WHO clinical consortium on healthy ageing 2023

Meeting report, Geneva, Switzerland, 5–7 December 2023

World Health Organization

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Contents

Acknowledgements iv
Abbreviations and acronyms v
Executive summary vi
Introduction 1

Panel 1. WHO's new initiatives on ageing and health 3
WHO-ESCEO initiative on bone health 3
WHO-EuGMS collaboration 5
Nutrition and ageing 6

Panel 2. Musculoskeletal health 9
Overview of musculoskeletal health for older people 9
WHO guideline for the non-surgical management of chronic primary low back pain in adults in primary and community care settings 10
WHO Package of interventions for rehabilitation 11
Prevention of loss of muscle mass and function 12

Panel 3. Implementation of the ICOPE approach 15
Progress on delivering person-centred integrated care and primary health services responsive to older people 15
Adaptation of ICOPE approach to the local context 17
Implementation of the ICOPE approach at system levels 19
Implementation of the ICOPE approach at clinical and service levels 26

Panel 4. Emerging themes to strengthen integrated care 35
HIV and ageing 35
NCD integration, ageing and multimorbidity 36
Competency-based education (WHO Global Competency and Outcomes Framework for Universal Health Coverage) 38
ICOPE training programme 40

Panel 5. Updating ICOPE care pathways 43
Updating the generic care pathway of the ICOPE approach 43
Updating the screening tool for the ICOPE approach in the community 46
Feasibility and validity of self-screening 47
Urinary incontinence care pathway 49

Panel 6. Multidimensional approach to research on healthy ageing 51
Research prioritization agenda 51
Intrinsic capacity and environment 53

Panel 7. CCHA and GNLTC joint panel: Continuum of integrated care for older people ... 56
Long-term care package for UHC 57
Operationalization of "continuum of integrated care": how to make ICOPE care pathways applicable for long-term care 59

The way forward 61
Planned WHO technical products on care for older people 61
References 63
Annex 1. WHO Clinical Consortium on Healthy Ageing 2023 meeting agenda 66
Annex 2. Meeting participants 71

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This report was written by Rachel Albone (AAH, WHO), with technical direction from Yuka Sumi and Matteo Cesari (AAH, WHO).

Abbreviations and acronyms

AADL	Advanced Activities of Daily Living scale
AAH	Ageing and Health Unit (WHO)
ADL	activities of daily living
BMI	body mass index
CCHA	Clinical Consortium on Healthy Ageing
CPLBP	chronic primary low back pain
CSO	civil society organization
DALYs	disability-adjusted life years
ELSI	Brazilian Longitudinal Study of Ageing
ESCEO	European Society for Clinical and Economic Aspects of Osteoporosis, Osteoarthritis and Musculoskeletal Diseases
EuGMS	European Geriatric Medicine Society
GNLTC	Global Network on Long-Term Care
HCW	health and care worker
HIV	human immunodeficiency virus
ICOPE	integrated care for older people
ICPOP	Integrated Care Programme for Older People (Ireland)
KPI	key performance indicator
LBP	low back pain
LMICs	low- and middle-income countries
LTC	long-term care
MCA	Department of Maternal, Newborn, Child and Adolescent Health and Ageing (WHO)
NCDs	noncommunicable diseases
PHC	primary health care
PIR	Package of interventions for rehabilitation (WHO)
RPA	research prioritization agenda
SDG	Sustainable Development Goal
TAG4MHA	Technical Advisory Group for Measurement, Monitoring and Evaluation of the UN Decade of Healthy Ageing
UHC	universal health coverage
UI	urinary incontinence
WHA	World Health Assembly
WHO	World Health Organization
YLDs	years lived with disability
YLLs	years of life lost

Executive summary

The 2023 meeting of the WHO Clinical Consortium on Healthy Ageing (CCHA) was the group's ninth gathering and took place in Geneva 5–7 December 2023. The meeting was structured around seven panels, with a series of technical presentations, plenary discussions and group work, and a final session outlining the work programme for 2024:

Panel 1. WHO's new initiatives on ageing and health

Panel 2. Musculoskeletal health

Panel 3. Implementation of the ICOPE approach

Panel 4. Emerging themes to strengthen integrated care

Panel 5. Updating ICOPE care pathways

Panel 6. Multidimensional approach to research on healthy ageing

Panel 7. CCHA and GNLTC joint panel: Continuum of integrated care for older people

The way forward.

The panels highlighted the range of work undertaken to progress efforts towards integration of care for older people. The meeting took place shortly after the launch of the first *Progress report on the United Nations Decade of Healthy Ageing, 2021–2023* (the Decade), which profiled many initiatives supporting integrated care. It highlighted the widespread interest in the integrated care for older people (ICOPE) approach from across the world.

WHO's new initiatives on ageing and health

Three new initiatives have begun since the last CCHA meeting. The first, a 5-year partnership between WHO and the European Society for Clinical and Economic Aspects of Osteoporosis, Osteoarthritis and Musculoskeletal Diseases (ESCEO) on bone health, includes a focus on the development and validation of a tool to assess the risk of fractures to inform the development of preventive strategies. The second is a WHO and European Geriatric Medicine Society (EuGMS) collaboration. This will raise awareness of the importance of reorienting health and social care services, and supporting capacity building on the continuum of quality, integrated health and long-term care (LTC) for healthy ageing. The third focuses on nutrition and ageing, bringing together the WHO Departments of Maternal, Newborn, Child and Adolescent Health and Ageing, and Nutrition to promote effective coverage of nutritional care in older people.

Actions for WHO include, working with partners to build evidence on fracture prevention and assessment tools, defining the role of the geriatrician, and expanding nutritional work to address quality of nutrition and hydration. CCHA participants will support the development and dissemination of integrated primary health services and LTC by training the care workforce on the ICOPE approach and raising awareness of undernutrition in older people.

Musculoskeletal health

Musculoskeletal health influences the performance of the locomotor system. Musculoskeletal conditions are the leading contributor to disability worldwide and, for people aged 70 and over, they account for 17.19% of years lived with disability per 100 000 globally. The *WHO guideline for the non-surgical management of chronic primary low back pain in adults in primary and community care settings* was launched at the end of the CCHA meeting. WHO has also published the *Package of interventions for rehabilitation,* which aims to support the planning, budgeting and integration of interventions for rehabilitation into health systems and includes musculoskeletal conditions. This panel also discussed muscle loss and function, highlighting the importance of physical activity and nutritional interventions, particularly increasing protein intake.

Actions from this panel include the CCHA taking multisectoral action to address musculoskeletal health issues, raising awareness of how to prevent declines in locomotor capacity and building evidence on physical performance tests to capture these declines. WHO plans to adopt a life course approach to any musculoskeletal health-related guidelines, and to consider care pathways on musculoskeletal pain.

Implementation of the ICOPE approach

The third panel focused on the implementation of the ICOPE approach; first, sharing examples from the global level, followed by presentations on pilot projects at the systems and services levels. At the global level, evidence shows progress by Member States in relation to integrated care, including an increasing proportion of countries having policies to support comprehensive assessments. Implementation experience has also shown the importance of adapting the ICOPE approach to local context; however, the adaptation process is not yet standardized or adequately considered.

Pilot projects at the systems level in Botswana, Cambodia, France, Qatar and Sri Lanka show implementation of the ICOPE approach usually begins with some adaptation, and often has an initial focus on training health and care workers (HCWs). The importance of a supportive policy environment was also highlighted, with many countries implementing the approach having policies or strategies related to healthy ageing or integrated care in place. At the clinical and services levels, a focus on health workforce capacity and training was also presented, alongside the integration of the ICOPE approach into existing care settings and services and the use of technology.

Based on discussions in this session, WHO will look to support the delivery of integrated care by developing an investment case, setting key performance indicators (KPIs), advising on the meaningful engagement of older people and monitoring the outcomes and impacts of integrated care through the next phase of the UN Decade of Healthy Ageing, 2021–2030. The CCHA agreed to share examples and good practices that strengthen the ICOPE approach, support WHO's monitoring work and report on adaptation processes.

Emerging themes to strengthen integrated care

Emerging themes in the delivery of integrated care include a growing number of older people living with HIV, and the increasing burden of noncommunicable diseases (NCDs) in a globally ageing population. Projections suggest more than 50% of people with HIV globally will be 50 and over by 2050, and that people with HIV may experience an early onset of geriatric syndromes and comorbidities. Themes commonly discussed in geriatric medicine are today emerging in the field of HIV. A key issue in relation to NCDs and ageing is multimorbidity, with over 50% of people aged 60 and over living with multiple conditions. In both the HIV and NCD sectors, polypharmacy is emerging as a key concern for older people, impacting on healthy ageing.

The remainder of this panel considered emerging issues in health workforce capacity and training, highlighting the WHO Global Competency and Outcomes Framework for Universal Health Care and its potential links with training HCWs to deliver integrated care. WHO is working to develop an ICOPE training programme to facilitate a shift in focus from a vertical approach aimed at "treating diseases" to

interdisciplinary comprehensive action at the primary health care (PHC) level.

Follow-up activities from this panel include the CCHA conducting research on older people living with HIV and multimorbidity and supporting the promotion of sustainable and acceptable capacity building on the ICOPE approach. WHO will aim to strengthen collaboration between technical units to ensure the integrated approach for older people living with HIV and multimorbidity. It will also revisit metrics on NCDs, including on "premature mortality", and continue to support training for HCWs on integrated care.

Updating ICOPE care pathways

The fifth panel focused on updating the ICOPE handbook and its care pathways. There were presentations on the generic care pathway, the ICOPE screening tool, and a potential new care pathway for urinary incontinence (UI), followed by group work. The update to the ICOPE care pathways is being driven by learning gained since the ICOPE approach was developed and the availability of a range of new evidence and tools. Key areas of focus for the update include the need to reinforce health and lifestyle advice (health promotion), how to deliver the components of person-centred assessment, the importance of engaging communities and supporting caregivers, and how to ensure the referral pathway and monitoring of the care plan.

Specific proposals were made for additions and modifications to the ICOPE screening tool, and the feasibility and validity of self-screening were discussed. Since the 2022 CCHA meeting, work has been undertaken on a care pathway on UI, given the high prevalence, underreporting and negative impact of UI for older people. This work will continue.

From this panel, WHO's actions include reviewing feedback from CCHA participants to inform the finalization of the ICOPE handbook version two, and clarifying what is meant by "integrated care" and how it relates to the ICOPE approach. The CCHA's actions include engaging in the review of the ICOPE handbook version two, piloting the updated care pathways and exploring the usefulness of self-screening.

Multidimensional approach to research on healthy ageing

A supportive environment can help to promote or maintain intrinsic capacity and functional ability. Research conducted in Japan shows the number of supportive environmental factors is positively associated with functional ability, particularly in people with low intrinsic capacity. In a study from Brazil, both intrinsic capacity and neighbourhood environment were shown to be significantly associated with advanced activities of daily living (AADL), when the definition of neighbourhood was restricted to objective items about where the person lives. In this panel, WHO also presented its initial work on a research prioritization agenda (RPA), to which CCHA participants have already contributed.

Supporting WHO to identify and engage researchers and other stakeholders in low- and middle-income countries (LMICs) and collaborating to fundraise for research in these contexts, are key actions for the CCHA from this panel. WHO will further develop its RPA, extending the number of contributors, especially from LMICs.

CCHA and GNLTC joint panel: Continuum of integrated care for older people

Taking advantage of the meeting of the WHO Global Network on Long-Term Care (GNLTC) taking place immediately after the CCHA meeting, a joint panel was held to discuss the continuum of care for older people. WHO presented *Long-term care for older people: package for universal health coverage*, and shared thinking on how the ICOPE care pathways can be adapted and made applicable to those who require LTC. In addition, there were discussions on the need to clarify the relationship between integrated primary health services and LTC, the importance of a continuum of care inclusive of all older people, and the need for longitudinal data.

Actions include the CCHA supporting consistent communication on “ICOPE” and “the continuum of care” and agreeing, with WHO, definitions and their use. The CCHA will also share examples of how the continuum of care can be operationalized across care settings. WHO will clarify how the ICOPE approach embraces LTC and what is included in appropriate assessment and quality services for people with significant losses of intrinsic capacity and functional ability. It will also provide training and guidance for caregivers.

The way forward

The final panel of the 2023 CCHA meeting focused on the way forward, looking at work planned by WHO and with the CCHA in the year ahead. WHO shared its planned technical products to be developed in 2024. Discussion and actions in this session focused on collaboration, considering the importance of partnerships across sectors, including with civil society, the private sector, researchers and other stakeholders in LMICs, between health and social care settings and providers, and with older people.

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CCHA 2023 meeting participants in Geneva, Switzerland, 2023

© Village Health Support Group/Mrs. Voeung Vanny, Battambang province

Vision screening conducted by a village support group in Battambang, Cambodia, 2023

Introduction

The 2023 annual meeting of the WHO Clinical Consortium on Healthy Ageing was the ninth gathering of an international multidisciplinary group representing clinical experts, academics, policy-makers and civil society. It was the first to take place in person since the start of the COVID-19 pandemic, with the majority of participants meeting at WHO headquarters in Geneva, and a smaller number of attendees joining online. The 2023 meeting drew from the full breadth of the field of ageing to progress the work agreed by Member States under the 2016 WHO Global Strategy and Action Plan on Ageing and Health and the United Nations Decade of Healthy Ageing, 2021–2030 (the Decade) *(1).*

The meeting was structured around eight panels/sessions, with a series of technical presentations, plenary discussions and group work:

Panel 1. WHO's new initiatives on ageing and health

Panel 2. Musculoskeletal health

Panel 3. Implementation of the ICOPE approach

Panel 4. Emerging themes to strengthen integrated care

Panel 5. Updating ICOPE care pathways

Panel 6. Multidimensional approach to research on healthy ageing

Panel 7. CCHA and GNLTC joint panel: Continuum of integrated care for older people

The way forward.

See Annex 1 for the full meeting agenda.

The presentations and discussions highlighted the range of work being undertaken by stakeholders across the ageing and health and care sector to progress efforts towards integrated care for older people. The CCHA meeting took place shortly after the launch of the first *Progress report on the United Nations Decade of Healthy Ageing, 2021–2023 (2),* which profiled a number of projects and initiatives supporting integrated care. The report also highlighted the widespread interest in the ICOPE approach from Member States across the world, and the opportunity it presents to achieve the commitment to deliver person-centred, integrated care and primary health services responsive to older people.

The ICOPE approach remains a key area of interest and engagement for CCHA participants, and a priority for WHO's work on implementing care for healthy ageing. The 2023 CCHA meeting therefore built on previous meetings in its focus on the approach, with particular emphasis on work to update the ICOPE care pathways (Panel 5).

Meeting objectives

1. To share experiences and learning from implementation of the ICOPE approach in different contexts.
2. To share opportunities to improve the ICOPE approach.
3. To discuss the integration of primary health services and LTC into an overarching continuum of care.
4. To inform the update of the ICOPE care pathways, reflecting field experience and emerging evidence, and adaptation to low-resource settings.

Meeting expected outcomes

1. Lessons shared to facilitate the implementation of the ICOPE approach at clinical, service and system levels.
2. Prioritization of emerging themes and opportunities for improvement of the ICOPE approach.
3. Feedback for the draft ICOPE handbook version 2, including adaptation to low-resource settings.
4. Guidance to promote integrated primary health services and LTC under one continuum of care.
5. Identified priority work for 2024.

As this is a report of presentations and discussions at a meeting, the statements and statistics included may not represent the views, policies and official statistics of WHO.

Update since 2022

At the start of the 2023 CCHA meeting, WHO provided an overview of activities and achievements on integrated care, including those involving the CCHA, since the last meeting. The 2022 meeting report, which includes the commitments for 2023, can be found on the AAH/CCHA pages of the WHO website.

With the support of CCHA participants and other partners, progress has been made in each of the six areas of focus of the 2022 meeting:

1. Monitoring the integrated continuum of care
2. Validation of the ICOPE screening tool
3. Care pathways for UI
4. Advancing measurement of intrinsic capacity
5. Validation of functional ability
6. The economic case for healthy ageing.

Achievements in relation to monitoring have included the development and launch of the first progress report on the Decade, the primary source of data for which was a process evaluation survey conducted with Member States (see Panel 3). These data have been added to the WHO Ageing Data Portal, which includes country profiles containing the 10 national progress indicators for the Decade and a range of additional questions on integrated care and the other action areas of the Decade. WHO has also continued to work with the Technical Advisory Group for Measurement, Monitoring and Evaluation of the UN Decade of Healthy Ageing (TAG4MHA) in the ongoing development of a guide for situation analysis, a national toolkit for monitoring and evaluation and the Global Ageing Population Survey.

Following exchanges on the sensitivity and specificity of the ICOPE screening tool during the 2022 meeting, further thinking and discussion on this issue were conducted, especially on the feasibility and validity of self-screening (see Panel 5). Furthermore, after presentation of the UI theme at the 2022 meeting, a small working group has refined a care pathway to be included in ICOPE handbook version 2 (see Panel 5).

Discussions on advancing measurements at the last meeting have led to an increase in data on intrinsic capacity and environment. These data are informing discussions on the operationalization of the functional ability concept (see Panel 6). The WHO guideline for the management of chronic primary low back pain (CPLBP) has been finalized and was launched at the end of the 2023 meeting (see Panel 2). And in 2023, WHO and ESCEO established a joint initiative on bone health (see Panel 1).

As with previous years, the main area of focus for WHO and CCHA participants has been the implementation of the ICOPE approach. In 2023, WHO has continued work to develop ICOPE training modules, with support from the CCHA. Training has been delivered for multidisciplinary teams in Botswana, Kuwait, Mauritius, and Singapore. Work has also been undertaken to sensitize policy-makers on the ICOPE approach, with workshops conducted in both the Eastern Mediterranean and Western Pacific WHO regions.

Panel 1.
WHO's new initiatives on ageing and health

The first panel provided an overview of WHO's new initiatives on ageing and health, with presentations on three areas of work:

- WHO-ESCEO initiative on bone health
- WHO-EuGMS collaboration
- Nutrition and ageing

WHO Resources for Panel 1

- WHO-ESCEO initiative: New collaboration targets better bone health and ageing
- WHO-EuGMS collaboration: Memorandum of Understanding between the World Health Organization (WHO) and the European Geriatric Medicine Society (EuGMS)
- United Nations Decade of Action on Nutrition, 2016–2025: Work programme

WHO-ESCEO initiative on bone health

Bone health is essential for healthy ageing, critical for locomotor capacity and the prevention of decline in functional ability. Bone density is inversely associated with the risk of fractures, which have detrimental outcomes for both the individual and public health. Data show that around 20% of older people are at risk of osteoporotic fractures, with risk increasing with age *(3)*. Women have a higher risk than men, and women's risk increases rapidly as they age.

The Global Burden of Disease estimates, including those for bone health-related conditions, are based on a combination of two metrics: the impact a condition has on disability (years lived with disability [YLDs]); and the impact a condition has on mortality (years of life lost [YLLs]). These two metrics are combined to determine disability-adjusted life years (DALYs). As with other diseases, using this approach for conditions related to bone health leads to limited understanding of the impact these conditions have on families, communities and wider systems and societies.

