WHO Clinical Consortium on Healthy Ageing 2020

REPORT OF CONSORTIUM MEETING, HELD VIRTUALLY 18–19 NOVEMBER 2020
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The World Health Organization (WHO), Department of Maternal, Newborn, Child & Adolescent Health & Ageing (MCA), Ageing and Health (AAH) unit would like to extend its warmest thanks to everyone who attended the meeting online and provided contributions to the work of the Consortium (see the Annex for the full list of participants).

It would like to acknowledge the key partners and organizations that have provided resources to advance the CCHA agenda: the Government of Kanagawa Prefecture, Government of Japan, Government of Germany and the Universal Health Coverage Partnership (the UHC Partnership is funded by the governments of Belgium, France, Ireland, Japan, Luxembourg, the United Kingdom, and the European Union and WHO).

WHO gratefully acknowledges the in-kind support of the WHO Collaborating Centre for Frailty, Clinical Research and Geriatric Training, Gérontopôle – Toulouse University Hospital; WHO Collaborating Centre for Public Health Aspects of Musculo-skeletal Health and Ageing, University of Liège.

This report was written and edited by Kai Lashley (Further Consulting), with technical inputs from Yuka Sumi from the WHO Department of MCA.
### Abbreviations

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<tr>
<td>AAH</td>
<td>Ageing and Health (unit)</td>
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<td>ADL</td>
<td>Activities for Daily Living</td>
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<td>COVID-19</td>
<td>coronavirus disease 2019</td>
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<td>CCHA</td>
<td>Clinical Consortium on Healthy Ageing</td>
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<td>CSO</td>
<td>civil society organization</td>
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<td>GDG</td>
<td>guideline development group</td>
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<td>GNLTC</td>
<td>Global Network on Long-Term Care</td>
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<td>GRADE</td>
<td>Grading of Recommendations, Assessment, Development and Evaluation</td>
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<td>IAGG</td>
<td>International Association of Gerontology and Geriatrics</td>
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<td>IC</td>
<td>intrinsic capacity</td>
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<td>ICOPE</td>
<td>integrated care for older people</td>
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<td>IPC</td>
<td>infection prevention and control</td>
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<td>LBP</td>
<td>low back pain</td>
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<td>LTCF</td>
<td>long-term care facility</td>
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<td>MCA</td>
<td>Department of Maternal, Newborn, Child &amp; Adolescent Health &amp; Ageing</td>
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<td>MHAS</td>
<td>Mexican Health and Aging Study</td>
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<td>NCD</td>
<td>noncommunicable disease</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<td>PICO</td>
<td>population, intervention, comparator and outcome</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UHC</td>
<td>universal health coverage</td>
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<td>WHO</td>
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Executive summary

The 2020 annual meeting of the World Health Organization (WHO) Clinical Consortium on Healthy Ageing (CCHA), held virtually on 18–19 November 2020, was the sixth 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 in World Health Assembly resolution WHA69.3: *The global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life.*

The year 2020 has been very challenging worldwide due to the coronavirus disease 2019 (COVID-19) pandemic which has not only taken so many lives but has impacted most everyone else in some way. Spurred by the outsized impact that COVID-19 is having on older people, the Ageing and Health (AAH) unit, Department of Maternal, Newborn, Child & Adolescent Health & Ageing (MCA), continues to advance the concept of healthy ageing and have worked to mitigate the effects of the COVID-19 pandemic among older people. The WHO technical guidance for COVID-19 and older people has been published and can be found on the WHO website.

In addition to work on guidance related to the COVID-19 pandemic, the AAH unit has had the integrated care for older people (ICOPE) implementation tools translated into all six official United Nations languages, and Portuguese and Vietnamese. ICOPE reflects a community-based approach that aims to reorient health and social services towards a more person-centred and coordinated model of care that supports optimizing functional ability for older people and maintaining intrinsic capacity (IC). Alongside ICOPE pilot projects and implementation scale-up, the IC score was also discussed during the meeting.

ICOPE is also an integral part of the UN Decade of Healthy Ageing (2021–2030), which was also discussed during the CCHA meeting. This includes the Decade's baseline report, which was recently published by WHO. Over the course of the meeting, CCHA members also separated into four work groups to advance the ICOPE pilot phase: training of health workforce; data governance; ICOPE interventions in universal health coverage; and implementing ICOPE care pathways in clinical practice.

Alongside, preliminary work on WHO guidelines on low back pain management was also shared, as was the WHO work on the integrated continuum of long-term care that is being advanced by the recently established Global Network on Long-Term Care (GNLTC). The GNLTC is a multidisciplinary, multi-institutional network of experts providing strategic and technical advice to WHO in developing norms and guidelines necessary for the implementation of the WHO global strategy and action plan on ageing and health as well as the UN Decade of Healthy Ageing in the area of long-term care.

Specific objectives of the 2020 meeting include the following.

- Report on process and preliminary results of the ICOPE implementation pilot study and discuss how to strengthen enabling activities and address challenges.
- Discuss the methodology on monitoring IC, that is, the IC score.
- Introduce the guideline development on low-back pain management for adults.
- Discuss WHO work on long-term care.

Expected outcomes include the following.

- ICOPE implementation pilot study refined.
- The methodology of IC monitoring developed.
- Guideline development on low-back pain management advanced.
- Next steps for priority work in 2021 identified.
Finally, CCHA members discussed the next steps of the Consortium and paid tribute to two colleagues who passed away in 2020: Dr Peter Salama, Executive Director of Universal Health Coverage, Life Course in January, and Dr Islene Araujo de Carvalho, Senior Strategic Advisor of the AAH unit and secretariat of CCHA, in September. Their dedication to health and particularly healthy ageing was an inspiration to all who worked with them; they will be missed.

Tribute to Dr Islene Araujo de Carvalho

A video tribute to Dr Islene Araujo de Carvalho was shared with participants. Following this video, participants shared their memories of Dr Araujo de Carvalho and the inspiration and dedication she brought to advancing the concept of healthy ageing at WHO, the creation and implementation of ICOPE and the myriad other ways she worked to ensure equity of older people and reverse attitudes of ageism. Dr Araujo de Carvalho was not only a colleague but a friend to those she worked with; and she valued and listened to all the stakeholders who were passionate about healthy ageing and advocated for the dignity of older people and their intrinsic worth to society. Her colleagues grieve along with her family at her passing. She will be sorely missed.
Introduction

Dr. Anshu Banerjee, Director of the Department of Maternal, Newborn, Child, Adolescent Health & Ageing (MCA) of the World Health Organization (WHO), welcomed participants to the annual meeting of the WHO Clinical Consortium on Healthy Ageing (CCHA). He indicated the meeting would facilitate the advance of the integrated care for older people (ICOPE) pilot study, and within the context of the Decade of Healthy Ageing, embed ICOPE as part of universal health coverage (UHC) – moving one step closer to the goal of getting 1 billion more people access to UHC by 2023.

