ICOPE

Integrated care for older people handbook

Guidance for person-centred assessment and pathways in primary care

Second edition

World Health Organization

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Contents

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Abbreviations and acronyms

ADL	activities of daily living
BADL	basic activities of daily living
BMI	body mass index
CBT	cognitive behavioural therapy
CCHA	Clinical Consortium on Healthy Ageing
CVD	cardiovascular disease
dBA	adjusted decibels
dBHL	decibels hearing level
FPG	fasting plasma glucose
IADL	instrumental activities of daily living
ICOPE	integrated care for older people approach
LBP	low back pain
LTC	long-term care
MUAC	mid-upper arm circumference
OSN	oral supplemental nutrition
PHC	primary health care
PTA	pure tone audiometry
SDG	Sustainable Development Goal
SPPB	short physical performance battery
TAP	Training in Assistive Products (WHO)
UHC	universal health coverage
UI	urinary incontinence
UN	United Nations
UTI	urinary tract infection
WHO	World Health Organization

Glossary

Ableism: A social prejudice that defines persons with disabilities by their disabilities and characterizes them as being inferior to those who do not have disabilities.

Age-friendly environment: Environment, such as home or community, that fosters healthy ageing by building and maintaining intrinsic capacity throughout the life course and by enabling greater functional ability in someone with a given level of capacity.

Ageing in place: The ability to live in one's own home and community safely, independently and comfortably, regardless of age, income or capacity. Ageing in (the right) place extends this concept to the ability to live in the place that closest fits a person's needs and preferences, which may or may not be their own home.

Assistive products: Assistive products maintain or improve functional ability and independence, and thereby promote well-being. Assistive products can range from physical products such as wheelchairs, spectacles, pill organizers, toilet chairs and hearing aids, to digital solutions such as fall alarms, time management software and captioning. Assistive technology is the umbrella term for assistive products and their related systems and services.

Basic activities of daily living (BADL): The basic activities necessary for daily life: bathing or showering, dressing, eating, getting in and out of bed or chairs, using the toilet, and getting around inside the home.

Brain health: The state of brain functioning across cognitive, sensory, social, emotional, behavioural and motor domains, allowing a person to realize their full potential over the life course, irrespective of the presence or absence of disorders.

Care coordinator: A health worker who ensures adequate communication and coordination of decisions and information among teams and services, facilitates navigation by an older person and carers through various systems and ensures integrated care delivery. Case managers frequently act as care coordinators. A care coordinator is often chosen from the members of the multidisciplinary team.

Care worker: A health worker who provides direct personal care services in the home, in health care and residential settings assisting with routine tasks of daily life, with the requisite training, remuneration, supervision and regulation in place. Examples include formal caregivers, social workers and nurses.

Carer: An individual such as a family member, partner, friend or neighbour who delivers care within households or the community, who commonly shares affective or social bonds with care recipients. They may provide regular, occasional or routine care or be involved in organizing care delivery by others. Carers are distinct from care workers, as they are not employed by organizations entitled to coordinate and deliver services. Their role is informal and unpaid.

Case manager: A health worker who supports, guides and coordinates care for older people, families and carers. They serve as the centre of communication, connecting individuals with members of a multidisciplinary team and community stakeholders. A case manager is usually chosen from the members of the multidisciplinary team.

Cognitive behavioural therapy (CBT): Psychological treatment that combines cognitive components, aimed at thinking differently (e.g. through identifying and challenging unrealistic negative thoughts) and behavioural components, aimed at doing things differently (e.g. by helping the person to do more rewarding activities).

Cognitive decline: A decline in one or more cognitive functions such as attention, problem solving, learning ability and memory.

Cognitive function: Processes involved in the acquisition and retention of knowledge (including language and social norms), manipulation of information, reasoning and emotional regulation.

Cognitive stimulation therapy: A nonpharmacological intervention that encompasses a variety of approaches including reality orientation, validation, and/or reminiscence through group activities and social interaction.

Cognitive training: An umbrella term referring to a group of non-pharmacological interventions in which a range of techniques are applied to engage thinking and cognition with various degrees of breadth and specificity. It targets isolated cognitive functions (e.g. memory) with individual, repetitive practice of standardized cognitive tasks.

Community-based health care: Services delivered by a range of health workers in the community, according to their training and capacity – lay and professional, formal and informal, paid and unpaid – as well as facility-based personnel who support and supervise them and provide outreach services and campaigns.

Community engagement: A process of developing and maintaining relationships that enable stakeholders who share a geographical location and/or thematic area of focus to work together to address health-related issues and promote well-being to achieve positive and sustainable health impact and outcomes.

Community health worker: Health workers who provide health services including health education, in partnership with health workers in health care facilities and referrals for a wide range of services, and provide support and assistance to communities, families and individuals. They provide preventive health measures and facilitate access to appropriate health and social services by bridging gaps between providers of health, social and community services and communities that may have difficulty in accessing these services. Community health workers are also known as village health worker, community health aide or promoter, health educator, or some other term.

Community stakeholders: Individuals, families, groups or organizations that have an interest or investment in a community and are affected by or can affect the decisions, policies and operations within that community. This includes but is not limited to civil society organizations (e.g. nongovernmental organizations, community-based organizations, faith-based organizations), private sector constituencies, older people's associations, groups or clubs, peer support groups, volunteers and home-based carers, operating within an organized programme. Community health workers are considered to be community stakeholders, while also being included under the definition of health workers.

Continuum of care: The spectrum of personal and population health and social care needed during all stages of intrinsic capacity, functional ability, disease, injury or event throughout the life course, including health promotion, prevention, treatment, rehabilitation, palliative care and long-term care.

Functional ability: The health-related attributes that enable people to be and to do what they have reason to value; it is made up of the intrinsic capacity of the individual, relevant environmental characteristics and the interactions between the individual and these characteristics.

Geriatrics: Medical speciality focused on providing patient-centred care to older people.

Health workers: All people primarily engaged in actions with the primary intent of enhancing health (e.g. health and care workers, health care professionals, health programme managers).

Healthy ageing: The process of developing and maintaining the functional ability that enables well-being in older age.

ICOPE handbook: The tool to support health workers to provide ICOPE in primary care, including the community.

Inappropriate medication(s): Inappropriate medication(s) are present when one or more medicines are prescribed that are not or no longer needed, either because: a) there is no evidence-based indication, the indication has expired or the dose is unnecessarily high; b) one or more medicines fail to achieve their therapeutic objectives; c) one, or the combination of several medicines, cause or are at risk of causing adverse drug reactions; and d) the patient is not willing or able to take one or more medicines as intended.

Instrumental activities of daily living (IADL): Activities that facilitate independent living: ability to use a telephone, shopping, food preparation, housekeeping, laundry, transportation method, use of medication, handling finances.

Integrated care: Services managed and delivered in a way that ensures people receive a continuum of care across health and social care, through a person-centred approach. This includes health promotion, prevention, diagnosis, treatment, rehabilitation and palliative care and social care services including long-term care. Service delivery is integrated across sectors, settings and sites across the life course.

Integrated care for older people approach (ICOPE): The WHO approach to provide a continuum of integrated care that helps to reorient health and social services towards a more person-centred and coordinated care that supports optimizing intrinsic capacity and functional ability for older people. The approach is referred to as "ICOPE".

Intrinsic capacity: The composite of all the physical and mental capacities that an individual can draw on.

Loneliness: A subjective experience arising from a mismatch between expected and the actual quality and quantity of connections.

Long-term care (LTC): The activities undertaken by others to ensure that people with a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity.

Multidisciplinary team: A group of health and care workers from various organizations and professions (e.g. doctors, nurses, physiotherapists, social workers) that work together to make decisions regarding the care of an older person and their carers, and provide care in a collaborative and coordinated manner.

Multimodal exercise: Exercise that is designed to develop balance, aerobic capacity, muscle strength, flexibility and coordination with the aim of maintaining and promoting intrinsic capacity (e.g. locomotor capacity, cognition), reducing the risk of falls and preventing injuries including fractures.

Palliative care: An approach that improves the quality of life of patients and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual.

Person-centred care: An approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants in, as well as beneficiaries of, health care and LTC systems that respond to their needs and preferences in humane and holistic ways. Person-centred care is organized around the needs, values, preferences and expectations of individuals rather than diseases.

Physical activity: Any bodily movement produced by skeletal muscles that requires energy expenditure – including activities undertaken while working, playing, carrying out household chores, travelling or engaging in recreational pursuits.

Physical exercise: Subcategory of physical activity that is planned, structured, repetitive and aims to improve or maintain one or more components of physical capacities.

Polypharmacy: The concurrent use of multiple medications often defined as the routine use of five or more medications. This includes over-the-counter, prescription and/or traditional and complementary medicines used by a patient.

Primary care: A key process in the health system that supports first-contact of care, often provided in primary care facilities, community health centres, health posts, mobile clinics and through outreach services. Primary care enables the continued provision of person-centred integrated care within close proximity to people's daily lives.

Primary health care (PHC): A whole-of-society approach to effectively organize and strengthen national health systems to bring services for health and well-being closer to communities. It has three components: integrated health services to meet people's health needs throughout their lives; addressing the broader determinants of health through multisectoral policy and action; and empowering individuals, families and communities to take charge of their own health.

Psychoeducation: An intervention to provide information to people with mental health conditions and their carers/family members about the nature of the condition, including its likely causes, progression, consequences, prognosis and treatment.

Rehabilitation: Rehabilitation refers to a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment. Rehabilitation helps older people to be as independent as possible in everyday activities and enables participation in education, work, recreation and meaningful life roles.

Rehabilitation services: Delivery of interventions for rehabilitation (see above definition) through a structured process of identifying needs, defining goals, planning, delivering and monitoring care, usually over a series of sessions.

Self-care: The ability of individuals, families and communities to promote and maintain their own health, prevent disease and to cope with illness – with or without the support of a health or care worker.

Self-management: The ability to use devices, medicines and knowledge to undertake self-medication, self-treatment, self-examination and self-injection.

Social care: Assistance and support to individuals and their families with the basic and instrumental activities of daily living (personal care) to promote quality of life and well-being.

Social isolation: Refers to the objective number of social connections and interactions an individual experiences. A person may be socially isolated if they have a small network of kin and non-kin relationships and thus few or infrequent interactions with others.

Social protection: Social protection is a human right and is defined as the set of policies and programmes designed to reduce and prevent poverty and vulnerability throughout the life course. Social protection includes benefits for children and families, maternity, unemployment, employment injury, sickness, older age, disability, as well as health protection.

Social support: Psychological, physical and financial support accessible to an individual through social ties to other individuals, groups and the wider community, which can provide a buffer against adverse life events, foster resilience and provide a positive resource for health.

Task sharing: An approach to optimize health workforce utilization, particularly in the face of workforce shortages, wherein specific tasks or roles are shared, where appropriate, to less specialized health workers in order to make more efficient use of the available personnel. It should be accompanied by appropriate measures in terms of education, supervision, management support, licensing, regulation and remuneration.

Universal health coverage (UHC): All people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care across the life course.

1 Integrated care for older people

Key points

- The key to supporting healthy ageing for all is optimizing people's intrinsic capacity and functional ability throughout the life course.
- Care-dependency can be reduced, delayed or prevented if the declines in intrinsic capacity are promptly identified, assessed, diagnosed and managed including through creating an enabling physical and social environment.
- The declines across the domains of intrinsic capacity are interrelated and so require an integrated and person-centred approach to assessment and management.
- Older people are key actors in their own health and should be empowered to understand their health, make their own decisions and set their own goals. Their meaningful engagement, and that of their carers, is crucial.
- Health workers in primary care, including in the community, can identify older people with loss(es) in intrinsic capacity and provide evidence-based interventions by using this guidance and adapting it to their context.
- Community stakeholders have an important role to play in supporting the delivery of integrated care for older people, and empowering them to engage with self-care and self-management.

The 2015 *World report on ageing and health* defines the goal of healthy ageing as "helping people to develop and maintain the functional ability that enables well-being in older age". Functional ability is defined as the "health-related attributes that enable people to be and to do what they have reason to value". Functional ability consists of the intrinsic capacity of the individual, their environment and the interactions between the two. Environments comprise all the factors in the extrinsic world (home and home surroundings, community and broader society) that form the context of an individual's life. Factors within these environments include the built (physical) environment, people and their relationships, attitudes and values, health and social policies, systems and services. Intrinsic capacity is "the composite of all the physical and mental capacities that an individual can draw on"(*1*).

This concept of healthy ageing inspires a new focus for health care for older people – a focus on optimizing people's intrinsic capacity and functional ability as they age. As an older person's intrinsic capacity changes, so too will their needs and preferences for health services and social care and support. The delivery of a continuum of integrated care, following the trajectory of intrinsic capacity and functional ability, is crucial in order to meet these diverse needs and support optimal functional ability. A continuum of care includes the full spectrum of care, from prevention and promotion to treatment, rehabilitation and palliative care and responds to a person's changing needs and intrinsic capacity, and disease progression.

Older people with significant loss of intrinsic capacity not only need health care, but also appropriate social care and support to compensate for their loss. This support may be provided by carers and can be facilitated by the use of assistive products to create an enabling environment. Long-term care (LTC) includes activities undertaken by others to support people with significant loss of intrinsic capacity to maintain a level of functional ability and sustain a dignified life, consistent with their basic rights and fundamental freedoms. Long-term care can be provided in various settings such as home, community and residential facilities. Much of the day-to-day care needed by older people is provided by carers, often family members, who also require support.

1.1
Why do we need integrated care for older people?

Older people make up a larger part of the world's population than ever before. In 2024, there were an estimated 1.18 billion people aged 60 years or over in the world (14.5% of the global population). This percentage will rise rapidly in the coming decades, particularly in low- and middle-income countries. By 2050, there will be 2.1 billion people aged 60 and over, constituting 22% of the global population *(2)*, and people aged 65 and over will outnumber those under 18 *(3)*. This reflects the combined impact of rapidly falling fertility rates and increasing life expectancy in much of the world, often accompanying socioeconomic development.

Maintaining the health of older people is an investment in human and social capital and supports the United Nations (UN) Sustainable Development Goals (SDGs) and the right of all people everywhere to the highest attainable standard of physical and mental health. At the same time, caring for the growing older population creates challenges for health and social care systems. A fundamental change in public health approaches to population ageing is needed.

Conventional approaches to health care for older people have focused on individual diseases, often in isolation, putting the diagnosis and management of these at the centre. Addressing these diseases remains important, but focusing too much on them can lead to difficulties when hearing, seeing, remembering, moving and the other common losses in intrinsic capacity that can come with ageing are overlooked.

A continuum of care requires the implementation of integrated services for older people and their carers across all health and social care settings, from older people's homes, primary care clinics and hospitals to LTC facilities. Communities have a particularly important role to play to enable "ageing in place".

A shift to an integrated continuum of care that is holistic and focuses on intrinsic capacity and functional ability besides diseases is required, based on a primary health care (PHC) approach. They share a bidirectional relationship, with poorly controlled diseases potentially precipitating the onset or acceleration of declines in intrinsic capacity, and impairments of intrinsic capacity potentially altering disease trajectories. Attention throughout the health and social care system(s) to the intrinsic capacity and functional ability of older people will contribute broadly to the welfare of this large and growing part of the population.

Health workers including care workers need guidance and training to recognize and effectively manage declines in intrinsic capacity and maintain functional ability, and to deliver care in an holistic and integrated way that responds to the diverse health and care needs of older people. As populations age, there is a pressing need to develop comprehensive community-based approaches that include interventions to prevent or delay declines in intrinsic capacity, optimize functional ability by enabling the physical and social environment, and to support the carers of older people.

1.2
What is the integrated care for older people approach?

ICOPE

The integrated care for older people approach, referred to as ICOPE, aims to facilitate the reorientation of health and social services towards more person-centred and coordinated care that supports the optimization of intrinsic capacity and functional ability for older people. ICOPE is WHO's approach to support the delivery of integrated care for older people within the context of a PHC-oriented health system.

Box 1.1 Ageism

Ageism refers to the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) directed towards people on the basis of their age. Ageism exists in our institutions, our relationships (interpersonal) and ourselves (self-directed). Ageism impacts negatively on older people's health and well-being (*4*).

Ageism within health systems and services: At the system level, health strategies often neglect older people or may include ageist policies, such as the denial of treatment on the basis of age; care for older people and specific services that address the most common issues faced in older age are often neglected; funding is not prioritized; and facilities are not designed to be accessible for older people. A lack of training and support and unchallenged cultural perceptions of ageing can also lead to health workers having negative attitudes towards older people or the ageing process, engaging in patronizing behaviour, failing to consult older people about their preferences for care, and exclusion of older people from clinical trials. Declines in intrinsic capacity are often overlooked by health workers, who interpret them as "normal" signs of ageing, which is a form of ageism. The attitudes of health workers and older people's experiences within health care settings can affect older people's health-seeking behaviour. The extent to which health workers hold ageist attitudes towards older people, while perceived to be high, is uncertain. A range of systemic and individual factors can influence attitudes, including policies, education, resource shortages, gender, whether the health worker chose to work specifically with older people, experience of intergenerational contact and cultural background.

Self-directed ageism: Self-directed ageism refers to ageism turned against oneself that has a negative impact on health. People internalize age-based biases from their surrounding culture after being repeatedly exposed to those biases. They may think that declines in intrinsic capacity are "normal" with increasing age and cannot be prevented or changed and may feel there is nothing they can do to improve their own health and well-being.

ICOPE offers an opportunity to tackle ageism by improving the competencies of health workers in older people's health and integrated care and by empowering older people and carers. Community stakeholders can play a role through raising awareness, including with older people themselves, about ageism and older people's right to health and care, the effectiveness of health promotion and prevention in older age, and that it is possible to manage losses in intrinsic capacity and to optimize functional ability.

ICOPE should be implemented in line with the following guiding principles:

- Older people have the right to the highest attainable standard of physical and mental health.
- Older people should have equal opportunity to access services that address the determinants of healthy ageing, and to be supported to adopt healthy behaviours, regardless of their social or economic status, place of birth, residence, age, gender or other social factors.
- Older people should be included as key decision-makers in their own care, respecting their autonomy.
- Care should be provided equally to all, without discrimination, particularly gender discrimination, ableism or ageism (**Box 1.1**).

The WHO *Integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity* set out 13 evidence-based recommendations for health workers to carry out person-centred integrated care for older people in primary care including in the community. In order to put these ICOPE recommendations into practice, WHO published the *Integrated care for older people handbook: guidance on person-centred assessment and pathways in primary care* in 2019 (*5*) to address the lack of guidance and training for most health workers in recognizing and effectively managing declines in intrinsic capacity and functional ability and delivering holistic and integrated care. It offered a care pathway, consisting of steps health workers should take in the delivery of integrated care for older people and detailed care pathways to manage declines in intrinsic capacity across six domains – cognitive decline, limited mobility, malnutrition, vision impairment, hearing loss, depressive symptoms – as well as to support carers and enable social care and support.

1.3 ICOPE in primary health care

WHO defines PHC as a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs as early as possible along the continuum from health promotion and prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment.

As outlined in the Declaration of Astana, PHC includes three inseparable and mutually influential components:

- putting primary care and the essential public health functions together at the core of integrated health services;
- leveraging multisectoral policy and action; and
- empowering people and communities as co-creators of their health.

Primary care is at the heart of the services component of PHC that supports first-contact, accessible, continuous, comprehensive and coordinated care, often provided in primary care facilities (polyclinics, walk-in clinics), homes, community health centres, health posts, mobile clinics and through outreach services. It is characterized as the delivery of a full spectrum of integrated health services, close to where people live, through a person-centred approach. Primary care can also drive other components of the PHC approach by engaging with the community and empowering older people and their carers.

The original care pathway in the first ICOPE handbook (2019) was designed to support health workers in primary care to provide person-centred integrated care within close proximity to an older person's daily life. The steps of the original care pathway can, however, be applied in different settings and with older people with varying levels of intrinsic capacity, including those with significant losses (LTC needs). This handbook (second edition) therefore offers an overarching care pathway comprised of four steps (**Fig. 1.1**, p. 5), that should be seen within a broader PHC approach at the population level, supporting the identification of older populations' needs; planning, designing, organizing, managing and monitoring of services. It can be adapted and expanded through the provision of detailed guidance for each step, to enable its implementation in different situations and settings (e.g. for older people in residential LTC facilities).

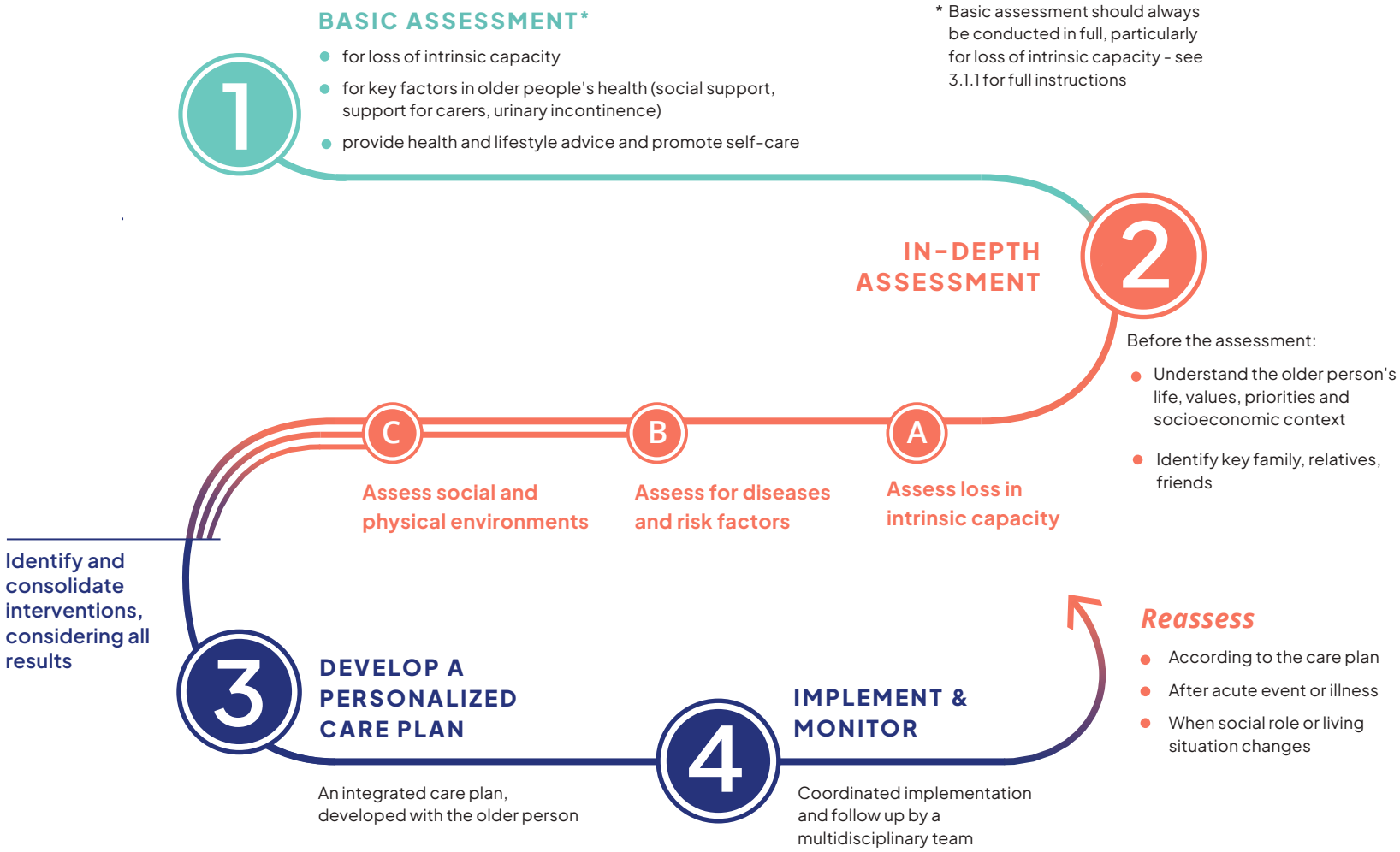
Any adaptation and development of the overarching care pathway should maintain a core focus on:

- an assessment of individual **needs, preferences and goals**;
- the development of **a personalized care plan**;
- **multidisciplinary** team-based service delivery;
- **longitudinal care provision** following the trajectory of intrinsic capacity;
- **coordinated health and social services,** driven towards the single goal of maintaining intrinsic capacity and functional ability; and
- reorientation towards a PHC approach to meet the needs of older people with services delivered through **primary care** including in the community.

This overarching care pathway can inform multisectoral policy and action, recognizing the important roles of sectors beyond health such as housing, transport and social welfare, in line with the vision of the UN Decade of Healthy Ageing (2021–2030) (**Box 1.2**, p. 6). The overarching care pathway can be used alongside the ICOPE care pathway in primary care to influence policy decision making with regard to service provision for older people. This will contribute to the strengthening of the PHC-oriented health systems required to enable the delivery of a continuum of integrated care for older people (Chapter 14). Implementation of ICOPE could also support the achievement of better health outcomes, improved equity, increased health security and better cost-efficiency; all closely linked with PHC.

The detailed care pathways (Chapters 3–13), focus explicitly on the implementation of integrated care for older people in primary care.

Fig. 1.1
ICOPE care pathway



Box 1.2 ICOPE in context

The UN Decade of Healthy Ageing, 2021–2030 includes a focus on the role of health systems in promoting healthy ageing by optimizing intrinsic capacity and functional ability, initially outlined in the WHO *Global Strategy and Action Plan on Ageing and Health (2016–2020) (6)*. The vision of the UN Decade is a world in which all people live long and healthy lives delivered through a global multisectoral collaboration for concerted and catalytic action on healthy ageing. It is focused on four action areas including the delivery of person-centred, integrated care and primary health services responsive to older people, and providing access to LTC for older people who need it. The ICOPE technical resources for primary care as well as the *Long-term care for older people: package for universal health coverage (7)* contribute to achieving these commitments.

Universal health coverage (UHC) is the foundation for achieving the health objectives of the SDGs and means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship *(8)*. To achieve UHC, older people's health needs must be addressed through a continuum of integrated care, delivered through health services that are based on a PHC-oriented health system.

WHO has developed a suite of resources to optimize primary care service delivery, including the UHC Service Planning, Delivery & Implementation (SPDI) Platform and the UHC Compendium. The SPDI is an online resource that supports countries to optimize and integrate service delivery, across the full spectrum of care and across the life course. Countries are able to build a package of health services using specific tools and resources, including the ICOPE technical resources.

Achieving health for all is the goal of UHC. To achieve this, all people, including all older people, need to have access to health services. Disability is not a natural part of ageing, but prevalence of disability does increase with age, from 5.8% in children and adolescents aged 0–14 years, to 34.4% among people aged > 60 years *(9)*. The delivery of disability inclusive health services requires intersectoral actions to support access for older people with disabilities, alongside all people living with disabilities. The *WHO Global report on health equity for people with disabilities* outlines 40 key actions for countries to take to strengthen their health systems and reduce health inequities for people with disabilities.

1.4 Integrated care for older people: guidance for person-centred assessment and pathways in primary care (ICOPE handbook), second edition

This second edition of the ICOPE handbook in primary care incorporates learning from the implementation of integrated care for older people in diverse contexts around the world and relevant new or updated guidelines produced by WHO. The ICOPE handbook (second edition) has been developed in collaboration with experts in healthy ageing and the care of older people through WHO's Clinical Consortium on Healthy Ageing (CCHA) and with colleagues across a range of technical units and regions in WHO.

Inputs were sought through field experiences as well as meetings of the CCHA, primarily the 2023 meeting, at which the update of the care pathways was the major agenda item. Participants at this meeting and other experts reviewed the revised care pathways and guidance in this handbook throughout its development. All those involved in the development and review of the handbook were asked to declare any conflicts of interest on the WHO form for declaration of interests by WHO experts. No declared interests were considered to be significant.

Key changes in the second edition of the handbook

1. Four-step care pathway
The ICOPE care pathway consists of four rather than five steps: basic assessment and community level interventions; in-depth assessment; developing a personalized care plan; and implementing and monitoring. The crucial role of community stakeholders and carers at all steps of the pathway has been recognized. In response, community engagement and supporting carers have been included as key elements across the four steps of the pathway, with a key focus in Step 1, rather than being addressed as a separate fifth step.

2. Expanded Step 1
To ensure the provision of key information, services and support, at the first point of contact with an older person, as well as to enable the delivery of care for older people within communities and by community stakeholders in resource-limited contexts, Step 1 has been expanded. Alongside a basic assessment (previously termed "screening"), health and lifestyle advice and community-based health care to address losses in intrinsic capacity can be provided. The term "basic assessment" is used, rather than screening, to reflect the move from a sole focus on potential losses in intrinsic capacity, to also identify social support needs, carers' needs for support and presence of urinary incontinence – key factors impacting older people's health. The expansion of Step 1 to include provision of services and support is particularly important in contexts where the latter steps of the ICOPE pathway, including in-depth assessment, are not feasible to deliver, or there may be a long delay between a basic and an in-depth assessment.

3. Community engagement
The ICOPE handbook (second edition) has an increased focus on community engagement. It provides examples of what community stakeholders can do at each step of the pathway, including in the delivery of the expanded Step 1, facilitating access to health and social care, providing direct support in the community and empowering older people in their health decision-making. Community stakeholders include individuals, groups and organizations, such as nongovernmental organizations, older people's clubs, community-based organizations, peer support groups, intergenerational groups and volunteers, among others.

4. Carers' support needs
Recognizing the role of carers, most of whom are women and girls, usually family members or friends, and the lack of support they often face, greater attention is given to the support needs of carers. This includes both information and training, and the need for support to ensure carers' own health and well-being. This issue was included in the previous version of the handbook but has now been given greater prominence with specific examples included in all chapters. In the handbook, the term "carer" is used to refer to an individual, such as a family member, friend or neighbour who provides informal care to an older person.

5. Key factors in older people's health
Additional factors important to older people's health and functional ability are included and/or given more emphasis. This includes early identification of social support needs and carers needs (where applicable) in the community, promotion of vaccination as one of the most cost-effective public health interventions, and inclusion of urinary incontinence (UI), for which a new care pathway has been developed.

1.5 How to use the ICOPE handbook (second edition)

Implementation in primary care should be done within and by existing services in a culturally appropriate way.

This handbook provides a global framework and guidance for the implementation of ICOPE that health workers can use to inform the delivery of integrated care for older people in primary care in their context. It aims to provide flexibility, to ensure feasibility of implementation across different countries, contexts and resource settings. To this end, prior to implementing ICOPE in primary care, programme and system managers should conduct an assessment of their readiness to deliver, to inform an adaptation of the approach. This is important as the needs of older populations as well as health and social care systems, service delivery structures and capacities are different. Health workers can undertake similar exercises to identify available resources in their own health care settings.→ **14.2**

The detail of the specific care pathways (Chapters 5–13), in terms of tools and instruments to be used and which evidence-based interventions to be offered, where and by whom, is flexible and should be considered as part of an adaptation process.

Examples of adaptation within the ICOPE handbook (second edition) include:

- Questions and tests in the ICOPE basic assessment and for key factors are given as examples based on available evidence and expert consultation and can be amended to ensure relevance to the local context. For example, the social support questions are intended to enable a broad understanding of an older person's social needs. The way questions are asked and the wording used should be adjusted to ensure they are relevant and appropriate culturally, religiously and societally, and will be understood by older people.

- Who does each step, where and how? Although this updated pathway suggests Step 1 is implemented by community stakeholders (→ **4.1.3**), it can also be conducted by health workers in a primary care facility.

- Instruments for use in the in-depth assessment are also intended as examples, based on global validation and recommendations. It is important that locally validated and existing tools are used where they exist.

- The interventions suggested for inclusion in personalized care plans, are recommendations, based on available evidence. A personalized care plan should be developed by a health worker with input from the older person and carers, where appropriate, and should respond to the person's goals and preferences. All interventions in the care plan must be feasible to provide.

In some contexts, the capacity of health and social care systems might affect the assessment of intrinsic capacity and need for social care and support, as well as provision of interventions. It is important to note that screening for diseases, such as hypertension, suggested as part of a basic assessment, is unethical if referral pathways are not in place to enable access to further assessment and treatment. The global guidance and framework in this handbook may, therefore, be aspirational in some settings, and can provide an aim to work towards.

In all contexts and resource settings, there will be things that can be done to support older people with losses in intrinsic capacity. Through the expanded first step of the care pathway, this handbook provides recommendations for what can be done in the community immediately following a basic ICOPE assessment by community health workers and other community stakeholders if an in-depth assessment is not feasible or there will be a long delay. These actions include health and lifestyle advice to prevent declines in intrinsic capacity and functional ability and community-based health care to address declines in intrinsic capacity.

The intention of including community-level interventions at the time of a basic assessment is not to reduce the importance of the in-depth assessment or the development and implementation of a personalized care plan, which should always be the aim to enable integrated person-centred care. Rather it is to demonstrate what can be done as a starting point and in contexts where it may not yet be possible to implement the full pathway. This information can be found at the start of all chapters, following the care pathway diagram, and is highlighted both on the pathway diagrams and within the text by a coloured/shaded background.

1.6 Who is this handbook for?

The primary audience for this handbook is health workers in primary care, which include doctors, nurses, community health workers, pharmacists, nutritionists, social workers, care workers and physiotherapists, among others. The language used is purposefully simple to make the handbook accessible to as many health workers as possible, with varying levels of training in older people's health and for whom English is not a first language.

Community stakeholders who provide services, advice and support for older people can utilize the handbook to support increased community engagement. The handbook should also inform health workers whose specialized knowledge will be called on, as needed, to assess and provide care for older people.

Additionally, authorities responsible for developing training and curricula and providing accreditation in medicine, nursing, social care and public health fields may draw on both the concepts and the practical approaches described here. Other audiences include health care managers and policy-makers, such as national, regional and district programme managers in charge of planning and organizing health care services, as well as agencies that fund and/or carry out public health programmes, including age-friendly cities and communities programmes.

1.7 What does this handbook offer?

This handbook seeks to support health workers with multidisciplinary backgrounds to identify and manage declines in intrinsic capacity, based on recommended interventions in the WHO *Integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity* and relevant WHO technical guidelines and guidance. It facilitates the provision of integrated person-centred care in primary care by addressing the health and social care needs of older people.

This guidance describes how to:

- Implement the step-by-step ICOPE care pathway in primary care, including the provision of community-level interventions.
- Ensure engagement across stakeholders and sectors, including with specialized services (Chapter 4).
- Assess and manage loss of intrinsic capacity, with consideration of associated diseases and environmental factors (Chapters 5–10).
- Assess need for and provide social care and support (Chapter 11).
- Assess need for and provide support for carers (Chapter 12).
- Assess and manage urinary incontinence (Chapter 13).
- Address key considerations in implementing ICOPE (Chapter 14).

MORE INFORMATION

- ***UHC Compendium Health interventions for Universal Health Coverage, Version 1.3.*** WHO; 2024 (https://www.who.int/universal-health-coverage/compendium).
- ***UHC Service Planning, Delivery & Implementation (SPDI) Platform.*** WHO; 2024 (https://www.who.int/universal-health-coverage/compendium/related-tools).
- ***UN Decade of Healthy Ageing: plan of action, 2021–2030.*** WHO; 2020 (https://www.who.int/publications/m/item/decade-of-healthy-ageing-plan-of-action).
- ***Integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity.*** WHO; 2017 (https://iris.who.int/handle/10665/258981).
- ***Implementing the primary health care approach: a primer.*** WHO; 2024 (https://iris.who.int/handle/10665/376777).
- ***Operational framework for primary health care: transforming vision into action.*** WHO and UNICEF; 2020 (https://iris.who.int/handle/10665/337641).

2 Optimizing intrinsic capacity and functional ability

This handbook supports maintaining functional ability by addressing declines in intrinsic capacity, enabling social and physical environments (including social care and support), providing support for carers' needs and assessing and managing urinary incontinence.

Key domains of intrinsic capacity

5 **Cognition** | Cognitive decline

6 **Locomotor capacity** | Limited mobility

7 **Vitality** | Malnutrition

8 **Vision** | Vision impairment

9 **Hearing** | Hearing loss

10 **Psychological capacity** | Depressive symptoms

Key factors in older people's health

11 **Social care and support**

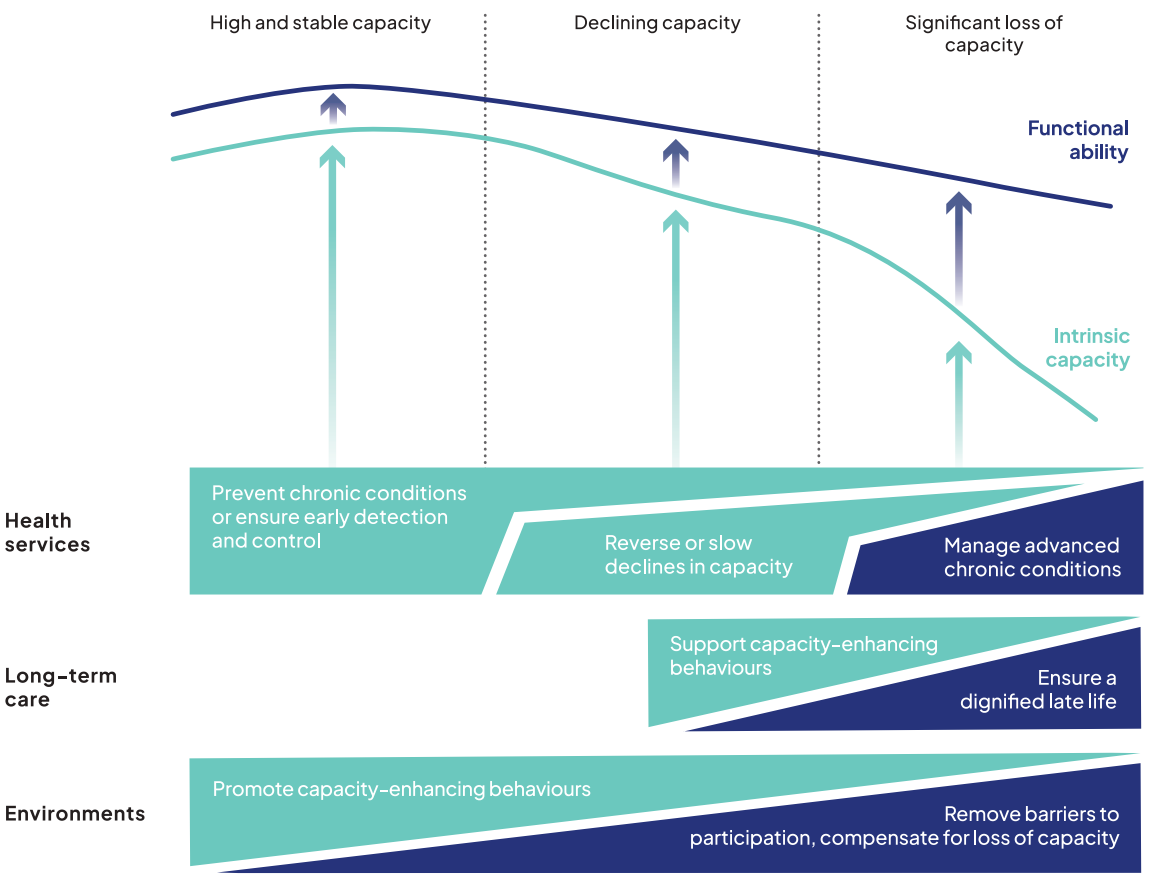
12 **Carer support**

13 **Urinary incontinence**

Key points

- Intrinsic capacity tends to decline with increasing age; however, a wide range of capacities around the average pattern, highlights the importance of a person-centred continuum of integrated care.
- Proactively identifying losses in intrinsic capacity in primary care provides an opportunity to slow or reverse declines and maintain intrinsic capacity and functional ability.
- Characteristics and behaviours that affect intrinsic capacity can often be modified through the adoption of healthy lifestyles and behaviours.
- Modifications to an older person's physical and social environment become increasingly important as intrinsic capacity declines, in order to optimize functional ability.
- Community stakeholders can advocate for the creation of environments in which older people are able to adopt healthy behaviours, while also providing direct services and support.

Fig. 2.1
Public health framework for healthy ageing: opportunities for public health action across the life course



Source: World report on ageing and health. WHO; 2015.

2.1
How does intrinsic capacity change over the life course?

Fig. 2.1 shows the typical pattern of intrinsic capacity and functional ability across the second half of life. Intrinsic capacity and functional ability decline with increasing age as a result of the ageing process as well as underlying diseases. This pattern can be divided into three common periods: a period of relatively high and stable capacity; a period of declining capacity; and a period of significant loss of capacity, characterized by dependence on care. ICOPE primarily aims to address the needs of an older person with declining capacity or with a significant loss of capacity, taking into consideration aspects of LTC and age-friendly environments of relevance to an individual's goals and care needs. For those with high and stable capacity, ICOPE provides an opportunity to ensure health promotion and prevention.

