THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

NATIONAL STRATEGY FOR THE PROVISION OF HEALTH SERVICES TO OLDER PEOPLE IN TANZANIA

2021 - 2030

Foreword

The population of older people in the world and including Tanzania is increasing rapidly. 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 have a National Strategy for the Provision of Health Services to Older People. This document aims to guide stakeholders including private providers, in planning, providing, monitoring and evaluating the provision of health services to older people. At the moment there is no guide for the provision of health services to older people; this has resulted in disorganised and inefficient approaches applied by different stakeholders. Circulars and directives issued by the Government regarding the provision of health services to older people go unheeded or are poorly implemented by some providers of health services to this important group of people.

Recognising the challenges facing the majority of older people and other vulnerable groups of the population in accessing quality health services, the Government has started the process of introducing the Universal Health Insurance (UHI). This health insurance scheme will be compulsory to all citizens. The Government will devise a system which will make sure that older people and other vulnerable groups' membership to the UHI is assured.

The Strategy also addresses the challenge of availability of trained personnel required to provide quality health services to older people. The Government has already reviewed the training curriculum for Mid-level nurses to equip them with knowledge and skills to care for older people. The Government has plans to review curriculums of other health cadres so that they are all capable of providing quality health services to older people. In addition, the Government will continue enforcing the implementation of its directive that public health facilities set aside 6% of funds provided for procuring medicines, equipment and supplies so that it can be used to purchase medicines and supplies required by older people in respective areas.

This Strategy is expected to reduce, if not completely eliminate the complaints from older people and service providers regarding financing of health services provided to older people.

Prof. Mabula D. Mchembe
Permanent Secretary (Health),

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The preparation of the National Strategy for the provision of Health Services to Older People, the Ministry worked in close collaboration with stakeholders, who provided technical and financial support. The Ministry would like to express its sincere gratitude to HelpAge Tanzania for its financial support which enabled the Consultant to prepare the first draft which was improved by various sessions of expert groups which was comprised of senior Ministry's Officials – the Ministry's Management Team (Health).

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Prof. Abel Makubi
Chief Medical Officer

Contents

Abbreviations

A&H	Alignment and Harmonization
AIDS	Acquired Immune Deficiency Syndrome
APHFTA	Association of Private Health Facilities in Tanzania
BMP	Basic Minimum Package
CBHC	Community Based Health Care
CCHP	Comprehensive Council Health Plan
CHWs	Community Health Workers
CPD	Continuous Professional Development
CSSC	Christian Social Services Commission
DED	District Executive Director
DMO	District Medical Officer
FBP	Full Blood Picture
GDP	Gross Domestic Product
GOT	Government of Tanzania
HIV	Human Immunodeficiency Virus
HSSP IV	Health Sector Strategic Plan Four
I-ACE	Integrated-All-inclusive Care for the Elderly
ICOPE	Integrated Care for Older People
LGA	Local Government Authority
MAPERECE	Magu Poverty Focus on Older People Rehabilitation Centre
MBP	Minimum Benefit Package
MOEST	Ministry of Education, Science and Technology
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
NBS	National Bureau of Statistics
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NSSF	National Social Security Fund

OP	Older People
OOP	Out of Pocket Payment
PACE	Program of All-inclusive Care for the Elderly
PMO- PPLEYD	Prime Minister's Office – Policy, Parliament, Labor, Employment, Youth and Disabled
PO-RALG	President's Office – Regional Administration and Local Government
RCH	Reproductive and Child Health
PSS	Psychosocial Care and Support Services
PSSSF	Public Services Social Security Fund
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
RMNCAH	Reproductive Maternal Neonatal Child and Adolescent Health
RR	Respiration Rate
RSWOs	Regional Social Welfare Officers
SDGs	Sustainable Development Goals
SIKIKA	Name of an NGO dealing with Social Accountability Monitoring and Quality of health services in Tanzania
SNHI	Single National Health Insurance
SOPs	Standard Operating Procedures
SWAPs	Sector Wide Approaches
UHC	Universal Health Coverage
UHI	Universal Health Insurance
VAT	Value Added Tax
WHO	World Health Organization

Definitions

Active Aging	It is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age[1]
Gender	Is a "lens" through which to consider the appropriateness of various policy options and how they will affect the wellbeing of both men and women.
Geriatrics	A term used in medicine representing care for older adults.
Healthy Ageing	Healthy aging means living a long, productive, meaningful life and enjoying a high quality of life. Research has shown that older adults who adopt healthy behaviors, use preventive health services, and are involved with their family, friends, and communities, are healthier and more independent. WHO report[2] defines it as "The process of developing and maintaining the intrinsic capacity and functional ability that enables well-being in older age"
Older People	People who are 60 years old or more (able and disabled)
Universal Health Coverage	All people and communities receive the quality health services they need without financial hardship[3].

[1] WHO 2002. Active Ageing: A policy framework
[2] WHO 2015. World Report on Ageing and Health. ISBN 978 92 4 156504 2 pg 28
[3] World Health Organization Regional Office for Africa, 2017. Leave no one behind: strengthening health systems for UHC and the SDGs in Africa. ISBN: 978-929023389-3 page 5.

Preamble

In an initiative to promote healthy ageing in the African Region[4] it is important to take note that there has been a significant gain in life expectancy in the Region, and there is a growing number of older people who face increased risk of chronic diseases, disabilities and premature death. By 2020, non-communicable diseases are already the main causes of morbidity among older people in this Region. This situation is putting an additional strain on the already overstretched health systems of developing countries, Tanzania included.

Elderly people in countries of the Region encounter problems related to chronic health conditions such as cardiovascular diseases, cancers, HIV, chronic respiratory diseases and diabetes, visual and hearing impairment, and decline of mental capacities. While this pattern of conditions also occurs elsewhere in the world, it is important to note that poverty and malnutrition contribute significantly to disease and disability among the elderly in many African countries; in this respect Tanzania is not an exception. During epidemics or emergency situations such as natural disasters and armed conflicts, specific attention is not given to the special needs of elderly refugees or internally displaced persons who are particularly vulnerable.

According Population and Housing Census conducted in 2012, Tanzania women aged 60 years and above accounted 52.1%of the elderly population. According to National Aging Policy (2003) and other studies carried out in different settings within the country had documented that many elderly women not only lack economic power but face age and gender discrimination which results in poor health and further disempowerment[5],[6].

Elderly people should not be seen as a burden on society. Guided by evidence in the World Report on Ageing and Health, countries should move the debate about the most appropriate public health response to population ageing into new – and much broader – territory. The overarching message 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[7]. In many community settings in Tanzania, older people continue to play a pivotal role as a source of wisdom (advisers/mediators) and custodians of customs and traditions and child carers[8]**. Acknowledging this role of the elderly in society and

[4] AFR/RC63/4 Healthy ageing in the African Region: Situation analysis and way forward

[5] A study of older people's livelihoods in Tanzania. HelpAge International and Cordaid, Janaury 2011.

https://www.helpage.org/silo/files/a-study-of-older-peoples-livelihoods-in-tanzania.pdf (Accessed JAN, 27-2021)

[6] Sanga GS. Challenges facing elderly people in accessing health services in government health facilities in Moshi Municipality area, elderly Moshi municipality (Dissertation of the Open University of Tanzania) http://repository.out.ac.tz/1014/1/DISSERTATION_-_SANGA_FINAL.pdf (accessed , 27-jan 2021)

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

[8] United Republic of Tanzania. National Ageing Policy. Ministry of Labour, Youth Development and Sports. September, 2003. http://interactions.eldis.org/sites/interactions.eldis.org/files/database_sp/Tanzania/National%20Ageing%20Policy/NAP.pdf (Accessed 27 January, 2021)

taking measures to optimize it will increase their contribution to the development agenda of the country.

1.0. SITUATION ANALYSIS

Up to the present time we are very likely to have provided health care to older people in a wasteful and more costly way considering we had neither a conceptual framework nor organized set up for geriatric care in our country. The net result has been some accessing care because they are able to pay and a relatively large proportion being denied access from inability to pay as the waivers and exemptions policy failed to deliver on its noble intent. This situation prevails despite the Ruling Party Election Manifesto stating that Older People regardless of their economic status will be provided with health services without having to pay.

It is important to balance the way we look at care needs of the elderly, and how healthy aging should be organized to optimize the care in a way that minimizes wastage and unnecessary suffering. First and foremost a multidisciplinary engagement is vital considering there are socio-economic considerations, cultural pivots, high costs of managing older people diseases (often long illnesses), higher levels of professionalism (a gap in the market), nutritional, psychological, mental, physical therapy and behavioral measures that call for social welfare, sports and recreation, agriculture and finance disciplines, regulatory measures and LGAs enforcement, beyond mere availability and payment of medical services. In other words, a systematic encounter must be conceived in order to render the envisaged strategy effective and operationally sustainable.

In Tanzania the number of older people is increasing along with the general population. Presently older people constitute about 5.6% of the general population[9]. This means there are about 2,600,000 older people now. Life expectancy in 2018 was 65.8 (F) and 62 (M). (WHO Data of 2018). It is estimated that by 2050, older people will constitute 11% of the country's population. This requires organized arrangements for providing health care to older people from now.

According to documentation in the Health Financing Strategy[10] "in 2015 Tanzania realized a total GDP of 45.7 billion US Dollars, an increase from 39.1 billion US Dollars in 2009. GDP growth in 2015 averaged 6.6 percent (NBS, 2016[11]). The per capita GDP increased from US$ 896 in 2012 to US $967 in 2015. The growth in GDP is mainly attributable to the services sector, which accounted for an average of 41.1 percent of total GDP between 2011- 2015. Agriculture and fishing is the second large contributor to the growth with an average of 29.9 percent while industry and construction as the third largest contributor to total GDP with an average share of 23 percent of total GDP (NBS, 2016[12])".

[9] MOHCDGEC 2019. National Health Policy 2019.
[10] MOHCDGEC2017. Tanzania Health Financing Strategy 2017/2018-2021/2022: Path towards Universal Health Coverage.
[11] 2015 Tanzania in Figures (2016), National Bureau of Statistics
[12] Statistical Abstract, 2015 (2016),), National Bureau of Statistics

In 2015, the World Health Organization (WHO) published the first *World report on ageing and health.*[13] This was followed in 2016 by the World Health Assembly's adoption of a *Global strategy and plan of action on ageing and health*,[14] which provide a clear mandate for action across health and social care sectors. Both documents reflect a new conceptual model of healthy ageing that is built around the functional ability of older people to do the things they value, rather than around the absence of disease. The WHO recommended societal approach to population ageing, which includes the goal of building an age-friendly world, requires a transformation of health systems away from disease-based curative models and towards the provision of integrated care that is centered on the needs of older people.

