WHO Clinical Consortium
on Healthy Ageing 2018

Report of Consortium meeting held 11-12 December 2018
in Geneva, Switzerland
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Acknowledgments

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WHO gratefully acknowledges the in-kind and financial support of the European Society for Clinical and Economic Aspects of Osteoporosis, Osteoarthritis and Musculoskeletal Diseases (ESCEO); WHO Collaborating Centre for Frailty, Clinical Research and Geriatric Training, Gérontopôle – Toulouse University Hospital; Chulalongkorn University; the Government of Japan; and the Kanagawa Prefecture Government, Japan.

Finally, we wish to thank Suzanna Volk (Department of Ageing and Life Course) and Constance de Seynes (WHO Collaborating Centre for Frailty, Clinical Research and Geriatric Training, Gérontopôle – Toulouse University Hospital) for their administrative support.

This report was written and edited by Kai Lashley (Further Consulting), and Islene Araujo de Carvalho and Yuka Sumi from the WHO Department of Ageing and Life Course oversaw the development of the report.
# Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACL</td>
<td>Administration for Community Living</td>
</tr>
<tr>
<td>App</td>
<td>(software) application</td>
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<tr>
<td>CCHA</td>
<td>Clinical Consortium on Healthy Ageing</td>
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<tr>
<td>CGA</td>
<td>comprehensive geriatric assessment</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>HCW</td>
<td>health care worker</td>
</tr>
<tr>
<td>IAGG</td>
<td>International Association of Gerontology and Geriatrics</td>
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<tr>
<td>IC</td>
<td>intrinsic capacity</td>
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<tr>
<td>ICOPE</td>
<td>integrated care for older people</td>
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<tr>
<td>M&amp;E</td>
<td>monitoring and evaluation</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<tr>
<td>RCT</td>
<td>randomized controlled trial</td>
</tr>
<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
</tr>
<tr>
<td>SPPB</td>
<td>Short Physical Performance Battery</td>
</tr>
<tr>
<td>SRHR</td>
<td>sexual and reproductive health and rights</td>
</tr>
<tr>
<td>UHC</td>
<td>universal health coverage</td>
</tr>
<tr>
<td>WG</td>
<td>working group</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</table>
Executive summary

The 2018 annual meeting of the World Health Organization (WHO) Clinical Consortium on Healthy Ageing (CCHA), held in Geneva 11–12 December 2018, was the fourth gathering of an international group of clinical leaders, drawn from the full breadth of the field of ageing to progress the work agreed by Member States under the 2016 WHO Global Strategy and Action Plan on Ageing and Health.

Following the work of Member States in 2016, WHO published in 2017 the Integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity. Integrated care for older people (ICOPE) reflects a community-based approach that will help to reorient health and social services towards a more person-centred and coordinated model of care that supports optimizing functional ability for older people. This programme supports achievement of the Sustainable Development Goals and universal health coverage (UHC), by committing to reduce the number of older people who are care dependant by 15 million by 2025.

The consultative design of the meeting included discussions and working group activities to further review and refine the intrinsic capacity tool (renamed the ICOPE screening tool), which will be pilot tested in 2019 in several countries worldwide; a multi-country study of these pilot tests is being designed to validate ICOPE screening tool. CCHA members also received updates on the ICOPE application, diagnostic tools related to intrinsic capacity, UHC indicators, building sustainable long-term care systems, the evidence base on studies assessing frailty and the sexual and reproductive health of older people. Also discussed was the Department’s preparation for the Decade of Healthy Ageing, set to begin in 2020.
The workplan for the year ahead

The CCHA brought its 2018 annual meeting to a conclusion by consulting on a workplan for the year ahead.

- Pilot testing of the ICOPE screening tool in multiple countries including finalization of a research protocol and training with stakeholders in each country.

- ICOPE guidance on person-centred assessment and pathways in primary care will be published, both in paper form and for use in the smartphone/tablet ICOPE application. See https://apps.who.int/iris/bitstream/handle/10665/326843/WHO-FWC-ALC-19.1-eng.pdf

- Additional work on operationalization of the vitality domain will begin in 2019: core biomarkers of vitality will be identified.

- Diagnostic tools will be further refined in 2019, through systematic reviews and a Delphi study. These activities will allow for the development of a set of evidence-based tools that can be used to assess intrinsic capacity.

- New topics to be addressed in 2019 include: development of pain management guidelines, development of an ICOPE module on self-care and refinement of the oral health care pathway.

Consortium members provided useful feedback to refine the ICOPE screening tool in preparation for its pilot testing in 2019. Comments on the ICOPE smartphone application, specifically related to self-care and self-monitoring, were also particularly useful. If older people are to maintain and extend their intrinsic capacity as they age, the ICOPE guidance will need to provide them tools with which to make healthy choices.

The aim of this report is to provide a summary of what was discussed at the meeting. The group looks forward to accomplishing the workplan activities in 2019 to help make ICOPE work in practice, pave the way for the Decade on healthy Ageing, and continue to capitalize on the tremendous momentum around Healthy Ageing built thus far.
Participants were welcomed to the fourth annual meeting of the Clinical Consortium on Healthy Ageing (CCHA). The meeting was dedicated to John Starr, a member of the CCHA who died in 2018. Among Professor Starr’s final compositions was this excerpt:

“I must be an old Romantic at heart, but for me living isn’t about accumulating a list of achievements, or “impacts” as they might be termed, to be read out as a eulogy at my funeral. No, living is about being alive, that sequence of moments strung together from cradle to grave; and moments which inspire me with a sense of wonder, however ephemeral, are when I feel really alive. Research, suddenly seeing things revealed, just like moments when relationships deepen and transform, is able to bring such wonder into our lives.”

The workplan from the CCHA 2017 annual meeting was reviewed. This included:

• developing a WHO intrinsic capacity tool as part of comprehensive assessment – the first task of which was to select its components;

• harmonizing clinical data across research on the term “healthy ageing” – to develop an evidence base and test the generalizability of instruments, among other tasks;

• conducting a multi-country study of the WHO integrated care for older people (ICOPE) pilot projects and implementation – including the development of a protocol for this research.

The progress towards fulfilling each of these activities was presented and discussed during the meeting. This began with an overview of the ICOPE approach.

ICOPE reflects a community-based approach that will help to reorient health and social services towards a more person-centred and coordinated model of care that supports optimizing functional ability for older people. This programme supports achievement of the Sustainable Development Goals (SDGs) and universal health coverage (UHC), by committing to reduce the number of older people who are care dependant. ICOPE also represents a paradigm shift in the way in which older people are assessed and managed in the health and social care system. In contrast to earlier approaches that targeted a specific disease or condition among older populations, ICOPE serves to address the person as a whole through a person-centred integrated approach.

The new intrinsic capacity (IC) tool – hereafter referred to as the “ICOPE screening tool” following adoption of the new name by the Consortium – was also discussed. The ICOPE screening tool, which will be updated based on the feedback from participants of the 2018 CCHA meeting, will be pilot-tested in several countries in 2019: China, France, India, Japan, Mexico, Spain and Thailand.

1 https://britishgeriatricssociety.wordpress.com/2018/05/11/my-heart-leaps-up/
OBJECTIVES OF THE 2018 MEETING

Specific objectives of the meeting included the following.

• Final review of the ICOPE guidance on person-centred assessments and pathways in primary care.

• Agree on the ICOPE screening tool (step 1).

• Recommendations on IC diagnostic tools (step 2).

• Share the outcomes of regional induction meetings: South-East Asia Region, African Region.

• Establish ICOPE network of implementers.

• Update CCHA members on the multi-country study: China, France, Japan (Kanagawa Prefecture), Mexico, Thailand.

Annex 1 contains the meeting agenda and list of participants.
Integrated care for older people (ICOPE) care pathways

ICOPE guidance on person-centred assessment and pathways in primary care

There are five domains within the ICOPE guidance: locomotor capacity, vitality, sensory capacity (vision and hearing), cognitive capacity and psychological capacity. ICOPE guidance on person-centred assessment and pathways in primary care was discussed as part of the overall approach shown in Fig. 1.