There is a wide range of intrinsic capacity around the average pattern evident both within and between countries. This is reflected in persistent differences in life expectancies, which range from 83 years and over in, for example, Australia, Italy, Japan, the Republic of Korea, Sweden and Switzerland, to less than 58 years in the Central African Republic, Chad, Lesotho, Nigeria and South Sudan (*10*).

Variation in intrinsic capacity is far greater across people in older age than across younger groups. Such diversity is one of the hallmarks of ageing, presenting both challenges and opportunities, including for person-centred approaches. One individual may be 10 years older than another but may have a similar intrinsic capacity and/or functional ability, while two older people of the same age can show very different intrinsic capacity. This is why chronological age is a poor marker of health status for older people.

2.2
Intervening to optimize intrinsic capacity and functional ability

Identifying losses in intrinsic capacity provides an opportunity to intervene to slow or reverse the declines and maintain intrinsic capacity and functional ability (**Fig. 2.1**, p. 12). Health workers in primary care, including community stakeholders, can detect declines in intrinsic capacity.

Many of the characteristics and behaviours that can determine or affect intrinsic capacity can be modified. For example, health and lifestyle advice can be provided stressing the importance of healthy diet, being physically active and avoiding a sedentary lifestyle, staying socially connected, vaccination and when and where to seek health services. These behaviours not only help directly with the maintenance of intrinsic capacity, but also reduce the risk of diseases that can contribute to losses in capacity. ICOPE in primary care supports these healthy behaviours and wider efforts towards optimizing intrinsic capacity and managing risk factors in the second half of life.

Repeated assessments over time and regular follow up make it possible to monitor any changes in intrinsic capacity while also managing chronic diseases. Specific interventions to address declines in intrinsic capacity as well as to provide social care and support can be offered in a timely manner. Multicomponent interventions that address different declines appear to be effective because of the interaction between the intrinsic capacity domains.

Community stakeholders can play a role in holding governments and local authorities to account on efforts to address social determinants of health and create environments in which older people are able to adopt healthy behaviours, while also providing services and support directly.

Modifications to an older person's physical and social environment become increasingly important as intrinsic capacity declines, in order to optimize functional ability. Five domains of functional ability (**Box 2.1**, p. 14) can all be supported by changes to an older person's home, home surroundings and other external environments. For example, making changes at home to reduce the risk of falls, or providing assistive products such as mobility aids can support older people to be mobile, while providing information on opportunities to engage with local community events and groups can encourage continued social contribution, as seen in examples provided by WHO's Global Network for Age-friendly Cities and Communities.

Carers also have an important role to play. They are often older themselves and may have their own care and support needs. The ICOPE care pathway includes an assessment of carers' needs and the provision of training and support.

An integrated approach is necessary to the assessment and management of declines in intrinsic capacity and functional ability and the provision of a continuum of care that brings together health and social care and support actors and services, including LTC.

Box 2.1 Domains of functional ability

- **To meet basic needs** such as financial security, housing and personal security, and access to health services.
- **To learn, grow and make decisions**, including continuing to learn and apply knowledge, engage in problem-solving, maintain personal development, and have the ability to make choices.
- **To be mobile,** to keep doing things around the home, accessing shops, services and facilities in the community, and participating in social, economic and cultural activities.
- **To build and maintain a broad range of relationships**, including with children and other family members, informal social relationships with friends and neighbours, as well as formal relationships with community health workers.
- **To contribute**, which is closely associated with engagement in social and cultural activities, such as assisting friends and neighbours, mentoring peers and younger people, volunteering, and caring for family members and the community.

3 Four-step ICOPE pathway in primary care

The four-step pathway in primary care includes basic assessment and interventions in the community; in-depth assessment; developing a personalized care plan; and implementing and monitoring the plan. Primary care is a key process in the health system that supports first-contact care, often provided in primary care facilities (e.g. walk-in clinics, polyclinics), homes, community health centres, health posts, mobile clinics and through outreach services. Primary care enables the continued provision of person-centred integrated care within close proximity to people's daily lives. The steps of this ICOPE care pathway in primary care can be implemented in any of these settings, and can often be delivered with community stakeholders.

Person-centred care takes the perspective that older people are individuals with unique needs and preferences within their specific social contexts. Their care goes beyond managing their diseases or health conditions to responding to their diverse needs, including their need for LTC, embracing their choices and experiences. It also addresses the impact older people's health conditions and care needs have on their family members and carers.

Key points

- Possible impairments in intrinsic capacity and social support needs can be identified in the community.
- Community health workers and other trained community stakeholders can provide tailored health and lifestyle advice to older people while conducting a basic assessment, and support them to undertake specific actions in response to potential losses of intrinsic capacity and to prevent risk factors.
- Those identified with potential losses of intrinsic capacity should be referred to primary care for in-depth assessment, which will inform the development of a personalized care plan, including referral to specialized care.
- The care plan may include multiple interventions, agreed in discussion with the older person (and carers), to manage impairments and prevent further declines of intrinsic capacity and to optimize functional ability.
- The prioritization and sequencing of the interventions can be guided by the urgency of an issue, the likelihood of success and the wider impact of addressing the issue, and what the older person feels is most important to them.
- Community stakeholders can play a role at each step of the care pathway and should be meaningfully engaged and appropriately supported to do so.

The ICOPE care pathway in primary care

COMMUNITY

1 BASIC ASSESSMENT* and initial intervention [1]

Test for loss of intrinsic capacity

PASS

Regardless of result:

- Provide health and lifestyle advice and promote self care, including vaccination
- Identify need for social support and provide the support
- Conduct basic assessment regularly

FAIL

- Community-based health care for intrinsic capacity loss
- Referral to primary care

* Basic assessment should always be conducted in full, see 3.1.1 for full instructions

PRIMARY CARE

2 IN-DEPTH ASSESSMENT [2]

(can be assessed in any order)

Before the assessment:

- Understand the older person's life, values, priorities and socioeconomical context
- Identify key family, relatives, friends

A Assess loss in intrinsic capacity

B Assess for diseases and risk factors

C Assess social and physical environments

Identify and consolidate interventions, considering all results

3 DEVELOP A PERSONALIZED CARE PLAN [3]

Discuss with the older person and carer(s) to:

- Define the goal of care
- Design an integrated care plan

4 IMPLEMENT & MONITOR [4]

- Convene multidisciplinary team across health and social care, and other sectors, where needed
- Coordinate implementation
- Ensure regular follow up

Reassess

- According to the care plan
- After acute event or illness
- When social role or living situation changes

1

Basic assessment and community-level interventions → 3.1

For all older people:

- Conduct basic assessment for loss of intrinsic capacity (Table 3.1)
- Provide health and lifestyle advice and promote self-care, including vaccination and management of cardiovascular disease (CVD) risk factors (3.1.3, 3.1.4)
- Identify need for social support (home environment, financial security, loneliness and social participation) and carer support and provide the support (Table 3.2)

For older people who fail the screening for loss of intrinsic capacity:

- In addition to above, provide community-based health care to address the specific losses in intrinsic capacity (3.1.5)
- Refer to primary care

Community engagement → 4.1.3

Community stakeholders including community health workers facilitate care provision for older people, their family and carers. Meaningful proactive community engagement is important in the delivery of all steps of the ICOPE pathway in primary care.

2

In-depth assessment → 3.2

A. Assess loss in intrinsic capacity

Confirmation of the impairment of intrinsic capacity for domain(s) that failed the screening test

B. Assess for diseases and risk factors

Assess need for:

- Management of diseases and risk factors
- Medication review
- Vaccination

C. Assess social and physical environment

Assess need for:

- Environmental modification
- Assistive products
- Social care and support, including risk of abuse and need for personal care and assistance for daily life (11.2, 11.4, 11.5)
- Carers' support needs (12.3)

3

Develop a personalized care plan → 3.3

- Self-care and self-management
- Community-based services and support
- Multi-component interventions to manage and prevent further declines in intrinsic capacity and functional ability
- Management of diseases and risk factors
- Vaccination
- Medication review
- Provision and maintenance of assistive products
- Social care and support → 11
- Support for carers → 12
- Referral to specialized care (e.g. geriatric care, palliative care, rehabilitation services)

4

Implement and monitor the personalized care plan → 3.4

- Coordination of health and social care across settings, including in the community
- Coordination with specialized care
- Regular and sustained follow up
- Monitor adherence and discuss changes to the care plan as necessary
- Regular information sharing among health workers in a multidisciplinary team including outcomes, barriers and complications of interventions

Community icon

This icon is used to denote actions that can be taken by community health workers and other trained community stakeholders

Health worker icon

This icon is used to show actions that should be undertaken by a health worker primarily providing care at a health facility, such as a doctor, nurse, social worker or other health professional

There are **four steps** to consider when addressing older people's health and social care needs through an integrated care approach in primary care (see p. 16). Throughout all steps, engaging older people and the wider community, and ensuring support for carers are critical. The four steps of the pathway will usually need to be undertaken over time, in a series of discussions with the older person, potentially involving multiple different health workers. In most contexts, Step 1 can be implemented within the community by community stakeholders (but may also be undertaken by health workers at primary care facilities). The in-depth assessment should be conducted by health workers at a primary care facility. Given that both the in-depth assessment and the development of a personalized care plan may require time and coordination between different health workers, these steps will likely need to be completed during scheduled meetings. Steps 3 and 4 require the involvement of health workers including care workers, community stakeholders and carers.

3.1 Basic assessment and community-level interventions

ICOPE in primary care provides an opportunity to engage older people, including those who may have limited access to health services, with the objective of enhancing health and well-being, by improving health literacy, promoting healthy lifestyles, providing social support, when needed, and increasing health-seeking behaviour. By offering a basic assessment, community health workers and other community stakeholders can reach older people with information and support and ensure an increased understanding of any challenges they may be facing.

In the second edition of this handbook, the expanded Step 1 of the ICOPE care pathway in primary care focuses on a basic assessment with the possibility of delivering timely community-level interventions, as appropriate:

- The basic assessment is aimed at identifying:
  - Loss(es) in intrinsic capacity.
  - Key factors impacting older people's health, such as urinary incontinence (UI) (where feasible) and the need for social support and carer support.
- Provision of health and lifestyle advice, including in relation to CVD risk factors.
- Provision of community-based health care to address loss(es) in intrinsic capacity including through supporting adaptations to an older person's environment.
- Referral to primary care for in-depth assessment (Step 2).

Expanding Step 1 aims to take maximum advantage of the first contact with an older person for health promotion and prevention. In addition to testing for the loss(es) of intrinsic capacity, Step 1 provides the opportunity to give specific information and support and deliver community-based health care in contexts where the implementation of all steps of the ICOPE pathway may not be immediately possible or where an older person might choose not to attend. As such, basic assessment and provision of health and lifestyle advice should be provided to all older people (tailored to respond to specific needs where possible). Older people identified as having potential loss(es) of intrinsic capacity or issues related to other key factors impacting their health should be referred to primary care and social services and provided with community-based health care where appropriate.

In the ICOPE basic assessment, simple questions and tests are used to identify potential impairments across six domains of intrinsic capacity (Table 3.1, p. 19), the need for social support and carers' support, and the presence of UI (Table 3.2, p. 27).

Table 3.1
Basic assessment for loss of intrinsic capacity

	Filter question If YES, proceed for in-depth assessment (Step 2)	Tests	Assess fully any domain with a checked circle	Pass
5 Cognitive decline (Cognition)	**Do you have problems with memory or orientation** (such as not knowing where you are or what day it is)**?**	1. **Remember three words** (use nouns, for example): flower, door, rice. 2. **Orientation in time and space:** What is the full date today? Where are you now (home, clinic, etc.)? 3. Recalls the three words?	○ Wrong to **either** question or does not know ○ Cannot recall all three words	○ Correct to **both** questions
6 Limited mobility (Locomotor capacity)		**Chair rise test** Rise from chair five times without using arms. Did the person complete five chair rises within 14 seconds?	○ No	○ Yes
7 Undernutrition (Vitality)		1. **Weight loss** Have you unintentionally lost more than 3 kg over the last 3 months? 2. **Appetite loss** Have you experienced loss of appetite?	○ Yes ○ Yes	○ No to **both** questions
8 Vision impairment (Vision) *with spectacles if normally worn	**Do you have any problems with your eyes: difficulties in seeing far or near*, eye pain or discomfort?** **Do you have diabetes, or hypertension, or are currently using steroids or eye medications?**	1. **External eye check** 2. **Visual acuity test** using WHO vision screening chart*: • Distance vision (6/12 for each eye) • Near vision (N6 for both eyes)	○ Fail ○ Fail	○ Pass ○ Pass for **both** distance and near vision
9 Hearing loss (Hearing)	**Do you have a hearing problem?** *For those using a hearing aid(s) add,* "even when using your hearing aid(s)".	**Whisper test** or **Screening audiometry** or **Digits-triplet-in-noise test**	○ Fail	○ Pass
10 Depressive symptoms (Psychological capacity)		**Over the past 2 weeks, have you been bothered by either of the following:** • Feeling down, depressed or hopeless? • Little interest or pleasure in doing things?	○ Yes ○ Yes	○ No to **both** questions

3.1.1
How to conduct a basic assessment for loss of intrinsic capacity

A basic assessment for loss of intrinsic capacity, which usually takes 8–12 minutes (**Table 3.1**, p. 19), can be conducted by trained community health workers, community volunteers, nurse assistants, nurses, doctors and social workers or other health workers.

It is strongly recommended to assess all domains of intrinsic capacity at one time, not separately. For cognition, vision and hearing, a filter question is suggested. If the older person's response is YES, they can be referred directly for an in-depth assessment (Step 2) and no further basic assessment for these domains is necessary. The basic assessment can be adapted to the local health system and capacity of health workers.

Basic assessment
Cognitive decline

Filter question

"Do you have problems with memory or orientation (such as not knowing where you are or what day it is)?"

If the answer is YES, go directly to Step 2 – in-depth assessment. → 5

Simple memory and orientation test

1. **Remembering three words:**
   Ask the person to remember three words that you will say. Use simple, concrete nouns such as "flower", "door", "rice".

2. **Orientation in time and space:**
   Then ask: "what is the full date today?" and "where are you now?" (home, clinic, etc.).

3. **Recalling three words:**
   Now ask the person to repeat the three words that you mentioned.

In-depth assessment is needed if:

- The person cannot answer one of the two questions about orientation; **OR**
- Cannot remember all three words. → 5

Basic assessment
Limited mobility

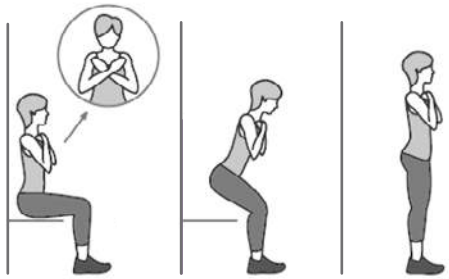
Chair rise test

For improved safety, place a sturdy chair, ideally without armrests, next to a wall and demonstrate to the person how to do the test. If a person using a walking stick feels safe conducting the chair rise test with it, ask them to do so.

Ask the person: *"Do you think it would be safe for you to try to stand up and sit down from a chair five times as quickly as possible without using your arms, and without causing yourself pain or discomfort?"*

If the answer is YES, ask them to:
- Sit in the middle of the chair.
- Cross and keep their arms over their chest.
- Stand up fully and sit down again.
- Repeat five times as quickly as possible without stopping.

Time the person taking the test in seconds.



In-depth assessment is needed if:

- The person is unable to attempt the chair rise test; **OR**
- Is unable to stand up five times within 14 seconds. → 6

Basic assessment
Undernutrition

Ask the following two questions:

- *"Have you unintentionally lost more than 3 kg over the last 3 months?"* (If body weight is unknown, ask: "have you noticed loose clothes, belts or wrist watches?")
- *"Have you experienced loss of appetite?"*

If equipment is available, weigh the person and record their weight.

In-depth assessment is needed if:

The person answers YES to **either** question. → 7

Basic assessment
Vision impairment

Filter question

"Do you have any problems with your eyes: difficulties in seeing far or near (with spectacles if normally worn), eye pain or discomfort?"

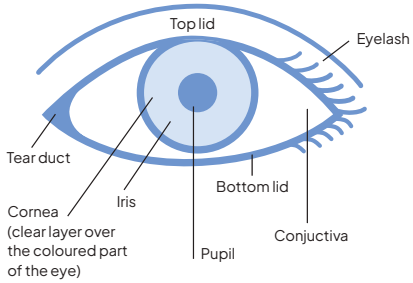
"Do you have diabetes or hypertension, or are currently using steroids or eye medications?"

If the answer is YES to either question, go directly to Step 2 – in-depth assessment. → 8

1. External eye check

Look at the appearance of the external eye, eyelids and eyelashes, and observe how the eyelids open and close.

The external eye



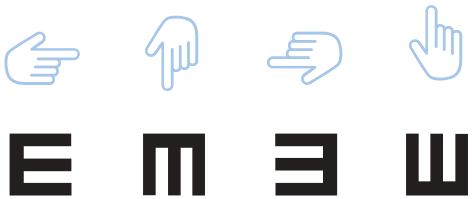
In-depth assessment is needed if:

Any of the following external eye abnormalities are observed: significant crust or pus on eyelid margin, excessive watery or sticky discharge from the eyes, eye lashes turn inward, abnormal lid closure, abnormal red on the white part of the eye, abnormal haziness or red on the coloured part of the eye. → 8

2. Visual acuity test

When testing visual acuity, the following points should be considered:

- A well-lit testing space that allows a testing distance of at least 3 m is required.
- Demonstrate how to do the E test by pointing with the fingers in the direction that the E is facing.



- Test **distance vision first followed by near vision** (with spectacles if normally worn).

The WHOeyes app is available as a free mobile phone app for vision screening in all six UN languages and some additional languages (https://www.who.int/teams/noncommunicable-diseases/sensory-functions-disability-and-rehabilitation/whoeyes)

In-depth assessment is needed if:

- The person's distance vision is worse than 6/12 in either eye; **OR**
- The person is unable to see N6 with the readymade reading spectacles. → 8

Test distance vision
with the WHO vision screening chart

- Test each eye separately (monocularly), starting with the right eye first, then the left eye.
- Use an occlude (or a hand) to cover the eye not being tested.
- Verify that the person is looking at the chart straight, without turning or twisting their head.
- Ensure the chart is 3 m from the person's eyes.
- Start with the large Es (6/60). If at least two of the large Es (6/6) are seen, continue the test with the small Es (6/12).
- Record the results for the right eye, and repeat the steps for the left eye.
- A pass result of the distance vision test is when each eye sees at least three of the small Es (6/12).

Test near vision
with the WHO vision screening chart

- Test both eyes together (binocularly).
- Hold the near chart at 40 cm from the person's eyes.
- A pass result of the near vision test is when both eyes see at least three of the Es (N6).
- If near vision is worse than N6, check if the person is able to see N6 clearly with trial readymade reading spectacles.

MORE INFORMATION

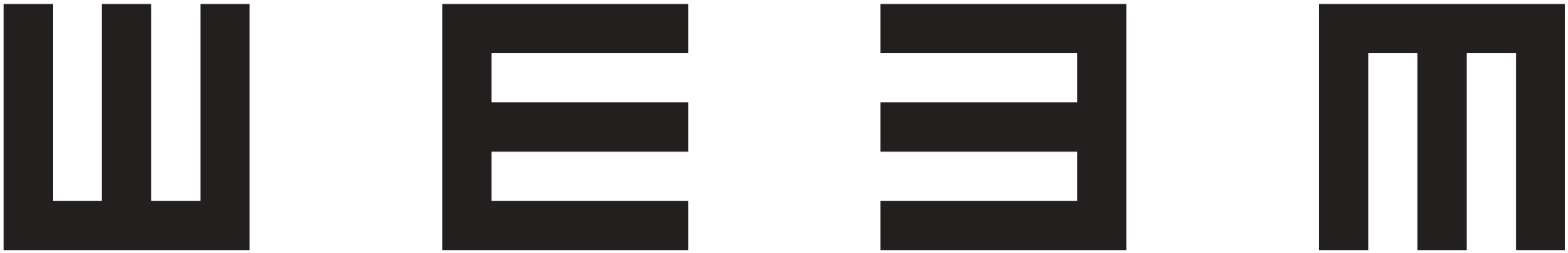
Vision and eye screening implementation handbook. WHO; 2023 (https://iris.who.int/handle/10665/375590).

Training on reading spectacles. WHO; 2024 Training in Assistive Products (gate-tap.org).

WHO DISTANCE VISION SCREENING CHART

(3 metre test distance)

10 cm



6/12

WHO NEAR VISION SCREENING CHART

(40 cm test distance)

N6

Basic assessment
Hearing loss

Filter question

"Do you have a hearing problem?" (for those using a hearing aid(s) add, *"even when using your aid(s)"*).

If the answer is YES, go directly to Step 2 – in-depth assessment (diagnostic audiometry). → 9

Hearing test

One of three possible tests can be used for a basic assessment of hearing. Headphones are required except for the whisper voice test. It is important to ensure that levels of background noise are below 40 dBA (adjusted decibels). This can be ensured by testing with a sound level meter or with the use of a validated smartphone app (e.g. NIOSH Sound Level Meter).

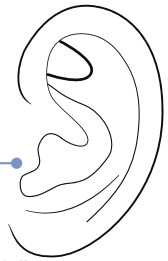
MORE INFORMATION

Hearing screening: considerations for implementation. WHO; 2021 (https://iris.who.int/handle/10665/344797).

1. Whisper voice test

This is the simplest option but should only be used when other tests are unavailable. **Tests 2 and 3 should be used where possible.**

- Stand about an arm's length away behind and to one side of the person.
- Ask the person to cover the ear that is NOT being tested by pressing one finger on the **tragus** (the small, pointed cartilage in front of the ear canal). Show how.



- Take a deep breath and exhale fully.

  Then whisper four common unrelated words (words should be familiar to the person, e.g. rice, fish, bicycle, garden, yellow, sky, dog). Speak the words one at a time, waiting for the person to repeat each word back to you.

  If the person repeats three or more words and you are sure that they can hear you clearly, then the person is likely to have normal hearing in this ear.

- Move to the other side of the person and test the other ear using different words.

In-depth assessment is needed if:

The person fails to repeat three or more of four words. → 9

2. Screening audiometry

Detection of pure tones in both ears (each ear separately) at a fixed dB level (35 dBHL [decibels hearing level]), at three frequencies (1 kHz, 2 kHz and 4 kHz). Results are recorded as "pass" (the test is passed) or "fail" (further evaluation is needed).

In-depth assessment is needed if:

The person fails to respond at 35 dBHL at one or more frequencies in either ear. → 9

3. Digits-triplet-in-noise test

Both ears are tested together using an automated digits-in-noise test to determine how well the person can identify the digits despite the background noise.

- A person listens to sets of three digits (e.g. 4–7–3) presented with background noise.
- The digits are spoken one at a time.
- The person must repeat the digits they hear.
- The result is recorded as either "pass" (correctly identify at least 50% of the digit triplets) or "fail" (low score).

hearWHO is available as mobile phone app for free, in English, Chinese, Spanish, Russian, Dutch and French (https://www.who.int/teams/noncommunicable-diseases/sensory-functions-disability-and-rehabilitation/hearwho)

In-depth assessment is needed if:

The person fails to respond at 35 dBHL (presented as low score, e.g. hearWHO app score is below 50). → 9

Basic assessment
Depressive symptoms

Ask the following two questions:

"Over the past 2 weeks, have you been bothered by either:

- *Feeling down, depressed or hopeless?*
- *Little interest or pleasure in doing things?"*

In-depth assessment is needed if:

The person answers YES to **either** question. → 10

After basic assessment for loss of intrinsic capacity

Explain the results and the importance of regular reassessment.

For all older people:

- Identify needs for support and provide the support. → **3.1.2**
- Provide health and lifestyle advice. → **3.1.3**
- Where possible, measure blood pressure to identify hypertension and enable management of CVD risk factors and refer where necessary. → **3.1.4**

For an older person identified as having potential loss(es) in intrinsic capacity:

- Refer to primary care for in-depth assessment (**Step 2**), if losses are not already being addressed.
- Provide community-based health care for loss of intrinsic capacity if appropriate.

3.1.2
Key factors impacting older people's health

After conducting a basic assessment for loss of intrinsic capacity, a second element of basic assessment can be used to identify other key factors impacting older people's health, including social support needs, support for carers and UI. Urinary incontinence is treated separately from the domains of intrinsic capacity because it is a disease (geriatric syndrome), not intrinsic capacity, but it affects and is affected by losses of intrinsic capacity.

Social support and support for carers: Understanding the social support needs of older people and their carers to enable the inclusion of appropriate interventions within a personalized care plan, and the delivery of these interventions, is crucial in the provision of integrated care. In recognition of the importance of these issues and their potential lack of prioritization, this handbook brings earlier attention to social support and support for carers, by including questions on these topics earlier in the ICOPE care pathway.

Addressing social determinants of health, such as socioeconomic status, social connectivity and housing is key to improving health outcomes for older people and optimizing functional ability. It is recommended that all older people are asked about their social support needs, irrespective of their intrinsic capacity. These questions can be asked by the person who has conducted the basic assessment, either directly after a negative ICOPE basic assessment (i.e. no potential losses are identified) OR in cases where potential losses have been identified but an in-depth assessment is not (immediately) possible. Alternatively they can also be asked during the in-depth assessment at a primary care facility, as part of the broader assessment of the social and physical environments.

Given social and cultural diversity, the wording of the social and carer support questions in Table 3.2 (p. 27), should be adjusted to ensure they are relevant and appropriate in the context in which they are being asked. It is important to ensure that any adjustment or adaptation to these questions does not lead to the use of discriminatory language, including ageist words or terminology.

Providing care, particularly for an older person with significant losses in intrinsic capacity, can be physically and psychologically demanding, and it can affect the carer's own health and well-being. It is important that the needs of carers are identified during a basic assessment or in-depth assessment as relevant, and support for carers is included in the development and implementation of a personalized care plan. Table 3.2 (p. 27) includes questions that should be asked to carers. → 11 12

Urinary incontinence: Urinary incontinence is a common condition affecting millions of older people, particularly older women *(11)* impairing their quality of life and well-being *(12)*. Given high levels of under reporting of UI, likely due to the stigma felt by those affected, and the resultant lack of access to care, it is recommended that questions on UI are asked to older people during a basic assessment in the community or in-depth assessment at a primary care facility when assessing relevant intrinsic capacity domains (e.g. cognitive decline, mobility loss, depressive symptoms). It is recognized that there are potential challenges of conducting sensitive discussions with older people in the range of environments ICOPE basic assessment takes place. → 13

Table 3.2
Basic assessment of key factors impacting older people's health

	Questions/assessment	Further assessment/ supplementary questions should be considered	Re-ask regularly
11 Social care and support	**Home environment** Do you have problems with your home, for example, house condition, location, safety?	○ Yes	○ No
	Financial situation Do you often have insufficient funds to pay for your food, housing and health care costs?	○ Yes	○ No
	Social isolation and loneliness Do you often feel lonely?	○ Yes	○ No
	Social engagement and participation Do you have difficulty in pursuing leisure interests and other activities that are important to you?	○ Yes	○ No
12 Carer support (Ask the carer of the older person in private)	Do you feel you have whatever support you need in your role as a carer?	○ No	○ Yes
	Do you feel confident in your ability to provide care and support?	○ No	○ Yes
	Assess if there is negative impact of the carer role (physically, mentally, financially, socially).	○ Yes	○ No
13 Urinary incontinence	Do you have any problems with bladder control, such as accidental leakage of urine?	○ Yes	○ No

Note: The wording of social support questions, shown as examples, can be adjusted to ensure the questions are relevant and appropriate in the local context.

Community-level interventions

Older people found to have potential impairment of intrinsic capacity through a basic assessment should be referred for an in-depth assessment at a primary care facility (**Step 2**) wherever possible. The community health worker or other trained stakeholder who conducted the basic assessment may facilitate access to services for this further assessment. Older people should be encouraged to have regular basic assessments (e.g. at least once a year), except for vision and hearing (e.g. every 1–2 years), and/or following an acute event or illness, and if their social role or situation changes (a change in residence, the death of a partner). **Periodic basic assessment enables the early detection of declines in intrinsic capacity and supports prompt intervention.** Older people should also be encouraged to set their own goals to stay healthy.

In addition to this referral to health and relevant social services, other community-level interventions can be provided during contact with an older person for a basic assessment, to ensure the best possible advice and support are provided at this first point of contact.

Community health workers and other trained community stakeholders can provide various types of tailored support and care: health promotion, through the provision of health and lifestyle advice, screening for CVD risk factors such as hypertension, and community-based health care that addresses specific losses in intrinsic capacity and other factors impacting older people's health.

3.1.3 Promoting healthy lifestyles

All older people can benefit from health and lifestyle advice, irrespective of their level of intrinsic capacity if they are able to understand and apply this advice to change their behaviour. Advice should be provided along with information to promote self-care and when and where to seek health care. Older people should also be asked about any existing diseases or conditions and self-management should be supported.

It is important to note that people learn and respond to information in different ways. Learning tends to happen through a combination of six main routes: through community conversations; the arts; printed materials; conventional mass media; digital media; and communication and interaction with health workers *(13)*. Community health workers and other community stakeholders should therefore consider different ways to provide information and advice to older people. This could include one-to-one conversations, group discussions and awareness-raising campaigns using different communication materials. Community groups, such as older people's clubs, could be engaged to organize events for older people, for example, peer discussions and local drama productions with health and lifestyle messages.

Other factors to consider when providing health and lifestyle advice include who to engage and what information to provide. People rarely make decisions about their health and related behaviours in isolation, and are likely to be influenced by others, including family and community members, and religious leaders. In some cases decisions will be taken communally. It is therefore important to reach and engage a wider group across an older person's community. Advice is also more likely to be understood and followed if it is accompanied by information on how to do it. For example, giving information on what constitutes a healthy diet, alongside advice on where to buy healthy foods and how to prepare them.

Health and lifestyle advice provided to older people as part of **Step 1** of the ICOPE care pathway in primary care should include both general information to support health and well-being and more specific actions related to the domains of intrinsic capacity. Where possible, advice should be targeted and tailored for the individual older person and their specific needs.

Healthy lifestyle advice for older people

1. Taking regular physical activity → 6.1

- All physical activity is beneficial and every move counts.
- It is good to start low, go slow and gradually increase physical activity.
- There are different options available, including walking, cycling, household tasks, gardening, dancing and sport, with a focus on activities that are enjoyable to the older person.
- It is important to avoid sedentary behaviour.
- Perceptions of physical activity can change towards positive acceptance and engagement, including in relation to cultural context and attitudes towards women's participation.

2. Eating a healthy diet → 7.1

- Older people should eat plenty of protein.
- It can be helpful to make eating a social activity by eating with other people.
- Suggest healthy foods available and affordable locally – what they are and where to get them.
- Older people should eat at least 400 g (five portions) of vegetables and fruits per day and less than 5 g or one teaspoon of salt.
- Wholegrains, vegetables, fruits and pulses (as carbohydrates), and nuts, seeds, beans, olives and fish (as healthy fats), are important.
- It is ok to eat smaller amounts more often if large meals are difficult.
- A high-fibre diet can prevent constipation.

3. Hydration → 7.1

- Drink at least 6–8 cups (1.6–2.0 L) per day (unless restrictions have been suggested on medical grounds), and a larger amount in particularly hot weather.
- Reduce caffeine intake, particularly in the case of UI.

4. Oral health → 7.1

- Brush teeth two times per day with fluoride-containing toothpaste (1000–1500 ppm).

5. Social connection and participation in the community → 11.1

- Spend time with friends and family.
- Be socially active and engage with the community in a way that is enjoyable and meaningful.

6. Preventing and managing diseases and CVD risk factors → 3.1.4

- Adhere to treatment, including medication to control diseases.
- Avoid the use of over-the-counter medication and supplements, without the advice of health worker(s).
- Manage weight to prevent obesity, including limiting fats and free sugars.
- Ensure good hygiene and sanitation practices (drinking safe water, food hygiene, hand washing).

… continued →

- Avoid or reduce alcohol and psychoactive substances:
  - Harmful use of alcohol impacts physical, mental, social, psychological and cognitive health
  - Seek support to be able to avoid alcohol use.
- Tobacco cessation:
  - Discourage non-smokers from starting to smoke.
  - Highlight the risks associated with tobacco use, including an increased risk of cancer, respiratory conditions, dementia, CVD, oral diseases and UI.
  - Give information on where to seek support to stop tobacco use.
- Be aware of risk factors for vision impairment (diabetes and hypertension).

7. Vaccination

- Routine vaccination in line with local vaccine regulations *(14)*.
- It is important to keep a record of vaccinations received.

8. Promoting mental health → 10.1

- Stress reduction when needed.
- Take regular breaks from caregiving (for carers).
- Do the activities you (used to) enjoy.

9. Good-quality regular sleep

- Maintain a healthy sleeping routine, including going to bed and waking at a consistent time.
- Get an adequate number of hours of sleep per day.

10. Optimizing brain health → 5.1

- Undertake regular cognitive stimulation activities including reading, playing games, learning something new and playing music.

11. Promoting eye/vision health → 8.1

- Regular eye and vision check-ups.
- Follow advice on how and when to use spectacles.
- Limit exposure to ultraviolet lights by wearing sunglasses and hats.
- Take regular breaks from near work activities (use of electronic media, reading, sewing).

12. Promoting ear/hearing health → 9.1

- Regular hearing check-ups.
- Seek advice if you suspect hearing loss.
- Clean the **outer part** of the ear with a soft cloth.
- Follow advice on how to use hearing aids.
- Don't put things **inside** the ears.
- Don't swim or wash in dirty water.
- Don't listen to loud sounds or music and use earplugs in noisy places.

Further information on specific health and lifestyle advice in relation to the domains of intrinsic capacity can be found in the relevant chapters of this handbook.

MORE INFORMATION

WHO health topics: alcohol, tobacco. WHO; 2024 (https://www.who.int/health-topics/alcohol; https://www.who.int/health-topics/tobacco).

3.1.4
Screening and prevention of risk factors for cardiovascular diseases

Cardiovascular diseases (CVD) are a group of disorders of the heart and blood vessels such as coronary heart disease and cerebrovascular disease (e.g. heart attack, stroke). In 2021, they were the leading cause of death globally *(15)*, with high prevalence in older people *(16)*. The risks for CVD include behavioural factors, such as tobacco use, an unhealthy diet, harmful use of alcohol and inadequate physical activity; and metabolic factors, including high blood pressure (hypertension), high blood cholesterol and high blood sugar (diabetes).

Given the high prevalence of CVD among older people, and high rates of undiagnosed hypertension *(17)* in some contexts, Step 1 of the ICOPE care pathway provides an important opportunity to raise awareness among older people, and where possible, identify the risk factors (Box 3.1). Health workers can provide individual advice and counselling to older people for whom behavioural risk factors are identified, with the aim of encouraging behavioural change. Counselling for healthy lifestyles in relation to CVD involves guiding and supporting an older person toward making changes in certain behaviours to reduce the risk of CVD and other conditions (diabetes, lung disease and cancer) as well as declines in intrinsic capacity such as cognitive decline and vision impairment.

A brief counselling intervention between a community health worker and an older person (and carers, where appropriate), during a basic assessment can identify potential problems, provide information and motivate and assist the older person to change their behaviour. The 5As tool (Ask, Advise, Assess, Assist, Arrange) can be used to identify risk factors and support behaviour change.

Community health workers could consider asking the following, or similar questions:

- Have you smoked or used any other tobacco product in the past 12 months?
- How many portions of fruit and vegetables do you eat each day?
- Do you ever drink alcohol?
- In the past week, on how many days have you been physically active for a total of 30 minutes or more? For example: walking, cycling, cleaning, gardening, climbing stairs, dancing or playing sport?

Box 3.1 Screening for hypertension

Alongside the provision of information and support for behaviour change, community health workers may also be able to screen for hypertension. Blood pressure can be measured in the community, if community health workers or other stakeholders have the appropriate training and equipment and are able to refer the person to primary care for further assessment and treatment. **Screening for hypertension if referral pathways are not in place and treatment is not accessible is unethical.**

Measuring blood pressure is the only way to diagnose hypertension, as most people with raised blood pressure do not have symptoms. For accurate blood pressure measurement:

- Use the appropriate cuff size.
- Ask the person to sit with their back supported, legs uncrossed, with an empty bladder, relaxed for 5 minutes, not talking.
- Take at least two readings and use the second reading.

In general, hypertension is diagnosed on two visits on different days: if the systolic blood pressure readings are ≥ 140 mmHg and/or the diastolic blood pressure readings are ≥ 90 mmHg. If hypertension is diagnosed, the person should be referred to primary care for further assessment and treatment including for other metabolic risk factors (diabetes and cholesterol). They should be given information on the risks associated with hypertension and the importance of attending for further assessment.

MORE INFORMATION

HEARTS: technical package for cardiovascular disease management in primary health care: healthy lifestyle counselling. WHO; 2018 (https://iris.who.int/handle/10665/260422).

3.1.5
Community-based health care to address losses in intrinsic capacity

When a basic ICOPE assessment identifies potential loss of intrinsic capacity, community-based health care can be provided by community health workers with the support of other community stakeholders, and in partnership with health workers in health care facilities, in some contexts. These interventions are important in settings where an in-depth assessment at a primary care facility may not be possible, where organizing or accessing a full assessment may take time, or where it is thought the older person may choose not to attend. Feasible interventions to deliver across contexts and resource settings include (see the relevant chapter for detailed information):

- Cognitive stimulation, physical exercise and advice for family members and carers for cognitive decline. → 5.2
- Physical exercise programmes for limited mobility with consideration of safety concerns. → 6.2
- Balanced diet including high protein foods for undernutrition. → 7.2
- Provision of reading spectacles and screening for hypertension for vision impairment. → 8.2
- Communications advice for hearing loss. → 9.2
- Stress management including relaxation techniques for depressive symptoms and pain. → 10.2, 6.5.2
- Provision of advice and information about available community services and activities for social participation and support. → 11.1
- Provision of advice and information about available community services to support carers. → 12.2
- Bladder training to manage UI. → 13.2

If in doubt about whether or how an intervention can be safely provided, refer to an appropriate health care worker with knowledge.

3.2 Undertake an in-depth assessment at a primary care facility

If during this assessment, another older person, for example, a spouse, is identified within the family, their need for integrated care should also be considered and a basic ICOPE assessment offered, as appropriate.

An in-depth assessment of health and social care needs at a primary care facility is critical to be able to provide appropriate services and support. An initial step is to gain a better understanding of the older person's life by taking a medical history, including current medications, and by asking about their values and priorities for their life including health and its management, their social context, and identifying key family members, other relatives and friends.

An in-depth assessment is likely to require a trained health worker(s) such as a nurse or doctor undertaking scheduled visits or appointments. There are three key elements to an in-depth assessment; investigating and confirming impairment of intrinsic capacity; evaluating underlying diseases and risk factors; and assessing the person's social and physical environment. These three elements can be undertaken in any order (unless otherwise stated). Based on the findings of all three elements, potential interventions should be identified. Each specific care pathway provides information on what to consider in the assessment and for interventions, which should inform a single consolidated personalized care plan.

3.2.1 Assess loss in intrinsic capacity

A potential impairment of intrinsic capacity needs to be confirmed by applying the tools/tests, that are locally available and validated. Examples of tools and tests are presented in each care pathway (Chapters 5–10).

3.2.2 Assess for associated diseases and risk factors

As people age, the likelihood of having diseases, such as CVD, hypertension, diabetes, cancer, chronic obstructive pulmonary disease, osteoarthritis, osteoporosis, cataracts and dementia, as well as multimorbidity (the coexistence of two or more chronic conditions) increases.

While some risk factors, such as arthritis, can present with symptoms, others, like hypertension and diabetes, may remain asymptomatic for years. Therefore, ensuring their early detection in primary care is crucial. WHO provides a range of guidance to address early detection and management of noncommunicable diseases, including risk-based CVD management and dementia. Blood pressure measurements should be conducted for all adults during routine visits to primary care facilities, including at the first presentation, and, if normal, periodically thereafter. A person with elevated blood pressure readings requires immediate follow-up as per the established protocol. For diabetes detection, it is recommended to test individuals presenting with symptoms using fasting plasma glucose (FPG) or random plasma glucose. Additionally, asymptomatic adults aged 40 and above with a body mass index (BMI) greater than 25 should be tested using FPG.

People's immune systems also tend to weaken over time, putting older people at higher risk for certain infectious diseases. An older persons' vaccination status should be monitored to reduce vaccine-preventable diseases.

Some diagnoses including multimorbidity or polypharmacy (→ **4.2.4**) may require specific diagnostic tests, equipment and specialized skills that are not always available in primary care. Depending on the setting, referral to secondary- or tertiary-level specialized services may be needed.

3.2.3
Assess social and physical environments

An in-depth assessment of the social and physical (built) environments at home, in the community and broader society and the identification of any needs for social care and support are both required.

Social environments include living conditions, financial security, loneliness (relationships), access to community activities and public services, freedom from abuse, among others. If needs for support are identified, services should be provided to enable older people to do the things that are important to them. An older person might need social support regardless of their level of intrinsic capacity.