Keynote address

Mr. Yuji Kuroiwa, governor of Kanagawa Prefecture in Japan, provided the keynote address. The Kanagawa Prefecture has the second largest population in Japan, and is home to 2.3 million people aged 65 years and older. He indicated that the global trends of ageing populations are particularly relevant in Kanagawa, where by 2050 the percentage of older people, especially people aged over 85 years will be much greater, which the current social systems will not be robust enough to support. Given this, Kanagawa Prefecture embarked on a new policy concept to overcome challenges of population ageing and to support healthy ageing: ME-BYO.

ME-BYO conceives health and illness as a continuum, with no specific points at which one ends or the other begins. In addition, similar to the healthy ageing concept, ME-BYO focuses on maintaining intrinsic capacity (IC) and functional ability rather than on disease. It focuses on three domains key to maintain and improve physical and mental health: exercise, diet and social activities. These are pillars of the Healthcare New Frontier policy, which leverages innovation in advanced medical technologies (such as robotics, artificial intelligence and advanced regenerative medicine) alongside the concept of ME-BYO to promote healthy ageing. To advance this policy beyond Japan, policy-makers in Kanagawa are collaborating with those worldwide.

During the ME-BYO summit in 2017 the ME-BYO Index was created with technical advice from WHO to change people’s health behaviours. The ME-BYO Index was later developed and integrated into the MY ME-BYO Record app1 in collaboration with the University of Tokyo, which estimates an individual’s current ME-BYO status and will be able to detect future risk of declines of physical and mental capacity (IC) in the future. Its measurements are based on the concept of IC and ICOPE and the app launched in March 2020. Nearly 1.3 million people have downloaded the MY ME-BYO Record app.

One of the model cases of ME-BYO and the Healthcare New Frontier policy is the Wakabadai housing complex in the city of Yokohama. Data show that residents in that housing complex (where 52.5% of residents are aged 65 years and over) require assisted care much less than the national average in Japan. An investigation revealed that the density of the housing complex’s intergenerational households, numerous community events and active resident associations appear to be particularly important factors to explain this.

It would seem that residents in Wakabadai then benefitted from a positive spirit and the diverse perspectives that come from intergenerational households. These states and experiences are embodied in another concept introduced: Vibrant Inochi. Inochi is a Japanese word which is usually translated as life in English, but which could also include terms such as positive spirit, longevity and well-being among others. This concept reminds us that everyone in society has a purpose and can shine, and that when meaningfully connected in community, we may live healthier, happier lives. Let us move towards vibrant Inochi!

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1 Available for download here: https://www.pref.kanagawa.jp/docs/fz7/cnt/f532715/p991437.html
Objectives of the 2020 meeting

SPECIFIC OBJECTIVES OF THE 2020 MEETING INCLUDE THE FOLLOWING

- Report on process and preliminary results of the ICOPE implementation pilot study and discuss how to strengthen enabling activities and address challenges.
- Discuss the methodology on monitoring IC (the IC score).
- Introduce the guideline development on low-back pain management for adults.
- Discuss WHO work on long-term care.

EXPECTED OUTCOMES INCLUDE THE FOLLOWING

- ICOPE implementation pilot study refined.
- The methodology of IC monitoring developed.
- Guideline development on low-back pain management advanced.
- Next steps for priority work in 2021 identified.

Activities in 2020

The year 2020 has been very challenging worldwide due to the coronavirus disease 2019 (COVID-19) pandemic which has not only taken so many lives but has impacted most everyone else in some way. The year has also personally affected the MCA Department through two losses since the last CCHA meeting: the deaths of Dr Peter Salama, Executive Director of Universal Health Coverage, Life Course in January 2020 and Dr Islene Araujo de Carvalho, Senior Strategic Advisor of the Ageing and Health (AAH) unit and secretariat of CCHA, in September 2020. Spurred by the dedication these two colleagues brought to improving health for all, and the outsized impact that COVID-19 is having on older people, the AAH unit, MCA Department, persists in advancing the concept of healthy ageing and have worked to mitigate the effects of the COVID-19 pandemic among older people. The WHO technical guidance for COVID-19 and older people has been published and can be found on the WHO website (1).

In addition to work on guidance related to the COVID-19 pandemic, the AAH unit has had the ICOPE implementation tools (2) translated into all six official United Nations (UN) languages, and Portuguese and Vietnamese. The AAH unit also welcomed two new partners: the WHO PAHO collaborating centre in Integrated Care for Healthy Ageing, Instituto Nacional de Geriatria, Mexico, and the WHO Collaborating Centre for Community Health Services, the Hong Kong Polytechnic University, China, both of which are supporting ICOPE implementation.

The annex contains the meeting agenda1 and list of participants.

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1 Due to the format of the online meeting, some presentations occurred in an order different than that listed in the agenda.
United Nations Decade of Healthy Ageing (2021–2030)

Decade of Healthy Ageing

Underpinned by the global strategy and action plan on ageing and health, the UN Decade of Healthy Ageing (2021–2030) is about fostering and building connections and collaborations and involving many sectors to improve healthy ageing, including health, finance, long-term care, social protections, education, labour, housing, transport, information and communication. This will involve governments, academia, civil society and experts such as those in CCHA and the Global Network on Long-Term Care (GNLTC). Central to every activity of the Decade will be engagement with older people.

The global population is ageing. It is estimated that by 2050 around 2.1 billion people will be aged 60 years or older and that 80% of them will be living in low- and middle-income countries.

<table>
<thead>
<tr>
<th>THE DECADE OF HEALTHY AGEING WILL FOCUS ON FOUR ACTION AREAS</th>
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<tr>
<td>Change how people think, feel and act towards age and ageing.</td>
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<td>Ensure that communities foster the abilities of older people.</td>
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<tr>
<td>Deliver person-centred integrated care and primary health services responsive to older people.</td>
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<td>Provide access to long-term care for older people who need it.</td>
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<th>FOUR OVERARCHING ENABLING ACTIVITIES WILL BE USED TO CARRY OUT THE ACTIONS WITHIN THE DECADE</th>
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<td>Engage and give voice to older people, families and communities.</td>
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<td>Nurture leadership and capacity building.</td>
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<tr>
<td>Connect stakeholders.</td>
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<tr>
<td>Strengthen data, research and innovation.</td>
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Baseline report

WHO will shortly be publishing the Decade of Healthy Ageing: baseline report (4). It includes cross-country comparable evidence from 42 countries with nationally representative studies. These studies measure some aspects of IC and/or functional ability of older people that could be used to establish a baseline from which to track progress during the Decade of Healthy Ageing (through 2030). The baseline report includes a wide range of information including a review of IC measures from 36 countries such as delayed word recall and hand grip strength (considered the best measure for IC and assessed under the Vitality ICOPE domain). It also presents a review of national policy to support comprehensive assessments of older people in a number of countries (found to be just 31%, but which has grown by 126% in the past two years) – one of the indicators of integrated care. Findings suggest that declines in grip strength are not inevitable; IC in this area can be improved through an early focus on healthy ageing and timely interventions in order to maintain IC over the life course – something that should become a part of the messaging around the Decade of Healthy Ageing.