The ICOPE screening tool (Table 1) is a tool for health-and social-care workers within the community on how to screen for priority conditions associated with declines in IC, based on the Integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity, published in 2017. This will lead to further in-depth assessment of the affected conditions.

### Table 1
Proposed ICOPE screening tool across six key domains

<table>
<thead>
<tr>
<th>Priority conditions associated with declines in intrinsic capacity</th>
<th>Tests</th>
<th>Assess fully any domain with a checked circle</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COGNITIVE DECLINE</strong></td>
<td>1. Remember three words: flower, door, rice (for example)</td>
<td>Wrong to either question or does not know</td>
</tr>
<tr>
<td></td>
<td>2. Orientation in time and space: What is the full date today? Where are you now (home, clinic, etc)?</td>
<td>Cannot recall all three words</td>
</tr>
<tr>
<td></td>
<td>3. Recalls the three words?</td>
<td></td>
</tr>
<tr>
<td><strong>LIMTED MOBILITY</strong></td>
<td>Chair rise test: Rise from chair five times without using arms. Did the person complete five chair rises within 14 seconds?</td>
<td>No</td>
</tr>
<tr>
<td><strong>MALNUTRITION</strong></td>
<td>1. Weight loss: Have you unintentionally lost more than 3 kg over the last three months?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>2. Appetite loss: Have you experienced loss of appetite?</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>VISUAL IMPAIRMENT</strong></td>
<td>Do you have any problems with your eyes: difficulties in seeing far, reading, eye diseases or currently under medical treatment (e.g. diabetes, high blood pressure)?</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>HEARING LOSS</strong></td>
<td>Hears whispers (whisper test) or Screening audiometry result is 35 dB or less or Passes automated app-based digits-in-noise test</td>
<td>Fail</td>
</tr>
<tr>
<td><strong>DEPRESSIVE SYMPTOMS</strong></td>
<td>Over the past two weeks, have you been bothered by – feeling down, depressed or hopeless?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>– little interest or pleasure in doing things?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
**Handbook**

Guidance on person-centred assessment and pathways in primary care

**Fig. 1**

The ICOPE approach

1. **Screen for losses in intrinsic capacity**
   - Assess in greater depth for conditions associated with loss in intrinsic capacity
   - Assess & manage underlying diseases
   - Assess & manage social and physical environments

2. **Person-centred assessment in primary care**
   - Assess in greater depth for conditions associated with loss in intrinsic capacity
   - Assess & manage underlying diseases
   - Assess & manage social and physical environments

3. **Design a personalized care plan**
   - Person-centred goal setting
   - Multidisciplinary team
   - Design a care plan including multi-component interventions, management of underlying diseases, self-care and self-management and social care and support
   - Referral and follow up

4. **Ensure referral pathway and monitoring of the care plan**
   - with links to specialized geriatric care

5. **Engage communities and support caregivers**
ICOPE smartphone application

The Ageing and Life Course Department has partnered with Universal Projects and Tools S.L. (also known as Universal Doctor) to create a smartphone application (app) to work alongside ICOPE; it will be launched in 2019 and thereafter be publically available for download.

Called the ICOPE Handbook app, it allows health workers to assess the health and social care needs of older people and deliver an integrated care plan. New patients are added after consent is given, whereupon demographic data is completed. Screening for declines in IC and development of a person-centred assessment and care plan in each of five IC domains is then possible, with tools built into the app to assist the health care worker (HCW) – for example a timer for conducting the chair rise test under the locomotor domain. (There are also separate apps that can be integrated in the screening [e.g. hearWHO\(^2\)], which work with this app.)

The in-depth assessment following the screening is only possible when the HCW logs into the app; once logged in, the app takes the HCW through the tests of each domain the patient failed to pass (e.g. in mobility, upon failing the chair rise screening test, the patient is asked to take additional tests in the Short Physical Performance Battery tests, SPPB).

\(^2\) https://www.who.int/deafness/hearWHO/en/
During the detailed discussion it was reiterated that the ICOPE Handbook app was designed for primary and community HCWs without specific training in geriatrics, and specifically to facilitate ICOPE screening in settings where it normally would not be possible or is currently not done, that is, outside of hospitals, in low-income countries, etc.

Several participants voiced concern about the nomenclature used in ICOPE and the app, particularly as the term “comprehensive assessment” is already being used in traditional algorithms such as comprehensive geriatric assessment (CGA); its use in ICOPE could lead to confusion. It was clarified that ICOPE is not a replacement of CGA, which requires specialized knowledge but a tool for use in community and primary care settings. It was therefore suggested to remove the term “comprehensive” from ICOPE guidance.

A point was raised about a potential strain on health care capacity if the ICOPE screening tool were to screen too many people into the health care system, where perhaps they could not afford or otherwise access care (e.g. in low-income settings).

The ability of ICOPE guidance to be an upstream screening tool was also discussed. For this to be effective, community/family links would need to be in place, and community health workers (i.e. CHWs actually working in communities, regardless of level of training) would need to be enrolled in the process.

Setting goals with and for each older person is an important part of care, which will be included in the app. The app will not only allow HCWs to assess older people, but will also allow older people to access interactive feedback about their assessment, including prompts (e.g. for exercise, balance) and resources to help them reach their goals. Participants considered this dimension important to include in the app, as well as an aspect that considers the referral to a higher level of care of patients failing the domain-specific screening tests.

Several participants felt that the ICOPE guidance needed to be more person-centred, with more practical guidance to support individuals. Six points were suggested to ensure this occurs.

- Following the assessment, a summary should be shared with the older person, affirming the results.
- Formal process of goal setting should then occur (adapted to culture and context).
- A review period is necessary – follow up and determine uptake at three months – though time period can be debated.
- Tools for self-monitoring need to be available – the ICOPE Handbook app is supposed to fill this need partially.
- Explicit data-sharing agreements must be in place.
- Determine the long-term follow up arrangements (e.g. annual review).

WHO is developing in parallel several monitoring approaches that deal with healthy ageing; the ICOPE guideline is just one. Other approaches include population-based monitoring that uses a range of existing data sources (e.g. household survey data), and a multisectoral approach that focuses on communities and cities. WHO is using all of these approaches to complementarily address the needs of older people and gather as much data as possible about this population.

A final point related to the definitions of terms such as “frailty” and “intrinsic capacity”: the former uses in its definition deficits, things that a patient is lacking, while the latter is built on the concept of reserves. However, the ICOPE screening tool is based on deficits. If the tool is to be truly integrated (it being touted as not focused on specific diseases or diagnoses), it should focus on the positive attributes of the domains one has to conduct their daily lives, rather than their lack – or make it clear why deficits were used instead.
**Working group activity on each care pathway**

Comments about the ICOPE guidance and ICOPE screening tool help to refine the guidance and tool – the point about focusing on positive attributes was particularly helpful. However, there is not yet enough evidence or clinical tools available to put this idea into practice. A new title for the ICOPE screening tool was also proposed: “Guidance on person-centred assessment and pathways in primary care”.

The next part of the meeting comprised working group sessions for each of the seven care pathways of the ICOPE guidance. The goal of the sessions was to ensure that text was appropriate and clear, particularly for community health and social-care workers, who may have limited training.