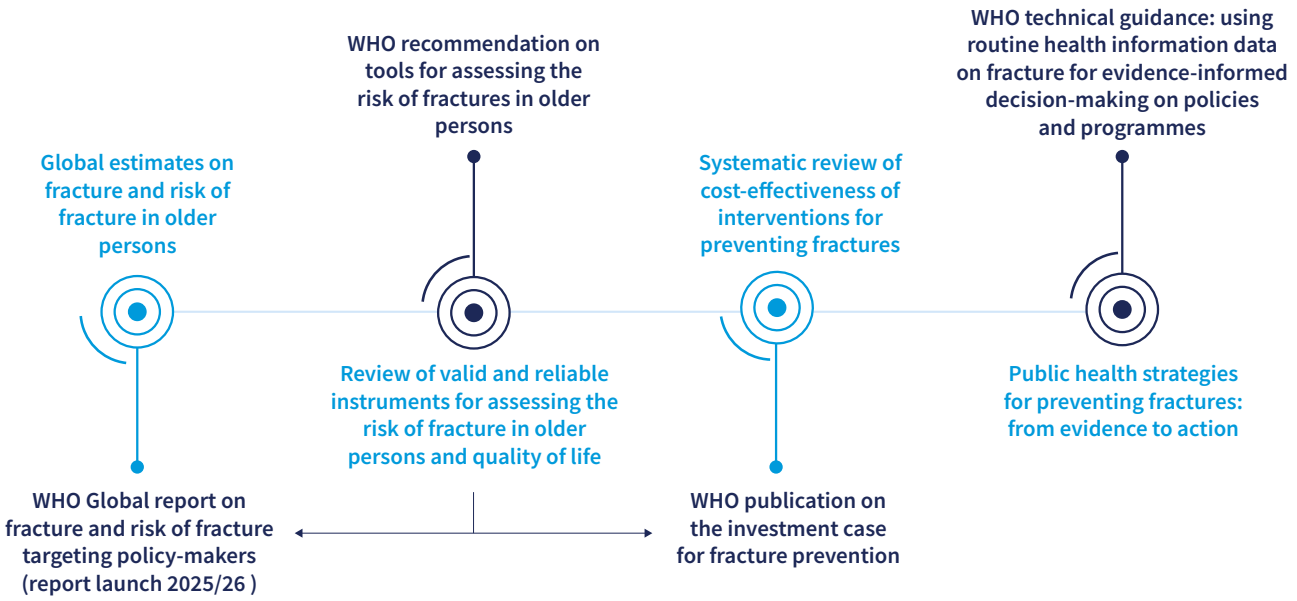
In response to this issue, WHO and the European Society for Clinical and Economic Aspects of Osteoporosis, Osteoarthritis and Musculoskeletal Diseases (ESCEO) launched a new initiative. Over the next 5 years an evaluation based on the direct and indirect costs incurred due to osteoporosis and fractures will be developed to enable a more meaningful picture of the societal impacts of bone health-related conditions.

The initiative will also focus on the development and validation of a tool to assess the risk of fractures, which is essential for the development of a preventive strategy. Multiple instruments are currently available, but there remains a lack of evidence of the validity and reliability of different tools. Furthermore, given the social and economic costs of fractures for the individual and public health systems, preventive strategies and

interventions have been proposed and tested. To date, approximately 500 randomized controlled trials have tested 36 interventions to prevent fractures. However, their scalability, especially in low-resource settings, often remains unclear.

The timeline for WHO-ESCEO to address these issues with a view to setting a global health agenda on bone health and advocating for a public health strategy is shown in Fig. 1. This work is made possible by support from ESCEO, which brings together multiple actors, from corporate partners to nongovernmental organizations and academia. The bone health initiative is being conducted with the support of the Bone Health Expert Working Group composed of 21 experts working in musculoskeletal health and representatives of the six WHO regions, including from LMICs. The group began its work in early 2023.

Fig. 1. WHO 5-year roadmap on bone health, 2023–2027



Discussion among CCHA 2023 meeting participants in Geneva, Switzerland, 2023

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Key discussion points

- **Integrating interventions for bone health:** A combination of interventions and their sequential use will be examined to help inform prioritization. An analysis of the cost-effectiveness of different interventions, from screening through follow up and training for HCWs, will help to determine approaches that support the whole person (i.e. holistic).
- **Investment case for bone health:** The development of an investment case for the prevention of fractures will be undertaken and include measurement of the economic and social impact of fractures.
- **Bone health across services:** The approach used in the analysis of evidence on interventions will focus on community prevention and also consider findings from specific care services (e.g. fracture liaison services).
- **Screening in low-resource settings:** Consideration will be given to issues in low-resource settings, including the availability of diagnostic tools and the prevalence of conditions associated with an increased risk of osteoporosis. Tools and instruments will be assessed against optimal thresholds in terms of sensitivity and specificity, and also for how they are able to respond to basic requirements for easy implementation and dissemination in low-resource settings.
- **Bone health and other clinical conditions:** WHO is exploring bone health in different clinical conditions, including infectious diseases (e.g. tuberculosis), and looking at issues of multimorbidity. A horizontal approach will be integral to ensure multidisciplinary stakeholders engage in and support a wide-ranging approach in the implementation of bone health initiatives.
- **ICOPE and bone health:** Bone health is not specifically included in the ICOPE technical resources. Consideration should be given to how bone health instruments and tools could be adopted as part of the ICOPE approach.

WHO-EuGMS collaboration

Geriatric medicine continues to evolve in response to challenges arising from global population ageing. Blending the principles of gerontology, internal medicine, rehabilitation and palliative care, geriatric medicine is recognized as an effective approach to deliver high-quality, person-centred, interdisciplinary, appropriate and cost-effective care to older people – proportionally the most significant group of health care users in European populations.

The European Geriatric Medicine Society (EuGMS) brings together HCWs, researchers and educators with a focus on promoting a high standard of care for older people, and enhancing knowledge, collaboration and advocacy in geriatric medicine, contributing to the well-being of older people across Europe. It is a non-profit association fostering the collaboration and coordination of 39 national geriatric medical societies.

In October 2023, WHO and EuGMS signed a 3-year memorandum of understanding to formalize collaboration to improve care for healthy ageing. WHO and EuGMS will work together to raise awareness on the importance of reorienting health and social care services to promote the continuum of quality, integrated health and LTC for healthy ageing. The WHO-EuGMS MoU has four pillars:

1. Provision of a formal definition of “geriatrician”
2. Training the care workforce to provide care for older people
3. Estimate the availability of geriatricians across countries
4. Measure the prevalence of geriatric conditions across European countries.

WHO and EuGMS will work together to build the capacities and skills of HCWs on the principles of geriatric medicine and the WHO ICOPE approach. The EuGMS has 24 special interest groups, each dedicated to a subspecialty of geriatrics. These groups will provide a valuable resource, facilitating discussion between EuGMS and WHO on specific topics.

Key discussion points

- **Involvement of geriatricians in healthy ageing:** In collaboration with other HCWs, geriatricians could play a role in the development and implementation of preventive strategies for healthy ageing, alongside their traditional role in the management of long-term chronic conditions. They could also act as champions to promote healthy ageing, supporting the reshaping of health and care services that are more responsive to older people's needs and priorities.
- **Defining roles within the geriatric workforce:** The initiative to formally define the role of the "geriatrician" could be extended to other associated HCWs. EuGMS could potentially support this wider effort over time, with the possible collaboration of additional partners.
- **Role of EuGMS:** The EuGMS is developing a new branch, the European Interdisciplinary Council on Ageing, which will broaden the scope of the EuGMS's work and support the collaboration with WHO.
- **Training future geriatricians:** There is a need to strengthen training programmes, especially at the undergraduate level, to increase the number of geriatricians in the future, especially in LMICs.

Nutrition and ageing

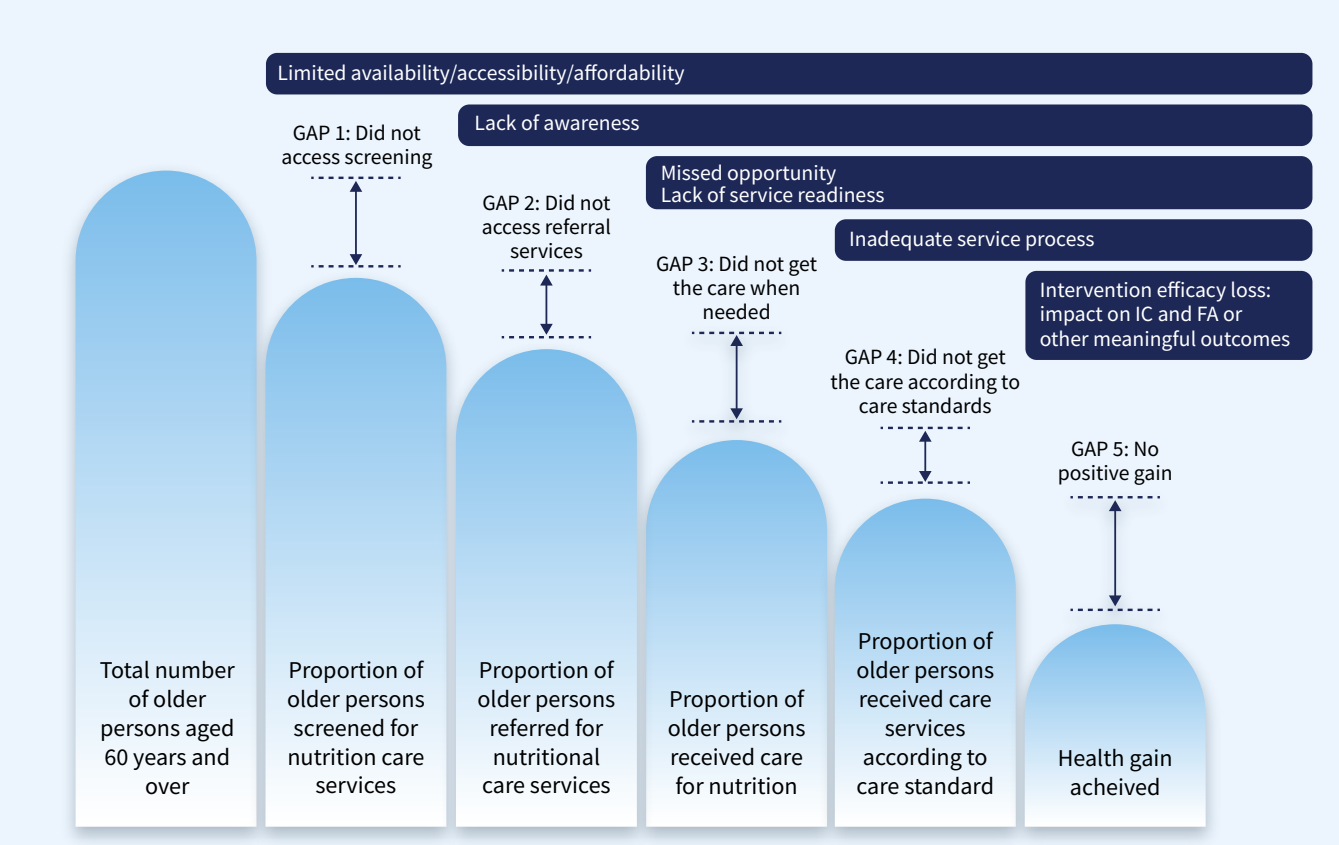
There have been a number of commitments by Member States focused on malnutrition since 2012, starting with the endorsement of a set of six global nutrition targets by World Health Assembly (WHA) resolution 65.6 *(4).* The Sustainable Development Goals (SDGs) include a goal of ending hunger and all forms of malnutrition by 2030 (SDG2) and the UN Decade of Action on Nutrition (2016–2025) is ongoing and coincides with the UN Decade of Healthy Ageing.

A study combining the results of multiple research studies has found that both low and high body mass index (BMI) in adults are associated with an increased risk of mortality. However, interestingly, for people aged 70 and older, the risk of mortality for high BMI is slightly lower than for younger adults. It is not yet clear whether this finding is biologically plausible or due to measurement errors (either differential or non-differential) *(5)*. Yet, a review of national policies on ageing and health from 70 out of 139 countries that participated in WHO's process evaluation survey for the UN Decade of Healthy Ageing shows nutrition for older people is largely neglected. It has also been noted that the nutritional status of older people is rarely properly monitored, even in clinical practice. To further support the current commitments addressing issues related to older people, a joint collaboration has been established between the Department of Maternal, Newborn, Child and Adolescent Health and Ageing and the Department of Nutrition at the WHO. This collaboration will promote effective coverage of nutritional care in older people, including the development and use of a set of indicators (Fig. 2) in the form of a cascade model, focusing on measurement gaps.

The model will be tested using longitudinal data from InterRAI, a collaborative network of researchers and practitioners in over 35 countries committed to improving care for people with disability or medically complex needs, especially older people. Through developing and testing this model, WHO aims to develop technical guidance on how to track nutrition care services for older people.

Work on the risks associated with obesity and older people is ongoing using more than 50 databases from different countries, to determine a cut-point of BMI that might more accurately capture obesity in older people. Global estimates of obesity, overweight and undernutrition in older people will be developed according to the revised cut-points. A policy brief will also be developed, "Ensuring older people are not left behind in the fight against malnutrition".

Fig. 2. Proposed indicators on nutritional care for older people



Notes: FA – functional ability; IC – intrinsic capacity.

Key discussion points

- **Approach to integrated care and nutrition:** A comprehensive approach is needed that addresses key elements of nutrition and ageing within integrated care. There were suggestions on the need to include healthy nutrition, quality of diet and hydration, and to engage nutritionists in the care of older people. A comprehensive approach might better support preventive strategies against conditions such as delirium where malnutrition is a common trigger.
- **Measuring obesity in older people:** The use of BMI to define obesity in older people is limiting and should not be relied upon. Alternatives to BMI such as a combination of BMI with another measure (e.g. waist circumference), replacing height with arm span, hip circumference or leg length, should be considered.
- **Nutrition and ageing:** A broader and more structured approach to nutrition in older people, through the new collaboration, presents an opportunity to strengthen WHO's work, including its technical guidance. The ICOPE guidance, for example, could be expanded to include nutritional care through assessment and management of overweight and obesity in older people, in addition to undernutrition.

WHO's new initiatives on ageing and health

Actions for CCHA

- EuGMS will support WHO in the development and dissemination of integrated primary health services and LTC by defining the role of the geriatrician and training the care workforce on the ICOPE approach.
- Raise awareness on undernutrition among older people by providing data on prevalence across countries.

Actions for WHO

- Build the evidence on fracture prevention and assessment tools applicable in LMICs.
- Develop a document defining the role of the geriatrician in collaboration with EuGMS and other stakeholders.
- Consider expanding the scope of nutritional work to address nutritional quality and hydration.

CCHA secretariat facilitating a meeting in Geneva, Switzerland, 2023

Panel 2.
Musculoskeletal health

The second panel focused on musculoskeletal health and included four presentations:

- Overview of musculoskeletal health for older people
- WHO guideline for the non-surgical management of chronic primary low back pain in adults in primary and community care settings
- WHO Package of interventions for rehabilitation
- Prevention of loss of muscle mass and function.

WHO Resources for Panel 2

- WHO guideline for the non-surgical management of chronic primary low back pain in adults in primary and community care settings
- Rehabilitation 2030 Initiative
- Package of interventions for rehabilitation
- Basic rehabilitation package clinical resource – information sheet for countries

Overview of musculoskeletal health for older people

Musculoskeletal health refers to the performance of the locomotor system, comprising intact muscles, bones, joints and adjacent connective tissues *(6).* It is a critical component of intrinsic capacity (especially for locomotor capacity) and functional ability (especially meeting basic needs, being mobile, contributing). Musculoskeletal conditions are the leading contributor to disability worldwide, with low back pain (LBP) being the single leading cause of disability in 160 countries. For people aged 70 and over, musculoskeletal conditions account for 17.19% of YLDs per 100 000 globally and are either the first or second cause of disability in all regions *(7).*

Despite the prevalence and impact of musculoskeletal conditions around the world, few Member States prioritize musculoskeletal health in policies, strategies or action plans *(8).* Responding to the burden of disease attributed to these conditions will require action at clinical, service and system levels to promote intrinsic capacity and functional ability (e.g. promotion of regular physical activity, prevention and reduction of obesity, prevention of injuries, effective early treatment, management of pain, and provision of effective and timely rehabilitation).

Key discussion points

- **Importance of musculoskeletal health in LTC:** Given the physical demands of providing LTC and support, musculoskeletal conditions can be common in caregivers, both paid and unpaid. Caregivers need training in how to protect and improve their musculoskeletal health, particularly in avoiding injury. Older people receiving LTC also require services to improve their locomotor capacity and maintain their musculoskeletal health.
- **Taking a life course approach:** Preventive services and support are needed across the life course, starting at younger ages and shifting from a disease-oriented towards a capacity-oriented approach.
- **Training health and care workers:** Different cadres of the health and care workforce, beyond physiotherapists, must be trained and included in musculoskeletal health services.

WHO guideline for the non-surgical management of chronic primary low back pain in adults in primary and community care settings

Low back pain is the leading cause of disability globally. In 2020, approximately 1 in 13 people (619 million people) experienced LBP, a 60% increase from 1990 *(9)*. The impacts can be significant, including mobility challenges, depressive symptoms and UI *(10)*. Chronic primary LBP refers to pain that lasts for more than 3 months that is not due to an underlying disease or other pathology. It is estimated to account for 90% of cases of LBP presentation in primary care and has wide-ranging impacts for individuals, families, communities and health systems *(11).*

During the 2023 CCHA meeting, WHO released a new guideline for non-surgical management of chronic primary low back pain in adults in primary and community care settings. The guideline targets health workers of all disciplines, and public health programme and system managers. It provides 10 evidence-based interventions that should be used as a part of routine care and recommends against the use of others (14 interventions).

Key discussion points

- **Opportunities:** The interventions detailed in the guideline could be integrated into the ICOPE approach, as the management of chronic LBP requires an integrated, person-centred approach.
- **Challenges:** Inappropriate diagnostic imaging and prescription, particularly for older people, pose challenges regarding health care resources and must be tackled. There remains a lack of high-quality evidence on interventions, particularly for older people.
- **Next steps:** An implementation guide that includes care pathways, is needed to ensure the guideline can be adopted into clinical practice. The difficulty of diagnosing chronic primary LBP, excluding in underlying conditions (e.g. vertebral fracture), especially for older people, is recognized. Member States will require support to make recommended interventions available and accessible at PHC level as part of universal health coverage (UHC).

WHO Package of interventions for rehabilitation

In 2017, WHO launched the Rehabilitation 2030 Initiative to integrate rehabilitation as a core component of health systems. In 2023 the WHA endorsed a resolution on strengthening rehabilitation *(12)* that calls for the expansion and integration of rehabilitation in health systems as part of UHC. The importance of rehabilitation as a strategy for healthy ageing was noted.

Following the WHA, WHO launched the *Package of interventions for rehabilitation* (PIR), targeting ministries of health, service planners and HCWs. The PIR aims to support the planning, budgeting and integration of interventions for rehabilitation into health systems. It provides information on:

- essential and evidence-based interventions for rehabilitation for 20 common health conditions with high levels of associated disability across seven disease areas;
- resources needed to support rehabilitation (assistive products, equipment, consumables); and
- human resource requirements.

The PIR includes musculoskeletal conditions: LBP, osteoarthritis, rheumatoid arthritis, sarcopenia, fractures and amputations. It is complementary to the *WHO guideline for the non-surgical management of chronic primary low back pain in adults in primary and community care settings*. It is recommended that both documents are used to inform decision-making for defining packages of care for people with LBP. Different methodologies were used to develop the two documents, in line with WHO approaches. While the selection of interventions for the PIR was informed by evidence from existing high-quality clinical practice guidelines, the LBP guideline evaluated the benefits and harms of a broader range of interventions, and so provides recommendations both for and against interventions. The LBP guideline also provides specific recommendations applicable for older people.

The next step for WHO's work on rehabilitation is development of the *Basic rehabilitation package clinical resource* – guidance on providing prioritized interventions for rehabilitation in PHC settings. It will provide guidance on low-cost, high-impact and evidence-based interventions for rehabilitation that can be easily, safely and effectively delivered by existing workforces in PHC settings, including low-resource settings. This basic package will provide interventions that could potentially be integrated in the ICOPE approach.

Key discussion points

- **Inclusion of age and gender:** The PIR does not make specific recommendations for different age groups or genders. Given that older people comprise a significant proportion of people requiring rehabilitation, consideration of older people's specific needs is important.
- **Accessibility of rehabilitation services:** Services should be available at the PHC level, close to where people live. Capacity building of HCWs at PHC level will be needed.
- **Rehabilitation and intrinsic capacity:** The extent to which current evidence that forms the basis of the PIR includes a sensitivity analysis on rehabilitation interventions for those who have significant loss of intrinsic capacity, including those requiring LTC services, is unclear and more evidence is needed.

Prevention of loss of muscle mass and function

Age-related loss of muscle mass, strength and function increases the risk of complications such as loss of mobility and independence, falls and fractures, disability, metabolic disorders and mortality. Loss of muscle mass should be prevented and managed to the greatest extent possible, including through regular physical activity and nutritional interventions, particularly increasing protein intake. Personalization of physical activity programmes, multicomponent interventions, and intergenerational and community-based programmes all support adherence and sustainability of physical activity in older people. An enabling environment is also critical.