An older person's need for assistive products used on or directly by the body (e.g. hearing aids, walking sticks, wheelchairs) can be assessed by health workers with training. → **4.2.2** An assessment of the physical environment at home and home surroundings, undertaken through asking questions to the older person or through home visits, where possible, can help inform necessary environmental modifications, including identifying any need for assistive products, risk of falls, and how to make the environment a safer and more accessible place to live. → **4.2.5**

If an older person has a significant loss in intrinsic capacity, social care (personal care and assistance with daily activities) might be needed. Social care needs can be identified by asking an older person whether they can perform various daily tasks without the help of others, and should consider needs and preferences for care at home, within the community and in institutions, and who could provide that care. This can inform specific needs for LTC services (where available) and their inclusion in a personalized care plan.

The pathway in Chapter 11 presents a set of questions for assessing and addressing social care and support needs in general. In addition, each care pathway notes possible social care and support needs specific to the intrinsic capacity domain and conditions. → 11

It is also important to consider the potential care and support needs of family and other carers involved in the care and support of an older person. Family carers, particularly those living with the person they care for, may feel there are constant demands. They are unlikely to have received any training and may well not have any support. This can lead to burnout, which has impacts for the carer's mental and physical health and for the quality of care they are able to provide. Need for respite care should be considered.

The pathway in Chapter 12 presents a set of questions for assessing and managing carers' needs. In addition, each care pathway notes specific support carers might need in relation to intrinsic capacity domains and conditions. → 12

MORE INFORMATION

- ***Guideline for the pharmacological treatment of hypertension in adults.*** WHO; 2021 (https://iris.who.int/handle/10665/344424).
- ***HEARTS: technical package for cardiovascular disease management in primary health care: evidence-based treatment protocols.*** WHO; 2018 (https://iris.who.int/handle/10665/260421).
- ***HEARTS: technical package for cardiovascular disease management in primary health care: risk-based CVD management.*** WHO; 2020 (https://iris.who.int/handle/10665/333221).
- ***WHO package of essential noncommunicable (PEN) disease interventions for primary care.*** WHO; 2020 (https://iris.who.int/handle/10665/334186).
- ***WHO clinical treatment guideline for tobacco cessation in adults.*** WHO; 2024 (https://iris.who.int/handle/10665/377825).

3.3 Develop a personalized care plan

Personalized care planning is a humanistic approach that moves away from the traditional disease-oriented methods and instead focuses on older people's needs, values and preferences. The process recognizes the person's skills and strengths, their experiences, the things that matter most to them, and their social context. A personalized care plan guides all aspects of health and social care and support and is essential in ensuring the integration of these services and how the older person accesses them. The results of an in-depth assessment across the domains of intrinsic capacity and any identified potential interventions, as outlined in Chapters 5–13, should be brought together into a consolidated personalized care plan, taking the following points into consideration:

- Interventions should be agreed based on the older person's goals, loss of intrinsic capacity, diseases and risk factors and opportunities to promote an enabling environment.
- A personalized care plan should include interventions delivered within primary care, with referrals to specialized care where needed. It should also include social services, and be adapted to the settings in which the services will be provided (home, community, institution), as appropriate.
- Sustained, regular follow up with reassessment is essential for the effective delivery of integrated care.
- Community-based services should be included, and can be delivered by community stakeholders.

3.3.1 Define and set the person-centred goal(s)

The starting point for developing a personalized care plan should be the older person's goals, identified through discussion with a health worker, ideally a doctor or nurse, led by a case manager or care coordinator. A doctor or nurse can fulfil the role of case manager/care coordinator. Health workers must involve the older person (and their carer(s), where appropriate) in decision-making about their own care, and respect their needs, values, preferences and priorities. Taking this approach can mark a transformational shift in the way health workers relate to older people.

For a multidisciplinary team (**Box 3.2**) supporting an older person, a unifying goal of optimizing intrinsic capacity and functional ability can be helpful to ensure the integration of care and ability

Box 3.2 Multidisciplinary team

A multidisciplinary team brings together the people involved in an older person's care to provide a broad range of services through a coordinated and integrated approach. The composition of a multidisciplinary team in primary care will vary by setting, but may include doctors, nurses, community health workers, social care workers, therapists (physiotherapy, occupational, speech and language, psychological), carers, care workers, pharmacists and volunteers. Depending on the capacity of health and social care systems, a core team comprising a small number of health workers most directly involved in the provision of care could be established, with others brought into discussions as and when possible.

How members of multidisciplinary teams work together, as a team, is crucial. There are things that can help facilitate effective ways of working, including: having an identified care coordinator or case manager who facilitates the work of the team; joint meetings to share insights and concerns; shared record keeping; and inclusion of a diversity of professions and disciplines, which reflect the needs of the person receiving integrated care.

to monitor progress. An older person's goals, which should be at the centre of the plan, can go beyond reducing the direct impact of diseases, to also address aspects that enable them to do what they value most, such as to age independently and safely in place, to maintain their personal development, to be included and to contribute to their communities while retaining their autonomy and health.

A personalized care plan can be developed with any older person, including those with significant multiple losses of intrinsic capacity which may be irreversible and those facing the end of life. A discussion between a health worker and an older person should consider any concerns the older person might have in relation to death and dying and determine any medical treatment or care the older person would not want. For an older person, facing a serious illness with a limited prognosis, special consideration is needed to identify a person-centred goal within the context of the expected disease trajectory.

A personalized care plan should include timebound goals. In addition to goals for the mid- to long term, it is recommended to include short-term goals to leverage more immediate improvements or benefits, with a view to keeping older people motivated and engaged.

How to set person-centred goal(s)

An example of how a health worker can undertake a person-centred goal-setting exercise with an older person, their family members and carers, where appropriate, is provided below. The plan should be based on the results of an in-depth assessment and the interventions that could be provided in response. The approach should be adapted to the local context.

Identify goals, by discussing:

- The things that matter most to the older person in all parts of their life.
- Some specific goals the older person has in their life.
- Some specific goals they have for their health.
- Three goals they would like to focus on in the short term (e.g. next 3 months) and longer term (e.g. 6–12 months).

Set goals – these can be adapted to the older person's needs and their own definition of problems by discussing:

- What specifically about goal one, two or three they would like to work on over the short and longer term.
- What they are currently doing about the goal(s).
- What would be an ideal yet possible target for them in achieving the goal(s).

Prioritize goals – agreement on prioritized goals of care between an older person and a health worker will demonstrate improved outcomes. Prioritization can be informed by discussing:

- Which of the goals they are most willing to work on in the short and longer term – either by themselves or with support from a health worker or care coordinator.

Source: Javadi et al; 2018. Adapted from original by Health Tapestry (http://healthtapestry.ca).

36

3.3.2 Developing an integrated personalized care plan

Developing an integrated personalized care plan that addresses all domains of intrinsic capacity for which losses have been identified, is important because some losses share some underlying physiological and behavioural determinants. As a result, interventions have benefits across domains.

For example, muscle strength training is the key intervention to prevent and manage loss of mobility, while at the same time, indirectly protecting against depressive symptoms and cognitive decline and helping to prevent falls.

For some people with significant loss of intrinsic capacity across several domains, an in-depth assessment may suggest that their impairments are unlikely to reverse. This may be, for example, in the presence of disability due to injuries or diseases (e.g. stroke) or progressive illness such as dementia or Parkinson's disease. The personalized care plan will need to take into account the likely trajectory as well as follow-up planning, which might need to continue lifelong. The balance among modification of intrinsic capacity and treatment of diseases, palliative care and provision of social care and support, including carer's support, would change over time.

Three main steps can be followed in the development of a personalized care plan:

1. **Review findings and discuss opportunities to improve intrinsic capacity, functional ability, health and well-being:**

   During a discussion to set goals, the results of the in-depth assessment and suggested interventions for different loss(es) of intrinsic capacity should be reviewed. Prioritization of interventions for inclusion in a care plan can be guided by the urgency of an issue from a clinical perspective; the likelihood of success of the intervention; the wider impact addressing a specific issue might have, including how addressing one loss may impact the ability to address another; the predictable burden of interventions; and take into consideration what the older person feels is most important to them.

   In order to determine potential interventions, health workers will need comprehensive knowledge of available services and resources across both health and social sectors.

2. **Agree on interventions**

   This agreement should have concurrence from the older person, based on informed consent and be in line with their goals, needs, preferences and priorities; include components of self-care and self-management; accommodate physical and social environments; and include carer support, where needs are identified. Each potential intervention should be discussed one by one with the older person. The examples of potential components of a personalized care plan are found in **Box 3.3** (p. 38).

   In many cases, the proposed interventions will require inputs from health workers across sectors and disciplines. Ideally, one case manager or care coordinator should coordinate a multidisciplinary team (**Box 3.2**, p. 35) that will be involved in the assessment, development, implementation and monitoring of a care plan. A partnership between the older person, their carers and the multidisciplinary team is important to sustain the older person's well-being where they live.

3. **Finalize and share the care plan**

   The health worker identified as the case manager or care coordinator should document in the care plan the agreed interventions and share the plan with the older person, their family members and carers (as appropriate) and the multidisciplinary team involved in their care, with the older person's consent. If interventions in the care plan require referral, the older person should be given guidance about how to make appointments and how health workers can support the process. An example care plan can be found in the **Annex**.

Box 3.3 Potential components of a personalized care plan

- Goal(s) informed by the priorities and preferences of the older person.
- Self-care and self-management to promote health and well-being
- Community-based services and support. Social prescribing provides a means to connect older people to a range of non-clinical services in the community to improve health and well-being (**Box 11.1**, p. 124).
- A package of multicomponent interventions to prevent and manage losses in intrinsic capacity. Most care plans will include interventions to improve nutrition and encourage multimodal exercise.
- The management of underlying diseases, geriatric syndromes (e.g. falls, UI) and risk factors, including for CVD.
- Periodic vaccination, including COVID-19 and annual influenza as well as other vaccines, depending on the schedule of vaccination by country.
- A medication review to identify inappropriate medications, and issues regarding access, adherence and practicalities for medication. → **4.2.4**
- Where applicable, the management of any advanced chronic conditions and life-threatening illness, including through palliative care, to ensure that older people can continue to live lives of meaning and dignity and that their rights are protected. → **4.2.3**
- Social care and support, including environmental adaptations, such as home adaptation and the provision and maintenance of assistive products; social support with the help of family members, friends and community and other services; personal care and assistance with daily activities, that can be delivered at home, in the community and institutions (day centres, care homes and other LTC facilities).
- Support for carers, based on a discussion with the carer(s). This could include advice on how to provide particular types of care and support, tips for self-care, opportunities for respite, psychosocial support, access to financial support, and support with grief and bereavement.
- Referral to specialized care, including rehabilitation services, palliative care and geriatric care, where needed and available, through local referral mechanisms.
- An agreed follow-up date to ensure any changes or further losses are identified and care can be modified accordingly.

38

Monitoring the implementation of the care plan and regular reassessment with the older person are vital for achieving agreed goals.

3.4

Implement and monitor the personalized care plan

Collaboration and coordination between members of a multidisciplinary team drawn from different levels and types of health and social care services, and guided by a care coordinator or case manager, are essential for implementing the interventions agreed in a personalized care plan. Such an approach promotes early detection of complications, including any adverse effects of interventions and enables identification of any challenges related to acute events and illnesses, and changes in social roles or living situation. It also allows for losses in new or additional domains of intrinsic capacity to be identified. Regular monitoring helps avoid unnecessary emergencies and saves costs by enabling early action. Regular follow up also enables frequent contact between the older person and their health workers, supporting the maintenance of a successful relationship.

The frequency of follow up is informed by the intensity of the care required, types of interventions being provided and the person's social context, and should be determined by the care coordinator or case manager and agreed with the older person. The care coordinator or case manager can provide reminders of all appointments, including those scheduled to conduct a reassessment. Follow up with older people can be provided in different ways, including in-person meetings and by phone or video call. The most appropriate mechanism for each individual should be determined by the health worker and agreed with the older person (and carer where appropriate).

The follow-up process includes, but is not limited to:

- Ensuring successful implementation of each step and intervention of the care plan.
- Proactive enquiry to identify possible side-effects or unanticipated consequences of the intervention.
- Repeating the basic and/or in-depth assessment and documenting any changes.
- Summarizing outcomes, barriers and complications of implementing the interventions.
- Identifying changes and new needs.
- Adapting the care plan as required.

3.5 Communication skills

Across all steps of the ICOPE care pathway in primary care, effective communication by health workers and community stakeholders is key to ensuring the successful delivery of a person-centred continuum of integrated care.

Health workers conducting an in-depth assessment and developing a care plan will need to take their time to properly engage with the older person in order to build trust. To enable this to happen, an appropriate environment is needed that is conducive to the older person feeling able to be open about any challenges they may have and their preferences, choices and goals.

As well as being mindful of the way they talk and listen to older people, health workers should be aware of nonverbal forms of communication, including body language and the importance of observing the behaviour of both the older person and any carers or relatives present.

There are a number of points health workers and community stakeholders should bear in mind when communicating with an older person. Most are useful for conversations with everyone but should be borne in mind particularly in relation to ageism within the health system, and its impacts.

- When first meeting an older person, make sure to use the proper culturally appropriate form of address and avoid using familiar terms (e.g. “dear”). After building a rapport, ask the person how they would like to be addressed.
- Be respectful and avoid ageist attitudes and words or phrases. You should not take anything for granted or make assumptions about an older person, including on their capacities for communication without testing them (e.g. hearing, cognition) (**Box 1.1**, p. 3).
- Consider the setting, and the need to balance privacy and the older person’s autonomy with inputs from their carer(s) where necessary or helpful. Only when deemed necessary due to specific loss of intrinsic capacity, such as cognitive decline, and in line with legal frameworks, should a carer or other person be asked to speak on behalf of an older person.
- Consider the setting from the perspective of the person’s mobility, ensuring that it is fully accessible (e.g.for a wheelchair).
- Sit at a suitable distance from the person and with an open posture.
- Consider any potential sensitivities regarding gender and, where appropriate and possible, offer a health worker of the same gender to meet with the older person.
- Before starting, let the older person know how long you would like to talk to them for and check they are happy to go ahead. Consider taking breaks if necessary.
- When asking questions try not to rush, avoid interrupting and distractions, maintain eye contact and show empathy. Use open questions where appropriate, that encourage the person to share their experiences, feelings and perspectives.
- Adapt communication approach and language to ensure understanding. For some older people this might mean sticking to one topic at a time, avoiding giving too much information at once, using short, simple words and sentences, speaking slowly and clearly and avoiding jargon.
- Practise active listening by occasionally summarizing what the older person says, reflecting a particular point back and clarifying by putting the person’s feelings into words.
- When communicating with an older person with hearing loss, adopt appropriate communication strategies. → 9.2.1
- When communicating with an older person with vision impairment, ensure adequate lighting, check if the person has brought and uses spectacles, make sure all instructions and materials are clear and typed in large font, and consider recording instructions, using diagrams, aids or devices. → 8.6
- Make sure recommendations are clear and understood by the older person (and carer, where appropriate). Provide clearly written notes about recommendations, prescriptions, future schedules and referrals.
- Be mindful of and observe for any warning signs of abuse or neglect. → 11.4

4 Stakeholders and cross-cutting services for the ICOPE care pathway in primary care

Implementation of the ICOPE care pathway in primary care requires the engagement of a range of stakeholders and collaboration and coordination across sectors and services. A number of factors, focused on who should be involved, what services will be needed and how they could be delivered should be considered when planning to implement ICOPE. These factors will be determined by the local context, (→**14.2**) including the structure and mechanism of primary care, the availability of specialist services, and the presence and capacity of community stakeholders. In some instances, health workers in primary care, may need to make referrals to specialists at other levels of the health system (secondary, tertiary) or social system, where this expertise, or service does not exist within primary care.

Key points

- Successful implementation of the ICOPE care pathway in primary care requires the engagement of a range of different stakeholders across the health and social care sectors and the community.
- Older people's meaningful engagement and empowering carers are key enablers across all steps of the ICOPE care pathway.
- Community stakeholders should be meaningfully engaged and appropriately supported in the delivery of integrated care for older people.
- Where referral to specialized care is needed, coordination and collaboration among health workers is important.
- Cross-cutting services and support in response to losses across multiple domains of intrinsic capacity should be provided in a holistic and integrated way.

4.1 Engagement of stakeholders

4.1.1 Meaningful engagement of older people

Older people's proactive engagement with and support for ICOPE and integrated care more broadly is fundamental to its success and can contribute to an increased sense of empowerment and self-fulfilment. This engagement can take two forms: older people's engagement with their own health and well-being through the ICOPE care pathway; and broader engagement to support healthy ageing within their communities, including through older people's clubs and associations. Age-friendly cities and communities help ensure the meaningful engagement of older people. Examples of the role older people's clubs or associations can play in the delivery of integrated care are provided. → **4.1.3**

A key first step to achieve this engagement is prioritizing co-design in services, improving services based on older people's feedback and shared decision-making as key principles when adapting all steps of the care pathway to local context. Efforts should be made to raise awareness among older people through locally appropriate and available channels highlighting the opportunity ICOPE provides for older people to be centrally involved in their own care and to state their own preferences and goals. → **3.3.1** Care plans should include components of self-care and self-management to empower older people (**Box 4.1**). Information campaigns, if well designed, can also help to raise awareness of ageism, including self-directed ageism (**Box 1.1**, p. 3) and abuse of older people. → 11.4

Box 4.1 Self-care and self-management for older people

Support for self-care and self-management involves providing older people and their carer(s) with the information, skills and tools they need to promote their health and well-being, reduce risk factors, manage their diseases, prevent complications, maximize their intrinsic capacity and maintain their functional ability.

This does not imply that older people will be expected to "go it alone" or that unreasonable or excessive demands will be placed on them. Instead, it recognizes their autonomy and ability to direct their own care, in consultation and partnership with health workers, their families and other carers. All older people should be provided with health and lifestyle advice, irrespective of their levels of intrinsic capacity. → **3.1.3**

The WHO mobile health for ageing (mAgeing) initiative can complement health workers' routine care by supporting self-care and self-management. By delivering health information, advice and reminders through mobile phones, it encourages healthy behaviours and helps older people to improve and maintain their intrinsic capacity.

MORE INFORMATION

- ***Be healthy, be mobile: a handbook on how to implement mAgeing.*** WHO; 2018 (https://iris.who.int/handle/10665/274576).
- ***Voice and meaningful engagement in the UN Decade of Healthy Ageing: a discussion paper.*** Decade of Healthy Ageing Platform; 2023 (https://www.decadeofhealthyageing.org/find-knowledge/resources/publications/detail/voice-and-meaningful-engagement-in-the-un-decade-of-healthy-ageing-a-discussion-paper).

4.1.2
Empowering and supporting carers

Carers, mostly women and girls, play a fundamental role in caring for older people and supporting their adherence to a personalized care plan and should be empowered in this role. The demands of caregiving and carers' need for support is acknowledged, in particular regarding the provision of training and advice for carers to ensure they are able to provide the best quality care possible; and ensuring adequate support to protect carers' own health and well-being. The main areas of support carers will likely benefit from are access to respite care, psychological support, financial support and support for their own health and well-being. → 12 This is particularly important if a carer is an older person, in which case they should also be offered a basic ICOPE assessment.

4.1.3
Engaging community stakeholders

Around the world, community stakeholders play a central role in the care of older people as highlighted by many ICOPE pilot projects *(19)*.

WHO defines community engagement as "a process of developing relationships that enable stakeholders to work together to address health-related issues and achieve positive health impact and outcomes" *(18)*.

The role of community stakeholders depends on the local context – the types of organizations and infrastructures that exist and their areas of focus and capacities, including human resources. They can raise awareness of older people's rights and entitlements, support the views, experiences and opinions of older people and their carers to be heard in programme and service delivery planning processes. They can also advocate for necessary changes to systems and services, including rapid changes in response to evolving needs. Community stakeholders can support the establishment and organization of mechanisms for older people and other community stakeholder's engagement. They have a role in holding service providers and others to account, including through a direct role in monitoring and evaluation. If community stakeholders, including community health workers, are involved in the direct provision of services and support for older people, they should be appropriately trained, supported, supervised and monitored.

The health care system owes a responsibility to work appropriately with and support its partners, particularly community organizations, volunteers and carers. While community stakeholders often act as a bridge between older people and health workers and can fill some gaps in formal service provision, they should not be expected to provide services that are the responsibility of health and social care systems.

The rights and well-being of individual community members who engage, whether as carers or in a paid, unpaid or voluntary role, should not be infringed upon, or negatively impacted by their engagement. Their health and well-being should be protected. **Box 4.2** (p. 44) provides self-care advice for community health workers and other community stakeholders.

Depending on their capacity, community stakeholders may be able to support each step of the ICOPE care pathway in primary care (Chapters 5–13). Examples of possible engagement include:

1 Step 1: Basic assessment and community-level interventions

Community venues or spaces (e.g. town halls, social care centres, post offices, religious and community meeting spaces) can be used to organize events for basic ICOPE assessments and awareness raising on healthy ageing, for example, to combat ageism and break down stereotypes around "normal ageing" and increase knowledge and understanding of health in older age, rights and entitlements. Community stakeholders can encourage older people's attendance. Health workers can work with community organizations to offer outreach basic assessments through older people's clubs or associations and by organizing home visits, at which older people eligible for a basic assessment can be identified. During a basic assessment, community health workers and other trained community stakeholders can provide various types of tailored advice, support and community-based health care. → **3.1.3**

Box 4.2 How to practice self-care for community stakeholders

Dos

- ✓ Set boundaries between your personal life and work.
- ✓ Try to make a routine and organize your daily activities to balance work, family and free time.
- ✓ Take time to eat, drink water, sleep, rest, reflect and relax.
- ✓ Build healthy habits, like exercising regularly and avoiding alcohol, tobacco and other harmful substances.
- ✓ Be aware of your emotions and try to recognize situations that may affect your feelings.
- ✓ Talk to family and friends and ask for support.
- ✓ Connect with colleagues and find ways to help each other at work.
- ✓ Reach out to a health worker if you need help.

Don'ts

- ✗ Don't force yourself to do things that make you feel bad.
- ✗ Don't routinely exceed your working hours.
- ✗ Don't think you're alone and don´t need help.
- ✗ Don't feel that talking about being unhappy is a sign of weakness.

Source: mhGAP community toolkit: Mental Health Gap Action Programme (mhGAP). WHO; 2019.

2 Step 2: In-depth assessment

While in-depth assessments should be conducted by health workers at a primary care facility, community stakeholders can play a role in ensuring access through organizing or providing transport for older people, as well as supporting health workers to assess an older person's social and physical environment. They could also follow up with older people after a basic assessment to ensure they understand their results, and where relevant, the importance of having an in-depth assessment and follow up.

3 Step 3: Personalized care plan

Care plans should include social care and support, which may be provided by community stakeholders. It may therefore be useful to engage with them during the development of a care plan to understand their services. Community stakeholders can also support a broader mapping exercise, detailing what services and support are available locally, whether delivered by community-based organizations, local government authorities or local businesses and for-profit actors. This information can then be provided to health workers, care coordinators or case managers, to inform the development of personalized care plans.

4 Step 4: Implementation and monitoring

There are multiple ways in which community stakeholders can support this step of the pathway:

- Organizing and managing social care and support, such as day centres, home-based care services, lunch clubs to encourage social dining, meal/food delivery services and services providing support with household tasks.

- Organizing group exercise activities and social events to support participation and tackle social isolation and loneliness, for example, through supporting older people to use digital technology to stay connected with family, friends and the community.
- Running events and information campaigns to support self-care and self-management, both for older people and their carers.
- Supporting access to health care facilities and services, through deliveries of medications, providing transport and offering regular venues and times for outreach services, including health camps and vaccination events.
- Establishing and facilitating support groups, including peer support for older people and carers, and groups focused on specific issues, to support psychosocial well-being.
- Liaising with local businesses and facilities to raise awareness around specific issues, for example, providing shops, cafes, market and kiosk venders with tips about how best to interact with someone with cognitive decline or asking local facilities to make their toilets available to older people.
- Building up a resource bank of information and advice on how to access other services and support, such as financial support, local meal deliveries, home repair, cleaning or gardening services. These types of support can be particularly important for carers, who may struggle to find the time for these activities. Accessing such services can help to reduce the demands on carers' time and their subsequent stress, and enable them to give a greater focus to the person they are caring for while also taking breaks for themselves.
- Monitoring the implementation of ICOPE and holding service providers (both non-profit and for-profit) and policy-makers to account for commitments they have made to the delivery of integrated care for older people.

4.1.4 Collaboration and coordination among multidisciplinary health workers

Collaboration and coordination between health and social care workers drawn from different levels and types of health and social care are essential for the successful delivery of integrated care for older people. → **3.4** Although health workers at primary care facilities can provide many services and specialized services might be available at primary care in some contexts, collaboration is key to ensuring referral pathways are in place that can enable timely access to specialized services, including for the provision of acute care, and to the social sector.

This coordination and collaboration can be guided by a care coordinator or case manager and should be supported by a multidisciplinary team (**Box 3.2**, p. 35). Specialist health professionals may be required, in cases where more specialized knowledge and skills are needed than can be provided by trained health workers in primary care. This includes, but is not limited to, ophthalmologists, audiologists, psychologists, dentists, and health professionals for geriatric care (**Box 4.3**), rehabilitation services and palliative care.

Box 4.3 Geriatric care

Specialists in geriatric care play an important role, where available, in the delivery of integrated care for older people, including during acute episodes and in the management of long-term conditions. Geriatric care is provided by geriatricians, supported by geriatric nurses and other health professionals. Geriatricians, specialized doctors in the care of older people, have expertise to assess and manage older people's health needs and their social consequences, including geriatric syndromes such as falls, UI, pressure ulcers and delirium, and in the management of polypharmacy. Geriatricians and geriatric nurses work with older people to enable autonomy and should be a key part of a multidisciplinary team and can support other team members.

4.2 Integration across services and sectors

Different health and social care services need to be brought together and provided in a way that responds to an older person's holistic needs, rather than addressing specific losses of intrinsic capacity or conditions, one by one.

Alongside coordination and collaboration between different stakeholders involved in the delivery of the ICOPE care pathway and integrated care more broadly, integration across services and sectors is fundamental. For example, losses across a number of domains of intrinsic capacity increase an older person's risk of falls. Therefore falls prevention services and support should address all losses and risk factors an older person has. The following services and support are likely to be required in response to multiple losses and conditions.

4.2.1 Rehabilitation services

Rehabilitation is a set of interventions designed to optimize functioning ("functioning" is an umbrella term used in the rehabilitation sector for body functions, body structures, activities and participation), alleviate pain and reduce disability. It is effective in shortening recovery time, preventing complications related to acute and chronic conditions, and improving intrinsic capacity and functional ability. Interventions for rehabilitation comprise therapeutic techniques and procedures, exercises and training (e.g. muscle-strengthening exercises, cognitive training, breathing exercises, training for activities of daily living [ADL], social skills or communication skills), provision and training in the use of assistive products, and environmental modifications. Interventions for rehabilitation also address self-management skills, including provision of education and advice on health conditions or self-directed exercises, and carer and family training on care-related techniques and tasks.

Rehabilitation services are typically provided by a range of health professionals including rehabilitation nurses and medical doctors, psychologists, occupational therapists and physiotherapists. However, health workers at primary care facilities can also be trained to provide a limited set of rehabilitation interventions. It is important to empower a person receiving rehabilitation services by educating and advising, motivating and coaching, and providing support. Safety considerations should always be applied to address any problems that may arise during the provision of rehabilitation interventions.

Interventions for rehabilitation may be required as a result of loss(es) of intrinsic capacity, in relation to diseases and risk factors and to support an older person's social and physical environments. WHO's *Package of interventions for rehabilitation* outlines the interventions for rehabilitation with information on workforce needs, assistive products, equipment and consumables. Examples across the domains of intrinsic capacity include:

- **Cognitive decline:** Rehabilitation interventions aim to improve specific cognitive function and help individuals compensate for cognitive decline. There are a number of interventions that can be used to stimulate memory with assistive products including memory aids and pill organizers. Cognitive stimulation therapy, cognitive behavioural therapy (CBT) and cognitive training, are often provided by psychologists or occupational therapists as part of rehabilitation services, depending on the capacity of health care. → 5

- **Limited mobility:** Rehabilitation interventions comprise guided exercises and training but also include advice on how to start and continue personalized exercise independently, which fits into the person's daily routine, and should check progress on/against the interventions being provided. The interventions can target joint and muscle function, muscle strength and associated pain and swelling with musculoskeletal conditions such as osteoarthritis, osteoporosis and sarcopenia. They can also include a nutrition intervention as an essential component for people with limited mobility. → 6

- **Undernutrition due to difficulties with swallowing (dysphagia):** Rehabilitation interventions include the instruction and training in different techniques and exercises such as postural techniques, supraglottic swallowing, expiratory muscle-strengthening exercises to improve food sucking, chewing, manipulating food in the mouth, salivation and swallowing; and advice on modification of food consistency. These techniques are practised repetitively and, if feasible, performed self-directed. → 7

- **Vision impairment:** Rehabilitation interventions include the provision of optical and non-optical and electronic assistive products, advice to optimize the living environment, orientation and mobility training and vision skills training, and psychological support. → 8

- **Hearing loss:** Interventions for rehabilitation include provision and training in the use of hearing devices and assistive products, and speech and language therapy to enhance perceptive skills and develop communication and linguistic abilities. Interventions also include training in the use of sign language and other means of sensory substitution, such as speech reading, use of print on palm or Tadoma, signed communication. These interventions are often provided by audiologists and speech and language therapists. → 9

MORE INFORMATION

- ***WHO's Package of interventions for rehabilitation.*** WHO;2023(https://iris.who.int/handle/10665/370502).
  - ***Module 2: Musculoskeletal conditions*** (https://iris.who.int/handle/10665/370503).
  - ***Module 3: Neurological conditions*** (https://iris.who.int/handle/10665/370504).
  - ***Module 6: Sensory conditions.*** (https://iris.who.int/handle/10665/370508).
- ***Training in assistive products (TAP).*** TAP; 2024 (https://www.gate-tap.org/).

4.2.2 Assistive products

Assistive products (also known as assistive devices or aids) include walkers, eating and drinking aids, spectacles, pill organizers, incontinence products, devices that support memory and hearing aids. They can support maintenance or improvement of an individual's functional ability and hence independence by addressing losses in intrinsic capacity, associated diseases and necessary adaptations to an older person's environment. They can also be used to prevent secondary complications, e.g. diabetic footwear or pressure relief mattresses, and can lessen the demands on carers.

Appropriate assistive products should be discussed by trained health workers to determine what is needed. Stigmatizing attitudes towards assistive products, linked to ableism, should be considered and may need to be overcome to ensure older people's use of such products. At the same time, unnecessary use may lead to reliance, which could reduce independence.

The following service provision steps are necessary to ensure the appropriate use of assistive products:

1. Selecting the best product for a person's needs.
2. Fitting the product to suit the person.
3. Teaching the person (and carers) how to use and take care of their product.
4. Ongoing monitoring to review whether the person's needs have changed, and carry out any maintenance and repair.

Assistive products can be provided by the health sector and/or the social sector by personnel with the appropriate competency. For example, a hearing aid is likely to be provided by a health worker; while the social care sector may be responsible for the placement and management of audio loops. Wheelchairs, canes and walking frames will usually be provided by the health system and grab rails and bars within a person's home may be organized and installed

by social services. The types of products provided by different sectors will depend on national systems. It is important that both an older person and their carer(s) are provided with information about assistive products, where to access them specific to their location, their use and maintenance.

Some simple assistive products can be provided by health workers in primary care with some additional training. This can reduce the need for multiple appointments at different specialist services. WHO's Training in Assistive Products (TAP) is available to support training of health workers in identification and provision of a range of simple assistive products. It is an online resource with training modules organized by six streams including vision, hearing, cognition, communication, mobility and self-care (personal care).

Examples of assistive products for different domains of intrinsic capacity are included in the social and physical environments sections of Chapters 5–13.

4.2.3 Palliative care

Palliative care is an approach that improves the quality of life of patients and their families who are facing problems associated with life-threatening illness and helps them to live as independently and actively as possible. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual. It also includes services to help families cope with emotional, social or spiritual distress during the patient's illness and during bereavement.

Palliative care should be provided by a multidisciplinary team in primary care including in older people's homes, according to their needs and preferences and delivered using an integrated approach alongside any symptom relieving or curative treatments being offered. All health workers should have basic palliative care skills to manage symptoms, prescribe essential palliative care medicines (including morphine and other opioids), and incorporate palliative care into a personalized care plan. Where available, specialized palliative care, can help manage complex pain and other symptoms, and address multidimensional suffering.

Advance care planning should be part of usual practice. Discussion and documentation of a health care proxy decision-maker and a person's preferences about future care are important. These discussions should include information about preferred location of care and place of death (e.g. home, LTC residential facility), choices related to medical treatments including transfer to hospital and high intensity care which may be potentially life-sustaining but impose a significant burden and potential suffering, important spiritual practices and practical matters surrounding death.

In older people expected to experience significant declines, particularly in their cognitive capacity or ability to communicate, discussing and making decisions about end-of-life care early, is essential. These conversations should be conducted in a sensitive manner, bearing in mind individual and cultural perceptions and attitudes towards death and dying and understanding of what palliative care is and the benefits it provides.

MORE INFORMATION

- ***Palliative care: symptom management and end-of-life care.*** WHO; 2004 (https://iris.who.int/handle/10665/68535).
- ***WHO guidelines for the pharmacological and radiotherapeutic management of cancer pain in adults and adolescents.*** WHO; 2018 (https://iris.who.int/handle/10665/279700).
- ***Integrating palliative care and symptom relief into primary health care.*** WHO; 2018 (https://iris.who.int/handle/10665/274559).

4.2.4
Inappropriate medication(s) and polypharmacy

Older people with multiple diseases may be more likely to present changes of pharmacokinetics and pharmacodynamics. Together with physiological ageing of the metabolic/catabolic pathways impacting organ systems, including renal and hepatic functions, there is an increased risk of adverse drug reactions. It is essential to ensure that the medications are appropriate for the individual to gain the most benefits with least harm.

Inappropriate medication(s) are present when medicine is prescribed that is not or no longer needed, either because:

- there is no evidence-based indication, the indication has expired, or the dose is unnecessarily high;
- medicine(s) fail to achieve their therapeutic objectives;
- one, or the combination, of several medicines cause or are at risk of causing adverse drug reactions; and
- the patient is not willing or able to take medicine(s) as intended.

Polypharmacy is commonly described as the daily use of five or more medicines, which include over-the-counter, prescription and/or traditional and complementary medicines. This use of multiple drugs can be associated with adverse drug reactions and increases the risk of negative health consequences, resulting in potentially avoidable losses in intrinsic capacity and acute hospital admissions.

Older people receiving fragmented care or who have been hospitalized recently (care transition) and those with multimorbidity are at greater risk of polypharmacy or inappropriate medications, highlighting the importance of integrated person-centred care.

A medication review is a structured evaluation of a patient's medicines with the aim of optimizing their use and improving health outcomes. Because inappropriate medications and polypharmacy can contribute to losses across multiple domains of intrinsic capacity, in-depth assessment should include a review of medicines. Risks can be reduced by eliminating unnecessary, ineffective medicines as well as medicines that share an active ingredient, and replacing with alternatives if the continuation of a medicine is necessary (**Box 4.4**, p. 50).

Community stakeholders can play a role in addressing inappropriate medications and improving adherence to treatments. Community health workers can work with local pharmacists to ensure access to medications for older people in line with local regulations. They can also support older people to take medication correctly and to provide community-level education and awareness-raising campaigns on the safe use of medication, including for pain.

MORE INFORMATION

Medication safety in polypharmacy: technical report. WHO; 2019 (https://iris.who.int/handle/10665/325454).

4.2.5
Falls prevention

Declines in any domain of intrinsic capacity can increase the risk of falls. The physical environment and the way a task or activity is performed can also be factors. It is therefore important to consider interventions that address both intrinsic capacity and environmental factors in efforts to reduce risks and prevent falls. With training, health workers can assess the risk of falls. If a home visit is not possible, they can give general instructions to the older person and/or a carer on how to identify home hazards and create a safer home environment.

Box 4.4 How to prescribe appropriately and reduce medication errors

- Obtain a complete medication history including over-the-counter medicines and traditional, complementary and herbal medicines, and medicines that have been stopped due to lack of efficacy or side-effects.
- Consider whether the medicines may negatively affect intrinsic capacity.
- Avoid prescribing before a diagnosis is made except in severe acute pain.
- Try non-pharmacologic treatment first, where appropriate.
- Review medications regularly, including after any major health event or hospital discharge (care transition) and before prescribing a new medicine.
- Monitor any adverse effects, drug interactions and toxicity of medicines.
- Try to use one medicine to treat two or more conditions (e.g. antidepressants to improve mood and manage sleep disorder) and identify opportunities to reduce medicines.
- Provide a pill card and make pill organizers available.
- Educate the older person and carer about each medicine including symptoms of potential side-effects and when to alert health workers and the importance of checking expiry dates.
- If new symptoms occur, check whether they could be the result of adverse drug reaction.
- Use pictures or visual aids to explain if an older person has literacy issues or other difficulties with reading and be aware of any hearing loss that might affect communication and understanding.

Note: If in doubt about whether a medication can be safely stopped, refer to an appropriate health care worker with knowledge (e.g. pharmacist, geriatrician).

A full assessment of the risk of falls includes:

- Taking a history of falls, including details of the activities being carried out.
- An assessment of:
  - Intrinsic capacity: mobility that includes muscle and joint function, gait, balance and flexibility; vision; cognition.
  - Cardiovascular and neurological status.
  - Urinary urgency incontinence, or nocturia (waking to urinate at night).
  - Foot problems including deformities of feet and peripheral neuropathy due to underlying diseases such as diabetes and arthritis.
  - Fear of falling.
- An assessment of the physical environment in the home and home surroundings to find possible hazards.
- Review of medications such as psychotropic medicines.

Some people will need further assessment and management for conditions such as syncope (blackouts), epilepsy and neurological disorders such as Parkinson's disease. A full assessment and management of a person's risk of falls requires specialized knowledge.

The risk of falls can be reduced by:

- Improving the older person's balance and coordination through multimodal exercise such as Tai chi.
- Identifying the need for home modifications and adapting their physical environment. A person's specific losses of intrinsic capacity will guide what environmental adaptations are most important.

This might include reducing clutter, removing loose rugs and slippery floor surfaces or coverings, smoothing out bumps in floors and steps, moving furniture and other hard objects to create a wide, unblocked usual walking path, improving lighting and access to the toilet, especially at night, adding handrails to stairs and grab bars in the bathroom. A ramp to the main doorway will make it easier for people who use wheelchairs and others with difficulty climbing steps.

- Identifying the need for assistive products such as spectacles for vision impairment and suitable footwear, and referral for assessment and prescription. Older people should be encouraged to wear enclosed sturdy shoes around the house, rather than slip-on footwear.

- Medication review to identify inappropriate medications and withdrawal of unnecessary or harmful medicines.

- For those with vision impairment specific changes can be made to the home and in a person's usual areas of movement to make daily tasks and leisure activities safer and easier and to reduce the risk of falls. →**8.6.2**

  - **Improve lighting:** good lighting is particularly important for near vision. Install lights in hallways, stairs, cupboards and small, dark spaces to provide direct light. Light is best coming from the side of the person (without creating shadow).

  - **Reduce glare:** brighter light is usually better. But glare from the sun or bright lights can bother some people.

  - **Create contrast:** good contrast within and between objects makes them easier to see, find or avoid. Use high contrast marking on the edges of steps (particularly for those with vision in only one eye), coloured plates so that food stands out in contrast, use a black pen for writing, colour the handles of household and kitchen tools to make them more visible and safer (e.g. wrapping a knife handle with brightly coloured adhesive tape or painting it).

Health workers can offer advice on things to be aware of related to housing and age-friendly initiatives.

Community stakeholders may be able to support efforts towards age-friendly environments inside and outside the home, including through age-friendly home programmes or initiatives to map and audit the local area. This could take the form of auditing green spaces, access to benches and public toilets and local services and facilities. Mapping problem areas, including where overgrown bushes and grass encroach on walkways, fallen obstacles such as trees and rocks block walkways, and holes in paths, can provide information that community stakeholders, including older people's clubs or associations, can use to advocate for local authorities to make repairs and ensure upkeep. Relevant community stakeholders may also be able to work with local authorities to undertake this work if appropriate training, support and compensation are provided.

MORE INFORMATION

- ***Step safely: strategies for preventing and managing falls across the life-course.*** WHO; 2012 (https://iris.who.int/handle/10665/340962).
- ***Integrated care for older people (ICOPE) implementation pilot programme: Findings from the 'ready' phase.*** WHO; 2022 (https://iris.who.int/handle/10665/353553).
- ***Global Database of Age-friendly Practices.*** WHO; 2024 (https://extranet.who.int/agefriendlyworld/age-friendly-practices/).
- ***WHO Global Network for Age-friendly Cities and Communities.*** WHO; 2024 (https://extranet.who.int/agefriendlyworld/who-network/).