At the same time, through the United Nations, Member States adopted the 2030 Agenda for Sustainable Development[15], pledging that no one will be left behind and that every human being will have an equal opportunity to fulfill their potential with dignity. The *World report on ageing and health (reference 10 in footnote below)* has made the following point: "It is already known that the demographic transition to older populations will occur, and we can plan to make the most of it by proposing the prioritization of interventions that optimize older people's physical and mental capacities over their life course".

This strategy for service provision to older people considers an integrated approach, taking into account the complex nature of service needs of older people: As people age, their health issues tend to become more chronic and complex, and multiple. The presence of multiple chronic conditions – becomes the norm rather than the exception. Physical, sensory and cognitive impairments become more prevalent and older people can develop complex health states, such as frailty, urinary incontinence and an increased risk of falling. These health states cannot be placed in discrete disease

Major chronic conditions affecting older people worldwide:

- 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

[13] World report on ageing and health. Geneva: World Health Organization; 2015. Available from: http://www.who.int/ageing/publications/world-report-2015/en/
[14] Multisectoral action for a life course approach to healthy ageing: draft global strategy and plan of action on ageing and health. Geneva: World Health Organization; 2016. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_17-en.pdf
[15] Resolution A/RES/70/1. Transforming our world: the 2030 agenda for sustainable development. In: Seventieth United Nations General Assembly, New York, 25 September 2015. New York: United Nations; 2015. Available from: http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E

categories except in case of those who can function without attendant support and those who can only function with support of an attendant at all times.

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The risk of having multiple non-communicable health conditions also increases with age and, if not properly addressed through robust care coordination, these conditions can lead to polypharmacy, hospitalization, disabilities and death[16].

A recent review of the progress made globally since 2002, covering more than 130 countries, noted that "there is low priority within health policy to the challenge of the demographic transition"; "there are low levels of training in geriatrics and gerontology within the health professions, despite increasing numbers of older persons"; and "care and support for caregivers. [17]Existing health systems manage older people health issues in a disconnected and fragmented way, there is inadequate coordination across care providers and settings and in the timing of the care provided, leading to higher costs of care delivered in an already constrained financial resource base. Older people often find it difficult to use health services even when they are available. In low- and lower-middle-income countries, older people use health services significantly less frequently than younger people despite suffering poorer health.[1819]

The greatest barriers to the use of health services appear to be the cost of health-care visits and difficulties with transportation: more than 60% of older people in low-income countries did not access health care because of the cost of the visit, the absence of transportation or an inability to pay for transportation [as observed in the World Health Report on ageing (2015)]. The majority of the older people in this country live in the rural areas and they face a number of challenges such as availability of health services close to where they live, availability of staff competent in geriatric care, availability of medicines required to treat common ailments which affect them (for instance the Section serving the elderly in health facilities is sometimes starved of medicines, inadequate infrastructure suitable to be used to provide health services to them). Additionally, problems being faced by older people having inadequate income to enable them live decent life including accessing health services; ensured security; adequate representation in decision making organs where they live and at higher levels (especially because involvement of the elderly is usually insufficient or absent) and availability of correct and adequate data on older people. The concern of this strategy

[16] Islene Araujo de Carvalho et al 2017. Organizing integrated health-care services to meet older people's needs. *Bulletin of the World Health Organization* 2017;95:756-763. doi: http://dx.doi.org/10.2471/BLT.16.187617.

[17] Overview of available policies and legislation, data and research, and institutional arrangements relating to older persons – progress since Madrid. New York: United Nations Population Fund, Help Age International; 2011 (http://www.ctc-health.org.cn/file/Older_Persons_Report.pdf, accessed 4 June 2015).

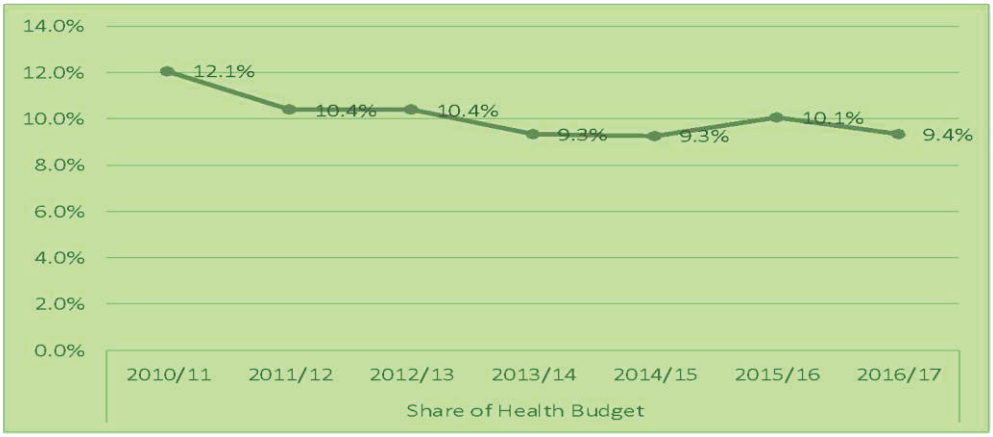
[18] McIntyre D. Health policy and older people in Africa. In: Lloyd-Sherlock P, editor. Living longer: ageing, development and social protection. London: Zed Books; 2004. pp. 160–83.

[19] Aboderin I, Kizito P. Dimensions and determinants of health in old age in Kenya. Nairobi: National Coordinating Agency for Population and Development; 2010.

is how older people can be guaranteed access to quality health services whenever they are in need: In this respect the Strategy addresses the issues of that assure their universal access and getting geriatric care service delivery organized at relevant health care settings. For the universal access to happen and geriatric services being organized, the total costs have to be met by sustainably available funds: presently this is a challenge. As can be appreciated from the figure below the Health Budget for 2016/17 was 5.6% short of the Abuja Target of 15% of the Government Budget. Health budgets chronically experience gaps often addressed by re-planning, reprioritization and innovation for cost containment.

GOT budget allocation to Health:

Figure 1 Health sector as a share of Total Government Budget



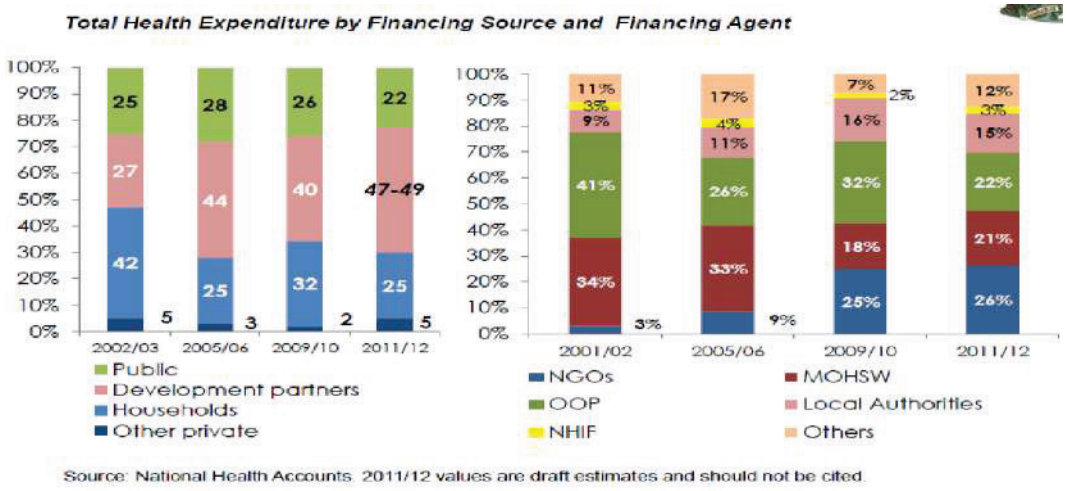
Source: Tanzania Health Financing Strategy 2017

According to finance analysts, the total health spending has been rising in Tanzania but mainly from out of pocket. Households and OOP as a source of spending for health is appreciably quite significant; and hence the need to shield it with other sources if headway is to be made in providing health care to OPs in a sustainable and costs prudent manner.

That older persons are recognized by the National Ageing Policy[20] 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 elder persons' access to quality health services and care in a well thought out conceptual design that critically considers their multi-

[20] URT MoLYDS 2003. National Ageing Policy p 5.

morbidity context. The WHO has been very clear in its report[21] that a new framework for action is required that will need to encompass the great diversity of older populations and address the inequities that lie beneath it**:** It must drive the development of new systems for health care and long-term care that are more in tune with the needs of older people, and it must ensure that all sectors focus on common goals so that action can be coordinated and balanced.



Source: National Health Accounts. 2011/12 values are draft estimates and should not be cited.

Above all, it will need to transcend outdated (negative) ways of thinking about ageing, foster a major shift in how we understand ageing and health, and inspire the development of transformative approaches. Because social change is ongoing and unpredictable, these cannot be prescriptive but, instead, should look to strengthen the ability of older people to thrive in the turbulent environment they are likely to live in.

The process of developing and maintaining the intrinsic capacity and functional ability that enables well-being in older age requires an understanding of abuses; that lead to poor health at older age start as early as adolescent and middle ages. For example poor diets and limited physical exercise at these younger ages combines with malpractices in sexual reproductive health and abuses that precipitate poor mental health, are contributors to negating healthy ageing. Hence action must begin very early well before older age sets in.

The Government, in its efforts to improve the availability and accessibility of quality health services provided to the older people all over the country, has in place a policy and Guidelines which direct public health facilities to provide health services to older people without any financial contributions from them. In addition, the Government has been issuing

[21] World report on ageing and health. Geneva: World Health Organization; 2015 p 18. Available from: http://www.who.int/ageing/publications/world-report-2015/en/

a number of directives to remind the heads of public health facilities to implement the policy and guidelines as regards the provision of health services to older people. Local Government authorities have also been directed to issue identity cards to all older people so that when they visit a public health facility they are attended without undue delays; with this card they are attended without paying since the LGA has to set aside budget for funding health care for the older people. How far this budget is realized from LGAs remains a question with unclear answers.

The National Health Policy[22] states that older people who qualify to get free health services are those who are unable to contribute to cost sharing; but "free health services" is a misnomer because those services have to be paid for from a certain source. Notwithstanding this policy provision, the Government has issued directives and circulars directing all public health facilities to provide free health services to older people regardless of their socioeconomic status. This was influenced by the fact that older people have served the nation for a long time and therefore they deserve to be honored this way in the last part of their lives.

The provision of health services to the older people has been such a concern to the Government to the extent that all public health facilities (those owned by the Government and the privately owned facilities which have signed service agreements with the Government – Central and Local) have been directed to set aside space and staff specifically to serve older people. In addition, they have been directed to set aside 6% of funds allocated for medicines and supplies to purchase medicines required by older people in *respective areas.* Application of the policy and guidance provided has not been consistent; has only worked to some extent where there is committed leadership and resource shifts in support. Majority of districts have not implemented the "waivers and exemption" policy to the letter: The source of funds to meet attendant costs was not sufficiently clear.

