The United Republic Of Tanzania

MINISTRY OF HEALTH

GUIDELINE FOR THE IMPLEMENTATION OF THE NATIONAL STRATEGY FOR THE PROVISION OF HEALTH SERVICES TO OLDER PEOPLE

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THE UNITED REPUBLIC OF TANZANIA

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Foreword

The population of older people in the world, including Tanzania is rapidly increasing. It is expected that come 2050 the population of older people in Tanzania will constitute 11% of the general population. This increase in number of older people means that the needs for health services for this group of the population will increase as well. In order to address those needs, the Ministry has decided to develop Implementation guidelines of the National Strategy for the Provision of Health Services to Older People.

This document aims to guide all stakeholders to address all key issues highlighted in the National Strategy for the Provision of Health Services to Older People including private providers, in planning, providing, monitoring and evaluating the provision of health services to older people. The document describes the implementation framework towards realization of gaps identified in the Strategey for Health Services of Older People. The roles and responsibilities of various actors in the provision of health services to older people are stipulated. It will be used as a reference guide by the Ministry responsible for Health, Prime Minister's Office-Regional Administration and Local Government (PMO-RALG), Regional health Management Teams, Council health Management Teams, Health facilities management teams and implementing partners who are directly engaged with healthy ageing.

Therefore, I call upon all stakeholders for provision of health services to older people to utilize this document while planning interventions related to older people. This inturn would contribute in increasing number of older people attended in health facilities as well as preventive health services targeted to this age category.

Dr. Seif A. Shekalaghe
Permanent Secretary

Acknowledgement

The accomplishment of this implementation guideline for National Strategy for the provision of Health Services to Older People, was due to the collaboration between the Ministry and stakeholders, who provided technical and financial support. The Ministry would like to express its sincere gratitude to HelpAge Tanzania whose financial support enabled the Consultation services during the preparation of this document. The Ministry greatly appreciate their continued support.

The Ministry would like to extend its gratitude to other stakeholders whose participation helped in refining and enriching this document. It is not possible to mention all those who contributed in one way or another during the process. However, the Ministry would like to acknowledge the contributions from represented stakeholders from Prime Minister Office-Regional Adminstration and Local Government (PMO-RALG), Ministry of Community Development, Gender, Women and Special Groups (MoCDGWSG), Mirembe Mental Health Specialized Hospital, Benjamin Mkapa Zonal Referral Hospital and Dodoma Regional Referral Hospital. Furthermore, I would like to appreciate coordination of Dr. Omary S. Ubuguyu; the then Acting Director of Curative Services, which enabled timely completion of this document.

Dr. Grace E. Magembe
Chief Medical Officer

Abbreviations

A&H	Alignment & Harmonization
AA	Active Ageing
AAAs	Active Ageing Associations
AACs	Active Ageing Clubs
AU	African Union
BCC	Behaviour Change Communication
CCHP	Comprehensive Council Health Plan
CDs	Communicable Diseases
CHMT	Council Health Management Team
CHOP	Comprehensive Hospital Operational Plan
CMO	Chief Medical Officer
CPD	Continuous Professional Development
CSO	Civil Society Organization
DED	District Executive Director
DMO	District Medical Officer
DPs	Development Partners
HA	Healthy Ageing
HSS	Health Systems Strengthening
MCAS	Ministry of Culture Arts and Sports
MoF	Ministry of Finance
NCDs	Non-Communicable Diseases
NSPHSOP	National Strategy for Provision of Health Services to Older People
OP	Older People (Persons above 60 years of age)
OPU	Older People care Unit
RAS	Regional Administrative Secretary
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
SARA	Service Availability and Readiness Assessment
STEPS	STEPwise approach to Non- Communicable Diseases risk factor Surveillance
SWAp	Sector Wide Approaches

TASAF	Tanzania Social Action Fund
TDHS	Tanzania Demographic and Health Survey
UHC	Universal Health Coverage
UHI	Universal Health Insurance
WEO	Ward Executive Officer
WHO	World Health Organization

Executive Summary

The ten-year (2021 -2030) National Strategy for Provision of Health Services to Older People (NSPHSOP) informs this implementation guideline that it calls for short term, medium and long-term measures to get established on a sustainable impactful footing. The implementation guideline provides a roadmap to establish a culture in which appropriate lifestyles nurture Healthy Ageing (HA). A second major theme for attaining desired changes for better care for Older People (OP) is embedded in promoting practices that reduce disease episodes amongst OP by having Active Ageing (AA) in several life course cohorts from 30 years on to old age defined to begin at 60 years.

Gains from health services costs reduction through AA and HA measures as well as risks pooling through Universal Health Insurance (UHI) shall be complemented by searching for opportunities to expand sources of financing for OP care. Deliberately programmed public education through a variety of channels and media shall be sustained long enough for mind-set change and behaviour change such that the cultural transformation benefits the young ages, middle and senior ages as a cherished continuum.

Competencies of health professionals on OP health care is addressed through actions to establish geriatrics discipline and geriatrics competent cadres at Certificate, graduate and specialized categories for deployment at appropriate levels while improving health care workers effective communication skills that will improve responsiveness to the needs of OP while seeking care in health facilities at all levels. This implementation guide therefore presents some briefs on the situation, the policy clearance, summary issues and objectives aspired for. A summary of roles, essentials to be done and tasks (activities) for different levels is presented including making the case for involving relevant sectors and stakeholders both in public and private domains.

Definitions

Active Ageing (AA)

It is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. One gets to optimize measures to improve own health, participate and attain safety (being secure) by being an active individual; when these go on continuously as one gains years of life the whole process is summarized as 'Active Ageing'.

Healthy Ageing (HA)

It means living a long, productive, meaningful life and enjoying a high quality of life. Research has shown that older adults who adopt healthy behaviours, use preventive health services, and are involved with their family, friends, and communities, are healthier and more independent. WHO report[1] defines healthy ageing as "The process of developing and maintaining the intrinsic capacity and functional ability that enables well-being in older age"

Geriatrics

A term used in medicine representing care for older adults.

Older People (OP)

People whose age is 60 years or more

Risk pooling

The insurance premium of those not falling into illness episode during a defined period is arranged to cover those who get into illness episodes and are unable to pay for the costs.

Universal Health Coverage

All people and communities receive quality health services they need without financial hardship

[1] WHO 2015. World Report on Ageing and Health. ISBN 978 92 4 156504 2 pg 28

Preamble

The overarching message on Older People care is optimistic: with the right policies and services in place, population ageing can be viewed as a rich new opportunity for both individuals and societies[2]. In many community settings, older people continue to play a pivotal role as a source of wisdom and custodians of traditional knowledge and identity, including family unity and as living libraries that pass on their time-tested knowledge and skills to younger generations. Acknowledging this role of older people in society and taking measures to optimize it will increase their contribution to the development agenda of the country in addition to mental alertness benefits to the older person from the interactions and relationships perceived positively.

Within the Health System, various professional disciplines function for Care for Children, Adolescents, Women of reproductive age, to actively working age population segments in such categories as paediatrics, obstetrics and gynaecology, psychiatry, orthopaedics and trauma, surgery and general internal medicine with specializations and super-specializations branching off from each category. The demographic dividend of the current time is the realization of increasing life expectancy with more numbers of older people to care for professionally. It is now high time to address Geriatrics discipline gap and build capacity relevant to various levels of care in this nation.

Individuals committed to Healthy Ageing discipline collectively produce a Healthy Ageing Nation through very feasible low-cost interventions. Individuals who are inactive as they age are eventually costly to the Nation from frequent illness episodes. Active stature during your Youth is like Gold in your hands. This implementation guide should appeal to you such that you hold on to that Gold into very mature age in your life. Healthy Ageing is a combination of physically active life and healthy lifestyle. Acquiring healthy lifestyle is like swimming in a stream and finding Diamonds hidden under the sand in the stream. Since diamonds are strong, they leave a strong trail on your path. A healthy lifestyle is the diamond in you that shapes strength at old age

[2] Margret Chan. Preface to World Report on Ageing and Health. WHO 2015. ISBN 978 92 4 069481 1 (PDF)

1.0. BACKGROUND

Up to the present time we provide health care to older people without fully considering the multiple disease conditions they usually have at their age that require avoidance of polypharmacy which may affect compliance to therapy, resulting in wastage and generating more costs of caring. Staff competency in geriatric care is a deficiency in the health system: This is a gap that the strategy and implementation guideline for the provision of health care services to older people is setting to address, since the population of older people is on a rising continuum as we go forward. The need for a clear conceptual framework to inform an operational frame and organized set up for geriatric care in this nation is being addressed now so that care for older people is practised at optimal quality at all health facilities at all levels, as clearly argued in a paper on Gerontology history and challenges[3]: It is also essential that communities and institutions are well informed and better prepared for this important task.