Recognizing the need to address this issue, the National Institute on Aging (United States) held a workshop in 2022 on the "Development of Function Promoting Therapies" with around 400 global attendees *(13).* The workshop produced several statements and recommendations for physical activity and nutritional interventions for older people. These included:

- Physical activity remains the most effective intervention in older age, that can reduce the onset of disability by 17% and improve quality of life.
- Combining functional training with behavioural strategy and nutrition interventions may lead to greater improvements in measures of physical function including muscle strength in older people.
- Epidemiological studies show muscle strength and mass can be accurately measured in older people.
- Protein intake and muscle strength and function in older people are complex. Amounts and types of protein, timing of intake, hormonal status and metabolic state require further research.
- The goal should always be to enhance older people's health, intrinsic capacity and functional ability, independence and quality of life.

Key discussion points

- **Validity and feasibility of "gait speed" for the screening of muscle function:** The ICOPE screening tool includes the chair rise test as a test for lower extremity muscle weakness, as a proxy of locomotor capacity. Gait speed can be considered as a measure of muscle function if evidence demonstrates sufficient sensitivity and specificity for its use in screening. The ICOPE approach and its tools are intended for adaptation to local context, and the test to be used should take into account the setting, feasibility and safety of conducting tests.
- **Supporting increased physical activity in older people:** Strategies to ensure adherence to exercise regimes are needed. This includes strategies that promote age-friendly cities and communities, address loneliness and isolation and tackle ageism. The development of such strategies may involve policy-makers, patient organizations, communicators and the general public.
- **Country examples:** In **China**, with the support of integrated care managers implementing the ICOPE approach, older people organize their own physical activity programmes and monitor adherence. The programmes often have a peer support element, are part of a social prescribing approach, and have proved successful. There is a concern that levels of physical activity have decreased in **Japan** during the last three years due to COVID-19, an issue that needs to be addressed *(14).* **Ireland** takes a multisectoral, life course approach to promoting physical activity *(15).* Recognizing the importance of enabling environments, emphasis has been given to how communities are designed, including lighting that enables people to feel safe to go out after dark

and the conversion of disused spaces into areas for physical activity. Adapting the approach to public health funding has also been key, particularly encouraging the use of resources that benefit the wider community. Reaching older people with significant loss of intrinsic capacity remains a challenge.

- **Importance of cross-sector collaboration:** An increased focus on working across groups and topics, e.g. ageing, rehabilitation, NCDs and disability, is important. This can support knowledge sharing, greater understanding of approaches to support healthy ageing, and develop action from available but underexplored opportunities.

Musculoskeletal health

Actions for CCHA

- ⊕ Consider integrating musculoskeletal interventions into LTC services and share examples.
- ⊕ Build evidence on physical performance tests to offer alternatives to capture declines in locomotor capacity in different settings.
- ⊕ Take multisectoral actions to address the issue of musculoskeletal health (e.g. age-friendly environments, ageism, social isolation and loneliness).
- ⊕ Raise awareness among older people and caregivers of how to prevent declines in locomotor capacity.

Actions for WHO

- ⊕ Adopt a life course approach to any musculoskeletal guidance, recognizing issues earlier in life affect musculoskeletal health in older age.
- ⊕ Raise awareness about polypharmacy and appropriate prescription for musculoskeletal pain in older people.
- ⊕ Further discuss how LBP care can be integrated into the ICOPE handbook.
- ⊕ Consider providing care pathways on musculoskeletal pain that include guidance on diagnosis, management and referrals, building on chronic primary LBP guideline.
- ⊕ Strengthen the collaboration and coordination across technical units (Ageing and Rehabilitation) to provide an integrated source of guidance on musculoskeletal health.

ICOPE awareness campaign organized by Ministry of Health Kuwait in Kuwait city, Kuwait, 2023

Panel 3.
Implementation of the ICOPE approach

Panel 3 focused on the implementation of integrated care for older people. It was split into three sections, starting with presentations providing a global overview, then moving on to experience of the implementation of the ICOPE approach at systems level, followed by clinical and services levels:

- Progress on delivering person-centred integrated care and primary health services responsive to older people
- Adaptation of ICOPE approach to the local context
- Implementation of the ICOPE approach at system levels (examples from Botswana, Cambodia, France, Qatar, Sri Lanka; critical reflection from Ireland)
- Implementation of the ICOPE approach at clinical and service levels (examples from China, France, Kuwait, Nepal, Singapore).

WHO Resources for Panel 3

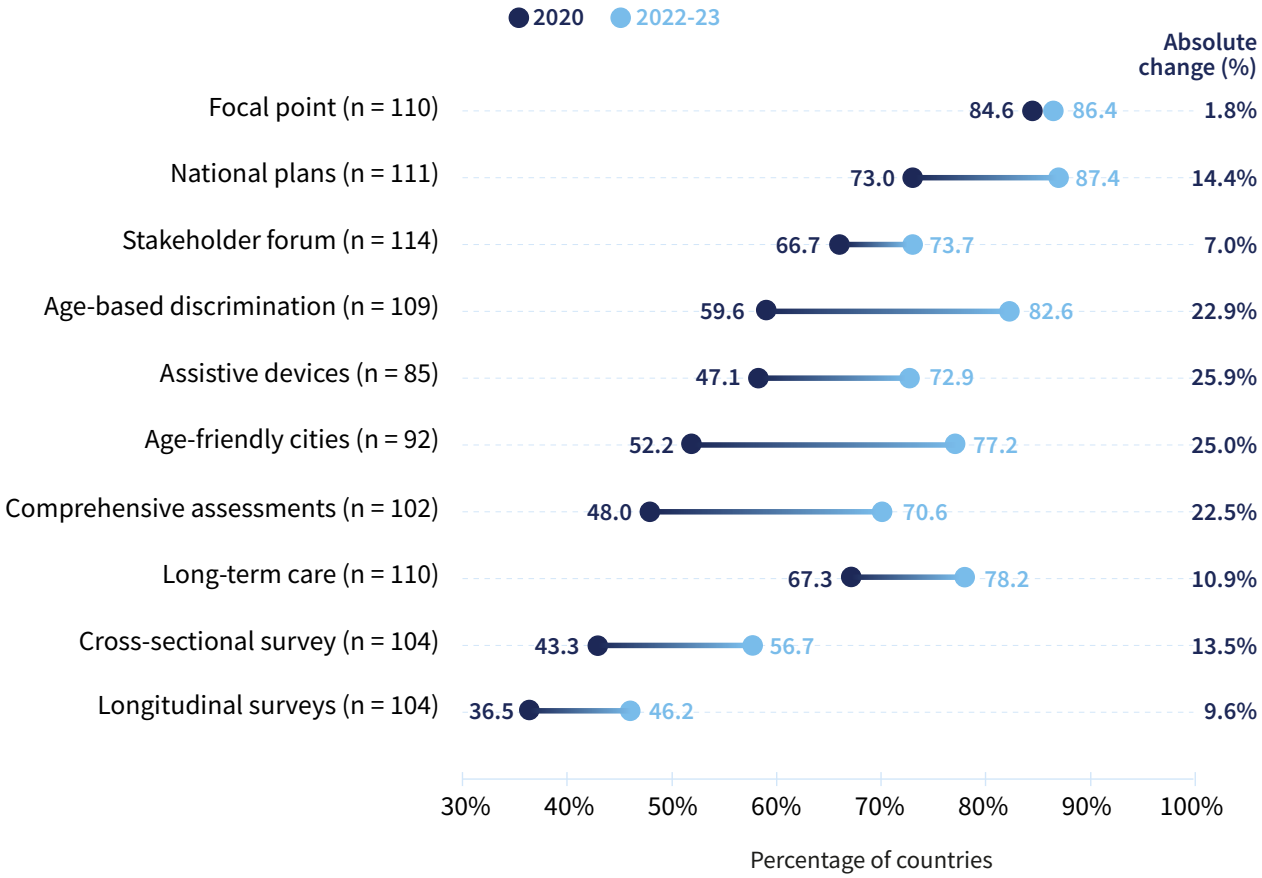
- Progress report on the United Nations Decade of Healthy Ageing, 2021–2023
- WHO Ageing data portal: Ageing – Integrated care for older people
- Integrated care for older people (ICOPE) implementation pilot programme: findings from the 'ready' phase
- Immunization Agenda 2030: A Global Strategy To Leave No One Behind

Progress on delivering person-centred integrated care and primary health services responsive to older people

In 2023, WHO published the first progress report on the UN Decade of Healthy Ageing *(2).* The report has three purposes: to assess progress made in implementing the Decade; to present examples of initiatives that are contributing to the Decade; and to inspire continued collaboration and implementation. The content of the report is drawn from two processes: a process evaluation survey undertaken with Member States focusing on the 10 national progress indicators; and a call for submissions on initiatives that are contributing to the Decade.

The report notes that increases have been observed across all the national progress indicators (Fig. 3). For four indicators > 20% increase was reported, including countries reporting having policies to support comprehensive assessments of health and social care needs of older people (from 48% to 71% between 2020 and 2023), and legislation or regulations that support older people's access to assistive devices (47% to 73% between 2020 and 2023).

Fig. 3. Changes in Member States reporting against national progress indicators, 2020 and 2023



Source: Progress report on the United Nations Decade of Healthy Ageing, 2021–2023; WHO; 2023.

Note: All data based on countries that responded in full to survey, not all countries globally.

In addition to the data on the national progress indicators (Fig 3), other findings from the Decade progress report were shared at the CCHA meeting, focusing on action area three of the Decade: delivering person-centred integrated care and primary health services responsive to older people. They included:

- 64% of reporting countries (N = 131) said they have plans to strengthen their geriatric and gerontology workforce.
- 57% (N = 131) reported having national guidelines for organizing geriatric care and training and 53% (N = 136) have a national competency framework for the geriatric and gerontology workforce.
- 80% (N = 131) reported having free-of-charge outpatient services for older people; 73% (N = 131) said they provide pharmaceutical products and other medical supplies free of charge; and 66% (N = 131) reported providing free-of-charge assistive products, with all three indicators focused specifically on services in the public sector.
- Across all indicators, rates were lowest in lower income countries.
- The ICOPE approach provides a useful tool for the implementation of integrated care for older people, with widespread interest from across the world.
- Member States are making progress on integrated care, but with only 27% (N = 132) reporting having adequate resources to take action forward, progress will likely be hindered.

Key discussion points

- **Moving from policy to practice for better outcomes:** The first progress report is focused on processes and does not address availability or quality of services for older people. The next report will have a greater focus on outcomes. The process evaluation survey used for the first report was self-reported by Member States, a limitation highlighted in the report.
- **Connecting and collaborating during the Decade and beyond:** Work undertaken as part of the Decade needs to focus on connections with other intergovernmental processes and commitments, particularly with a view to sustainability. Existing complementary initiatives (e.g. the UN Decade of Action on Nutrition, Immunization Agenda 2030) present opportunities for collaboration, and current processes, for example, the Summit of the Future, should include healthy ageing to ensure the agenda is taken forward beyond 2030.

Adaptation of ICOPE approach to the local context

Since the ICOPE guidance was published in 2019, countries have been encouraged to adapt the approach to their context, considering their local health care system, service delivery mechanisms, health financing, and workforce composition and capacity. It has been observed that, as countries have begun their engagement with the ICOPE approach, many have prioritized training for HCWs. Sometimes, adaptation of the screening and assessment tools was conducted without adequately considering the contextualization of the ICOPE approach as a whole. Indeed, for effective adaptation and implementation, a critical initial step should be to identify existing resources and mechanisms to enable the reorientation of services and pathways in the country.

When adapting the ICOPE approach, it is crucial to engage all stakeholders, including HCWs, across disciplines, different ministries, local authorities, civil society organizations (CSOs), volunteers and, most importantly, older people and their family members. Co-design with older people is crucial at each step of the adaptation process.

The initial step of adaptation, identifying resources, mechanisms and needs, should focus on older people and HCWs through situation analysis. It is important to consult with older people to understand their priorities and needs, alongside health and well-being at a population level. Conducting key informant interviews and surveys with older people can be a useful process. When focusing on HCWs, to understand existing resources and capacities, the following items are important to consider:

- Who are the HCWs in local organizations (e.g. community health workers, CSOs, older people's associations, religious groups, intergenerational groups, academic associations)?
- Capacity of HCWs (time, knowledge, skills).
- Current training on caring for older people and need for capacity building.
- Roles and responsibilities of different HCWs on scope of services (what, when, where, by whom).
- Availability of multidisciplinary team and local network for health and social care (horizontal in the community and vertical from primary to specialized care).

To identify and understand existing care services and pathways, the following issues can be considered:

- Availability, accessibility (i.e. cost, distance, transportation, age friendliness) and acceptability of health and care services and programmes for older people and their caregivers, including assistive products and social support at different settings.
- Existing care pathways, including first point of contact with HCWs and referral mechanisms.
- Remuneration for services including whether services are part of a service package (UHC).

- Entry points to integrate the ICOPE approach into current service delivery (e.g. NCD clinic, mobile clinic, home visit for maternal and newborn care, outreach mechanism in the community, vaccination).
- Infrastructure to implement care pathways (e.g. place, diagnostic instruments, data collection and sharing platform).
- Available screening and assessment tools for care for older people.

The next stage in adapting the ICOPE approach is to develop care pathways specific to the local context. Key considerations include: understanding available and acceptable screening and assessment tools that focus on intrinsic capacity and functional ability; how to adapt care pathways into existing, routine practice and service delivery; how systems of service delivery might need to be strengthened to support effective implementation of the ICOPE approach; what HCWs training is needed and how the workforce can be incentivized to implement the ICOPE approach; how to raise awareness of the importance of integrated care with older people and the wider public; how to develop a pilot study to test the feasibility, acceptability and sustainability of the approach; and how to monitor and evaluate implementation.

Key discussion points

- **Working with the private sector:** The private sector plays a key role in health and care and is increasingly engaged in care for older people. There are private entities at all levels of health systems, and their roles and activities may include direct provision of health care, management of health care institutions, manufacturing of health care goods and services, and financing of health care products and services *(16).* Private sector entities are often engaged in the provision and management of LTC. Private sector actors need to be incentivized to engage with activities to ensure integrated care for older people, and must be appropriately monitored, assessed and regulated. Further thinking on how to achieve this is needed.
- **Implementation challenges in LMICs:** HCW capacity presents a major challenge for implementation of the ICOPE approach, especially considering how time-consuming an in-depth person-centred assessment with an older person might be. However, the first phase of the ICOPE pilot programme has shown strong buy-in by older people and motivation and willingness of HCWs, including in LMICs. These are opportunities that can be capitalized on.
- **Cost-benefit analysis of ICOPE:** An economic case for investment could provide an entry point for discussion with Member States. The ICOPE pilot in France includes the provision of financial support and coordination to HCWs for their engagement in the screening and assessment of older people; the pilot project results are expected in 2025. The pilot in China showed that compared with 6 months before joining the pilot, 7.7% of participants (N = 469) reduced their number of hospital visits and 14.3% spent less on health care during the 6 months of ICOPE intervention *(17).*
- **Monitoring implementation of ICOPE:** Indicators are needed to measure the engagement of older people. Ongoing work to develop indicators for the ICOPE approach and to monitor the implementation of the Decade will inform this need.

Implementation of the ICOPE approach at system levels

Country representatives from Botswana, Cambodia, France, Qatar and Sri Lanka shared their experiences from piloting the ICOPE approach at the systems level, and Ireland provided a critical reflection. Then followed a focus on the clinical and service levels with presentations from China, France, Kuwait, Nepal and Singapore. The contexts differ significantly (Table 1), but all the countries are committed to promoting healthy ageing and delivering integrated care for older people.

Table 1. Demographics in a selection of countries implementing the ICOPE approach

	Botswana	Cambodia	France	Qatar	Sri Lanka	Ireland	China	Kuwait	Nepal	Singapore
Population (x 1000)	2630	16 768	67 971	2695	22 181	4967	1 412 175	4269	30 548	5637
% of people > 60 years old	6.3	10.4	28.6	3.7	17.6	20.9	20.5	11.0	9.2	25.0
Life expectancy at age 60 (years)	16.2	17.7	25.3	19.5	20.8	24.2	21.1	24	18.0	25.5
Healthy life expectancy at age 60 (years)	11.8	13.2	19.7	14.2	15.7	18.6	15.9	17.8	13.3	20.0

Sources: United Nations Population Division. World Population Prospects: 2022; WHO ageing data portal.

© Village Health Support Group, Battambang Province/Mrs. Roeun Chanly

Vision screening conducted by a village support group in Battambang, Cambodia, 2023

Box 1. Botswana

In 2022, Botswana launched its healthy ageing strategy, developed with the support of WHO, and informed by a situational analysis on the health of older people. To support the implementation of the strategy, the Ministry of Health has begun work to implement the ICOPE approach starting with the development of guidelines for integrated care for older people. The guidelines are aimed at providing support to HCWs on the detection of impairments and management of intrinsic capacity.

Situation of older people and healthy ageing

- 70% of older people live with NCDs.
- Cognitive impairment represents a major issue, often leading to stigma, including accusations of witchcraft against older women, especially those with dementia.
- HIV prevalence for adults aged 15 and over is 19%. 30% of people living with HIV are aged 50 and over.
- Low levels of care-seeking behaviour due to the perception that symptoms are part of "normal ageing".
- 91% of older people live below the poverty line.
- Lack of knowledge on ageing and ageist attitudes among HCWs.
- Over 50% of older people live in rural areas, with limited access to safe water, sanitation and electricity.
- The Botswana Health and Active Ageing Program Strategy, 2021–2026, has the ICOPE approach as a mechanism for its implementation.

Adaptation and pilot process for the implementation of the ICOPE approach

- Botswana's ICOPE guideline and health monitoring tool were developed with inputs from older people.
- The health monitoring tool provides a standardized assessment for HCWs in both the public and private health sectors.
- Botswana's ICOPE guideline includes specific sections on conditions of special interest for the country: oral health, sexual health and UI.
- Training on the ICOPE approach was conducted with national- and district-level HCWs in 2023.
- Implementation of the ICOPE approach at national level was launched in 2024.

Challenges

- Limited funds for care for older people.
- Stigma and discrimination experienced by older people living with HIV.
- Fragmented care for older people with HIV; mostly operated by the private sector.

Enablers

- The establishment of a multisectoral committee involving different ministries.
- Role of a multidisciplinary technical working group in adapting the ICOPE approach to the Botswana context.

Next steps

- Finalization of national policy for older people.
- Adoption of a life course approach to address NCDs, HIV and early detection of declines of intrinsic capacity.
- Combating ageism through the implementation of the ICOPE approach with community mobilization.

Sources:

Situational analysis of ageing and health of older adults in Botswana; Ministry of Health and Wellness, Government of Botswana, Gaborone; 2019. Botswana to be a better place to grow old; Gaborone: World Health Organization; 2022 (https://www.afro.who.int/countries/botswana/news/botswana-be-better-place-grow-old).

Global data on HIV epidemiology and response; Geneva: UNAIDS; 2024 (AIDSinfo).

Box 2. Cambodia

Cambodia is in the early stages of its engagement with integrated care for older people but has been focusing on ageing for some time, with the development its National Ageing Policy 2017–2030. The policy provides a platform for increased engagement on healthy ageing and integrated care.

Situation of older people and healthy ageing

- The National Ageing Policy 2017–2030 mapped the pace of population ageing, demonstrating the need for integrated care.
- NCDs are major causes of disability. Sensory organ and musculoskeletal diseases are the leading cause of YLDs.
- Prevalence of oral conditions is high. 22% of people aged 65–89 are edentulous.
- More than 80% of older people live in rural areas.

Adaptation and pilot process for the implementation of the ICOPE approach

- Establishment of a technical working group on ageing and health to support the pilot on the ICOPE approach implementation.
- Development of a training curriculum on the ICOPE approach for HCWs, including an additional section on oral health.
- Delivery of training of trainers on the ICOPE approach for 22 doctors and nurses from three provinces (Kampong Cham, Kampong Speu and Kampot).
- Training 200 HCWs from the same three provinces.

Challenges

- Limited awareness and support for integrated care in the community.
- Limited accessibility and availability of specialized services for older people.
- Sustainability (finance and human resources).

Next steps

- Conducting a baseline assessment of the situation of older people.
- Translation of the ICOPE screening tool for PHC into Khmer.
- Developing pilot sites for the ICOPE approach implementation in three operational districts: Moung Reussey (ICOPE screening at health centres); Battambang (health centre staff provide mobile screening at village level); Sangke (village health support groups trained to conduct screening).
- Integration of ICOPE approach into minimum package of activity and integrated outreach guidelines.
- Development of national ICOPE monitoring and evaluation framework.