5 Cognition

Care pathway to manage cognitive decline

Cognitive decline presents differently in each person, and it may include increased forgetfulness, loss of attention, language difficulties, changes in judgement and reduced ability to solve problems. It is associated with conditions including hearing loss, and noncommunicable diseases such as depression, hypertension, diabetes and Alzheimer disease and other dementias. Other factors for increased risk of cognitive decline include lack of physical exercise, social isolation and a low level of education.

Cognitive decline is commonly accompanied by changes in mood, emotional control, behaviour or motivation and it becomes of greatest concern when it starts to interfere with a person's ability to function effectively in their environment (dementia). It has physical, psychological, social and economic impacts, not only for the person with cognitive decline, but also for their carers, families and society at large. Cognitive decline and dementia are not part of normal ageing and many people will not experience cognitive decline or dementia in older age. The estimated prevalence of dementia in people over 60 years old in 2019 varied by region from 2.9% in South East Asia to 6.5% in Europe. The global prevalence rises rapidly with age, from 1.1% in people aged 60–64 to 35.9% in those aged 90 and over *(20)*.

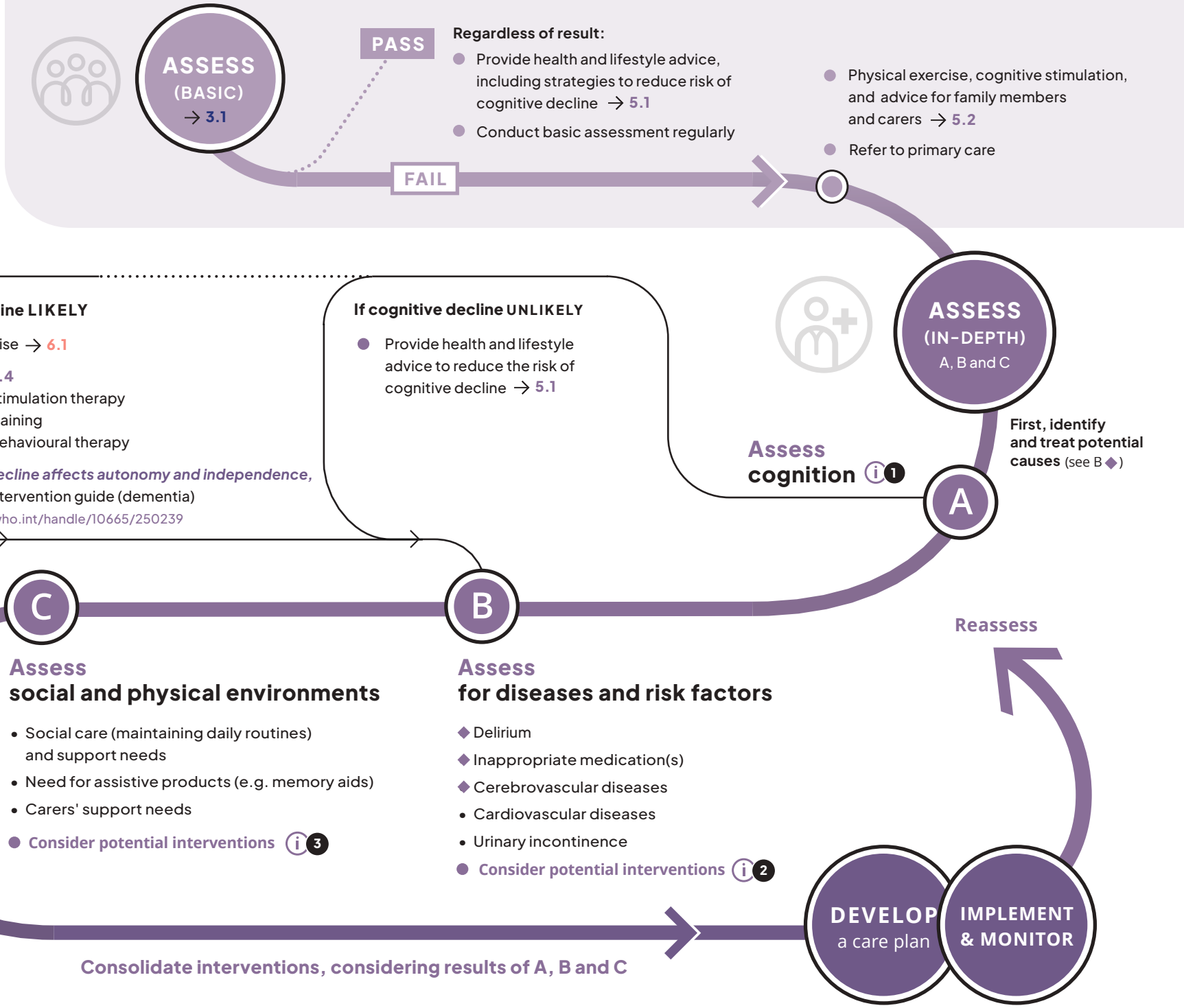
Key points

- Health workers in the community can conduct a basic assessment for cognitive decline using a set of questions.
- Promoting a healthy lifestyle, including physical exercise, cognitive stimulation and social engagement, can optimize brain health, including for those with cognitive decline.
- Carers of people with cognitive decline or dementia need advice on how to best provide appropriate care as well as support for their own health and well-being.
- For a person with dementia, a more specific, targeted or tailored approach is needed.
- Community stakeholders can raise awareness of cognitive decline, stressing that people with cognitive decline or dementia should not face stigma or discrimination and their rights and dignity should be protected. They can support people with cognitive decline to remain socially connected.

5

Cognition

Care pathway to manage cognitive decline



Need for specialized knowledge and training

- Management of people with multiple diseases or delirium, and with social contexts, including being socially isolated, that require a more comprehensive approach
- Management of behaviours and psychological symptoms associated with dementia, such as walking about, apathy (appearing uninterested), agitation, aggression, delusions, and hallucinations
- Provision of cognitive behavioural therapy (5.4.3)

1 Assess cognition → 5.3

In-depth assessment of cognitive capacity should use a locally validated tool. Table 5.1 provides a list of options for assessing cognition in primary care facilities.

What is dementia?

Dementia is a chronic and progressive syndrome due to changes in the brain. While Alzheimer disease is the most common form, dementia can be caused by a variety of diseases and injuries to the brain. Dementia results in decline in cognitive functioning, and interferes with memories and skills needed to carry out everyday activities such as washing, dressing, eating and personal hygiene as well as managing finances and personal affairs and household chores. Other common symptoms include deterioration in emotional control, social behaviour and motivation .

Table 5.1 Example of brief cognitive assessment tools for use in primary care

TOOL/TEST	ADVANTAGE	DISADVANTAGE	TIME
Mini-Cog https://mini-cog.com/download-the-mini-cog-instrument/	Brief; minimal language, educational and racial bias; can be an alternative screening tool	Use of different word lists may affect scoring	2–4 min
Montreal cognitive assessment (MoCA) https://mocacognition.com/paper/	Can identify mild cognitive impairment; available in multiple languages	Educational and cultural bias; limited published data; and training and cost implications (e.g. copyright)	10–15 min
Mini mental state examination (MMSE) https://www.parinc.com/products/pkey/237	Widely used and studied	Subject to age and cultural bias; ceiling effects; and training and cost implications (e.g. copyright)	7–10 min
General practitioner assessment of cognition (GPCOG) http://gpcog.com.au/index/downloads	Minimal cultural and educational bias; available in multiple languages	May be challenging to get an informant's report	5–6 min
Rowland Universal Dementia Assessment Scale (RUDAS) https://www.dementia.org.au/professionals/assessment-and-diagnosis-dementia/rowland-universal-dementia-assessment-scale-rudas	Minimal language, educational, and socio-cultural bias	Limited published data	10 min

2 Interventions for diseases and risk factors → 5.5

- **Delirium** → Identify cause (severe dehydration, infection, medication, electrolyte metabolic abnormalities) and treat (5.5.1)
- **Inappropriate medication(s)** → Review medication and withdraw or prescribe alternatives (5.5.2)
- **Cerebrovascular and cardiovascular diseases** → Management of diseases and reduce risk factors (5.5.3, 5.5.4)
- **Urinary incontinence** → See UI care pathway → 13

3 Interventions for social and physical environment → 5.6

- **Social care and support needs** → Enable social participation and ability to maintain daily routines (5.6.1)
- **Social care and support needs** → Provide personal care and support with activities of daily living (11.6)
- **Social care and support needs** → Identify and manage risk of falls at home and home surroundings (4.2.5)
- **Need for assistive products** → Provide guidance on memory aids (notes, reminders and calendars) (5.6.2)
- **Carer's support needs** → Provide advice (5.2.3) and training on how to support an older person with cognitive decline and support for the carers' well-being (12.4)

5.1
Health and lifestyle advice to reduce the risk of cognitive decline

Community health workers and community stakeholders can give older people and their carers advice on health and lifestyle behaviours and strategies to reduce the risk of cognitive decline, alongside more general advice. → 3.1.3 This advice remains relevant for people with cognitive decline, for whom prevention of further loss may be possible. Specific targeted advice may also be useful for people with cognitive decline.

For all older people, the importance of:

- Managing risk factors for CVD.
- Doing cognitive training through repetitive practice to improve memory.
- Doing regular cognitive stimulation activities, undertaken alone, including reading, playing games, learning something new and playing music.
- Being socially active and engaging with the community (e.g. interacting with children and grandchildren, practising hobbies, listening to and discussing news and current affairs).
- Managing hearing loss and depression. → 9 10

For older people with (potential) cognitive decline, the importance of:

- Understanding the nature of their condition, available treatment options and support.

The information can be provided through one-to-one conversations, group meetings and discussions and awareness-raising campaigns. These broader campaigns are important in challenging often widely held misconceptions around cognitive decline. Communities need to be educated to understand that cognitive decline is not a "normal part of ageing" and to tackle harmful cultural beliefs around cognitive decline as "punishment" or "witchcraft" and the stigmatization and abuse that can happen as a result. Stigma and discrimination heighten the already significant psychological, social, emotional and financial impacts that dementia has on individuals, their carers, families and communities.

5.2
Community-based health care to address cognitive decline

If an older person is identified with potential cognitive decline through a basic ICOPE assessment, and an in-depth assessment is not immediately available, community health workers and community stakeholders can provide support with physical exercise, cognitive stimulation and advice for family members.

5.2.1
Physical exercise

Being physically active may reduce the risk of (further) cognitive decline. A variety of physical exercises, including aerobic exercise with moderate intensity as well as balance and muscle strengthening exercises such as Tai chi, have positive effects on cognitive function and everyday function (21)(22)(23). Community stakeholders can support older people to undertake physical exercise (three to four times per week for 30–45 minutes for more than 12 weeks) through setting up and running exercise programmes and making these programmes accessible and affordable. → 6.1

5.2.2
Cognitive stimulation

With training community health workers and other community stakeholders can support an older person through cognitive stimulation. Depending on the setting and the capacity of the community stakeholders, individual or group sessions can be organized in a more or less formal way, such as organizing a line dancing group, chess club or language class. Groups are efficient if the members of the group share a common purpose.

5.2.3
Advice to family members and carers

Providing practical advice for daily life to family members and carers might be helpful in supporting them to care for an older person with cognitive decline.

- Support an older person with writing down appointments, setting reminders and having a calendar on the fridge or wall with these appointments and an order of tasks throughout the day.
- Support the social care needs of an older person with cognitive decline, including through developing plans for ADL.
- Provide orienting information, such as the date, current community events, identity of visitors, weather, news of family members.
- Encourage and arrange contact and activities with friends and family members at home and in the community.
- Make and keep the home safe to reduce the risk of falls and injury. → **4.2.5**
- Post signs in the home to help the person find their way about (e.g. for the toilet, bedroom, door to outside).
- Arrange for and join in social activities (as appropriate to the person's capacities). → 9 10
- Learn about and understand the nature of the condition of the person they are caring for, and available treatment options and support.
- Importance of taking care of their own health and well-being. → 12

MORE INFORMATION

- ***Risk reduction of cognitive decline and dementia: WHO guidelines.*** WHO; 2019 (https://iris.who.int/handle/10665/312180).
- ***Field test version: mhGAP community toolkit: Mental Health Gap Action Programme (mhGAP).*** WHO; 2019 (https://iris.who.int/handle/10665/328742).
- ***Towards a dementia inclusive society: WHO toolkit for dementia-friendly initiatives.*** WHO; 2021 (https://iris.who.int/handle/10665/343780).

5.3 Assess cognition

Cognition is a process associated with thinking, that includes reasoning, remembering, judgement, problem-solving and planning. An important step, before any diagnostic tests for cognition, is to identify and treat any reversible causes (◆). → 5.5

Almost all standard cognitive assessments used for the basic assessment or diagnosis of cognitive decline assume a minimal amount of education (Table 5.1, p. 55). If a person has low levels of education, or they are illiterate, cognitive assessment can be limited *(24) (25)*. Other sociocultural factors, such as language to be used and socioeconomic status, can also affect the efficacy of an assessment. These factors should be considered and where necessary interview and clinical judgement should be used instead. For these individuals, enrolling in an adult literacy programme (if available) is highly recommended, as it promotes brain health.

The care pathway outlines two different paths based on the results of an in-depth cognitive assessment. Those assessed to have normal cognition should still be assessed for diseases and risk factors and social and physical environments.

A person with cognitive decline, should also be assessed for difficulty with ADL or instrumental activities of daily living (IADL). Their basic assessment results for other linked domains of intrinsic capacity, such as limited mobility, hearing loss and depressive symptoms should also be verified and an in-depth assessment conducted as necessary. → 6 9 10 This information is important for integrating interventions related to other losses in intrinsic capacity and social care and support needs as part of a personalized care plan. → 11

5.4 Manage cognitive decline

Interventions to manage cognitive decline should always be provided as part of a comprehensive personalized care plan addressing the underlying diseases (e.g. CVD), symptoms such as delirium and risk factors, along with interventions that address other domains of intrinsic capacity.

For a person with dementia, a more specific, targeted or tailored approach is appropriate. Referral to those with specialized knowledge might be needed in cases with multiple associated diseases or delirium and with behavioural and psychological symptoms such as walking about, apathy, agitation, aggression, delusions and hallucinations.

In addition to physical exercise and cognitive stimulation, which can be provided in the community, there are multiple other ways to manage cognitive decline. Cognitive stimulation therapy, cognitive training, CBT, and referral to rehabilitation services (→ **4.2.1**), should be considered in alignment with the WHO *Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders*. These interventions are often provided by psychologists or occupational therapists, but can be delivered by a trained health worker at a primary care facility with supervision. Local protocols should be applied for referral to specialists.

Prescription of anti-dementia medicines for cognitive decline without diagnosis of dementia is not recommended. Health workers need to be trained and supervised to ensure competence in diagnosis and monitoring for the prescription of anti-dementia medicines.

5.4.1
Cognitive stimulation therapy

Cognitive stimulation therapy encompasses a variety of approaches including reality orientation, validation, and/or reminiscence. The standard group approach emphasizes social interaction by stimulating multiple cognitive functions simultaneously and involves up to 14 themed sessions of about 45 minutes each, held twice a week. Typically, a session might start with some non-cognitive warm-up activity and then move to a variety of cognitive tasks, including reality orientation (for example, a board displaying such information as place, date and time), led by a facilitator. Sessions focus on different themes, for example, childhood, use of money, word games, cooking or music. These activities generally avoid factual recall but instead focus on questions such as: "What do these (words or objects) have in common?"

5.4.2
Cognitive training

Cognitive training refers to a range of techniques that are applied to engage thinking and cognition with various degrees of breadth and specificity. It targets isolated cognitive functions (e.g. memory) with individual, repetitive practice of standardized cognitive tasks. For example, placing five everyday items (e.g. cup, pen, key) on a table, studying them for a minute, covering them with a cloth and then trying to recall the items. To progress the exercise, a greater number of items can be used and the time between covering the items and recall can be extended. The goals include improving or maintaining cognitive processes or addressing the impact of impairment in cognitive processes on associated functional ability in daily life.

It is important to encourage family members and carers to regularly provide older people with information such as day, date, weather, time and names of people, which helps them to remain oriented in time and place.

Providing materials such as newspapers, radio and TV programmes, family albums and household items can promote communication, orient an older person to current events, stimulate memories and enable the person to share and value their experiences.

5.4.3
Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) is an umbrella term covering a wide range of psychological approaches that aim to improve affective function. CBT focuses on the process of thought rather than content to help people accept their thoughts. CBT can have positive effects on everyday functioning and quality of life, and reduction of depressive symptoms as a comorbid condition. →10.4.2

MORE INFORMATION

- ***Optimizing brain health across the life course: WHO position paper.*** WHO; 2022 (https://iris.who.int/handle/10665/361251).
- ***mhGAP guideline for mental, neurological and substance use disorders, [3rd ed.].*** WHO; 2023 (https://iris.who.int/handle/10665/374250).
- ***mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings, version 2.0.*** WHO; 2016 (https://iris.who.int/handle/10665/250239).

5.5 Assess and manage associated diseases and risk factors

An assessment of diseases and risk factors for cognitive decline should start by identifying and treating possible causes (◆). Common reversible conditions and risk factors that can cause cognitive decline include delirium, medication(s) and cerebrovascular diseases. In some cases, treatment of these conditions results in improvement in cognition. If cognitive decline persists, further assessment will be required.

Uncovering a reversible cause of cognitive decline involves a full diagnostic work-up, sometimes including blood tests. It may be necessary to explore several different potential explanations of symptoms to arrive at an accurate approach for a care plan.

5.5.1 Delirium ◆

Delirium is acute, fluctuant loss of the ability to direct, shift, sustain and focus attention. People also become confused about where they are and what the time is. Delirium develops over a short period of time and tends to come and go during the course of a day. It can be accompanied by other disturbances of perception, memory, thinking, emotions and concentration. For a person with significant cognitive decline, including dementia, any sudden change in circumstances such as moving home or a bereavement may precipitate a worsening of confusion or delirium. In most people, the common precipitating factors are illness particularly infection, dehydration, new medication, metabolic abnormalities (such as hypoglycaemia, hyponatraemia, hypothyroidism, vitamin deficiency), injury, substance intoxication or substance withdrawal.

5.5.2 Inappropriate medication(s) ◆

Two or more medicines may interact and cause adverse side-effects. →4.2.4 The potential harm of these medicines can also outweigh their benefits for some people. These include, but are not limited to: opioids, antidepressants, psychotropic medicines, dihydropyridines, antihistamines and anti-muscarinics *(26)*.

5.5.3 Cerebrovascular disease ◆

Vascular disease in the brain is closely associated with cognitive decline. If the patient has a history of stroke or transient ischaemic event, then prevention of further events is the primary approach to stop further declines in cognition.

5.5.4 Cardiovascular diseases and risk factors

Cardiovascular diseases and risk factors, such as hypertension, diabetes and high cholesterol, are modifiable factors for cognitive decline. The risk of developing CVD can be reduced by adopting a healthy lifestyle. Early diagnosis and treatment of CVDs are essential to prevent complications. Screening for hypertension can be integrated in the community by measuring blood pressure, followed by a prompt referral. →3.1.5, 3.2.2 The early detection of diabetes at a primary care facility is encouraged by testing those who are symptomatic, overweight or obese. For those with CVD, support should be provided to ensure adherence to treatment, including medication.

5.5.5 Urinary incontinence → 13

Urinary incontinence is common in people with cognitive decline and should be assessed for and managed as appropriate.

5.6 Assess and manage social and physical environments

5.6.1 Social care and support → 11

With training and support from health workers, family members and carers can develop plans for ADL that maximize independent activity, enhance functional ability, help to adapt and develop skills, and minimize the need for support.

For those with dementia, specific measures may be needed to support daily activities while keeping the person safe. These measures should be commensurate with the person's abilities, changing as their condition progresses. For example, someone with more advanced symptoms of dementia should avoid driving, avoid the use of gas for cooking, cook with someone else present and carry a note with them with their name and address in case they get lost.

Carers can also inform friends and neighbours about the person's dementia, in case they get disoriented and are found in the community. In some contexts, tele-assistance services may be available that include emergency buttons and other devices to help older people with dementia stay safe at home and in community settings, while also providing reassurance for carers.

Community stakeholders can help create age-friendly and dementia-inclusive environments, from outdoor spaces to public services (e.g. libraries, cafés) and businesses.

5.6.2 Assistive products including memory aids

Assistive products including memory aids (notes, reminders and calendars) can help a person with cognitive decline to remember important things and to continue to live with some independence. It can be helpful to place notes and other reminders around the home, for example, a list or pictures near the door to remind the person what they should take with them when leaving the house. Labelling cupboards so the person can identify where to find things, and labelling items specifying their use, could also help. If a smartphone is available, alerts, apps and calendar functions can be useful memory aids. Using pill boxes or organizers can assist with remembering to take medications as prescribed.

Note reminders can include:

- household chores
- medications and when to take them
- shopping lists
- phone numbers of close friends, family, emergency services
- how to perform important tasks.

5.6.3 Optimize the physical environment to reduce the risk of falls

An assessment of and modifications to the physical environment can be useful in reducing the risk of falls. →4.2.5

5.6.4
Support for carers → 12

Caring for an older person with cognitive decline, including dementia, can be overwhelming. As cognitive decline progresses, the person may become forgetful and increasingly need help with daily tasks. They may not recognize relatives or friends and may experience changes in their behaviour that can be distressing and difficult for their carers to manage. These demands can put carers' health and well-being at risk.

It is important that carers receive support for their well-being and information and training to support their ability to provide care.

This can focus on the importance of maintaining a daily routine, identifying and modifying environmental falls risk factors, detailed recording of falls incidents (→ **4.2.5**), how to use assistive products, what to do in response to challenging behaviour and how to respond when/if the person they are caring for does not remember them.

MORE INFORMATION

- ***WHO iSupport for dementia: training and support manual for carers of people with dementia.*** WHO; 2019 (https://iris.who.int/handle/10665/324794).

6 Locomotor capacity

Care pathway to improve mobility

Musculoskeletal health refers to the performance of the locomotor system, comprising muscles, bones, joints, nerves and connective tissues. Locomotor capacity is defined as the status of a person's musculoskeletal system, encompassing endurance, balance, muscle strength, function and power, and joint function, and how these change over time *(27)*. Mobility is the interaction of locomotor capacity and a person's environment. Mobility is a critical determining factor for maintaining autonomy and independence.

Nutritional status is closely associated with locomotor capacity. Pain also impacts mobility, balance and coordination, which may increase the risk of falls. There are effective strategies to improve and maintain locomotor capacity and mobility in older age.

Key points

- Health workers in the community can conduct a basic assessment for limited mobility with a simple test.
- A multimodal exercise programme, tailored to individual capacities, preferences and needs, is the most important approach to improve or maintain locomotor capacity, alongside nutritional interventions.
- Health workers should assess pain and include pain management interventions in a personalized care plan.
- Assistive products can enable older people to maintain mobility despite reduced locomotor capacity.
- Environmental adaptations to the home and home surroundings can support the functional ability of older people with limited mobility.
- Community-based organizations and older people themselves can support adherence to physical activity including exercise, through establishing their own activities and peer support.

6

Locomotor capacity

Care pathway to improve mobility

ASSESS (BASIC) → 3.1

PASS

Regardless of result:

- Provide health and lifestyle advice including advice to promote physical activity → 6.1
- Conduct basic assessment regularly

FAIL

- Physical exercise programmes for limited mobility → 6.2
- Refer to primary care

ASSESS (IN-DEPTH) A, B and C

(A, B and C can be assessed in any order)

A

Assess mobility

Example: Short Physical Performance Battery (SPPB) [1]

IF NORMAL MOBILITY
(SPPB score 10–12 points)

- Provide health and lifestyle advice to promote physical activity and prevent falls → 6.1, 4.2.5

IF LIMITED MOBILITY
(SPPB score 0–9 points)

- Provide support for self-care and self-management
- Provide multimodal exercise with close supervision → 6.4.2
- Consider increasing protein intake → 7.2

Multimodal exercise

A multimodal exercise programme for people with limited mobility combines different types of exercise with emphasis on the core muscle groups of back, thigh, abdomen and lower body

B

Assess for diseases and risk factors

- Inappropriate medication(s)
- Pain
- Musculoskeletal conditions (e.g. osteoarthritis, osteoporosis and sarcopenia)
- Urinary Incontinence

Consider potential interventions [2]

C

Assess social and physical environments

- Risk of falls in home and home surroundings
- Need for mobility assistive products
- Social care and support needs including with ADLs
- Carers' support needs (training on transfer)

Consider potential interventions [3]

Consolidate interventions, considering results of A, B and C

DEVELOP a care plan

IMPLEMENT & MONITOR

Reassess

Need for specialized knowledge and training

- Rehabilitation for those with significant loss of intrinsic capacity and multimorbidity (4.2.1)
- Management of chronic pain that limits activity (6.5.2)
- Management of pain and multidimensional suffering, associated with life-threatening illness (4.2.3)
- Tailored exercise informed by an assessment of safety risks (**Box 6.1**)
- Provision and maintenance of mobility assistive products (6.6.2)

1 Assess mobility → 6.3

Short Physical Performance Battery (SPPB)

SPPB measures timed performance on three tasks, each scored out of four, for a total score from 0 (worst) to 12 (best).

Describe each test and ask if the person feels able to do it. If not, score accordingly and move to the next step.

1. **Balance:** Stand for 10 seconds with feet in each of the three positions. Use the sum of the three scores. If any not attempted, end balance tests.

2. **Gait speed:** time to walk 4 m

< 4.82 seconds	4 points
4.82–6.20 seconds	3 points
6.21–8.70 seconds	2 points
> 8.70 seconds	1 point
Unable to complete	0 points

3. **Chair rise:** time to rise from a chair five times

< 11.19 seconds	4 points
11.2–13.69 seconds	3 points
13.7–16.69 seconds	2 points
16.7–59.90 seconds	1 point
> 60 seconds or unable to complete	0 points

Final SPPB score = sum of scores for the three tests above.

Side-by-side stand:

Held for 10 seconds	1 point
Not held for 10 seconds	0 points
Not attempted	0 points

Semi-tandem stand

Held for 10 seconds	1 point
Not held for 10 seconds	0 points
Not attempted	0 points

Tandem stand

Held for 10 seconds	2 points
Held for 3 to < 10 seconds	1 point
Held for < 3 seconds	0 points
Not attempted	0 points

If any of the above are not attempted, end balance tests

2 Interventions for diseases and risk factors → 6.5

- **Inappropriate medication(s)** → Review medication and withdraw or prescribe alternatives (6.5.1)
- **Pain** → Pain management including through physical exercise and psychological interventions (6.5.2)
- **Musculoskeletal conditions** → Management of diseases (6.5.3)
- **Urinary incontinence** → See UI care pathway → 13

3 Interventions for social and physical environment → 6.6

- **Risk of falls** → Optimize physical environments at home and home surroundings (4.2.5)
- **Need for assistive products** → Provide mobility assistive products and advise on use and maintenance (6.6.2)
- **Social care and support needs** → Provide personal care and support with activities of daily living (11.6)
- **Social care and support needs** → Support access to health care and getting medications (6.6.3)
- **Carers' support needs** → Provide training on positioning and transfer of an older person with mobility loss (12.4)

How pain affects mobility → 6.5.2

Pain is a unique and unpleasant sensory and emotional experience that can limit activities and make daily life difficult. It may cause discomfort, limit movement, affect sleep and social participation. It is affected by a person's physical, psychological, social, cultural and spiritual circumstances. Pain can also impact mood, motivation, overall well-being and depressive symptoms. It can be acute but is often chronic (longer than 3 months) in older people. Severe pain associated with movement can limit or prevent physical exercise. Addressing pain includes a comprehensive pain assessment, understanding of the person's goals for pain management and use of non-pharmacological and pharmacological approaches to achieve optimal pain control.

6.1

Health and lifestyle advice to promote physical activity

Physical activity is important for carers too, supporting their physical and mental health and their resilience. This may become more important if an older person's locomotor capacity declines and carers have to take on more physically demanding tasks, supporting with moving, transfer and lifting.

Everyone should undertake regular physical activity. The benefits are well established, including for older people and those with pain. The benefits include helping to prevent and control CVD risk factors; reducing depressive symptoms and anxiety, and enhancing cognitive function; promoting and maintaining locomotor capacity and preventing falls; and improving bone health thus preventing osteoporosis *(28)*.

Community health workers and other community stakeholders can provide advice on physical activity to all older people, including those with potential loss of mobility. This advice can be provided alongside the more general health and lifestyle advice. →**3.1.3** Advice on physical activity should take into consideration the person's intrinsic capacity and social and physical environment, and cultural perceptions and acceptability of physical activity in their context. Advice should also include the fact that activity that is too intense, including physical work, may not be beneficial.

For all older people and carers:

- All older people can benefit from physical activity, regardless of their level of mobility.
- Every move counts. Any amount of physical activity is better than none. Older people can start slowly, doing small amounts of physical activity and gradually increase frequency and intensity. Try walking, cycling, jogging, swimming, everyday household tasks, gardening, dancing and sport.
- Too much sedentary behaviour is unhealthy. Getting moving and replacing sedentary time with physical activity of any intensity provides health benefits.
- Physical activity should be adjusted to a person's ability.
- A healthy diet is also important. →7.1

Each week:

- Get at least 150 minutes of moderate intensity aerobic physical activity or at least 75 minutes of vigorous intensity aerobic physical activity, or an equivalent combination of both.
- Aim for 300 minutes of moderate intensity activity or 150 minutes of vigorous intensity activity for substantial health benefits.
- Exercise at least 10 minutes at a time.
- Do muscle-strengthening activities that involve all major muscle groups 2 days or more.
- Perform physical activity that enhances balance on 3 days or more.
- Do multimodal physical activity combining both balance and strength training on 3 days or more.
- If you cannot exercise as much as recommended, be as physically active as you can.

Moderate intensity activity: heart is beating faster than usual, and you are breaking a sweat. Carrying on a conversation is difficult but not impossible.

Vigorous intensity activity: heart is beating very fast, and you are breathing hard. Carrying on a conversation is almost impossible and you are likely sweating profusely.

For older people with (potential) limited mobility, to prevent falls:

- Certain activities can help prevent falls, including balance activities like yoga.
- Adapt the home environment using lighting, contrast and the use of colours, installation of handrails and grab bars.
- Practising good foot care and hygiene and wearing appropriate footwear.

6.2 Community-based health care to address limited mobility

6.2.1 Physical exercise

If an older person is identified as potentially having limited mobility through a basic ICOPE assessment, and an in-depth assessment is not immediately available, community health workers and other community stakeholders can provide more specific advice and facilitate access to community-level opportunities for physical exercise. This can include organized exercise classes, and more informal groups and activities. Community stakeholders, including older people's groups, can set up physical exercise activities, such as brisk walking groups, regular Tai chi classes in a local park, or yoga classes in a community hall, organizing trained people to guide these exercises. This will provide opportunities for social engagement and peer support, which may encourage older people to stick with their physical exercise.

If in doubt about the safety of exercise, refer to an appropriate health care worker with knowledge (Box 6.1, p. 69).

Intergenerational activities could also be offered where appropriate and desirable for older people. Community stakeholders might be able to work with local authorities and other service providers (e.g. religious gatherings, gyms) to secure dedicated time for older people's exercise and to improve the physical environment through age-friendly cities and communities programmes.

MORE INFORMATION

- ***Physical activity.*** WHO; 2024 (https://www.who.int/initiatives/behealthy/physical-activity).
- ***Promoting physical activity for older people: a toolkit for action.*** WHO; 2023 (https://iris.who.int/handle/10665/373332).
- ***WHO guidelines on physical activity and sedentary behaviour: at a glance.*** WHO; 2020 (https://iris.who.int/handle/10665/337001).

6.3 Assess mobility

More information on the SPPB, what it involves and how it is scored can be found on p.65 (i) 1

Mobility can be assessed more fully by using a physical performance test. The short physical performance battery (SPPB) *(29)* is one of the most commonly used and widely recommended tools. It has superior measurement properties and is useful across a range of capacities. The SPPB comprises a balance test, a walking speed test and a chair rise test with scores added together to determine a person's physical performance, including locomotor capacity. If a person uses assistive product(s), alternative or modified tests, conducted with or without the product(s), can be considered.

This care pathway outlines two different paths based on the total score. Those assessed to have normal locomotor capacity should still be assessed for diseases and risk factors and social and physical environments.

The basic assessment results for other linked domains of intrinsic capacity, such as undernutrition should be verified and an assessment conducted as necessary. → 7

Urinary incontinence should be assessed for and managed as appropriate. → 13

6.4 Manage limited mobility

Interventions to manage limited mobility should always be provided as part of a comprehensive personalized care plan, including underlying diseases (e.g. musculoskeletal conditions) and factors contributing to limited mobility, such as pain or joint issues, along with interventions for other domains of intrinsic capacity.

In addition to promoting physical activity, including exercise provided in the community, there are multiple other ways to manage limited mobility. Multimodal exercise programmes, increased protein intake and referral to rehabilitation services should be considered.

6.4.1 Support for self-care and self-management

Support for self-care and self-management of physical activity increases adherence and benefits, and helps to address pain. People whose SPPB scores are in the range of 10–12 (considered as normal mobility) can exercise on their own at home and in the community, as can those with a lower score if advice, support and close follow up are provided.

6.4.2 Multimodal exercise

For those with limited mobility, a multimodal exercise programme should be tailored to suit individual capacity, needs and preferences and provided with supervision to ensure the safety of exercise (Box 6.1, p. 69). The use of safe and familiar equipment and careful warming up and cooling down should be prioritized to prevent injury. Consideration should be given to cultural perceptions and gender-specific factors, including in relation to the acceptability of exercise. Multimodal exercise can also help reduce the risk of falls. → 4.2.5

Where pain limits mobility, pacing exercise in manageable chunks of time and slowly increasing physical tasks helps to build the body's resilience and manage pain. Pain management should be considered and provided as appropriate alongside physical exercise. For people with significant loss of locomotor capacity, exercise training in bed or seated on a chair can be a starting point. For people with cognitive decline or dementia, a simple and less structured exercise programme may be more suitable.

Box 6.1 Safety of exercise

Before giving advice on exercise or planning an exercise programme, ask about health conditions that would affect the type and intensity of the activity. If the person answers yes to any of the following questions, a health professional should develop a tailored exercise programme.

- Have you experienced chest pain or palpitations in the last month?
- Have you had a heart attack within the last 6 months?
- Have you fainted or lost consciousness?
- Have you fallen in the past 12 months?
- Have you broken a bone in the last month?
- Do you get out of breath doing ordinary daily activities at home, such as getting dressed?
- When you walk, do you need to use objects to support yourself, for example, holding on to furniture or leaning on another person?
- Do you have a joint or muscle disease that limits exercise?
- Has a health worker advised you to limit exercise?

If an older person has chronic conditions or significant loss of intrinsic capacity or pain limits mobility, health professionals should be consulted for advice on the type and amount of physical exercise.

A multimodal exercise programme for people with limited mobility should be designed with the local context in mind, considering the exercise facilities and equipment available. There are multiple ways people can exercise and specific types of training can be adapted. A gym and/or specialist equipment are not necessary. A programme for older people with limited mobility should include:

- **Strength/resistance training**, which requires muscles to work under load, using weights, resistance bands or body weight exercises such as squats, lunges and sit-to-stand exercises; other examples are heavy gardening and climbing stairs. If exercise weights are not available a household item can be used, for example, tins of food or bags of beans or rice.
- **Aerobic/cardiovascular training**, such as fast walking, cycling or dancing that increases heart rate until the person is slightly out of breath but can maintain a conversation; it is important to warm up and cool down after aerobic exercise by doing light stretches and walking at a gentler pace.
- **Balance training**, which challenges balance and coordination, including static and dynamic exercises; can progress to different surfaces and with eyes open and shut; examples are standing on one leg at a time and walking heel-to-toe in a straight line.
- **Flexibility training**, which improves the extensibility of soft tissues, such as muscle, and the range of joint movement; examples are stretching, yoga, Tai chi and Pilates exercises.

The Vivifrail project offers a practical guide to developing a tailored exercise programme, based on locomotor capacity and risk of falls (30).

Nutritional interventions, including the provision of dietary advice such as increased protein intake, can enhance the benefits of an exercise programme. → 7

6.5 Assess and manage associated diseases and risk factors

6.5.1 Inappropriate medication(s)

Some medicines can impair or interfere with locomotor capacity yet are sometimes still prescribed. The potential harm of these medicines can outweigh their benefits for some people *(31)*. These include, but are not limited to, medicine that affects the central nervous system including those with anticholinergic effects (e.g. benzodiazepines, opioids, antidepressants). →4.2.4

6.5.2 Pain

Pain can make an older person's daily life difficult. It is important that pain is assessed and managed.

Assess pain

It is helpful to rate the severity of pain as part of a person-centred assessment, both to help with designing an exercise programme and for managing pain. Early identification of pain (severity and cause) should be performed proactively to facilitate the management of loss of locomotor capacity and depressive symptoms. There are several pain scales such as numeric rating scale and the Brief Pain Inventory *(32)*. The numeric rating scale is an 11–point scale for patient self-reporting of pain. The person should be asked to rate the severity of their pain, when the pain is experienced (morning, during sleeping at night, during or after exercise), and duration of the pain.

Numeric rating scale for pain
0 = no hurt
2 = hurts little bit
4 = hurts little more
6 = hurts even more
8 = hurts whole lot
10 = hurts worst imaginable

Manage pain

The goal of pain management *(33)* is to relieve pain to a level that allows for an acceptable quality of life. Where pain is a significant barrier to movement and activity, a health professional with specialized knowledge of pain management should develop pain management interventions, including medications with close monitoring, for integration into a consolidated personalized care plan, that may also include referral to rehabilitation services or palliative care.→4.2.1, 4.2.3

Community stakeholders, including older people's groups, could also provide advice and support for older people living with pain, including through establishing peer support groups.

Interventions for pain might include:

- self-management, including staying physically active, applying heat and cold, changing posture and reducing inactive posture, managing stress, including through relaxation techniques, sleeping well and modifying thinking to focus more on positive thoughts;
- physical exercises;
- manual therapy such as massage, joint manipulation and joint mobilization;
- psychological therapy including CBT; →10.4
- acupuncture;
- assistive products to aid mobility; and
- medication such as nonsteroidal anti-inflammatory medicines, which should be used with extreme caution, due to substantially increased risk of gastrointestinal adverse events and renal impairment. Where absolutely necessary, prescription requires careful attention to medical history, medication review, close follow up and the shortest duration of treatment possible.

Pain related to serious illnesses

Pain is one of the most frequent, serious symptoms experienced by patients with serious illnesses. Palliative care should be provided, including for those with life-threatening or chronic and/or progressive diseases (e.g. dementia, chronic obstructive pulmonary disease, cardiac failure) to prevent and relieve suffering

The benefit of pain relief must be balanced against the risk of adverse effects and overdose that may result in respiratory depression. Regular monitoring is important to reduce the risks associated with opioids, promoting early identification of potential adverse effects.

through the early identification, correct assessment and treatment of pain and other issues. Pain relief might be required at all stages of a disease, not only at the end of life. Such patients must be reviewed regularly, as they may require increasing doses of analgesia with progression of their disease. →4.2.3

Pain related to musculoskeletal conditions

Musculoskeletal conditions that impair locomotor capacity often involve chronic pain. A specific biological cause of persistent pain is not always found. Holistic assessment and personalized care from a biopsychosocial perspective, therefore, addresses multiple factors that may be associated with pain – physical factors such as muscle strength, range of movement and endurance, psychological well-being such as coping with pain and social factors.

Chronic low back pain

Chronic/recurrent low back pain (LBP) (longer than 3 months) is commonly experienced by older people in addition to pain from other musculoskeletal conditions. Chronic LBP results in high levels of disability and a pronounced impact on quality of life. Since health workers may identify underlying disease or structural lesions (e.g. arthritis, old fracture) among older people, their clinical judgement and a comprehensive approach is critical to diagnose chronic primary LBP. The *WHO guideline for non-surgical management of chronic primary low back pain in adults in primary and community care settings* recommends 10 interventions related to education, physical, psychological, medicines and multicomponent interventions (Table 6.1). Besides these interventions, mobility assistive products should be considered.

6.5.3 Management of muscoskeletal conditions

Musculoskeletal conditions such as osteoarthritis, osteoporosis and sarcopenia can impair locomotor capacity.

Osteoarthritis is a degenerative joint condition, which affects the joint and surrounding tissues. It causes pain, swelling and stiffness, can lead to significant losses in locomotor capacity, reduced social participation and quality of life and increased psychological distress. It is most common in the knees, hips, spine and hands.