Major chronic conditions affecting older people:

- Cardiovascular diseases (such as coronary heart disease)
- Hypertension and • Stroke
- Diabetes
- Cancer
- Chronic obstructive pulmonary disease
- Musculoskeletal conditions (such as arthritis and osteoporosis)
- Mental health conditions (mostly dementia and depression)
- Blindness and visual impairment

Source: WHO Active Ageing Policy Framework

Denying older people access to health care from inability to pay for services following inadequately implemented “waivers and exemptions policy” has been under rethinking and now calls for innovation in optimizing existing opportunities; this is one of the key intentions of the National Strategy for Provision of Health Services of Older Person (NSPHSOP) implementation guideline. Deliberate pooling of financial resources across population groups for the sake of ensuring older people benefit from Universal health

[3] Gerontology in Canada: History, Challenges, Research Gavin J. Andrews & Lori Campbell & Margaret Denton & Kathy S. McGilton Published online: 26 November 2009 # Springer Science+Business Media, LLC 2009

coverage (UHC) policy, is in line with the Sustainable Development Goals (goal 3 targets 3.8 and 3c).

Health Sector Strategic Plan V (HSSP V; 2021-2026) has taken note that Non-communicable diseases (NCDs) such as cardiovascular diseases, diabetes, cancer, chronic respiratory diseases, injuries and mental health now contribute about a third of all deaths in the country and are a source of an increasing disability in Tanzania. It is estimated that there was an increase of NCDs deaths from 27% in 2010 to 33% in 2016. The HSSP V has also taken note on the importance of improvement in preventive services through sensitisation of communities on communicable diseases (CD) such as COVID-19, HIV/AIDS, viral hepatitis and neglected tropical diseases (NTDs).

Table 1: Proportional mortality in 2016

Disease Category	Percentage
Non-communicable diseases (NCDs)	33%
Cardiovascular disease	13%
Cancers	7%
Chronic respiratory diseases	2%
Diabetes	2%
Other NCDs	10%
Communicable, maternal, perinatal, and nutritional disorders	56%
Injuries	11%

Source: NCD Country Profile, WHO, 2018

Available NCDs data are derived from the last STEPS survey conducted in 2012. It is not yet possible to interpret recent trends in NCDs. Hospital data show that NCDs are increasing yearly. There was a dramatic increase in the number of NCD cases in 2019, compared to 2017 and 2018 (according to HSSP V). Injuries that OP faced in their life course may later pose a need for assistive devices to be availed to those in need. Hence the importance of data on mental health, neurological conditions and accidents among OP cannot be overemphasized. Limited interaction with OP are forerunners of some mental ill-health conditions; and this has to be changed by re-introducing interactive visits to OP, encouraging walking together, chatting, merry making, exchange of views (social clubs, as well as measures to minimize occurrence of accidents).

1.1 National policy directives

In Tanzania the National Ageing Policy[4] has taken into consideration the United Nations Organization Declaration No. 46 of 1991 on the following older people's rights:-

- Independence
- Participation
- Care
- Self – fulfilment
- Dignity

That older persons are recognized by the National Ageing Policy[5] as a resource that should be optimized in the national development agenda, presents a fairly strong base from which to have a robust institutional arrangements for older persons' access to quality health services and care in a well thought out conceptual design that critically considers their multi-morbidity context and unique needs that cut across sectors. The National Health Policy[6] states that older people who qualify to get health services without paying are those who are unable to contribute to cost sharing. The main objective of the health policy is to improve health and health status of all Tanzanians with a focus on those most at risk by establishing a health service delivery system that meets the needs of citizens and increase the life expectancy and quality of life of citizens.

A supportive environment for making good progress in ensuring quality health care and attention to Older People's concerns is in place in Tanzania; the evidence is as follows:

- After independence the Country embarked on the fight against Ignorance, Poverty and Diseases.
- During early 1970s the Country established the Basic Health Services Focus that attended both rural and urban settings
- Since 1978 the Country accepted the Health for All policy and strategy (PHC)
- The National Health Policy is functional and OP supportive
- A functional Sector Wide Approaches (SWAp) was established since the late 1990s and this is supportive of HSS and work across sectors

[4] URT MoLYDS 2003. National Ageing Policy p 9
[5] URT MoLYDS 2003. National Ageing Policy p 5.
[6] MOHSW, National Health Policy of 2007

- Supportive Alignment and Harmonization (A&H) of Development Partners assistance assists in encouraging the momentum to pool resources and strengthen management structure(s) in terms of accountability.
- Institutional flexibilities to pool and govern pooled financial resources and possibilities to legally enable the arrangement under decentralization.
- Equity underwrites Socio-Economic development policies and strategy with grassroots attention through the Tanzania Social Action Fund (TASAF) engagements.
- As one examines the content of NCD Alliance educational materials the practical exercises and behaviours promoted show 'Healthy Ageing' has been adopted and promoted to some degree as a prevention strategy.

1.2. From Strategy to Implementation

A context specific condition for the strategy's applicability is:-

Presence and commitment to OP's continued contribution to societal development is a cherished value amongst key social segments and society overall and therefore guaranteeing OP unimpeded access to health care has to be covered under the country's Social Security structures and regulations. Attention and care to OP should be handled at all levels of the health care delivery system from Community (Household) level to National level (Tertiary Hospitals). All levels of health care should have capabilities to deliver quality health care services to OP at all times.

Presence of extended family support norm and culturally determined practice of caring for OP is 'gold' readily available amongst us. Maintenance of this cultural practice shall be optimized to take on board measures to reduce morbidity episodes (active ageing and healthy lifestyles), contribution to pooling resources, and the poorest claiming health care access facilitation from pooled funds.

Operating Principles as an endeavour to implement this guideline include:-

- Attain equity through universal access to health care services for OP
- Integrated all-inclusive Care for the OP
- Solidarity as a basis for sustainability
- What OP value is supreme – hence handled with respect.
- Do no harm – avoid overmedication
- OP participation in designing and advocacy for healthy ageing.

1.3. Summary of issues from the NSPHSOP

a) As people age, their health conditions and diseases tend to become more chronic, complex, and multiple – poly pharmacy may compound their problems. Staff competencies have to be put in place as part and parcel of implementation.

b) Funds to pay for OP's health care are often not available at respective Local Government Authorities (LGAs) resulting in negatively affecting the exemptions policy. This call for broadening the financial resource base aiming at sustainable ventures going forward.

c) Non-availability of correct and adequate data on OP situations, and insufficient documentation of patterns of illnesses and frequencies of NCDs and CDs among them. Corrective measures in health information shall be taken to enable data driven planning and forecasting.

d) Health professionals in leadership positions fail to address care for older people within the immediately available resource envelope when they have limited knowledge and attitudes to enable OP to benefit from befitting access to health care (few District Medical Officers (DMOs) and District Executive Directors (DEDs) have shown committed leadership). Leaders sensitization has to be included in implementation tasks to gain efficiency, effectiveness and engender positive impact on OP lives.

e) Geriatric care competency is limited amongst existing health cadres. Curriculum for Short courses as well as longer duration courses shall need to be rapidly established and implemented in order to quicken the pace of addressing skills gaps.

f) Apart from youth activities in sports and games there is limited engagement in Active Ageing activities among higher age cohorts. Appeals to higher age cohorts shall emphasize the urgency and benefits of the physical activities.