*What follows are the main points shared by each working group.*

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**WG1**

**Locomotor – loss of locomotor capacity**

<table>
<thead>
<tr>
<th>ARE THE QUESTIONS APPROPRIATE? IS TEXT CLEAR AND USABLE?</th>
<th>PROPOSED CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is important that the document on IC operationalization avoids ambiguities with the frailty construct.</td>
<td>▶ Suggest changing model might easily/equally work if IC replaces frailty.</td>
</tr>
<tr>
<td>A person screening positive at the chair rise test (i.e. &gt; 14 sec) is very likely to already have 2 points lost at the SPPB, meaning normal locomotor capacity limited to 10, and not from 10 to 12 points. This could lead to ambiguity about the nature of the algorithm.</td>
<td>▶ Suggest alternative ways for measuring the locomotor domain of IC. For example, gait speed test as entry point to the evaluation of locomotor function instead of the chair rise test. In this case, the cut-point might be set at &gt; 0.8 m/sec, considering that 1) lower speed might define frailty; and 2) a linear relationship between gait speed and negative health-related events exists (making every cut-point quite arbitrary).</td>
</tr>
<tr>
<td>It is unclear where the clinical expertise of a physician is introduced in the model.</td>
<td>▶ Suggest making this clear to avoid ambiguity.</td>
</tr>
<tr>
<td>It was felt that the longitudinal/dynamic nature of IC is here undervalued. That is, by taking a picture of the locomotor capacity and cross-sectionally applying cut-points, the aspect of working on trajectories is lost.</td>
<td>▶ Suggest including a section on follow-up of people who pass the screening test.</td>
</tr>
<tr>
<td>Nomenclature: focus is on progression of disease and its mitigation rather than promoting well-being and healthy ageing.</td>
<td>▶ Suggest promoting the positive aspect of the locomotor capacity tools and use them for setting the goals of the interventions – that is stating that the person should take less than 14 seconds at the chair rise test may provide the same messages, but in more positive terms (i.e. look at the healthy ageing).</td>
</tr>
</tbody>
</table>

*Note: IC, intrinsic capacity; SPPB, Short Physical Performance Battery*
### Psychological – depressive symptoms

#### ARE THE QUESTIONS APPROPRIATE? IS TEXT CLEAR AND USABLE?

<table>
<thead>
<tr>
<th>Question</th>
<th>Proposed Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening questions are appropriate, however, some additions could make the algorithm more usable.</td>
<td>As older persons use a wide variety of terms to denote a low mood (e.g. sadness, depressed, down, etc.), suggest adding a short comment that different words can be used in the first screening question by those being screened. This would allow the algorithm to catch more people who have a low mood.</td>
</tr>
<tr>
<td>Concerns about the nature of the care pathway suggesting a timeline, which it is not.</td>
<td>Suggest a hierarchy might be more appropriate: screening questions on top, thereafter a division in no risk of depression (pass), depressive symptoms (fail 1) and depressive disorder (fail 2). Activities would come thereafter (which all should be checked in case of depressive symptoms as well as a depressive disorder, although for a depressive disorder referral to specialized care is sufficient to mention).</td>
</tr>
</tbody>
</table>
| Depression symptoms (clinically relevant depressive symptoms) actually encompass in fact three subtypes, which are not indicated in the algorithm. | Subtypes:  
• A prodromal state of a full-blown depressive disorder. In that case, psychological therapies might be needed to prevent depression. Most evidence available is for self-help cognitive behavioural therapy (including guided bibliotherapy) and problem solving treatment.  
• Clinically relevant depressive symptoms due to a somatic cause. These causes should be recognized and managed.  
• Social deprivation. These problems should be recognized and managed. |
| It is noted that no pharmacological solutions are suggested in the algorithm. However, there is a risk that in primary care, general practitioners will prescribe antidepressants after screening due to minimal accessibility of psychological care. | Suggest adding a specific comment NOT to prescribe antidepressants; this may prevent adverse effects of screening. |
| Text related to the association between somatic and social triggers of depression can be clarified. | Suggest increasing the emphasis (in the explanatory text) that association is bidirectional. For example, depression leads to polypharmacy and polypharmacy to depression. Therefore, addressing depressive symptoms is important to break the vicious circle. |
| Physical frailty and sarcopenia are highly prevalent in depressed patients, but this is not addressed. | Suggest this be recognized and managed as well. |
| Anxiety, an important condition linked to psychological capacity, is not mentioned within the pathway but is a measure that could be measured effectively, and would be applicable to older people. | Potential screening questions for anxiety should relate to excessive worrying and panic attacks. Suggest:  
Screening for panic attacks: Have you ever experienced an abrupt surge of intense fear or discomfort seemingly for no reason, which lasted several minutes?  
Screening for generalized anxiety: Do you experience excessive worry, which is difficult to control or causes distress? Subsequent explorative questions could be:  
• Do you experience excessive worry?  
• Is your worry excessive in intensity, frequency or amount of distress it causes?  
• Do you find it difficult to control the worry (or stop worrying) once it starts?  
• Do you worry excessively or uncontrollably about minor things such as being late for an appointment, minor repairs, homework, etc.? |
## Cognition – cognitive decline

<table>
<thead>
<tr>
<th>Are the questions appropriate? Is text clear and usable?</th>
<th>Proposed Changes</th>
</tr>
</thead>
</table>
| Applicability for screening of people for this domain should be clarified. | There should be three ways a person enters the pathway:  
  - The person themselves comes to get assessed.  
  - The family brings the person because they know that s/he has a cognitive problem.  
  - The person has exhibited cognitive problems which have already been identified. |
| Text referencing “cognitive decline” in the pathway is incorrect. | Suggest “cognitive impairment” be used instead of “cognitive decline” (the terms are not synonymous). |
| Question under “orientation in time and space” difficult to understand. | Suggest replacing the question “What is the full date today?” with day of the week and month. |
| The three words used in the pathway to learn (flower, door, rice) are questioned. | |
| The statement under assess cognitive capacity – If a person has less than five or six years of schooling or no schooling, cognitive assessment cannot use the formal tools – is not evidence based. | |
| The list of cognitive assessment tools should be justified – i.e. evidence based. | |
### WG4

**Vitality – malnutrition**

<table>
<thead>
<tr>
<th>ARE THE QUESTIONS APPROPRIATE? IS TEXT CLEAR AND USABLE?</th>
<th>PROPOSED CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain title does not accurately reflect the content of the care pathway.</td>
<td>Suggest renaming this domain “malnutrition”. This would adequately represent all aspects of over- and malnutrition and incorporate other relevant topics such as oral health.</td>
</tr>
<tr>
<td>The algorithm seems to be weighted towards screening for under-nutrition. In some countries the prevalence of obesity in individuals aged over 60 years is over 40%.</td>
<td>Suggest a more even distribution of weighting for both over- and under-nutrition.</td>
</tr>
<tr>
<td>The MNA instrument is an appropriate screening tool for identifying individuals who are malnourished. However, it has limitations with respect to identifying specific micro- and macro-nutrient deficiencies.</td>
<td>Suggest that based on the results of the MNA further (more specific) evaluation may be necessary.</td>
</tr>
<tr>
<td>There is one factual error in the text. It is stated repeatedly that “protein absorption is decreased with age”, which is incorrect.</td>
<td>Suggest correcting this error with text that incorporates the following notion: The increase in muscle protein synthesis in response to a meal or protein feeding is blunted with advancing age, probably as a result of reduction in anabolic signalling in response to food (anabolic resistance).</td>
</tr>
<tr>
<td>It is possible that country-specific age criteria for assessment may need to be defined (e.g. 60, 70, 80 years).</td>
<td></td>
</tr>
<tr>
<td>This care pathway could be better integrated with other care pathways, specifically motor function and cognitive care.</td>
<td></td>
</tr>
</tbody>
</table>

*Note: MNA, Mini Nutritional Assessment*
## Sensory – visual impairment

<table>
<thead>
<tr>
<th>ARE THE QUESTIONS APPROPRIATE?</th>
<th>PROPOSED CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical visualization of the algorithm could be improved.</td>
<td>Suggest thicker arrows, colour coding (e.g. red for fail, green for success).</td>
</tr>
<tr>
<td>Initial screening questions in the care pathway could include more questions about associated conditions.</td>
<td>Suggest including questions about associated conditions (hypertension, diabetes, steroid use) – as for local adaptation, other prompts should be used, such as medication for arthritis or other conditions where steroids are used.</td>
</tr>
</tbody>
</table>
| Referral to service could be more comprehensive, particularly for national/local adaptation and in low-income countries. | Suggest two aspects be addressed:  
  • Link to further information on what is a comprehensive eye and vision exam*.  
  • Adapt locally to specify where to get assistive devices, and services – and how to access them. |
| More attention could be paid to specific social care needs. | Suggest highlighting prevention and additional items for local adaptation. |
| Gathering the data on the outcomes of those seeking and getting cataract surgery should also be considered. | Suggest that any activities related to cataracts within the care pathway be aligned with capturing the effective coverage of cataracts. |

Note: * This is currently being addressed in a parallel process, which includes the types of tests and what should be identified, including cataracts, retinopathy, glaucoma diagnosis treatment/management.
**WG6**