According to HSSP IV[23], the government will improve Geriatric care especially as regards non-communicable diseases and cancer treatment. National, Zonal and Regional Referral hospitals will improve their services and will provide support to lower levels. The multi-morbidity scenario with its implications as regards requisite know-how will need geriatric care to be organized as a distinct discipline and the structure needed to deliver the service within existing cadres or through creating a new cadre. Efforts, opportunities and experiences of Faith Based organizations and any other organizations that have insights into elderly care will be recognized and utilized at an expanded scale. Critically important is the role played by Older Persons Forums and Councils at all levels, both established and

[22] MOHCDGEC, National Health Policy 2019 pg 18.
[23] MOHSW 2015. Health Sector Strategic Plan IV July 2015 to June 2020. Reaching households with Quality Health Care Section 5.7.3.3 pp 52.

those in process of development, as an OP inclusive approach for advocacy on OP support and access to health services in respective areas.

Human resources for health crisis at health facilities will need to be tackled more vigorously to assure quality health services for OPs; to complement them and provide for the continuum of care LGAs need to support the CHWs placements to take care of community level interventions and take care of Home-Based Care. Within LGAs the Social Welfare professionals need to be more actively engaged than is currently happening.

2.0 JUSTIFICATION

The logic that argues and justifies guaranteed access to health services for children under the age of five years and for women prenatal natal and post-natal services is the same that justifies guaranteed access to health services for older people who occupy the other end of human life continuum. While "aging" is not a disease per se but just a normal biological process, it is a known fact that unhealthy aging is a precursor to increased frequency of disease episodes among OP. There are many other justifications for devoting public resources to improving the health of older populations[24]. The first is the human right that older people have to the highest attainable standard of health[25]. This right is enshrined in international law. Yet older people often experience stigma and discrimination, and violations of their rights at individual, community and institutional levels simply because of their age. A rights-based approach to healthy ageing can help address the legal, social and structural barriers to good health for older people, and clarify the legal obligations of state and non-state actors to respect, protect and fulfill these rights[26]

The second reason: With increasing life expectancy and level of education, the older persons will be at less risk of communicable diseases in comparison to non-communicable diseases (NCDs). They will be suffering from several of the NCDs that may occur concurrently and hence will require a more complex sort of management that will call for avoidance of poly-pharmacy to keep adverse medicines reactions at bay and application of conservative management in some cases: Care providers will require more skills than the usual single disease management capability.

Thirdly: When older persons present for care at many health facilities, they face mal-application of the waivers and exemption policy. In actual fact the policy is not fully implemented in many health facilities as instructed. This happens despite the recognition that older people are a resource[27] that carries valuable institutional memory that, when consulted, complements the national development agenda very well, resulting in savings from avoiding expensive repetitions of what is already known. The social capital inherent in older persons needs to be optimized and given deserving attention at every opportunity. Political stances and national policy have given clear positions in support of health services for older people without financial or other impediments. But the problems experienced with regard to implementing the policy have not been addressed analytically.

The Universal Health Care (UHC) coverage imperative (advocated for by SDGs and the Health Financing Strategy -2015) obliges systems to be in place that guarantee care for

[24] Beard JR, Biggs S, Bloom DE, Fried LP, Hogan P, Kalache A, et al. Introduction. In: Beard JR, Biggs S, Bloom DE, Fried LP, Hogan P, Kalache A, et al., editors. Global population ageing: peril or promise? Geneva: World Economic Forum; 2012:4–13. (http://www3.weforum.org/docs/WEF_GAC_GlobalPopulationAgeing_Report_2012.pdf

[25] Baera B, Bhushan A, Abou Taleb H, Vasquez J, Thomas R, Fergusen L. The right to health of older people. Gerontologist. 2016 (In press).

[26] WHO 2015. World Report and Aging and Health, ISBN 978 92 4 069481 1 (PDF) cap 1 p 14.

[27] URT MoLYDS 2003. National Ageing Policy p 5

older people irrespective of the age and set of ailments and diseases, taking into account that financial liquidity at older age is non-existent for most people in the older age category.

Current status of older people

From the World Report on Ageing and Health (WHO 2015) older people carry with them a diversity of experiences, knowledge and skills: In other words, they are not a homogeneous group. There should be initiatives to provide continuity in benefiting from this diversity: An example in point here is encouragement of the **formation of Active Ageing Associations (AAAs)**[28]. Such associations are still not prominently spread in the country even though one would see some individuals and groups teaming up to conduct jogging, brisk walks or for those that afford, attend gyms and sports at private clubs. These individual initiatives are very much needed but they should be taken to a higher and wider scale for the following key disturbing factors - refer arguments in text box below:

- Obesity is now becoming commoner in young ages. Potbellied people seen as well to do or better off; culturally perceived positive-
- Alcoholics and drug abusers eventuality end up in dementia and depression
- Need to quantify introverts and antisocial psychopaths who negatively affect relationships
- Growing numbers of motorists that have limited physical exercise
- Growing numbers of NCDs among younger people
- Sports perceived as preoccupation of youth
- Effects of mobile phones on interpersonal relations
- Traditional cultural norms being replaced by aping 'modern' dilutions of values and moral fabric.

Where OP Forums have been formed (at Village/ Hamlet, Ward and District) these would be challenged to advocate strongly for formation of AAAs to deal systematically with ageing issues across generations rather than dealing with these issues at more advanced age sets within which the damage has already happened or already fast approaching.

Older people have tended to be left out or marginally treated in communities and Health Insurance schemes. Health-financing policies would be aligned with goals for universal health coverage of ageing populations, which is defined by WHO as ensuring that all people have access to needed health services – such as health promotion, prevention, treatment and rehabilitation – without the risk of financial hardship associated with accessing services[29]. OPs are included under the universal health access policy and strategic direction.

[28] WHO 2015. World Report on Ageing and Health chapter 4.

[29] World health report 2010. Health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010 (http://www.who.int/whr/2010/en/)

Pooling resources across population groups ensures efficient risk sharing, and is particularly important for ageing populations. Deliberate pooling for the sake of ensuring older people benefit from UHC policy is in line with the Sustainable Development Goals (goal 3 targets 3.8 and 3c).

With a total population projected at 54.2 million people in 2018 and improving life expectancy, the total number of older people in Tanzania is expected to be not less than 2.6 million (At census 2012 there were 1,182,113 males and 1,290,595 females aged 60 years and above[30]). Data is not readily available on morbidity and mortality in this age group.

Improved data collection (without age limitations) that facilitates better understand the impact of HIV/AIDS on older people is urgently needed. HIV/AIDS information, education and prevention activities as well as treatment services should apply to all ages. The need for data also applies to other diseases common among OP not to forget mortality causes and trends.

Living with Multiple Health Problems

As already observed, many ill older people have more than one health problem at a given point in time. In fact, more than half of all adults 65 and older have three or more ongoing health problems. Taking care of older adults with multiple health problems can be tricky, even for healthcare professionals who specialize in caring for older adults. Having multiple health problems can mean you take several medications that may interact with one another in potentially harmful ways. Also, most clinical guidelines for healthcare providers focus on how to manage a single disease or condition, instead of how to manage multiple health problems. In addition, older adults with multiple health problems are often not included in research studies to test new drugs and other treatments. the situation is exacerbated by the absence of staff specifically trained (including Geriatricians) to care for older people. This means that there is less information (evidence) about how medications and other treatments affect people with multiple health problems.[31]

Older persons multiple health problems becoming common in Tanzania - examples:

Heart disease,
Diabetes,
Arthritis,
High blood pressure
Renal disorders
Cancers
Chronic respiratory diseases

Bearing in mind that most of the time we may not be dealing with a single disease in an elderly person, there are five essential elements of quality care that should help a service provider to keep the focus on the best alternatives which include:

[30] https://www.nbs.go.tz/nbs/takwimu/census2012/Fertility%20and%20Nuptiality%20Monograph.pdf
[31] American Geriatrics Society 2012. Report on *Patient-Centered Care for Older Adults with Multiple Health Problems: A Stepwise Approach from the American Geriatrics Society*. Published in the September 19, 2012 early online edition.

a) Considering patient preferences
b) Considering available medical research
c) Making treatment decisions based on possible risks, benefits, and prognosis
d) Assessing treatment options
e) Optimizing treatments and care plans - Maximize benefits and minimize risks from therapy, within the overall treatment plan.

Services for older people – current arrangements; policy implementation status, constraints, challenges

Although day care centers for the elderly are currently coming up in developed countries, the common arrangement of care for older people in our country and other developing countries is intra-household, the immediate family taking responsibility and sometimes supported by Faith Based Organisations which provide services for older people. This apparently culture-driven set up has begun to be threatened by modernization given busy schedules of relatives and time constraints increasingly tightened by urbanization and pressures from technological advancements. However, the Government will continue advocating that immediate families and where possible communities where older people live should continue caring for their older people.

Pursuit of healthy ageing through regular exercise, optimal nutrition, body hygiene and safe environment, social visits, inclusion in events that are within their ability to attend and participate, constitute a therapeutic intervention just as much as or even more than an actual prescription of a given allowable combination of medicines. This holistic package can be offered as counseling service whose cost can be determined and *paid for under universal health insurance* through determined negotiations with the insurers and a mix of financiers. It is through this design that various disciplines can pool efforts and address the multi-morbidity situation and multiple problems of older people. Dependence on health sector budget alone is unrealistic especially because there are many competing priorities and limitation in budget allocation.

In addition, 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, 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' -** a vital feature for rendering this strategy feasible. In the context of ageing, availability implies considering the extent to which health facilities, goods and services meet the specific health needs of older people (not a narrow frame). Availability refers to having a sufficient quantity of effective public-health

interventions and health care facilities, goods and services, as well as programs that meet older people needs.

The accessibility of health facilities, goods and services has four sub-dimensions: nondiscrimination, physical accessibility, economic accessibility (or affordability), and the accessibility to information. All are particularly relevant to older people who may face aged-based rationing of services, physical limitations that make access particularly difficult, financial insecurity as a result of their age, and information barriers ranging from literacy to the ability to use web-based material, a form with which they may not be familiar or have access to.

Older people's right to health also upholds the element of the acceptability of health facilities, goods and services, in keeping with the standards of medical ethics and the use of gender-responsive and culturally appropriate approaches. For example, assessing acceptability includes considering whether services are age-friendly or responsive to older people's needs and taking into account the diversity of older people, who are not a homogeneous group but face varying health risks and circumstances. In some low-income countries, services may be available but require queuing for many hours, which may be difficult for some older people due to physical limitations or the need to frequently use the toilet. Some countries have taken steps to address these needs by setting aside certain times to see only older people, providing chairs to sit on and ensuring that older people can use the toilet without losing their place in a queue. The Government will endure to address such challenges facing older people in this country.