Public health professionals have been vocal in anti-tobacco and alcohol abuse prevention advocacy; drugs and other substance abuse prevention have been attended but to some degree. A more systematically organized Healthy Ageing advocacy would eventually change lifestyles for improved mental health, prevention of NCDs, disabilities and optimal liver and lung functions besides other disease management and prevention benefits.

2.0. OBJECTIVES OF THIS GUIDELINE

The NSPHSOP covers a broad menu of issues and ways to address them. In order to render it feasible to implement, it has to be understood and internalized by various role players. This implementation guideline is supposed to facilitate role players to capture a roadmap for essential actions to get the strategy intentions realized in practical terms. Key objectives of this implementation guideline include:

2.1 To facilitate a common understanding of the NSPHSOP at all levels of its use.

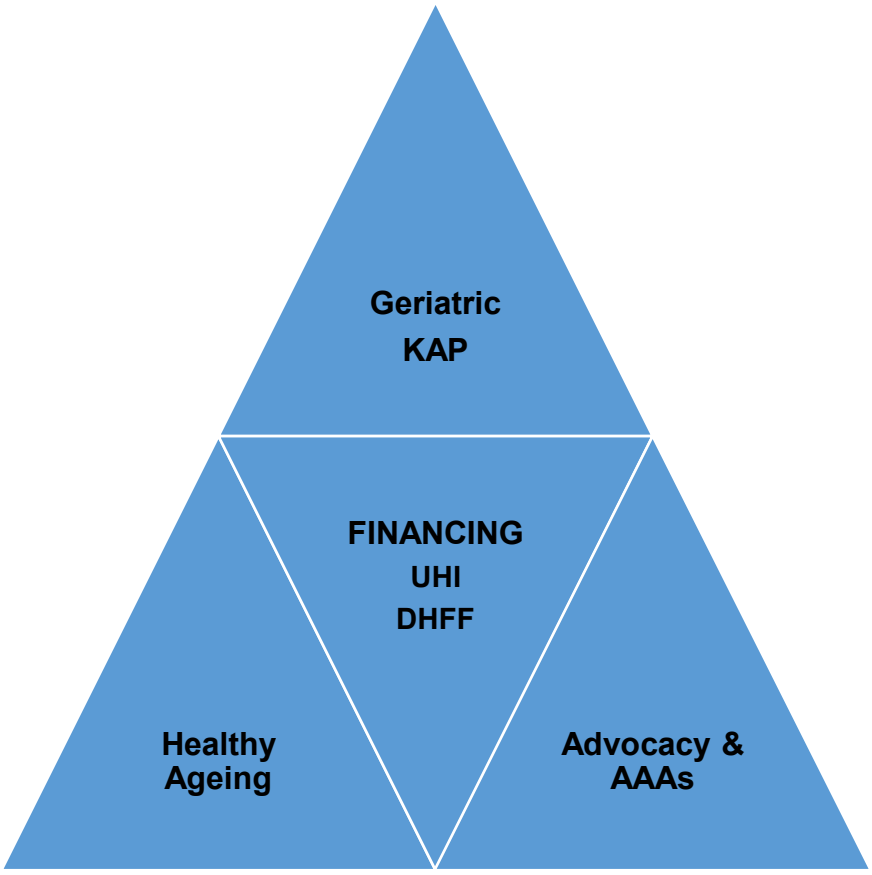
2.2 To enable Councils and Health Facilities (Public and Private) to plan for the delivery of quality health services to OP in their respective areas of jurisdiction and hence facilitate uniform implementation of the NSPHSOP.

3.0. IMPLEMENTATION FRAMEWORK

The implementation framework of this guidelines spins around four key areas namely: Geriatrics; financing; health ageing; and advocacy and establishment of active ageing clubs.

3.1. GERIATRICS

Knowledge, Attitudes and Practice (KAP) on care for OP stands out as a discipline in the health system to ensure no one is left out as the UHC strategy is taken forward into tangible actions. Health Staff at primary level facilities shall be capacitated through short courses to provide quality health services addressing needs of OP. Secondary and Tertiary level health institutions shall be obliged to seek for Geriatrics trained postgraduates and specialists. A development programme to establish this professional discipline has to be handled by higher level academic institutions in Health closely working with University Teaching Hospitals. Specifically this shall include review of various undergraduate courses and post graduate levels (At time of developing this implementation guideline ordinary Diploma in Clinical Medicine and MMed- Internal Medicine has module for Geriatric).



3.2. FINANCING

OP in Tanzania as in other many African countries lack access to reliable health care financing, a situation which is detrimental to healthy ageing as it is known that OP faces various health challenges which require huge financial costs. According to World Health Organisation (2010), reliable health care financing mechanism is an important factor for healthy ageing[7]. Financing is at the centre stage of this implementation guideline because as it will require pooling resources across population groups and ensures efficient risk sharing and is particularly important for ageing populations. Deliberate pooling for the sake of ensuring OP benefit from UHC policy is in line with the Sustainable Development Goals (goal 3 targets 3.8 and 3c). The establishment of Universal Health Insurance (UHI), contributions from health facilities (in form of waiver of some provided services) and establishment of any other feasible financing mechanisms carry potential to become sustainability avenues towards financing delivery of health services to OP. A reliable fund for health care financing of the elderly is the responsibility of household, community, state, and non-state actors available in the country.

3.3. HEALTHY AGEING

Pursuit of Healthy Ageing through regular exercise, optimal nutrition, body hygiene and safe environment, social visits, inclusion in events that are within the OP's ability to attend and participate, constitute effective prevention interventions that augment therapeutic measures among OP with a complement of improving quality of their lives. In summary it is the pursuit of healthy lifestyle including avoiding insidiously injurious entities like excessive indulgence in alcohol consumption, tobacco smoking, unsafe sex practices, drugs and substance abuse at all ages and living in pollution ridden environment as one sails from junior to advanced age cohorts of the life course.

3.4. ADVOCACY AND ESTABLISHMENT OF ACTIVE AGEING CLUBS

At either multigenerational Associations or OP Forums efforts to popularize active engagements, mind-sets change, appeal for inclusion in all social events as part and parcel of the agenda/menu. Active ageing clubs are required to be established in various localities which should be composed of various age cohorts including OP. Communiy members are anticipated to include OP in various organized social events such as sports and games, cycling, fund raising charity walks, walking visits, attending various celebration parties or competition events, deliberate or unplanned social visits to one another, physical exercises at agreed locations, gyms or at home.

Cohorts such as 20-39, 40-59 and 60-79 years are challenged to conduct entertainment-educative events that shall be optimized for mutual benefits at existing clubs, new ones or religious congregations at churches or mosques. Benefits from AACs include reduced

[7] World Health Organization. The World Health Report: Health Systems Financing. Geneva, Switzerland: WHO Press; 2010.

number of disease episodes per individual per unit time, improved physical, mental and social wellbeing of members. The advocacy shall be effected on variable-interval schedule focussed on promoting, following up and reinforcing community based supervised interventions through various modalities such that it becomes part of Tanzanian cultural norms guiding practice.

4.0. ORGANIZATIONAL HOME

Families and household members have the primary role of being the first in care giving to an OP. Hence experience in running Home-Based Care under HIV/AIDS activities should be optimized and extended to cover OP care at home settings. The bulk of the implementation and contacts with OPs shall happen at home, communities and primary health care facilities. Institutional support to monitor regularly how physical, mental and social needs of the elder are addressed at households (*Refer Household and Self-care package in annex*) can be addressed via the agency of Social Welfare cadres and Community Health Workers.

This implementation guideline has many specific interventions of the Ministry of Health, it also includes a fair proportion of cross cutting aspects that call into action agencies and institutions that are answerable to other sector ministries. A significant portion of policy, systems development and technical support shall originate from the Ministry of Health: The ministry shall be the key driver of the program and its overall coordination.

But considering the current arrangement where primary health care facilities and community based health care organizational activities fall under the PMORALG by virtue of proximity and contact with the population, it makes practical sense to operationalize the greatest bulk of primary OP care activities under oversight and coordination of respective LGAs. The PMORALG has a critical role to keep the momentum of implementation at an optimal dynamic so that the desired change for better OP care near home is ensured in the context of Universal Health Care coverage.