**Sensory – hearing loss**

<table>
<thead>
<tr>
<th>ARE THE QUESTIONS APPROPRIATE? IS TEXT CLEAR AND USABLE?</th>
<th>PROPOSED CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>The pathway was clear and made sense but was too detailed in some areas – although the issues are important to a few people affected, the points were either too vague or needed skills to interpret so would be inconsistently applied or result in too many referrals.</td>
<td>Suggest addressing the red flags of chronic otitis media and dizziness.</td>
</tr>
<tr>
<td>The conduct of the whisper test needs more detail.</td>
<td>Suggest the following changes:</td>
</tr>
<tr>
<td></td>
<td>• Replace the word “several” with a specific number.</td>
</tr>
<tr>
<td></td>
<td>• State that each word should be spoken one by one, waiting for a response to each one – not waiting to respond to all at once.</td>
</tr>
<tr>
<td></td>
<td>• Define normal (apparently it is over 50%) heard correctly.</td>
</tr>
<tr>
<td></td>
<td>• More sensible to suggest 4 words of which 3 or 4 must be heard.</td>
</tr>
<tr>
<td>It is unclear what asymmetry means at the screening stage of the whisper test.</td>
<td>Suggest that it is not useful to include asymmetry at all – as if either ear is abnormal then it results in diagnostic audiology. The detail about specialist assessment is probably unnecessary.</td>
</tr>
<tr>
<td>Connection with other domains during the summary assessment for care planning should be strengthened.</td>
<td>Section 3 mentions the connection between this domain and others when a summary assessment for care planning is developed, but it should be made clearer (and this section might need to be moved to later in the care pathway).</td>
</tr>
</tbody>
</table>

**WG7**

**Social care and support**

Details from this working group were presented on day 2; see *Integration of social care and support services in ICOPE programme* for details.
3 Vitality

Report on the IAGG/WHO Vitality meeting

The term vitality and the care pathway should be viewed within the continuum of the overall life course, as part of healthy ageing. Unlike other care pathways, organic function and clinical performance in the vitality pathway are not directly linked. The importance of establishing a baseline of vitality from which to define movement along the care pathway was also presented. It was stressed that vitality is not unidirectional (people recover after strokes and depression for example) and so one or more metrics are needed that can account for this. The matrix to assess vitality is therefore more complex than for other care pathways.

Vitality was defined as “bio-physiological status”, which was a broader definition of vitality presented during the International Association of Gerontology and Geriatrics/WHO vitality meeting in September 2018. What follows is a summary of the key points from that September meeting.

Ideas on “Vitality” from IAGG/WHO meeting

The following provides a suggestion for the attributes of vitality and their measurement, which could lead to overlapping domains, allowing for measurability of each (Fig. 2).

- Stress response system (homeostasis/mutual regulatory physiologic systems) – Measures: CRP, IL6, cortisol, heart rate variability, TNF-alpha1.
- Damage/repair (integrity of organ systems) – Measures: FEV1, kidney function, muscle mass, vascular/cardiac function.

In advance of the discussion, participants were then asked if the attributes were correct or needed changing, or whether other mechanisms of describing vitality would be more useful.

DISCUSSION SUMMARY

Participants welcomed the creation of a framework to define vitality, which is a term difficult to define in a way that lends itself to measurement and analysis – for example, terms like “reserves” and “resilience” are largely subjective. One notion coming from the IAGG/WHO meeting was the “capacity to retain capacity” (which itself would require capacity to achieve).

Several participants questioned the biomarkers presented, as part of a technical discussion on biomarkers in general. One participant suggested waist circumference seems a promising biomarker in terms of measurability and applicability based on a study he is involved in.

One suggestion involved using big data to help define and measure vitality. As use of smartphones and wearable technologies increases, the data these provide could be used to measure people’s activities over time, offering insights into levels of vitality.

Another suggestion was the use of a simpler variable, like the indicator “self-reported fatigue”, which might be able to capture the notion of vitality. Ultimately the goal is to frame the construct so that simple ways to measure vitality can be identified.
Intrinsic capacity

Vitality / resilience / reserves:

Overt expressions:
Locomotor
Cognitive
Sensory
Psychological
Other

Fig. 2
Venn diagram of possible attributes of vitality and means for their measurement

Note: SASP, senescence-associated secretory phenotype
WHO AMRO readiness to implement ICOPE

Under the title “Integrated care for older persons: are we ready?”, 10 countries participated in a technical review meeting in 2018: Mexico, Costa Rica, Cuba, Barbados, Trinidad and Tobago, Jamaica, Brazil, Uruguay, Argentina and Chile. Analysing the feasibility of the ICOPE approach within the context of UHC and the redes integradas de servicios de salud [Integrated Networks of Health Services] in the Americas was not the only objective of the meeting; it also sought to get commitments from participating countries and other strategic partners to outline a project of sustainable and collaborative work towards the implementation of effective integrated care.

During the meeting, each country was assessed based on the ICOPE implementation score card (https://apps.who.int/iris/handle/10665/325669), which showed that improvements in services and systems continue to be needed. Following a preparatory period, the Region of the Americas will begin to scale up ICOPE implementation (2021–2024). This will be followed by a rigorous evaluation of the programme (2025–2026).

WHO AFRO priorities and next steps

The “Intercountry orientation workshop on implementation guidance for ICOPE and longer-term care systems in the African Region” was held in Pretoria in November 2018, attended by 20 countries from the region. Among other issues, the workshop established a roadmap for advancing healthy ageing, including scaling-up implementation of the ICOPE approach.

Challenges to that scale up were also identified; among the many pressing health burdens in the African Region, issues critical to healthy ageing were often overshadowed. For example, reliable data on health and social needs of older populations is practically non-existent; few countries have a national healthy ageing policy and or programme (or policy on long-term care); and there is a dearth of specialists and training in gerontology and geriatrics.

Next steps identified at the end of the ICOPE workshop include addressing the identified challenges and scaling up ICOPE implementation. Among these is strengthening monitoring and evaluation (M&E) of programmes and data collection overall and increasing training in ICOPE and training of trainers once the ICOPE approach is finalized. To make ICOPE implementation a success in the Region, the remaining 27 countries not attending the meeting need to be briefed on the approach.
DISCUSSION SUMMARY

While participants welcomed participation of countries from the African Region in the ICOPE approach, there was agreement that ICOPE implementation in the context of a weak health system would not serve anyone. The suggestion was to get commitment of capacity to manage noncommunicable diseases at primary health care level first.

The increase in political commitment regarding healthy ageing among governments within the African Region has been striking. This has been due largely to sensitization of focal points on the topic, who have then become advocates within governments.

The need for sensitization extends to WHO itself: while one of the items in the WHO thirteenth general programme of work 2019–2023, approved by the Seventy-First World Health Assembly, is achieving UHC and integrated care within UHC, WHO does not necessarily see the advantage of or need for addressing older people as a group. Importantly, ICOPE has been designed to address this group, and is being used as a starting point for discussing the high-level agenda and reforms of the health and social care system to be more inclusive of older people. Before the higher-level work can begin, however, the systemic issue of ageism must first be addressed.

4 https://www.who.int/about/what-we-do/gpw-thirteen-consultation/en/
5 Report from CCHA work streams

ICOPE screening tool

The rationale for using IC as a metric in ICOPE was made. To be most effective, the ICOPE screening tool needs to be used consistently (allowing for follow up and adaptation of interventions) and shared widely between health care professionals (to define integrated care plans and facilitate knowledge transfer, i.e. training of trainers). Only once those results have been validated can the tool be proven to address the needs of older people. However, there remain several questions with respect to the metrics to assess the efficacy of the tool, such as how they would be implemented in practice, how often and how completely they would need to be repeated.

To find answers to those questions, a network of HCWs would be needed. Funding from the European Union has led to the establishment of such a network in southern France and northern Spain. One of the working groups of the network is focused specifically on assessing intrinsic capacity, and has begun a feasibility study of the ICOPE screening tool; a database has already been established, which will allow researchers to share data between France and Spain.

Further research is needed to outline the evidence about questions related to the ICOPE screening tool, such as usability by health and social care staff, ability of the tool to detect outcomes effectively, whether the tool detects what it is designed to detect and cost-effectiveness, among others.