In some settings attitudes of leaders (RMOs, DED, DMO etc.) when these are pro-elderly care, the seemingly formidable becomes do-able and there are good examples to this. Health insurance modality as a way to assure access for all is one of the ways to support this strategy but it does not offer all the answers; further analysis of how insurance for all can be made financially viable from other sources beyond the public domain needs to be done.

Resource allocation in the Health Sector is hampered by a myriad of factors. One salient challenge is the allocation of certain resources that is not harmonious with Health Sector policy, strategic plan and critical public health priorities. Allocation of funds based on DP priorities that are not harmonised further complicates the picture. There are delays in disbursement of funds and health basket funds, due to challenges with reporting at all levels, and of CHF matching funds and relatively complex administrative requirements compared to staff capacity. Bottlenecks at the district as well as the national level prevent facilities from being adequately reimbursed for service delivery, particularly as regards to CHF, and service agreements. Furthermore, vulnerable groups are insufficiently taken care of by the current system. Provider payment is largely input rather than output-based and there's potential for

conflicting incentives in the multitude of payment systems used. Together, many of these factors give less incentive to improve efficiency and quality of service in general; for OP these challenges pose a dire situation. The guidance on waivers and exemptions falls short in terms of defining the source of funds to pay for OP's health services access costs; this is the reason for wide variations in putting the policy guidance into effective implementation at LGAs (see illustration of this point in annex 2- snapshot from field observations).

Considerations to help generate a new and informed understanding

Deal with outdated stereotypes:

Some of the most important barriers to developing good public-health policy on ageing are pervasive misconceptions, attitudes and assumptions about older people. Although there is substantial evidence that older people contributed and continue contributing to society in many ways, they are instead often stereotyped as frail, out of touch, burdensome or dependent. These ageist attitudes limit the way problems are conceptualized, the questions that are asked, and the capacity to seize innovative opportunities. Some stakeholders' have emphasized the need to change stereotype thinking that marginalizes the elderly. As a starting point for policy-making, change in stereotype thinking often leads to great emphasis on cost containment and befitting resourcing of elderly care.

Life course over-categorization:

Limited thinking extends the way we often frame the life course, assuming it is inevitably categorized into fixed stages. In high income settings, these are typically early childhood, student-hood, a defined period of working age, and then retirement. Yet these are social constructs that have little physiological basis. The notion of retirement is relatively new, and for many people in low- and middle-income countries it remains abstract. This construction carries with it the negative phenomenon of neglecting the time-tested experience of the elderly, pushing away tested and mature skills, sub-optimizing the utilization of elders' knowledge-library and the resources they have accumulated over the years.

Life-long learning not appreciated:

The idea that learning is something that should occur only during the early stages of life reflects outdated employment patterns in which a person trained for a role and, with luck, worked at it for life, sometimes with a single employer. One consequence of framing of the life course is that the extra years that accrue from longevity are often considered as simply extending the period of retirement, conveniently forgetting learning and sharing should also go on during retirement.

Opportunities and flexibilities in healthy ageing:

For example, the anticipation of living longer might allow people to raise children and then start a career at age 40 or even 60, to change career paths at any stage in life, or perhaps to choose to retire for a while at 35 and then re-enter the workforce. Retirement itself may evolve into choices that are less stark. Thus, if policies permit, the combination of greater longevity and good health can allow endless variations on the traditional categories of the life course. Such shifts may benefit not only the individual but also society more broadly, by offering expanded opportunities for older people to contribute through participation in the workforce and other social activities.

A need to initiate a champions group for wide awareness creation and advocacy for Healthy Ageing is at hand: Such a champion group may start at middle ages as an “Active Ageing Association” that includes active elderly to thrust it forward with enthusiasm. The youth of today have a package of behavioral issues that merit addressing now and nurture into ageing-friendly behaviors. 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.

Deal with hitherto neglected areas:
Understand the impact of HIV/AIDS on older people as an urgent issue so that information, education and prevention activities as well as treatment and support services apply to all ages.

Financial security in older age:
Developing policies that can ensure the financial security essential for well-being in older age while providing the flexibility for innovative approaches to the life course will be vital; and, at the same time, these policies being financially sustainable and fair will be major challenges for governments. How pension funds and health insurance are designed and regulated to guarantee unimpeded access to older persons in the context of universal health coverage should be guided by the principle of equity BUT one should think beyond the current arrangements given what is revealed from recent National Health Accounts in table below:

Table 1: Total Health Expenditures by Source (percent)

	FY2005/06	FY2009/10	2013/14	2014/15
Government domestic	28 %	26 %	26%	28%
Donors	44 %	40 %	41%	37%
Health Insurance	3 %	2 %	6%	9%
Out of Pocket	25 %	32 %	27%	26%

Source: NHA Reports in Tanzania National Health Financing Strategy 2017.

Key challenges here are (a) low coverage of Health Insurance, (b) high out of pocket payment (OOP) which is a hidden underlying cause of inequities in access to health care (c) high degree of financial risk for catastrophic health expenditures (d) a high degree of donor dependency of Health spending (e) comorbidities of diseases among older people.
Public-health policy would be better aimed at empowering older people to achieve things previous generations could never imagine. Even though health insurance is the smallest proportion in the table above one should not lose sight that it is very informative in terms of its rising trend: A more recent analysis may show a much higher proportion as the application of insurance increases amongst health practitioners.

3.0 INTERNATIONAL AND LOCAL EXPERIENCES AND LESSONS

In 2002, the United Nations General Assembly endorsed the *Political declaration and Madrid international plan of action on ageing*[32] Three priorities for action were identified in their recommendations: **"older persons and development; advancing health and well-being into old age; and ensuring that older people benefit from enabling and supportive environments"**.

Several key issues were flagged in the plan.

a) Promoting health and well-being throughout life;
b) Ensuring universal and equal access to health-care services;
c) Providing appropriate services for older persons with HIV or AIDS;
d) Training care providers and health professionals;
e) Meeting the mental health needs of older persons;
f) Providing appropriate services for older persons with disability;
g) Providing care and support for caregivers;
h) Preventing neglect and abuse of, and violence against, older people.

In Tanzania the National Ageing Policy[33] has taken into consideration the United Nations Organization declaration No. 46 of 1991 on the following older peoples' rights:-

• Independence
• Participation
• Care
• Self – fulfillment
• Dignity

Due to multiple problems presented by the elderly patient, a team approach to care of older people is the modern way. The team may comprise of:

- Geriatrician
- Nurse
- Physician assistant
- Social worker
- Consultant pharmacist
- Nutritionist
- Physical therapist
- Occupational therapist

[32] International Covenant on Economic, Social and Cultural Rights. New York: United Nations; 1966 (http://www.ohchr.org/Documents/ProfessionalInterest/cescr.pdf,
[33] URT MoLYDS 2003. National Ageing Policy p 9

- Speech and hearing specialist
- Geriatric psychiatrist

In Ghana a task team was set up and tasked to review all the research that was available on ageing in the country[34]. Some key data came from the WHO Study on global Ageing and adult health (SAGE), a project that is collecting comprehensive information on the status and health needs of older people in six low- and middle-income countries. In Ghana, the SAGE study interviewed over 4000 people aged 50 and above. They provided information on their household, social and economic circumstances, health behaviors, diagnosis and treatment of chronic conditions, and access to health services. Their height and weight were recorded, along with blood pressure and lung capacity. The task team identified five priority areas for action.

These covered prevention and treatment of disease as well as improvements to the health system:

- undiagnosed and untreated hypertension
- difficulties in carrying out everyday tasks and social isolation
- poor utilization of health services
- inadequate preparedness of the health workforce to care for older people
- undetected and/or unmanaged problems with eyesight and hearing loss.

The recommendations from the task team ranged from community sensitization and improving health workers' ability to deal with the needs of the elderly, to broadening coverage of national health insurance schemes and making hearing devices and eye glasses available to people who need them.

Other Sub Saharan African (SSA) countries, including Tanzania may be experiencing a more or less similar pattern of problems facing OP. Two major concerns in SSA include (a) vulnerability of OP to detrimental health outcomes and (b) Limited access to health care. OP's health status has been investigated (WHO SAGE Studies and In-DEPTH network)[35] but elaboration on health care access inequalities among OP has not come out. The IN-DEPTH study sites included South Africa, Tanzania, Vietnam, Uganda, Indonesia and Bangladesh. In the Ugandan study, health need factors (self-reported NCDs, severity of illness and mobility limitations) were the most important determinants of accessing healthcare in the last 30 days among older persons. In addition, enabling factors in general, and household wealth status and earnings in particular, were associated with access to

[34] http://www.who.int/features/2013/ghana-living-longer/en/ **… Ghana: looking after its older people. October 2013.**

[35] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4354736

healthcare. Poor older persons were less likely to access healthcare in the last 30 days. Also, physical disability significantly reduced access to healthcare among older persons. The findings from Uganda had implications related to scaling up measures to reduce poverty among OP in order to deal with limitations to health care access due to economic factors and scaling up coverage beyond targeted districts. The need to strengthen the primary healthcare system in Uganda to provide long-term care to older persons with chronic NCDs such as diabetes, heart disease and hypertension was underscored by the study: It was further recommended to have specialized services from geriatricians and gerontologists in the health care delivery system, as well as promote access to health care for OP with physical disabilities through community outreach and targeted home care services.

In settings where qualified human resources is a severe constraint, such as in this country, persons qualified in geriatric care are not available. A revised curriculum for mid-level Nurses has just begun being used to train nurses in caring for older people. Review of other curriculums is planned. Mainstreaming services to older people in the teams that provide outreach services on specified frequencies and having the same team available at the Council level hospital is most practical immediate term measure. These professionals will among other services, evaluate the older person's medical, social, emotional, and other needs. The team will also focus on health concerns common in older people such as incontinence, falls, memory problems, and managing multiple chronic conditions and medications. The team would comprise of: -

- A Medical Officer or Assistant Medical Officer
- A Public Health Nurse
- A Social Welfare Officer
- Pharmaceutical Assistant
- Nutrition Officer
- Physiotherapist
- Mental Health Counselor

In these settings the best arrangement for elderly care is to ensure they see a minimum of Clinical Officer and/or a Nurse, plus a possibility to be referred to Social Welfare Assistant/Para-Social Workers/Community Case Workers and Community Health Worker for follow up measures at home, as needed. Complicated cases shall be referred upwards and hence the argument to set up Geriatrics Departments or care units for elderly at Hospitals. For those who would need to be hospitalized, will be admitted in available wards

Geriatric departments/unit at hospitals shall need the following units established for efficiency of care: -

- ✓ Reception and records
- ✓ Clinical consultation including Acute Care Screening

- ✓ Basic diagnostics
- ✓ Informed pharmaceutical service
- ✓ Physiotherapy and massage orientations
- ✓ Psychosocial care/therapy and support
- ✓ Specialized consultation Units

Essential services and equipment for geriatric care departments include

- Computerized medical and health records
- Calibrated BP machines
- ECG machine
- Thermotherapy/ massage machine
- Physiotherapy facilities (weights, skipping ropes, cycles, vibrators etc.)
- Snellen's chart
- Laryngoscope
- Otoscope
- Blood sugar test
- Uristix and kidney function testing access
- Neurological assessment capability/ access
- Musculoskeletal review capacity
- Cardiovascular testing capability
- Wheelchairs, crutches
- Stretchers

The foregoing measures require substantial financial resources to get up and running countrywide. To reach the eventuality of quality assured health care services access for OP, one has to reckon with the high-cost implications of the venture.