5.0. GOVERNANCE AND LOCAL ACCOUNTABILITY

Oversight of care for OP shall not have a parallel governance and accountability arrangement but it shall utilize these structures and in the process pay attention to debating and coming up with actionable resolutions on how the structures can be rendered more effective where weaknesses are observed. Existing structures shall be utilized and oriented to provide the function of governance and accountability.

From a national level perspective the governance framework outlined in HSSP V (section 6.3) should inform the various players and responsible focal points to contextualize the section such that it addresses needs of OP health care, OP issues governance and accountability, as well as strengthening leadership aspects such as working in consultation with OP Forums and timely responding to critical needs of OP.

5.1. MoH Level

A subunit/desk overseeing OP health related issues has been established. It will have at least three senior officers (Medical/Dental, Nurse Officer and Social Welfare Officer). The subunit will be within the Directorate/Division overseeing Curative Health services.

5.2. PMO RALG Level

Within the Health,Social Welfare and Nutrition Services Division, health and social welfare related issues of OP will be overseen by a team of three senior Officers. Will be headed by Coordinator of Elderly services assisted by Coordinator of NCD services and Nurse Officer.

5.3. Regional Level

Within the Regional Health Management Team, isues related to OP are overseen by Social Welfare Officer (RSWO). In coordinating issues related to health of OP, RSWO shall be assisted by Regional NCD Coordinator and Regional Nutrition Officer.

5.4. Council Level

Within the Council Health Management Team, isues related to OP are overseen by Social Welfare Officer (CSWO). In coordinating issues related to health of OP, CSWO shall be assisted by Council NCD Coordinator and Council Nutrition Officer.

5.5. Health facility level

Each staff at respective health facility shall be required to pay attention to OP if stranded while seeking health services. However for coordination, there shall be a team that is responsible of elderly health issues. It will be composed by a Clinician, Nurse and Social worker.

In each area of jurisdiction particular Hospitals Advisory Boards (for Regional Referral Hospitals), Council Health Services Boards, Health Facility Governing Committees (Council Hospitals, Health centres and dispensaries) shall be briefed to take up the oversight responsibility and providers be accountable to these structures that include community representation.

Experienced NGOs that have been undertaking quality of care monitoring and performance accountability monitoring using the Community Score Card shall be encouraged to extend their activities to cover OP care monitoring along with their current areas of responsibility. The same approach shall be applied with respect to disease measures i.e. NGOs that have technical expertise in prevention and public health practice can draw from their experiences in Alcohol and Tobacco harm aversion measures, drugs and substance abuses, Covid 19 response, and HIV/AIDS to name a few. In this sense the area of governance shall gain from Public Private Partnership arrangements.

6.0. ROLES, RESPONSIBILITIES AND TASKS

6.1. BY SECTOR/MINISTRY

National Role	Essentials to be done	Tasks	Action Focal Points
MoH – Leadership, educating the public on OP care	Dissemination of the NSPHSOP and other educational materials on health care for OP including the Implementation Guide for the ten-year strategy.	1. Launch the Strategy with wide prior publicity of the event 1.2 Organize dissemination event 1.2.2 Translate the documents into Kiswahili version. 1.2.3 Print enough copies of documents for distribution. 1.2.4 Allocate budget for initiating OP care awareness and need for effective support services 1.2.5 Provide sponsorship in geriatric course 2. Brief all Directors and section leaders on content of the NSPHSOP and content of its Implementation Guideline 3. Organize working sessions for Regional referral, Specialized, Zonal and National Hospitals to examine completeness of the Geriatrics practice menu for the higher level and make inputs to render it more complete. 4. Plan for establishing Geriatrics care discipline at the Regional, Specialized, Zonal and National Hospitals.	Director of Curative Services
MoH new program oversight	Track strategy orientations and briefings	1. Create an Older People's Unit (OPU) staffed by a Senior Doctor, Senior Nurse and Senior Social Welfare Officer.	DCS in consultation with CMO

	Coordinate and Monitor implementation guidelines compliance, Compile various reports and submit to Senior Management in MoH and PMORALG	2. Appoint them; assign them with job descriptions including regular reporting of progress at Senior Management Meetings	
Sharing operational tasks effectively	Mobilizing middle and lower levels to internalize the OP's Health care Strategy implementation guideline content and their tasks to move it forward.	3. Post the documents on the MOH website and other easily accessible web education points in the country. 3.1. Collaborate with PMORALG to prepare presentations that inform as well as assign responsibilities and tasks to RMOs and DMOs at their Annual Conference 3.2 Brief the paper presenters ahead of the conference. 3.3 Assign the documentation of views shared, issues raised and unforeseen challenges by Conference participants and provide guiding responses accordingly.	OPU & DICT
Transformative (perceptions, attitudes and practices) supported by hard evidence	Educate the society for behaviour change to be better informed about psychosocial aspects of OP health care and embracing HA practices.	Organize a meeting of Councils/governing structures of all (faith communities and local authorities at all levels) to orient them to the Older People Health Strategy objectives, organization going forward, and activities of major institutions and the overall process to move forward healthy ageing and its forerunner namely active ageing. Share details of the following activities at the meeting:	Health Promotion Head

		1. Conducting advocacy and educational sessions (on Healthy Ageing and establishing AACs) in social media, newspapers, radios and TV channels. 2. Engaging artists and musicians to develop competitive works of art, theatre, educative entertaining songs on AACs and HA. 3. Drafting short and easy to convey messages and channel them as sms through telephone companies as 'phone for health of OP' and WhatsApp groups messages or videos. 4. Channelling the advocacy and educational materials to Schools, Faith congregation leaders, political campaigns and social development campaigns, using short stories, theatre depicting short accounts of live field practices that OP face etc. 5. Collaborating with Physical Activity Association of Tanzania (PAAT) to broaden the establishment and coverage of AAAs and AA Clubs countrywide. 6. Contracting experienced NGOs and Implementation Research experts to document BCC impact at communities and come up with workable recommendations for further improvements.	
Technical education	Promote pro-health behaviours	Source Kiswahili constructed educational pamphlets or booklets on disease prevention and management from all programs and organize wide dissemination to reach OPFs (e.g., NCDs Alliance reader in	DCS assisted by DPS

		Kiswahili is pro Older People and hence a pragmatic example).	
Establishing operational procedures (SOPs)	Organize a camp of Clinicians and Senior Nurses to outline SOPs for Older People health care for tertiary, secondary and primary levels of health care referring to NCDs as a focal entry point.	Select Clinicians, Nurses, Pharmacists, Physiotherapists and Mental Health professionals who have experienced caring for an older person and have sufficient insight 1. Produce a draft of OP health care SOPs guided by clinical and nursing texts together with Standard Treatment Guidelines[8]. 1.3 Ensure inclusion of clear feedback loops for any referred patients[9]. 2. Translate the draft into Kiswahili. 3. Clear the draft through Professional Councils 4. Print and disseminate the SOPs 5. Avail guidance on use of the SOPs to health facilities via phones for health and social media 6. Monitor the implementation of SOPs	DCS
Capacity and competencies development	Assign a team of Clinicians, Nurses and Tutors to engage in curriculum development for building know how and skills on geriatric care	1. Organize once per year Continuous Professional Development sessions by distance-learning for all health and social welfare cadres. 2. Establish geriatric care services units/ departments (human resource and infrastructure at all levels) in order to be more effective in dealing with NCDs and other	DCS assisted by Director HRD and Management

[8] MoHCDGEC 2021. Standard Treatment Guidelines & NEMLIT sixth edition
[9] Mo
HCDGEC, 2020. National guidelines for patients/clients referral at all Health Facility Levels pg. 16.