DISCUSSION

SUMMARY

It was clarified during the discussion that the tool would be evaluated across different settings, and that the settings themselves would inform the evaluation as well.

Assessing the effectiveness of the thresholds for each of the five domains in the ICOPE tool still needs to be done. In addition, in order to repeat the self-assessment, incentives would need to be offered. Such incentives would likely be culture-specific.

One participant was concerned with the risk of making “normal” a clinical state. Even people for whom “normal” functioning is still present (i.e. IC is undiminished), simple lifestyle changes suggested by the ICOPE guidance can prolong that period of normal. Ultimately the ICOPE guidance is not just to measure, but also to promote healthy lifestyle changes.
An overview of systematic reviews: tools to assess intrinsic capacity

A rigorous protocol is used to get ICOPE tools endorsed by WHO. Three steps are required; this presentation focused on the first: collect all the evidence on the accuracy of tests to measure conditions associated with declines in IC. The methods to do this involve an overview of systematic reviews to collect, synthesis and compare the evidence on diagnostic tests for each IC domain; and a Delphi study with expert stakeholders. The presentation also addressed the way to conduct a systematic review for those unfamiliar with the process.

One potential issue identified is the challenge with finding reviews/studies that meet the IC definition.

DISCUSSION

SUMMARY

Participants were encouraged to hear this research is ready to be undertaken. While the start date of the review has been delayed, funding for it has been secured. Once begun, the review should take eight to twelve months (at a minimum) to complete.

To be as inclusive as possible, more than one gold standard per domain is to be considered, that is, review all the evidence that meets the search criteria for each domain. The Delphi study will be used to then organize and review the results further.

It was suggested to include reviews in languages other than English, particularly if studies on particular domains were limited in English. It was also suggested that the domain “vitality” be uncoupled from “nutrition”; rather that the studies be reviewed to see what they return under the search term “vitality”.
**ICOPE UHC indicator**

With the increasing focus on UHC, which seeks to provide health coverage to 1 billion more people by 2023 as part of meeting the SDGs, WHO needs high-level indicators in place to measure progress effectively.

To determine if the thresholds of the indicators are appropriate for older people, tracer indicators are used, which are correlated with health gains. An indicator for older people used in the presentation was: “Percentage of older people at risk of care dependency who received interventions to prevent it”, with the caveat that there currently is no data source for this proposal. The current set of tracer indicators for this indicator is:

1. **effective** coverage for cataract
2. **effective** coverage for severe hip osteoarthritis measured by hip replacement
3. **effective** coverage of dental care.

It has been shown, however, that just because one has coverage for a specific medical intervention does not mean that s/he receives it, or that the intervention is successful; also possible is that multiple needed interventions are not addressed. Therefore such indicators need to be weighted to determine effectiveness, and “full coverage” needs to be identified as well.

Finally, questions were shared with participants to refine the indicator and tracer indicators presented.

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**DISCUSSION**

Discussion following this presentation was quite animated. Many participants took issue with the suggested tracer indicators. For example, some people were concerned that the indicators were disease-related rather than being related to well-being or capacity – use of surgical interventions as indicators sends the wrong message. One comment questioned the need for tracer conditions at all. Another concern was that indicators 1–3 are not good interventions as proxy for older people, as relatively few data can be found for each. A number of alternatives were shared during the discussion:

- Use of number of trained workforce per 100,000 population as an indicator.
- Use of the 13 recommendations in the ICOPE guidelines, all of which are based on evidence.
- Use of the SDG targets themselves as the indicators, which could be used to measure increase in UHC.
- Use of social and healthy well-being rather than tracer indicators.

One practical suggestion was to use the example shared during the presentation (receiving treatment for multiple conditions, diabetes and hypertension) as a good indicator to measure effectiveness of health care coverage.

It was pointed out that Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Survey (MICS) currently do not collect data on older populations, which is a major gap.

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1 Effective in this context means that the indicator leads to a lower burden of disease overall
2 [https://apps.who.int/iris/bitstream/handle/10665/258981/9789241550109-eng.pdf?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/258981/9789241550109-eng.pdf?sequence=1)
Research protocol for ICOPE pilots and evaluation

The research protocol (Fig. 3) for the ICOPE pilot projects has two main objectives: to validate the ICOPE screening tool (primary goal) and developing a multimodal intervention in older subjects at risk of care dependence aged ≥ 65 years in comparison with usual clinical practice (secondary goal). Within the second objective are embedded goals such as assessing clinical efficacy of the intervention, at a global level, feasibility of the implementation in various settings (e.g. local, regional, primary care vs hospital settings) and how to scale up programmes for countries, like Mexico, participating in the pilot project.

Work on this activity has been and will continue to be incredibly complex – from enrolling participants to designing the studies, conducting surveillance and management of the process, etc., all of which will require funding and time. Nevertheless, research questions have been framed, which consider both qualitative and quantitative outcomes.

Also shared was the process by which the care pathways and domains of the ICOPE were developed, including the breakdown of the factor analysis of the five domains (vitality was not included here, as it cannot be mapped in this way). The results of the factor analysis showed that the current groupings seem quite appropriate and should be documented for further research.

The proposed study trial design for Mexico includes 3000 patients to be assessed, 1200 to be followed up, with active intervention in 300. Patients aged 60 and older will be recruited from primary care clinics, and screened using the ICOPE screening tool.

Fig. 3
ICOPE research protocol

<table>
<thead>
<tr>
<th>FUNDS</th>
<th>RESEARCH DESIGN</th>
</tr>
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<tbody>
<tr>
<td>• Funding availability</td>
<td>• Cross-sectional study</td>
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<td>• Basket of funds</td>
<td>• Outcome variables</td>
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</table>

<table>
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<tr>
<th>STUDY PARTICIPANTS AND RECRUITMENT</th>
<th>DATA COLLECTION AND MANAGEMENT</th>
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<tr>
<td>• Criteria for older person</td>
<td>• Manual of operations</td>
</tr>
<tr>
<td>• Other eligibility criteria</td>
<td>• Paper form/web-based data management system</td>
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</table>

<table>
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<tr>
<th>QUALITY CONTROL PROCEDURES</th>
<th>ETHICS</th>
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<tr>
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<td>• Informed consent</td>
</tr>
<tr>
<td>• Pilot</td>
<td>• Ethical approval</td>
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<tr>
<td>• Validity cross-checks</td>
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<table>
<thead>
<tr>
<th>PROJECT IMPLEMENTATION AND MANAGEMENT</th>
<th>ANALYSIS PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Country coordination</td>
<td>• General analytical approach</td>
</tr>
<tr>
<td></td>
<td>• Secondary analysis</td>
</tr>
<tr>
<td></td>
<td>• Publication plan</td>
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</tbody>
</table>
Participants discussed a number of points related to the study in Mexico and the research protocol. It was noted that the proposed research protocol will be further refined through a working group and in liaison with WHO. The study in Mexico is to begin in January 2019, on pre-fail and frail populations; the study cohort comprises middle-class people.

Further discussed was the validation of the ICOPE screening tool, the first objective of the study. Validation is a long-term goal, which begins with assessing and addressing the problems that arise. Developing effective interventions for each domain is the most important short-term goal, rather than assessing what the range of interventions across all domains will be able to accomplish. It was noted that each domain and its interventions will be complex to study, but the immediate goal is to show that the interventions benefit patients. Later, randomized controlled trials (RCTs) will prove the cost-effectiveness of the interventions.
An update was shared on the community of practice of the integrated care of older people. Currently in a trial period, the community of practice will open to the countries pilot-testing the ICOPE screening tool. In the coming months, a call to the public will be shared for expressions of interest to join as well.

Integration of social care and support services in ICOPE programme

There are differences in social care, and programmes across countries are often underdeveloped. While family care is the foundation of social care, it is insufficient to meet the needs of older people alone. Training in the person-centred approach is largely lacking, and there is a need to create a comprehensive approach to person-centred care that can be applied widely. This training should aim to provide guidance to HCWs on how to detect and manage declines in IC.

The working group session on day 1 led to changes of screening questions in this care pathway. The proposed changes include: focusing on goals of functional ability rather than the disadvantages/diseases of ageing. One of the proposed changes to the screening question follows: “Are you independent and able to do the things which are important to you?”