Table 6.1
Recommended interventions for chronic primary low back pain in adults

Intervention class	Interventions
Education	• Structured and standardized education and/or advice
Physical interventions	• Structured exercise therapies or programmes • Needing therapies • Spinal manipulative therapy • Massage • Mobility assistive products
Psychological interventions	• Operant therapy • Cognitive behavioural therapy
Medicines	• Non-steroidal anti-inflammatory drugs (NSAIDS)* • Topical cayenne pepper (*Capsicum frutescens*)
Multicomponent interventions	• Multicomponent biopsychosocial care

*This recommendation does not include older people

MORE INFORMATION

- ***WHO guideline for non-surgical management of chronic primary low back pain in adults in primary and community care settings.*** WHO; 2023 (https://iris.who.int/handle/10665/374726).
- ***Executive summary: WHO guideline for non-surgical management of chronic primary low back pain in adults in primary and community care settings.*** WHO; 2023 (https://iris.who.int/handle/10665/374531).

Osteoporosis is characterized by low bone mass and structural deterioration of bone tissue, leading to an increased susceptibility to fractures, especially of the hip, spine and wrist. Osteoporosis is more common in women often being caused by hormonal changes after the menopause. Smoking, alcohol, long-term use of steroids, lack of calcium and vitamin D, and being underweight are the main risk factors.

Sarcopenia is a progressive skeletal muscle condition involving the loss of muscle mass and strength, which is associated with increased adverse outcomes including falls, limitations in performing ADL, social participation, loss of independence and mortality. →7.5.1

6.5.4
Urinary incontinence → 13

There is evidence that demonstrates the link between UI and limited mobility (*34*), which can negatively affect access to the toilet. If a loss of locomotor capacity is identified, UI should be assessed and managed as appropriate.

6.6
Assess and manage social and physical environments

6.6.1
Optimize the physical environment to reduce the risk of falls

An assessment of and modifications to the physical environment can be useful in reducing the risk of falls. →4.2.5

6.6.2
Assistive products

Mobility assistive products can improve an older person's independence and safety and enable them to live at home for as long as possible. Mobility assistive products include walking aids, portable ramps, grab bars, transfer boards and wheelchairs. →4.2.2

Assistive products can:

- Help a person sit up, stand or walk.
- Support a person to be more independent in their basic ADLs.
- Reduce the risk of fall whilst walking.
- Provide people who cannot walk with a different way of moving around.
- Support a person to access their environment (home and home surroundings), including access to health and social services.

6.6.3
Social care and support → 11

An older person with limited mobility might need assistance with daily tasks including washing, dressing, going to the toilet and getting out of the house. Potential challenges with accessing health care and getting medications (e.g. going to the pharmacy) linked to reduced mobility may also need to be addressed, with carers and community stakeholders exploring alternative ways to facilitate access.

6.6.4
Support for carers → 12

Carers should be provided with training on how to assist someone to move safely, while also protecting themselves from injury.

MORE INFORMATION

Mobility assistive products, walking aids, portable ramps. TAP (https://www.gate-tap.org/).

7 Vitality

Care pathway to manage malnutrition

WHO uses the term vitality to describe the physiological factors that contribute to an individual's intrinsic capacity. These may include energy balance and metabolism, neuromuscular function, and immune and stress response functions of the body (*35*). Body composition changes occur with ageing with fat mass replacing muscle mass and inadequate nutrition also contributes to the loss of muscle mass and strength (sarcopenia). Nutritional status, including hydration, one of the key factors for vitality, significantly affects an older person's health, functional ability and quality of life. Impairment of oral function may affect chewing and swallowing ability and therefore nutrition. This handbook addresses malnutrition, focusing on undernutrition.

Key points

- Health workers in the community can easily make an initial assessment of nutritional status. A full assessment requires specialized knowledge and usually blood tests.
- A high protein diet through locally available protein rich foods is important for older people.
- Not drinking enough causes dehydration. Older people should be encouraged and supported to drink well.
- A balanced diet in adequate amounts usually provides the necessary vitamins and minerals for older people, but deficiencies in vitamins D and B12 are common.
- Overweight and obesity are major risk factors for noncommunicable diseases and should be prevented and managed through diet and exercise.
- Making eating a social activity, by eating together at home or within community groups, can encourage older people to eat more healthily and avoid isolation.

7

Vitality

Care pathway to manage malnutrition

ASSESS (BASIC) → 3.1

PASS

FAIL

Regardless of result:

- Provide health and lifestyle advice, including advice on good nutrition, hydration and locally available foods → 7.1
- Promote oral health (Box 7.1)
- Conduct basic assessment regularly

- Balanced diet including high protein foods for undernutrition → 7.2
- Refer to primary care

IF MALNOURISHED → 7.4.1

- Provide personalized diet advice
- Provide **oral supplemental nutrition*** with increased protein intake (400–600 kcal/day) (Box 7.2)
- Monitor dietary intake and weight closely

IF AT RISK OF UNDERNUTRITION → 7.4.2

- Provide personalized diet advice
- Record and adapt eating patterns
- Monitor weight closely
- Consider multimodal exercise → 6.4.2
- Consider **oral supplemental nutrition*** *if unable to improve food intake*

IF NORMAL
(or low risk of undernutrition)

- Provide advice on hydration and locally available foods → 7.1
- Promote oral health (Box 7.1)

A

Assess
nutritional status (i) 1

ASSESS (IN-DEPTH)
A, B and C

(A, B and C can be assessed in any order)

B

Assess
for diseases and risk factors

- Sarcopenia
- Gastrointestinal conditions
- Oral diseases and issues with chewing or swallowing

Consider potential interventions (i) 2

C

Assess
social and physical environments

- Social eating habits
- Social care and support needs (access, preparation and provision of food and drinks)
- Need for assistive products (eating and drinking aids, dentures)
- Carers' support needs

Consider potential interventions (i) 3

Reassess

DEVELOP a care plan

IMPLEMENT & MONITOR

Consolidate interventions, considering results of A, B and C

Need for specialized knowledge and training

- Management of gastrointestinal symptoms (e.g. chronic vomiting, diarrhoea, abdominal pain) (7.5.2)
- Management of malnutrition in the presence of diseases affecting metabolism (e.g. cancer, heart failure, respiratory diseases, renal dysfunction, liver dysfunction, diabetes)
- Personalized nutritional counselling for those with malnutrition
- Oral diseases and issues with chewing and swallowing (7.5.3)

1

Assess nutritional status → 7.3

Several tools are available to determine the risk of under-nutrition (normal nutritional status/low risk of malnutrition, medium risk of malnutrition, and malnourished/at high risk of malnutrition) without a blood test. For example:

- **Mini nutritional assessment (MNA)** https://www.sciencedirect.com/science/article/abs/pii/S0899900798001713
- **Malnutrition universal screening tool (MUST)** https://www.bapen.org.uk/pdfs/must/must_full.pdf
- **Seniors in the community risk evaluation for eating and nutrition questionnaire, version II (SCREEN II)** https://olderadultnutritionscreening.com/screen-tools/
- **Short nutritional assessment questionnaire 65+ (SNAQ65+)** https://clinicalnutrition.science/en/nrs/screenings/snaq-65-.html)

2

Interventions for diseases and risk factors → 7.5

Sarcopenia	Consider rehabilitation to improve muscle function (7.5.1)
Gastrointestinal conditions	Management of diseases (7.5.2)
Oral diseases and issues with chewing or swallowing	Management of oral diseases (7.5.3)
	Advice on consistency and texture of drink and food (chopped, minced, pureed) (7.5.3)

3

Interventions for social and physical environment → 7.6

Social eating habits	Encourage family and social dining in the community (7.6.1)
Social care and support needs	Arrange assistance with access, preparation and provision of food and drinks (7.6.2)
Need for assistive products	Advise the appropriate positioning and assistance with feeding (11.6)
Carers' support needs	Provide eating and drinking aids, and dentures (7.6.3)
	Provide advice on food preparation, feeding and drinking (12.4)

What is dehydration? → 7.3.2

Dehydration, "an insufficient amount of water in the body" is a common condition in older people (*36*). One in every four older people living in the community or in LTC facility has low-intake dehydration (dehydration due to drinking too little) (*37*). It is important to encourage and support sufficient intake of water based on individual capacity and social context.

7.1

Health and lifestyle advice to promote good nutrition and oral health

Our diets and the way we eat are influenced by our culture and, for many people, eating is a social event. As such, communities and families, including carers, can play a key role in supporting healthy diets and promoting oral health. → 3.1.3

All older people can benefit from healthy diet advice, including those at risk of or affected by undernutrition. When providing advice on healthy diets, including hydration, it is important to note that older people should follow any medical advice they have been given, for example, the need to restrict certain foods or drinks due to underlying diseases and conditions, including medication (drug-food interaction).

Remember: It is important that family members and other carers as well as the older person receive this advice, together with information on where specific affordable foods, with adequate energy (e.g. carbohydrates, protein) and micronutrients such as vitamins and minerals, can be purchased or sourced (shops, markets) locally.

For all older people, the importance of:

- Food hygiene: keep hands and food preparation areas clean and raw and cooked food separate, cook food thoroughly, store food properly and use safe, clean water.
- Eating enough: eat smaller amounts more often (5–6 times per day) if having large meals is difficult.
- Family-style meals and social dining can help, particularly for older people living alone or who are socially isolated.
- Carbohydrate intake should primarily come from wholegrains, vegetables, fruits and pulses and fats from wholefoods, such as nuts, seeds, beans, olives and fatty fish.
- Hydration: drink at least 1.6–2 L (6–8 glasses or cups) per day, regularly throughout the day. Drinks can include water, tea, coffee, fruit juice, soft drinks and soups, Other fluids will come from food. The amount of liquid should be increased during particularly hot weather or in hot places.
- Doing physical activity, which enables protein to be incorporated into muscle and builds appetite, and helps to prevent and manage overweight and obesity. → 6.1
- Safe exposure to sunlight to allow the skin to manufacture vitamin D. The vitamin D in food may not be enough for older people to maintain optimal levels.
- Promote oral health (Box 7.1, p. 77)
- For older people who are overweight or obese, limit energy intake from total fats and free sugars and increase consumption of fruit and vegetables, legumes, wholegrains and nuts.
- For some older people, including those with UI and limited mobility, it may be beneficial to avoid frequent trips to the toilet during the night. In such cases, drinking could be reduced in the evening.

For older people with (potential) undernutrition:

- Advise on what and how much to eat. A person with diabetes, renal or liver dysfunction should be advised to consult a health worker for diet advice.
- Encourage to keep a record of food and drink consumed on a chart every day – both at meals and between meals. This can make it easier to follow a good diet and stay hydrated.

In addition to organizing community meetings to provide nutrition advice, community stakeholders can also support healthy nutrition by encouraging eating as a social event, and organizing lunch clubs and other regular community meetings with a meal provided. They could work with local authorities and others to identify small areas of land that could be used for community allotments or kitchen gardens and older people and families who already grow food could organize amongst themselves to exchange surpluses for more dietary diversity.

MORE INFORMATION

- ***Nutrition and food safety poster.*** WHO; 2024 (https://www.who.int/teams/nutrition-and-food-safety/multisectoral-actions-in-food-systems/five-keys-to-safer-food-poster).
- ***Healthy diet.*** WHO; 2024 (https://www.who.int/news-room/fact-sheets/detail/healthy-diet).
- ***Oral health training course for community health workers in Africa.*** OpenWHO; 2024 (https://openwho.org/courses/oral-health-community-AFRO).

Box 7.1 Promote oral health

WHO defines oral health as the state of the mouth, teeth and orofacial structures that enables individuals to perform essential functions such as eating, breathing and speaking. It encompasses psychosocial dimensions, such as self-confidence, well-being and the ability to socialize and work without pain, discomfort and embarrassment. Poor oral hygiene is a risk factor for oral diseases, which negatively affect nutrition intake. Oral diseases are also associated with CVD risk factors, particularly diabetes mellites. Community stakeholders can provide the following advice:

- Brush teeth twice a day with fluoride toothpaste (1000–1500 ppm) and safe water after breakfast and before going to bed. For those with no teeth, brushing gums and tongue with a soft toothbrush twice per day to remove food debris and bacteria is advised.
- Advise on denture hygiene, if applicable.
- Limit free sugar intake.
- Stop the use of all forms of tobacco including chewing of areca nuts and betel quid.

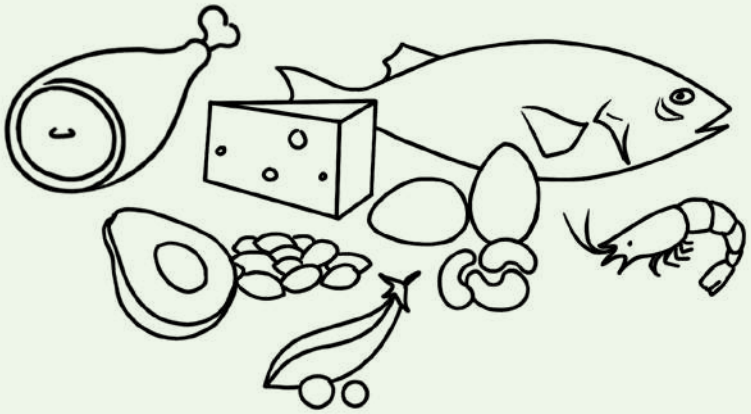
7.2
Community-based health care to address undernutrition

7.2.1
High-protein diet

If an older person is identified as potentially experiencing undernutrition through a basic ICOPE assessment, and in-depth assessment is not immediately available, community health workers can support them with guidance on a high-protein diet. Proteins are needed for cell and tissue growth and they support muscle contraction and movement and digestive and immune functions. A high-protein diet is important for older people who are undernourished because the body's ability to absorb protein decreases with age.

For an older person with undernutrition, protein intake of 1.0–1.2 g per kg of body weight is recommended. A person recovering from weight loss or an acute illness or injury may need up to 1.5 g per kg of body weight. Guidance should also be provided on safely increasing physical activity, as this enables protein to be incorporated into muscle and builds appetite.

Foods rich in proteins (> 20 g per 100 g) include legumes such as nuts, beans, lentils, peas and pluses, seeds, cereals, grains, cheese, meat and fish. Community health workers can use a food composition table to identify local foods with high protein and micronutrients (https://www.fao.org/infoods/infoods/tables-and-databases/faoinfoods-databases/en/). Although some dried pulses have a protein content similar to animal protein sources, when cooked they are not comparable. Given the diversity in availability of different food groups and types and cultural practices and tastes, developing a local food list can be helpful for older people to access locally available foods high in protein.



7.3 Assess nutritional status

Nutritional status and risk of undernutrition should be identified through an in-depth assessment using locally available and validated tools.

Examples of tools can be found on p. 75 i 1

Most nutrition assessment tools *(38)* ask about:

- food and fluid intake
- recent weight loss
- mobility
- recent psychological stress or acute disease
- mental conditions
- living situation.

They also record:

- weight
- height
- body mass index (BMI – kg/m^2)
- mid-upper arm circumference (MUAC) and calf circumference.

A deficiency in micronutrients; vitamins such as A, B12, D; and minerals such as iron, folic acid and calcium can cause diseases and health conditions such as anaemia and osteoporosis *(39)*. A blood test can identify specific vitamin and mineral deficiencies to inform nutritional interventions. Specific oral nutrient supplements or injections can treat these deficiencies.

This care pathway outlines three different paths based on the risk of undernutrition. Those assessed to have normal nutritional status (low risk of undernutrition) should still be assessed for diseases and risk factors and social and physical environments.

The basic assessment results for other linked domains of intrinsic capacity, such as limited mobility and depressive symptoms, should also be verified and an assessment conducted as necessary. → 6 10

7.3.1 Body mass composition and ageing

Typically after around 60 years of age, muscle mass tends to decrease. Both inadequate nutrition and inadequate physical activity lead to loss of muscle mass and strength. Body weight may decrease, or it may remain the same, masking these possible harmful changes.

The use of BMI in older people has limitations, for example, loss of height can be caused by vertebral collapse and change in posture. An older person with undernutrition might have lost crucial lean body tissue and still have a BMI in the accepted or even overweight range, due to increased fat.

Anthropometric proxy indicators of malnutrition such as MUAC and calf circumference are simple and convenient tools. The available data suggest that a MUAC of 23.5–25.0 cm, on the non-dominant arm can be used to identify the risk of undernutrition for adults in the community *(40) (41) (42)*.

A trained health worker could assess muscle strength and function and undernutrition with a tool such as a hand dynamometer to measure grip strength, if available. This tool measures how hard a person can squeeze the tool with one hand. Low hand grip strength indicates the need for exercise and a diet that includes more protein.

7.3.2
Dehydration

Dehydration (*43*) is associated with adverse health outcomes such as urinary tract infection (UTI), renal failure, constipation, delirium and cognitive decline and has multiple causes and contributors, including age-related reductions in the thirst sensation and fluid reserves, uncontrolled diabetes and renal dysfunction. Cognitive decline, swallowing difficulties, mobility loss, UI and difficulty in feeding may also limit an older person's intake of water. An older person with UI may actively choose to limit their fluid intake, thinking this will help manage their UI. Certain medicines, such as diuretics and laxatives, can contribute to fluid losses, and older people can also be particularly susceptible to fever, diarrhoea and vomiting, which all cause dehydration.

Health workers can:

- Look for symptoms of dehydration, such as dryness of the mouth, lips and tongue, sunken eyes, constipation, less frequent urination, tachycardia, headaches, weakness, confusion and dizziness, although an older person may not show typical clinical symptoms or signs (*44*).
- Advise the older person (and carers) to keep track of fluid consumption, including water, fruit juices and soups.
- Set an individualized daily fluid intake goal. This should be at least 1.6–2 L (6–8 glasses or cups) when no clinical conditions are present that require a different approach and take into account environmental factors, such as hot weather.
- Encourage the older person (and carers) to keep a supply of fluids they enjoy made the way they like to hand, and make use of drinking aids (e.g. light containers, straws and spoons) where needed.
- Discuss and support the older person to manage UI to enable them to drink well. → 13

7.3.3
Obesity

The prevalence of obesity among older people is rising worldwide (*45*). Obesity is associated with multiple chronic diseases including CVDs and cancer, as well as loss of locomotor capacity and quality of life. For older people, the benefits of weight loss need to be weighed against potential risks, such as loss of muscle mass, which can exacerbate sarcopenia and increase the risk of fractures. Promoting healthy lifestyles (nutrition, physical activity) is critical to maintain muscle mass and bone density during any caloric restriction. → **3.1.3**

Health workers in primary care facilities should:

- Assess the weight and height of older people regularly.
- Provide counselling on healthy diet and lifestyle.
- Monitor and manage CVD risk factors (→ **3.1.4)** and assess the presence of comorbidities, including mental health conditions.
- When a person is diagnosed with overweight or obesity:
  - Provide health services to manage obesity including dietary intervention, physical exercise and medical measures where indicated.
  - Assess for the presence of diabetes.
  - Refer to a specialist dietitian where available.

MORE INFORMATION

Obesity and overweight. WHO; 2024 (https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight).

7.4 Manage undernutrition

Nutritional interventions should always be provided as part of a comprehensive personalized care plan addressing the underlying diseases (e.g. gastrointestinal or oral diseases, malignancy) and factors contributing to poor nutrition, along with interventions that address other domains of intrinsic capacity. These factors include sensory impairments (a decreased sense of taste and smell), poor oral health such as chewing problems and swallowing difficulties, social isolation, loneliness, low income and long-term chronic conditions. Some medications can also interfere with taste or smell or cause nausea and vomiting.

In addition to a high-protein diet, there are multiple other ways to manage undernutrition such as nutritional counselling with weight monitoring, multimodal exercise and OSN.

Box 7.2 Oral supplemental nutrition: key points

- Food comes first. Unless the need for OSN is urgent, improvements in diet and more frequent meals should be tried first.
- OSN adds to food. It should not replace food. A person taking OSN should understand the need to keep eating as well as possible.
- People need instruction in how to mix OSN, how much to take at a time and when to take it.
- OSN should be taken between meals, not at mealtimes.
- People often need continuing support and encouragement (from family members, carers and health workers) to keep taking OSN.
- People may become tired of the taste and texture of one kind of OSN. A variety of flavours could be used where available.
- Weight should be closely monitored and recorded regularly.
- Ideally, the goal should be to stop OSN once the risk of malnutrition has passed and the diet provides adequate nutrition.

7.4.1 Risk of undernutrition

Health workers can provide personalized diet advice, with close weight monitoring, to prevent the development of undernutrition. They should start by recording eating patterns (types and amounts of foods including fluids, and frequency) then adapt these eating patterns to suit the individual's cultural or personal preferences to increase protein and required nutrients. If an older person is unable to increase their food intake, including protein, OSN should be considered (Box 7.2).

When a risk of undernutrition is identified, it is important to also consider multimodal exercise, as nutrition and exercise are key factors to maintain and improve muscle strength and function. Adequate energy and protein intake will make multimodal exercise programmes more effective. → 6.4.2

7.4.2 Malnutrition

In cases of malnutrition, health workers need to give immediate personalized dietary advice (nutritional counselling) and assess and manage contributing factors. A health worker with specialized knowledge (e.g. dietitian) should conduct an in-depth assessment of nutritional status, offer customized dietary advice and prescribe OSN, if needed and available.

Additional high-quality protein, calories and adequate amounts of vitamins and minerals can be provided by OSN where deficiency is identified. Specialized knowledge is needed to develop a plan for OSN that is tailored to an individual's needs and physical and psychological impairments. The assessment allows for choice of the best method of supplementation – whether through nutrient-rich foods, vitamin or mineral supplementation or through specialized commercial products or non-commercial nutritional formulations *(46)(47)*. OSN should be prescribed only when a person cannot consume sufficient calorie- and nutrient-dense regular food or when OSN is a temporary strategy in addition to regular food to increase caloric intake. Community health workers can support and monitor people using OSN (Box 7.2).

7.5 Assess and manage associated diseases and risk factors

7.5.1 Sarcopenia

Sarcopenia, a loss of muscle mass and strength, that results in decreased muscle function may require rehabilitation interventions including nutritional management with a focus on protein intake.
→4.2.1, 6.5.3

7.5.2 Gastrointestinal conditions

All functions of the gastrointestinal system such as movement of foods, enzyme and hormone secretion, digestion and absorption, can be affected in older age. Gastrointestinal diseases are one of the common etiologies for unintentional weight loss *(48)*. Physical examination and history taking can identify common gastrointestinal diseases such as constipation, diarrhoea, inflammatory bowel diseases and peptic ulcers, and disease management should be provided.

7.5.3 Oral diseases and issues with chewing or swallowing

Oral diseases and issues with chewing or swallowing have a major impact on nutritional status. The main oral diseases include dental caries (tooth decay), periodontal (gum) disease, edentulism (total tooth loss) and oral cancer *(49)*. Losing teeth is often wrongly thought of as an inevitable part of ageing and is socially accepted in many cultures. However, it can be psychologically traumatic, socially damaging and negatively affect intrinsic capacity and functional ability. Most oral diseases are preventable through self-care (Box 7.1, p. 77) and with access to appropriate oral health services.

Health workers at primary care facilities can identify oral diseases and conditions by asking about:

- difficulty in eating/chewing food
- difficulty in swallowing food or drink
- number of remaining natural teeth (less than 20 natural teeth correlated with worse outcomes)
- dental caries
- gums bleeding while brushing
- experience of having a dry mouth
- pain/swelling/non-healing ulcer.

Oral diseases can be addressed by a trained health worker in a primary care facility, in line with local rules and regulations, including through arresting dental caries, filling after the removal of a decayed tooth and managing periodontal disease with saline and/or disinfected mouthwash. However, further assessment and management require a referral to a health professional with specialized knowledge (e.g. dentist, dental assistant, hygienist).

Difficulties with swallowing (dysphagia), comprise problems occurring during the passage of solids or liquids from the mouth to the stomach, including sucking, chewing and biting, manipulating food in the mouth, salivation and swallowing. Severe complications in swallowing may include aspiration, dehydration or weight loss. These difficulties can occur as a result of a number of conditions more common in older age, including oesophageal dysfunction, stroke, Parkinson's disease and dementia.

Advice should include the importance of considering the consistency and texture of food and drink to make swallowing easier and reduce the risk of choking or aspiration.

Some older people may benefit from food being more finely chopped, minced or pureed. For a person with dysphagia, it is recommended to avoid mixed texture foods (e.g. soup with solid pieces) to reduce the risk of aspiration.

Training to strengthen the muscles for swallowing and improve coordination of the swallowing mechanism, can be provided, including exercises with chewing, singing and saying words quickly to maintain the muscles around the mouth. Salivary gland massage could be instructed to stimulate saliva production. If an older person has a significant impairment in swallowing, they should be referred to rehabilitation services if available and accessible. → **4.2.1**

Dentures

Dentures are removable false teeth that fit over the gums to replace missing teeth and eliminate potential problems caused by gaps. Dentures can help prevent problems with eating, subsequent undernutrition and speech. They can also improve self-confidence by changing a person's appearance. Dentures can be measured and fitted by a health professional with specialized knowledge (e.g. dentist, dental technician) who can also provide advice on how to wear, clean and look after them. They should be checked regularly, including for fit, especially if the person's weight is changing.

MORE INFORMATION

Promoting oral health in primary health care settings. OpenWHO; 2024 (https://openwho.org/courses/oral-health-promotion-PHC).

7.6 Assess and manage social and physical environments

7.6.1 Social eating habits

Making eating a social activity can have a positive impact, not only in terms of nutrition and hydration status, but also psychologically, helping to foster belonging and prevent loneliness.

Carers and community stakeholders can help to overcome barriers to older people's social eating habits by organizing social dining events for older people, including providing food at meetings or activities, and families eating meals together. Community organizations can facilitate access to healthier food options (e.g. through community gardens, community food markets).

7.6.2 Social care and support → 11

Social care and support for an older person with or at risk of malnutrition and/or dehydration might include supporting access to prepared and ready-to-eat meals, helping with cooking, providing drinks, including collection of water.

If an older person or/and their carer has difficulties in accessing food, community stakeholders may be able to help, by organizing grocery deliveries and providing financial advice and support. If an older person has difficulties in feeding, they may also be able to provide assistance with appropriate positioning at a table and feeding.

7.6.3
Assistive products

Simple eating and drinking aids can help a person with weakness or poor coordination to eat and drink independently.

Community health workers can identify when these simple assistive products may be helpful. Dentures may also be needed for those with tooth loss, to manage problems with eating. Simple training is available in how to identify and provide eating and drinking aids.

7.6.4
Support for carers → 12

Carers should have access to advice on the importance of hydration and how to prepare food for older people, including softer foods if chewing or swallowing is difficult. They should also be provided with information on how to help with feeding.

Carers should be supported with information on what to expect at the end of life. A reduction in eating and drinking is a normal part of the end-stage of a serious illness. Carers may find this difficult as food is often how people show love for each other. Information and support should be provided, including helping carers find other ways to show their love, like oral and skin care.

Having a healthy diet is equally as important for the carer, but carers may neglect their own diet, particularly if feeling overwhelmed or stressed by their caregiving role. If an older person needs assistance with feeding, a carer may focus on that rather than eating and enjoying their own meal. Sharing meals with family or friends can help, as others will be available to provide support.

MORE INFORMATION

- ***Training on eating and drinking aids.*** TAP; 2024 (https://www.gate-tap.org/).

8 Vision

Care pathway to manage vision impairment

Vision is a critical component of intrinsic capacity, enabling people to be mobile and to interact safely with their peers and the environment. Around 80% of distance vision impairment and 67% of near vision impairment occur in people aged 50 years or older *(50)*. Far-sightedness (presbyopia), cataracts, glaucoma and age-related macular degeneration are common eye conditions among older people.

Vision impairment severely impacts quality of life and is associated with depression, cognitive decline, anxiety, social isolation and higher risk of falls. It can cause difficulties in moving safely, maintaining family and other social relationships, ability to work and secure an income and in accessing information.

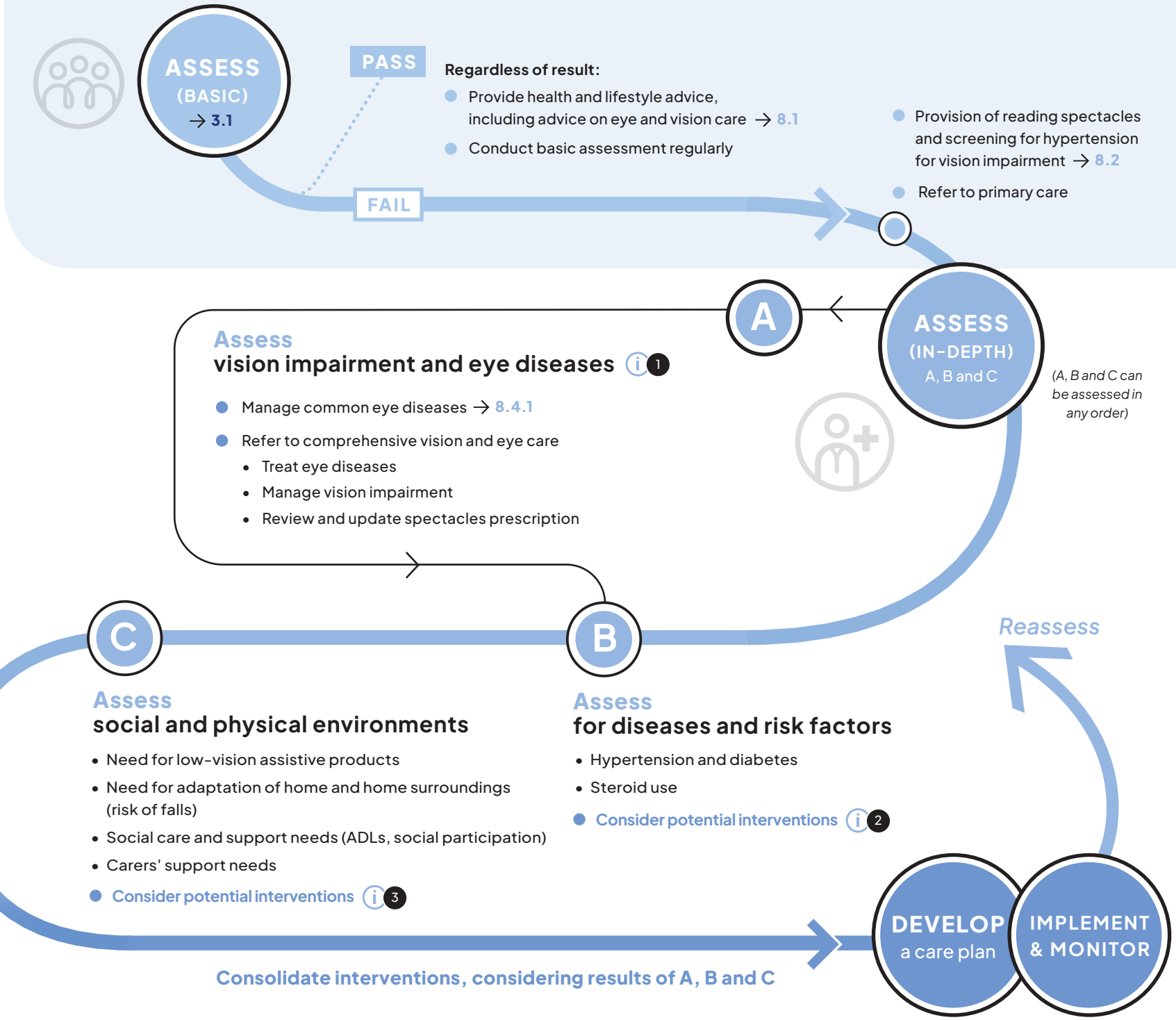
Key points

- With a simple eye chart, health workers in the community can conduct a basic assessment for vision impairment.
- The majority of cases of vision impairment and blindness can be prevented through early detection and timely management of eye diseases.
- Spectacles can often correct loss of near or distance vision.
- Assistive products such as magnifiers and white canes can support those with vision impairment that cannot be corrected with spectacles.
- Environmental modifications such as better lighting can improve the functional ability of older people with vision impairment and prevent falls.
- Community stakeholders can support older people with vision impairment by mapping and auditing local environments and establishing peer support groups.

8

Vision

Care pathway to manage vision impairment



Need for specialized knowledge and training

- Sudden or rapidly progressing vision impairment
- Provision of spectacles for correction of distance vision impairment
- Control of retinal disease related to hypertension and diabetes and other eye diseases (e.g. glaucoma, cataracts, macular degeneration) (8.5)
- Issues with the external eye (e.g. significant discharge including pus, abnormal red on the white part of the eye, abnormal haziness or red on the coloured part of the eye)

1

Assess vision impairment and common eye diseases →8.3

A person's ability to identify or distinguish an object or letter clearly at a given distance (visual acuity) is measured using a tumbling E chart. Visual acuity assessment is an important clinical measure when evaluating refractive error.

To conduct this assessment, a space with good lighting and big enough to ensure the correct testing distance (e.g. 3 m for distance vision, 40 cm for near vision) is required.

If the person already wears spectacles, examine visual acuity while wearing them.

Common eye diseases such as such as red eye, abnormal lashes, conjunctivitis and dry eye disease can be further assessed by examining the appearance of the external eye, eyelids and eyelashes using a torch.

Refractive error

Uncorrected refractive error is the most common cause of vision impairment globally. Refractive error occurs when the shape of the eye prevents light from focusing directly on the retina, leading to blurred vision. Common types of refractive errors include myopia (distance vision impairment), hyperopia (near vision impairment), presbyopia (age-related near vision impairment) and astigmatism (blurred vision at any distances).

2

Interventions for diseases and risk factors →8.5

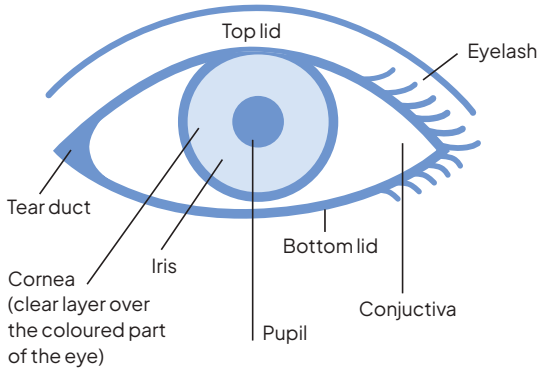
- **Hypertension and diabetes**
  - Management of CVD risk factors (8.5.1)
  - Annual retinal check (8.5.1)
- **Steroid use**
  - Regular review of steroid prescription (8.5.2)
  - Regular eye and vision examination (8.5.2)

3

Interventions for social and physical environment →8.6

- **Need for assistive products**
  - Provide low-vision assistive products (optical and non-optical) (8.6.1)
- **Need for adaptation of home and home surroundings**
  - Optimize physical environments (home and home surroundings) to reduce the risk of falls (4.2.5)
  - Advise on the use of household objects with larger more legible font (8.6.2)
- **Social care and support needs**
  - Support tasks of daily living, opportunities for social participation (8.6.3)
  - Provide psychosocial support (8.6.3)
- **Carers' support needs**
  - Provide advice and training including adaptation of communication (8.6.4)

The external eye



8.1 Health and lifestyle advice to promote eye and vision care

Community health workers and other community stakeholders can provide advice to all older people, including those with potential vision impairment, to support eye and vision care, including:

For all older people:

- Addressing common misconceptions, such as vision impairment being part of the normal ageing process.
- Importance of management of risk factors for vision impairment, including diabetes, hypertension and use of steroids.
- Having regular eye check-ups with a health worker and seeking advice if experiencing any problems.
- Taking regular breaks from near work activities such as use of electronic media (phones, tablets, etc), reading and sewing.
- Limiting exposure to ultraviolet lights by wearing sunglasses and hats.
- Washing hands regularly, avoiding rubbing or touching the eyes and only using mild soap to wash eyelids.
- Smoking cessation, as smoking increases the risk of eye diseases (e.g. cataracts, macular degeneration).

For older people with (potential) vision impairment:

- How to optimize the home and home surroundings to reduce the risk of falls, by using lighting, contrast and colours.
- Following advice on how and when to use spectacles, for example, if you have been told you need them for reading.

8.2 Community-based health care to address vision impairment

8.2.1 Provision of reading spectacles

If an older person is identified as potentially having vision impairment through a basic ICOPE assessment, and an in-depth assessment (for eye diseases, external abnormality and vision impairment) is not immediately available, community health workers can help. They can facilitate access to readymade reading spectacles, where available, for those with near vision impairment. Many people aged 50 years and older have difficulty seeing or reading at short distances. Reading spectacles can be an effective and quick solution to correct presbyopia (near vision impairment) by making close-up objects appear larger.

Readymade reading spectacles may be available at low cost in various magnification strengths (+1.00, +1.50, +2.00, +2.50, +3.00). There are several ways to prescribe reading spectacles. One commonly used method is to combine a person's age with trial and error.

Age group	Power of reading spectacles
40–50 years	+1.00 DS to +2.00 DS
≥ 50 years	+2.00 DS to +3.00 DS

Reading spectacles should be trialled in a well-lit room using the near vision acuity test card (p. 23). The frame should fit the person comfortably and correctly, making sure it is not too small or loose and it fits over the ears without pressing on the side of the head. When simple reading spectacles do not resolve the problem, comprehensive eye and vision examination by a health professional with specialized knowledge (e.g. ophthalmic nurse/optometrist/ophthalmologist) is advisable.

Community stakeholders can provide information on where readymade reading spectacles are available locally and how they work. Community-based groups, including older people's organizations, can work with health workers to facilitate mobile outreach services to provide and trial reading spectacles with older people.

8.2.2
Screening for hypertension

The risks for eye diseases and vision impairment posed by hypertension can also be screened. Community health workers should test blood pressure, if they have appropriate training and equipment, to identify the risk factors for CVDs and give advice on the management of these risk factors. → **3.1.4** If a person has already been diagnosed with hypertension and diabetes, they should be referred to primary care for follow up and a systematic retinal check should be recommended.

MORE INFORMATION

- ***Training in provision of reading glasses, magnifiers, and telescopes.*** TAP; 2024 (https://www.gate-tap.org).
- ***Vision and eye screening implementation handbook.*** WHO; 2023 (https://iris.who.int/handle/10665/375590).

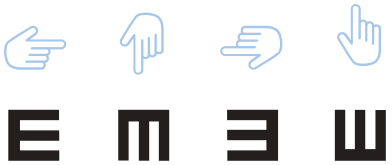
8.3 Assess vision impairment and eye diseases

Eye care services may be offered within primary care facilities, through proper supervision and the training of existing health workers, or the adoption of standalone primary eye care services, either in fixed facilities or through mobile units.

Health workers in primary care facilities can carry out eye and vision examination. They can measure the ability of a person to identify or distinguish an object or letter clearly at a given distance (visual acuity). They can also examine for common eye diseases, such as red eye, abnormal lashes, conjunctivitis, dry eye disease and eyelid inflammation, using a torch.

In some cases when specialized knowledge is needed, a referral to a health professional (e.g. ophthalmic nurse/optometrist/ophthalmologist) should be made. That includes more in-depth eye examinations such as subjective refraction, direct ophthalmoscopy and retinal imaging, provision of spectacles or contact lenses for distance vision impairment (myopia) as well as diagnosing and treating eye diseases such as cataract and retinopathy due to diabetes and hypertension.

The results of basic assessment for other linked domains of intrinsic capacity, such as cognitive decline and depressive symptoms, should also be verified and an in-depth assessment conducted as necessary. → 5 10



A "tumbling E" chart is widely applicable, while a LogMAR (EDTRS) chart requires knowledge of the Latin alphabet.

Box 8.1 Cataract

Cataract is clouding of the lens of the eye, which prevents clear vision, often related to the ageing process. Diabetes and obesity are risk factors. Along with refractive errors, it is the leading cause of preventable vision impairment and blindness (*51*). Reduction of smoking and ultraviolet light exposure may prevent or delay the development of cataract. Early detection and surgical correction can restore vision and save large numbers from losing their sight. Surgical intervention involves the removal of the clouded lens in the eye and the implantation of an artificial intraocular lens.

8.4 Manage vision impairment and eye diseases

Interventions to manage vision impairment and eye diseases should always be provided as part of a comprehensive personalized care plan addressing the underlying diseases (e.g. hypertension, diabetes) and other factors, along with interventions that address other domains of intrinsic capacity. In addition to provision of reading spectacles and screening for hypertension there are multiple other ways to manage vision impairment.

8.4.1 Management of common eye diseases

Health workers can provide treatment and/or first aid care at primary care facilities with advice on follow up for people presenting with red eye and/or abnormal lashes, infective and allergic conjunctivitis, dry eye disease, eyelid inflammation (blepharitis), ocular foreign body and keratitis (corneal inflammation). If there is little or no improvement, timely referral to a health professional with specialized knowledge is needed.

8.4.2 Management of refractive errors

Management of refractive errors includes regular eye examinations and comprehensive vision and eye care. Corrective measures such as spectacles, contact lenses and refractive surgery can effectively manage refractive errors. These treatments are safe and can significantly improve vision, enhancing quality of life.