Fig. 1. The pathway to accelerate impact on improving functional ability of older people

1 CLARIFY
   - Clarify what will be optimized within each domain of functional ability
   - Set priorities
     (What is important?)

Is there demand from older people and/or decision-makers?

2 IDENTIFY
   - Identify the interventions
     - Addressing intrinsic capacity
     - Addressing environments
   - Know the context
     - Living situations
     - Level of care dependance

Is there compelling evidence?

3 DESIGN & ASSESS
   Assess intervention impact together with older people

Is there proof it can be done under ideal conditions?

NO
   - Work on better understanding what older people and their families want
   - Nurture leadership

YES

NO
   - Do more research
   - Synthesize evidence (relevant to low-resource settings)
   - Evaluate effectiveness
     - Outcomes
     - intrinsic capacity
     - functional ability
     - environments

YES

NO
   - Implement pilots, assessing:
     - feasibility
   - acceptability

YES
While comparable data are generally scarce, or strength of evidence is weak to moderate, the baseline report details the current status of the factors in place to enable healthy ageing and then considers what the situation would be in 2030 if trends shown in the baseline were followed with no further external advocacy. It also proposes a range of activities to advocate for healthy ageing during the Decade and potential effects those activities might have by 2030.

The report also outlines implications for change and accelerating impact from a focus on functional ability through collaboration (Fig. 1). Collaboration includes older people themselves, noncommunicable disease (NCD) programmes within WHO (advocating for healthy ageing and person-centred care to transform a disease-based approach), local and national governments, civil society organizations (CSOs), nongovernmental organizations (NGOs) and the private sector. The MY ME-BYO Record app, which is discussed in the baseline report, is an example of such collaboration.
Discussion summary

Concern was expressed that the measures being used to assess functional ability in the baseline report were based only on the loss of three Activities of Daily Living (ADLs): getting dressed, taking medication and managing money. Use of the loss of those ADLs marks a return to the dependency model of ageing rather than the model of healthy ageing, which should rather be the focus of the Decade of Healthy Ageing. It was noted in response that functional ability includes five domains: meeting basic needs; being mobile; learning, growing and making decisions; building and maintaining relationships; and contributing to society. Three items – getting dressed, taking medication, and managing money – were consistently identified in nationally representative surveys from 37 out of the 42 countries (mentioned above) and are used to partially represent the domain of meeting basic needs. These items reflect the person’s capacities and interaction with their environment, and the methods utilized are consistent with the concepts and operational approach of healthy ageing. Additional comparative items for this and all other domains will be pursued over the course of the Decade. A background paper detailing item selection rationale is pending publication on WHO’s website.

It was noted that adoption of ICOPE and person-centred care is proving to be very challenging to implement. Even with substantial resources at its disposal, the WHO Collaborating Centre for Frailty, Clinical Research and Geriatric Training, Gérontopôle – Toulouse University Hospital faces challenges in changing behaviours, particularly at the primary health care level. Stakeholder engagement will need to be increased to facilitate the widespread use of ICOPE.

It was noted that the challenge presented by implementing the activities of the Decade of Healthy Ageing would require substantial dedicated resources, both human and financial. The current WHO teams working on the Decade may need to be scaled up to most effectively meet the challenge.
Monitoring IC

IC score: implications for clinical research

The IC score is a combination of a person’s physical and mental capacities, captured by the domains in ICOPE: Cognition, Locomotion, Vitality, Sensory and Psychological; these domains are central to measuring IC. Determining a composite IC score could be useful for clinical research:

- as an outcome, which would be useful to monitor IC trajectories;
- as a predictor of care dependence (in a similar way that the cognitive composite score is used for Alzheimer disease), which would be more sensitive to changes over time compared to single measures; and
- its use will allow researchers to reduce the sample size of clinical trials (and their costs).

Use of such a score in clinical practice would allow the possibility of defining cut-offs to create categories and classify individuals based on IC. It would also allow the use of the outcome as a continuous measure. Once a cut-off is established, it will help clinicians to identify patients with higher risk of care dependence early on; to identify subjects more likely to benefit from personalized ICOPE care pathways; to determine the most beneficial clinical interventions to apply; and to monitor the patients’ response to those interventions.

Statistical methodology and output

The methodology being used to construct, model and validate domain and composite IC scores was shared.

- Possible composite scores will be derived empirically and tested across multiple datasets from several countries.
- Performance will be measured by the mean to standard deviation ratio of the change score in individuals who later have functional events relative to those who remain healthy over time.
- Theoretical considerations such as domain representation will be used to select from among the composite scores that perform well.
- Validation assessment will include split sample validation, external dataset validation, predictive validity, construct validity and external validity against real-world functional event rates.

The methodology will define terms such as optimal and minimal performance and the target range of IC scores (i.e. an upper and lower range within which a person maintains IC and avoids complications stemming from significant loss of IC later in life), which will be set at first assessment. Such scores would be predictive of functional performance and future illnesses, which would lead to the ability to provide interventions (earlier), positively impacting the IC of a person (Fig. 2). Subsequent interventions could thereafter be applied that would maintain IC for a period of time.

Composite and separate domain scores (Cognition, Locomotion, Vitality, Sensory and Psychological) would dictate when an intervention should be introduced, that is, through a small worsening in the total IC score or a moderate worsening in a single domain. If all items reflect the impact on functional independence, with weighting determined by the environmental considerations, total IC score would detect meaningful changes. This methodology provides the beginning of determining a quantifiable approach to IC and functional ability.
Process for developing IC score

The *World report on ageing and health* (5), published in 2015, defined IC, developed through a method for computing a composite score using Item Response Theory. A series of domains were tested to determine which would be the most measureable and impactful domains to inform the IC score. Using a theory-driven approach, the domains that were ultimately chosen – Cognition, Locomotion, Vitality, Sensory and Psychological – were developed within the ICOPE guidance for countries to operationalize, measure, monitor and evaluate the effect of interventions among older people. In future, the CCHA Secretariat and partners aim to move from cross-sectional validation of IC domains and their scores – a moment in time – to longitudinal validation – measuring change over time.

To that end, a working group was established to develop a method for constructing the composite IC score using a valid approach. The group will review the validity of the longitudinal structure, assess the sensitivity of the measure to detect change within individuals over time, assess the predictive validity of the IC score computed using different methods (e.g. weighted, unweighted), and if necessary, develop a reference standard and percentile charts for the score. Following this, testing in real-world clinical settings will be done. If these processes show that the composite IC score is valid and useful, it will be incorporated to the ICOPE and integrated continuum of long-term care guidance and tools.