Sources:

Ageing and migration in Cambodia; Ministry of Planning, Royal Government of Cambodia; 2013 (Ageing&MigrationinCambodia26Dec2013.pdf (unfpa.org)).

National Ageing Policy 2017–2030; Royal Government of Cambodia; 2017.

National multisectoral action plan for the prevention and control of noncommunicable diseases 2018-2027; Ministry of Health, Royal Government of Cambodia; 2018.

Global Burden of Disease Study 2019; Seattle: Institute of Health Metrics and Evaluation; 2020.

Box 3. France

The most extensive pilot of the ICOPE approach is being conducted in France. In 2020, the Ministry of Health and Prevention published its national healthy ageing strategy 2020–2022 for preventing loss of autonomy. The implementation of the ICOPE approach in PHC was included as a key activity. Article 51, France's social security financing law, passed in 2018, provided a source of funding for the pilot project, with its focus on supporting the testing of new and innovative health programmes.

Situation of older people and healthy ageing

- National healthy ageing strategy 2020–2022 included integrated care as a key focus.
- Commitment to gradually move from a disease- to a capacity-oriented approach.
- Collaboration and coordination of two ministries (Ministry of Health and Prevention and Ministry of Solidarity and Families).

Adaptation and pilot process for the implementation of the ICOPE approach

- National pilot to adapt the ICOPE approach and evaluate the most suitable mechanisms to deliver integrated care at PHC level and ensure financial sustainability.
- Establishment of multisectoral national coordination project team.
- Funding for the screening and assessment of intrinsic capacity at PHC (budget €8.07 million).
- 55 000 older people (> 60 years) and 13 organizations from nine regions enrolled in the pilot with the results expected in 2025.

Challenges

- Mobilization of HCWs at PHC level.
- Need for capacity building of HCWs to deliver in-depth assessment of intrinsic capacity.
- Operationalization of digital tools and information system.

Enablers

- Older people's buy-in for the ICOPE approach.
- Establishment of a community of practice to share experience and resources by the Agence nationale d'appui à la performance.

Next steps

- Independent external evaluation will assess the feasibility, effectiveness/efficiency and reproducibility.
- Discussion on how to scale up by a technical committee and a strategic council on innovation in health.
- Identification of the most efficient mechanism to reach older people who are most at risk.
- Discussion of the national scale up of the ICOPE approach in the "ageing well" law.

Sources:

Vieillir en bonne santé: une stratégie globale pour prévenir la perte d'autonomie 2020–2022; dossier de presse; Ministre des Solidarités et de la Santé; 2020 (https://sante.gouv.fr/IMG/pdf/dossier_de_presse_vieillir_en_bonne_sante_2020-2022.pdf).

Order of 19 July 2022 amending the Order of 28 December 2021 relating to the experimentation "Programme for the prevention of loss of autonomy based on multidimensional screening for age-related functional decline (ICOPE)": https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000046083020

Expérimentation d'un programme de prévention de la perte d'autonomie axé sur le dépistage multidimensionnel du déclin fonctionnel lié à l'âge (ICOPE); Legifrance; 2022 Ministère des solidarités et de la santé – Direction générale de la santé (DGS), Direction Générale de la cohésion sociale (DGCS), Direction générale de l'organisation des soins (DGOS) https://sante.gouv.fr/IMG/pdf/icope_cahier_des_charges_cpts_limousin_paca_071022.pdf.

Box 4. Qatar

In Qatar, a multidisciplinary team involving specialists in ageing, ophthalmology, audiology, cognition, and falls, as well as social workers and physiotherapists, came together to consider the ICOPE approach and how it might be applicable in the country. To facilitate the implementation of the ICOPE approach, functionality was added to the electronic medical records system. This was an early focus of the work.

Situation of older people and healthy ageing

- High prevalence of NCDs.
- The National Health Strategy 2018–2022 includes "healthy ageing" as one of the priorities.

Adaptation and pilot process for the implementation of the ICOPE approach

- Adaptation of the ICOPE screening tool.
- Integration of data on intrinsic capacity into the electronic medical records system.
- Training of HCWs at PHC level.
- The launch of an ICOPE clinic to conduct screenings and assessments of intrinsic capacity. The clinic is open daily and five new older people are enrolled in the programme every week.
- Development of a care coordinator role to support the multidisciplinary team involved in the integration of care at the PHC level.
- Development of a training course for family health doctors ("geriatrics for non-geriatricians") to enable them to support the implementation of the ICOPE approach.
- Initial screening results (n = 100, mean age 64.7 years) show 30% of older people do not present intrinsic capacity impairments, 34% have a positive screening for one intrinsic capacity domain, 20% for two and 13% for three.
- At both screening and assessment, the highest rates of impairment are seen in vision followed by mobility and nutrition.

Challenges

- Language barriers between nurses (most do not speak Arabic) and older people during screening.
- People screening positive for possible cognitive impairment often refuse further assessment and intervention, most likely due to stigma.

Enablers

- The development of the care coordinator role to support the multidisciplinary team and ensure follow-up care and timely referral.

Next steps

- Extend ICOPE clinic model to more PHC centres.
- Build the capacity and skills of PHC and community doctors, followed by nurses, to expand the trained workforce.
- Share knowledge and experience based on the implementation at ICOPE clinics.
- Scale up the ICOPE approach at national and regional levels.

Sources:

Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019; Lancet. 2020;396(10258):1204-1222. doi: 10.1016/S0140-6736***(20)***30925-9 (https://pubmed.ncbi.nlm.nih.gov/33069326/).

National health strategy 2018–2022: our health, our future; Ministry of Public Health, State of Qatar; 2018 (https://andp.unescwa.org/sites/default/files/2020-10/National%20Health%20Strategy%202018-2022.pdf).

Box 5. Sri Lanka

Since the start of the UN Decade of Healthy Ageing, the Sri Lanka Ministry of Health has undertaken a situation analysis to better understand the relevance of the Decade framework for the country. Qualitative and quantitative methods were used, including in-depth interviews, focus group discussions, analysis of records and existing national survey reports. The analysis demonstrated a need for integrated care for older people. The importance of considering how the integration of care can be conducted across Sri Lanka's existing services and mechanisms (the health delivery plan for older people and PHC reforms) has been considered.

Situation of older people and healthy ageing

- 79% of older people live in rural areas.
- High prevalence of disability, especially vision, hearing and mobility in older people.
- A health delivery plan for older people (2017) identified health care institutions and community-based institutions and the services for older people, and demand for services to determine gaps.

Adaptation and pilot process for the implementation of the ICOPE approach

- Identification of health services and facilities to support the ICOPE approach.
- Delivery of training of trainers on the ICOPE approach with the adapted trainers' manual.
- Adaptation of ICOPE trainers' manual for physicians by the WHO Regional Office for South-East Asia.
- Delivery of training for multidisciplinary HCWs on the screening of intrinsic capacity at PHC, with 200 trained by August 2023.
- Piloting of the ICOPE approach in existing health service delivery at community level in 6 rural districts.
- Integration of the ICOPE approach with other community and PHC services.
- Mobilization of social service officers and elder rights promotion officers to facilitate the integration of health and social care.
- Development of a list of priority assistive products.

Challenges

- Limited understanding of ageing among HCWs.
- Sustainability, particularly in terms of financial resources.
- Monitoring and evaluation capacity.

Enablers

- Integration of the ICOPE approach into national funding systems. Initial implementation of the ICOPE approach was supported by WHO. It has since been identified as an item within the state sector health budget allocation, with ICOPE activities now being funded by the state sector.
- Existing health and social care roles to support implementation (field officers, elder rights promotion officers and social service officers).

Next steps

- Scale up of the ICOPE approach to all 25 districts of Sri Lanka.
- Multistakeholder capacity building, including policy-makers.
- Finalization of indicators to monitor the implementation of the ICOPE approach.
- Improved coordination and integration between community services and PHC.
- Promotion of a life course approach integrating different services (NCDs, mental health).

Sources:

Reorganising primary health care in Sri Lanka; Ministry of Health, Nutrition and Indigenous Medicine; 2017 (https://www.hsep.lk/images/Downloads/Publications/ReorgPrimaryHealthCare.pdf).

Ageing population in Sri Lanka: emerging issues, needs, and policy implications; UNFPA Sri Lanka and Department of Census and Statistics, Sri Lanka; 2017 (https://srilanka.unfpa.org/en/publications/ageing-population-sri-lanka).

Census and population and housing; Department of Census and Statistics Ministry of Finance and Planning; 2012 (http://www.statistics.gov.lk/Resource/en/Population/CPH_2011/CPH_2012_5Per_Rpt.pdf).

National elderly health care policy for Sri Lanka; Ministry of Health, Nutrition and Indigenous Medicine; 2017 (https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/sri_lanka/srl_natioanl_elderly_health_policy.pdf).

Ireland: critical reflection

Under Ireland's national health policy, a reform of health and social care is taking place. Through these reforms the provision of care and support for older people has been significantly enhanced. Ireland has the aim of putting in place an integrated care pathway across every acute hospital and community health care area in the country. To achieve this, Ireland is implementing its Integrated Care Programme for Older People (ICPOP). ICPOP is adapted from the WHO ICOPE approach and seeks to ensure older people with complex care needs can access care quickly at/near home through care pathways specifically designed for older people and targeting frailty, falls and dementia.

As of October 2023, there are 24 ICPOP teams, and it is envisaged that in 2024, there will be 30 covering the whole country. Ireland has faced challenges in its implementation due to workforce shortages alongside increased demand. To guide the implementation of integrated care, several reviews have been undertaken. A 2018 review of health service capacity to forecast future capacity requirements included services for older people for the period up to 2031 *(18)*. An update to this review, currently under way, will forecast needs up to 2040.

A workforce advisory group was established in 2022 to address the critical shortage in the care workforce. It made recommendations on recruitment, pay and conditions of employment, and integration of social care with health care. Over 1000 new permits for care workers from outside the European Economic Area (Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands (Kingdom of the), Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden) have been made available *(19).*

Key discussion points

- **Buy-in for integrated care:** Pilots of the ICOPE approach have shown both the possibility of achieving buy-in for integrated care from the national policy level to the community, and the impact this buy-in can make.
- **Mainstreaming ICOPE:** To ensure sustainability, it is important that integrated care for older people is mainstreamed into broader PHC and LTC processes and commitments, including towards the achievement of UHC.

Implementation of the ICOPE approach at clinical and service levels

Box 6. China

The ICOPE pilot in China is being conducted in a district of Beijing, coordinated by the Pinetree Care Group. The pilot has been presented at previous CCHA meetings and initial findings included in WHO's report *Integrated care for older people (ICOPE) implementation pilot programme: findings from the 'ready' phase*.

Situation of older people and healthy ageing

- 21% of the 3.45 million population in Chaoyang (implementation site) are aged 60 years and over.
- China's older persons' health promotion agenda, under the Healthy China Action Programme aims at increasing the number of geriatric services in China.

Adaptation and pilot process for the implementation of the ICOPE approach

- Delivery of training nationwide, via online and offline courses.
- Introduction of pre- and post-training assessments with HCWs.
- Introduction of the ICOPE approach in preventive programmes with older people in multiple provinces besides Beijing, with some focusing on rural areas.
- Extension of validation studies of additional screening and assessment tools supporting the ICOPE approach in PHC.
- Use of technology, including artificial intelligence to reach older people. Artificial intelligence is being used to empower older people and caregivers in self-care and self-management and by HCWs to digitize the development of personalized care plans.
- Preliminary results show significant improvements in nutrition, mobility, psychological domains of intrinsic capacity from the ICOPE intervention after 6 months (N = 537 vs 1611 ICOPE intervention vs control).

Challenges

- Fragmentation of care.
- Distance between older people and health services.

Enablers

- Experience gained through the initial phases of the pilot has informed subsequent phases, national and local policies.
- The establishment and training of 1800 integrated care managers, with an ongoing continued medical education programme.
- Collaboration with the Ministry of Education and the China Association of Gerontology and Geriatrics.

Next steps

- Expansion of activities in line with the national policy to support the national geriatric network.
- Increased use of technology, including training and testing of generative artificial intelligence.

Key discussion points

- **The results of the ICOPE pilot can support national policy priorities:** By offering the evidence to transform usual approaches to integrated care for older people, the results can facilitate the integration of services and reduce inappropriate or unnecessary provision.
- **The funding environment for older people's care in China:** This is expected to improve with increased investment in the development of the national geriatric network. This could support further rollout of the ICOPE approach, including using technology.
- **The importance of reaching those hardest to reach:** In the next steps of the pilot in China, actions are planned to implement the ICOPE approach in lower income areas and consideration is being given to the digital divide between urban and rural areas.

Sources:

Healthy China Initiative (2019–2030); Healthy China Action Promotion Committee; 2019 (https://www.gov.cn/xinwen/2019-07/15/content_5409694.htm).

Wang N, Liu X, Kong X, Sumi Y, Chhetri JK, Hu L et al. Implementation and impact of the World Health Organization integrated care for older people (ICOPE) program in China: a randomised controlled trial. Age Ageing. 2024;53**(1)**:afad249 (https://doi.org/10.1093/ageing/afad249).

ICOPE screening conducted as FAMILY program in Bei Huang, China

Box 7. France

As detailed previously, France has been undertaking an extensive pilot project on the ICOPE approach in PHC. Implementation began in 2019, coordinated by the Gérontopôle, University Hospital Toulouse. The aim of the pilot at the clinical level was to preserve the autonomy of older people living at home.

Situation of older people and healthy ageing

See Box 3.

Adaptation and pilot process for the implementation of the ICOPE approach (all data from ICOPE MONITOR database)

- Further dissemination and utilization of digital tools (ICOPE MONITOR and ICOPEBOT) by 10 000 HCWs and to support self-screening.
- Development of an e-learning platform for HCWs with multiple training modules on the ICOPE approach. 4900 HCWs have been trained in the screening of intrinsic capacity.
- Development of awareness raising materials targeting older people (fliers, posters, videos, webinars).
- Establishment of multistakeholder partnerships to support the design, organization and management of integrated care for older people.
- 44 000 people (mean age 74.4 years) reached through the pilot (ICOPE-CARE) in France between 2019 and November 2023.
- 73 700 screenings conducted including baseline, follow up and self-screening using the ICOPE MONITOR app.
- 5363 people (63% women, mean age 74.4 years) have had an assessment and a care plan developed.
- Cognition (51%) and hearing (47%) are the intrinsic capacity domains with most frequent impairments identified.
- Recommendations on nutrition, mobility and cognition being commonly provided.

Challenges

- Lack of training in older people's health for HCWs.
- Lack of awareness among older people.
- Recommendations made during care planning that require the intervention of a third party are less frequently followed (55%) compared with those based on self-management (70%).

Enablers

- Support from the regional health agency and Ministry of Health and Prevention.
- Provision of incentives for HCWs to implement the ICOPE approach (the costs of conducting screening and assessment of intrinsic capacity are covered under Article 51).

Next steps

- Advancements in the screening and assessment of older people with efforts to implement and follow up the care plan.
- Refining and strengthening activities based on self-assessment and use of technologies.
- Work to improve the personalized care plan with a stronger involvement of families and HCWs.
- Launch of a randomized controlled trial in 2024 aimed at exploring the cost-effectiveness of the ICOPE programme on the prevention of dependency.
- Ongoing study to assess older people's perspectives and experiences with ICOPE.
- Launch of an ICOPE monitor website to support awareness raising.

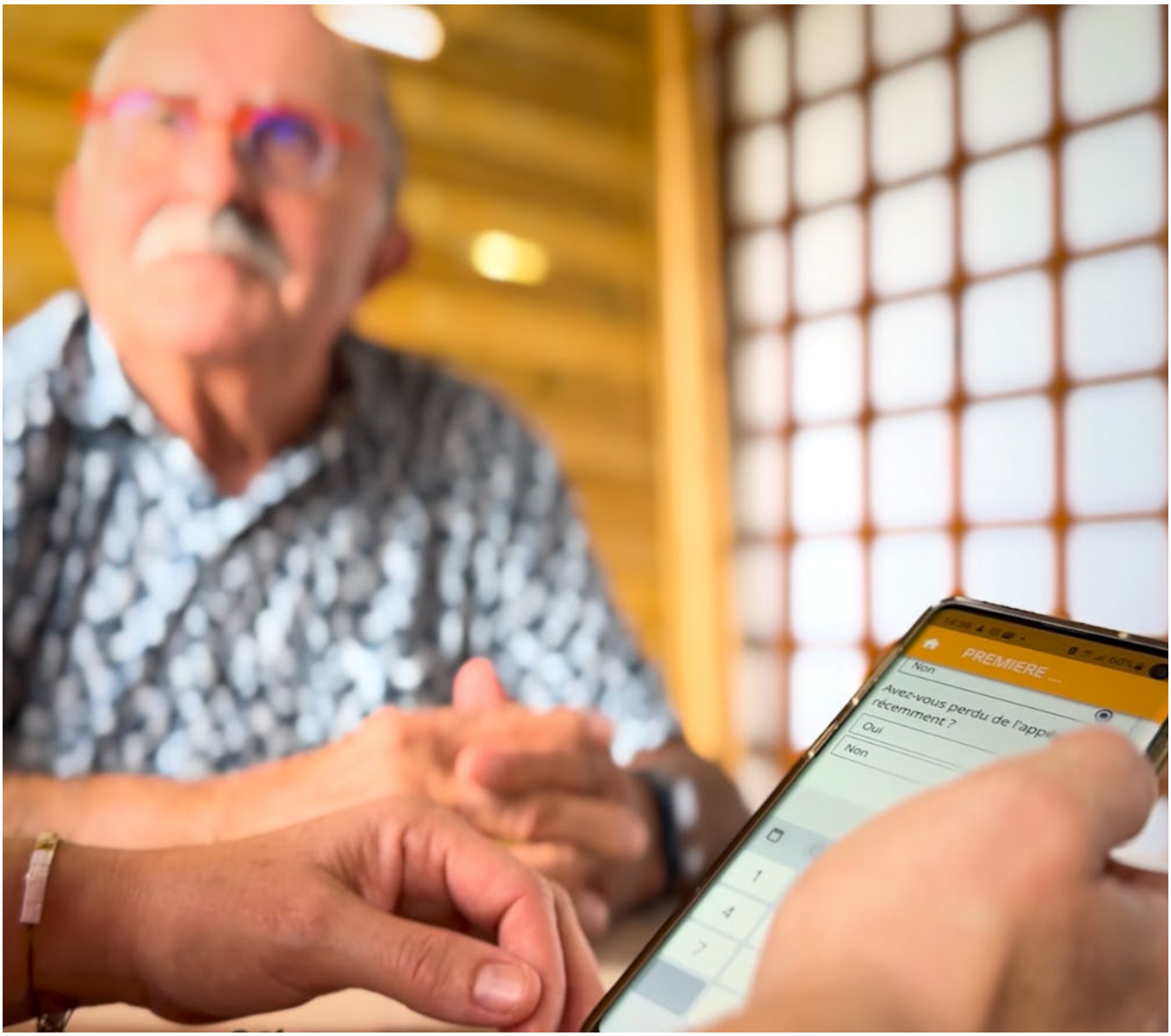
Key discussion points

- The need for research on the trajectory of intrinsic capacity in older people.
- The importance of engaging communities, for example, through collaboration with CSOs and community-based organizations.
- The availability of data from Toulouse could support the improvement of future clinical activities by informing how best to deliver personalized care plans based on the results of the intrinsic capacity assessment.

Sources:

Tavassoli N, de Souto Barreto P, Berbon C, Mathieu C, de Kerimel J, Lafont C et al. Implementation of the WHO integrated care for older people (ICOPE) programme in clinical practice: a prospective study. Lancet Healthy Longev. 2022;3(6):e394-e404. doi: 10.1016/S2666-7568(22)00097-6.

Formation à la démarche ICOPE de l'Organisation Mondiale de la Santé (https://icope-formation.com/).



ICOPE screening conducted by using ICOPEMONITOR application in Toulouse, France, 2023

Box 8. Kuwait

Kuwait has a national geriatric strategy in place that aligns with WHO's healthy ageing framework and the ICOPE approach. The Ministry of Health is currently finalizing the new geriatric strategic plan, 2024–2030, which is under approval from the higher strategic plan directorate. These strategies and plans have provided a useful starting point to achieve political commitment for implementing the ICOPE approach at the clinical and service levels, and a platform for piloting the ICOPE approach at PHC.