8.4.3 Irreversible vision impairment and blindness

Many people have low vision for which prescription spectacles cannot correct their vision sufficiently. For these people, low-vision assistive products can make tasks involving near vision possible, such as reading a book or newspaper, identifying money, reading labels, sewing and inspecting small objects or parts of large objects. They should be referred to rehabilitation services, if available and accessible, for advice on how to enable their participation in social life by maximizing the use of residual vision and providing practical adaptations to address the social, psychological and economic consequences of vision impairment. → 4.2.1

Community stakeholders can support people with low or no vision to navigate their local community. This could include accompanying a person walking or taking a journey on a route they would like to learn, for example, from their home to a family member's home. Doing this a number of times will help the person to get used to the environment and build their confidence in making the journey. Developing audio maps of local environments, describing where things are and how to find particular facilities and services could also be useful.

MORE INFORMATION

Package of eye care interventions. WHO; 2022 (https://iris.who.int/handle/10665/354256).

8.5 Assess and manage associated diseases and risk factors

8.5.1 Hypertension and diabetes

Hypertension and diabetes are important risk factors for retinal diseases and glaucoma (a leading cause of preventable vision impairment and blindness). Diabetic retinopathy is the most common microvascular complication of diabetes. In addition to managing CVD risk factors (→ **3.1.4**), a systematic retinal check (i.e. annually or biennially, depending on the setting) for people with hypertension or/and diabetes, followed by treatment is recommended. Retinopathy can be detected and monitored using ophthalmoscopy by a health professional with specialized knowledge or retinal imaging with either local interpretation or telemedicine-based programmes with centralized grading.

8.5.2 Steroid use

In some people, long-term treatment with corticosteroids can increase pressure in the eyeball or lead to cataract. This increased pressure (glaucoma) can lead to vision impairment and blindness, by damaging the optic nerve, if not treated. Anyone receiving long-term steroid treatment needs regular comprehensive eye and vision examination including eye pressure checks. The appropriateness of steroid prescription including dosage should be regularly reviewed.

8.6 Assess and manage social and physical environments

8.6.1 Low-vision assistive products

A range of assistive products can be used to help older people with vision impairment continue with their daily lives and interests. These include optical assistive products such as magnifiers, telescopes and spectacles, non-optical assistive products such as audio books and players, talking watches, white canes, screen readers and adapted mobile phones. Many mobile telephones and computer programs now have text-to-speech functions. Pill organizers with raised text or braille might be helpful.

8.6.2 Environment modification at home and in home surroundings

In addition to the use of low-vision assistive products, simple changes can be made to the home and home surroundings to reduce the risk of falls for older people with vision impairments. → **4.2.5** Besides these modifications, changes to make daily tasks and leisure activities easier can include:

- **Use of the most legible type:** For printed materials and electronic display screens on computers and telephones, large, sans serif type (such as the type in this handbook) that stands out clearly from a uniform background colour is easiest to read.

- **Choosing household objects with larger type and good contrast:** Products are commonly available that use larger letters and numbers or good contrast, for example, clocks, watches and large-print books. For leisure, large game boards and pieces, and playing cards with large print and symbols can be bought or made.

- **Use of talking assistive products:** Consider talking watches, thermometers and scales.

8.6.3
Social care and support → 11

Older people with vision impairment may require support with ADL. Besides assistance with daily activities such as eating and dressing, older people can be supported to organize their belongings to make them easy to find and distinguish.

For example, keeping similar items like cutlery together in drawers and not mixing them with screwdrivers. Clothes can be organized in drawers or cupboards as coordinated outfits or by arranging them according to the occasions on which they are worn.

Older people with vision impairment may feel unhappy, lonely or hopeless, and have an increased risk of depression, anxiety, fatigue or grief related to (progressive) vision loss. They can experience social isolation, particularly if they find it difficult to get out of the house to attend social gatherings and events and may benefit from psychological support.

Carers and community stakeholders can help by organizing local events and accompanying people to attend, mapping local environments and establishing peer support groups. They can also advocate for and implement solutions to improve the readability of signs in both private and public facilities (e.g. in health care facilities, restaurant menus) as well as in outdoor spaces (e.g. traffic and street signs).

8.6.4
Support for carers → 12

Training for carers of older people with vision impairment could include, how to help the person move around, ranging from modifying the home environment to make it safer to how to walk with someone with vision impairment. It could also focus on how to adapt communication styles and methods, including:

- Be patient – give the person enough time to navigate an environment especially if it is unfamiliar.

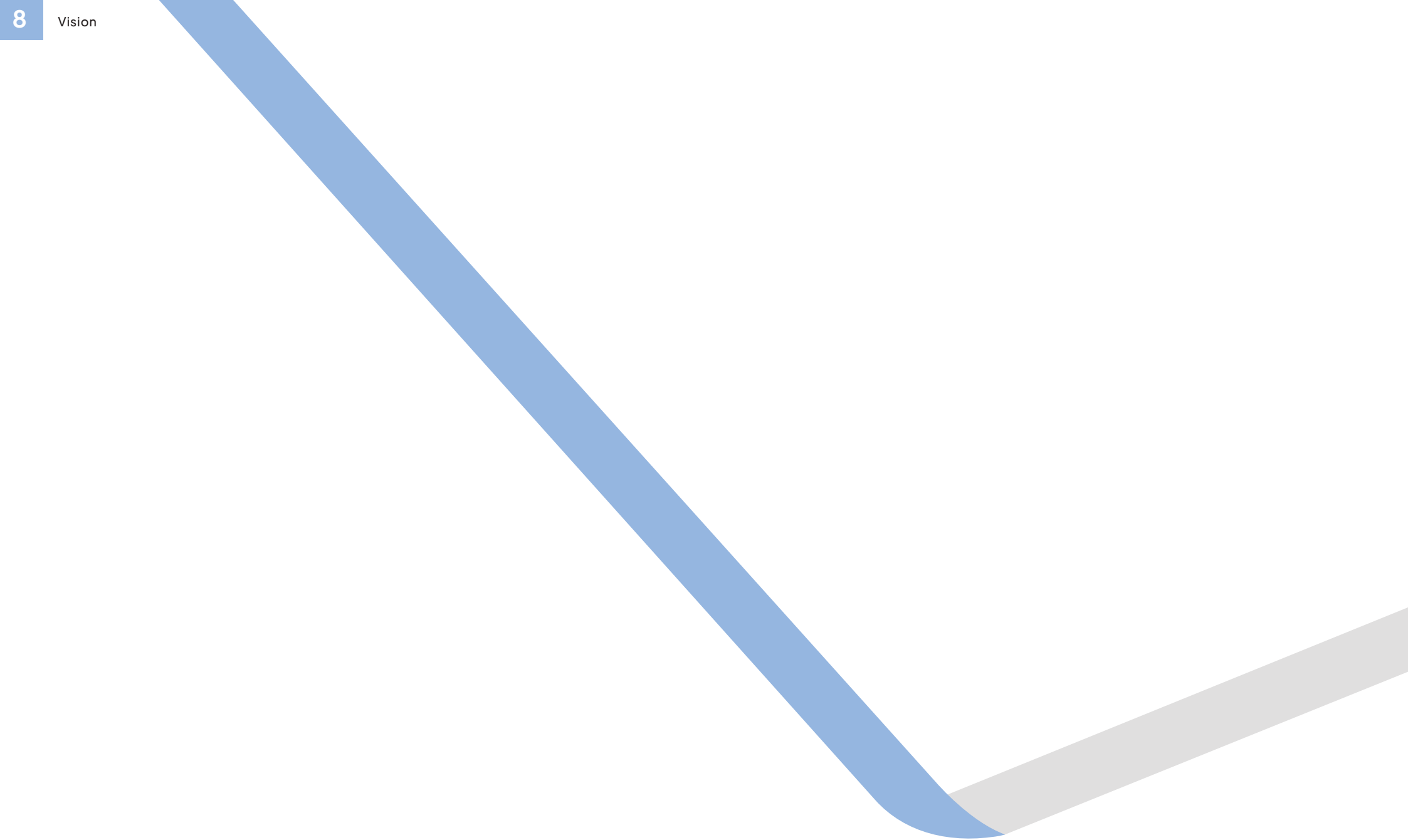
- Offer help when needed, but respect the person's independence, allowing them to do things for themselves when possible.

- Describe the environment, for example, surroundings, layout, objects and people in a room.

- Be alert – walk a few steps ahead to provide cues and alert the person to potential hazards, such as steps.

- Avoid assuming what the person with vision impairment can or cannot do. Allow them to express their needs and preferences.

- Encourage the use of assistive products to help the person stay independent and connected.



9 Hearing

Care pathway to manage hearing loss

Age-related hearing loss may be the most common sensory impairment in older people. Untreated hearing loss interferes with communication and can lead to social isolation. Limitations of other domains of intrinsic capacity, such as cognitive decline, can make these social consequences worse. Hearing loss is linked to many other health issues, including depression and anxiety, poor balance and falls. Hearing loss has been identified as a potentially modifiable risk for dementia *(52)*. Its management through the use of hearing devices can effectively reduce this risk.

Key points

- Health workers in the community can conduct a basic assessment for hearing loss with simple portable equipment or a whisper voice test.
- Simple actions in the household and community can reduce the impact of hearing loss, including adopting communication strategies.
- Hearing aids can be fitted by a trained health worker. However, some people may need guidance from a specialist on fitting and use to ensure the hearing aid works to maximum benefit.
- Community stakeholders can support older people with hearing loss by providing information and advice, adapting communication styles during community events and meetings and establishing peer support groups.

9

Hearing

Care pathway to manage hearing loss

ASSESS (BASIC) → 3.1

PASS

Regardless of result:

- Provide health and lifestyle advice, including advice on caring for ears and when to suspect hearing loss → 9.1
- Conduct basic assessment regularly

FAIL

- Communication strategies for hearing loss → 9.2
- Refer to primary care

ASSESS (IN-DEPTH) A, B and C

First, perform ear exam using otoscopy (i) 1

If wax impaction, treat and repeat hearing test

Assess hearing capacity

Diagnostic audiometry (i) 2

A

IF NORMAL OR MILD HEARING LOSS
(Audiometry: < 35 dB)

- Provide advice on caring for ears and when to suspect hearing loss → 9.1
- Encourage regular hearing check-up (every 1–3 years)

IF MODERATE TO SEVERE HEARING LOSS
(Audiometry: 35–< 80 dB)

- Refer to trained health worker
  - Provide hearing aids
- *If no hearing aids available,* inform about communication strategies → 9.2

IF DEAFNESS
(Audiometry: ≥ 80 dB)

- Refer to specialized hearing care
  - Evaluate and provide hearing device (hearing aids or cochlear implants)
- *If no hearing device available,* inform about communication strategies → 9.2

B

C

Assess for red flags

- Inappropriate medication(s) (ototoxic medication)
- Noise exposure
- History of sudden or rapidly progressive hearing loss
- Unilateral or asymmetric hearing loss
- Complaint of ear pain, discharge or dizziness
- History of ear diseases, such as recurrent or chronic otitis media

Consider potential interventions (i) 3

Assess social and physical environments

- Need for home adaptations
- Need for assistive products (vibrating or flashing alarms, sound amplifiers)
- Social care and support needs (ADLs, social participation)
- Carers' support needs

Consider potential interventions (i) 4

Reassess

DEVELOP a care plan

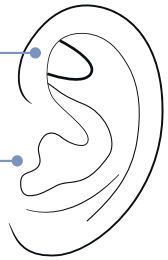
IMPLEMENT & MONITOR

Consolidate interventions, considering results of A, B and C

*

1 Ear exam using otoscopy

- Use one hand to gently pull the **pinna** backwards and upwards to straighten the ear canal.
- With the other hand, gently pull the **tragus** forwards with your finger to open the ear canal.
- Shine a light into the ear canal (with the otoscopy, if available, or ask an assistant to help with a torch), to help you look for:
  - Ear wax, pus, or discharge
  - Swelling and redness
  - Foreign body in the ear canal



Ear wax can be removed by doing an ear washout.

Hearing test should be repeated after wax removal.

2 Diagnostic audiometry → 9.3.2

A non-invasive hearing test that measures the ability to hear different sounds, pitches or frequencies. The test requires a quiet room and earphones. There are two tests: pure tone audiometry and speech audiometry.

Ear wax

Wax is made by the ear canal to clean the ear and is normally expelled from the canal by the ear itself. Impacted wax can lead to pain and hearing loss, and affect the performance of hearing aids. If an older person fails the hearing screening test, wax impaction should be identified and addressed if present.

Ear wax can be removed with an ear washout with clean, body temperature water (37 °C). If the wax cannot be safely removed, refer to a specialized care.

Need for specialized knowledge and training

- Fitting hearing aids for moderate hearing loss (9.4.3)
- Evaluation and management of severe hearing loss/ deafness and provision and use of hearing device
- Management of an underlying problem that causes or contributes to hearing loss
- If any red flags identified (9.5)

3 Interventions for red flags → 9.5

Inappropriate medication(s) (ototoxic medication) → Review medication and withdraw or prescribe alternatives (9.5.1)

Noise exposure → Advise on safe listening volume and use of earplugs (9.5.2)

History of sudden or rapidly progressive hearing loss
Unilateral or asymmetric hearing loss
Complaint of ear pain, discharge or dizziness
History of ear diseases such as recurrent or chronic otitis media
→ Refer to specialized hearing care

4 Interventions for social and physical environments → 9.6

Need for home adaptation → Arrange the home to aid communication (9.6.1)

Need for assistive products → Provide assistive products such as vibrating or flashing telephones and doorbells, portable sound amplifiers (9.6.2)

Social care and support needs → Support tasks of daily living, opportunities for social participation (11.6)

Carers' support needs → Advise carers on communication strategies (9.2)

9.1

Health and lifestyle advice to promote ear and hearing care

Community health workers and other community stakeholders can play a role in the provision of general ear and hearing care and lifestyle advice for all older people, including those with hearing loss. Information that can be shared includes do's and don'ts for healthy ears, importance of regular hearing checks, as well as when to seek health care, including when to suspect hearing loss.

Advice for all older people:

- Clean only the outer part of the ear with a soft cloth.
- Do not put things inside the ears, for example, Q tips/cotton buds, hopi candles, oils, liquids such as kerosene, sticks, homemade remedies or dirty fingers.
- Do not swim or wash in dirty water.
- Do not share earphones or earplugs with other people.
- Do not listen to loud sounds or music, and use earplugs in noisy places.
- Have regular hearing check-ups with a health worker and seek advice in the case of ear pain, discharge or any difficulty in hearing.
- See a health worker ***if hearing loss is suspected***, based on:
  - Often asking people to repeat themselves.
  - Turning up the volume on the radio or television.
  - Having difficulty following conversations in noisy places.
  - Having difficulty in understanding what is said over the phone.
  - Having a ringing sensation in the ear (tinnitus).
  - Having problems hearing sounds like a doorbell, alarm or telephone.
  - Being told by others that you speak loudly.

Community stakeholders can also arrange advice sessions or discussions on how hearing loss can be managed, including through the use of hearing aids and other assistive products. They can also help to address stigma associated with hearing aid use. Awareness-raising campaigns can educate people that hearing loss is nothing to be ashamed of or to hide. One out of every 20 people has a hearing loss that needs management (53).

9.2 Community-based health care to address hearing loss

9.2.1 Communication strategies

If an older person is identified as having potential hearing loss through a basic ICOPE assessment and diagnostic audiometry is not immediately available, community health workers and community stakeholders can advise on communication strategies, whether or not hearing aids are available. Advice should include:

- Give the person your full attention, particularly if they also have speech difficulty.
- Let the person see your face when you speak and make eye contact to show you are actively listening and that you value what they have to say.
- Make sure there is good light on your face to help the listener to see your lips. Do not exaggerate or distort lip movements.
- Get the person's attention before you speak.
- Reduce background noise or move to a quieter setting.
- Speak clearly and more slowly. Do not shout.
- Give the person time to speak. Don't interrupt or finish sentences for them.
- Remember that the person may need extra time to communicate. Be patient and respectful.
- Use nonverbal signals like nodding your head to indicate you are following the conversation.
- In groups, do not all talk at once. Encourage people to speak one at a time.
- Do not give up speaking to a person with hearing loss.
- If the person has difficulty speaking, use visual aids like pictures or written notes to assist them.
- Be aware of and look out for different reasons for communication challenges that are not related to hearing loss, such as cognitive decline.

MORE INFORMATION

- ***Tips for healthy ears.*** WHO; 2023 (https://www.who.int/publications/m/item/community-resource-5-tips-for-healthy-ears).
- ***Hearing loss in adults.*** WHO; 2023 (https://www.who.int/publications/m/item/community-resource-1a-when-to-suspect-hearing-loss-in-an-adult).
- ***Basic ear and hearing care resource.*** WHO; 2020 (https://iris.who.int/handle/10665/331171).
- ***Tips for hearing aid users.*** WHO; 2023 (https://www.who.int/publications/m/item/community-resource-4-tips-for-hearing-aid-users).

9.3 Assess ear problems and hearing capacity

An important step before any diagnostic tests for hearing capacity is to identify and treat wax using otoscopy.

9.3.1 Otoscopy

Make sure to always examine both ears, even if the person's complaint is in one ear only.

Otoscopy is the procedure that allows identification of conditions that cause hearing loss, such as earwax or perforations of the tympanic membrane. There are many kinds of otoscope. Some can connect to a computer or mobile phone and record pictures or videos of what is being viewed. An otoscope needs a speculum, an attachment (usually plastic) for looking into the ear canal.

9.3.2 In-depth hearing assessment

An in-depth hearing assessment can involve three tests with equipment – a diagnostic audiometer for pure tone; speech audiometry; and a tympanometer for middle ear assessment. These tests can help to identify the need for hearing devices and support. Doing these tests needs specialized training.

- **Pure tone audiometry (PTA):** This tests a person's ability to hear sounds of different pure tone frequencies (pitches). It consists of playing pre-recorded sounds louder and louder until the person can hear them to identify the hearing threshold. It tests air conduction and bone conduction of sounds to assess hearing thresholds at frequencies from 125 Hz (very low) to 8000 Hz (very high). This test helps to determine the severity and type of hearing loss.
- **Speech audiometry:** Older people benefit from this additional test. In a speech audiometry test a series of pre-recorded simple words are played at increasing volumes, and the person is asked to repeat the words when they hear them. This test cross-checks the results of the PTA. It helps to determine whether speech recognition is consistent with the PTA results, if there is an asymmetry of speech perception that is not predicted by the PTA, and identifies which ear to fit with a hearing aid if only one hearing aid is being fitted.
- **Tympanometry:** This tests the compliance (or mobility) of the eardrum – how effective the eardrum is at transmitting sound to the middle ear cavity and therefore the inner ear. This test can support the pure tone and speech audiometry results to determine the type of hearing problem.

The care pathway shows the management of hearing loss by three categories (normal, moderate to severe and deafness). Where the capacity of the health system permits, and it is considered more suitable, mild hearing loss (20 to < 35 dB) can also be identified (Table 9.1, p. 101). Those assessed to have normal hearing capacity should still be assessed for red flags and social and physical environments.

In addition to hearing tests, results of basic assessment for other linked domains of intrinsic capacity, such as cognitive decline and depressive symptoms, should also be verified and an in-depth assessment conducted as necessary. → 5 10

Table 9.1
Hearing loss classified according to severity

Grade	Hearing threshold in better hearing ear (dB)	Hearing experience in a quiet environment
Normal hearing	< 20 dB	No problem hearing sounds
Mild hearing loss	20 to < 35 dB	Does not have problems hearing conversational speech in a quiet environment
Moderate to severe hearing loss	35 to < 80 dB	Difficulty hearing conversational speech in a quiet environment; if severe hearing loss, even with raised voices
Deafness	≥ 80 dB	Extreme difficulty hearing raised voices

9.4 Manage hearing loss

People with hearing loss may report feelings of embarrassment, anxiety and loss of self-esteem, leading to less participation in social activities, social isolation and loneliness, all of which contribute to depression. → 10

Interventions to manage hearing loss should always be provided as part of a comprehensive personalized care plan responding to underlying factors, along with interventions that address other domains of intrinsic capacity. In addition to supporting communication strategies, there are multiple other ways to manage hearing loss, including provision of hearing devices and referral to rehabilitation services. → **4.2.1**

Basic education and counselling on hearing loss should be provided to encourage and support psychological acceptance and adjustment. This includes communication strategies, adaptations in environments, how to use hearing aids and peer mentoring. Older people and their family members and carers may benefit from counselling to help them accept and adjust to their hearing loss, including learning to overcome the stigmatizing attitudes of others.

9.4.1 Moderate to severe hearing loss

It is important that older people with moderate to severe hearing loss are provided with information and support to help them to adjust and live with their hearing loss. The benefits of hearing devices such as hearing aids should be explained both to the person with hearing loss and their carers along with information on where to get them and how to use them. Once a person has a hearing aid, a health worker can support and encourage its use.

9.4.2
Deafness

An older person with severe hearing loss or deafness or who does not benefit from the above interventions will need another approach, such as provision of a cochlear implant, if available. This can only be decided in consultation with a hearing care specialist.

9.4.3
Hearing devices

Most hearing devices should be provided by a trained health worker who is authorized, in line with local rules and regulations. If hearing devices are not available, community health workers and other community stakeholders can provide information on communication strategies.

Hearing aids: A hearing aid is an electronic device that is worn on or inside the ear. It helps to amplify sounds to allow a person with hearing loss to better hear speech and other sounds. It is usually the most useful and convenient technology for older people with hearing loss. Audiometry alone should not determine whether a person needs a hearing aid. A person must be assessed for their overall need before a hearing aid is suggested. It is important to explain to people that hearing aids do not cure or treat hearing loss. Advice should be provided regarding their use and maintenance, including regular replacement of the battery and earpiece.

Some countries have regulations that provide access to hearing aids over-the-counter without prescription, such as pre-programmed hearing aids and self-fitting hearing aids. These hearing aids are commonly suitable for those with mild or moderate hearing loss, without any red flags. Pre-programmed hearing aids are already programmed according to the most common types of hearing loss in older people. A trained health worker can decide which pre-programmed hearing aid is suitable and fit it.

Advice and information for the use of hearing aids include:

- How hearing aids work and the importance of using them regularly during waking hours.
- Caring for a hearing aid, including:
  - keeping it in a safe, cool place when not in use, and away from water and heat at all times;
  - removing it while bathing or showering;
  - opening the battery drawer at night;
  - making sure it is switched off when not being used;
  - cleaning the earpiece with a dry cloth every day.
- Changing or recharging the batteries and where to access affordable batteries.
- Common problems when using hearing aids and how to address them.
- The likelihood of hearing aids being effective – to manage expectations.

Cochlear implants: A Cochlear implant is an electronic medical device for people with severe hearing loss who are unable to benefit from hearing aids. It has two parts, an external processor that picks up the sounds and delivers them to the implantable part that is surgically placed in the ear. It turns sounds into electrical impulses and sends them to the nerves of the ear. A person must be evaluated carefully to see if a cochlear implant will help. If cochlear implantation is not available or feasible, an older person and their family should be informed about different communication strategies.

MORE INFORMATION

- ***Training on hearing assistive products.*** TAP; 2024 (https://www.gate-tap.org/).
- ***Hearing aid service delivery approaches for low- and middle-income settings.*** WHO; 2023 (https://iris.who.int/handle/10665/376092).
- ***Primary ear and hearing care: training manual.*** WHO; 2023 (https://iris.who.int/handle/10665/366334).

9.5 Assess and manage red flags

There are a number of "red flags" in relation to hearing loss, including potential causes and issues that should be considered as requiring referral to a health professional with specialized knowledge (e.g. ear nose throat specialist).

9.5.1 Inappropriate medication(s)

Certain medications can cause damage to the inner ear, resulting in hearing loss and/or loss of balance (*54*), for example:

- antibiotics such as streptomycin and gentamicin;
- antimalarials such as quinine and chloroquine;
- injection treatment of multidrug-resistant tuberculosis;
- diuretics such as furosemide; and
- nonsteroidal anti-inflammatory drugs such as aspirin.

A full medication review and adjustment of medications may require specialized knowledge. Where such ototoxic treatment is essential, it is important that hearing is checked regularly to detect hearing loss at the earliest stage and take appropriate action.

9.5.2 Noise exposure

Noise-induced hearing loss can be caused by a variety of environments and behaviours at work, home or from recreational activities. The volume of sounds, the duration of listening and frequency of exposure to loud sounds all have an impact on hearing. In the case of hearing loss caused by the unsafe use of personal audio devices, there are simple, effective practices such as keeping the volume within safe listening levels and limiting the time spent engaged in noisy activities.

9.5.3 Other red flags

Conditions that may underlie hearing loss and need specialized diagnosis and management include:

- history of sudden or rapidly progressive hearing loss;
- unilateral or asymmetric hearing loss;
- complaint of pain in the ear, ear discharge or dizziness with moderate to severe hearing loss; and
- history of ear diseases, such as recurrent or chronic otitis media (middle ear infection).

9.6 Assess and manage social and physical environments

9.6.1 Home adaptation

Environmental modification at home and in the home surroundings can help those with hearing loss. Examples include, adding lights to ensure people can be seen during conversations, arranging furniture so that chairs face each other to aid communication, fixing doorbells in different places in the home and installing flashing alarms.

9.6.2 Assistive products

Besides hearing devices, assistive products that can help people with hearing loss include telephone amplifiers, portable sound amplifiers, text messaging devices, apps and programmes that enable captioning and subtitling of audio content on different media channels and to convert speech to text. Hearing induction loops can also be helpful. They comprise a wire or wires placed around a space (e.g. meeting room or service counter). The wires send signals from a microphone and amplifier to certain types of hearing aids.

Community stakeholders can help to identify what is available locally and provide information and support. Community organizations that run classes to support older people to learn about and use digital technology could include sessions focused on how to use captioning and speech to text apps.

9.6.3 Social care and support → 11

Regular social interaction may reduce the risk of cognitive decline, depression and other psychological and behavioural consequences of hearing loss. In times of particular distress, social support networks can help.

Community stakeholders and family members can play a role by continuing to communicate with a person with hearing loss and organizing activities that keep the person involved in social networks.

Alongside support to enable social participation, people with hearing loss may need other forms of assistance in their daily lives. For example, if communication is a challenge, support might be needed with making phone calls or appointments.

9.6.4 Support for carers → 12

Carers can support an older person with hearing loss by adopting the communication strategies detailed above. They may also need support themselves.

10 Psychological capacity

Care pathway to manage depressive symptoms

People with "depressive symptoms" have two or more simultaneous symptoms of depression most of the time for at least 2 weeks, but do not meet the criteria for a diagnosis of depression. Depressive symptoms are common in older people with long-term and disabling conditions and can be associated with declines in all other domains of intrinsic capacity. It is also common for those who are socially isolated or who are carers with demanding care responsibilities to experience depressive symptoms. They can affect all aspects of life, including relationships with family, friends and community.

Depressive symptoms represent one dimension of many that compose psychological capacity (anxiety, personality characteristics, coping and mastery).

This chapter provides guidance on preventing and managing depressive symptoms in older people. Further guidance on interventions for depression (moderate to severe) as well as anxiety can be found in the *mhGAP intervention guide* and *mhGAP guideline*.

Key points

- By asking questions, health workers in the community can identify those with depressive symptoms.
- Using psychological interventions, trained and supervised non-specialist health workers can help people with depressive symptoms.
- For a person with depression (moderate to severe), a more specific, targeted or tailored approach is needed.
- If an imminent risk of self-harm or suicide is identified, prompt referral to specialized care is needed.
- Community stakeholders can raise awareness and understanding of depressive symptoms in order to address stigma. They can also help to address social isolation.

10

Psychological capacity

Care pathway to manage depressive symptoms

ASSESS (BASIC) → 3.1

PASS

Regardless of result:

- Provide health and lifestyle advice, including advice to promote mental health → 10.1
- Conduct basic assessment regularly

FAIL

- Stress management including relaxation techniques for depressive symptoms → 10.2
- Refer to primary care

ASSESS (IN-DEPTH) A, B and C

First, identify and treat potential causes (see B ◆)

A

Assess depressive symptoms ⓘ 1

IF DEPRESSIVE SYMPTOMS (0–2 additional symptoms) → 10.4

- Stress management → 10.2
- Psychoeducation
- Brief structured psychological interventions

IF DEPRESSION (MODERATE TO SEVERE) (≥ 3 additional symptoms) → 10.4.4

- Assess the risk for self-harm/suicide
- Manage depression
  See *mhGAP intervention guide* (depression)
  https://apps.who.int/iris/handle/10665/250239

If risk is imminent:

- Refer immediately to health professionals with specialized knowledge and training
- Mobilize family, friends, concerned colleagues or other individuals to ensure close monitoring
- Link the person to community resources including mental health or suicide phonelines
- Remove access to means of self-harm

B

Assess for diseases and risk factors

- ◆ Inappropriate medication(s)
- ◆ Anaemia, malnutrition, hypothyroidism
- ◆ Pain
- Major loss (bereavement) in the last 6 months
- Disability due to illness or injury
- History of mania

Consider potential interventions ⓘ 2

C

Assess social and physical environments

- Social isolation and lonliness
- Social care and support needs (ADLs, social participation)
- Carers' support needs

Consider potential interventions ⓘ 3

DEVELOP a care plan

IMPLEMENT & MONITOR

Reassess

Consolidate interventions, considering results of A, B and C

1 Assess depressive symptoms → 10.3

If a person reports **at least one of the core symptoms** – feeling down, depressed or hopeless and having little interest or pleasure in doing things – do a further assessment.

ASK: Over the last two weeks, have you been bothered by any of the following problems?

- Trouble falling or staying asleep, or sleeping too much
- Feeling tired or having little energy
- Poor appetite or overeating
- Feeling bad about yourself or that you are a failure or that you have let yourself or your family down
- Trouble concentrating on things such as reading the newspaper or watching television
- Moving or speaking so slowly that other people could notice
- Being so restless or agitated that you have been moving around a lot more than usual
- Thoughts that you would be better off dead or of hurting yourself in some way

If a person has **more than two additional symptoms**, they may have depression (moderate to severe). It is important to distinguish depressive symptoms from depression because their treatments differ.

Tips when asking questions

- Meet the person in a private space, if possible.
- Be empathic and sensitive.
- Show extra sensitivity with difficult topics.
- Remind the person that what they tell you will remain confidential unless there is a risk of self-harm or suicide.
- Don't judge people by their behaviours and appearance.
- Acknowledge that it may have been difficult for the person to disclose information.
- If carers are present, suggest speaking with the person alone.

Need for specialized knowledge and training

- Imminent risk of self-harm or suicide (10.4.4)
- Management of bipolar disorder or psychosis (delusions, hallucinations, disorganized behaviour, disturbances of emotion) (10.5.4)
- Provision of brief structured psychological interventions (10.4.2)
- Management of chronic pain, that requires comprehensive care (6.5.2)

2 Interventions for diseases and risk factors → 10.5

Inappropriate medication(s)	Review medication and withdraw or prescribe alternatives (10.5.1)
Anaemia, malnutrition, hypothyroidism	Management of diseases (10.5.2)
Pain	Assess and manage pain (6.5.2)
Major loss (bereavement) in the last 6 months	Advice for culturally appropriate adjustment and mourning processes
Disability due to illness or injury	Advice on stress reduction and strengthen social support
History of mania	See the *mhGAP intervention guide* (psychoses)

3 Interventions for social and physical environments → 10.6

Social isolation and loneliness	Identify and tackle loneliness and social isolation (11.3.3)
Social care and support needs	Support tasks of daily living including with ADLs (11.6)
	Encourage participation in community activities (11.3.4)
Carers' support needs	Provide psychoeducation and psychosocial support (12.4)

10.1 Health and lifestyle advice to promote mental health

Community health workers and other community stakeholders can provide advice to all older people, including those experiencing depressive symptoms about healthy lifestyles to promote mental health and manage depressive symptoms.

Advice for all older people includes the importance of:

- Taking regular physical activity.
- Getting good quality sleep, including by maintaining the same routine of sleep and waking times.
- Eating a healthy and balanced diet.
- Maintaining social connection and being socially active.
- The benefits of stress reduction techniques.
- Avoiding and reducing harmful use of alcohol and other psychoactive substances. Alcohol use disorders and depression can both increase risk of suicide and affect quality of sleep.

Alongside healthy lifestyle advice, community stakeholders can provide other information about depressive symptoms and other mental health conditions. Raising awareness can help older people and carers to be better equipped to understand and manage depressive symptoms. Normalizing mental health conditions can also help to reduce stigma, discrimination and social exclusion and can support people to be more open about their feelings. It is also important to educate people that depressive symptoms are not a normal or inevitable part of ageing, but if they occur, they can be treated or managed.

10.2 Community-based health care to address depressive symptoms

10.2.1 Stress management

If an older person is identified as potentially having depressive symptoms through a basic ICOPE assessment and an in-depth assessment is not immediately available, community health workers can provide guidance on stress management. This an be provided through unguided self-help or guided formats. This guidance can also be provided to carers. →12.1

Physical exercise, restorative sleep and spending quality time with loved ones are all useful to help manage stress. Physical exercise should be encouraged, tailored to the person's locomotor capacity and preferences, due to its positive effect on reducing stress, relieving symptoms of anxiety and sadness, boosting energy levels and improving sleep. →6.1

Relaxation techniques and engaging in pleasant activities of interest with friends or loved ones can also be beneficial. Deep breathing and stretching and muscle relaxation are quick and effective ways to reduce the physical and psychological impact of stress. It can be useful to practise these techniques daily to help maintain resilience and so that a routine is established for any difficult times when they are particularly needed.

MORE INFORMATION

- ***Field test version: mhGAP community toolkit: Mental Health Gap Action Programme (mhGAP).*** WHO; 2019 (https://iris.who.int/handle/10665/328742).
- ***Doing what matters in times of stress: an illustrated guide.*** WHO; 2020 (https://iris.who.int/handle/10665/331901).

10.3 Assess depressive symptoms

An important first step when conducting an in-depth assessment for depressive symptoms is to identify and treat any potential reversible causes that can resemble or exacerbate depressive symptoms (◆). → 10.5

A health worker should also assess psychological stressors such as bereavement and traumatic events that can explain depressive symptoms.

Following this, by asking a series of questions, a health worker can identify those with depressive symptoms and distinguish depressive symptoms from depression (moderate to severe) at a primary care facility. If a person reports at least one of the core symptoms – feeling down, depressed or hopeless and having little interest or pleasure in doing things – and one or two additional signs, they may have depressive symptoms. If a person has more than two additional symptoms, they may qualify for a diagnosis of moderate to severe depression. A person with moderate to severe depression usually has considerable difficulty with daily functioning in personal, family, social or other situations.

In addition to an in-depth assessment for depressive symptoms, results of basic assessments for other linked domains of intrinsic capacity, such as cognitive decline, vision impairment and hearing loss should also be verified and in-depth assessments conducted as necessary. → 5 8 9

More information on p. 107 ⓘ 1

See the section on depression in the *mhGAP intervention guide* for details of how to conduct an assessment. Tools can be used for the assessment of depression, e.g. the *Patient Health Questionnaire* (PHQ-9).

10.4 Manage depressive symptoms

Interventions to manage depressive symptoms should always be provided as part of a comprehensive personalized care plan responding to underlying factors, along with interventions that address other domains of intrinsic capacity.

In addition to guidance on stress management, there are multiple other ways to manage depressive symptoms including psychoeducation and brief structured psychological interventions. It is recommended to apply **a stepped care approach**, starting with a self-help low-intensity intervention (stress management) and monitoring symptoms and provision of further interventions, in case of no improvement or worsening.

10.4.1 Psychoeducation

Psychoeducation refers to educational programmes targeting an older person with depressive symptoms and their carers focused on improving understanding of their symptoms, including likely cause, symptom monitoring and coping strategies, taking into account their specific difficulties with ADL and problem-solving. This information:

- Helps improve a person's knowledge about their condition and enables informed decision-making about treatment.
- Improves understanding about how and why treatment can be helpful, encouraging adherence, and realistic expectations.
- May increase feelings of control and empowerment and reduce anxiety.
- Provides hope for recovery.
- Can improve carers' and family members' knowledge, helping them to better support the person.

It is important to provide brief amounts of information at a time, use simple language and relevant examples, and check the person or group's understanding of the information provided.

Psychoeducation can be delivered individually or in group settings if the therapeutic components are adapted for delivery in a structured psychoeducational format.

10.4.2
Brief structured psychological interventions

Psychological interventions are the informed and intentional use of clinical techniques developed from psychological principles to help people modify their psychological skills (e.g. emotional, interpersonal, behavioural and cognitive skills). If there is no improvement of depressive symptoms by providing guidance on stress management and psychoeducation, brief structured psychological interventions, such as behavioural activation therapy, CBT, problem-solving therapy and third-wave therapies, may be considered.

Different formats for the delivery of psychological interventions (average 8–10 sessions) can be considered with older people including individual and/or group face-to-face psychological treatments. Health professionals in mental health such as psychologists would usually administer these interventions. Health workers in primary care facilities could provide them if they are skilled and trained in the mental health issues faced by older people, as the benefits outweigh the harms.

While face-to-face psychological treatments are likely to have better outcomes than unguided self-help, the latter may be suitable for those who either do not have access to face-to-face psychological treatment or are not willing to access such treatments.

- **Behavioural activation therapy:** This focuses on improving mood by (re)engaging in activities that are task-oriented and used to be enjoyable, in spite of current low mood. It may be used as a stand-alone treatment, and it is also a component of CBT.
- **Cognitive behavioural therapy (CBT):** A person with depressive symptoms may have unrealistic, distorted negative thoughts that can lead to harmful behaviour. CBT, which combines thinking differently (e.g. through identifying and challenging unrealistic negative thoughts) and doing things differently (e.g. by helping the person to do more rewarding activities) can be helpful.
- **Problem-solving therapy:** A problem-solving therapy involves the systematic use of problem identification and problem-solving techniques over a number of sessions. It offers direct and practical support by breaking problems down into specific, manageable tasks and then developing coping strategies for specific problems.
- **Third-wave therapies:** These include mindfulness-based interventions, acceptance and commitment therapy, metacognitive therapy and dialectical behavioural therapy. "Mindfulness-based interventions" is used here as an umbrella term for mindfulness, meditation and yoga techniques, as well as mindfulness-based cognitive therapy and mindfulness-based stress reduction. Mindfulness consists of paying attention to what is happening in the present moment instead of being carried along by a train of thoughts about the past, future, wishes, responsibilities or regrets.

Community stakeholders can provide information on available services and support and can help break down stigma around mental health. This can be particularly effective if trusted and respected community leaders, including faith leaders, are involved. Community-based organizations can help to identify those in their communities who may be experiencing depressive symptoms and who may need support, as well as their carers, who may experience symptoms themselves. They can help by referring people to appropriate services, establishing peer support groups, organizing events to promote social participation and helping with day-to-day tasks which may be causing stress.

10.4.3
Cognitive decline → 5

Cognitive decline and dementia may be associated with depressive symptoms. Results of a basic assessment for cognitive decline should be validated and an in-depth assessment conducted as necessary. The cognitive functions that can be affected in depression are attention and memory, as well as executive functions. Depression could be a psychological response to an individual's self-awareness of mild cognitive decline that has not yet begun to interfere with daily functioning.

A person with dementia often complains of mood or behavioural problems, such as lack of interest, loss of emotional control or difficulties carrying out usual work, domestic or social activities. Psychological interventions, such as CBT, interpersonal therapy, structured counselling and behavioural activation therapy, should be considered for people with dementia and mild to moderate depression (see *mhGAP guideline*).

10.4.4
Manage moderate to severe depression

For a person with depression (moderate to severe), a more specific, targeted or tailored approach is needed. That includes assessment of potential thoughts, plans or acts of self-harm or suicide offering evidence-based interventions such as antidepressants and brief structured psychological interventions.

Asking about self-harm or suicide does NOT provoke acts of self-harm. It often reduces anxiety associated with these thoughts or acts and provides a sense of relief. However, it is important to establish a relationship with the person before asking such questions. To introduce questions about suicide, acknowledge that when people are very upset or feel hopeless, they may have thoughts about death or ending their own life and that these thoughts are not uncommon, and people should not feel ashamed.

After checking whether the person agrees to discuss these issues, questions like "In the past month, have you had serious thoughts of ending your life or a plan to end your life? Or have you taken any actions to end your life in the past year?" can be asked.

If imminent risk of self-harm or suicide is identified, the person should be referred immediately to health workers with training in mental health or specialized care, if available. Family members, friends and other colleagues or neighbours should be mobilized to monitor the person and access to means of self-harm should be removed. The person and their carers should be linked with community resources, for example, mental health or suicide phonelines that provide advice and support.

Prescription of antidepressants requires knowledge of managing mental health conditions. Antidepressant medicine alone for people with depression (moderate to severe) should only be considered when structured psychological interventions are not available.

MORE INFORMATION

- ***mhGAP intervention guide for mental, neurological and substance use disorder in non-specialized settings: mental health Gap Action Programme (mhGAP), version 2.0.*** WHO; 2016 (https://iris.who.int/handle/10665/250239).
- ***Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders, [3rd ed.].*** WHO; 2023 (https://iris.who.int/handle/10665/374250).
- ***Psychological interventions implementation manual: integrating evidence-based psychological interventions into existing services.*** WHO; 2024 (https://iris.who.int/handle/10665/376208).