		geriatric health care services for OPs. 3. Facilitate establishment of Post graduate programme in Geriatrics at institutes of higher learning.	
Evidence drive	Strengthening M&E on OP care	1. Ensure availability of high-quality data on NCD and selected CDs risk factors, morbidity and mortality reported by age, sex, location and by other demographic and social determinants is available. 1.1 Monitor and report on capacity development for NCDs prevention. 1.2 Monitor progress in Health Promotion interventions/approaches targeting modifiable risk factors. 1.3 Monitor and report on health system reorientation activities to address NCDs prevention, curative and rehabilitation services 1.4 Monitor and report on NCDs surveillance and research for evidence-based planning. 2. Compile, analyse and use the emerging information for planning and monitoring of effectiveness of NCD and selected CDs interventions and country capacity according to national NCD and selected CDs monitoring framework. 3. Attend NIMR annual scientific conference to present OP research findings including NCD and selected CDs with the aim of	Directo M&E

		promoting utilization of the research findings. 4. Follow up (electronically or otherwise) the multi sectoral commitments action implementation.	
Resources and legislation considerations debated	Engage Parliamentarians to debate OP predicament and what society can do in the spirit of self-determination and self reliance and advise the Government on steps to be taken to address the situation	MoH in collaboration with PMORALG to hold high level consultations to prepare for engaging Members of Parliament in better organization of OP care for the benefit of optimizing their accumulated knowledge and experiences and ensuring proposed legislation on Mandatory Health Insurance yields intended results in a frame of efficient and effective financial resources mobilization and investment. ✓ Organize a meeting to brief the Parliamentary Social Services Committee on a new approach to OP health care covered in the NSPHSOP and implementation guide. ✓ Prepare a briefing paper for presenting to Parliament Secure Parliament's feedback on the best way forward and indication of the best point to assign the role of organizational coordination of the OP care initiative.	PSs, CMO, DPP, and Director of Health, Social Welfare and Nutrition Services in PMORALG
Synergies, complementary effects and sustainability	Convene an advocacy meeting involving multi-sectoral Stakeholders to deliberate and register their commitment to address health care for Older	1. Invite high level officials from PMO, PMORALG, Education (secondary and tertiary), Industries and Trade, Youths and Sports (MCAS), Community Development, Gender, Women and Special Groups (MOCDGWSG), Home Affairs, NSSF, PSSSF, MOF&P, NHIF, NGOs, CSOs and FBOs,	PS assisted by Director of Policy and Planning and Head of Health Sector Resources Secretariat

	People and related issues, in addition to firming up their roles and responsibilities in supporting Healthy Ageing and requisite investments in OP care.	Business Community via Chamber of Commerce, Mining Conglomerates, Agriculture Livestock and Fisheries, Land Housing and infrastructure development, plus Tourism sector. Solicit statements from respective participants to clarify the extent to which their policies and/or strategies reflect on and attend to Healthy Ageing and Active Ageing before and after reaching older age. 2. Prepare and present sector or institution specific issues papers to guide the deliberations 2.1 Present the AU protocol on rights of Older People for discussion 2.1.1 Recommend concrete steps to be taken to attain its ratification and roll it into implementation. 3. Agree on a follow up frame that shall monitor performance and report progress and challenges at annual or preferably two yearly Healthy Ageing conferences 4. Invite presentation of sector specific commitment progress, unforeseen challenges and solutions at the two-yearly HA conferences.	
Partnership and governance	Orient DPG-H and other SWAPs Stakeholders to gain their support and views for further improvements on the OP care initiative.	1. Prepare papers for presentation at MoH Technical Committee and SWAp Annual Review to register DPs commitments to OP Health Care support. 2. Propose an accountability approach to oversight	Director of Policy and Planning and Head of Health Sector Resources Secretariat

		performance of OP health care effectively	
Evidence	Select indicators for M&E on OP health care covering key thematic areas in the strategy, the implementation guideline and progress tracking in routine, medium to longer term and modality for capturing the requisite data.	1. Define key M&E outputs to inform a focussed action plan to inform progress, capacity aspects and systems responsiveness** 2. Conduct meeting to select and refine indicators on NCDs and selected CDs reduction plus other program elements including disaggregation by rural/urban, age and sex, regional and Council distributions 3. Follow up (electronically or otherwise) the multi sectoral commitments action implementation. 4. Monitor and report on capacity development for NCDs and selected CDs prevention. 5. Monitor progress in Health Promotion interventions/approaches targeting modifiable risk factors. 6. Monitor and report on health system reorientation activities to address NCDs and selected CDs prevention, curative and rehabilitation services 7. Monitor and report on NCDs and selected CDs surveillance and research for evidence-based planning.	Director M&E
Planning ahead	OPU biennial work plans focussed on program development and oversight of progress and challenges.	1. Collect reports on what has been ongoing in relation to OP care and support countrywide (mapping OP care initiatives) 2. Encourage individual and NGO initiatives to link up with relevant regional and Council	OPU

	OPU networking with prime movers and innovators	authorities to foster learning from each other. 3. Keep an inventory of AACs or Active Ageing Associations that have been started, encourage innovators and invite news media to visit, observe, participate and propagate messages from innovative works for OP (such as BEES initiative in Segerea, Tanga OP clubs etc) 4. Develop and get approval for a biennial work plan for the OPU that addresses promoting new developments for moving the implementation guide forward, analysing field reports on progress from Regions and Councils, documenting best practices and lessons, tracking thematic areas progress (AA, HA, Geriatrics, Innovative financing), checking how monitoring of SOPs is done, track other sectors progress on their respective commitments. 5. Appeal to Innovators on HA and AA to publicize their initiatives using various media and a variety of communication channels. 6. Engage with Environmental Health experts and Social Scientists to set up a campaign for urban Good Neighbourhoods (uGN**)** health pursuits, security, environment friendly engagements such as kitchen gardening, sanitary waste disposal, water supply protection and safe nutritious foods promotion. 7. In consultation with Social Welfare design a package of	

		services to address mental and social needs of the elders through the agency of grassroots level Social Welfare Staff	
Health Action by all – a shared noble responsibility	Define a Healthy Ageing program content and its promotion/advocacy framework	1. Invite key stakeholders to a consensus generating meeting on a medium to long term national program on Healthy Ageing. 2. Define key content and contextual factors to be addressed in the HA Program and its operating principles*, as well as clarifying involvement of different age cohorts (30-40, 41-50, 51-60, Over 60), promoting AACs clubs, uGNs, social-cultural events and AACs linkage and support from OP Forums (Mabaraza ya Wazee ya Vijiji na Kata). 3. Outline the program promotion and its wide publicity. 4. Promote families and individual participation in Universal Health Insurance	OPU & Key Stakeholders
Care and therapy	Forecasting of medicines and supplies needed to ensure inclusion of OP health care items and assistive devices	1. Use currently available data from health facilities to forecast medicines and supply needs ensuring adequate estimates are made to cover OP morbidity and disabilities 2. Use the latest Standard Treatment Guidelines (13) to source therapeutic measures on OP conditions such as NCDs etc.	Chief Pharmacist

6.2. Regional and Council level

Role	Essentials to be done	Tasks	Action Focal Points
Informing Region OP Stakeholders	Feedback to extend the national sharing sessions content	1. RAS to convene a Regional OP Stakeholders meeting (multisectoral key actors) to focus on the following: ▪ Presenting a detailed briefing and orientations from the RMOs and DMOs Annual Conference regarding OP care and developments to establish Geriatrics care discipline in the Health System. ▪ Get an appraisal of the functioning of Older Peoples' Window – availability of Equipped Space, Medicines and Staff (Medical Doctor, Nurse and Social Welfare Office). ▪ Agree on inclusion in the CHOP, Health CCHP and Facility Plans of OPs issues including Budgetary allocation. 2. Register individual and institutional commitments of Regional Stakeholders to the OP care implementation guidance. 3. Provide guidance that Older peoples' health related issues is a permanent agenda in Regional and Councils' decision-making forums	RMO
Attending to Geriatrics at RRH	OP health package fully addressed at the RRH	1. Brief RRH Board on implementation requirements for implementing the OP Strategy and Implementation Guideline content.	MO i/c and RRH Management