If the answer is no, the revised additional questions follow:

Is this because...

1. You need help or support with daily living activities such as bathing, dressing, keeping up your appearance?
2. You have difficulty getting around indoors?
3. You have difficulty getting around outdoors, including shopping or getting to public services?
4. You feel lonely or isolated?
5. You have problems with your accommodation?
6. You have limited financial resources?
7. You feel threatened or harassed?
8. You lack access to leisure facilities, clubs, faith groups, education, employment or volunteering opportunities?

Several questions are intentionally open-ended, and it was stressed that follow-up question 7 must remain in the list. Following that, it was suggested that HCWs summarize the results of the IC and social care needs assessment, prioritize concerns in discussion with the older person and agree on interventions (using a local resource check-list) and set goals. Review of uptake and impact of the interventions should be done at three months, with long-term follow up (at least annually).
U.S. Department of Health and Human Services programs integrating health and support services for older adults and people with disabilities

The Administration for Community Living (ACL), established in 2012, is part of the Department of Health and Human Services. Its goal is to offer a comprehensive package of services to older adults, in the areas of health, independence and preventive services, among others. Embedded in the ACL are performance indicators used for monitoring and evaluation of the program’s effectiveness. A toll-free number also connects older adults with the US Aging Network and Support Activities line, which provides services and meetings available by postcode – a national locator and engagement tool.

A five-year clinical trial is currently being conducted related to falls and fall prevention, using a home-management model for falls, which includes a care plan for study participants. Data from the community aspect of this program should be available later in 2019.

In summary, ACL and its partners at the state level support people to live independently and fully integrated into communities. The ACL program could provide insights for other countries and WHO to integrate health and support services for older adults.

Integrated health and social care in Brazil

In Brazil in 2013, the Sistema Único de Saúde [Brazilian health service] spent US$ 275 million on inpatient care for people aged 60 years and older for conditions suited to outpatient care, despite an inadequate number of hospital beds in the country. According to a poll, 95% of Brazilians either do not care or are unaware of the issue of inefficiency in the health system.

Awareness of the concept of social care however is growing in Brazil, evidenced by an increase in residential services – but there are gaps: in 2013 a majority of people aged 65 years and older with care needs received no assistance. Some of the barriers include steep terrain and lack of local infrastructure. In addition, it was found that primary-level nurses were often unaware of older people in their communities.

In building a robust social care network in Brazil stakeholders sought to increase capacity from the bottom up, such as identifying and training local nurses, community health workers and social workers (and facilitating cross-communication). In an example from the state of Ceará, state and local governments are equal partners in determining the health needs of the state’s older population, and families with people aged 70 and older are registered in a database, so HCWs can check on them.

DISCUSSION

Summary

During the discussion, participants agreed that the term “independent” should be removed from the question above, because independence comes from a variety of factors outside the individual. It was therefore decided the question should be shortened to: “Are you able to do the things which are important to you?”

Some questioned the subjective nature of the follow-up questions – such as “You have limited financial resources?” – suggesting that for questions about care it would be more effective to ask about level of care.

The language of the questions needs to be further edited and terms defined, particularly “family”, which is very dependent on culture (note the different perceptions of this term seen in for example Brazil and Germany). As the ICOPE is global guidance, base definitions should be clear and translatable to various cultures.

Discussion

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Exploring emerging issues

Frailty common data elements

As one ages, increases in frailty are linked with decreases in IC. There is, however, a lack of data on frailty, so a systematic review of all RCTs was done. In total 202 RCTs were included, which studied the impact of an intervention on a frail patient – any care setting and any intervention. Outcomes of those studies were varied, however, so only 25% of those studies were reviewed (those that studied overall “function”). Of those reviewed, population descriptors varied widely, e.g. almost half of the studies did not define frailty for enrolment; others had no objective measure of frailty.

Thankfully, work has begun on a core domain set of standardized indicators for studies about frailty, which are harmonized with ICOPE. Such standardization will make review and comparability easier, and increases opportunities for funding as well. The next step is to determine the right outcome(s) to measure, such as mortality, quality of life, qualitative/quantitative, etc. It was stressed that the outcomes and the core domain set would take account of patients’ perceptions of care as well.

DISCUSSION

Participants welcomed the work of Queen’s University and partners, noting that great benefits would come from the research being done in this project, particularly in standardizing the core set of outcomes of healthy ageing. The clinical work being done would be even more beneficial if it informed the Cochrane Review.

SUMMARY
Sexual and reproductive health of older people

The sexual health of older people is a topic often overlooked or not considered by society. At least partly due to this there is a dearth of sexual and reproductive health and rights (SRHR) data of older age groups. Data that do exist show that sexually transmitted infections are high and increasing among older people (e.g. 45% of Americans living with diagnosed HIV are aged 50 years or older). More data are urgently needed. Increasing rates of HIV, now a chronic condition thanks to antiretroviral medicine, will place increasing burdens on health systems.

WHO has formulated a people-centred, evidence-based guideline on self-care interventions for SRHR. While not specifically targeted to older people, the guideline does align with ICOPE's approach – by focusing on the individual.

DISCUSSION

The WHO guidelines were lauded for focusing on maintaining healthy (and positive) aspects of sex and sexual health rather than on disease – though such an approach should also contain an aspect particularly tailored to older people.

Further discussion highlighted the fact that in culture (and even within WHO), sex and sexuality is often addressed clinically rather than holistically; questions related to sexual and reproductive health, particularly of older people, still go unasked – the desires of younger age groups are just implied and applied to older age groups. As part of this trend, society considers older people, particularly women, to be asexual – and sex among this group a taboo topic. Online and mobile-based apps are helping to breaking this taboo.
The way forward and closure of the meeting

A Decade of Healthy Ageing

Member States have mandated that WHO address healthy ageing within the context of the SDGs. The provisionally-titled Decade of Healthy Ageing is a way to execute that mandate and expand on the momentum built by the Department of Ageing and Life Course and stakeholders in the area of healthy ageing and ICOPE. The idea around the decade is to galvanize (and inform) public opinion and political will on the topic. Its overall goal is to improve the lives of older people, their families and communities, specifically in the area of social care and support.

In order to maximize the decade’s effectiveness, the Department of Ageing and Life Course needs to learn the lessons from earlier decade-initiatives of other programmes. Increasing the pool of stakeholders engaged with the Decade of Healthy Ageing will be critical to its success as well (e.g. private sector, civil society, academia). The work will begin with a baseline of data in place along with a comprehensive system of monitoring and evaluation to monitor the progress over the course of the decade.

The final draft of the proposal for the decade needs to be sent to the Executive Board of WHO by October 2019, with a number of milestones (such as additional consultations with stakeholders like organizations representing older people) occurring between now and October 2019.

Platform on Population Ageing

In a survey about stakeholder needs for the Decade of Healthy Ageing, “connection” was the most important need cited about what to focus on in the decade – connection between peers, experts, civil society and older people themselves. Next most important was learning from others – through training and studies on cost-effectiveness. In response to the survey, WHO organized a stakeholder consultation on 15–16 November 2018 to expand on these topics. As with many of the challenges facing humanity at this moment in time, business-as-usual actions will not lead to new results; what is needed for the Decade of Healthy Ageing are new approaches to achieve breakthroughs – approaches that nurture leadership, catalyse innovation, identify successful interventions, enable research and connect stakeholders.
Various names for the decade were suggested, including Successfully Ageing Societies, and Society for All. It was noted, however, that the use of adjectives like “successful” have been employed too often with ageing, making them hackneyed. The spirit of societal/society being captured in the title, however, was met with enthusiasm.

Most decade-initiatives are created top down. With its person-centred approach, ICOPE has pushed the idea of working from the individual outwards; if the Decade of Healthy Ageing can expand on this idea, meaningfully sharing the needs and desires of individual older people within a construct built from the bottom up, the decade will succeed.

Potentially helpful in hearing the needs of older people directly are global community surveys. The WHO Department of Reproductive Health and Research has used such surveys in the past to get feedback from people, communities and HCWs on guidance developed in the Department.