10.5 Assess and manage associated diseases and risk factors

An assessment of diseases and risk factors for depressive symptoms should start by identifying and treating possible causes (◆). Common conditions and risk factors that can cause depressive symptoms include medication(s), anaemia, malnutrition, hypothyroidism, and pain. In some cases, treatment of these conditions results in improvement in depressive symptoms. If depressive symptoms persist, further assessment will be required. Uncovering possible cause(s) of depressive symptoms involves a full diagnostic work-up, sometimes including blood tests.

10.5.1 Inappropriate medication(s) ◆

Some medications can lead to depressive symptoms. These include, but are not limited to medicines that act primarily on the central nervous system, such as antihistamines, psychotropic medicines, muscle relaxants and other non-psychotropic drugs with anticholinergic properties, and steroids. The potential harm of these medicines can also outweigh their benefits for some people. Eliminating unnecessary, ineffective medicines as well as medicines that share an active ingredient reduces polypharmacy. → 4.2.4

10.5.2 Anaemia, malnutrition and hypothyroidism ◆

Various diseases affect depressive symptoms, such as heart diseases, chronic obstructive pulmonary disease, cancer, autoimmune diseases, anaemia, malnutrition and hypothyroidism. It is important to control these diseases, which can resemble or exacerbate depressive symptoms.

Anaemia and malnutrition can lead to depressive symptoms because of deficiencies of iron, vitamins such as folate, vitamin B6 and vitamin B12. Depressive symptoms can also play a role in the development of anaemia. For example, loss of appetite and lack of interest in performing daily activities (such as shopping and cooking), both associated with depressive symptoms, can reduce quality and quantity of nutrition, potentially leading to the development of anaemia and malnutrition. To manage depressive symptoms, it is crucial to manage anaemia and improve nutritional status. → 7

Hypothyroidism is a common disorder in older people, especially women. The symptoms of hypothyroidism can be non-specific such as fatigue and dry skin and can include depressive symptoms. The diagnosis of hypothyroidism usually requires a blood test and care should be managed by health workers with specialized knowledge.

10.5.3 Pain ◆

There is a bidirectional relationship between pain and depressive symptoms. Individuals reporting chronic pain often have depressive symptoms and depressive symptoms can present as physical symptoms such as vague aches and pains. Some people experience a vicious cycle in which pain worsens depressive symptoms, and the resulting depression magnifies feelings of pain. It is important to address pain and depressive symptoms in a comprehensive, holistic manner. → 6.5.2

10.5.4
Other associated conditions

The presence of the following associated conditions would suggest a different approach from treatment for depressive symptoms is needed.

- **Major loss (bereavement) in the last 6 months:** Bereavement is a normal process of loss, grief and recovery associated with death. Grief has both mental and physical effects and people grieve in different ways, for example, showing strong emotions or a limited reaction. In most cases, grief diminishes over time. A discussion on and support for culturally appropriate adjustment and/or mourning processes are important to manage grief. If a person's symptoms involve considerable difficulty with daily functioning lasting longer than 6 months and include severe preoccupation with or intense longing for the deceased person and intense emotional pain, grief disorder should be suspected. In this case, a health worker with specialist knowledge should be consulted.

- **Disability due to illness or injury:** People who experience disability due to illness or injury undergo stress; they must also cope with life transitions. The stages of adjusting to a new form of disability include shock, denial and adjustment/acceptance. Older people with new disabilities are at risk of developing anxiety and depression. In most cases the symptoms are likely to diminish over time, particularly if the person gets social support and engages in stress reduction.

- **History of mania:** Mania is an episode of mood elevation and increased energy and activity. People who experience manic episodes are classified as having bipolar disorder, characterized by alternate manic and depressive episodes. History of mania can be identified by checking several symptoms, including decreased need for sleep, increased talkativeness or rapid speech and impulsive or reckless behaviours occurring simultaneously, lasting for at least 1 week, and severe enough to interfere significantly with work and social activities or requiring hospitalization or confinement. Management of mania requires health professionals with training in mental health or specialized care, if available.

10.6
Assess and manage social and physical environments

10.6.1
Social isolation and loneliness

Loss of interest in activities that used to be interesting or pleasurable is common in people with depressive symptoms and can lead to social isolation and loneliness. It is important to try and understand any factors that may be leading to or exacerbating social isolation and loneliness, in addition to depressive symptoms, which could include challenging personal relationships. Asking an older person if there are activities they would like to try and engage with and providing support to enable this can be helpful. →11.3.3

10.6.2
Social care and support

An older person with depressive symptoms may find it difficult to manage everyday activities and may need social care and support. This can start with providing help with addressing basic needs, facilitating access to services and connecting with family and other forms of social support.

It is important to identify and discuss relevant issues that place stress on the person and/or impact their life including, but not limited to, family and relationship problems, housing, finances, access to basic security and services, stigma, discrimination and maltreatment (abuse of older people including neglect). →11.4

10.6.3
Support for carers → 12

Carers of people with depressive symptoms should be provided with information and advice, including through psychoeducation interventions. Psychoeducation may produce a wide range of positive effects including a reduction in a carer's depressive symptoms, if present, care burden and stress, and anxiety; as well as increased well-being and health-related quality of life.

Health workers can support carers by:

- Helping them to understand that depressive symptoms are a common occurrence. They are not a sign of weakness or laziness and cannot be controlled by willpower.
- Encouraging openness and communication between carers and the person they care for, including:
  - Listening with empathy without judgement.
  - Being there for them and making them feel they are not alone and are understood.
  - Acknowledging their feelings.
- Providing knowledge on depressive symptoms and mental health services.
- Explaining that people with depressive symptoms tend to have unrealistic negative thoughts about themselves and their lives, but that this will likely improve once their symptoms improve.
- Supporting what carers can do to help the person adhere to treatment (e.g. by assisting with making appointments).
- Educating the carer about crisis plans and what to do in emergency situations, including the person they are caring for displaying thoughts or acts or self-harm or suicide.
- Explaining the importance of respecting the dignity and rights of the person with depressive symptoms.

It is also important to acknowledge that caring for someone with depressive symptoms can be challenging, and the carer may need support for their own health and well-being. The psychosocial impact and needs of the carer should be assessed to ensure the appropriate support can be provided.

11 Social care and support

Care pathway for social care and support

All older people might require social care and support at some point to enable them to live meaningful and dignified lives. This need may arise irrespective of their intrinsic capacity, and may change over time. Social care and support needs may result from changes in intrinsic capacity and functional ability, for example the need for support with BADLs and IADLs, but needs and preferences for support and acceptability for how it is provided will differ both individually and socioculturally. Provision of social care and support enables an older person to continue to do the things that are important to them in the place of their choice.

The most appropriate person to ask about social care and support needs, in most instances, is the older person themselves. However, there may be situations in which questions should be directed to someone else. If an older person has cognitive decline, for example, questions about BADLs and finances may be best asked of someone who knows the person well, such as a family member or carer.

Key points

- Health workers in the community and other community stakeholders can ask questions to identify needs for social support.
- Interventions and advice from multiple sectors, such as from social services, including LTC, finance, social protection and legal services, are important in supporting older people.
- Personal assistance might be required to support older people with significant losses in intrinsic capacity with daily tasks, including bathing, dressing, toileting and eating.
- Health workers in primary care and community stakeholders should observe potential signs of abuse and neglect of older people and take action.
- Community stakeholders are crucial providers of social care and support, often involved in organizing and managing home-based care programmes and community clubs and activities.

11

Social care and support

Care pathway to provide social care and support

* These are examples of questions that could be used. Please adapt to your context.

ASK*

Regardless of result:

- Provide health and lifestyle advice, including information on opportunities for social engagement → 11.1
- Re-ask regularly

Home environment

Do you have problems with your home, for example, house condition, location, safety?

YES →

Ask supplementary questions

Do you have concerns because of:

- *safety and security*
- *housing condition including maintenance*
- *location*
- *living independently*
- *size of home*

Financial situation

Do you often have insufficient funds to pay for your food, housing and health care costs?

YES →

- *Are you able to manage your money and financial affairs?*
- *Would you like advice about financial allowances or benefits?*

Social isolation and loneliness

Do you often feel lonely?

YES →

- *Do you have close relationships (e.g. with spouse, family, friends)?*
- *Are you aware of social activities and opportunities to contribute in the community?*
- *Are you able to stay in touch with friends and family via phone, computer etc?*

Social engagement and participation

Do you have difficulty in pursuing leisure interests and other activities that are important to you?

YES →

You are not able to pursue… because of:

- *cost*
- *distance*
- *transport*
- *lack of opportunities*

(i) 1

If YES to one or more question, OR a loss in intrinsic capacity, continue with assessment

ASSESS A and B

A

Assess

risk of abuse by observing behaviour and for signs of neglect or abuse → Table 11.1

If abuse is suspected (i) 2

If any immediate threat to life or physical safety refer for specialist assessment, adult protection, such as temporary shelter or law enforcement systems

B

If a loss in intrinsic capacity

Assess

the needs for personal assistance with daily activities (example: BADLs, IADLs): → 11.5

- Transferring e.g. from bed to chair
- Personal hygiene - toileting, bathing, dressing
- Meal preparation and feeding
- Use of medication and adherence to treatment
- Ability to use a telephone and manage transportation

(i) 3

Reassess

BADLs and IADLs

Basic activities of daily living (BADLs) are the basic skills required to independently care for oneself in daily life: bathing, dressing, toileting, transferring, continence and feeding.

Instrumental activities of daily living (IADLs) are more complex activities that facilitate independent living: ability to use a telephone, shopping, food preparation, housekeeping, laundry, transportation method, use of medication, handling finances.

Need for specialized knowledge and training

Social care and support involve many sectors in addition to health, including housing, finance, transport and law enforcement which can provide services for:

- Significant home adaptation or repair and access to these services, or for legal advice in relation to housing disputes such as safety and cost (11.3.1)
- Financial support and provision of financial advice, including eligibility and entitlements for social protection payments (pensions, allowances, grants) (11.3.2)
- Assessment of the need for delegation of financial and health care decision-making and to ensure legal protection (11.3.2)
- Provision of advice on employment, education and volunteering opportunities, support groups and rights (11.3.3)
- Assessment of risk of abuse and provision of protection and law enforcement (11.4)
- Assessment of eligibility for and provision of formal LTC services (11.6)
- Assessment of the need for assistive products, ensuring access and providing advice on their use and maintenance (4.2.2)

1 Social support → 11.3

Home environment → 11.3.1

- Consider home adaptation
- Consider alternative accommodation
- Consider referral to social welfare or community housing programmes or support networks

Financial situation → 11.3.2

- Consider referral to social services for access to social protection (pensions, grants, allowances)
- Consider referral for financial advice
- Provide advice on delegation of financial decision-making with protection against financial abuse, if needed

Social isolation and loneliness → 11.3.3

- Provide support to address challenging personal relationships
- Provide a list of opportunities for social activities, volunteering, employment and education in the community
- Provide advice and support with using digital technology to maintain contact with friends and family

Social engagement and participation → 11.3.4

- Discuss personal interests and preferences
- Provide a list of local community services, such as leisure facilities and clubs, adult education programmes, volunteering and employment advisory services
- Provide advice on services that support participation, for example, subsidized transport, free activities and discounts for older people
- Provide support to maintain contact with trusted organizations and institutions, including religious or spiritual networks and leaders

2 Abuse of older people → 11.4

- Refer for further assessment through social services
- Offer close monitoring of the situation, for example, through visits by a community health worker or social worker and encouragement to attend a health facility or other service for support
- Consider referral to psychosocial services, such as counselling
- If any immediate threat to life or physical safety, refer to law enforcement systems and provide temporary shelter, where possible

3 Personal care and assistance with daily activities → 11.6

- Modify home environment to improve mobility and prevent falls (4.2.5)
- Consider use of assistive products (e.g. shower chairs, dressing aids, modified cutlery, plates and cups, pill organizers) with information on access and maintenance (4.2.2)
- Assess the need for rehabilitation services and ensure access, if available (4.2.1)
- Assess support from spouse, family or other carers, and identify the needs of the carer
- Review needs for support from care workers (12.3)
- Link to locally available services such as home-based care, day-care, or residential LTC facilities, as available and culturally acceptable

11.1 Advice on social support and opportunities to participate

If an older person's answers to initial questions on social support suggest they may need support from others, a community health worker or other community stakeholder can provide advice and guidance while waiting for an in-depth assessment or if an in-depth assessment is not available. This guidance can include:

- Simple modifications that could be made to the home environment, for example, removing trip hazards. →4.2.5
- Basic advice on available financial support, for example, social protection entitlements or organizations supporting income-generating activities.
- Encouragement to reach out to and engage with friends, family and neighbours.
- Suggestions of how to participate in the community, for example, through joining an older people's club.
- Community-level information and resources for those with potential need for personal care and assistance with daily activities.

11.2 Assess social support needs

Social support should be included as part of a personalized care plan. Support may focus on enabling an older person's participation in community and social life to reduce social isolation and loneliness and addressing key factors in their lives such as their home environment and financial situation. There are several opportunities to identify need for social support, including during a basic assessment in the community or as part of an in-depth assessment at a primary care facility. The risk for abuse should be also considered as some older people may face greater risks than others (Table 11.1, p. 122).

An older person with significant loss of intrinsic capacity would also benefit from a full assessment of social care and support needs to indicate whether they have reached the point of no longer being able to take care of themselves without the help of others. This assessment includes the initial four questions followed by an assessment of the risk of abuse and their need for personal care and assistance with daily activities.

The issues addressed through these questions and assessments, and the specific challenges older people may face are highly contextual. The questions provided in the social care and support pathway serve as examples, and should be adapted to suit the context.

11.3 Manage social support needs

A number of sectors will need to work together to deliver interventions to address challenges including housing services, social services, occupational health, benefit advisory services (where available), and humanitarian actors in response to emergency and disaster situations that may lead to displacement.

Social support includes support with the home environment, financial security, loneliness, social participation and engagement including through access to community facilities and public services. Health workers should be aware of local opportunities, services and support, including community-based groups which are often key service providers. →4.1.3 They should also facilitate links with those with specialized knowledge, including social welfare, employment, education and voluntary services, transport services and faith leaders. Age-friendly cities and communities programmes are a good source of this information.

11.3.1 Home environment

The place where an older person lives can affect their health, well-being, independence and social participation, particularly if there are challenges with the size of the home, access, condition, location, safety and security.

Problems with the home environment can be mitigated by introducing new security measures, having a number to call in the event of an emergency and making adaptations for a safer environment to maintain independent living. →4.2.5 Financial benefits may be available to help with accommodation costs, and for repair and maintenance. If these measures do not help, a move to more suitable accommodation should be considered if possible.

11.3.2 Financial situation

A person's financial situation is strongly associated with health, independence and well-being in older age. Problems can include having too little money to meet basic needs or to fully participate in society and worries that money will run out. Older people may also be concerned that they will become unable to manage their finances.

Financial problems, including being unable to pay for basic needs may be mitigated though independent advice about financial planning and management, and eligibility and entitlement for available social protection, including pensions, disability grants and carers' allowances. Advice may be needed from those with specialized knowledge in these areas, including benefit advisory services, employment services, organizations providing support with income-generating activities and social workers. Arrangements can be put in place for devolved authority to a trusted third party for managing finances, provided legal protection is in place to prevent financial abuse, especially for those with cognitive decline.

If carers provide financial support for older people, or incur costs due to their caregiving role, they should also receive information and advice, including on how costs for care may change as an older person's functional ability declines and their need for care and support increases.

11.3.3
Social isolation and loneliness

Social isolation and loneliness are common in older people with some lacking social networks and up to a third of older people reporting they feel lonely *(55)*. Loneliness is subjective and is measured by asking people how they feel. Both social isolation and loneliness are associated with an increased likelihood of preventable mortality and diseases and mental conditions such as CVD, stroke, anxiety, depression and dementia. It is important that these conditions are considered and results of a basic assessment for relevant domains of intrinsic capacity are validated through an in-depth assessment where necessary, if loneliness is identified as a potential issue. → 5 9 10

It is important to discuss issues in a sensitive way, being aware that how questions are asked and the setting may influence responses. The older person should be reassured that the discussion is confidential, to help overcome any fears about revealing the nature of personal relationships.

If an older person discloses that they feel lonely or they have few social connections, there are follow-up questions that can identify need for support and suitable interventions. There is often a stigma attached to loneliness, and the reason someone feels lonely may be linked to challenging personal relationships. Being alone (or living alone) is not the same as being lonely – an older person can be lonely even when surrounded by other people, if the quality of their relationships is poor.

It can be helpful to ask an older person, who expresses loneliness, if increased social contact with family and friends, or meeting others with similar interests, would help to reduce their sense of loneliness, and also to understand whether they are aware of local social activities. These discussions should inform interventions to be included in a care plan.

Use of community facilities such as clubs, faith groups, day centres and sports, leisure or education services should be encouraged. There may be opportunities to contribute through volunteering or paid employment. Social connections can also be increased through opportunities to engage with people of different generations. Having a pet also reduces loneliness for many older people *(56)*. Community stakeholders can provide support by organizing events and facilitating older people's access to reduce social isolation. → **4.1.3**

11.3.4
Social engagement and participation

Every older person is unique and will have different priorities, values and things they like to do. It is important to find out about the things older people enjoy and find meaningful by understanding the person's life, priorities and preferences, for example their hobbies, leisure activities, work, learning and spiritual activities. This information should guide the development of the personalized care plan in relation to social engagement and participation.

Supplementary questions can be asked to identify any barriers to social participation such as cost, accessibility (distance and transport) and opportunity. Health workers should know about local opportunities for engagement and participation, discuss whether these might be of interest to the older person and support them to participate. Charges for some of these services may be subsidized to allow older people and those on reduced incomes to participate.

11.4
Abuse of older people

Around one in six older people experience some form of abuse (*57*), a figure higher than previously estimated (*58*). Abuse can take many forms, including neglect, psychological, physical, sexual and financial (including property and inheritance rights). Anyone can experience abuse, but there are a number of risk factors that make an older person more vulnerable, notably, cognitive decline, poor mental or physical health, and disability. Other factors include social isolation, history of abuse, family violence or conflict, ethnic background and low income or living in poverty. Although not often recognized or adequately tackled, violence against women continues in older age. In 2018, for women aged 60 and over the lifetime prevalence of physical and/or intimate partner violence is 23% (*59*).

In line with these risk factors, an older person with loss of intrinsic capacity should be assessed for signs of abuse. Due to the links between abuse of older people and social isolation and low income, an assessment should also be conducted with any older person identified to have issues with their home environment, financial situation, social isolation and loneliness or social participation. Specific consideration should be given to an assessment for signs of abuse of an older person with cognitive decline, as changes in behaviour could be linked to their condition, rather than potential abuse.

Observational information based on the behaviour of the older person and that of their carers or relatives, or signs of physical abuse should be used to identify potential abuse (**Table 11.1**, p. 122).

During any interaction, a community health worker should look for signs of despair, fear and poor eye contact and note the physical appearance and hygiene of the older person, such as the state of their nails, skin and grooming. →**3.5**

In addition, during a physical examination in a primary care facility a health worker should look for physical signs of abuse. If injuries are noted, the health worker should look at the stage of healing, the size of bruises and consistency of the injury with the reported cause. Identification of dehydration, malnutrition, noncompliance with medications or health care appointments increase suspicion of neglect.

If there is any suggestion of abuse, further assessment and management will be needed. The health worker should inform the older person of their concerns and that they will ask for specialist help, for example, from social workers or law enforcement services. They should also record their concerns and the action taken, and closely monitor the situation while waiting for referral. If a health worker identifies any immediate threat to life or physical safety, they should refer for specialist assessment and action (e.g. temporary shelter), adult protective service or law enforcement systems. Referral to psychosocial services, including counselling, should also be considered, if available.

MORE INFORMATION

Abuse of older people: key facts. WHO; 2024 (https://www.who.int/news-room/fact-sheets/detail/abuse-of-older-people).

Table 11.1
Observational cues for potential abuse

Behaviour of the older person	Behaviour of the carer	Physical abuse	Neglect
• Seems fearful of or hostile towards the carer • Does not want to answer when asked, or looks with anxiety at the carer before responding • Behaviour changes when the carer enters or exits the room • Refers to the carer in terms such as "strong willed" or often "tired" or "bad tempered", or as becoming irritable/very anxious/highly stressed • Shows exaggerated respect or extreme deference for the carer, or appears very restless or indifferent in their presence	• Hinders or prevents the health worker and the older person from talking in private, or keeps finding reasons to interrupt the flow of the assessment • Interrupts or insists on answering questions that are addressed to the older person • Provides a conflicting account of events from that of the older person • Finds excuses to prevent health and/or social workers visiting to provide assistance at home for the older person • Demonstrates a high level of dissatisfaction about having to take care of the older person • Attempts to convince the health worker that the older person is "crazy" or "demented", or that the person does not know what they are saying due to confusion, when this is not the case • Is unengaged, inattentive, overwhelmed, frustrated, hostile, angry, tired or impatient during the interview • Evidence that the carer (or older person) has issues with alcohol or substance use	• Injuries (cuts, burns, bruises and scratches) that are unlikely to have happened accidentally • Injuries that do not match the explanation given for them • Injuries and wounds in concealed places or protected areas (e.g. underarms) • Bruising that is shaped like fingers from rough handling (often upper arms) • Multiple injuries at different stages of healing including untreated injuries • Medication underuse or overuse • Recurrent visits to a health care facility, particularly an emergency department, for similar injuries	• Malnutrition, dehydration and pressure sores • Poor body and oral hygiene • Dirty, severely worn clothing, unchanged incontinence pad/pants • Noncompliance with medications, appointments or health worker directions • Delay between onset of illness or injury and seeking medical attention

11.5
Assess social care needs

(Personal care and assistance)

A person's specific needs for personal care and assistance will depend on how to compensate for their loss of intrinsic capacity in order to optimize their functional ability (i.e. to meet their basic needs; learn, grow and make decisions; be mobile; build and maintain relationships; and contribute), alongside their preferences, choices and goals.

An in-depth assessment can be conducted to determine needs by understanding an older person's abilities in relation to BADLs and IADLs. Frequently used questionnaires that measure function include the Katz Index of Independence in Activities of Daily Living and the Lawton Instrumental Activities of Daily Living Scale. Various factors affect IADL limitations including gender, culture and social norms.

An assessment and provision of personal care should include but not be limited to:

- **Transferring:** This covers a number of activities, such as moving from a bed to a chair. Limited mobility increases the risk of falls and the need for personal care with these activities.

- **Personal hygiene:** Toileting, bathing, dressing – ability to get to and use the toilet, to wash yourself, to get dressed and with grooming, including brushing teeth and hair and cutting nails. This may particularly be the case for older people with limited mobility or cognitive decline.

- **Meal preparation and feeding:** Ability to shop for groceries, prepare meals and to eat independently may be affected by limited mobility, cognitive decline and vision impairment. It may also be both a result of and a factor in undernutrition.

- **Use of medication:** Ability to adhere to prescribed treatment for diseases including medication and assistive products (e.g. hearing aid) is critical for older people with multimorbidity. Safe medication use includes remembering to take medication as prescribed – the right medication, in the right dose, at the right time. The efficacy of medication may also be affected by any challenges with meal preparation and feeding. Adhering to treatment may be difficult for people with cognitive decline or vision impairment.

- **Ability to use a telephone and manage transportation:** This can affect utilization of health and social care services because of difficulties with making appointments, either by phone, online or in person, understanding correspondence with health workers about upcoming or past appointments and getting to and from facilities. This may be challenging for older people with limited mobility, hearing loss or vision impairment and cognitive decline.

Older people with depressive symptoms may struggle with any of these tasks. This may be linked to a lack of interest in doing these things, rather than their physical capacity.

MORE INFORMATION

WHO Long-term care for older people: package for universal health coverage. WHO; 2024 (https://iris.who.int/handle/10665/376585).

11.6 Manage social care needs

Many older people do not want to rely on others for help with daily tasks, and support and training should be provided to enable them to do as much as they can. For example, an older person who needs assistance with bathing, may still be able to wash some parts of themselves, and should be encouraged to do so. Similarly, someone who is unable to reach down to put on their shoes, may be able to put on their other clothes. Carers should be supported with information and advice, on how to provide personal care, but also the importance of the older person maintaining as much independence as possible. When a carer is tired and overstretched, getting tasks done as quickly as possible may seem preferable, so the benefits of taking time with the older person, encouraging them to do what they can, should be explained by health workers including social care workers.

Older people who have a significant loss of intrinsic capacity and difficulties with BADL and IADL may benefit from rehabilitation services (→ **4.2.1**), provision of assistive products (→ **4.2.2**) and/or environmental adaptations to optimize functional ability. Accessing these types of support can help the older person with daily tasks and also reduce the demands on their carer(s).

In addition to the personal care provided by a carer in an older person's home, other services and support should also be sought as needed. This includes home-based care, day care services and other facility-based care and support, as available and culturally acceptable. Community stakeholders can provide information and advice and link older people and carers with formal LTC services. They can also support carers' psychosocial well-being, through facilitating respite and peer support. → 12

Social prescribing can be a mechanism through which to deliver social care and support to ensure the delivery of services through formalized relationships with community stakeholders (**Box 11.1**).

Box 11.1 Social prescribing

Social prescribing is a means of connecting people to a range of non-clinical services in the community to improve their health and well-being and can be used as a way to address social care and support needs. It can take various forms and can be adapted in different communities and contexts. For example, health workers at primary care facilities refer an older person to a "case worker" or "care coordinator" who works with an older person to identify their social care and support needs and develops a personalized plan. The case worker or care coordinator also regularly follows up with the older person. Social prescribing can be included as part of a personalized care plan. → **3.3**

An important step in social prescribing is mapping local services, associations and organizations in the community to inform possible referrals. This mapping should include services for welfare, legal, financial, housing support and food security; social care services, including mental health and disability support; support for survivors of abuse; social activities; employment services; activities for lifelong learning and education; health care and health promotion services, including physical activity and nutrition; in urban areas, opportunities for spending time outdoors; culture-related activities; and volunteering opportunities.

With appropriate support and supervision from health workers, a member of a civil society organization can act as a case worker or care coordinator working closely with multidisciplinary health workers. Community stakeholders are also often best placed to map available services.

MORE INFORMATION

- ***A toolkit on how to implement social prescribing.*** WHO; 2022 (https://iris.who.int/handle/10665/354456).
- ***Social prescribing.*** Open WHO; 2024 (https://openwho.org/courses/social-prescribing-WPRO).

12 Carer support

Care pathway to support carers

The demands and stress of caring for older people with significant losses in intrinsic capacity and functional ability can affect the health and well-being of carers. The role carers play is rarely well recognized or valued or adequately supported, exacerbating the challenges associated with providing care. Being a carer can also result in reduced opportunity to undertake paid work, particularly for women. Carers' needs should be identified and interventions to support them should be included in a personalized care plan.

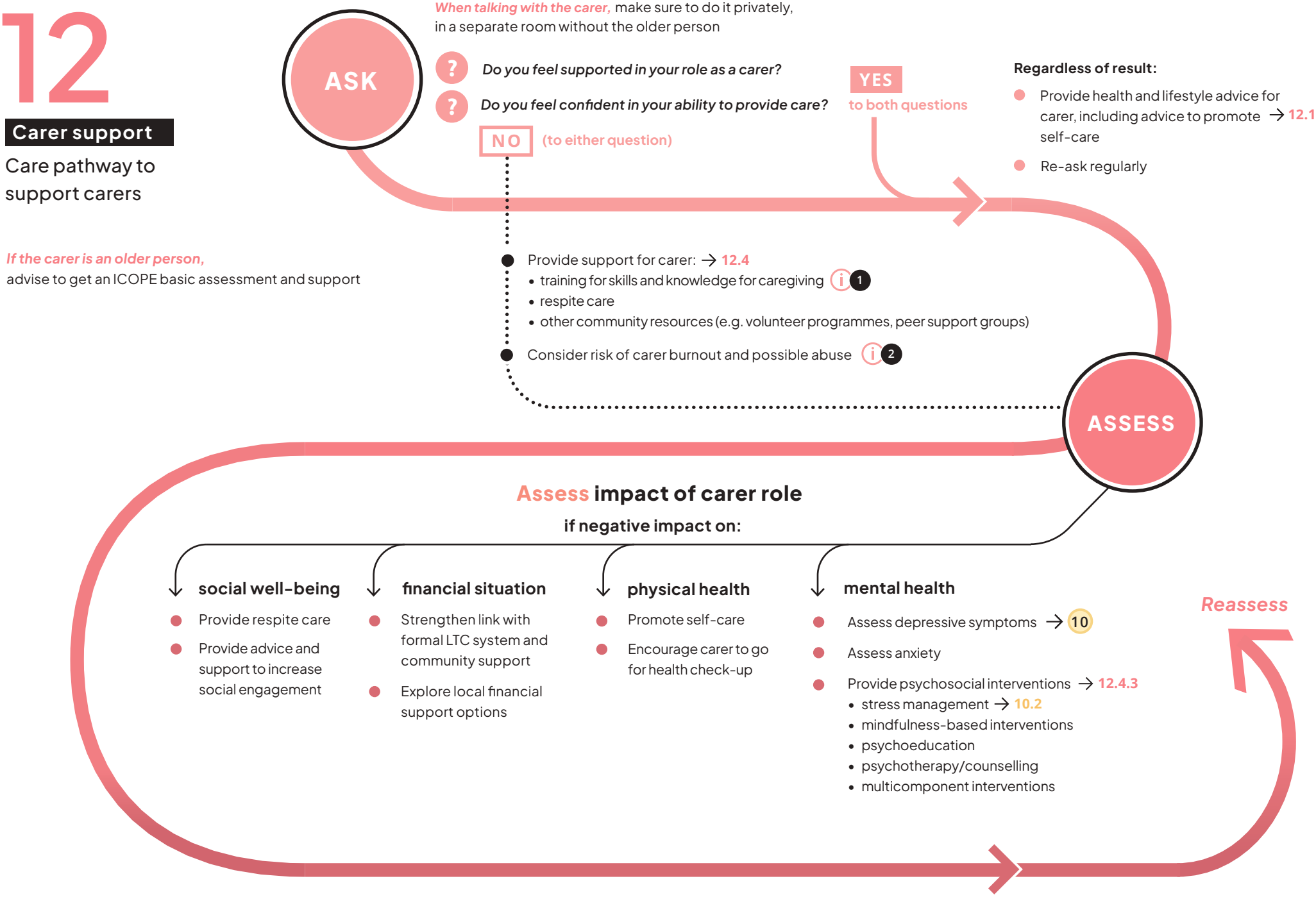
Key points

- Health workers in the community can identify carers' needs and ways to support their health and well-being.
- A range of interventions – advice, training, respite care, financial support and psychological interventions – can help carers to sustain a satisfactory and healthy caring relationship and provide quality care while maintaining their own health and well-being.
- In cases where a carer is an older person, an assessment of the carer's own health, including intrinsic capacity, is recommended.
- Health workers, including community health workers, should be aware of signs of abuse to look for during an assessment of either an older person or their carer.
- A carer's role should be recognized, valued and supported and efforts should be made to redistribute care work. Community stakeholders can advocate for this recognition while also providing ongoing training, including refresher training and support to carers.

12

Carer support

Care pathway to support carers



1

Training and advice needed for carers → 12.4.1

Carers should be supported with specific training and advice to enable them to provide good quality care. Besides how to identify deterioration in signs of functioning, management of medications, navigating health and social services and systems, as well as managing their own needs, the type of training and information will depend on the loss of intrinsic capacity of the person they are caring for.

- **Cognitive decline:** the importance of maintaining a daily routine, how to use memory aids, what to do in response to challenging behaviour and how to respond when/if the person they are caring for does not remember them.
- **Limited mobility:** how to assist the person to move safely, while also protecting themselves from injury, how to access and use assistive products.
- **Undernutrition:** how to access and use (or help the older person to use) assistive products, particularly for feeding, the types and amount of food and liquid required and how best to prepare them.
- **Vision impairment:** how to help the person move around, modifying the home environment to make it safer, how to walk with someone with vision impairment and help them to map their environment, how to adapt communication styles and methods and how to use assistive products.
- **Hearing loss:** how best to communicate with the person, how to use and maintain hearing aids and assistive products.
- **Depressive symptoms:** how to communicate openly with older person, what to do if the immediate risk of self-harm is suspected, how to prevent social isolation.
- **Urinary incontinence:** how to assist with personal care, use of incontinence pads and products, encouraging prompted voiding, and cleaning and safely disposing of soiled clothes, bedding and incontinence pads.

2

The risk of abuse

The two-way relationship between the person receiving care and the carer may be complex. Healthy, happy carers are capable of extraordinary support, but sometimes the caring relationship can be more challenging, including being unwanted by one or both participants. Without adequate support, carers can become overwhelmed and experience burnout. This increases the risk of abuse of the person being cared for.

Abuse can take the form of neglect, financial or material abuse or physical, emotional or sexual abuse. Neglect may be intentional or may occur due to a lack of skills or knowledge regarding how to provide care or lack of external support or supervision.

Carers can also experience abuse, including from the person they are caring for. This abuse can take the same forms as those detailed above, and may occur for similar reasons. A carer of a person with dementia may face particular risks due to challenging behaviours associated with dementia in some people.

Neither the older person nor the carer may disclose an abusive situation to a health worker. Observational information based on the behaviour of the older person, their carers or families is therefore important, as are noting any signs of physical abuse (Table 11.1).

If an abusive relationship is suspected, a more detailed assessment is needed, following local referral pathways, where they exist, and relevant and available services should be engaged. In many cases the provision of additional support for carers may be more effective in addressing an abusive relationship than punitive measures. Health workers should seek legal advice.

Need for specialized knowledge and training

- Provision of support for a carer with depression or anxiety
- Carer themself has significant loss of intrinsic capacity and/or multiple diseases
- Imminent risk of self-harm or suicide of carer (10.4.4)
- Abusive relationship is suspected (11.4)
- Provision of brief structured psychological interventions (10.4.2)
- Financial support and provision of financial advice, including eligibility and entitlements related to caregiving (11.3.2)

Factors that increase the likelihood of being abused:

Care recipient with

- significant care dependence
- behavioural and psychological symptoms of dementia
- low income or living in poverty

Factors that increase the likelihood of becoming a perpetrator of abuse:

Carer with

- poor mental health
- substance abuse and dependency
- stress and burnout
- financial dependency on the person being cared for

Other factors that can increase the likelihood of an abusive relationship include a history of family or partner violence and a poor long-term relationship.

12.1
Health and lifestyle advice to promote carers' well-being

Providing care can be tiring and stressful, particularly for family carers living with the person they are caring for, impacting carers' health and well-being. Community health workers and other community stakeholders can provide advice to support carer well-being, including:

- Starting again (or continuing) activities that were previously enjoyed.
- Maintaining a regular sleeping routine.
- Being as physically active as possible.
- Having a healthy balanced diet and eating proper meals regularly.
- Spending time with friends and family.
- Participating in community and other social activities.
- Taking regular breaks.

12.2
Community-based health care to promote carers' well-being

Carers may provide regular (including daily), occasional or routine care or be involved in organizing care delivery by others. In countries with policies in place, carers may receive social benefits such as paid leave and cash-for-care transfers. Based on a carer's needs, varied types of support should be considered, both for the carer's well-being and to enable them to provide quality care.

Community-based organizations can play a role in identifying carers who may need support. They can establish peer support groups and provide spaces such as community halls for carers to meet and share their experiences. They may be able to organize trips or coffee mornings to give carers an opportunity to take time for themselves to do something enjoyable and to share their experiences, feelings and knowledge with others.

Available resources and information on where and how to seek support in the community should also be provided (e.g. provision of respite care at home or through a day care centre, if available, and culturally acceptable). Organizations that run or manage home-based care programmes, either working with paid care workers or volunteers, can provide information and advice and, where possible, provide care to an older person, giving the family carer some respite.

If a carer is identified as being negatively impacted by their role, and an in-depth assessment is not immediately available, there are actions community health workers can take to provide support. Alongside health and lifestyle advice, they can provide guidance on stress reduction and relaxation (→10.2) and some simple mindfulness techniques.

12.3 Assess carers' needs

It is important that a carer's need for support is assessed, including their health and well-being, the social and economic impacts of providing care and their confidence in fulfilling their caregiving role.

Such assessments should be made routinely, as a carer's need for support may change over time, and different support mechanisms may need to be introduced according to their changing situation.

12.3.1 Ask the carer

The discussion around a carer's needs is best done away from the person they are caring for, to reduce the carer's embarrassment or hesitation about speaking openly. This can either be done at the same time as the assessment with the older person, but in a separate room or space, or may require a separate appointment. The accounts of the older person and the carer may differ for various reasons, including memory problems of the older person, if they have cognitive decline, so the results of the older person's basic and in-depth assessments should be borne in mind.

The carer support pathway provides two example questions to identify how a carer feels and the support they currently receive or may need. A response to either question that suggests the carer is struggling or facing challenges should lead to practical support being offered, including training, respite care and linking with community resources. The carer should also have an in-depth assessment of the impact of their role, including their psychological and physical health, and their social and financial well-being. Responses from a discussion on psychological well-being may suggest the need for an in-depth assessment for depressive symptoms and anxiety, for which a separate meeting with the carer should be arranged.

For those for whom providing care is having a negative financial impact, examples of how to access financial support and advice should be provided.

When talking with a carer, a health worker should look for any signs of exhaustion, anger, frustration or disrespect. If the carer appears stressed or burnt out, attention should be paid to any signs of abuse or neglect by the carer of the person they are caring for. →11.4 They should also be aware of potential signs suggesting the carer may be being abused by the care recipient. These situations may well not be disclosed by the carer so it is important for the health worker to observe what might be happening (i 2, p. 127).

12.3.2 Assessment of depression and anxiety

Caregiving is associated with poorer mental health outcomes for carers compared with the general population, with depression and anxiety being particularly common. It also may be complicated by feelings of bereavement over loss of the previous relationship between the older person and the carer, particularly if the carer is a spouse. It is important for health workers to acknowledge that caregiving can be extremely frustrating and stressful. Health workers should consider whether a carer needs an assessment to identify depression or/and anxiety and if they need any care and support. → 10

12.4 Support for carers

A range of support may be needed including direct help and support from paid care workers and organizations, assistive products and home modifications to facilitate the provision of care, especially if the carer is living with the person being cared for, psychosocial support to address anxiety or depression, and respite care. Provision of information and training for carers is also important.

Health workers and community stakeholders can create a network to share available resources for the training of carers and where to access psychosocial and other forms of support. Peer support groups for carers may be included or combined with other interventions as part of multicomponent interventions to support carers. Digital assistive products can be useful in supporting carers in their role, both through enabling those receiving care to continue doing things for themselves and providing carers with tools to improve the quality of care they can provide (Box 12.1).

Box 12.1 Digital assistive products

Innovative digital assistive products, such as remote monitoring and assistive robots, can enhance the functional ability of older people, improving their quality of life as well as that of their carers, increasing choice, safety, independence and a sense of control, and enabling ageing in place. The use of these products should be based on the needs and preferences of older people and their carers, and availability of resources and appropriate training.

12.4.1 Training

Care workers, supported and supervised through the health and social care system or a service-providing organization should support carers with training and advice. To understand the carer's training needs, the health worker including care worker can ask what caring tasks are needed based on loss of intrinsic capacity and functional ability of the older person being cared for and how often these tasks are undertaken. They can also observe aspects of care that could be improved through training, advice and practical support. Support should reflect the carer's choices and emphasize optimizing quality of care and the carer's well-being.

Topics for training for carers might include, but should not be limited to, the care of older people who need assistance; how to identify deterioration in signs of functioning; prevention and responses to falls; management of medications; management of pain; navigating health and social services and systems; how to communicate effectively with the person being cared for; and managing their own needs. The type of training a carer should receive will be determined by the care needs of the person they are supporting. Specific training topics related to the loss of intrinsic capacity and UI are suggested (i 1, p. 127). Training and education opportunities should be provided for carers who are interested to gain more formal skills, which could translate into future work opportunities.

WHO *iSupport* is a self-help skills and training programme for carers of people with dementia that aims to prevent and/or decrease mental and physical health problems associated with caregiving and to improve the quality of life of those caring for people with dementia.

12.4.2
Respite care

Respite care refers to the temporary relief from caregiving duties through the provision of substitute care in the form of home-based care, day care or temporary admission of the person being cared for to a care facility. Respite from caregiving may help to keep the caring relationship healthy and sustainable, and if properly organized and managed, periods away from the usual carer should not have a negative effect on the person receiving care.

When caring has become too demanding, respite care should be considered. A health worker should explore whether another person can temporarily supervise and care for the older person and support this to happen. This could be another member of the family or household, or a trained social care worker, whether professional or volunteer, in the home or in a care facility.

In some contexts, day care may not be deemed appropriate or culturally acceptable, and may not be in line with an older person's preferences. In this case, other types of community-based care and support can offer similar opportunities for respite, for example, lunch clubs and older people's social gatherings and activities.