Attention to equity concerns

In various country settings it is important to pay particular attention to equity issues while attending to older persons care services. Some population groups may be neglected unless deliberate attention is ushered in. "Older women who are alone are highly vulnerable to poverty and social isolation. In some cultures, degrading and destructive attitudes and practices around burial rights and inheritance may rob widows of their property and possessions, their health and independence and, in some cases, their very lives"[36]. Older women may often be widows (70% of women aged 70 year and above are widows in some Eastern European countries: snap surveys may reveal a similar picture in African settings). A conscious effort shall ensure they are not forgotten. Persons in a state of abject poverty, such as persons with disability, also fall in the category of special attention to their needs.

[36] WHO 2002. Active Ageing: Policy Framework. A contribution of the World Health Organization to the Second United Nations World Assembly on Ageing, Madrid, Spain, April 2002. Pg 40.

When Universal Health Coverage and Mandatory Health Insurance for all is put to effective functionality, older persons who were not covered by insurance schemes and those who fall in catastrophic health expenditures from OOPs shall be rescued and cared for by the government.

Context specific conditions for the strategy to be applicable

- Country acceptance of the Health for All policy and strategy
- Functional and OP supportive National Health Policy
- Functional supportive Sector Wide Approaches (SWAPs)
- Supportive Alignment and Harmonization (A&H) of Development Partners assistance
- Flexibilities across related sectors/ disciplines
- Experience with resource pooling and existence of its management structure(s)
- Institutional flexibilities to pool and govern pooled financial resources and possibilities to legally enable the arrangement
- Equity underwrites Socio-Economic development policies and strategy.
- Healthy Ageing adopted and defined as a core among NCD prevention strategies
- Presence and commitment to older people's continued contribution to societal development is a cherished value amongst key social segments and society overall and hence covered under the country's Social Security structures and regulations.
- Presence of extended family support norm and culturally determined practice of caring for older people.

4.0 VISION, MISSION, PRINCIPLES, GOAL AND OBJECTIVES OF THE STRATEGY

Vision:

All older people regardless of their status lead healthy, active and dignified lives.

Mission:

To improve general health status of older people by ensuring access to quality promotive, preventive, curative and rehabilitative health services throughout the nation.

Principles

- Attain equity through universal access to health care services for older people
- Integrated all-inclusive Care for the older people (I-ACE)
- Solidarity as a basis for sustaining the strategy
- What older people value is supreme – hence handled with respect.
- Do no harm – avoid overmedication
- Ageing mainstreaming in public and private health service delivery
- OP participation in designing and advocacy for healthy ageing

Goal: Healthy ageing attained at a high level, for the benefit of national development and benefit to the older people.

Objectives:

4.1 To enable relevant authorities and Health Facilities (Public and Private) plan for the delivery of quality health services to older people in their respective areas of jurisdiction.

4.2 To facilitate access to quality health services by all older people according to prevailing circumstances.

4.3 To facilitate the establishment of Geriatric Departments/Units in Health facilities and at the Ministry together with availability of trained Staff including Specialists for geriatric care.

4.4 To facilitate the implementation of the Government's policy and Guidelines regarding the provision of quality health services to older people countrywide

5.0 THE HEALTH PACKAGE FOR OLDER PEOPLE

Providing Quality Care for Ageing Populations compels rethinking in a new way bearing in mind the following considerations: -

As populations age, one of the greatest challenges in health policy is to strike a balance between support for self-care (people looking after themselves), informal support (care from family members and friends), and formal care (health and social services). Formal care includes primary health care (delivered mostly at the community level including first line health facilities up to Council level Hospital), secondary health care, tertiary health care, and institutional care (either in hospitals or nursing homes).

While it is clear that most of the care individuals need is provided by themselves or their informal caregivers, most countries allot their financial resources inversely, i.e., the greatest share of expenditure is on institutional care. In many countries, family members, friends and neighbors (most of whom are women) provide the bulk of support and care to older adults that need assistance. In other settings, Faith Based Organisations also provide care to older people from compassionate grounds. Some policy makers fear that providing more formal care services will lessen the involvement of families. Studies show that this is not the case. When appropriate formal services are provided, informal care remains a key partner.[37] In the formal setting it is important to disaggregate care elements by level and each level be held accountable according to their capability and response capacity with due flexibility to give room for innovation.

Of concern though are recent demographic trends in a large number of countries indicating the increase in the proportion of childless women, changes in divorce and marriage patterns and the overall much smaller number of children of future cohorts of older people, all contributing to a shrinking pool of family support [38].

Summary of packages:

Packaging contextual framework is based on a commitment that Older People and their immediate two younger age groups engage effectively to put in place a healthy ageing and wellbeing programs at family and community level leading at national level advocacy.

[37] WHO (2000). *Long-Term Care Laws in Five Developed Countries: A Review*. WHO/NMH/CCL/00.2. Geneva: World Health Organization.
[38] Wolf DA (2001) "Population change: friend or foe of the chronic care system" *Health Affairs* Vol.20 (6) 28-42

5.1 Intra household and self-care

The package should preferably include:

- Washing facilities and clean bedding; safety checked showers/bathrooms
- Feeding and fluids
- Toilet management (older people friendly facilities and tools like urinals, bedpans and pampers as needed)
- Wheel chair friendly house construction
- Physical exercise routine and body massage/physiotherapy
- Disease complications prevention measures
- Eye care, oral care, throat care, skin care
- Maintenance of social contacts and mental health
- Home visits of Social Workers and Community Health Workers

The package outlined above provides a menu of health needs for the older person. The individual and family providing care is advised to use this package as a menu. It will be vital to assess the older person's capabilities to self-care on each of the items listed above so that you determine what external or extra support he/she needs. An important point to follow in implementing various components in the foregoing package is "asking the person cared for at every intended intervention what his needs are and elicit preferred mode for receiving the particular care". In other words carry a listening attitude and fulfill a listening role. A supportive attitude and measured supportive actions are helpful if they also encourage the person cared for to self-help whenever he/she can i.e optimize the older persons available/ remaining potential functions to avoid incapacitating through dependency creation. The care giver should be on the look-out for any signs of illness or needs for professional health care and arrange for the cared to access timely. Also very important is to ensure the older person is well cared for in a hygienic environment and personal hygiene is maintained at all times.

The carer should ensure the older person's dignity and rights are respected and protected by getting all family members on level understanding of the same in order to safeguard his mental health. Ask the older person what social events, programs or activities he/she would enjoy and let his/her preference be met as far as practically feasible.

The role of the individual and family caring for an older person therefore includes:-

- Monitoring the OP functional abilities and offering support according to the functional capability that is deemed deficient of reduced.
- Checking wellness of the OP in terms of checking their respiration (whether labored or not), their heart rate (if lower than 60 or higher than 80 beats per

minute, seeking assistance of a nearby health facility to check the Blood Pressure and other basic medical examination routines as found necessary.

- Helping the unable OP to bath, brush teeth after every meal, to discharge urine and attend bowels in toilet or in bed according to extent of physical limitation.
- Ensuring the OP gets balanced meals regularly according to what has been determined as fit for his/her condition
- Ensuring the immediate environment of the OP is safe; encouraging the OP to take walks around the home and if possible, around the neighborhood for the purpose of refreshing exercises.
- Facilitating the OP to get eye checkup, dental/oral care, throat care and skin care as conditions dictate, on an established routine.
- Providing the OP with items (reading materials) or events that help mental alertness and social contacts.
- Overseeing that the OP takes medication according to stipulated expert guidance and reporting early to a health facility that regularly takes care of the individual in case of illness or side effects of the medicines.
- Listening to the OP concerns, feelings, and preferences, in order to consider these in his/her overall management on daily basis.

5.2 Community and First Line Health Facility

Integrated Care for Older People (ICOPE)[39] has been conceived by the World Health Organization addressing the need for services to be orientated around the needs of older people rather than the needs of the services themselves. Services should respond to a diversity of older people that ranges from those with high and stable levels of intrinsic capacity through those with declining capacity, to people whose capacity has deteriorated to the point of needing the care and support of others. Important elements of integrated care at the community level are:

- 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
- comprehensive referral and linkages and monitoring follow-up processes
- Community engagement (sensitization, resolve to sustainable actions) and caregiver support.
- Community protection measures

[39] WHO Synopsis of ICOPE guidelines; full version www.who.int/ageing/health-systems/icope

5.2.1 Older people services to be expected from First line Health Facilities (Dispensaries and Health Centers)

- Health checks (Pulse, BP, RR, systems review)
- Basic tests (urine, stool, random and fasting blood sugar, Hb, FBP if deemed necessary)
- Recording prescribed medicines compliance and attendant challenges
- Counseling on what to pay attention to at home
- Referral and linkages on medical and social services

5.3 Geriatric 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 status
- Provide Psychosocial Care and Support Services (PSS) based on presenting problems
- Integrate OP outreach into RMNCAH outreach services

5.4. 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, Cancers and Renal functions including prostate status)
- Screen for any signs of cancer
- Assure Heart problem, Diabetes, Arthritis and Hypertension are fully at check;
- Counsel on how to avoid medicines interactions from poly-pharmacy
- Review mental and neurological status
- Review and counsel on nutrition and exercises.
- Specialized Psychosocial acre and support services (PSS)

Geriatrics providers focus on 5 key areas, known as the Geriatric 5Ms*. The “Ms” stand for the targets that are important to care for us all as we age.