Update on the training resources developed following the survey: over the past 12 months the training curriculum has been developed. It includes both online and in-person components to train groups of four or five at a time. Part of the first unit of the training is interviewing older people to learn their needs; the interviews would then be analysed for overarching themes and students would create a proposal to address these themes through concrete actions. Seed funding is there for a pilot test in one country to assess effectiveness. Based on the outcomes, implementation in more countries will be planned.
The 2019 CCHA work plan

CCHA logistics

The date of the next CCHA meeting was agreed on: the third week of November 2019.

Review of comments made during the meeting

Participants decided to amend the name of the ICOPE screening tool, removing “comprehensive” as discussed earlier. The proposal was to rename it: “The ICOPE person-centred assessment and pathways in primary care”.

Dr Araujo De Carvalho thanked participants for the comments related to the ICOPE screening tool. Those comments will be ranked: critical comments will be incorporated into the draft tool prior to it being sent in early 2019 to countries that will pilot test it, while other comments can be incorporated into the next iteration of the tool, in one or two years.

Some participants felt the ICOPE guidance had some important problems: i) that it is not as integrated as is possible; and ii) the process of continuing care has been missed. While the CCHA Secretariat agreed these points needed addressing, it suggested leaving these for the next iteration of the ICOPE screening tool, as these issues can be addressed during the review of the pilot projects. This comment was also made in light of a pilot test of a field test version, which was deemed too complex to use. The smartphone app should also help manage the integration of the different care pathways.

The ICOPE guidance has been made general so it can be applicable to as many contexts as possible. It will, however, be tailored to regional contexts, as necessary, for example to screen for and address tooth loss (oral health pathway has been proposed; see below) in older people.

Multi-country pilot study

The countries of China, France, India, Japan, Mexico, Spain and Thailand have agreed to take part in a multi-country study of the ICOPE screening tool. Luis Miguel Gutierrez Robledo has been made the principal investigator for the overall multi-country study. A programme manager will be identified. Each country involved should also appoint a principal investigator as well. Once the research protocol is finalized, meetings will be held with each country to share the training component of the research protocol. Representatives from countries involved (and those interested) in the multi-country study will meet in Miami in February 2019.

Self-care guidance

A front-line health worker reviewing the ICOPE screening tool suggested giving people who pass the ICOPE screening test information on self-care. Participants agreed that self-care guidance for healthy ageing should be developed (e.g. as a booklet). Such booklets would detail practical advice on how to maintain IC for people who did not yet need ICOPE interventions.

Vitality

Additional work on the operationalization of the vitality domain will begin in 2019 as well: core biomarkers for vitality and ageing will be identified. IAGG will work with WHO to discuss the issue.

Diagnostic tools

The systematic reviews and Delphi study presented by doctor Jack O’Sullivan will be initiated in 2019. These activities will allow for the development of a set of evidence-based diagnostic tools that can be used to assess conditions associated with IC. These will then be recommended to WHO.
New topics

New topics are to be addressed in 2019.

• Pain management guidelines will be developed (contingent on funding), which will begin with reviewing current guidelines worldwide, assessing the investment case, and analysing other gaps; a deep dive on this via a working group will be needed.

• Ageism is a topic to be addressed.

• Sexual health – follow up discussion will occur via email.

• Continence is a topic to be addressed.

• Oral health – discussed below.

Work on the last four topics will also include how each could be included within the ICOPE approach.

Suggestions for improvement

The CCHA Secretariat asked participants what it could do better for the next meeting. Responses included: invite nurses and social workers to the meeting; and update CCHA members on topics the Secretariat/Department is working on between the annual CCHA meetings, to keep Consortium members abreast of changes. The CCHA Secretariat indicated Consortium members share a list of topics with the Secretariat for which updates would be useful. Review can then occur at the next annual meeting to see if such updates are useful.

Oral Health care pathway

The contextualized deep dive on the ICOPE of oral health is advancing, as shown by the inclusion of questions about chewing and smoking tobacco. Representatives from countries interested in getting involved in developing the care pathway further are encouraged to contact the CCHA Secretariat.

Closure of the meeting

John Beard closed the meeting by commending all the stakeholders involved in the CCHA for their collaboration over the past several years, from ICOPE to the work paving the way for the Decade on Healthy Ageing and the tremendous momentum built thus far.

He then thanked all the participants of the meeting, and the CCHA Secretariat, and WHO team including Islene Araujo De Carvalho, Yuka Sumi, Alana Officer and Suzanna Volk. He also thanked donors for their generous contributions. Finally, Dr Beard thanked all the experts and members of the Clinical Consortium for sharing their time and expertise to prioritize the health and well-being of older people.

This meeting was John Beard’s last as Director of the Department on Healthy Ageing – he retired from WHO following the meeting.
## WHO Clinical Consortium on Healthy Ageing - Annual Meeting

Intercontinental Hotel Geneva, 11-12 December 2018

### Tuesday, 11 December 2018 (Day 1) - Comprehensive assessment and care pathways

<table>
<thead>
<tr>
<th>TIME</th>
<th>ACTIVITY</th>
<th>PERSON RESPONSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30–9:00</td>
<td>Registration</td>
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<tr>
<td>9:00–9:40</td>
<td>Introduction and objectives of the meeting</td>
<td>Chairs: CCHA Steering Group</td>
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<tr>
<td>9:00–9:10</td>
<td>Welcoming remarks</td>
<td>John Beard, WHO</td>
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<tr>
<td>9:10–9:40</td>
<td>Introduction of participants and objectives of the meeting</td>
<td>Islene Araujo De Carvalho, WHO</td>
</tr>
<tr>
<td>9:40–12:25</td>
<td>Panel 1: Integrated Care for Older People (ICOPE) Care pathways</td>
<td>Chair: David Price, Toronto University</td>
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<tr>
<td>9:40–9:50</td>
<td>ICOPE Guidance on comprehensive assessment and care pathways</td>
<td>Yuka Sumi, WHO</td>
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<tr>
<td>9:50–10:00</td>
<td>ICOPE App</td>
<td>Jordi Serrano Pons, Universal Doctor</td>
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<tr>
<td>10:00–10:30</td>
<td>Questions and answers</td>
<td>Chair: David Price, Toronto University</td>
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<tr>
<td>10:30–10:50</td>
<td>Coffee break</td>
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<tr>
<td>10:50–10:55</td>
<td>Introduction of WG activity</td>
<td>Yuka Sumi, WHO</td>
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<tr>
<td>10:55–11:25</td>
<td>Working groups on each pathway</td>
<td>Facilitators:</td>
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<tr>
<td></td>
<td>WG1: Locomotor</td>
<td>Matteo Cesari, University of Milan</td>
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<td></td>
<td>WG2: Psychological - depressive symptoms</td>
<td>Richard Oude Voshaar, University of Groningen</td>
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<td>WG3: Cognition - cognitive decline</td>
<td>Martin Prince, King’s College London</td>
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<tr>
<td></td>
<td>WG4: Vitality - malnutrition</td>
<td>Maria Nieves Garcia Casal, WHO</td>
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<td>WG5: Sensory - visual impairment</td>
<td>Silvio Mariotti, WHO</td>
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<tr>
<td></td>
<td>WG6: Sensory - hearing loss</td>
<td>Finbarr Martin, King’s College London</td>
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<td>WG7: Social care and support</td>
<td>Alana Officer, WHO</td>
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<tr>
<td>11:25–12:25</td>
<td>Plenary: Feedback from WG</td>
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<tr>
<td>12:25–14:10</td>
<td>Panel 2: Vitality</td>
<td>Chair: John Beard, WHO</td>
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<tr>
<td>12:35–12:45</td>
<td>Ideas on ‘Vitality’ from IAGG/WHO meeting</td>
<td>John Beard, WHO</td>
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<tr>
<td>12:45–13:10</td>
<td>Plenary discussion</td>
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<tr>
<td>13:10–14:10</td>
<td>Group photo and lunch</td>
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<tr>
<td>14:10–15:00</td>
<td>Panel 3: ICOPE Implementation Networks</td>
<td>Chair: Islene Araujo De Carvalho, WHO</td>
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<tr>
<td>14:10–14:25</td>
<td>WHO AMRO readiness to implement ICOPE</td>
<td>Enrique Vega Garcia, WHO AMRO</td>
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<tr>
<td>14:25–14:40</td>
<td>WHO AFRO priorities and next steps</td>
<td>Taiwo Oyelade, WHO AFRO</td>
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<tr>
<td>14:40–15:00</td>
<td>Plenary discussion</td>
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<tr>
<td>15:00–17:00</td>
<td>Panel 4: Report from CCHA work streams</td>
<td>Chair: Leocadio Rodriguez Manas, University Hospital of Getafe</td>
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<tr>
<td>15:00–15:15</td>
<td>Intrinsic Capacity (IC) screening tool</td>
<td>Sandrine Andrieu, WHO CC, Hôpitaux de Toulouse</td>
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<tr>
<td>15:30–15:50</td>
<td>Coffee break</td>
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<tr>
<td>15:50–16:05</td>
<td>ICOPE UHC indicator</td>
<td>Somnath Chatterji, WHO</td>
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<tr>
<td>16:05–16:20</td>
<td>Research protocol for ICOPE pilots and evaluation</td>
<td>Luis Miguel Gutierrez Robledo, Instituto Nacional de Geriatria Mexico</td>
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<tr>
<td>16:20–17:00</td>
<td>Plenary discussion</td>
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<tr>
<td>17:00–17:20</td>
<td>Conclusion of day 1</td>
<td>Chair: John Beard, WHO</td>
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</table>
## Wednesday, 12 December 2018 (Day 2) - The way forward: CCHA 2019 Work Plan