Development of the composite IC score is being done in collaboration with the WHO Collaborating Centre for Frailty, Clinical Research and Geriatric Training, Gérontopôle – Toulouse University Hospital. Consortium members interested in being a part of the process are encouraged to contact the CCHA Secretariat.

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**Fig. 2. Effect of an intervention on IC within the context of the IC range**
Discussion began on the modelling and weighting of the measures within the IC composite score. Determining those measures that are early signals of disease, and weighting them more, should make the models more predictive, yet it is important to clearly define what the model aims to measure before proceeding, and what the IC score's goal is with the measure: for example, a tool to monitor trajectory of change versus an outcome to be used in clinical research. It was also noted that models using composite measures are less sensitive than those using a single measure.

Limiting the items considered for inclusion in the IC composite score to those that are “clinically meaningful” (i.e. clinically relevant) could be problematic – for one, this would not accurately measure population health and it would miss catching early stages of disease, which were not yet “clinically meaningful”, but which if caught early could prevent a clinical outcome. The current model considers this point by taking a flexible, person-centred approach; that is, the model is tailored by looking at what is changing with the individual, what is meaningful in their specific health context, considering their environment, age, etc. Such an approach will also allow it to be tailored to different country contexts.

Discussion also focused on the upper and lower bounds of optimal IC, specifically whether these should be age specific or applied over the entire life cycle. Discussion favoured the latter.

General practitioners (and others in primary health care) will want to know what extra benefit the proposed model has over the measures of grip strength and frailty. Evidence of the proposed model should be used to inform the model's advocacy to these groups to increase its uptake. Use of the model should also consider reimbursement schemes through UHC to increase uptake.

Deliver person-centred integrated care and primary health services responsive to older people.
Comparable population survey data worldwide continue to be scarce (e.g. only two IC-related data could be compared across countries, and for these only 36 countries had such data) (4). It is hoped that the forthcoming baseline report of the Decade of Healthy Ageing will spur data collection.

ICOPE implementation in Toulouse, France includes a cohort of 5000 people. Studies such as this will generate new data to inform the model. It was also noted that the average age of people involved in the ICOPE pilot is 74 years; at this age, interventions have a likelier chance of success in maintaining IC, than when people are assessed in their eighties. Intervening earlier in the life course also means increasing the possibility of active participation of the person or patient being treated – a critical component of person-centred care.

In order to determine the critical variables on which to intervene, longitudinal studies will be needed. Until those data are collected and validated, it will be difficult to translate the IC score into clinical practice.

It is planned to use artificial intelligence to assist in making projections about healthy behaviours in combination with health interventions among individuals. For example, if three or four time-point assessments of a person's IC were available, a forecast could be made about the future IC trends of that individual based on their potential behaviour change or status-quo behaviour (and with and without interventions). A series of pilot tests needs to be done before that can happen, which will require CCHA member support.

The WHO World Health Survey plus (WHS+) (6) aims to launch an internationally comparable study to assess foundational health and its determinants. Among the questions of the survey will be one or more that measure IC. CCHA members are encouraged to review those questions to ensure they are worded in such a way as to maximize the usefulness of the responses.
ICOPE pilot programme and scale up of implementation

ICOPE is being implemented in various countries; the focused areas of implementation are in different stages, as shown below.

- Stakeholder capacity building facilitated with language translation of tools: Viet Nam, China
- Technology utilization: France, Andorra, China (e.g. the ICOPE app)
- Health care worker training programmes: India, Mexico
- ICOPE screening tool validation: China, France, Andorra, Mexico
- Prospective pilot: China, Andorra
- Health care practice adoption: India

ICOPE pilot protocol

The ready, set and go phases of the ICOPE pilot programme were shared (Fig. 3), which will lead to implementation of ICOPE more widely. Countries have been identified from each WHO region for the research field of the ready phase, that is, to validate the tool; three are reported on below: China, Mexico and Andorra. Scale up of ICOPE implementation is also discussed through the examples of four countries: China, India, France and Viet Nam.

The ultimate goal of scaling up the ICOPE approach widely is to promote IC, functional ability and minimize care dependency of older people globally. Alongside, functional data will be collected to inform better health practice, policy and systems.

**Fig. 3. ICOPE implementation phases**
The ready phase includes two substudies, which are discussed under ICOPE pilot phase 1 “Ready” (enablers and barriers).

The first substudy will address usability and feasibility of the ICOPE Handbook in the field (i.e. micro level, targeted at health and social care workers). This substudy aims to assess the overall process of ICOPE implementation, including how people engage with ICOPE (older people and health care professionals), their experience with the ICOPE handbook (7) as well as collecting data on metrics such IC and functional ability, social support and staff training/education needs.

The second substudy will address implementation readiness at system and service levels (macro and meso levels, targeted at policy-makers and programme managers in 10 or more countries who would be part of subsequent Set and Go phases). An online survey using an ICOPE implementation scorecard will be used to assess the readiness of the system and service levels, as well as the MICRO survey to assess the facilitators and challenges at the clinical level, discussed below.

**ICOPE tool validation**

Updates on validation of the ICOPE tool were shared.

**CHINA**

As noted in the CCHA annual meeting report 2019 (8), ICOPE has been translated into Chinese. In China, the study of the ICOPE tool followed three steps: evaluation and validation of WHO IC screening tool; standardization of interventions; and evaluation of integrated care (combination of IC screening and interventions) on the outcomes of older people. Details of the research protocol employed in the observational study are shown in Table 1. In the study, the IC screening tool will be compared with several other measures, such as frailty.

<table>
<thead>
<tr>
<th>STUDY ELEMENTS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of the study</td>
<td>Multi-Center Study on Validation of WHO IC Screening Tool</td>
</tr>
<tr>
<td>Aim</td>
<td>Evaluation and validation of WHO IC screening tool in China</td>
</tr>
<tr>
<td>Population (setting and age)</td>
<td>Community-dwelling older people, and out- and in-patients aged over 65 years</td>
</tr>
<tr>
<td>Geographical location</td>
<td>Forty sites across China</td>
</tr>
<tr>
<td>Number of subjects</td>
<td>About 150/site, total 6000</td>
</tr>
<tr>
<td>Study design</td>
<td>Observational</td>
</tr>
<tr>
<td>Follow up</td>
<td>At least one year</td>
</tr>
<tr>
<td>Intervention</td>
<td>No</td>
</tr>
<tr>
<td>Measures</td>
<td>IC (SPPB, MMSE, GDS, MNA, Frailty) ADL/IADL, multimorbidity, drug use</td>
</tr>
<tr>
<td>Study period</td>
<td>January 2021 to December 2022</td>
</tr>
</tbody>
</table>
The study has two substudies: cohort of community-dwelling adults — Frailty Dynapenia and Sarcopenia in Mexican Adults (FraDySMex) and a cohort from the Mexican Health and Aging Study 2015 (MHAS-2015), shown in Table 2 and Table 3 (9). In the former, the aim is to compare the IC tool and short/long version of an IC index and test their cross-sectional association with relevant health outcomes in older adults. In the latter, it is to explore domains for IC that screen as positive, in order to estimate its frequency and related phenomena in Mexican older adults, i.e. to see how the screening tool worked at the population level.