Geriatric 5Ms Focus Areas:

MIND	• Maintaining mental activity • Helping manage dementia (a decline in memory and other mental abilities that make daily living difficult) • Helping treat and prevent delirium (an abrupt, rapid change in mental function-goes well beyond the typical forgetfulness of aging) • Working to evaluate and treat depression (a mood disorder that can interfere with all aspects of your daily life) ✓ Encourage timed workouts three times a week for those still able
MOBILITY	• Maintaining the ability to walk and/or maintain balance • Preventing falls and other types of common injuries ✓ Encourage gardening among those that have capability for this
MEDICATIONS	• Reducing poly-pharmacy (the medical term for taking several medications) • De-prescribing (the opportunity to stop unnecessary medications) • Prescribing treatments exactly for an older person’s needs • Helping build awareness of harmful medication effects ✓ Avoid use of insufficiently researched herbal therapy
MULTI COMPLEXITY	• Helping older adults manage a variety of health conditions • Assessing living conditions when they are impacted by age, health conditions, and social concerns ✓ Break social isolation; optimize the OP functional capabilities
MATTERS MOST	• Coordinating advance care planning • Helping manage goals of care • Making sure that a person’s individual, personally meaningful health outcomes, goals, and care preferences are reflected in treatment plans

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✓ Consultant’s additions

6.0 HEALTH SYSTEMS ISSUES THAT AFFECT SERVICES FOR OLDER PEOPLE AND HEALTH GOVERNANCE OF OLDER PEOPLE

Factors which might affect either directly or indirectly any WHO building blocks of the health system, it affects also the service delivery regardless of the age of patients. In turn, investment made in each block is envisaged to have a contribution towards holistic health system performance. The issue which has been shown to affect services for older people includes:

a) Availability and competency of human resources (health professionals): Absence of health staff specifically trained to care for older people, (only midlevel nurses are now trained to care for older people after their curriculum was reviewed). A cadre of Geriatricians is another gap in the system but caution should be exercised to ensure they are fully utilized when they are eventually introduced, trained and deployed.

b) Quality service delivery continuum: e.g. for resolving distance issues, after first visit subsequent follow up should/could be by setting up a 'refilling' system at lower levels of health care.

c) Regular availability of medicines and supplies: Stocks management that minimizes incidences of "out of stock" recordings (note this is also a Central supply issue).

d) Availability and use of SOPs: Rigorous supportive supervision with mentoring should increase SOPs applications in practice settings to ensure care is always optimal for all.

e) Completeness of health information: Due consideration to older people statistics, morbidity, mortality and attendant causes in HMIS shall help district and facility level health planning.

f) Fair financing arrangements and budget; effectiveness in application of waivers and exemptions policy and variations in LGAs management capability on Community Health Insurance Fund are substantial for reasons related to leadership commitment and more fundamentally lack of funds to finance the cost of free health care to exempt groups (Universal Health Insurance paid from a special pool of funds will be the way out of this predicament).

g) Accountability for older people benefitting in UHC and their voice in governance: Recording this in OP Forums will be informative for users as well as cement mutual

trust between providers and the OP intended to be served. *Inclusion of OP* concerns in access to quality health and wellbeing services calls for updating the Client's Charter so that the rights of OP are protected and observed including community awareness of their rights and obligations.

h) Functional supportive supervision, coaching, mentoring overall, and Continuous Professional Development encouraged for all health and social welfare cadres.

i) Insufficient attention to OP needs for free health services seem to be related to weak governance from low political will (or capability) to maximize communities' engagement and discourage dependency syndrome.
j) Less prioritization of ageing in community health outreach programs. There must be integration of health ageing during awareness and education of NCDs and geriatric conditions.

6.1: HEALTH GOVERNANCE FOR OLDER PEOPLE

The governance for provision of health services will embrace Decentralization by Devolution (D by D) policy across all organizational structure levels. These levels includes community, health facility, sub-national (council and regional) and national level (MOHCDGEC and PO-RALG)

6.1.1 Sub-District and Community role

In order to fulfill the essential requirement of accountability for UHC and voice for older people, Ward Development Committee, Hamlet/Village Government involvement shall recognize concrete actions in support of older people including consulting them at the stage of annual planning. Community level concrete actions shall be a solicited requirement for Faith Communities and Clubs that meet regularly (weekly, daily etc.) focused on tracking how care for older people is advocated for, how it is organized, how it is supported and taking measures to address shortfalls. Governance structures at these levels shall actively pursue compliance to UHC and popularizing outreach clinics for care of OP.

6.1.2 LGAs role

LGAs shall take full responsibility for OP care and welfare at all Councils with clear guidance on source of funds. Planning for geriatric care shall be part and parcel of the Council Comprehensive Health Plan (CCHP) within respective LGAs: In the CCHP ensures the home-based geriatric care appears as part and parcel of Community Based Health Care (CBHC). In this way the new cadre of Health Assistants- Community i.e. Community Health Workers, community case workers, community owned resource persons shall take up OP follow up and support their home-based care tasks as needed. The facility package (Health Centers, Dispensaries and level one Hospital) is defined in section 5.2 and 5.3 above: Ideally there should be arrangements to organize elderly clinics (once or twice a week) in more or less similar fashion to RCH clinics.

In the CCHP the OP services component shall cover investigation, treatment and care for the following TEN conditions commonly affecting OP:

- Hypertension
- Arthritis
- Diabetes
- Respiratory Tract Infections
- Congestive Cardiac Failure
- Urinary Tract conditions
- HIV
- Nutrition counseling
- Eye care
- Dental care
- Psychosocial care and life saving support services

The Health Systems and care issues already highlighted above shall be addressed within the CCHP.

Enforcing the regulatory framework to implement the guaranteed health services for older people shall fall under Social Welfare Officer of the Council; this shall include prosecuting offenders. Should the option of financing OP health services involve LGAs, the responsibility to provide all OPs with a card for identification when accessing health services shall rest with respective LGAs. When the Mandatory Health Insurance becomes a reality the personal National Health Insurance card shall be supreme replacing all other pre-existing health services access ID cards.

In summary the CCHP shall include the package of OP promotive, preventive, curative and rehabilitative care, as deemed necessary; counseling, psychosocial care and support services, professionals outreach support, CBHC promotion including HBC measures and

overall advocacy initiatives using the framework of OP Forums and formation of Active Ageing Associations.

6.1.3. Regional Secretariat

At regional level, health services for older people will be overseen by Regional Secretariat under the technical arm of Regional health Management Team (RHMT). The RHMT will advise, coordinate and build capacity all LGAs in the region so that quality health services are provided to all OP visiting health facilities within the region.

6.1.4. PO-RALG role

Through Department of Health, Social Welfare and Nutrition , will oversees all aspects of general administrative matters which when taken on board will contribute to realization of provision of health and wellbeing services at lower levels an all councils. Matters intended to be overseen includes: budgeting, equitable resource recruitment and initiate policy and guideline change requirements and contributes to their development

6.1.5. MOHCDGEC role

The Ministry established a desk dedicated to health services for Older People. What this desk has managed to achieve up to now should be taken to a higher level so as to address the critical uncovered issues, including development of geriatrics as an organized discipline within the health care delivery system. Organizing teaching of geriatrics to produce competent professionals in the field requires sufficient correct information on the subject matter, scope to be covered, career progression, stimulating interest in the actual discipline and other attendant challenges. In tracking this line of capacity development it is wise to recognize the 'strong feeling amongst gerontologists that academic leaders in professional faculties have to insure that their curriculum includes a sound preparation in aging and gerontological care; students need excellent assessment skills to determine the patients' unmet needs and respond according to their assessment of those needs and *that it is essential to* ensure that faculty members are sufficiently knowledgeable about the care of older people to be able to teach it and provide competent clinical supervision'[40].

[40]Gerontology in Canada: History, Challenges, Research Gavin J. Andrews & Lori Campbell & Margaret Denton & Kathy S. McGilton

To take on a leading and initiating role the MOHCDGEC needs to promote and commission development of a strong academic base that shall strive for passionate and capable scholars in this field. Consultation with Older People experienced organizations should provide clues on initial essential steps. Dedicated funding opportunities, having the ear of interested policy makers, and the support of representative groups and organizations shall make the task easy to handle. The MOHCDGEC shall undertake the following roles:

- Coordinate development of geriatric care training curriculum for use in producing a new cadre responsible for geriatric care in the country. The curriculum shall be integrated in the current curriculum of each health cadre. Determine entry qualifications for persons to undergo the postgraduate geriatric care training. Procure the expertise required to get the course running. Recruit the teaching staff (for training institutions under the Ministry) and orient them to the curriculum and concepts covered in the geriatrics discipline including determination of course duration. Commission the course and advertise to get student applicants through selection process and invitation to respective qualified colleges. Deploy the graduates at level one, two and tertiary health facilities. Due to relative unattractiveness of various professionals to the geriatrics discipline, it may be conceived as a specialization area amongst existing cadres (clinicians, nurses, pharmacists, mental health counselors), recognizing it as a promotional step in scheme of service.
- Guide all level I, II III and IV hospitals as well as the National Hospital to establish geriatrics departments/units (not necessarily wards). Get them to populate these departments and wards with the requisite expertise and essential equipment for optimal care for older people. While the responsibility of educating and updating the nation on Healthy Ageing shall rest with the Hospital Geriatric Departments/units, Active Ageing content can be introduced in curricula of colleges of various disciplines by the Unit responsible for geriatrics at the MOHCDGEC.

Essentials of geriatric departments at Hospitals include ordering essential equipment and medicines, maintaining the equipment and infrastructure, organizing team consultative meetings to keep abreast with quality of services to older people, to oversee CPD for geriatric care, and provide feedback to lower levels in terms of strengthening the continuum of care.

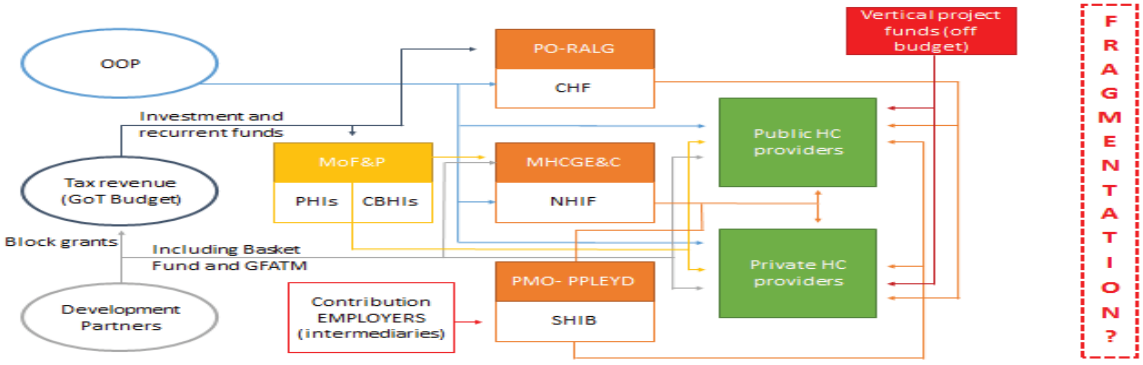
While preparing for establishment of geriatrics discipline in the country, interim measures should be undertaken such as training RHMTs as mentors of OP care, training Nurse Tutors, including health cadres' curricula updates. CHWs training curriculum should be updated to include OP care at households and community levels.