Situation of older people and healthy ageing

- The Minister of Health has committed to a national-level comprehensive programme that focuses on older people's needs and outcomes.
- The ICOPE approach aligns with Kuwait's national geriatric strategy in its focus on intrinsic capacity and functional ability, a person-centred approach and support for caregivers.

Adaptation and pilot process for the implementation of the ICOPE approach

- Development of national operational plan for the implementation of integrated care for older people with six pillars: situation analysis; capacity building for HCWs at PHC level; development of KPIs; digitalization of data on the ICOPE approach, including development of an app; pilot implementation and auditing; and understanding older people and caregivers' experience.
- Delivery of training of trainers on the ICOPE approach.
- Delivery of two training programmes for HCWs at PHC level during 2023.
- Implementation of the ICOPE approach in 10 pilot sites (May–September 2023) – 648 older people (aged 65 and over) screened, 343 of whom presented with possible impairments in intrinsic capacity.

Challenges

- Walk-in system at PHC centres means only screening can be offered as time is too limited for person-centred in-depth assessment. Specific appointments need to be made if assessment is required.
- Limited time for follow-up discussion.
- Referral systems require strengthening, including collaboration and coordination between PHC and specialized care.

Enablers

- National-level political commitment.
- Alignment of Kuwait's current national health strategy for the care of older adults and the upcoming geriatric strategic plan, 2024–2030 with the WHO ICOPE approach.
- Ongoing awareness raising activities on healthy ageing bringing together multiple stakeholders, including older people and caregivers.

Next steps

- Ensuring assessments based on the ICOPE approach for all those with a positive screening for intrinsic capacity impairment, through referral to existing geriatric clinics at PHC level.
- Analysis of pilot results to identify the enablers and challenges for scale up.

Sources:

National health strategy for the care of older adults in the state of Kuwait; Ministry of Health, Kuwait; 2016.

Unifying health services to care for older adults in primary health care centres (unpublished project plan).

Box 9. Nepal

In 2021, Nepal launched its national Geriatric Health Service Strategy (2021–2030) in line with the UN Decade of Healthy Ageing. The strategy has objectives to provide health promotion and preventive health services throughout the life course, including for older people; build an effective and accountable health service delivery system for older people; and strengthen and extend social health insurance for all older people. The strategy provides a platform for the implementation of integrated care at PHC level in Nepal.

Situation of older people and healthy ageing

- The National Geriatric Health Service Strategy (2021–2030) includes objectives to provide health promotion and preventive health services throughout the life course and to build an effective and accountable health service delivery system for older people.

Adaptation and pilot process for the implementation of the ICOPE approach

- Initiation of training on the ICOPE approach for HCWs.
- Development of fellowship programmes to support geriatric medicine and older persons' care.
- Implementation of the ICOPE approach as a component of comprehensive geriatric assessment in four tertiary care centres in Nepal.
- Identification of different needs and priorities among older people in different areas (urban, semi-urban, rural).
- Preliminary results indicate psychological capacity is the intrinsic capacity domain with the most frequent potential impairments, identified by screening (58–68%) (N = 428, mean age 66 years), followed by vision (20–25%).
- People in rural areas tend to be more robust, more socially connected, and have fewer clinical conditions.

Challenges

- Lack of training of HCWs in older people's health.
- The need for a flexible and adaptable approach that can respond to diverse needs and priorities.

Enablers

- National policy defining the need for geriatric outpatient and inpatient units in hospitals.
- Commitment to offer the ICOPE approach to older people admitted to geriatric units.
- Collaboration with the government for the training of HCWs.

Next steps

- Continued implementation across services and areas with parallel adaptation of instruments and interventions to the local context.
- Development and collection of additional indicators across Nepal to enable more targeted and appropriate interventions and monitoring.

Source:

Geriatric Health Service Strategy 2078/79 to 2086/87 (2021–2030); Kathmandu: Ministry of Health and Population, Government of Nepal, 2021 (https://www.nhssp.org.np/Resources/GESI/Geriatric%20health%20service%20strategy%20English%20version%20-%202022.pdf).

Box 10. Singapore

In Singapore, research has been focused on intrinsic capacity in older age, including studies on falls, risk for decline in activities of daily living (ADLs), risks of malnutrition and depression in older people. These studies have highlighted the need for holistic, integrated services and support for older people, leading to Singapore's engagement with the ICOPE approach.

Situation of older people and healthy ageing

- White Paper *Healthier SG* aligns with integrated care for older people.

Adaptation and pilot process for the implementation of the ICOPE approach

- Delivery of a training programme for HCWs and community assessors via an in-person course with an online course on the ICOPE approach starting in 2024.
- Implementation of the pilot study on the ICOPE approach with 367 older people, aged 60 and over, with a mean age of 71.8 years.
- Pilot study found that 77.4% of people screen positive for potential impairments in intrinsic capacity (especially vision, hearing and cognition).
- Development of referral systems across health and social care involving multidisciplinary teams to support a continuum of care.
- Focus groups with older people to inform approaches to communicating to raise awareness of the ICOPE approach and the importance of older people setting their own goals and objectives.
- Focus groups with ICOPE assessors to understand their views of using the ICOPE approach in Singapore, highlighting the feasibility of implementing the approach and the value of a person-centred focus to empower older people to be healthy.

Challenges

- Limited understanding of how best to communicate with older people, especially on intrinsic capacity and what it means.
- Need for further testing of the feasibility of the ICOPE approach in the community and PHC.
- Need for further education with the health and social care sector on the benefits of using the ICOPE approach in the context of various assessments being in place in Singapore.

Enablers

- Inclusion of healthy ageing in national policies and priorities.
- Recent launch of the White Paper, *Healthier SG*, which promotes preventive care.
- Strategies in place to connect health and social care systems and different stakeholders.
- Launch of the *National frailty strategy policy report* by the Ministry of Health in 2023, which includes recommendations on the implementation of the ICOPE approach.
- Funding received by the Ministry of Health to conduct the Infinity ICOPE project led by Singapore Health Services.

Next steps

- Refining and optimization of care pathways bridging the health and social sectors, and bringing together multisector expertise.
- Expansion of data collection and testing of the ICOPE approach across the pathway (beyond screening).

Key discussion points

- Singapore includes social prescribing as a part of follow-up services for older people within the *Healthier SG* strategy. This could provide an opportunity for increased integration of health and social care.
- Technology could offer a tool to empower older people, including through enabling self-screening.
- The network of 200 active ageing centres in Singapore might offer an opportunity for the implementation of the ICOPE approach, providing a close link with older people at the community level.
- It is hoped the results of ICOPE pilots will lead to greater inclusion of older people's health and integrated care in Singapore's policies and frameworks, including potential inclusion of specific indicators in *Healthier SG.*

Sources:

Tay L, Tay EL, Mah SM, Latib C, Koh C, Ng Y-S. Association of intrinsic capacity with frailty, physical fitness and adverse health outcomes in community-dwelling older adults. J Frailty Aging. 2023;12:7-15 (https://doi.org/10.14283/jfa.2022.28).

Healthier SG; White Paper; Ministry of Health, Singapore; 2022 (https://www.healthiersg.gov.sg/resources/white-paper/).

National frailty strategy policy report; Ministry of Health; Singapore; 2023 (https://www.moh.gov.sg/docs/librariesprovider5/resources-statistics/reports/moh-frailty-strategy-policy-report.pdf).

Optimising Intrinsic Capacity for Functional Independence and to Impede FrailTY in Older Adults: adaptation of the WHO-ICOPE for healthy ageing in Singapore (INFINITY-ICOPE); Singapore Health Services; 2023 (Awarded Project Details (researchgrant.gov.sg)).

ICOPE implementation

Actions for CCHA

- ⊕ Share examples and good practices that strengthen the ICOPE approach for specific contexts and populations (e.g. migration, people who are socially isolated, rural and urban areas).
- ⊕ Support WHO to develop methods on measuring and estimating the effect of the integration of health and social care at PHC level, and conduct cost-benefit analysis.
- ⊕ Share examples of enablers and challenges to implementing community-based care.
- ⊕ Report on the adaptation and implementation process of the ICOPE approach.

Actions for WHO

- ⊕ For the next progress report (2026), look at outcomes and impacts, further engaging with CSOs and stakeholders from the field.
- ⊕ Link the Decade to other global, intergovernmental agendas (nutrition, vaccination, etc.) and think beyond 2030.
- ⊕ Support system changes including through the development of an investment case for government and other stakeholders, including private sectors.
- ⊕ Set KPIs at system and organization levels for the ICOPE programme.
- ⊕ Advise countries on meaningful engagement of older people and caregivers.
- ⊕ Connect countries within regional platforms to share and discuss their practices.

Whisper test conducted by a registered nurse, Dang, Nepal, 2023

Panel 4.
Emerging themes to strengthen integrated care

The fourth panel looked at emerging themes in integrated care for older people and how approaches to integrated care could be strengthened to include these themes. The panel included presentations on:

- HIV and ageing
- NCD integration, ageing and multimorbidity
- Competency-based education (WHO Global Competency and Outcomes Framework for Universal Health Coverage)
- ICOPE training programme.

WHO Resources for Panel 4

- Noncommunicable diseases key facts
- Technical series on safer primary care: multimorbidity
- Strengthening NCD service delivery through UHC benefit package: technical meeting report, 2020
- Tackling NCDs: "best buys" and recommended interventions for the prevention and control of noncommunicable diseases
- Integrating the prevention and control of noncommunicable diseases in HIV/AIDS, tuberculosis, and sexual and reproductive health programmes: implementation guidance
- WHO acceleration plan to stop obesity
- Global Competency and Outcomes Framework for Universal Health Coverage

HIV and ageing

Around 39 million people are living with HIV globally, the large majority in LMICs. Around 30 million are on treatment, and there are approximately 1.3 million new infections each year. There were 630 000 deaths due to AIDS in 2022 *(20)*. There has been a four-fold increase in the number of people on antiretroviral therapy since 2010. Access to treatment has led to significant changes in the AIDS epidemic. Whereas HIV was characterized by acute conditions, the occurrence of opportunistic infections and high mortality rates, today, HIV is increasingly seen as a chronic comorbidity, associated with other diseases, mostly NCDs.

It is estimated in 2022 that almost 10 million people with HIV were aged 50 years and older, accounting for nearly 25% of all people with the virus globally. Approximately 80% live in LMICs *(21)*. Projections suggest the number of people aged 50 and over living with HIV will increase by 50% between 2022 and 2030 *(22)*. These figures show the importance of focusing on older people living with HIV and ageing with the virus. Several themes usually discussed in geriatric medicine are emerging in HIV, including ageism, polypharmacy and integrated care.

As more people live for longer with HIV, evidence shows that people with the virus may experience an early onset of geriatric syndromes and comorbidities. Older people living with HIV also face stigma, with a combination of discrimination and prejudice related to both HIV status and age, affecting older people's care. Polypharmacy presents another challenge, with treatment for HIV and other medications taken for comorbidities tending to increase in number and complexity with ageing. Preventing comorbidities and improving therapeutic regimens and their interactions are increasingly important. Some drug toxicities pose particular challenges for older people (e.g. bone, renal, central nervous system) and require specific consideration. The fact that people can be and are being newly infected with HIV in older age also remains overlooked. Viral suppression and access to preventive tools remain important for people in older age.

As with people of all ages and population groups, the meaningful engagement of older people living with HIV and their communities in the HIV response is crucial. Several forums have emerged on the social impact of HIV and ageing, with quality of life and multidimensional evaluations of the impact of HIV key focuses. Research initiatives have also begun in recent years, with multiple cohort studies focused on HIV and ageing *(23, 24).* There is scope and opportunity for increased collaboration between the HIV and Ageing teams at WHO, and across the wider HIV and ageing sectors.

Key discussion points

- **Need for research in LMICs:** Most people living with HIV are in sub-Saharan Africa, but scientific evidence, including on older people, remains mostly generated in high-income countries, with resources for HIV and ageing also skewed towards these contexts. This leads to a lack of understanding of the needs of older people with HIV in LMICs. WHO is working to increase visibility and ensure experiences and perspectives from LMICs are heard.
- **Understanding comorbidities:** The study of comorbidities is an emerging focus for research, but few initiatives are looking at comorbidities with HIV in older people. This gap needs to be addressed.
- **Access to care for older people:** Limited UHC in LMICs and a reliance on health insurance linked to formal employment means older people with HIV face challenges in paying for care. This needs to be addressed and better links need to be made between the private and public sectors on HIV treatment and care.

NCD integration, ageing and multimorbidity

More than 70% of deaths globally are caused by NCDs, with the greatest proportion due to ischaemic heart disease, stroke, chronic obstructive pulmonary disease, cancer and dementia *(25).* There are huge global inequalities in the likelihood of dying "prematurely" (defined as dying before the age of 70) *(26)* from a major NCD. This inequality is seen within and between countries. In response, WHO has established a data portal to support countries in the definition of their NCD burden and risk profile, and with monitoring their progress. The portal is regularly updated with new data.

A key focus for WHO's work on NCDs is the integration of NCDs into efforts towards UHC, working towards a horizontal rather than vertical approach to systems and service delivery. Considering the package of interventions needed, from prevention to treatment and control, is important. Financial protection is a priority, recognizing the need for benefits packages that enable access to care for NCDs without financial hardship. WHO has developed multiple instruments to support countries in the development of packages of interventions with strong focuses on cost-effectiveness and feasibility *(27, 28).* Some specific guidance has also been produced that addresses the integration of NCDs with other conditions, including HIV *(29).*

A key issue in relation to NCDs and ageing is multimorbidity: the coexistence of two or more chronic conditions in the same individual. The prevalence of multimorbidity is increasing around the world; globally, in 2021 it stood at 37.2%, with noticeable demographic and regional differences *(28)*. More than

50% of people aged 60 and over live with multimorbidity *(30).* People with multimorbidity are at higher risk of polypharmacy and are likely to face more complex disease management, requiring more frequent interactions with health care services. They will also face more demanding self-management regimes. The complexities of multimorbidity highlight the importance of an integrated continuum of care. WHO guidance on multimorbidity remains limited, although others have published on this issue, including a 2016 document by the National Institute for Health and Care Excellence (United Kingdom) describing how to include multimorbidity in personalized care plans *(31).*

Further research is needed on multimorbidity with NCDs, particularly in LMICs, to support the development of guidance. The ICOPE approach offers an opportunity for integration, but further thinking is needed on incorporating NCD management.

Key discussion points

- **Obesity and NCDs:** There are differing views as to whether obesity should be considered a risk factor or a disease, including in relation to multimorbidity. WHO has a Global Obesity Acceleration Plan *(32)* with 28 frontrunner countries promoting prevention and integrating the NCDs and obesity agendas.
- **NCDs in LMICs**: Greater focus is needed on NCDs in LMICs given the rapidly increasing prevalence and growing burden from NCDs in these countries (see Panel 3).
- **NCD metrics**: The use of the term "premature mortality" and the focus of data collection for this age group risks a deprioritization of NCD interventions for people aged 70 and over. It suggests a devaluing of health and life after the age of 70 and is viewed by external stakeholders as ageist. The use of YLLs was suggested as an age-neutral alternative metric. The measurement of cost-effectiveness of NCD interventions is based on healthy life years gained, and so offers an opportunity to change the data approach.
- **Multimorbidity:** The traditional approach focused on standalone diseases and their accumulation (i.e. multimorbidity) in older people might hinder the person-centred assessment and personalized care that is a principle of the ICOPE approach. To move forward and promote integrated care for older people, it is important to address this gap, and build a common narrative that might bring opportunities and entry points that existing services could offer. The management of NCDs remains a cornerstone of clinical evaluation. However, this may lead to partial and misleading results and care if the older person's intrinsic capacity and environment are not considered. Only the comprehensive person-centred assessment of the individual enables the appropriate design and delivery of a meaningful and effective care plan responsive to the older person's needs and priorities.
- **Defining multimorbidity:** The current definition may risk inadequately defining clinical complexity, as the number of conditions does not capture their impact. More comprehensive evaluation is important in helping to determine the care someone might need through an integrated care approach. The development and implementation of instruments to predict LTC needs could be beneficial, particularly for PHC.
- **Health workforce capacity:** A lack of training for HCWs on how to support older people with multimorbidity impacts the quality of care. This could be addressed through the provision of training under the ICOPE approach, if NCDs were more explicitly included.

Competency-based education (WHO Global Competency and Outcomes Framework for Universal Health Coverage)

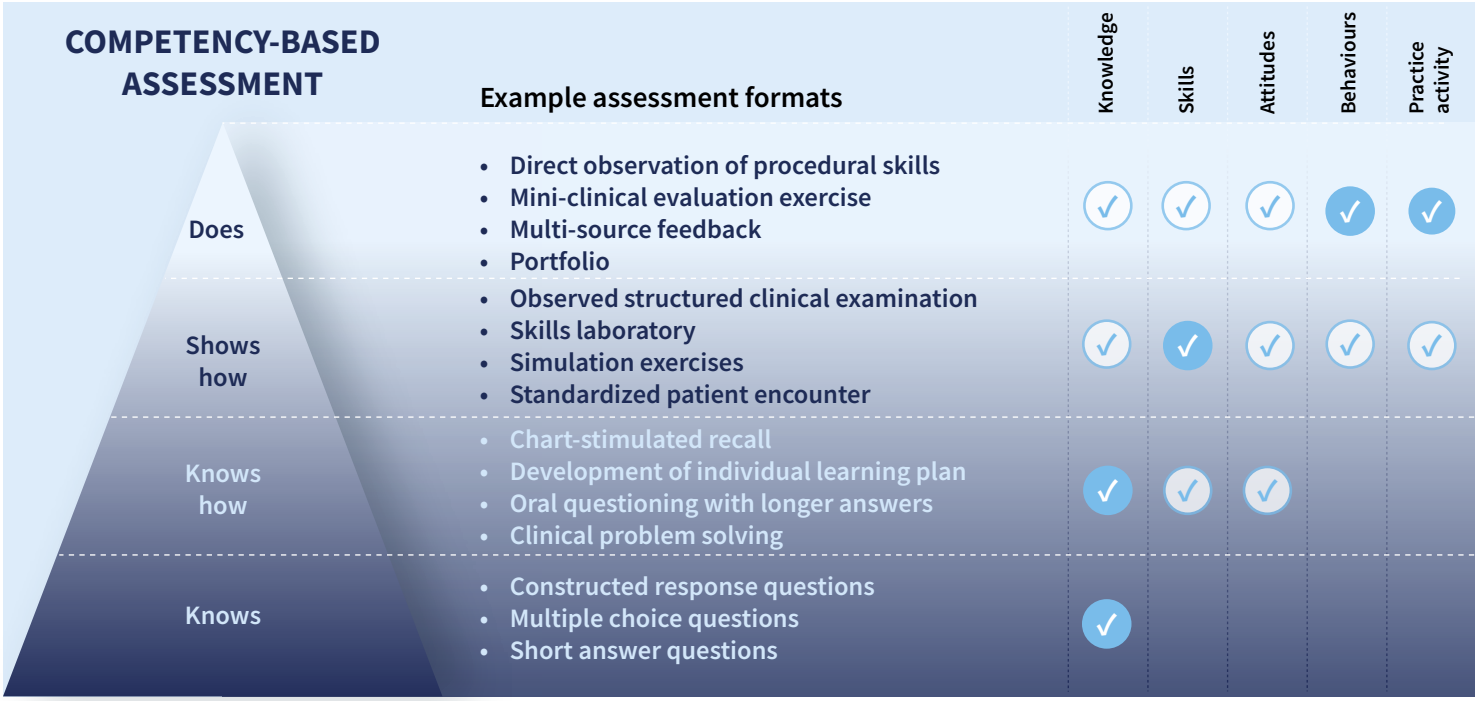
Competency-based education as an approach has been used across different sectors since the 1950s, and in the health sector since the 1970s. The first step in using the approach is to identify the expected education outcomes for HCWs, indicating which areas of practice the programme is aimed at. Then, a learning journey is designed, oriented to those defined competency-based outcomes and encompassing a sequenced progression, tailored learning experiences, competency-focused instruction and programmatic assessment.

