total population)
80-89 years	Total sum (% of total population)	Total sum (% of total population)
90+ years	Total sum (% of total population)	Total sum (% of total population)
Total		

Annex 2: Essential list of generic drugs for chronic diseases[23]

Antiasthmatic

- beclometasone 50 mcg/dose inhaler
- salbutamol 0.1 mg/dose inhaler

Antidiabetic

- glibenclamide 5 mg tablet/capsule
- metformin 500 mg tablet/capsule

Serum lipid reducing (against high levels of cholesterol)

- lovastatin 20 mg tablet/capsule

Antihypertensive

- atenolol 50 mg tablet/capsule (note: present in the IEHK)
- captopril 25 mg tablet/capsule
- hydrochlorothiazide 25 mg tablet/capsule
- losartan 50 mg tablet/capsule
- nifedipine retard 20 mg retard tablet

Antacid

- omeprazole 20 mg tablet/capsule
- ranitidine 150 mg tablet/capsule

Anti-inflammatory

- diclofenac 25 mg tablet/capsule

Antiepileptic

- carbamazepine 200 mg tablet/capsule
- phenytoin 100 mg tablet/capsule

Anti-Parkinsonian

- levodopa + carbidopa, tablet: 100 mg + 10 mg; 250 mg + 25 mg
- biperiden injection: 5 mg (lactate) in 1 ml, tablet: 2 mg (hydrochloride)

Antipsychotic

- fluphenazine decanoate 25 mg/ml injection

Anxiolytic

- diazepam 5 mg tablet/capsule

Antidepressant

- amitriptyline 25 mg tablet/capsule
- fluoxetine 20 mg tablet/capsule

23. This list is only an indication. The name of the drugs is the generic name, not the commercial name which varies from country to country. The list is inspired by *"Price, availability and affordability: An international comparison of chronic disease medicines. Background report prepared for the WHO Planning Meeting on the Global Initiative for Treatment of Chronic Diseases held in Cairo in December 2005"*, WHO and Health Action International, 2006

Annex 3: List of basic aids and hygiene kits for older people

Mobility aids

- wheel chairs: adapted to the terrain
- crutches
- canes and walking sticks

Hearing aids

A hearing aid is a device that consists of:

- a microphone
- an amplifier
- a loudspeaker
- a battery

Resources:

Guidelines for hearing aids and services for developing countries, 2nd edition, September 2004, WHO, Prevention of Blindness and Deafness.

Visual aids

Build a partnership with a specialised health facility or NGO in order to get the appropriate equipment and glasses.

Hygiene kit

Example of the Democratic Republic of Congo:

- body soap
- toothbrush and toothpaste
- nail clipper
- washing powder for clothes

Possible additional items:

- urinary pads

Annex 4: Sample advocacy plan

A good advocacy plan respects the principles of "SMART": your goal should be **S**pecific, **M**easurable, **A**chievable, **R**ealistic and defined by an appropriate **T**ime-frame.

While your goals may be based in principles or ideals, you should be realistic about what you can achieve given the resources available to you and the external situation. In the immediate aftermath of a disaster or at the onset of a crisis, your goals will probably focus on "small victories" (eg securing funding for mobility aids for older people) and have very short timeframes. As relief moves towards recovery you will probably begin to advocate for higher-level policy changes over a longer time period (eg the provision of free health services to older people), and have multiple objectives and activities supporting your goal.

In general an advocacy strategy should include at least the following elements and could be presented as a narrative or organised like a logframe in the following way:

SMART Advocacy Goal						
Justification						
Main strategies						
Success indicators						
SMART Objective	**Primary Targets**	**Messages**	**Activities**	**Allies & Opportunities**	**Resources**	**Materials**

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