In the FraDySMex substudy, validation between the IC score and other related measurements showed significant associations with several measurements.

Table 2. Details of the FraDySMex study

<table>
<thead>
<tr>
<th>STUDY ELEMENTS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of the study</td>
<td>Frailty, Dynapenia and Sarcopenia in Mexican Adults (FraDySMex)</td>
</tr>
<tr>
<td>Aim</td>
<td>To investigate the associated factors of frailty, changes in body composition and falls</td>
</tr>
<tr>
<td>Population (setting and age)</td>
<td>Community-dwelling adults aged 50 years and older</td>
</tr>
<tr>
<td>Geographical location</td>
<td>Two municipalities in Mexico City</td>
</tr>
<tr>
<td>Number of subjects</td>
<td>A total of 543, from which 435 had complete data on the variables of interest</td>
</tr>
<tr>
<td>Study design</td>
<td>Cohort of community-dwelling adults (three-round design)</td>
</tr>
<tr>
<td>Follow up</td>
<td>2014, 2015 and 2019</td>
</tr>
<tr>
<td>Intervention</td>
<td>No</td>
</tr>
<tr>
<td>Measures</td>
<td>IC long version: MMSE, Snellen Eye Test, hearing self-reported, CES D-7, Goldberg Anxiety Scale, MNA, Phase angle, Grip strength, Gait Speed, Chair Rise Test, SPPB</td>
</tr>
<tr>
<td></td>
<td>IC short version: MMSE, Snellen Eye Test, hearing self-reported, CES D-7, MNA, SPPB</td>
</tr>
<tr>
<td></td>
<td>Both long and short versions included sociodemographic variables, health and lifestyle, functionality, nutrition, body composition</td>
</tr>
<tr>
<td>Study period</td>
<td>October 2015 and December 2015</td>
</tr>
</tbody>
</table>

Table 3. Details of the MHAS-2015 study

<table>
<thead>
<tr>
<th>STUDY ELEMENTS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of the study</td>
<td>Mexican Health and Aging Study 2015 (MHAS-2015)</td>
</tr>
<tr>
<td>Aim</td>
<td>To prospectively evaluate the impact of disease on the health, function and mortality of adults aged over 50 years</td>
</tr>
<tr>
<td>Geographical location</td>
<td>National, with a locality cut off of 100 000 and more inhabitants, and less than 100 000 inhabitants</td>
</tr>
<tr>
<td>Population (setting and age)</td>
<td>Adults aged 50 years and older</td>
</tr>
<tr>
<td>Number of subjects</td>
<td>The sample of the 2015 round of MHAS consisted of 14 779 people, from which 12 459 (84.3%) had complete information for all IC domains</td>
</tr>
<tr>
<td>Study design</td>
<td>Longitudinal study</td>
</tr>
<tr>
<td>Follow up</td>
<td>Starting in 2001, and currently planning a follow-up in 2021, MHAS has had five rounds of data collection — 2001 (baseline), 2003, 2012 (sample refreshment), 2015 and 2018</td>
</tr>
<tr>
<td>Intervention</td>
<td>No</td>
</tr>
<tr>
<td>Measures</td>
<td>IC screening tool (cognition, depression, hearing, vision, anorexia, weight loss and mobility), including social, economic, demographic, health-related, biomarkers and mental health variables</td>
</tr>
<tr>
<td>Study period</td>
<td>2015</td>
</tr>
</tbody>
</table>
An online training programme for health professionals on ICOPE was also conducted. At the end of the programme, participants answered the ICOPE implementation scorecard and other questions to measure the acceptability, relevance and feasibility of new interventions such as ICOPE. Initial results from the ICOPE implementation scorecard were also shared (Fig. 4).

**Fig. 4. ICOPE implementation scorecard results**

<table>
<thead>
<tr>
<th>OVERALL LEVELS OF IMPLEMENTATION</th>
<th>NO TO MINIMAL IMPLEMENTATION</th>
<th>INITIATING IMPLEMENTATION</th>
<th>SUSTAINING IMPLEMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERVICES</td>
<td>0-10</td>
<td>11-18</td>
<td>19-26</td>
</tr>
<tr>
<td>SYSTEMS</td>
<td>0-10</td>
<td>11-18</td>
<td>19-26</td>
</tr>
<tr>
<td>OVERALL</td>
<td>0-20</td>
<td>22-36</td>
<td>38-52</td>
</tr>
</tbody>
</table>

Overall score (average): 46 (sustaining implementation)

Services score (average): 23 (sustaining implementation)

Systems score (average): 22 (sustaining implementation)

ICOPE, I find it very feasible and applicable, because it has the appropriate and easy tool to apply them as it takes us by the hand. Because it is a complete instrument that is easy to apply and very understandable and adapted for the older people. Definitely applicable for any context in Mexico.

Andorra:

In Andorra, a study (that is ongoing) was set up to evaluate the IC of people aged > 65 years to validate the ICOPE tool and highlight the health and social needs of older people (n=72; 39 women and 33 men; average age: 73 years). Details of the study are shown in Table 4.

**Table 4. Details of the protocol to validate the ICOPE Handbook App in Andorra**

<table>
<thead>
<tr>
<th>STUDY ELEMENTS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of the study</td>
<td>The WHO ICOPE Handbook App Validation in Andorra</td>
</tr>
<tr>
<td>Aim</td>
<td>The objective of the study is to compare the results of step 1 with step 2 (considered the gold standard) of the WHO ICOPE Handbook App to validate step 1 statistically</td>
</tr>
<tr>
<td>Population (setting and age)</td>
<td>People aged over 65 years from Canillo (Andorra)</td>
</tr>
<tr>
<td>Geographical location</td>
<td>Canillo (Andorra)</td>
</tr>
<tr>
<td>Number of subjects</td>
<td>In total 72 people</td>
</tr>
<tr>
<td>Study design</td>
<td>Observational study</td>
</tr>
<tr>
<td>Follow up</td>
<td>At 6 months</td>
</tr>
<tr>
<td>Intervention</td>
<td>Personalized plans with physical activities, cognition stimulation and social support according to the evaluation results</td>
</tr>
<tr>
<td>Measures</td>
<td>Measuring the IC of performing step 1 and step 2 on all subjects regardless of the results of step 1</td>
</tr>
<tr>
<td>Study period</td>
<td>13 July to 4 September 2020</td>
</tr>
</tbody>
</table>
Participants started the discussion about the feasibility of lay people (e.g. community health workers) using the ICOPE screening tool. Results from the pre-pilot study in China (discussed in the 2019 CCHA meeting report) indicate that most lay people could use the tool; one caveat to that statement is use of the tool for the domain of cognition, which could be a challenge for lay people.