In 2022, WHO published the Global Competency and Outcomes Framework for Universal Health Coverage *(33)*, providing a template that can be adapted to different contexts. The framework adopts an holistic approach to competence, focusing on the practice activities for health services, and the requisite competencies, knowledge and skills to provide them to the necessary standards.

The focus of the WHO framework is on "practice activities", a core function of health practice comprising a group of related tasks. Practice activities are time-limited, trainable and, through the performance of tasks, measurable. In other words, practice activities are what somebody does in practice, taking into account their context. This focus aims to support integrated care, moving away from vertical tasks and services. The adaptation of practice to context is based on competencies, which are defined as "the abilities of a person to integrate knowledge, skills and attitudes in their performance of tasks in a given context". Knowledge remains foundational, with an emphasis on how knowledge is applied in practice.

Within the competency framework, competence is the state of proficiency of a person to perform the required practice activities to the defined standard. Competence is multidimensional and dynamic; changing over time and based on experience and setting. The framework uses Miller's pyramid to inform a competency-based assessment (Fig. 4).

Fig. 4. Miller's pyramid for the assessment of clinical competency



Source: WHO (2022) Global Competency and Outcomes Framework for UHC, adapted from Miller, G (1990) The assessment of clinical skills/competence/performance. Academic Medicine. 1990;65(9):63–7.

In the context of UHC, practice activities may be provided for individual health level (e.g. gathering information through interview and assessment, formulating judgement following a clinical encounter, managing conversations with individuals and their families); for population health (e.g. assessing community health needs, planning and delivering community health programmes, managing public health communication); and for management and organization (e.g. accessing and documenting information, registering individuals for health services, delivering quality improvement activities).

The competencies for UHC that emerged as relevant to all health workers in all contexts were related to:

- provision of health services that incorporate the perspectives of individuals, caregivers, families and communities as participants in and beneficiaries of health systems;
- approach to decision-making;
- effective communication;
- generation of evidence and information and their integration into practice;
- practice philosophy of teamwork; and
- self-governed behaviours, such as professionalism.

Key discussion points

- **Individual vs group competencies:** Skills mix is an important consideration in ensuring effective teams. From an education perspective, understanding the level of skill and competency in a group or team is important in integrated care, given the focus on multidisciplinary teams. Competencies are, however, individual attributes, and an individual cannot be held responsible for the actions of others. It is possible to hold the individual responsible for how they collaborate with others, which could support the effectiveness of a multidisciplinary team. Performance of teams can also be monitored to identify any challenges.
- **Training on the ICOPE approach:** The training programmes on the ICOPE approach have frequently had a strong focus on delivery of knowledge, without sufficiently considering the importance of more comprehensively building health workforce capacity, i.e. the application and transfer of knowledge to practice, and the competencies to do so. The WHO framework could be useful in shifting this focus more on “shows how” and “does”.

ICOPE training programme

WHO has received numerous requests from Member States for support with implementation of the ICOPE approach in PHC. In response to the need for capacity building of HCWs, the team is developing the ICOPE training programme to facilitate a shift in the focus of HCWs from a vertical approach aimed at "curing diseases" to interdisciplinary comprehensive action for personalized care.

The programme primarily aims to promote interdisciplinarity in the provision of high-quality care at PHC level and is therefore targeted at HCWs who provide care to older people in community and PHC settings. However, HCWs involved in the management of older people in different settings (e.g. secondary and tertiary care) and representatives of public health authorities involved in the design and implementation of services (programme and system managers) for older people can also participate. The expected learning outcomes of the programmes are to:

- understand the subnational, national, regional and global context to promote the reorientation and integration of care services for older people;
- describe the different aspects of the ICOPE approach in PHC;
- integrate and apply the instruments and recommendations to implement the ICOPE approach into PHC practice;
- be able to adapt the ICOPE approach to the local context of PHC;
- potentially serve as trainers in the ICOPE approach for the care workforce; and
- promote health equity and inclusive strategies in the provision of care for marginalized groups of older people.

The ICOPE training programme is currently designed as an in-person programme for 3–4 days. Following a request from Member States (commonly health ministries), WHO works with relevant WHO regional and country offices to provide the training. Trainees are assessed at the end of the course and are invited to provide feedback.

In 2023, the ICOPE training programme was delivered in Botswana, Kuwait and Mauritius. These trainings reached a multidisciplinary audience (33% PHC physicians, 19% nurses, 8% specialists, 7% social workers, 7% physical therapists, 7% psychologists, 4% nutritionists, 4% administrative staff, 4% pharmacists, 2% dentists, 1% midwives, 4% others), enabling increased collaboration, and more widely informed discussions on the adaptation of the ICOPE approach to the local context and definition of the care pathways. Assessments and feedback have shown high levels of satisfaction and an increase in knowledge among trainees. Areas for improvement have also been identified, for example, more hands-on workshops are requested. Engagement with the training has enabled the three levels of WHO to better support Member States, learning from the experiences of HCWs involved in the care of older people.

The next steps for the ICOPE training programme include splitting the course into two modules: Module A, an online, self-paced course focused on knowledge delivery; and Module B, in-person, onsite training to be attended following completion of Module A. Module B focuses on developing capacities in the ICOPE approach, building on competency-based education and supporting adaptation to the local context. A training-of-trainers module will also be developed. The idea of identifying local centres of excellence within countries that could support training and implementation on the ICOPE approach in PHC is also being considered.

- **Adapting the ICOPE approach to local contexts:** Diversity in health infrastructure, human resources and clinical needs, requires the adaptation of the ICOPE approach to ensure applicability to local contexts. For example, in countries where HIV prevalence in older people is high, the ICOPE approach needs to be adapted to ensure related needs are met. In countries with high rates of obesity among older people, adaptation will also be key, as the approach currently places more emphasis on undernutrition. Adaptation is a fundamental component of the training programme.
- **Sustainability of the integration of care for older people at PHC:** To ensure the sustainability of the ICOPE approach efforts must focus on the reorientation of existing services and structures to improve the delivery of care for older people. Exploring how care pathways can be built into health workers' routines is important to support sustainability.

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Training for trainers for ICOPE approach organized by WHO and Ministry of Health Botswana in Francis town, Botswana, 2023

© Ministry of Health (MOH), Kuwait

Training for trainers for ICOPE approach organized by WHO and Ministry of Health Kuwait in Kuwait city, Kuwait, 2023

Key discussion points

- **The importance of implementing the care pathways on the management of intrinsic capacity at PHC:** A gradual implementation of the ICOPE approach has been seen in some countries, with an initial focus on screening, followed by later implementation of step two (assessment) and so on. This is seen by some as a more realistic and achievable approach. However, offering screening without having interventions in place if a need is identified is unethical. Further discussions were undertaken in group sessions at the CCHA meeting on identifying and shortlisting interventions that can be proposed for easy implementation at the community level, including in LMICs.
- **Measuring the domains of intrinsic capacity:** Although the ICOPE guidance includes a set of recommended tools, others may be used based on what is already present in local systems and contexts. Identification of suitable tools is part of the local adaptation process.
- **The ICOPE approach and PHC:** There are multiple interconnected discussions related to healthy ageing at local, national and global levels; for example, on integrated care, links between health and social care, supporting informal caregivers, decentralization of care to PHC level, community delivery and engagement. A clear narrative is needed on the ICOPE approach and its aims.
- **Delivery of training:** Online training is becoming more widely accepted by the health and care workforce but a mixed online and in-person approach is needed to enable group discussion and learning, and assessment of capacity to implement knowledge (e.g. *shows how* and *does,* see previous presentation).
- **Targets for training on the ICOPE approach:** It will be important not only to train existing HCWs but also incorporate the ICOPE approach into wider training for undergraduates and new staff to support sustainability.

Emerging themes to strengthen integrated care

Actions for CCHA

- ⊕ Conduct research on intrinsic capacity, functional ability and environment in older people living with HIV and with multimorbidity.
- ⊕ Be consistent with the WHO training methodology (e.g. competency-based training) to promote sustainable and acceptable capacity building on the ICOPE approach, adapting a different mode of delivery (e.g. digital, onsite, mentorship).

Actions for WHO

- ⊕ Strengthen relationships within WHO on HIV and ageing to initiate collaborative work.
- ⊕ Revisit the metrics on NCDs, including premature mortality.
- ⊕ Consider guidance development for older people in relation to multimorbidity.

Panel 5.
Updating ICOPE care pathways

In Panel 5 the CCHA focused on the process to update the care pathways in the ICOPE handbook (ICOPE handbook: guidance on person-centred assessment and pathways in primary care). Detailed group discussions (not documented in this report) followed a series of presentations on:

- Updating the generic care pathway of the ICOPE approach
- Updating the screening tool for the ICOPE approach in the community
- Feasibility and validity of self-screening
- Urinary incontinence care pathway.

WHO Resources for Panel 5

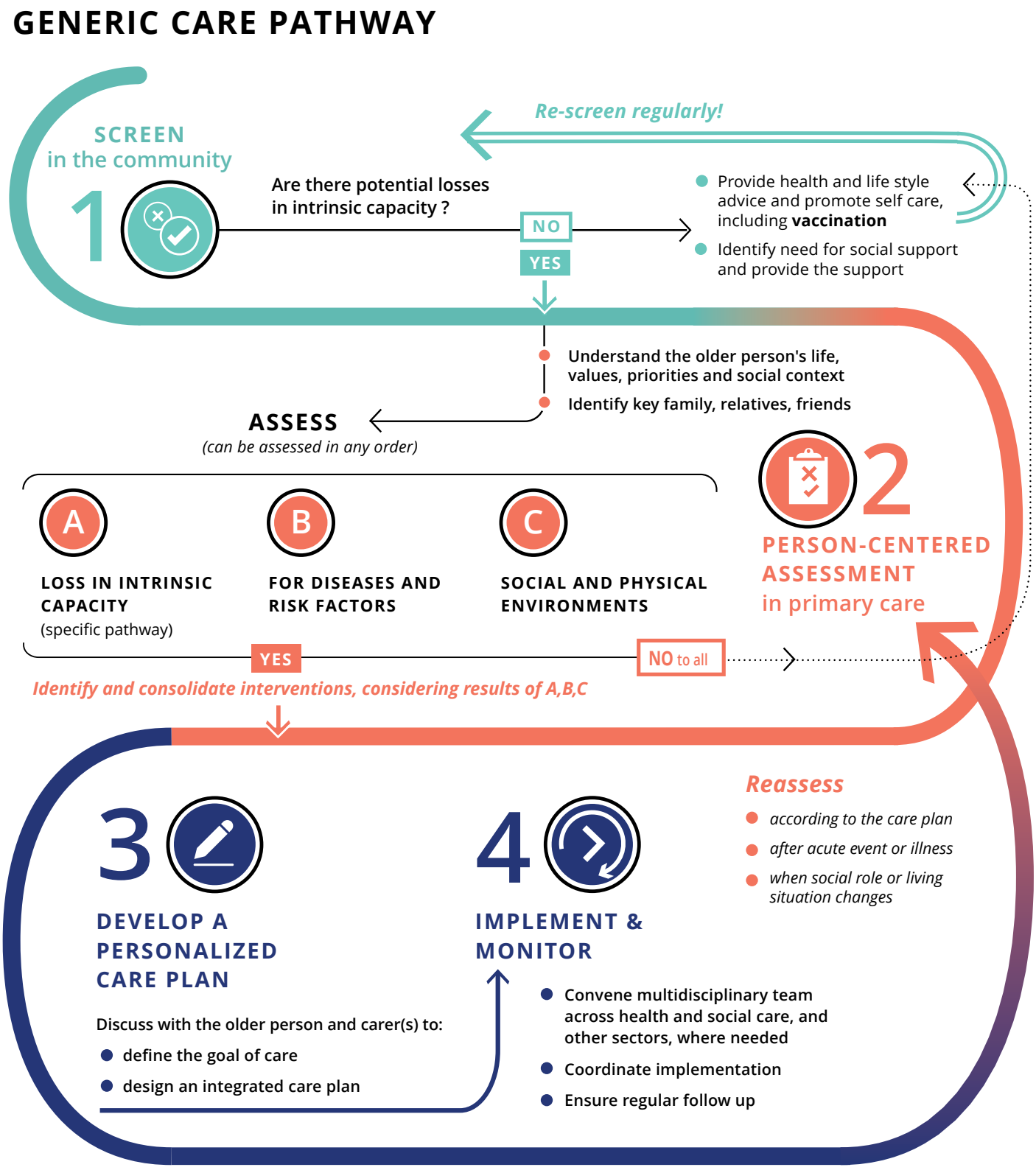
- ICOPE handbook: guidance for person-centred assessment and pathways in primary care
- WHO guidelines on physical activity and sedentary behaviour
- Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders
- Hearing screening: considerations for implementation
- Immunization Agenda 2030: A Global Strategy To Leave No One Behind

Updating the generic care pathway of the ICOPE approach

The ICOPE pilot sites, including those documented in Panel 3, set up since the ICOPE implementation guides (ICOPE handbook and ICOPE implementation framework) were published, have provided feedback on the approach based on real-life implementation. A range of other guidelines and documents relevant to older people's health have also been developed (see WHO resources) since 2019. WHO is planning to update the generic care pathway of the ICOPE approach (Fig. 5) in 2024. Discussions at the 2023 CCHA meeting will inform this update.

Reinforce generic health and lifestyle advice or usual care: Discussion on this element of the generic care pathway focused on strengthening health promotion, or healthy lifestyle advice, in the community. Feedback has been received, and questions raised about what can be done at the community level for those screening negative and those waiting for the in-depth person-centred assessment (step 2). Specific points have been raised about how health promotion can be strengthened and healthy lifestyle advice provided in contexts where it is difficult for older people to access PHC. The advice given at this step of the pathway guides self-care and self-management in accordance with an older person's goals, and should include tobacco cessation, avoiding harmful use of alcohol, physical activity, falls prevention, vaccination, nutrition and social participation. Delivery of this advice at the community level can be by CHWs, volunteers, CSOs and older people's associations.

Fig. 5. Draft generic care pathway for integrated care for older people



Source: Draft proposed updated ICOPE generic care pathway

Three components of person-centred assessment (step 2): Feedback has focused on the fact that the three components (see Fig. 5) should be given equal weight, with no hierarchy applied. It is crucial that all components are assessed. Opportunities should be sought to integrate the components with existing care, for example, for NCDs at PHC.

Engage communities and support caregivers (step 5): This final step of the care pathway is not being prioritized and, in some instances, is being neglected. To address this, identification of the needs of caregivers could happen as part of the comprehensive assessment of the individual because supporting caregivers should be part of a personalized care plan, where needed. Similarly, the community engagement could be activated during the definition of a personalized care plan to ensure opportunities and possible resources in the community are included.

Key discussion points

- **Ensure referral pathway and monitoring of the care plan:** The care pathway needs to take an ongoing cyclical approach, with a focus on monitoring. Irrespective of the results of screening or assessment, older people should be continuously monitored and reassessed throughout their later life. Regular screening, assessment and monitoring of the care plan is crucial.
- **Prioritization within a care plan:** Within the ICOPE approach, a single care plan is needed that addresses the challenges being experienced by an older person (and their caregivers). This plan must be based on priorities, preferences and feasibility, including the availability of health and social services. A key question for the development of a care plan, relates to the prioritization of needed interventions. Prioritization can be guided by the urgency of an issue from a clinical perspective, the likelihood of success when responding to an issue and the wider impact addressing this issue might have, and/or what the older person feels is most important to them. A balance needs to be struck, through shared decision-making in which HCWs and the older person have distinct but complementary roles. The HCWs can explain the potential health trajectories and how these may be modified (or not) by health and social care interventions, including the benefits, risks and burdens of interventions. The older person can apply their own attitudes and priorities to decide how they value the possible trajectories (outcomes) to enable the discussion to arrive at an agreed course of action (care plan). While the older person's view should be central, HCWs have a critical role to support shared decision-making in terms of prioritization.
- **Approaches to engaging and supporting caregivers:** Different approaches are available from countries that highlight how caregivers could be engaged and supported. Japan has established more than 5400 community general support centres and care managers that coordinate multidisciplinary teams to prevent care dependency, facilitate the provision of social care and support, and support people's access to LTC. These care managers and centres also provide support for caregivers *(34).*
- **Maintaining the ICOPE handbook as a "simple" tool:** There is broad agreement that the care pathways to manage intrinsic capacity at PHC level (ICOPE handbook) need to be updated. However, it was recommended to not complicate the approach with the aim of facilitating the implementation of the ICOPE approach in different contexts, particularly in LMICs. The care pathway to manage intrinsic capacity at PHC level (ICOPE handbook) is meant to promote quality care for older people in PHC through the integration of services; it is not meant to certify knowledge and skills as a geriatric specialist.

Updating the screening tool for the ICOPE approach in the community

The first step of the generic care pathway in the ICOPE approach is screening for losses of intrinsic capacity in the community. As part of the update of the ICOPE handbook, adaptations to the screening instrument were proposed. These include adding new questions and modifying existing questions.

Additional questions: WHO's Immunization Agenda 2030 has a goal of all people benefiting from recommended immunizations throughout the life course, effectively integrated with other essential health services. It is proposed that in the updated version of the screening tool, the following question (according to/in line with national regulation) is included: "have you been vaccinated against seasonal influenza?" The inclusion of this question could help to improve immunization rates in older people.

Another possible addition relates to social care and support. The current screening tool focuses on the detection of impairment of intrinsic capacity, but feedback from implementation has shown that older people's care needs are often related to social issues. In response, four questions included in the assessment were proposed to be moved to the screening phase to support the immediate identification of needs for social support. If the answer to any of these questions was "yes", an in-depth assessment of social support and referral to social services in the community would be recommended. The four questions, currently included in the social care and support care pathway, are:

1. Do you have problems with the place where you live (accommodation)? Yes/No
2. Do you have problems with your finances? Yes/No
3. Do you feel lonely? Yes/No
4. Are you able to pursue leisure interests, hobbies, work, volunteering, supporting your family, educational or spiritual activities that are important to you? Yes/No

This proposal does not include a fifth question on elder abuse.

Modified questions/tests: Modifications to current questions or tests related to vision and hearing are proposed (Table 2).

Table 2. Draft proposed modifications to questions on vision and hearing

Vision		
Current question	Revised question	Rationale
Do you have any problems with your eyes: difficulties in seeing far, reading; eye diseases; or currently under medical treatment (e.g. diabetes, high blood pressure)?	Do you have any problems with your eyes: difficulties in seeing far, reading ***with eye glasses if normally worn; eye pain or discomfort***; eye diseases; or currently under medical treatment (e.g. diabetes, high blood pressure)?"	Revised question proposed to evaluate vision, with assistive products (eye glasses or spectacles), in alignment with the *WHO vision and eye screening implementation handbook (35).*
Hearing		
Screening audiometry Automated app-based digits in noise test Whisper voice test	Add filter questions before hearing screening test: a. If the person has hearing complaints, directly send to diagnostic audiometry. b. For those with hearing devices, ask "how would you characterize your hearing with your hearing device?". If fair or poor, undergo the screening of hearing.	Filter questions are proposed in alignment with WHO *Hearing screening: considerations for implementation (36)*. If the person has hearing complaints, it is critical to define better ways of communicating during the screening and assessment. Regarding hearing devices, an exhausted battery is a common issue that needs to be identified.

Key discussion points

- **Getting the right balance:** The suggested adaptations are important and would be useful. However, consideration should be given to the original aims of the ICOPE approach, particularly in terms of providing simple tools that could be used around the world in different income settings. At what point will making additions result in the ICOPE approach becoming too complicated? A balance will be needed. It will be important that any additions are simple and feasible to implement. However, the decision to not include other issues could mean a less comprehensive approach that risks neglecting key challenges experienced by older people.
- **Applicability of additional questions for older people with significant loss of intrinsic capacity:** The additional questions being discussed suggest a move towards a more holistic screening that can be used with all older people, including those with a significant loss of intrinsic capacity. If this is the case, there are many other social issues that would need to be included. Social care issues and needs, mostly related to ADL, are currently included in the assessment within the ICOPE approach. The proposal is that these four additional questions be addressed at the first contact with the older person, leaving other items for an in-depth assessment (step 2).