Role	Essentials to be done	Tasks	Action Focal Points
		2. Interpret the operational details of the OP package topics for the RRH level (Annex 2.4) 3. Cross-check geriatric care requirements for the RRH making reference to what is suggested in the NSPHSOP and propose essential steps to realize capacity to discharge this service effectively at the RRH.	
Regional – Oversight Council compliance	Supervise and monitor compliance to national directive on inclusion of Older people health care costs in all Health Facility Plans at Region, Councils, Health Centres and Dispensaries	Receive and review CHOP. CCHPs and RRH Plans to ascertain their inclusion of OP care intent and costs.	RMO assigns RHMT
	Follow up compliance to SOPs at supervision visits	1. Orient QITs and WITs on using SOPs for OP health care service monitoring 2. Observe regular QITs reporting of performance on OP health care, including supervision, mentoring and coaching.	QI Focal Persons in RHMTs and CHMTs
Councils Oversight Primary Health Facility compliance	Supervise and monitor compliance to national directive on inclusion of Older people health care costs in all Health Primary level Facility Plans (at Councils Hospital, Health Centres and Dispensaries)	1. DEDs to convene a Council OP Stakeholders meeting (multisectoral key actors). 2. Present the detailed briefing and orientations from the RMOs and DMOs Annual Conference regarding OP care and developments to establish Geriatrics care discipline in the Health System and advocacy for Healthy Ageing and Active Ageing including:-	DMO

Role	Essentials to be done	Tasks	Action Focal Points
		✓ Functioning Older Peoples' Window – availability of Equipped Space, Medicines and Staff (Medical Doctor, Nurse and Social Welfare Office). ✓ Inclusion in the CCHP and Facility Plans of OPs issues including Budgetary allocation. 3. Register individual and institutional commitments of Councils Stakeholders to the OP care implementation guidance. 4. Brief the Full Council on new developments in OP care and present the output of the Councils Stakeholders' meeting where capacity development, AA and HA were shared and discussed. 5. Organize a seminar for orienting different Stakeholders operating at Council level (including Faith leaders by optimizing the interfaith entry point), to Older People care, healthy lifestyles, and active ageing in order to get the participants to relay the message that concrete learning about old age care, lifestyles and active ageing shall become topics for discussion and action deliberations every week. 6. Promote families and individual participation in Universal Health Insurance 7. Promote families, individual and communities to lead healthy lifestyle and healthy eating habits	

Role	Essentials to be done	Tasks	Action Focal Points
		(nutritionally balanced meals at right times) 8. Promote psychosocial care and support to OPs	
Council – Oversight Health Facilities compliance and Ward level engagement	Guide Ward Elders' Councils to promote Active Ageing and Healthy Ageing	1. Orient Ward Elders' Councils to the benefits of having Older People Forums (OPFs) and how these could be practitioners of AA and HA.	LGA – DED
	Provide orientation to Health Facility Staff on the OP Health Care Implementation Guide	1. Conduct seminars on OP care Implementation Guide familiarization and compliance at Health Facility supervision visits. 2. Facilitate Health Facility Annual Planning to include OP care according to the package topics approved for the level (Annex 2.2 for first line facilities and 2.3 for Council level 1 Hospital)	DMO
Assuring finances	Guide Health Facility Teams to include an item to meet Older People (OP) health care costs in the Direct Health Facility Financing planning framework.	1. Estimate health care costs for OP and reflect in CCHP and Health Facility Plans 2. Audit orders of medicines and supplies to ensure inclusion of OP health care items and assistive devices according to commonly expressed/observed needs. 3. Assign a dedicated staff to manage the OP health service section otherwise fast track OP at regular OPDs 4. Promote families and individual participation in Universal Health Insurance including sensitizing families, individual and communities to	Health Facility i/c

Role	Essentials to be done	Tasks	Action Focal Points
		lead healthy lifestyle and healthy eating habits. Promote psychosocial care and support to OPs	
	Expose Staff in all Health Facilities to SOPs for OP health care	1. Orient QITs and WITs on use of SOPs for OP health care service monitoring 2. Observe regular QITs reporting of performance on OP health care 3. Orient staff at Health Facilities to SOPs of OP health care	QI Focal Persons
Ward and community leadership	Orient Ward and Community leaders on health service delivery to OPs at FLH Facilities	1. Facilitate OPs to improve health seeking behavior (at formal health facilities learning from others who have already started this practice. 2. Facilitate inclusion of assistive devices as part of supplies for OP care according to identified needs	HF i/c
	Leadership for community empowerment for health promotion and prevention of NCDs	1. Orient CHWs and other community groups on NCDs prevention through health promotion and advocacy tools. 2. Convene and supervise annual planning of activities to deliver the Community Package for OP (Annex 2.2 opening text) by CHWs and other resource persons at community level. 3. Promote families and individual participation in Universal Health Insurance	HF i/c with WEOs
Villages and Hamlets engagement	Follow up Elders Councils to advocate for AAAs and Older Peoples Forums (OPFs)	1. Conduct an orientation meeting for Ward level Staff and Leaders of Ward Elders' Councils on OP health care implementation guide.	Social Welfare Officer at Ward level.

Role	Essentials to be done	Tasks	Action Focal Points
		2. Facilitate discussions on HA and AA to generate action proposals to constitute AACs and OPFs. 3. Follow up implementation and report to WDC for subsequent transmission to the LGA for their record and acknowledgement. 4. Promote families and individual participation in Universal Health Insurance	
	Guide OPFs to run Healthy Ageing activities as per implementation guide.	1. Provide OPFs brief written notes on Healthy Ageing aimed at stimulating physical activities, nutritious diets and fun making at regular weekly socializing sessions 2. Schedule visits to at least three to four OPFs monthly for encouragement, recording challenges and discussing solutions. 3. Promote families and individual participation in Universal Health Insurance 4. Submit summary reports to LGA (SW Officer) on OP care issues, HA and AAAs progress plus regularity of OPFs	Social Welfare Officer at Ward level

6.3. Referrals and feedback communication from health facilities

Feedback loop is made up of two elements: (1) an outward referral, which communicates the patient/client condition and status to the receiving facility, (2) feedback from the receiving facility to the initiating facility indicates how the referred patient was managed and any continuity of care that the client should receive at the initiating facility. When sending an OP home after health facility care very clear written instructions of advice and

measures recommended for application at home must be given to a responsible carer that takes over from the health care facility. The person that escorted the OP that needed higher level care shall be assigned the responsibility to deliver the feedback communication and ensure compliance with the care instructions.

7.0. MONITORING AND EVALUATION

7.1 Monitoring and evaluation framework

Monitoring and evaluation is an essential element of every step in implementation of the national strategy for the provision of health services to OP, as it provides a way of assessing the progress in achieving its goals, objectives and activities and informing key stakeholders about the results.

During the implememtation of this strategy monitoring and evaluation will be guided by the M&E framework and M&E plan as reflected below in **table No. 1** and **2** respectivelly. The M&E framework includes goal to be achieved, the outcomes and outputs after implementation of activities as reflected in M&E plan of this implantation guideline.

The M&E plan will specify the specific indicators and data sources that will be utilized to measure key outcomes related to elder health, well-being, and access to essential services. It also delineates the frequency of data collection, responsible parties, and the methods for data analysis and reporting. Moreover, the plan highlights the mechanisms for feedback and continuous improvement, allowing policymakers and stakeholders to make evidence-based decisions, identify areas for intervention, and ensure the guideline's successful impact on enhancing the overall care and support provided to the elderly population. The definition of each key indicators used to monitor progress of service to OP has been provided in **subsection 7.2** of this document.

Table No. 1 M&E framework: Key performance indicators (KPI's) for implementation of national strategy for provision of health services to older people.