The validity of self-reporting with respect to the hearing loss was discussed. Self-reporting of impaired hearing loss has been found to be unreliable. In the MHAS study, such was the study design for this domain, but researchers there recognized this as a weakness and considered this when analysing the results; results were not considered precise but rather were considered as an approximate distribution of deficits within the population and different age groups.

There is a WHO app for hearing screening that can be used to objectively screen hearing loss in the community, using the digits-in-noise test (10) (a validated test).

Various ways to modify ICOPE screening tools were noted that could increase the sensitivity and specificity of results within the study conducted in Andorra.
Scale up implementation

CHINA

Local ethics approval of the ICOPE implementation pilot study in China was granted in November 2020, and enrolment of participants is beginning (Table 5). It is to be done within the context of the person-centred health delivery system in China, and across stakeholders and through multiple layers (Fig. 6), which has become the focus of health care delivery in China beginning in 2013.

Table 5. Details of the protocol of the implementation pilot study in China

<table>
<thead>
<tr>
<th>STUDY ELEMENTS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of the study</td>
<td>Research on Integrated Care Model for Older People in the Community of Chaoyang</td>
</tr>
<tr>
<td>Aim</td>
<td>To test the readiness for China to introduce an innovative care model such as ICOPE through a prospective study, to study the sustainability and scalability of the model design to support healthy ageing-related policy, research and practice, so as to ensure that the health and care needs of older people can be met in a timely manner</td>
</tr>
<tr>
<td>Population (setting and age)</td>
<td>Those living in communities, aged 80 years and older with risk of declines in IC determined through ICOPE screening questions</td>
</tr>
<tr>
<td>Geographical Location</td>
<td>Chaoyang district (urban, suburban and rural), Beijing, China</td>
</tr>
<tr>
<td>Number of subjects</td>
<td>In total 2200 people (25% intervention group; 75% control group)</td>
</tr>
<tr>
<td>Study design</td>
<td>Randomized controlled trial with multiple time series (1, 3, 6 and 12 months)</td>
</tr>
<tr>
<td>Intervention</td>
<td>Personalized care plan with health and social care services coordinated by integrated care managers</td>
</tr>
<tr>
<td>Follow up</td>
<td>A period of 6–12 months depending on enrolment date (a longer study will be considered following data showing efficacy, with a lower age possible for enrolment)</td>
</tr>
<tr>
<td>Study period</td>
<td>September 2020 to August 2021</td>
</tr>
<tr>
<td>Intervention coordinators</td>
<td>Integrated care managers (which could be community health workers); they are being trained to understand the care plan and deliver the ICOPE guidance</td>
</tr>
<tr>
<td>Amendments to the study protocol</td>
<td>Informatics &amp; telecare supporting continuum with all hospitals/health centres in Chaoyang and leading health care research/teaching institutions across Beijing was added to the study protocol in response to changes in communities’ &amp; healthcare facilities’ access control measures since the COVID-19 pandemic</td>
</tr>
</tbody>
</table>

Fig. 6. Multiple stakeholders work together to provide person-centred care using the ICOPE handbook

HRSS: human resources & social security; PUMCH: Peking Union Medical College Hospital; HCBS: home & community-based services.
In India, the ICOPE implementation pilot study has three aims: i) to assess the effectiveness of adapting ICOPE guidance in rural settings; ii) aligning ICOPE to the existing primary care system for the care of older people; and iii) assessing health system requirements to implement ICOPE. The study will take place in the southwest of the state of Rajasthan.

Due to the low literacy rates of older people in this state, app-based self-ICOPE screening by older adults in rural areas is not feasible. Screening and assessment by community health workers, however, is possible. Community-based data collection by house-to-house surveys will form the basis of interventions. Community health workers, case managers and navigators (the latter are people trained to assist patients in seeking the right level of care in hospital settings; see Fig. 7) will help align health and social services and facilitate referral of rural older adults.

The health care system will require the ICOPE screening tool is further adapted to the local context. The cognitive assessment will need the flexibility to be modified to suit colloquially used syntax and vocabulary, with the inclusion of Hindi Mental State Examination for the cognitive evaluation in step 2; shown in Fig. 7). This adaptation includes integrating ICOPE into rural India’s local health care pathway, though no single solution will suit the entire country.

**Fig. 7. Integration of ICOPE guidance into the health care pathway in rural India**
FRANCE

What follows is information about the INSPIRE study (11) which has allowed for the assessment of ICOPE implementation scale up in the Occitania region of France by Toulouse University Hospital Gérontopôle, the WHO Collaborating Centre for Frailty, Clinical Research and Geriatric Training. More details of the study can be found in Table 6, the CCHA annual meeting report 2019 (8) and in an article published in the Journal of Frailty and Aging (12).

Table 6. Details of the INSPIRE study in France

<table>
<thead>
<tr>
<th>STUDY ELEMENTS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of the study</td>
<td>INSPIRE</td>
</tr>
</tbody>
</table>
| Aim | 1. Identifying biomarkers of ageing. INSPIRE will provide clinical and digital data as well as biospecimens from both human and animals, to foster the identification and validation of (a set of) biomarkers of ageing
2. Implementing IC-centred health care pathway for ageing (ICOPE care pathways). Beyond implementation of ICOPE care pathways, INSPIRE aims to foster investigations on both the biological changes related to healthy ageing and the development of new technologies and metrics to enable the continuous monitoring of the ageing process |
| Population (setting and age) | For the study of ageing biomarkers and IC: 1,000 men and women, aged 20 years and older (no upper limit), mostly community-dwellers (some institutionalized people have been recruited as well)
For ICOPE implementation: older people using primary care services (community nurses, general practitioners, etc.) |
| Geographical location | Occitania Region of France |
| Number of subjects | For the study of ageing biomarkers and IC: observational 10-year longitudinal study
For ICOPE implementation: pragmatic implementation of ICOPE in the health care system |
| Study design | For the study of ageing biomarkers and IC: observational 10-year longitudinal study
For ICOPE implementation: pragmatic implementation of ICOPE in the health care system |
| Follow up | — |
| Intervention | Implementation of ICOPE |
| Measures | ICOPE screening and full assessments, comprehensive battery of geriatric clinical assessments, body composition, maximal tests (VO₂ max, isokinetic strength), biospecimens (fluids and cells/tissues) |
| Study period | Foreseen to last 10 years: from October 2019 to September 2028 |

In the study all domains of IC are systematically monitored through ICOPE tools, particularly step 1, which has been adapted in digital form to make remote and large-scale monitoring possible. Two tools were developed: a mobile application called the ICOPE MONITOR (13) and the ICOPE BOT, a conversational robot (both are connected to the Gérontopôle frailty database). Step 1 is performed every 4–6 months by health care professionals or older people themselves (Fig. 8). If deterioration in one or more domains of IC is identified, an algorithm alerts health care professionals so they can quickly intervene. If abnormalities are determined in step 1, nurses use a telemedicine platform to refer the older person to a primary care provider for steps 2, 3 and 4 and propose a tele-consultation by professionals with expertise in geriatric care.