The opportunity for an older person to attend a day care centre or receive day care at home can relieve the main carer, who can then rest or carry out other activities. Day care is a type of community support service, which provides personal care (bathing, feeding, shaving, toileting), recreational and social activity programmes, meals and transportation, several hours a day for a number of days a week. Day care also provides support services for carers such as home visits, family activities, support groups and training.

MORE INFORMATION

Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders, [3rd ed.] WHO; 2023 (https://iris.who.int/handle/10665/374250).

12.4.3
Psychological interventions

A health worker can address a carer's psychological stress with psychosocial interventions, including mindfulness-based interventions, multicomponent interventions, psychoeducation and psychotherapy/counselling. This can be particularly helpful when the care being provided is complex and extensive and the strain on the carer is great. Different modes of delivery of psychosocial interventions can be used: face-to-face or digital/remote interventions, which have been reported to be effective. Group-based interventions are likely most effective.

Psychosocial interventions include:

- **Mindfulness-based interventions**, such as mindfulness, meditation, yoga techniques, mindfulness-based cognitive therapy and mindfulness-based stress reduction.
- **Psychoeducation**, which comprises educational programmes that provide standardized information and focus on increasing carers' knowledge of common conditions in older age and developing specific coping skills to deal with caregiving challenges. →10.4.1
- **Psychotherapy/counselling,** focused on interventions that involve implementation of specific forms of individual or group therapy or counselling, including behaviour therapy, cognitive therapy, conventional CBT and newer theoretical orientations such as acceptance-commitment programmes. These are usually delivered by a health professional with specialized knowledge, such as psychologists or therapists, and place strong emphasis on the development and utilization of the therapeutic relationship as part of the treatment process.
- **Multicomponent interventions**, which use multiple approaches such as counselling, support groups and respite provided in the one programme without any one being dominant.

12.4.4
Interventions to support physical health and social well-being

Carers should be advised to look after their own health, including through having regular health checks, including for their intrinsic capacity if they are older. They should also be given advice and support to tackle loneliness and isolation and maintain or increase their social engagement and participation. →11.3.3, 11.3.4

12.4.5
Financial support

If providing care is having a negative impact on a carer's finances, a health worker should provide advice and link the carer to available sources of information and support, including financial advice and available support through formal LTC systems. The carer themselves may also be eligible for financial support through social protection schemes including carer's allowances and non-contributory pensions. Employers may have some provision for carers in terms of leave allowances and flexible working arrangements.

MORE INFORMATION

- ***Long-term care for older people: package for universal health coverage (Annex 6).*** WHO; 2024 (https://iris.who.int/handle/10665/376585).
- ***WHO iSupport for dementia: training and support manual for carers of people with dementia.*** WHO; 2019 (https://iris.who.int/handle/10665/324794).

13 Urinary incontinence

Care pathway to manage urinary incontinence

Urinary incontinence (UI) is a common condition affecting many older people, with women more likely to be affected than men *(11)*. but is not a natural or inevitable consequence of ageing. It is under recognized and under-reported. This could be due to a number of factors, including stigma and older people thinking it is normal in older age. It is associated with depression, loss of mobility, cognitive decline and comorbidities such as urinary tract infection (UTI), obesity, stroke and diabetes. It has a significant impact on quality of life and well-being. Urinary incontinence can affect an older person's self-esteem and confidence about going out, and subsequently their social participation, leading to possible isolation and loneliness *(60)*.

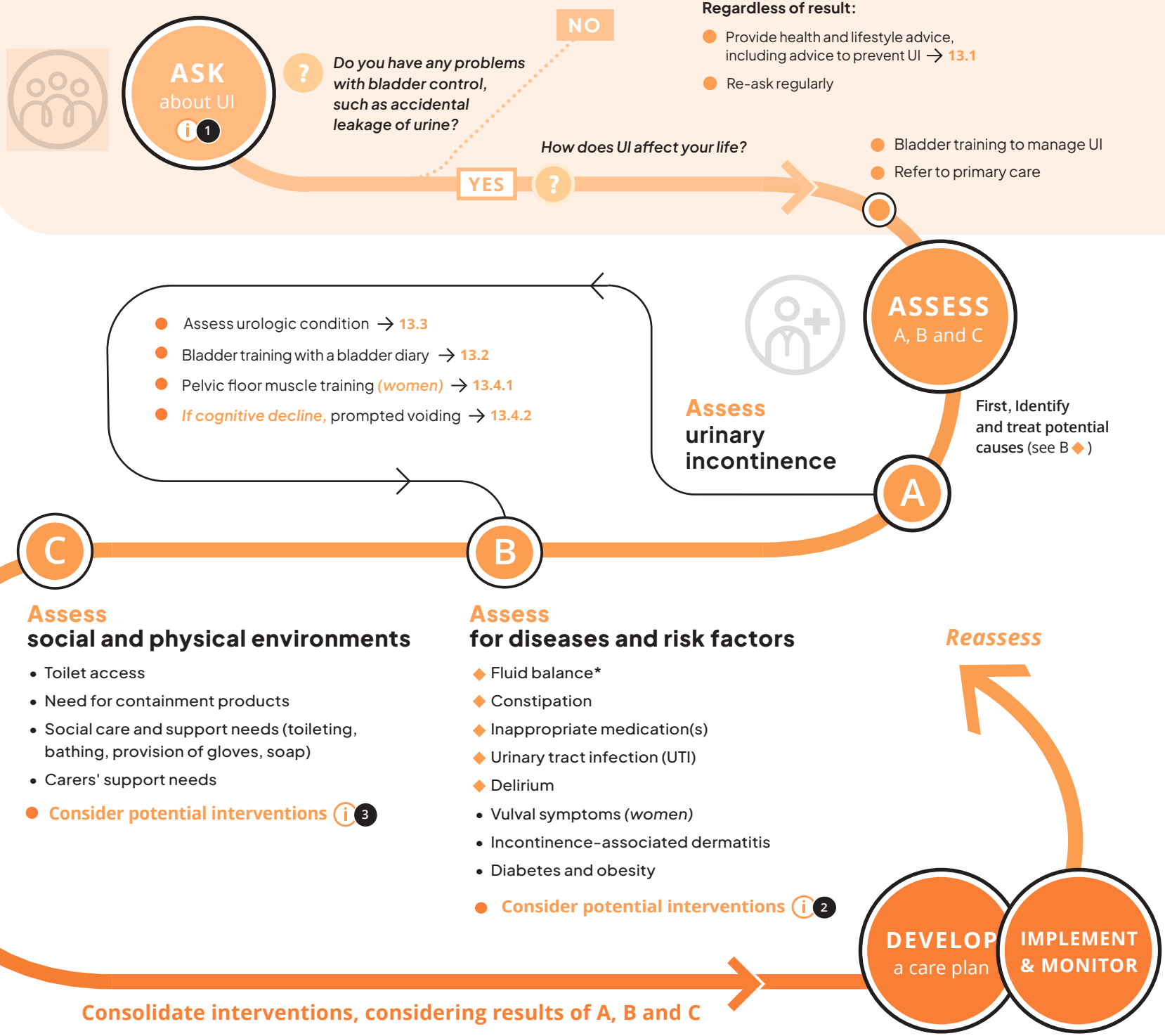
Key points

- Health workers should be proactive in discussing UI but mindful of how to ask questions, due to the sensitivity of the issue and people feeling embarrassed and reluctant to have an assessment.
- There are effective behavioural strategies and interventions, such as pelvic floor muscle training to manage UI.
- Adopting a life-course approach to UI can enable the identification of risk factors earlier in life, including obesity, that can be addressed to prevent its onset.
- Assistive products such as toilet chairs, urinals and containment products, help to manage UI and improve quality of life.
- Community stakeholders can raise awareness that UI is not a "normal" part of ageing and support older people with UI through the establishment of peer support groups.

13

Urinary incontinence

Care pathway to manage urinary incontinence (UI)



* **Fluid balance**
Be mindful about the appropriate fluid balance, as restriction of fluid intake might increase the risk of UTI and dehydration. → 7.3.2

1

Asking questions about urinary incontinence

Urinary incontinence can be a sensitive subject with people feeling embarrassed to raise issues themselves or answer questions when asked. It is preferable to have a health worker of the same sex as the older person conduct the conversation.

When having a discussion on UI:

- find a private place to talk
- spend time to build trust and confidence
- actively listen and avoid language that suggests you are making judgements
- use simple language if necessary, e.g. wetting yourself

The discussion should also include the negative impact of UI on the person's life, to motivate and encourage further assessment and inform potential interventions. It is important to note that many older people feel UI is normal and this view may influence its perceived impact.

Ask the older person if UI is affecting their daily behaviors and activities including:

- Going out
- Engaging with friends, family, community
- Hobbies and social participation
- Physical activity including exercise
- Fluid intake
- The kind of clothes they choose to wear
- Sex life
- Psychological state: embarrassment, anxiety, confidence
- Need for assistive products, including containment products such as pads

Need for specialized knowledge and training

- Full assessment and management of a potential urologic conditions (13.3) suggested by:
  - Palpable bladder
  - Pelvic mass
  - Macro haematuria (blood is visible to the naked eye in the urine)
  - Recurrent symptomatic UTI
  - Large prostate (men)
  - Prolapse (descent of the uterus, cervix or vaginal walls) (women)
  - Suspected fistula (women)
- UI with history of pelvic irradiation and surgery
- If the interventions to manage UI do not work after 3–6 months (13.4)

2

Interventions for diseases and risk factors → 13.5

Fluid balance	Encourage normal fluid balance and trial of caffeine restriction (13.5.1)
Constipation	Treat constipation including through high fibre diets and physical activity (13.5.2)
Inappropriate medication(s)	Review medications and withdraw or prescribe alternatives (13.5.3)
Urinary tract infection (UTI)	Treat UTI **if symptomatic** (13.5.4)
Delirium	Identify cause and treat (5.5.1)
Vulval symptoms (women)	Prescribe topical vaginal moisturizers (13.5.6)
Incontinence-associated dermatitis	Skin hygiene and treat secondary infection (13.5.7)
Diabetes and obesity	Management of diseases and CVD risk factors (13.5.8)

3

Interventions for social and physical environments → 13.6

Toilet access	Home modifications for easier access (13.6.1) Consider assistive products (e.g. raised toilet seat, commode, chair) (13.6.1)
Need for containment products	Support access to containment products (13.6.2)
Social care and support needs	Provide assistance with toileting, bathing, dressing and hygiene and sanitation products (gloves, wipes, soap) (13.6.3) Provide psychosocial support (13.6.3)
Carers' support needs	Provide training on prompted voiding and appropriate use of containment products (13.6.4)

13.1 Health and lifestyle advice to prevent urinary incontinence

Urinary incontinence remains a stigmatized and often taboo subject, which can lead to people not seeking support and not getting the services they need. Community stakeholders can provide health and lifestyle advice to all older people including those with UI to reduce risks and manage UI, highlighting the importance of:

- Maintaining good drinking habits, i.e. drinking at least 1.6–2 L (6–8 glasses or cups) a day, unless indicated by a health professional due to underlying diseases (e.g. heart or kidney diseases). Drinking less can reduce the bladder's capacity and make UI worse, and can lead to dehydration. →7.3.2
- Decreasing caffeine and alcohol, particularly at night, which can increase the need to urinate. Coffee, tea or caffeinated fizzy drinks can be substituted with low-caffeine versions.
- Having a healthy diet, including fibre to reduce the risk of constipation, which can make UI worse as straining to go to the toilet can weaken the pelvic floor.
- Managing weight – being obese can weaken the pelvic floor muscles. →7.3.3
- Doing physical exercise can help strengthen muscles, which can help with UI. Individual advice should be sought on the types of exercise that would be best.
- Tobacco cessation, as smoking weakens the bladder and coughing puts a strain on pelvic floor muscles.

Awareness campaigns can also be helpful in addressing the stigma associated with UI and in encouraging people to seek health care.

13.2 Community-based health care to address urinary incontinence

13.2.1 Bladder training

If an older person is found to potentially have UI and an in-depth assessment is not immediately available, community health workers can support the older person and their carer with bladder training. A bladder diary is used to track a person's toileting patterns and inform appropriate interventions and behaviour change. This can help reinforce learning of new habits. A progressive voiding schedule can be effective, especially for those with urgency UI by voiding the bladder every 2 hours and gradually increasing the time between urination, in combination with distraction techniques, such as, sitting on a hard surface, or doing an activity that requires concentration. It is important not to be prescriptive and to recognize an individual's limits and abilities. Bladder training with a bladder diary should be implemented for at least 6 weeks.

Bladder diary

Date, time	Fluid intake		Urine		Leakage		
	Type	Quantity (mL)	Volume (mL or *S/M/L)	Urgency of need to urinate (1–5)	Volume (S/M/L)	Activity engaged in	Pad change

* If it is not possible to measure or estimate in mL, record volume as small, medium or large

13.3 Assess urinary incontinence and urological conditions

Urinary incontinence is the involuntary leakage of urine. It occurs in association with not only lower urinary tract dysfunction but also loss of mobility, cognitive decline and other diseases. An important step, before an in-depth assessment for UI is to identify and treat any reversible causes (◆). → 13.5

Potential UI can be identified by asking about leakage, with sudden urgency and/or caused by coughing or lifting. Information about severity and quantity of urine lost, frequency of incontinence episodes, and duration of the complaint should be sought. There are different types of UI (Box 13.1); however, diagnosing the type of UI is not essential at primary care to be able to provide interventions.

Box 13.1 Types of urinary incontinence

- **Urgency urinary incontinence:** UI immediately preceded by a sense of urinary urgency. Most common in older people.
- **Stress urinary incontinence:** UI occurring with abrupt increase of intra-abdominal pressure (e.g. coughing, lifting), due to pelvic floor weakness or a weak urinary sphincter. Associated with obesity and women who have experienced vaginal childbirth.
- **Mixed incontinence:** Combination of stress and urgency UI.
- **Overflow incontinence:** UI from overly full bladder due to impaired bladder contractile function and/or bladder outlet obstruction. This is common in men.
- **Disability-associated incontinence:** Due to cognitive decline, limited mobility or comorbidities.

Assessment of urologic conditions should be conducted by a trained health worker and include the examinations listed below. In most cases, urologic assessment is not necessary during the initial assessment, but reversible causes should be identified and treated.

- Abdominal examination to identify a palpable bladder.
- Digital rectal examination to identify a pelvic mass, large prostate (for men, approximately ping pong ball size, e.g. bigger than 40 cc) and stool impaction (constipation).
- Urinalysis to identify haematuria and UTI. Be aware of the limitation of urinalysis stick as it does not differentiate between haemoglobin and myoglobin. Microscopy (if available) is recommended to confirm haematuria.
- For women, external genitalia examination to check for prolapse (descent of the uterus, cervix or vaginal walls) and fistula (a hole between the vagina and bladder), suspected by abnormal vaginal discharge, continuous urine loss or odour in urine.

Results of basic assessment for other linked domains of intrinsic capacity, such as cognitive decline, limited mobility and depressive symptoms should also be verified and an in-depth assessment conducted as necessary. → 5 6 10

13.4 Manage urinary incontinence

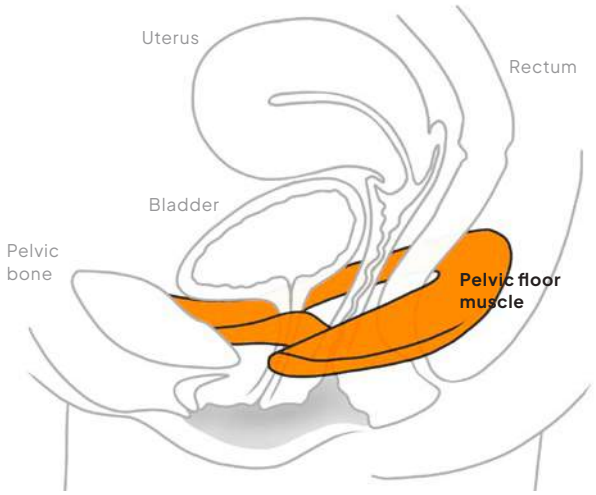
Interventions to manage UI should always be provided as part of a comprehensive personalized care plan responding to underlying factors, along with interventions that address other domains of intrinsic capacity. In addition to bladder training, there are multiple ways to manage UI including pelvic floor muscle training for women and prompted voiding for those with cognitive decline.

13.4.1 Pelvic floor muscle training

The pelvic floor muscles span the bottom of the pelvis and support the pelvic organs (the bladder and bowel, and the uterus in women) (Fig. 13.1).

Pelvic floor muscle training can be recommended to older women with UI. As this is commonly provided in health services as part of postnatal care, if adequately trained and resourced, health workers should be able to provide information and support to older women (Box 13.2). Undertaking three sets of 10 contractions with adequate relaxation between contractions daily, should be advised. To improve pelvic floor function, these exercises should be maintained for at least 3 months.

Fig. 13.1
Pelvic floor muscles



Box 13.2 How to exercise pelvic floor muscles

Health workers can provide information to older women on pelvic floor exercises. It is important for older women to learn to do the exercises in the right way, and to periodically check that they are still being done correctly. Health workers can help older women to understand the exercises by using diagrams, drawings and models and by sharing the following tips:

- In the upright position, the woman should sit comfortably with feet and knees wide apart. If preferred, they can also lie down flat with legs slightly apart. They should remember to keep breathing throughout and keep their stomach, leg and buttock muscles relaxed.
- The woman should imagine she is trying to stop herself from passing gas from the bowel and at the same time trying to stop the flow of urine from the bladder. She should feel a lifting and tightening around the vagina and anus.
- Women may not be able to contract and relax their pelvic floor adequately at first. This can take practice and most women will learn how to do it if they are given some time to try.

These measures may be challenging if the older person has dementia or limited ability to collaborate or if more than two people are needed to transfer them.

13.4.2
Prompted voiding

People with cognitive decline will need specific support for UI. This should include prompted voiding to increase the person's toilet use and decrease the number of UI episodes. A carer should suggest the older person go to the toilet every 2 hours throughout the day and assist them to do so. They can try to reinforce the positive behaviour of frequent toilet visits by spending time in the toilet, having a conversation and not rushing the older person. The carer should also ask the person whether they are wet, to encourage them to notice and act on this. If the person cannot reliably self-report, the carer should check for wetness during toilet visits, and record each wet check in a bladder diary to build up a pattern of urination that could help to pre-empt incontinence episodes.

The effect of each of the above interventions should be monitored for 3–6 months. If no improvement is seen the older person should be referred to specialized care.

13.5
Assess and manage associated diseases and risk factors

An assessment of diseases and risk factors for UI should start by identifying and treating possible causes, including fluid imbalance, constipation, medication, UTI and delirium. Identifying reversible cause(s) of UI involves a full diagnostic work-up at a primary care facility. It may be necessary to explore several different potential explanations of symptoms to arrive at an appropriate approach for a care plan.

13.5.1
Fluid balance ◆

Excessive fluid intake can be a risk factor for UI. Fluid balance should be checked to identify potential cause of excess urine output. Certain drinks and foods such as caffeine may act as diuretics, increasing volume of urine produced. Normal fluid balance should be encouraged and the risks of restricting fluid intake (increased risk of UTI, dehydration) explained. A reduction in caffeine can be tried for 6 weeks. →7.3.2

13.5.2
Constipation ◆

Infrequent stools or difficult stool passage, due to reduced bowel movement, can be a cause, or contributing factor to UI. Stool impaction can be identified by symptoms, stool diaries and physical assessment (e.g. digital rectal exam). High-fibre diets, adequate fluid intake, regular physical activity, and having a bowel movement at the same time every day (e.g. after breakfast) can help manage constipation.

13.5.3
Inappropriate medication(s) ◆

A review of medications should be undertaken to identify any medications that might lead to UI.

Medications that might lead to urinary incontinence:

- Diuretics
- Alpha adrenoreceptor antagonists
- Angiotensin-converting enzyme (ACE) inhibitors
- Calcium channel antagonists
- Psychotropic medicines (clozapine, selective serotonin reuptake inhibitors, benzodiazepines, lithium)
- Anti-Parkinsonian medicines
- Antihistamines

Following a review, medications can be withdrawn or alternatives prescribed if deemed appropriate by a health worker.

13.5.4
Urinary tract infection (UTI) ◆

Acute UTI should be suspected on the basis of urinalysis. It can cause symptoms such as an urgent or frequent need to urinate, a burning feeling while urinating and blood in the urine. UTIs can manifest commonly as delirium or confusion in the absence of a fever. The treatment of bacteriuria is only indicated when symptoms are present or when there is evidence that it may be the cause of UI. Recurrent symptomatic UTIs (two or more infections in 6 months or three or more infections per year) require a referral to specialized care.

13.5.5
Delirium ◆

Delirium is a sudden, fluctuant loss of the ability to direct, shift, sustain and focus attention and can be a cause of UI. A person with delirium may be unaware of their bladder filling or the need to void. →5.5.1

13.5.6
Vulval symptoms (women)

Vulval symptoms include discomfort (e.g. itching, dryness or burning, pain) around the outer part of the female genitals as a part of genitourinary syndrome of menopause. They have a profound negative impact on quality of life. Women should be made aware of these problems and treated, including with topical vaginal moisturizers and oestrogen, if appropriate, available and accessible.

13.5.7
Incontinence-associated dermatitis

An examination of external genitalia should be conducted to assess possible skin inflammation due to prolonged contact with urine. Prolonged use of containment products such as incontinence pants or pads can lead to dermatitis and infection. Incontinence-associated dermatitis appears initially as erythema which looks different on different skin tones: on lighter skin: ranging from pink to red; and on darker skin: skin may be paler, darker, purple, dark red or yellow.

The affected area usually has poorly defined edges and may be patchy or continuous over large areas. Advanced incontinence-associated dermatitis shows areas of superficial skin erosion with pain. If dermatitis is found, advise on mild cleansing and protecting the skin with appropriate topical products including barrier creams or films, treat any secondary infection and recommend appropriate containment products.

13.5.8
Diabetes and obesity

Diabetes is associated with UI due to excessive urine output and alterations in bladder muscle function. Obesity has been shown to be a strong risk factor for UI, specifically, the higher prevalence of UI in older women is linearly correlated with higher BMI *(61)*. As intra-abdominal pressure increases with obesity, the increased bladder pressure weakens the pelvic floor. Management of CVD and risk factors should be provided through healthy diet and physical activity including exercise, together with medication. For older people, the benefits of weight loss need to be weighed against potential risks, such as concurrent muscle mass reduction. →7.3.1

13.6 Assess and manage social and physical environments

13.6.1 Access to a toilet

An older person's access to a toilet, should be assessed, including distance within the home to the toilet, and for those with shared toilet facilities outside of the home, distance, terrain, safety and security. The usability of the toilet itself should also be considered, including the type of toilet (sit or squat), need for grab rails, space for people using mobility assistive products to manoeuvre. Commode (toilet) chairs and urinals may be useful if the distance to a toilet is not manageable, or if the person is unable to use the toilet. Additional lighting in the toilet, contrasting strips to indicate any steps and a coloured marker on the flush, could be helpful for people with vision impairment. Clothing that is easy to undo or take off might also be beneficial.

It can also be useful to assess access to toilet facilities in the local community. A lack of access may hinder an older person's ability or willingness to go out and participate in activities, leading to social isolation and loneliness.

Community stakeholders can provide maps of where public toilets are located, and speak with local shops, cafés and other businesses to ask if their toilet facilities could be made available to older people.

13.6.2 Containment products

If treatment for UI is not possible or does not work, the use of containment products can help to improve quality of life. Absorbent containment products include incontinence pants and pads; different products should be used at different times and for different activities. For example, a smaller product could be used during the day while a larger one may be needed at night. Containment products may be reusable or disposable. Reusable products should be washed and dried carefully. These products can be prohibitively expensive but may be subsidized, in some contexts through various mechanisms.

Community stakeholders can support access to containment products through working with local authorities and health workers to make products available (and affordable) and holding them to account on their commitments.

Indwelling urinary catheters should be avoided as they cause infections and other harms such as blood or debris in the catheter tube that might block the drainage system.

MORE INFORMATION

Training on self-care assistive products and absorbent (containment) products. TAP; 2024 (https://www.gate-tap.org/).

13.6.3
Social care and support → 11

Social care and support needs may include assistance with toileting, bathing and dressing. If a person with UI who uses containment products needs support from a carer to go to the toilet and get dressed, the ease of use of containment products should be considered, including whether it is possible to change without removing outer clothing. Day care and other LTC facilities in the community should ensure adequate space for older people to be assisted in going to the toilet and changing.

Older people with UI might benefit from psychosocial support, including peer support. Community stakeholders can establish support groups, to give older people the opportunity to share their experiences and seek advice from others in a similar situation. This could help to empower older people with UI to speak up and ask for help.

13.6.4
Support for carers → 12

Looking after someone with UI can be physically and psychologically challenging. Carers, including family members at home with the older person all day, should receive training in how best to provide care, including how to safely assist the older person to walk and to transfer on to and off of a toilet; how to assist with personal care, including cleaning and skin care to avoid infection; appropriate use of incontinence pads and other products to avoid a reliance on these products if they are not necessary; how to encourage the person to keep drinking and not restrict their fluid intake; how to encourage prompted voiding; and how to clean and safely dispose of soiled clothes, bedding and incontinence pads.

It is also important to provide support and advice for carers on how to manage any feelings of embarrassment or anxiety associated with providing personal care. Carers may find it difficult to discuss issues related to UI with the person they are caring for, and may feel uncomfortable providing personal care. They should be given advice and information on how to approach sensitive conversations and how to provide personal care in a way that promotes dignity and autonomy.

14 Implementation considerations for ICOPE

ICOPE can support a transformation in health and social care systems and services to deliver an integrated, person-centred continuum of care for older people with the aim of optimizing functional ability. The overarching ICOPE care pathway within a PHC approach can support the identification of the older population's needs and provision of services (**Fig. 1.1**, p. 5). The implementation of ICOPE should therefore align closely with efforts to strengthen PHC, utilizing the levers of PHC outlined in the WHO and UNICEF *Operational Framework for Primary Health Care*.

ICOPE has been piloted in multiple countries around the world across a range of income levels and with different structures and capacities within their health and social care systems. Learnings from these pilots highlight key considerations for implementation relevant to project and system managers.

Key points

- Before implementing an ICOPE care pathway an assessment of readiness at service and system level is recommended.
- Adapting and developing local care pathways starts with mapping available resources and identifying the entry points and opportunities to implement the ICOPE approach.
- Engagement of older people and their carers is key for successful and sustainable implementation of integrated care.
- Optimizing the intrinsic capacity and functional ability of older people begins in the community. Health and social care systems should support and enable delivery of community-level services through strengthened primary care and engagement with community stakeholders.
- Health workers should receive training, support and proper remuneration to enable the delivery of person-centred integrated care within routine practice.
- ICOPE requires the integration of health and social care, including LTC. Care can be delivered by and with multiple sectors and across settings. Effective coordination and collaboration across sectors, settings and services is crucial.

14.1 Adapting ICOPE to local contexts

ICOPE should be adapted to ensure the steps of the care pathway can be effectively implemented within and by existing services and settings in a culturally appropriate and sustainable way.

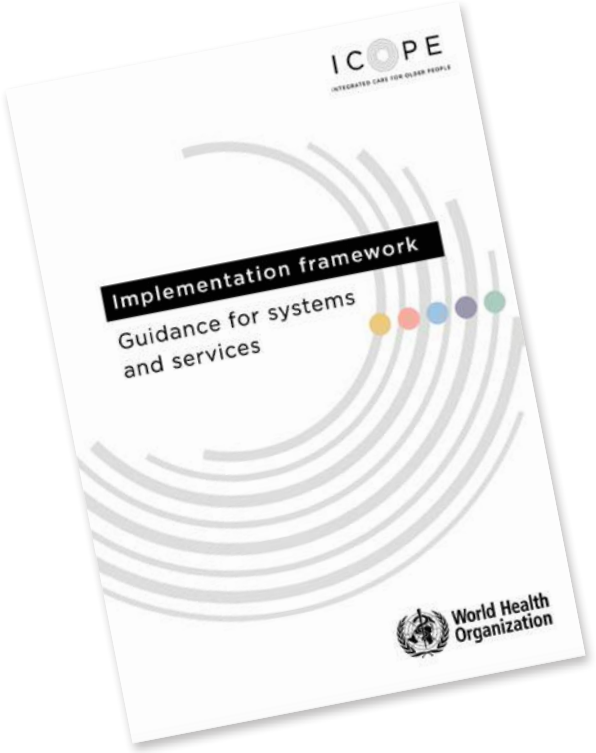
Prior to implementing ICOPE at scale, countries should conduct an assessment of readiness to deliver integrated care to inform an adaptation of the approach to the local context. The WHO *ICOPE implementation framework* provides a scorecard to guide the assessment of overall capacity of health and social care services and systems to deliver integrated care in primary care, and also informs implementation action plans based on readiness to implement (none to minimal, initiating, sustaining). Scoring can highlight the areas of opportunity and be used to monitor ongoing progress of implementation.

This is an important step as all health and social care systems are different, with varied service delivery approaches, workforce structures and regulations, referral pathways and resource capacities. It is possible to start implementing ICOPE by piloting and adapting the approach in a community or clinical setting, engaging relevant local stakeholders.

To inform local or national adaptation, a comprehensive mapping exercise (**Box 14.1**, p. 145) should be undertaken with the involvement of older people, carers, health and social care workers from different settings, public health authorities and community stakeholders. The mapping process can be used to build support and collaboration for the approach.

The information collected through a mapping exercise should inform the development of care pathways specific to the local context. This exercise should focus on working with existing routine practice and using basic and in-depth assessment tools already available and validated that address intrinsic capacity and functional ability, and building workforce capacity and incentives and strengthening services where needed. Adapted care pathways should be translated into relevant languages and piloted to test their feasibility and acceptability.

Health workers can undertake similar exercises to identify available resources in their own health care setting, building a multidisciplinary team and a collaboration mechanism among different health and social care services, and identifying entry points to integrate the ICOPE care pathway into routine clinical practice. This process can inform where, how and with whom to start piloting the approach. The first phase of a pilot should be to assess the feasibility of implementing ICOPE and identify barriers and enablers to its implementation.



Box 14.1 Elements of comprehensive mapping to inform adaptation of ICOPE

Older people and their carers:

- Situation analysis of health and well-being of older people informed by key informant interviews and a survey (population or facility based).
- Older people and their carers' health literacy.
- Identification of where older people in need of care are, including those unable to access health care facilities, whose engagement will need to happen at home or in the community.

Models of care: A model of care is a conceptualization of how services should be delivered, including the processes of care, organization of providers and management of services. It is supported by mapping:

- Availability, accessibility (cost, distance, transportation, age friendliness), acceptability and quality of services for older people at different levels of the health system.
- Care pathways (usual first and regular point of contact, referral mechanisms).
- Entry points for implementation of ICOPE within existing service delivery (e.g. through noncommunicable diseases clinics or mobile outreach services).
- Available infrastructure (diagnostics, health and care data collection and sharing mechanisms, space for assessment).
- Screening and assessment tools for impairments of intrinsic capacity.
- Essential medicines, vaccines and health products including assistive products.
- Availability, accessibility and acceptability of social care services, including LTC, and community services for social support.

Partnerships:

- Formalized engagement between health and social care sectors across different settings and community stakeholders.
- Clarity of roles and responsibilities.
- Recognition, training and support for community stakeholders.

Coordination:

- Mechanisms for collaboration between health and social care services and workers.
- Ways of working that enable a multidisciplinary team approach.
- Structure and capacity of LTC services and workers.
- Utilization of social support such as social prescribing.
- Existing partnerships with other sectors, including transport, education, employment, justice and law enforcement.

Human resources:

- Who the health workers are in primary care, including community health workers, their capacity (time, knowledge, skills, remuneration) and composition of multidisciplinary teams (if they already exist).
- The training currently received, and necessary knowledge currently not being provided.
- Roles and responsibilities of different health workers across health care settings (primary, secondary, tertiary) and social care settings including LTC facilities.
- Other human resources including volunteers and community stakeholders.

Financial resources:

- Budget currently available that could be utilized for promoting quality person-centred care for older people.
- Costings of the provision of integrated care and budget gaps.

Note: The elements of comprehensive mapping to inform adaptation of ICOPE can be undertaken in any order.

Box 14.2 Summary of actions from the ICOPE implementation framework

Actions for systems (macro level)

- **Strengthen governance and accountability systems**
  Engage stakeholders in policy and service development; develop policy and regulation to support integrated care and responses to abuse of older people; undertake continuous quality assurance and quality improvement; regularly review capacity to deliver care equitably.

- **Enable systems strengthening**
  Develop workforce capacity, financing and human resources management; use technology to exchange information among service providers; collect and report data on intrinsic capacity and functional ability; use digital technologies to support self-management.

Actions for services (meso level)

- **Engage and empower people and communities**
  Engage older people, their families and civil society in service delivery; support and train carers.

- **Support the coordination of services provided by multidisciplinary teams**
  Identify older people in the community who need care, undertake comprehensive assessments and develop comprehensive care plans; establish networks of health and social care workers.

- **Orient services toward community-based care**
  Deliver effective and acceptable care focused on functional ability through community-based workers and services backed by adequate age-friendly infrastructure.

14.2 Implementation considerations

Following the readiness assessment and adaptation of ICOPE, there are a number of further considerations for its implementation. The WHO and UNICEF *Operational Framework for Primary Health Care* provides interdependent and inter-related levers (strategic and operational) to guide countries' efforts to strengthen PHC-oriented health systems.

The *ICOPE implementation framework* sets out 19 actions, that complement the PHC levers, to support Member States, focused on the system (macro) and services (meso) levels (**Box 14.2**). The macro-level components are intended to support policy-makers, system-level planners, funders and decision-makers; while the meso-level actions are targeted at service and programme managers and decision-makers. In alignment with operational levers of PHC, such as models of care, PHC workforce, digital technology and monitoring and evaluation, the following implementation considerations, drawn from the implementation framework and learning gained through ICOPE pilot programmes, aim to support implementation at the service level.

14.2.1 Integrating health services, prioritizing primary care

Most health systems around the world are designed to treat and cure diseases, often through vertical services. Despite efforts to strengthen PHC, they are often not equipped to deliver integrated person-centred care that requires a more horizontal comprehensive approach, allowing for flexibility and multidisciplinary working. Therefore, primary care services as a first and regular point of contact, and the first component of PHC, need to be prioritized with the delivery of a continuum of integrated care as a key aim, to enable quality care including the implementation of the ICOPE care pathway. This can be supported by including ICOPE interventions in an essential service package at primary care.

Consideration should be given to the level of coordination between health systems including the suitability and age-friendliness of infrastructure and availability of appropriate tools and technologies, including medicines, vaccines and health products such as assistive products, ensuring effective referral mechanisms, both within the health service, including to specialized care at secondary and tertiary levels, and between health and social care services, and establishing and/or strengthening systems for data collection and sharing.

14.2.2
Human and financial resources

Additional investment is most likely needed to support the implementation of ICOPE, particularly in relation to human resources to ensure a more effective and efficient approach while better aligning with current and future needs of the population. Capacity building of multidisciplinary health workers usually involves the provision of competency-based training at all levels, especially at primary care, to increase understanding of ICOPE and how it can be applied.

Multidisciplinary teams that optimize health workers' skills mix, should enable the delivery of a continuum of integrated person-centred care.

In many contexts, community health workers play an increasingly significant role in the delivery of health services but may lack training and support and often work in a voluntary or unpaid capacity, all of which affect sustainability (e.g. recruitment, retention). Provision of job security, supportive supervision and career development pathways are important. Alternative workforce configurations might be needed, based on the setting and resource availability to respond to evolving health needs and populations. Task sharing among health workers can support the delivery of integrated care and may also require adjustment of regulation, recognition of new roles and specific remuneration.

Building incentives for public health and rewards for health workers for integrated care, financing mechanisms and performance monitoring can encourage the shift towards quality care for older people. Authorities responsible for developing training and curricula and providing accreditation, and national and local professional societies can play an important role.

14.2.3
Coordination among health and social care sectors

Structures and mechanisms are required at the service level to enable referral between health and social care and collaboration between health and social workers, facilitated by a care coordinator, as part of a multidisciplinary team. This coordination should include LTC services and integration of information and quality assurance systems.

WHO's *Long-term care for older people: package for universal health coverage*, provides a list of LTC interventions for countries to consider, prioritize and provide. In some countries, the mechanism for assessment for eligibility for LTC services and care provision is organized by different sectors. Whatever the local arrangements, the principles of a person-centred integrated approach are the same, although different staff (in the community or in residential settings) and specialist skills may be needed. The health and social care sectors will be better able to adopt and apply ICOPE when national policies support an integrated approach to health and social care. These policies should take into account how health and social care services are provided and by whom, including the role of the private sector in the provision of LTC, in particular, and the need for strengthened public-private partnerships.

14.2.4
Digital technology

The use of digital technology as a potential enabling factor has been highlighted by learning from ICOPE pilots, which have shown its use leading to improvements in the efficiency and effectiveness of integrated care.

Digital tools can support health workers to access training (e-learning), to conduct the basic and in-depth assessments of the ICOPE care pathway, and to monitor and analyse outcomes of interventions. Digital technologies can also enable and improve communication with older people and their carers, such as through telehealth and mobile health and using video and other online media to raise awareness of integrated care and provide health and lifestyle advice. Digital technology can be used to support functional ability, reduce the need for care and to assist carers in their role (Box 12.1, p. 130).

Advances in information and communications technologies (electronic health records) also facilitate data sharing in real-time among health workers, including community health workers and social care workers, and support aggregation of data to monitor and improve the targeting of public health efforts.

Ageist assumptions that older people cannot or do not want to use digital technology should be tackled.

When considering the use of digital technology, potential challenges need to be considered, including digital literacy among older people and inequalities in access to technology, interoperability, integrity, data governance, cybersecurity and usability.

14.2.5 Monitoring and evaluation

Within the context of PHC, countries will need to assess gaps, determine priorities, establish baselines and targets, and track progress and performance towards UHC across their health and social care systems.

Monitoring, evaluation and review of health progress and performance are essential to ensure that priority actions and decisions are implemented as planned against agreed objectives and targets for older people. Robust monitoring and evaluation of ICOPE, including a focus on the health status (intrinsic capacity and functional ability) of an older person and older populations, should be included as part of this wider monitoring and evaluation process. Building capacity to collect, analyse and use data for local decision-making is crucial. Reliable service-level data collected through standardized indicators support understanding of the effectiveness of ICOPE and inform priority setting and changes to service delivery, helping to assure accountability, including towards older people and their carers.

Community stakeholders can play a role in accountability, including: holding health systems accountable to older populations' needs; and contributing to accountability in the governance, planning, delivery and evaluation of health care.

The development of an approach to monitor ICOPE within the monitoring and evaluation lever of PHC can also be taken forward as part of a broader monitoring and evaluation of healthy ageing, guided by the WHO framework and indicators for measuring the progress and impact of the UN Decade of Healthy Ageing (2021–2030).

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Annex: Example of a simplified care plan

This is an example of a simple summary care plan that can be shared by the case manager or care coordinator with the older person.
It is not intended to capture a full medical history or act as a medical record.

Date: DD/MM/YY **Location:** xxx primary care clinic

Personal information

Date of birth (Age): (75) **Gender:** Male **ID:** XXX

Person-centred goals

(Short term) I would like to join my granddaughter's school soccer game next month. To do so, I want to be able to walk to the school.

(Long term) I would like to keep being able to walk to church over the next year. This is becoming more difficult.

Assessment summary

Intrinsic capacity

- Limited mobility with knee pain
- Moderate hearing loss without red flags

Diseases and risk factors

- Controlled hypertension and hyperlipidemia
- Osteoarthritis of knees

Social and physical environment

Living with his wife on the third floor without a lift. His son, daughter-in-law and grandchildren live locally and visit weekly.

Participating in community activities regularly, including church groups and having coffee with friends but limited mobility has begun to reduce his participation recently and he sometimes struggles to follow conversations if the environment is noisy.

Proposed and agreed interventions

Proposed interventions	Agreed by older person	Actions
Multimodal exercise programme with referral to rehabilitation service	Yes	Referral letter is being prepared to make an appointment with rehabilitation service
Referral to the hearing care	Yes	Referral letter is being prepared to make an appointment with hearing care
Pain assessment and management	No	Declined referral for pain assessment. Advised to make a record when pain is felt and intensity of pain (0–10)
Continued management of diseases (hypertension and hyperlipidemia)	Yes	Continue checking blood pressure at home Take medications as prescribed and next blood test in 2 months
Diet advice to increase protein intake	No	Stated did not want to increase protein consumption. Advised to try to eat locally available protein rich foods.
Assessment of risk of falls at home	No	Advised how to make home and home surroundings safe
Assessment of carer (his wife) needs	Yes	An assessment is being scheduled with the carer (wife)
Mobility assistive products	Yes	Referral letter to be prepared to make an appointment with rehabilitation service

Assessor name: xxx

Date recommended for next appointment: DD/MM/YY

For more information:

https://www.who.int/teams/maternal-new-born-child-adolescent-health-and-ageing/ageing-and-health/integrated-care-for-older-people-icope

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