Goal	Objective	Outcome	Output	Indicators	Indicator Type	Baseline - 2020	Targets - 2031	Data Source	Frequency
Healthy ageing attained at a high level, for the benefit of national development and benefit to the OP.	Prevention and Control of Communicable, Non-Communicable and Neglected Tropical Diseases Improved.	% of OP protected against incidence of Communicable and non-communicable diseases	Incidence of Communicable and non-communicable diseases to older people reduced	Proportion of OP with access to essential healthcare services.	Outcome	52%		DHIS2	Annualy
		% of OP supported to activities of daily living (ADL's).	Mobility to older with activity limitation and participation restriction improved	Proportion of OP with access to assistive products services.	Output	0.0%		DHIS2, Cummunity records	Annualy
		% of OP protected against chronic diseases prevalence.	OP reported with common chronic diseases reduced	Prevalence of common chronic diseases (hypertension) among older people	Outcome	11.2%		DHIS2	Annualy
				Prevalence of common chronic diseases (diabetes) among older people	Outcome	4.2%		DHIS2	Annualy
		% of healthcare facilities providing age-friendly services.	Healthcare facilities with age-friendly services increased.	Percentage of healthcare facilities that are age-friendly.	Output			Administrative records: MoH	Annualy
		% of older people protected against incidence of Communicable and non-communicable diseases	Incidence of Communicable and non-communicable diseases to older people reduced	Proportion of elders who have received health education and preventive care information.	Output	0%		Cummunity records	Annualy

Goal	Objective	Outcome	Output	Indicators	Indicator Type	Baseline - 2020	Targets - 2031	Data Source	Frequency
		% of staffing with skills to provide age-friendly services strengthened	Prevalence of diseases among older people reduced	Number of Health Care Workers Trained on Age-Friendly Service (doctors, nurses, therapists, social welfare officers) for geriatric service.	Output	0%		Administrative records: MoH	Annualy
		% of older people protected against incidence of Communicable and non-communicable diseases	Incidence of Communicable and non-communicable diseases to older people reduced	Percentage of elders who participate in social activities or community programs (community gatherings, clubs, or volunteering).	Output	0%		Community records	Annualy
		% of OP protected against incidence of Communicable and non-communicable diseases	Incidence of Communicable and non-communicable diseases to OP reduced	Mortality Rate among OP aging to 60+	Impact			DHIS2	Annualy

Table No. 2 M&E plan with Gantt chart– activities for implementation of national strategy for provision of health services to older people.

Objective	Specific Objectives	Activity	Resources	Budget (lumpsum)	Period (FY's)					Responsible person
					2026/27	2027/28	2028/29	2029/30	2030/31	
Prevention and Control of Communicable, Non-Communicable and Neglected Tropical Diseases Improved.	To enable relevant authorities and Health Facilities (Public and Private) provide age-friendly health services to older people in their respective areas of jurisdiction.	To conduct 5 days capacity building to 600 healthcare workers from 200 health facilities on provision of quality age-friendly services to older people by June 2031.	Human, Finance, Transport, Office consumambles	600,000,000.00						DCS
	To facilitate the establishment of Geriatric Departments/Units in Health facilities and together with availability of appropriately trained Staff.	To prepare and disseminate a guideline for establishing Geriatric Units at all levels of health facilities (from Dispensary to National Referral Hospitals) to 100 key stakeholders by June 2031.	Human, Finance, Transport, Office consumambles	67,000,000.00						DCS
	To facilitate the implementation of the National Strategy for the Provision of Health Services to older people countrywide.	To disseminate National Strategy for the Provision of Health Services to Older People to 100 key stakeholders by June 2028.	Human, Finance, Transport, Office consumambles	67,000,000.00						DCS
		To conduct sensitization meeting with key stakeholders (hospital/research institutions/universities) to do research on geriatric care by June 2027.	Human, Finance, Transport, Office consumambles	- 12,000,000.00						DCS
		To conduct two days meeting for mapping stakeholder involved in health services of older people by June 2027.	Human, Finance, Transport, Office consumambles	12,000,000.00						DCS

Objective	Specific Objectives	Activity	Resources	Budget (lumpsum)	Period (FY's)					Responsible person
					2026/27	2027/28	2028/29	2029/30	2030/31	
		To develop national guideline for establishing and operationalisation of Active Ageing Clubs by June 2027.	Human, Finance, Transport, Office consumambles	28,000,000.00						DCS
	To facilitate access to quality health services by all older people according to prevailing circumstances.	To conduct 2 days advocacy meeting to 100 key stakeholders (older people, healthcare providers, and relevant authorities) on the need of providing quality and age-friendly services to older people by June 2031.	Human, Finance, Transport, Office consumambles	120,000,000.00						DCS
		To conduct quarterly supportive supervison to 200 health facilities providing age-friendly health services by June 2031.	Human, Finance, Transport, Office consumambles	160,500,000.00						DCS
		To prepare quarterly reports for implementation of health services to older people by June 2031.	Human, Finance, Office consumambles	12,000,000.00						DCS
		To conduct quarterly performance review meeting with 50 key stakeholders (older people, healthcare providers, and relevant authorities) on implementation of health services to older people by June 2031.	Human, Finance, Transport, Office consumambles	135,000,000.00						DCS

7.2. Key Indicators defininition, measurement and calculation

7.2.1 Healthcare Access Indicator:

Indicator: Proportion of OP with access to essential healthcare services.

Definition: This indicator measures the percentage of OP who have access to necessary healthcare services, including preventive care, treatment, and rehabilitation.

Measurement: Conduct surveys or analyze, healthcare facility data to determine the proportion of OP who have accessed essential healthcare services within a defined period.

Calculation:(Number of OP with access to essential healthcare services / Total number of OP) * 100. NB: N = OPD data element number 1 “new patients attended for the first time in the year at any facility in the country (*).

7.2.2 Elder-Friendly Healthcare Facilities Indicator

Indicator: Percentage of healthcare facilities that are OP-friendly.

Definition: This indicator assesses the availability and accessibility of OP-friendly healthcare facilities that meet the unique needs of theOP population.

Measurement: Conduct facility assessments or use audit tools to evaluate the OP-friendliness of healthcare facilities.

Calculation:(Number of OP-Friendly Facilities / Total Number of Operating Health Facilities) × 100

7.2.3 Health Education and Awareness Indicator:

Indicator: Proportion of OP who have received health education and preventive care information.

Definition: This indicator measures the percentage of OP who have received health education on relevant topics, such as nutrition, medication management, and disease prevention.

Measurement: Conduct surveys or review healthcare records to determine the proportion of OP who have received health education and preventive care information.

Calculation:(Number of OP who received health education and preventive care information / Total number of elders in the target population) × 100

7.2.4 Prevalence of Chronic Diseases:

Indicator: Prevalence of common chronic diseases among OP.

Definition: This indicator assesses the occurrence of prevalent chronic conditions such as diabetes, hypertension, heart disease, and respiratory illnesses among the OP population.

Measurement: Use data from health records, surveys, or disease registries to determine the prevalence of chronic diseases among elders.

Calculation:(Number of elders diagnosed with the chronic disease / Total number of OP in the population) × 100

7.2.5 Work force for geriatric services

Indicator: Number of Health Care Workers Trained on Age-Friendly Service for geriatric service

Definition: Age-friendly service training refers to educational programs and workshops provided to healthcare workers to enhance their knowledge, skills, and attitudes in delivering care that is responsive to the needs of OP. It may cover topics such as geriatric care, communication with older patients, handling age-related conditions, and promoting a patient-centered approach.

Measure: The measure is the number of healthcare workers, including doctors, nurses, therapists, and social welfare officers, who have successfully completed the age-friendly service training program.

Calculation: The calculation involves counting the number of healthcare workers who have completed the age-friendly service training and expressing it as a total count.

7.2.6 Social engagement

Indicator: Percentage of OP who participate in social activities or community programs (community gatherings, clubs, or volunteering).

Definition: Participation in social activities or community programs refers to OP' active engagement in events, gatherings, clubs, or volunteering initiatives within their communities. It includes any organized social activities that bring older adults together to interact, contribute, and foster a sense of belonging.

Measure: The measure is the number of older adults who are actively participating in social activities or community programs.

Calculation: (Number of Participating OP / Total number of OP) × 100

7.2.7 Death

Indicator: Mortality Rate among OP aging to 60+

Definition: The Mortality Rate among OP aging to 60+ is the number of deaths that occur in the population aged 60 years and older during a specific period, usually expressed as a rate per 1,000 or 100,000 population.

Measure: The measure is the count of deaths recorded among individuals aged 60 years and older during the designated time period.

Calculation: (Number of Deaths among the 60+ population / Total number of individuals in the 60+ age group) × (1,000 or 100,000)

7.2.8 Access to assistive device

Indicator: Proportion of OP with access to assistive products services.

Definition: This indicator refers to the percentage of OP (usually aged 60 years and above) who can access and utilize assistive products and services. Assistive products are devices, tools, or technologies that assist older individuals in performing tasks and activities, promoting their independence and well-being.