<table>
<thead>
<tr>
<th>TIME</th>
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<tbody>
<tr>
<td>8:30–9:00</td>
<td>Welcome coffee</td>
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<tr>
<td>9:00–10:15</td>
<td>Building sustainable Long-term Care Systems</td>
<td>Chair: Bruno Vellas, WHO CC, Hôpitaux de Toulouse</td>
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<tr>
<td>9:00–9:15</td>
<td>Integration of social care and support services in ICOPE programme</td>
<td>Ian Philp, University of Stirling</td>
</tr>
<tr>
<td>9:15–9:30</td>
<td>U.S. Department of Health and Human Services Programs Integrating Health and Support Services for Older Adults and People with Disabilities</td>
<td>Rosaly Correa-de-Araujo, National Institute on Aging</td>
</tr>
<tr>
<td>9:30–9:45</td>
<td>Integrated health and social care in Brazil</td>
<td>Peter Lloyd-Sherlock, University of East Anglia</td>
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<tr>
<td>9:45–10:15</td>
<td>Plenary discussion</td>
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<tr>
<td>10:15–11:15</td>
<td>Planet 6: Exploring emerging issues</td>
<td>Chair: Cyrus Cooper, University of Oxford</td>
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<tr>
<td>10:15–10:30</td>
<td>Frailty common data elements</td>
<td>John Muscedere, Queen's University</td>
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<tr>
<td>10:30–10:45</td>
<td>Sexual and reproductive health of older people</td>
<td>Manjulaa Narasimhan, WHO</td>
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<tr>
<td>10:45–11:00</td>
<td>Plenary discussion</td>
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<tr>
<td>11:00–11:15</td>
<td>Coffee break</td>
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<tr>
<td>11:15–12:40</td>
<td>The way forward and closure of the meeting</td>
<td>Chairs: CCHA Steering Group</td>
</tr>
<tr>
<td>11:15–11:25</td>
<td>A Decade of Healthy Ageing</td>
<td>John Beard, WHO</td>
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<tr>
<td>11:25–11:35</td>
<td>Platform on Population Ageing</td>
<td>Alana Officer, WHO</td>
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<tr>
<td>11:35–11:55</td>
<td>Questions and answers</td>
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<tr>
<td>11:55–12:25</td>
<td>Discussion on the 2019 CCHA work plan, The date of CCHA 2019 meeting</td>
<td>Isiene Araujo De Carvalho, WHO</td>
</tr>
<tr>
<td>12:25–12:40</td>
<td>Closure of the meeting</td>
<td>John Beard, WHO</td>
</tr>
<tr>
<td>12:40–13:40</td>
<td>Casual lunch</td>
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</tbody>
</table>
Experts

Sandrine ANDRIEU
Professor of Epidemiology and Public Health, University Paul Sabatier, Toulouse, France
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Intensivist, Kingston General Hospital, ON, Canada
Scientific Director and Chief Executive Officer,
Canadian Frailty Network (CFN)

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Faculty of Dentistry, Niigata University, Japan
Director, WHO Collaborating Centre for Translation of
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Division of Preventive Dentistry, Niigata University
Graduate School of Medical and Dental Sciences,
Niigata, Japan

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Stanford University, Palo Alto, CA, United States

Richard OUDE VOSHAAR
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Medical Center, Groningen, The Netherlands

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Chair, Geneva NGO Committee on Ageing, Geneva
International Longevity Centre Global Alliance (ILC GA)
representative to the UN

Ion PHILP
Professor of Global Ageing, University of Stirling,
Scotland, United Kingdom
<table>
<thead>
<tr>
<th>Name</th>
<th>Title, Institution</th>
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<tbody>
<tr>
<td>David PRICE</td>
<td>Professor and Chair, Department of Family Medicine, David Braley Health Sciences Center, McMaster University, Hamilton, ON, Canada</td>
</tr>
<tr>
<td>Martin PRINCE</td>
<td>Professor of Epidemiological Psychiatry Health Service and Population Research, King's College London, United Kingdom Co-Director, Center for Global Mental Health, King's College London, United Kingdom</td>
</tr>
<tr>
<td>René RIZZOLI</td>
<td>Professor of Medicine, Geneva University Hospital, Geneva, Switzerland Head, Division of Bone Diseases, Geneva University Hospitals and Faculty of Medicine, Geneva, Switzerland</td>
</tr>
<tr>
<td>Leocadio RODRIGUE MANAS</td>
<td>Head, Geriatrics Department, University Hospital of Getafe, Getafe (Madrid), Spain Director, IAGG's Global Research Aging Network (GARN)</td>
</tr>
<tr>
<td>John ROWE</td>
<td>Professor of Health Policy and Aging, Department of Public Health and Aging, Mailman School of Public Health, Columbia University, New York, NY, United States President, International Association of Gerontology and Geriatrics (IAGG)</td>
</tr>
<tr>
<td>Cornel SIEBER</td>
<td>Director, Institute for Biomedicine of Aging, Nuremberg, Germany</td>
</tr>
<tr>
<td>Stephanie STUDENSKI</td>
<td>Director, Longitudinal Studies Section, National Institute on Aging, National Health Institutes, Bethesda, MD, United States</td>
</tr>
<tr>
<td>Bruno VELLAS</td>
<td>Professor of Medicine, Paul Sabatier University, Toulouse, France Head, Gérontopôle, Toulouse University Hospital, Toulouse, France Director, WHO Collaborating Centre for Frailty, Clinical Research and Geriatric Training, Gérontopôle, Toulouse University Hospital, Toulouse, France</td>
</tr>
<tr>
<td>Ninie WANG</td>
<td>Founder &amp; CEO, Pinetree Care Group, Beijing, China</td>
</tr>
<tr>
<td>Jean WOO</td>
<td>Professor of Medicine and Henry G Leong Research Professor of Gerontology and Geriatrics, Faculty of Medicine, Chinese University of Hong Kong Director, CUHK Jockey Club Institute of Aging, Chinese University of Hong Kong Director, SH Ho Center for Gerontology and Geriatrics, Chinese University of Hong Kong Director, Center for Nutritional Studies, Chinese University of Hong Kong</td>
</tr>
<tr>
<td>Other invitees</td>
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</tr>
<tr>
<td>Kai LASHLEY</td>
<td>Independent writer and editor, Further Consulting, Amsterdam, Netherlands</td>
</tr>
<tr>
<td>Jordi SERRANO PONS</td>
<td>Chief Executive Officer, Universal Doctor, digital global health solutions, Barcelona, Spain</td>
</tr>
<tr>
<td>Constance de SEYNES</td>
<td>WHO Collaborating Centre for Frailty, Clinical Research and Geriatric Training, Gérontopôle, Toulouse University Hospital, Toulouse, France</td>
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</tbody>
</table>
WHO staff

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Website:
www.who.int/ageing/health-systems/clinical-consortium