Feasibility and validity of self-screening

The validity of self-screening for intrinsic capacity impairment by older people is an area of interest among those implementing the approach. The ICOPE pilot in France has included self-screening *(37).* From January 2020 to October 2023 more than 3600 older people (mean age 69.4 years) have self-screened, while about 33 600 individuals (mean age 76.6 years) have been screened by HCWs. Data are available for a subset of 100 older people who self-screened and then went on to have an in-depth assessment by HCWs. These data showed positive results for the sensitivity and specificity of the self-screening for psychology and locomotion (psychology: sensitivity = 78.8%, specificity = 76.7%; locomotion: sensitivity = 71.4%, specificity = 80.3%), but weaker results for sensitivity for cognition, hearing and vitality (cognition: sensitivity = 52.9%, specificity = 62.4%; hearing: sensitivity = 57.1%, specificity = 70.6%; vitality: sensitivity = 31.6%, specificity = 90.9%).

Further data for 70 people aged 60 and over who received follow-up care after self-screening show that of those who received a positive screening in a particular domain or domains, 24% received cognitive stimulation, 18.5% support with multimodal exercise, 20% had a psychological consultation, 49% received nutritional advice, 14% were referred to an ophthalmologist, and 20% had a referral to specialized ear care. Many older people have also been referred to receive “multidomain interventions”, which are often composed of exercise, cognitive stimulation and nutritional advice.

In a second study in Toulouse, 79 older people self-screened and were screened by health workers on the same day, enabling a comparison of the screening results. Of the 79 people, 34 were aged 60 and over. Although data are limited, there was good agreement between the results obtained from the self-screening and the screening administered by a health worker for nutrition, depressive mood and loss of locomotor capacity (agreement coefficient 0.97, 0.91, 0.87). Poor agreement was seen in cognition.

The studies in Toulouse show self-screening can empower individuals, and potentially support the identification of older people who can benefit from interventions. However, further studies are needed to confirm the validity and effectiveness of self-screening within the ICOPE approach.

Key discussion points

- **Self-screening and cognition:** The screening for intrinsic capacity impairments in the community in the ICOPE approach can be done by an older person or a family member. In either instance, it is important for the screening tool to use simple language. Self-screening is challenging with the cognition domain, as a person with cognitive impairment is likely to underreport. More accurate results may be obtained by a family member. Literacy rates, level of education and knowledge of and skills in using digital technology can also affect cognition screening results.
- **Benefits of self-screening:** The degree of sensitivity of a self-screening tool can pose challenges in terms of accurate detection of losses in intrinsic capacity. But self-screening offers other benefits, including raising awareness among older people of signs and symptoms that might otherwise be dismissed as "normal ageing", supporting health promotion and increasing self-empowerment.
- **Costs of self-screening:** Self-screening could lead to increased demands for health services on already overstretched health systems and overworked HCWs. Health systems strengthening, including capacity building for health workers, needs to happen alongside a rollout of self-screening activities during the implementation of the ICOPE approach.

ICOPE screening conducted by a doctor in Vic-Fezensac, France, 2023

Urinary incontinence care pathway

The prevalence of UI (involuntary leakage of urine) increases with age and is more common in women. It is underreported, often due to stigma, resulting in people not receiving the care they need. Urinary incontinence impacts many domains of intrinsic capacity, including depressive mood and locomotor, and affects functional ability.

Following discussions on UI at the 2022 CCHA meeting, a small working group refined the care pathway for UI. The proposed pathway follows a similar multistep structure as per care pathways for the other domains of intrinsic capacity, but also includes a specific gender perspective. The pathway is summarized in Table 3 (four steps are included, building on the update of the generic care pathway, see Panel 5: Updating the generic care pathway of the ICOPE approach).

Table 3. Draft proposed care pathway on urinary incontinence

Step 1	Step 2	Step 3	Step 4
Approach: Case finding question followed by assessment of impact of UI in the community	Approach: Person-centred assessment at PHC with referral to specialized care, where needed and available	Approach: Develop a personalized consolidated care plan to manage UI, associated conditions, and social and physical environment	Approach: Monitor and follow up the care plan
Question: Do you have any problems with bladder control, such as accidental leakage of urine?	Assessment of associated reversible conditions: • Delirium • Urinary tract infection • Medications • Psychological symptoms • Loss of mobility • Constipation • Excessive urine output • Obesity	Manage UI: • Bladder training with a bladder diary • Normal fluid balance, trial of caffeine restriction • Pelvic floor muscle training (***for women***) • Prompted voiding (for person with cognitive decline)	Monitor the effect and adherence of the intervention for 3–6 months
Healthy lifestyle advice: • Good fluid balance • Avoid constipation (high-fibre diet, adequate fluid intake) • Physical activity • Prevent and manage obesity • Smoking cessation	Assess urologic conditions: • Digital rectal examination • Bedside urinalysis • Abdominal examination • External genitalia and perineum examination • Prostate evaluation (***for men***) • Descent of the uterus and cervix, suspected fistula, vulvar symptoms (***for women***)	Manage associated conditions: • Treat constipation • Manage loss of mobility (multimodal exercise) • Manage depressive symptoms • Medication review	Refer to specialized care, where needed and available
	Assess social and physical environment: • Social isolation • Social support for access to containment products • Need for caregiver support	Manage social and physical environments: • Home modification for toilet access including easy access with assistive products • Support effective containment of leakage • Access to containment products and appliances with hygiene routines • Social care and support to avoid social isolation • Support caregivers through encouragement and reinforcement	

Key discussion points

- **Inclusion of UI at screening (step 1) or in-depth assessment (step 2):** A case finding question on UI could be asked at either the screening or assessment step. Older people who are identified at the screening stage as having possible impairments in intrinsic capacity domains linked to UI (e.g. depressive symptoms, cognitive decline, loss of mobility) could be assessed for UI during the in-depth assessment. A balance needs to be struck between keeping the screening tool simple and including UI at the screening stage within the ICOPE approach due to its relevance and underreporting. Including UI at the screening stage could help raise awareness that UI is not a part of "normal ageing". Furthermore, this might facilitate the delivery of immediate effective interventions. Whether questions on UI are included at step 1 or step 2, careful consideration of who will ask these questions, how and where is needed.
- **Use of containment products:** Caregivers may encourage the use of containment products before trying other interventions, as they reduce caregiver burden in comparison with frequent trips to the toilet. It is important to educate and motivate caregivers to ensure containment products are used appropriately.
- **Pelvic floor muscle training:** Should be feasible to offer for older women, including in LMICs, as this is part of routine postnatal care. The potential application of pelvic floor muscle training in men needs further consideration as there is currently insufficient evidence of its impact on men with undifferentiated UI. There is evidence that pelvic floor muscle training works for urgent UI in men *(38, 39).*
- **Fluid intake:** Older people may intentionally restrict fluid intake because of UI, increasing risk of urinary infection and dehydration. This needs to be considered as part of care planning and follow up.
- **Medication review:** A review of medication should also be considered due to the likelihood of polypharmacy in older people and the impacts in terms of UI.

Breakout sessions for each care pathway

Breakout group sessions focused on detailed discussion on the proposed revision of each of the ICOPE care pathways (cognition, locomotion, malnutrition, hearing, psychological, vision, social care and support, and caregiver support). The WHO will use the points raised in these groups to inform the update of the ICOPE handbook.

Updating ICOPE care pathways

Actions for CCHA

- ⊕ Engage in the review and finalization of the ICOPE handbook version 2.
- ⊕ Pilot the updated care pathways for the management of intrinsic capacity at PHC level (ICOPE handbook version 2) to build evidence of feasibility and effectiveness.
- ⊕ Explore the usefulness of self-screening in the identification of an older person's needs and provision of care.

Actions for WHO

- ⊕ Review feedback from the CCHA 2023 meeting to inform the ICOPE handbook version 2, including the positioning of the new items.
- ⊕ Clarify that integrated care for older people goes beyond the ICOPE handbook (screening tool and care pathways at PHC level to manage declines in intrinsic capacity) to avoid ambiguities and open the pathway to further developments in the framework.

Panel 6.
Multidimensional approach to research on healthy ageing

Panel 6 focused on a multidimensional approach to research on healthy ageing. The following presentations were made:

- Research prioritization agenda
- Intrinsic capacity and environment: Japan; Brazil.

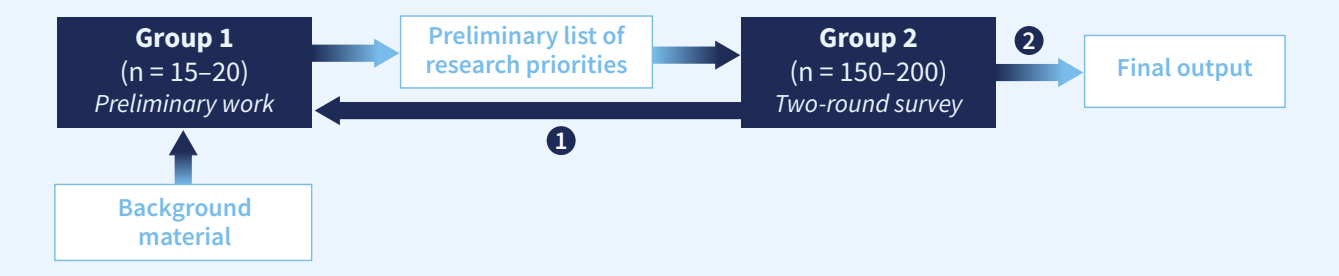
Research prioritization agenda

WHO is undertaking an exercise to develop a research prioritization agenda (RPA) to improve care for healthy ageing. A clear definition of research priorities is needed to build the evidence for the reorganization of service delivery to optimize older people's intrinsic capacity and functional ability and to improve services to enable older people's health and care needs to be met. The targets of this exercise include stakeholders involved in the funding, design, organization, delivery and monitoring of older people's care.

Background material is currently being collated by WHO that will form the basis of a small working group discussion on research prioritization. This background material builds on the results of the survey with the CCHA and GNLTC in July 2023, who were asked to "think about how care is usually provided to older people. Which are the topics, themes, or areas requiring research prioritization and development of specific research to improve it?" A total of 126 experts were invited to participate and 91 (74%) completed the survey (58.7% from high-income countries). Almost 400 research priorities were reported by participants and entries were organized by theme (care, specific clinical conditions, theoretical concepts, health economics, low-resource settings, methodology of research, technologies, training of the care workforce [formal and informal], understanding the older person).

The working group will develop a preliminary list of research priorities from the background material. This list will then be provided to a wider group of experts for review using a two-round Delphi survey methodology. This wider group will further prioritize, analyse and modify the list, with the option of adding aspects not considered by the initial group. The wider group will use three factors to prioritize research topics: public health benefit; feasibility; and cost. Both groups will be made up of representatives from across stakeholder groups and geographies. Fig. 6 shows a summary of the methodology to be used.

Fig. 6. Methodology for WHO's research prioritization agenda



The revised research list will be used by WHO to develop a final RPA and a range of supporting outputs.The RPA, planned for development in 2024/25, will show where more research is needed and will allow researchers to better define and develop innovative and meaningful activities. The development of the RPA will enable WHO to put in place a process for the continuous identification and prioritization of research gaps hampering the delivery of person-centred, integrated care and primary health services for older people, and their access to LTC.

Key discussion points

- **Longer term focus of the RPA:** The RPA will provide a timeline for research priorities, considering what might be achievable when. The outcomes of priorities that can be addressed in the shorter term will inform longer term efforts, and the ongoing updating of priorities.
- **Healthy ageing research in LMICs:** Given the lack of research and evidence from LMICs, it will be important to ensure governments and organizations in LMICs are involved, while ensuring good geographic and income level representation to avoid bias.

Discussion among CCHA 2023 meeting participants in Geneva, Switzerland, 2023

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Intrinsic capacity and environment

Joint effect of intrinsic capacity and environmental factors for functional ability, Japan

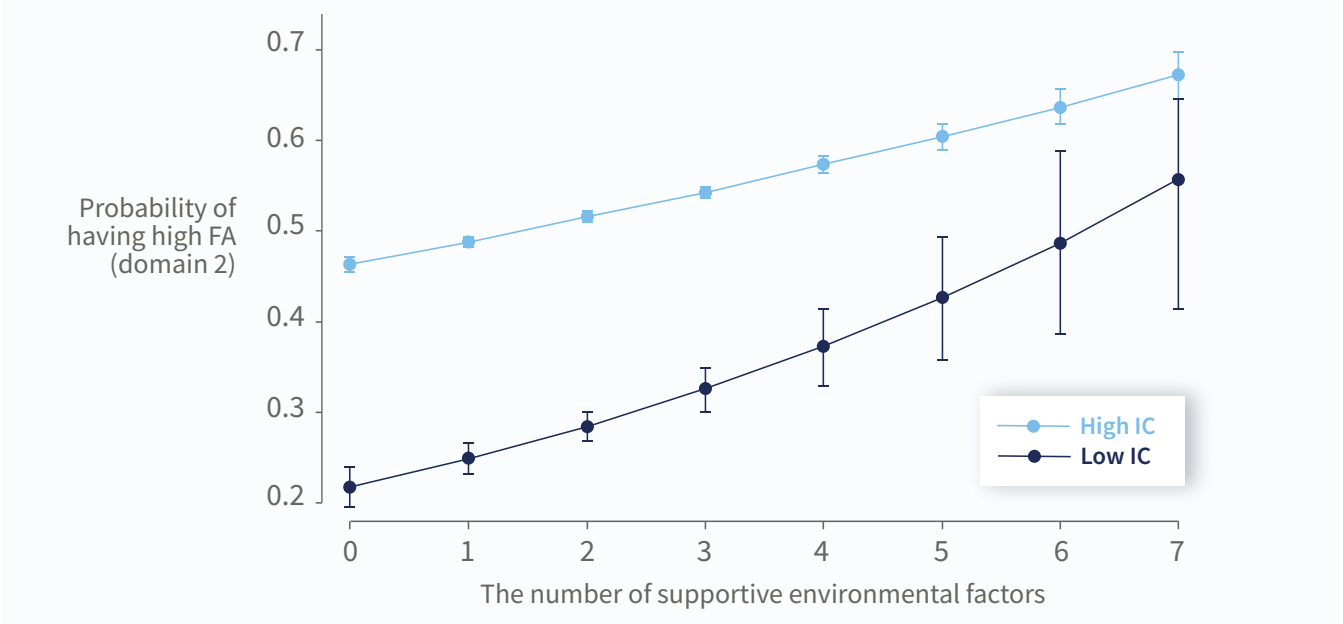
As detailed in the healthy ageing framework, a supportive environment can help to increase or maintain intrinsic capacity and functional ability. In Japan, a study has investigated the interactive contribution of locomotor capacity and the environment in the improvement of functional ability, in particular, the ability to meet basic needs and be mobile *(40).*

The study used data from the Japan Gerontological Evaluation Study. More than 54 000 community-dwelling, functionally independent older people were assessed through a self-administered questionnaire in 2016 and again in 2019. A standardized factor score of functional ability was calculated from the answers provided, focused on daily activities (e.g. cooking, finances, administrative tasks, shopping, social networking, transportation, need of assistance). The score was then dichotomized (i.e. high vs low functional ability) according to the median value. Five items from the Kihon checklist *(41),* a national standardized instrument for assessing frailty in older people, were then used to define the locomotor capacity, as an indicator of intrinsic capacity. The score was also dichotomized to indicate high vs low intrinsic capacity.

A measure of the environment was then computed, based on the number of transportation means used by the older person. A conceptual model of the hypothetical relationship between the three variables over time was developed using a modified Poisson regression analysis. A strong, positive and independent relationship between transportation and functional ability was reported; including after possible confounders (including intrinsic capacity) were considered in the regression model. Intrinsic capacity was also predictive of functional ability.

As shown in Fig. 7, the number of supportive environmental factors (i.e. means of transportation) was positively associated with functional ability, especially in persons presenting low intrinsic capacity.

Fig. 7. Association between supportive environmental factors and functional ability



Source: Unpublished data courtesy of Naoki Kondo, Professor, Department of Social Epidemiology, Graduate School of Medicine and School of Public Health, Kyoto University, Kyoto, Japan.

Notes: FA – functional ability; IC – intrinsic capacity.

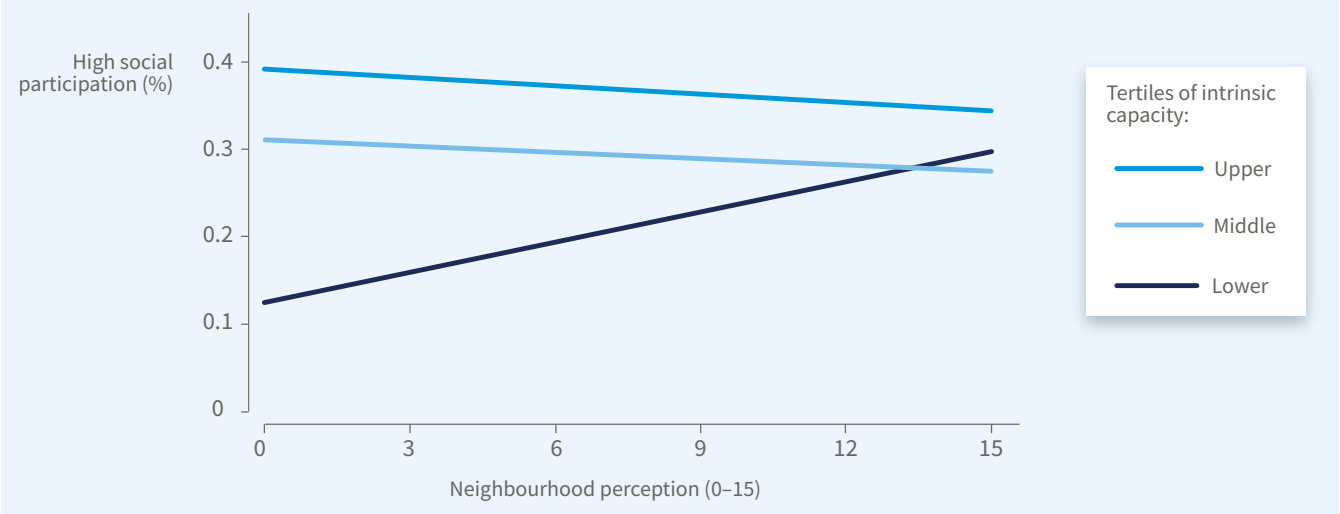
The study highlighted the impact geographical factors have on mobility and the environment, and the importance of integrating cost-effectiveness measures aimed at improving the environment into programmes designed to improve intrinsic capacity and functional ability. The study takes into account the broadness of the environment, not limited to the physical place a person lives but also the person's life experience. Efforts to develop age-friendly environments should consider older people's futures as well as their current circumstances, embracing a life course approach to ageing.

Healthy ageing in urban contexts: exploring the interplay of intrinsic capacity and neighbourhood perception for social participation, Brazil

A study in Brazil into the links between intrinsic capacity and neighbourhood perception used data from a representative cohort of 5418 people (54% female, 40% white) aged 50 and over living in urban areas in Brazil (2016-wave of the Brazilian Longitudinal Study of Ageing [ELSI]) *(42).* The intrinsic capacity variable used, validated in a previous study, was associated with a measure of social participation defined by the 14-item Advanced Activities of Daily Living (AADL) scale *(43).* The environment was measured using a score generated from information on 15 characteristics of the neighbourhood, including accessibility, resources available in the community, transportation, safety, recreation, cleanliness and state of preservation *(44).* The characteristics included both objective measures and the participant's subjective perceptions. The study sample had a mean age of 62 years and a median of 6 years' formal education. Participants with low intrinsic capacity tended to be older, less likely to be white, had fewer years in formal education and had lower per capita family income.

The study investigated the association of intrinsic capacity and the environment on social participation using the AADL scale. The logistic regression models showed that both intrinsic capacity and the environment (restricted to three items objectively capturing the context of where a person lives) are significantly associated with social participation, independent of potential confounders. Interestingly, when the subjects are stratified based on the tertiles of intrinsic capacity, the environment is shown to be particularly important for social participation in people with low intrinsic capacity, and better environment correlates with higher social participation (black line in Fig. 8). These findings suggest the importance of an age-friendly environment to support social participation for those with low intrinsic capacity, and to ensure equity, including for those who are socioeconomically disadvantaged.

Fig. 8. Interaction of intrinsic capacity and environment on social participation



Source: Unpublished data courtesy of Marlon Aliberti, Assistant Professor, Department of Internal Medicine, Division of Geriatrics, University of São Paulo Medical School, São Paulo, Brazil.