Fig. 8. ICOPE Resource and Research Platform for Digital Health in the INSPIRE study
Initial results of the study (as of 5 November 2020) include the following.

- In total 1010 health care professionals have downloaded the ICOPE MONITOR app.
- In total 4356 older people are being followed using the ICOPE MONITOR app.
- Average age: 73.8 years, 61% women; only 5.3% have no IC abnormality.
- Most frequent problems with IC reported are: vision (75%); memory (56%); hearing (48%); psychological (34%); mobility (35%); and nutrition (19%).
- Fifty-seven per cent agreed to be contacted to participate in future clinical research programmes.

FRANCE continued

In 2019 the ICOPE Handbook and ICOPE Handbook App were introduced in Viet Nam and are now available in Vietnamese. In order to effectively apply ICOPE at community level will require training for community health workers and will need to overcome several challenges for mainstreaming of ICOPE into the routine tasks for community health workers.

- Implementing ICOPE requires intersectoral collaboration and good coordination at both decision-making and implementing levels. Many actors are involved in decision-making within the ministry of health and beyond (e.g. finance; investment and planning, welfare, social security fund); in the absence of strong leadership, this leads to a fragmented system.
- Implementing ICOPE requires a strong primary care system but this system is currently weak.
- The country currently lacks a formal social/long-term care system, and the health system alone cannot address the needs of older people in comprehensive and integrated ways.

Solutions have been identified to address these challenges.

- Identify a champion/focal point who can drive leadership across the concerned sectors – using high-level advocacy.
- Establish a mechanism or system, at both central and community levels, which has oversight of the primary care system and ensures it is effectively functioning and able to deliver ICOPE.
- Support the government in designing and piloting a community-based integrated care model, coordinating health, long-term care and social sectors, suitable to local context.

VIET NAM

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- Establish a mechanism or system, at both central and community levels, which has oversight of the primary care system and ensures it is effectively functioning and able to deliver ICOPE.
- Support the government in designing and piloting a community-based integrated care model, coordinating health, long-term care and social sectors, suitable to local context.

These solutions are part of the overall systems approach being taken in the WHO country office in Viet Nam, to better align and synergize different programmes, such as ICOPE, NCD prevention and management, and overall systems strengthening towards a strong primary care system as the foundation of UHC.
ICOPE pilot phase 1 “Ready” (enablers and barriers)

Despite the incredible challenges facing the world due to the global COVID-19 pandemic in 2020 and the personal challenges facing the AAH unit due to the death of Dr Araujo De Carvalho, a great deal of work to establish ICOPE pilot projects has been achieved. For that, all those involved in ICOPE implementation should be commended. Enablers and barriers to the pilot phase are shown in Table 7.

Another important challenge is developing an evidence-based business model for ICOPE implementation, which countries can use and which donors could likely support. Two potential models were shared from China and India, which both showed the complexity of ICOPE integration with existing health systems, and the need for tailoring to the country context. One possible way of facilitating that integration with existing health systems was shared from China, through the training and use of integrated care managers. Another challenge with integration, particularly in high-income countries, is modification of reimbursement models under UHC; a possible solution was proposed in France, through direct payment to nurses who initiate step 1 of ICOPE. Limited funding to support ICOPE implementation within countries, but also at WHO, are barriers as well. Finally, well-functioning digital tools are a prerequisite to effective implementation, such that it will be one of the topics of the break-out sessions during the meeting.

The MICRO survey targets experienced primary care health care workers charged with taking care of older people at the local and clinical level. It asks these health care workers about their impressions on a number of challenges related to ICOPE (e.g. feasibility of the five steps of ICOPE implementation, health service delivery’ readiness for change), and sensitizes in the process the target audience on the ICOPE survey. This survey is nearing completion and will be pilot tested in 2021.

Table 7. Enablers and barriers to ICOPE implementation

<table>
<thead>
<tr>
<th>ENABLERS</th>
<th>BARRIERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 provides an opportunity because it has revealed the interdependency of humans societally and of intrinsic capacity, i.e. that one domain affects the others</td>
<td>COVID-19 pandemic</td>
</tr>
<tr>
<td>On-the-fly learning about ICOPE implementation</td>
<td>Business model for how to implement ICOPE in health and social care systems</td>
</tr>
<tr>
<td>New models and approaches, e.g. integrated care managers in China</td>
<td>Health system inertia, fragmentation and territorial policy implementation</td>
</tr>
<tr>
<td>New funding incentives for change at the micro-, meso- and macro levels</td>
<td>High-income country reimbursement models and professionally-mandated practices</td>
</tr>
<tr>
<td>Low- and middle-income country commitment to ICOPE implementation</td>
<td>Insufficient resources to implement</td>
</tr>
<tr>
<td>Strategic and stakeholder value</td>
<td>Focus exclusively on step 1 screening</td>
</tr>
<tr>
<td>Prioritize highest incremental marginal value</td>
<td>Scarce WHO resources to support implementation</td>
</tr>
<tr>
<td>ICOPE training programmes already developed and could be scaled up and disseminated</td>
<td>Insufficient number of trained health care workers</td>
</tr>
<tr>
<td>ICOPE digital tools for on-the-ground implementation</td>
<td>Digital ecosystem lacking, including literacy, security, governance, sharing, management, infrastructure and expertise</td>
</tr>
</tbody>
</table>
Presentations from the break-out sessions

Break-out sessions were designed to further discuss each of four areas within the ICOPE pilot; these were then shared in plenary on day 2 of the meeting. The areas were: i) training; ii) data governance; iii) ICOPE interventions in UHC; and iv) implementation of ICOPE care pathways.

Training of health workforce

Points that were considered by the group were the following.

- **Whom to train.** Participants of this group suggested training should be available to health professionals, community workers and volunteers. ICOPE self-screening should be offered to older people themselves and/or their family members (e.g. those providing care in the home) with these health workers’ support. It is expected that self-screening done remotely will assume broader appeal in the near future, particularly given the expected declining numbers of health workforce precipitated by the COVID-19 pandemic.