On the other hand, MOHCDGEC (Community Development) will be responsible for initiating the development/review of policies, guidelines, strategies and legislations related to rigths, development and welfare of older persons. Furthermore, the Ministry will monitor and evaluate the implementation of various interventions in the provision of welfare services to the elderly.

7.0. FINANCING OLDER PEOPLE'S HEALTH SERVICE DELIVERY: STRATEGY OPERATIONAL FRAMEWORK

With three major sources of financing and apparent coordination challenges of responsible agencies in both public and private domains, it only makes sense to devise an integrated pooled system of financing older peoples' health care, given the potential high risk to be marginalized within current arrangements.

Figure 2: Current health financing structure



The introduction of Universal Health Coverage (financed through Universal Health Insurance Scheme - UHI) will address many of the challenges which currently face the financing of health care to older people. The Government will devise a way which will ensure that all older people are members of the UHI. While the introduction of UHI is awaited, the present options of financing health services to older people will continue being applied as required this included the reviewed CHF.

The current options include:-
NHIF for retired civil servants and other individuals, SHIB for older people in the private sector, Improved CHF/TIKA and OOP
Which option is applied shall depend in which group the concerned older person fit.

8.0. WAY FORWARD

The provision of health and wellbeing services for OP as outlined in this strategy calls a multisectoral approach and multi-level actions. The participation of each stakeholder which includes various ministries, MDA, NGOs and CSOs would contribute towards attaining the set objectives of formulating this strategy.

8.1. Multidisciplinary action;

- Education - Should consider introducing a topic on Healthy Ageing publicity at all sports events in primary and secondary schools.
    - Higher education should intensify sports and gyms activities and undertake advocacy for Healthy Ageing Clubs or Associations.

Industries and Trade;

- Food safety, cosmetics safety, safe disposal of industrial chemicals, promotion of ageing focused industrial researches and products

Youth, Sports, Culture and Information;

- Popularizing healthy life style, physical exercise for ages from 5 years onwards, building a culture of Healthy Ageing.

Social Welfare -Popularize solidarity for OP care: Trust Fund to pay insurance for Older People guaranteed access to health care and support.

Local Government

- OP issues included in Local Council planning; Making by-laws and legal enforcement.

Ministry of Home Affairs - OP Trust Fund Registration

Ministry of Health Community Development, Gender, Elderly and Children

- Develop Geriatrics care competencies starting with tailor made On Job Training in the immediate to short-term
- Develop curriculum and training capacity targeted at selected existing cadres. Establish Geriatrics Management focal points as a medium-term agenda.
- Produce Geriatrics cadre, establish units at health facilities and equip them starting from level one hospital to higher level.

- Social Welfare and Community Development hold consultations so that they jointly develop Active Ageing Associations (AAAs) establishment program with in-built M&E.
- To strengthen unit for Social welfare and equip them starting at ward to higher level implementation units.

8.2. Multilevel action in Urban and Rural areas

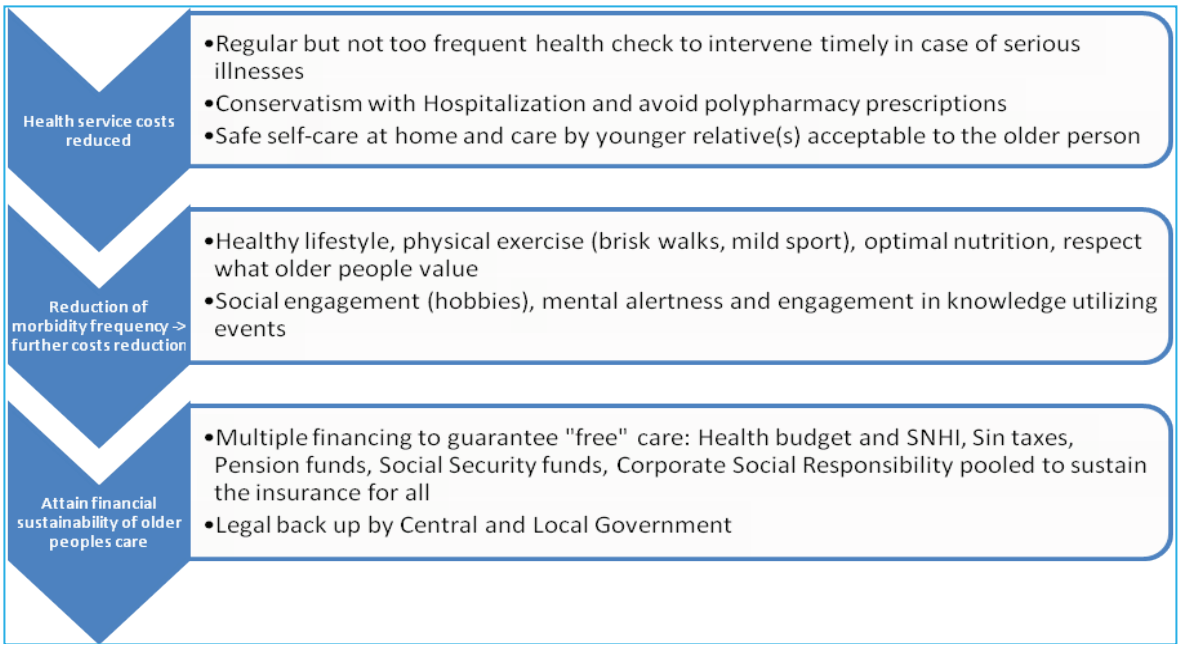
- LGAs, (social welfare officers, youth officers and Community Development Officers) negotiate with key Stakeholders (Private Clubs, FBOs, NGOs) the pragmatic actions to get Active Ageing Associations in place countrywide.
- LGA (Medical officers and Social Welfare Officers) engage OP Councils at Wards to promote advocacy for and actual practicing of Healthy Ageing plus strengthening their know-how on implementing capacity on rights and obligations of OP through wide publicity.

8.3. Immediate intra-sectoral measures

a. Assign translation of the Strategy into Kiswahili.
b. Share the document with Social Welfare, Community Development, Health Departments, youth officers, sports officers and Agencies requesting their feedback and action commitments.
c. Initiate inter-ministerial consultations and feed outcome of these to higher levels for policy level commitment on what is proposed.

9.0 CARDINAL FEATURES TO RENDER THE STRATEGY WORKABLE

A MULTISECTORAL APPROACH TO SUPPORTING CARE: MEET COSTS TO GUARANTEE 'FREE' ACCESS



Financial back up through a compassionate trust fund (Older People Trust Fund – OPTF)

Essential moves to render the strategy functional include (5Fs):

- Freedom from stereotype thinking on OP attained through mass sensitization.
- Fitness promotion at three critical age cohorts (11-30, 31-50, 51-70 + years).
- Feeding and nutrition assurance at all ages.
- Financing OP health care through forthcoming 'Mandatory Health Insurance for All'
- Favorable environment for Older People Trust Fund to operate independently (solidarity, pooling, investment, contribution to UHC practices).

10.0 FISCAL SPACE CONSIDERATIONS

Older people will be encountered as retirees from various walks of life, various sectors, institutions (public or private) and the self-employed not benefitting from neither pension nor insurance scheme. The Government will ensure that older people are fully catered for under Mandatory Health Insurance.

Healthy Ageing innovative volunteers' schemes which address care for disabled, transportation for medical appointments for those in need, running home errands for frail adults, covering care for children etc.) – a token compensation could be worked out that would be far much cheaper than institutional care (Nursing Homes, Hospitalization).

The Government understands that for the time being, older people not covered by health insurance may face limitations in the range of services available to them and limits posed by cost sharing and fees despite the directive to facilities that they provide health services to older people without them paying. In collaboration with older peoples' representatives and other stakeholders, the Government will continue enforcing its directives regarding this issue.

The challenge observed in the Health Financing Strategy, the fragmentation of pooling system not only in existing health insurance schemes but also in donor funding and Government structures whereby different ministries are responsible for different health insurances including MOHCDGEC, MOF&P, PMO- PPLEYD and PO-RALG will be addressed by the introduction of the Universal Health Insurance.

11.0 ASSUMPTIONS AND RISKS

The population of older people will continue to grow as life expectancy improves from enhanced uptake of public health measures, behavior change from health promotion and effective application of essential health interventions.

The national economy now enjoying a positive growth trend and measures to attain equity in distribution of national cake shall give due consideration to the need to assure healthy aging. Without the Single National Health Insurance (SNHI) or innovative financing as a proportion allocated to health from sources such as sin taxes, ability to tap the retained revenues of parastatal bodies, and other the fiscal space is significantly smaller[41]. Down to earth innovative design is called for preferably supported within and outside the Health Ministry.

The philanthropic stance required to move forward daringly with healthy aging, and providing older people guaranteed access to health services that they shall need, may change if there is a negative change in policy towards older people. Sustained application of existing policy, irrespective of change in political circles, is expected to engender a sense of pride to citizens as well as enhanced patriotism lifelong passed on socio-culturally as a cascade between generations.

Preparedness to establish a geriatrics cadre in the Health Sector shall consider their full utilization when they are eventually deployed: Of merit here is the utilization of this cadre to build capacity in respective hospitals and lower health facilities to handle geriatric cases with sufficient know-how and quality assurance.

[41] Op cit, p 79.

12.0. MONITORING, EVALUATION AND REVIEW

The policy on healthy ageing and guaranteed access to health care and wellbeing services for older people shall require a full- fledged unit to monitor how well it is working, evaluate the policy implementation and review the operating systems in order to make requisite adjustments and corrections timely. Such a unit should be instrumental in identifying/ defining a minimum set of indicators to track on older people's health care and support system thereof.

Accurate information needed on population of older people gender disaggregated, morbidity and mortality statistics, age at death and causes of death, qualitative information on quality of support and its regularity. Most of these bits of information should be collected in the routine data system of HMIS where the current HMIS tools might be reviewed to accommodate elderly related information intended to be collected. Indicators tracking health services delivery in elderly shall be developed.

Oversight through duly capacitated supervisors shall ensure monitoring is of desired quantity and includes important parameters.

A system review will be undertaken two years after rolling it out to fix initial shortfalls if any. The next review could be set at year 5 and year 10 according to need and requirements of stakeholders.