Key discussion points

- **Importance of environment in social participation:** The environment, including geographic characteristics, may impact social participation, including access to care. To support further research, better and more objective measures of environmental characteristics are needed.
- **Priorities for further research:** The lack of data and research in LMICs needs to be addressed, including in relation to intrinsic capacity and environment. LMICs tend to exhibit greater environmental heterogeneity than high-income countries, making studies involving the environment in LMICs particularly promising. One approach could be to replicate any initiative started in a high-income country with an adapted initiative in a LMIC. Partnerships between researchers in higher and lower income countries should be established to support such work, and to ensure expertise is built in LMICs. A specific session on research in LMICs could be useful at the next CCHA meeting. In addition to prioritizing research in LMICs, further study is needed on older people's perception of their environment, and consideration of the opportunities of research on intrinsic capacity and environment in clinical settings will be important.

Multidimensional approach to research on healthy ageing

Actions for CCHA

- ⊕ Support WHO to identify and engage researchers, clinicians and different stakeholders in LMICs.
- ⊕ Collaborate with WHO on fundraising to conduct studies in LMICs including implementation research.
- ⊕ Build the evidence on the relationship between intrinsic capacity and environment to identify critical factors to be addressed.
- ⊕ Raise the profile of ageing and health in research, in cross-cutting themes.

Actions for WHO

- ⊕ In the research prioritization work, consider feasibility of LMIC representation.
- ⊕ Consider how to improve the research agenda for LMICs.

Panel 7.
CCHA and GNLTC joint panel: Continuum of integrated care for older people

In a joint CCHA and GNLTC panel on the continuum of care for older people, WHO made two presentations on its current work:

- Long-term care package for UHC
- Operationalization of "continuum of integrated care": how to make ICOPE care pathways applicable for long-term care.

WHO Resources for Panel 7

- Framework for countries to achieve an integrated continuum of long-term care
- Long-term care for older people: package for universal health coverage

This joint CCHA and GNLTC session aimed to explore how to better align WHO and other work on integrated primary health services and LTC, and ensure the delivery of a continuum of care for older people. In framing the presentations and discussion in this panel, four issues were raised:

1. **Need to clarify the relationship between integrated primary health services and LTC:** There is some confusion among stakeholders about how integrated primary health services and LTC relate to each other, and whether, for example, "the ICOPE approach includes long-term care". Some of this confusion is linked to terminology, and what the acronym "ICOPE" means and whether the acronym is being used in a consistent and correct way.
2. **The importance of a continuum of care that is inclusive of all older people:** WHO's work, including with the CCHA and GNLTC, needs to be relevant to and accessible by all older people, irrespective of their level of intrinsic capacity, need for care or where they live, including those who live in LTC facilities.
3. **Importance of longitudinal data on all older people:** If collected on an ongoing basis and with all older people (as outlined in point 2, above), data from the screening, assessment and management of intrinsic capacity at PHC can provide valuable insight into how the individual's care needs and priorities evolve over time through later life.
4. **Operationalizing an inclusive continuum of care:** Implementing the ICOPE approach with all older people, across all settings, including in LTC facilities, would require human and financial resources. In some instances, there might also be a duplication of effort, if older people have already undergone a comprehensive geriatric assessment.

Long-term care package for UHC

WHO has developed the *Long-term care for older people: package for universal health coverage* to support countries in designing, establishing and strengthening LTC systems and services as part of UHC. The package provides a set of recommended interventions that address the LTC needs of older people and carers, both paid and unpaid, across care settings, including home, community and LTC facilities.

This new document sets out that these interventions should be provided through a person-centred, integrated health and social care approach, delivered by a multidisciplinary team and should also involve education and training for care workers to ensure the provision of safe, quality interventions (Fig. 9).

A six-step cycle for the implementation of the package of interventions has been developed (Fig. 10):

1. Assess national or/and local population needs for LTC
2. Map current LTC coverage
3. Design LTC package
4. Integrate and align interventions in services and settings
5. Monitor care delivery, quality and coordination mechanism
6. Review and expand the coverage and repeat step 1 based on the review.

The package states the need to engage older people and their caregivers in their care, including in the implementation of the package of interventions. The new LTC package will be integrated into WHO's UHC compendium of health interventions, to ensure that these services are an integral part of national UHC packages. The next steps for WHO's LTC work include the development of a competency framework and training modules for care workers, including unpaid caregivers, an investment case for LTC, including a cost-benefit analysis, and efforts to ensure the integration of social care and support into health benefit packages.

Fig. 9. Summary of the elements of WHO's Long-term care package of interventions for UHC

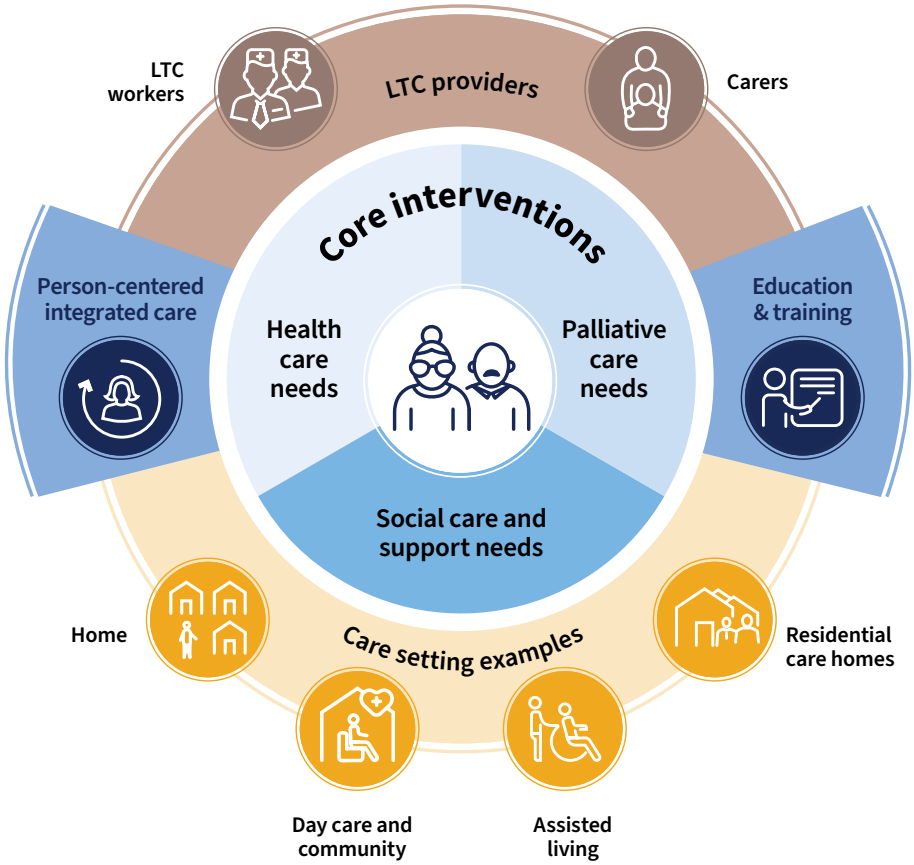


Fig. 10. Six-step cycle for the implementation of long-term care interventions

Key discussion points

- **LTC workforce:** Demand for LTC is increasing alongside shortages in the LTC workforce. Strategies are needed to address these shortages, including through improved training and remuneration, recognition of the value of LTC roles, and efforts to address gender imbalance.
- **The goal of integrated primary health services and LTC:** Irrespective of someone's intrinsic capacity, the goal of integrated primary health services and LTC is to improve functional ability and quality of life. For those requiring LTC, efforts might shift more towards a focus on quality of life through support to adapt older people's home and living environments, alongside maintaining intrinsic capacity, hence a person-centred approach that responds to an older person's goals is important.
- **Costing LTC and the package of interventions:** Different interventions provided in a range of settings and at different levels must be costed. Costing LTC should happen as part of a broader approach to costing the delivery of integrated care. Differences in the desired outcomes for older people, based on their intrinsic capacity and personal goals, will have an impact on cost.
- **Inclusion of palliative care:** Different skills and expertise are necessary for the delivery of palliative care.
- **Context-specific care:** Packages of care, whether LTC or broader integrated care, need to be context specific, with adaptations based on models and services that already exist at local level.

Operationalization of "continuum of integrated care": how to make ICOPE care pathways applicable for long-term care

Integrated primary health services and LTC are closely related in terms of their goals of ensuring a continuum of care for older people. WHO has focused on the provision of integrated care at the PHC level to support prevention and promotion and older people's access to services close to where they live. However, when considering a continuum of care, ensuring services at PHC level is not sufficient, and efforts must also include the proper monitoring and evaluation of interventions, and an approach that allows for care to evolve as needs change.

Given WHO's framework for healthy ageing *(45)* is universal in nature, requiring the inclusion of all older people irrespective of where they live or receive care, the ICOPE approach, with its emphasis on PHC, can be adapted for implementation across different care settings. These adaptations will require modification of the tools and instruments needed to monitor intrinsic capacity, functional ability and environment in different settings. An adapted and updated generic care pathway, as detailed in Panel 5, could be used to guide the delivery of integrated care for those with significant declines in intrinsic capacity, including those living in LTC facilities.

Key discussion points

- **Screening and assessment:** In some instances, screening might not be required. For example, in an older person with an existing significant loss of intrinsic capacity, an assessment would be the appropriate first step. Within the screening and assessment steps, further work is needed on how to capture functional ability beyond the ADL and instrumental ADL scales. An assessment should always begin with a person-centred conversation focused on the older person's goals and preferences.
- **Personalized care plan:** Work may be needed to define what a care plan is. Understanding why a certain task is needed and the value of providing it may increase the recognition and legitimacy of more "informal" tasks (personal assistance) undertaken by caregivers, such as bathing, dressing and feeding. There might be a need to distinguish between tasks and care. If the care plan is articulated in terms of the functional ability outcomes desired, then the tasks become the mechanisms to achieve them, and the competencies would become the design and delivery and adaptation of "tasks" to achieve functional ability as the goals.
- **Implementing and monitoring:** An articulation of the importance of monitoring the personalized care plan should include an emphasis on the quality of services received.
- **Implementation in local contexts:** It cannot be assumed that people in LTC facilities or with significant losses of intrinsic capacity will have had a comprehensive geriatric assessment. This is not always the case, particularly in unregulated LTC systems.
- **Community engagement:** If a continuum of care is to be achieved, community engagement will be crucial, particularly where there is a reliance on, or preference for services delivered within the community and by community organizations.

CCHA and GNLTC joint panel "continuum of integrated care for older people"

Actions for CCHA

- ⊕ Support consistent communication on "ICOPE" and "the continuum of care", agreeing with WHO, definitions and uses for different terms that focus on a person-centred approach and differentiate between care for those with high and declining intrinsic capacity and those with LTC needs.
- ⊕ Build evidence on the intrinsic capacity trajectory and its relation to care transitions and different settings.
- ⊕ Share examples of how the continuum of care can be operationalized in practice at different entry-points and in different settings.
- ⊕ Support research to better address the environmental factors for people with significant loss of intrinsic capacity and functional ability.

Actions for WHO

- ⊕ Work to clarify how the ICOPE approach embraces LTC and what is included in appropriate assessment and quality services for people with significant loss of intrinsic capacity and functional ability.
- ⊕ Provide training and guidance for caregivers to address increased demand for LTC services.

The way forward

The final panel of the 2023 CCHA meeting focused on the way forward, looking at work planned by WHO and with the CCHA in the year ahead. A summary of the action points for both CCHA participants and WHO for each of the panels was presented (shown at the end of each panel in this report). WHO also shared an overview of its technical products planned for development in 2024–2025, including with inputs from CCHA participants.

Planned WHO technical products on care for older people

- ICOPE handbook version 2
- Training modules on the ICOPE approach
- LTC package integration into the WHO UHC compendium
- Integrate interventions from the WHO guideline for the management of chronic primary LBP into WHO UHC compendium
- Implementing tools for LTC systems and services
- Informal caregiver training and support tools
- National toolkit for monitoring the UN Decade of Healthy Ageing (2021–2030), including indicators to monitor action area 3 on integrated care

Key discussion points

- Global Ageing Population Survey
- Research prioritization agenda to improve care for healthy ageing.

The discussion considered what general developments in the work of WHO, supported by the CCHA, could facilitate achievement of the actions listed related to each panel, and influence the vision and scope of future work.

- **Partnership and collaboration with civil society:** CSOs play a key role in the delivery of services for older people, in advocating and influencing policy on healthy ageing and in holding governments and other service providers to account. They are also often engaged with research agendas, in conducting research and disseminating findings, but also in flagging gaps in research to support advocacy and policy change. Partnerships with civil society to support the delivery of integrated care could be strengthened, including through the CCHA.
- **Engagement with the private sector:** Much more thinking is needed on engagement with the private sector, both within the CCHA and for the implementation of the continuum of care. As discussed in Panel 3, there are private entities at all levels of health and care systems, and their roles and activities vary. Strategic or local operational partnerships could be created with private/independent for-profit or not-for-profit providers, many of whom are already providing services

or activities related to healthy ageing. Health and care regulators might provide an opportunity to bring different stakeholders in integrated primary health services and LTC together for increased collaboration.

- **Meaningful engagement of older people:** The importance of direct and meaningful engagement with older people needs to be more clearly recognized and articulated. This has received limited focus from the CCHA to date, and needs to become a higher priority.
- **An ethical framework and responsibilities towards global health and care workforce challenges:** The global rollout of integrated care for older people is happening in the context of health and care workforce shortages. The movement of HCWs from LMICs, to address shortages in high-income countries, is leading to a loss of expertise and capacity in lower income settings and creating communities consisting primarily of older people and children, with the middle generation absent. This increases the burden of informal care on older people who take on increasing responsibilities for childcare and care for their peers. The rollout of integrated care for older people could contribute to these challenges and needs to be considered within an ethical framework that takes into account health practitioner regulation *(46).*

The way forward

Actions for CCHA

- ⊕ Identify potential collaborations with the private sector where joint actions or synergies can contribute to the realization of integrated care of older people.
- ⊕ Work to advocate for collaboration and coordination between the health and social sectors at national and local levels.
- ⊕ Share good practice on multisectoral collaboration and facilitate implementation of best practices.

Actions for WHO

- ⊕ Further engage more CSOs and care service providers in WHO's activities as critical actors, especially at the community level, including in holding service providers to account.
- ⊕ Keep the ICOPE handbook, and particularly the screening tool for PHC, as simple as possible to maintain easy implementation.
- ⊕ Explore how to engage the private sector for a common agenda within a regulatory framework.
- ⊕ Engage more researchers and clinicians from LMICs to improve representation and understanding.

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Annex 1. WHO Clinical Consortium on Healthy Ageing 2023 meeting agenda

Tuesday 5 December 2023 (Day 1)

09:00–09:30	*Welcome*	
09:30–10:20	**Introduction and objectives of the meeting**	
09:30–09:35	Welcoming remarks	Anshu Banerjee
09:35–09:50	Update from 2022 and objectives of the meeting	Yuka Sumi
09:50-10:20	Introduction of participants	All
10:20–11:00	**Panel 1. WHO's new initiatives on ageing and health**	Chair: Jane Barratt
10:20–10:33	WHO-ESCEO initiative on bone health	Jotheeswaran Amuthavalli Thiyagarajan
	Reflection	Jean-Yves Reginster René Rizzoli
10:33–10:46	WHO-EuGMS collaboration	Cornel Sieber
10:46–11:00	Nutrition and ageing	Jotheeswaran Amuthavalli Thiyagarajan
11:00–11:15	*Break*	
11:15–12:50	**Panel 2. Musculoskeletal health**	Chair: Hidenori Arai
11:15–11:30	Overview of musculoskeletal health for older people	Anthony Woolf
11:30–11:50	WHO guideline for the non-surgical management of chronic primary low back pain in adults	Yuka Sumi
11:50–12:05	WHO Package of interventions for rehabilitation	Antony Duttine
12:05–12:20	Prevention of loss of muscle mass and function	Rosaly Correa-de-Araujo
12:20–12:50	Plenary discussion: How to integrate and strengthen musculoskeletal care for older people	
12:50–14:00	*Lunch break*	

14:00–17:30	**Panel 3. Implementation of the ICOPE approach**	Chair: Fatemah Bendhafari
14:00–14:15	Progress on delivering person-centred integrated care and primary health services responsive to older people	Rachel Albone
14:15–14:30	Adaptation of ICOPE approach to local context	Yuka Sumi
14:30–15:30	Implementation of the ICOPE approach at system levels	Country representatives
	Botswana	Batisi Ogopoleng
	Qatar	Hanadi Khamis Mubarak Alhamad
	Sri Lanka	Shiromi Maduwage (online)
	Cambodia	Hero Kol
	France	Azeb Sebatlab (online)
	Ireland: *critical reflection*:	Siobhan McArdle
15:30–15:50	Plenary discussion: How to transform and integrate health and social care system?	
15:50–16:05	*Break*	
16:05–16:55	Implementation of the ICOPE approach at clinical and service levels	Chair: Saniya Sabzwari
	Kuwait	Fatemah Bendhafari
	France	Neda Tavassoli
	China	Ninie Wang
	Nepal	Ramesh Kandel
	Singapore	Carol Ma
16:55–17:25	Plenary discussion: How to strengthen integrated care in the community and primary care?	
17:25–17:30	Wrap up Day 1	Matteo Cesari

Wednesday 6 December 2023 (Day 2)

08:15–08:45	*Welcome*	
08:45–08:50	Recap of Day 1	Matteo Cesari
08:50–10:10	**Panel 4. Emerging themes to strengthen integrated care**	Chair: Camilla Williamson
08:50–09:05	HIV and ageing	Marco Vitoria
09:05–09:20	NCD integration, ageing and multimorbidity	Slim Slama
09:20–09:40	Plenary discussion	
09:40–09:55	WHO Global Competency and Outcomes Framework for UHC	Siobhan Fitzpatrick (online)
09:55–10:10	ICOPE training programme	Matteo Cesari
10:10–10:30	Plenary discussion	
10:30–10:45	*Group photo and break*	
10:45–17:30	**Panel 5. Updating ICOPE care pathways**	Chair: Arvind Mathur
10:45–11:00	Updating ICOPE generic care pathways	Yuka Sumi
11:00–11:15	Updating the ICOPE screening tool	Matteo Cesari
11:15–11:35	Plenary discussion	
11:35–11:50	Feasibility and validity of self-screening	Philipe de Souto Barreto
11:50–12:10	Plenary discussion	
12:10–12:15	Instructions for the following breakout session	Yuka Sumi
12:15–13:15	*Lunch break*	

13:15–17:30	**Breakout sessions for each care pathway**	Chair: Eduardo Ferriolli
13:15–13:55	WG1. Cognition WG2. Locomotion WG3. Malnutrition WG4. Hearing WG5. Psychological WG6. Vision WG7. Social care and support WG8. Caregiver support	
13:55–14:10	Urinary incontinence care pathway	Yuka Sumi
14:10–14:25	Plenary discussion	
14:25–15:25	Reporting of breakout session and discussion WG1. Cognition WG2. Locomotion WG3. Malnutrition WG4. Hearing	
15:25–15:35	*Break*	
15:35–16:35	Reporting of breakout session and discussion WG5. Psychological WG6. Vision WG7. Social care and support WG8. Caregiver support	
16:35–17:25	Plenary discussion	
17:25–17:30	Wrap up Day 2	Yuka Sumi

Thursday 7 December 2023 (Day 3)

08:15–08:45	*Welcome*	
08:45–08:50	Recap of Day 2	Hyobum Jang
08:50–09:50	**Panel 6. Multidimensional approach to research on healthy ageing**	Chair: Leon Geffen
08:50–09:05	Research prioritization agenda	Matteo Cesari
09:05–09:35	Intrinsic capacity and environment	
	Japan	Naoki Kondo
	Brazil	Marlon Aliberti
09:35–10:00	Plenary discussion	
10:00–10:15	*Break*	
10:15–11:15	**Panel 7. CCHA and GNLTC joint panel: continuum of integrated care for older people**	Chair: Jack Rowe
10:15–10:30	Long-term care package for UHC	Hyobum Jang
10:30–10:45	Operationalization of “continuum of integrated care”: how to make ICOPE care pathways applicable for LTC?	Matteo Cesari
10:45–11:15	Plenary discussion	
11:15–11:40	**Panel 8. The way forward**	
11:15–11:40	Plenary discussion: The way forward	Finbarr Martin, Yuka Sumi
11:40–11:45	Closing remarks	Yuka Sumi Anshu Banerjee

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