Measure: The measure is the count of OP who have access to and use assistive products and services. This data can be obtained through surveys, assessments, or data from healthcare facilities and assistive technology providers.

Calculation: (Number of OP with Access assistive products / Total number of OP) × 100

8.0. IMPLEMENTATION RESEARCH AND APPLIED HEALTH RESEARCH

Achievements in implementing health care for OP and sustaining those achievements gains insight from Implementation Research and Applied Health Research. The wide range of aspects to research on is best captioned in the five categories listed below. Most operational details of the respective categories are provided to the researcher in the Fifth National Health Research Agenda (2021/2022-2025/2026).

Geriatrics five focus areas that should drive research priorities include

1. Mobility
2. Medications
3. Multi-complexity
4. State of mind (Mental Health status)
5. What *matters-most* to the Older Person

The Fifth National Health Research Agenda (2021/2022-2025/2026) covers OP disease conditions majority of which are NCDs. Section 4.2 of the research agenda covers the focus area of NCDs with clearly outlined research questions per specific entity. Focus area number 1 on Community health system and number 5 on Health System Strengthening provide extra dimensions that render the research agenda for OP health care fairly comprehensive. The agenda has leverage to address the foregoing geriatric care areas except area number 5. What matters most to OP has the potential to improve compliance to interventions and hence also merits to be researched preferably by considering individual perceptions, beliefs and practices related to specified NCD and CD entities, specifically seeking to evidence why and how some key interventions succeeded or failed.

Investing in the guided research priorities shall eventually help in keeping track on progress with Healthy Ageing, Active Ageing, and development of Geriatrics discipline and care monitoring, besides informing on how costs could be rationalised and financial sustainability measures be envisioned and applied.

9.0. CONTINUITY AND SUSTAINABILITY

9.1. Active Ageing advocacy

Active Ageing should be a continuous entity in one's mind set. When schools promote sporting activities, gymnastics, artistic ventures in dances concerts and cycling, it should be emphasized that this is part and parcel of School Health services setting a foundation that students and teachers should be encouraged to advocate for the next age cohort: In this way it has potential to become a continuous process in life that shall not be neglected at Older Age stages. Keeping one's body active shall be emphasized to remain a permanent life agenda that keeps physical strength up-beat. The number of Non-Communicable disease episodes is effectively cut down by getting the human body to enjoy physical exercise; thus costs to the health care delivery system are reduced with savings directed to other pressing health priorities.

9.2. Networking beyond the Health Ministry

Formation of Active Ageing forums/ associations/clubs will be advocated that will allow people to interact and share life events emphasizing positive outlook, mutual interests, and positive interactions sharing constructive stimulating points of view on various life ventures. This will include counselling and encouraging one another to adopt nutritious and healthy food and lifestyles that build one's health and wellbeing, individuals practicing this continuously shall never stop because they see themselves reaping benefits. But in principal the program shall hinge its success on smooth rolling out of UHI (Mandatory Health Insurance shall ensure universal coverage contingent upon legal enforcement).

A key instrument to enable the program to roll out while at the same time respecting human rights of OP is the AU Protocol (1) to the African Charter on human and peoples' rights on the rights of Older Persons in Africa. Legal experts are advised to be guided by this instrument to draft a legal clause/regulation, in the event they identify an issue that shall require legislation.

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Annexes

Annex 1:1. Problems and prospects related to ageing

1.1 Poor health at older age starts as early as adolescent and Middle Ages: Examples of major influencing factors include poor diets, limited physical exercise at younger ages, malpractices in sexual reproductive health and drugs addiction and other abuses that precipitate poor mental health. *The youth of today have a package of behavioural issues that merit addressing now and nurture into ageing-friendly behaviours. Included in this package are (a) avoidance of sedentary lifestyles (b) avoidance of junk foods (c) avoidance of alcohol abuse (d) avoidance of substance abuse (e) avoidance of various types of addictions including smoking (f) avoidance of unsafe sex and sexual abuses.*

1.2 Sports, gymnastics, athletics marching or walking, singing and music competitions, educative seminars rallies or symposia. Invitations to merry making events present antidotes to Annex 1.1.

1.3 The human rights-based approach countries are supposed to pursue shall see countries striking achievements that embrace a wide range of socioeconomic interventions that promote conditions in which people can lead a healthy life (e.g., through mutual support, care for one another, harmonious relations etc); and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment; with net results in *'medical care cost containment through Healthy Ageing'* - a vital feature for rendering the NSPHSOP feasible.

1.4 How pension funds and health insurance are designed and regulated to guarantee unimpeded access to OP in the context of UHC should be guided by the principle of equity: situation of older women care (widows in particular) needs careful attention in this respect.

Annex.2: The Health Package for Older People by level (NSPHSOP section 5)

2.1. Intra household and self-care

2.1.1. Physical conditions and safety:

- Washing facilities and clean bedding; safety checked showers/bathrooms; avail soap, assure clothes cleanliness, dust clear sleeping and relaxing spaces.
- Feeding (nutritious food) and fluids i.e balanced food that includes proteins, vitamins and less carbohydrates and less fat; drinking water from unsafe sources should always be boiled.
- Toilet management (older people friendly facilities and tools like urinals, bedpans and pampers as needed). Clean toilet or VIP with water-dripping facilities for washing hands
- Wheel chair friendly house construction
- Physical exercise routine and body massage/physiotherapy; walking at least once a day but preferably two times.
- Disease complications prevention measures as counselled at health facility.
- Eye care, oral care, throat care, skin care, deafness.

2.1.2. Social wellbeing and Mental Health:

- Maintenance of social contacts and mental health e.g engaging in social events, amusement episodes, celebrations, engaging positively in discussions and sharing ideas, adequate sleep (at least 8 hours at night), keeping track of trends in news, reading interesting and amusing features tales or stories to defer memory loss as alertness is stimulated.
- Home visits of Social Workers and Community Health Workers to check and address specific social issues like breaking isolation tendency, unconscious stigma, encourage participation in daily chores, breaking resigned attitudes. CHWs shall in addition monitor compliance to specific disease interventions (e.g., measures averting dangers of emergency diseases such as Covid 19, essential immunizations compliance etc)
- Avail assistive devices as necessary

2.2. Community and First Line Health Facility

2.2.1. Community

- A comprehensive assessment and care plan shared with all providers
- Common care and treatment goals across different providers
- Community outreach and home-based interventions
- Support for self-management including assistive devices
- Comprehensive referral and monitoring activities
- Community engagement (sensitization, resolve to sustainable actions) and caregiver support.

2.2.2. Dispensaries and Health Centres

- Health checks (Pulse, BP, RR, systems review)
- Check mental health status
- Perform basic tests (urine, stool, random and fasting blood sugar, Hb, FBP if deemed necessary)
- Recording prescribed medicines compliance and attendant challenges
- Counselling on what to pay attention to at home
- Provision of assistive devices as necessary

2.3. Older people focussed services at first level Hospitals

- Check vital signs and BP; basic laboratory tests and FBP
- Review systems
- Check cardiac and renal functionality
- Perform requisite tests and investigations according to presenting problems (Diabetes, Hypertension, Cardiovascular diseases, Arthritis, Respiratory, Cancers and Renal functions)
- Choose and prescribe the medicines combination that will do no harm (Avoid polypharmacy)
- Discuss care needs not met at home and options to meet those needs
- Review physical and mental health status
- Provide counselling based on presenting problems
- Integrate OP outreach into other ongoing outreach services
- Provision of assistive devices as necessary

2.4. Geriatric services at Secondary and Tertiary care Hospitals

- Review care last given at primary care and level one hospital
- Determine need and justify if a complete health check will be necessary
- Carry out the health check as needed (Diabetes, Hypertension, Cardiovascular diseases, Arthritis, Respiratory, Renal functions including prostate status)
- Screen for any signs of cancer
- Assure Heart problem, Diabetes, Arthritis and Hypertension are fully at check;
- Determine need for physiotherapy and apply as necessary
- Counsel on how to avoid medicines interactions from polypharmacy
- Determine presence of the need for specialist care and advise accordingly
- Review mental and neurological status
- Review and counsel on nutrition and exercises.