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ANNEXES

Annex 1: The recommendations provided on integrated care for older people (ICOPE)

Module I: Declining physical and mental capacities	
Mobility loss	**Recommendation 1:** Multimodal exercise, including progressive strength resistance training and other exercise components (balance, flexibility and aerobic training), should be recommended for older people with declining physical capacity, measured by gait speed, grip strength and other physical performance measures. *(Quality of the evidence: moderate; Strength of the recommendation: strong)*
Malnutrition	**Recommendation 2:** Oral supplemental nutrition with dietary advice should be recommended for older people affected by undernutrition. *(Quality of the evidence: moderate; Strength of the recommendation: strong)*
Visual impairment	**Recommendation 3:** Older people should receive routine screening for visual impairment in the primary care setting, and timely provision of comprehensive eye care. *(Quality of the evidence: low; Strength of the recommendation: strong)*
Hearing loss	**Recommendation 4:** Screening followed by provision of hearing aids should be offered to older people for timely identification and management of hearing loss. *(Quality of the evidence: low; Strength of the recommendation: strong)*
Cognitive impairment	**Recommendation 5:** Cognitive stimulation can be offered to older people with cognitive impairment, with or without a formal diagnosis of dementia. *(Quality of the evidence: low; Strength of the recommendation: conditional)*
Depressive symptoms	**Recommendation 6:** Older adults who are experiencing depressive symptoms can be offered brief, structured psychological interventions, in accordance with WHO mhGAP intervention guidelines, delivered by health care professionals with a good understanding of mental health care for older adults. (*Quality of the evidence: very low; Strength of the recommendation: conditional)*

Module II: Geriatric syndromes	
Urinary incontinence	**Recommendation 7:** Prompted voiding for the management of urinary incontinence can be offered for older people with cognitive impairment. *(Quality of the evidence: very low; Strength of the recommendation: conditional)* **Recommendation 8:** Pelvic floor muscle training (PFMT), alone or combined with bladder control strategies and self-monitoring, should be recommended for older women with urinary incontinence (urge, stress or mixed). (Quality of the evidence: moderate; Strength of the recommendation: strong)
Risk of falls	**Recommendation 9:** Medication review and withdrawal (of unnecessary or harmful medication) can be recommended for older people at risk of falls. *(Quality of the evidence: low; Strength of the recommendation: conditional)* **Recommendation 10:** Multimodal exercise (balance, strength, flexibility and functional training) should be recommended for older people at risk of falls. *(Quality of the evidence: moderate; Strength of the recommendation: strong)* **Recommendation 11:** Following a specialist's assessment, home modifications to remove environmental hazards that could cause falls should be recommended for older people at risk of falls. *(Quality of the evidence: moderate; Strength of the recommendation: strong)* **Recommendation 12:** Multifactorial interventions integrating assessment with individually tailored interventions can be recommended to reduce the risk and incidence of falls among older people. *(Quality of the evidence: low; Strength of the recommendation: conditional)*
Module III: Caregiver support	
	Recommendation 13: Psychosocial intervention, training and support should be offered to family members and other informal caregivers of care-dependent

	older people, particularly but not exclusively when the need for care is complex and extensive and/or there is significant caregiver strain. *(Quality of the evidence: moderate; Strength of the recommendation: strong)*

Annex2: Snapshot from field observation

Awareness raising, facilitation, advocacy on OP issues performed by age care organizations supported by HelpAge Tanzania to include MAPERECE based in Magu, and NABROH Society for the Aged based in Busega, PADI based in Ruvuma, TAWLAE based in Shinyanga, MOREPEO based in Morogoro and AFRIWAG based in Tanfa and other agencies, has made a significant difference to the situation of Older People in the implementing districts. Those NGOs have collaborated very effectively with stakeholders and engaged Government agencies such as the Police force, militias, criminal investigators and security personnel to bring to an end the killings of OP driven by false beliefs and criminal motives that fueled witch hunting, and killings or maiming innocent individuals.

These initial efforts paid off as they subsequently lead to developing and implementing positively inclined projects focused on human rights awareness creation and action to reduce poverty and improve living conditions of OP. A visit to three districts (Magu, Busega and Bariadi Town) accompanied and facilitated by knowledgeable MAPERECE and NABROH project managers ended up in gaining the following insights:

Positive features

- The Waivers and Exemptions policy is well accepted by the LGA, technical staff and OP forums.
- OP forums serve as a platform at which OP issues start to be articulated and targeted for relevant course of mitigation action.
- Insecurity that threatened OP in the past has been effectively clamped down.
- ID cards for OP free health services access have given concrete attention to and listening to OP problems (first served as soon as they report, dedicated room/space for serving OP, clear signage, documenting their numbers and disease conditions in the information system).
- Inclusive approach followed by CHMTs and LGA health facilities in support of OP health service needs as a pragmatic way to comply with the Waivers and Exemptions policy guidance within their limited budgets and shortfall in releases.
- A good level of assertiveness and clarity on issues among OP Forum members.

Negative features

- No guidance to LGAs on source of funds to cover the 'free health service' costs of OP illnesses
- Medicines frequently out of stock include a significant number of items for OP; hence they are given prescriptions to purchase from private vendors.
- Staff competencies to handle OP in the event of illness often fall below expectation and ideal practice (privacy, dignity, trust, stereotype behaviors, insensitivity to poly-pharmacy effects, insensitivity to patient preferences etc).
- Limited proportion of OP issued with ID cards
- ID cards not recognized for service at higher level health facilities; neither can they be used in a neighboring district or town council.

Kisarawe district:

Despite proximity to Dar-es-Salaam city with substantial number of potential supportive partners, as evidenced by presence of partners activities on various health issues, Kisarawe district lacks a key supporter of challenges facing OP.

Status of implementing the waivers and exemption policy guidelines:

- ✓ The district hospital has set aside a room for providing health services to OP.
- ✓ Most vulnerable OP in the district have been identified and counted – there are a total 5,200.
- ✓ The district prepared and issued 2633 ID cards which have proved quite useful.
- ✓ More recently the district made efforts to get up and running with an improved CHF targeted at enhancing access to medicines with effect from the next financial year (The scheme operates within Coast Region at Tshs 30,000 premium).

Successes:

- Reduced bureaucracy of OP identification.
- Reduced complainants crowding Social Welfare Officers with aim of getting ID cards.

Constraints:

- No funds specifically set aside to cater for OP free health services access; As a result implementing without an earmarked budget meant encroaching on earmarked budget categories leading to overall district budgetary shortfalls.

- Occurrence of OP neglected by own families – last year they encountered three cases.

Challenges:

- About 33% of OP Forums (6/17) are dormant. The active forums have been playing a positive advocacy role on free treatment access; this useful lesson has not been translated to a wider practice through innovation (f.i use of sms on mobile phones to reach out to the dormant ones).
- Medicines 'out of stock' was experienced frequently in the past (before DMO established a loan from NHIF with which he improved the Pharmaceuticals and Supplies system with stores monitored from his desk using CCTV cameras facility).

Insights shared with the DMO:

The district officials were concerned that Children and OP visits and re-attendances last year were running into millions due to cross border clients from Dar-es-Salaam. From Social Welfare Office we learnt that within its jurisdiction the district attended 2153 Older Persons in 2018 whose costs were 10,765,000 for consultation; 10,765,000 for diagnostics, and 14,380,000 for medicines. Total costs incurred for the exempted OP were TZS shillings 35,910,000 which works out to an average of Tsh 16,600 per client.

Expecting the district Councils to cover services to the large volume of exempted clients (when you pool them together) within its current resource envelope in the absence of additional funds is practically unrealistic and actually reveals a weakness in understanding bottlenecks of policy implementation. He shared from local and international experiences (Israel where he had opportunity to practice) that splitting between providers and purchasers on one hand, and policy making /oversight and Hospital ownership/management is important for the future of Health Services. A solidarity fund in support of OP health services free access is a good idea BUT it needs a policy and a law including a regulatory framework to protect and sustain it.

A visit to OP consulting room captured the following:

- The signage on OP needs better focus of message (better state 'Let OP be given first preference in the queue')
- Staff feel that OP complaints are quite severe when medicines are 'OS'.
- Staff observe that not all OPs have been issued with ID cards.

- Some OP come from a neighboring district, a fact that encroaches on the already limited district health budget.
- Common illnesses of OP seen – Hypertension, HIV, Malaria and Diabetes

The OP Forum Treasurer shared that most prevalent illnesses of OP from their point of view include

- High blood pressure
- Arthritis
- Diabetes
- Prostrate problems
- Low backache among women

From the Kisarawe District Council scenario we could extrapolate the TAS 16,600 per OP treated: Of the 2,600,000 Older People currently living in Tanzania if 25% would need treatment, the total cost would amount to 10.79 billion shillings a year.

Amana Regional Referral Hospital

Successes noted

- OP access to a limited package of Health Care is a good beginning.

Challenges

- Inability to give full complement of services to OP due to budget shortfall.
- Irregularity in National Policy for Older People definition of “inability to pay” leading to its abuse by OP who are well to do.
- Abandoned OPs face ‘hunger’ as a key problem resulting in some defecting from OP homes (for those facing severe stress and isolation/ abandonment) and going to beg on the street.

Stress points

- Transport to hospital
- Isolation and neglect by relatives and community
- Deficient financial capability of OP

Data: 2017 and 2018 data on cost items for OP attended were requested and obtained.

It is impressive they collect electronically and share these reports on a quarterly basis. In 2017 the total cost of providing services to exempt categories stood at T shillings 2,446,821,491/-: Costs for Older People care alone stood at 90,993,671/- for a total 3,756

OP attendances. Thus the cost per attendance works out to be 24,226/-. Quarterly summaries for 2018 indicate a trend towards a figure similar to 2017.

If 25% of OP are attended at Regional Hospitals the extrapolated Amana figures give a country total cost of TZS 15.75 billion shillings per annum.

Estimates derived from a private Specialized Hospital within Ilala revealed costs (in Tshillings) for treating OP presenting with more than one disease as follows:

(A) Patient with Hypertension and Diabetes 1st Visit 190,000 Repeat visits 215,000
(B) Patient with Hypertension, Diabetes and Cardiac Failure range 1,490,000 to 1,740,000
(C) Patient with Renal failure and Hypertension 1st visit 1,190,000 on admission 2,500,000

Source: Patient records showing billing to NHIF

The higher the level the more sophisticated the care for OP and hence the more expensive and challenging to pay for.

Conclusion:

1. Willingness of LGAs and Health Staff to support OP free health services care is not in doubt. Accomplishment of issuance of ID cards has gained momentum and been worked on enthusiastically in some areas. The OP Forums are recognized and consulted although not yet intensively/ systematically in a number of facilities visited.
2. The establishment of OP Forums demonstrates clear benefits to OP welfare and address to OP concerns where Help Age International has supported and facilitated local networking and advocacy work.
3. LGAs see clearly the lack of resources and lack of guidance on source of the resources as a major hindrance to advancement of free health care to OP. The situation is the same at the Regional Referral Hospital.
4. There was consistent agreement with UHC and Mandatory Health Insurance (MHI) for all as the rational way forward at the level of technical staff and OP Forums.
5. A single national pool of funds to pay for costs of health services to OP was well received as an idea for further engagement, deliberation and definitive decision at National level.