- **Types of training to provide (use of technology).** Given the context of the COVID-19 pandemic, it is expected that online or mobile application-based training tools will be preferred in the short term, and may become the norm thereafter. Computer/digital illiteracy and/or poor mobile penetration (e.g. due to mountainous geography) can present a challenge to online training, which itself may require some training or infrastructure improvements to overcome. Pilot studies on technology-based training programmes, therefore, will be required to ensure such training is effective and reaching the target groups; this includes adaptation to the local
context. Multimodal self-care training targeting older people and their caregivers was also suggested, as part of the online training. It is essential that competency-training programmes be included for primary care workers, but also family/informal caregivers, so that ICOPE can be implemented in community settings.

- **Motivating the health workforce to engage in ICOPE.** Ways to increase uptake of the ICOPE modality by the health workforce include top-down and bottom-up approaches. For the former, a country could adopt ICOPE as part of its health system strategy targeting older people, or/and as a component of age-friendly health systems. For the latter, financial incentives could be tried (such as that being used in France in the ICOPE pilot phase). Advocacy efforts, appealing to people’s social consciousness and altruistic nature, could also be applied. The disproportionate mortality among older people from COVID-19 has raised awareness among the general public of the needs of older people, making them more amenable to advocacy.

- **Conducting the training.** Multidisciplinary health care workers (doctors, nurses, physiotherapists, etc.) can become training teachers. This should be done in collaboration with training institutions and professional bodies such as the International Association of Gerontology and Geriatrics (IAGG).

- **Assessment of the training programme.** This will require developing modalities for quality assurance in training and programme implementation. This could be done in collaboration with one or more training institutions, where such quality assurance programmes have already been developed.

- **Synergizing work among high-level stakeholders.** WHO could develop generic training material to be adapted to country settings, as part of its technical leadership in the area of health and ICOPE, specifically. The Organization could advocate countries adopt ICOPE and assist them in conducting training (e.g. pilot projects) on the approach. The IAGG and other (country) professional bodies should promote ICOPE as a person-centred integrated approach to care of older people.

### Data governance

Points that were considered by the group were the following.

- **WHO data principles framework.** WHO is developing a data principles framework, which is expected to be launched in 2021. The framework will help define the values and standards that govern how data that flows into, across and out of WHO is collected, processed, shared and used. More about data principles at WHO in general can be read here (14). Participants of this group noted that the ICOPE app could have a provision to ensure data quality/validate data, in keeping with the framework.

- **Regulatory compliance.** WHO should consider elements of regulatory compliance with respect to data governance. Participants of this group noted this differs by country and region, so it may be a challenge to create one overarching structure to determine it.

- **Data privacy.** This subject is a key consideration and the process for how this will be ensured should be detailed (i.e. through a standard framework); this is being addressed in the forthcoming data principles framework.

- **Data consent form.** Participants of this group suggested adding an easy-to-use consent form to the ICOPE app.

- **Data access.** The current set-up for data access relies on local servers, which requires requests for data on a case-by-case basis. A potential solution could be developing an application...
programing interface for data access, which, with the appropriate consent, would enable sharing of data between local and WHO servers. Addition of this to the ICOPE app may provide the easiest pathway to implementation in countries that do not have competing IT systems or platforms (e.g. low- and middle-income countries); this could be considered relatively easy to achieve in the short term.

- **App integration and data linkage** for monitoring health status and treatment coverage. There is the potential for interfacing the app with already existing databases, such as the Biobank in the United Kingdom, or integrating the app with electronic medical records and government administrative data.

- **Data sharing.** It must be made explicit which data are shared with WHO and to what purpose the Organization will use them (they will follow established WHO data principles). This includes clearly indicating that WHO will have access to limited data that does not include data that identify individuals, and that data are shared with WHO for aggregation and development of dashboards for comparisons. Data are to remain the property of the country sharing them. Some further considerations include: how best to gain access to paper-based data; and use of “data shields” for data, that is, use algorithms in local servers that ensure that only relevant data for the dashboards is extracted.

**ICOPE interventions in UHC**

Points that were considered by the group were the following.

- **Stakeholder involvement.** Stakeholders may vary from country to country but all relevant stakeholders should be involved (e.g. government ministries, health economists, researchers, older people, caregivers, the health workforce). In this context, teaching/training places where the next generation of the health workforce is trained (e.g. universities, professional schools) should also be considered as stakeholders.

- **Additional evidence.** Every component of ICOPE is based on evidence, although ICOPE as a whole may lack formal validity. This means that every single ICOPE intervention can be promoted immediately, while evidence is generated for the whole approach. This needs to be expressed when WHO advocates countries implement ICOPE. More research is needed for generation of additional evidence in the field. Signals should be given that ICOPE is inclusive and open to innovation.

- **Tailoring the message for advocacy.** The business/economic case for ICOPE needs to be made: ICOPE offers value to the payers, as it is robust and with a potential to become a cost-effective approach to IC decline. It is meant to address the challenges that come from our ageing societies. Focus should be on the message that ICOPE leads to better care. ICOPE is more than just a tool; it is an overarching approach to address the diverse needs of older people. Focus on the message that ICOPE is a public health programme/intervention that goes beyond a clinical intervention. The ICOPE approach should be an essential component of UHC.

- **Advocating for older people among diverse organizations.** WHO should consider expanding advocacy efforts to CSOs and those championing older people to explain that ICOPE will substantially change the health status of their members. Advocating that successfully may translate into their support in promoting the initiative to other local and regional stakeholders. Raise awareness through training/certification programmes, and particularly target young health workforce.
Implementing ICOPE care pathways in clinical settings

Points that were considered by the group were the following.

- **ICOPE care pathways.** Implementing ICOPE care pathways depends on the local resources and the health systems in place, so locally adopted models should be considered. Identification of common pathways should be considered, in order to envision the needs of specialized care, local resources, costs, etc. Typologies of pathways can help to anticipate meaningful responses and what service providers and resources should be in place. There is a need to conduct more exploratory investigations in order to describe some experiences at each step of the care pathways (steps 1–5; Fig. 9). Much can be learned from the experiences of countries pilot testing ICOPE; these experiences will indicate which may be feasible in which context.

- **Building the evidence base, and its use in advocacy.** Establish measurable outcomes and impact on people’s well-being, such as the benefits of ICOPE to older people and to health systems – and include such outcomes and the underlying evidence where appropriate in advocacy messages to the users and beneficiaries of ICOPE. The messaging is important for convincing policy-makers and other stakeholders that ICOPE is beneficial for well-being and a cost–effective investment, as noted by the previous break-out group.

- **Define the target population.** The target population must be clearly defined when considering ICOPE implementation: that is, promoting the ICOPE approach among older people in the community will be implemented differently than for older people that are already in the health system or in long-term care.

- **Involving stakeholders in clinical settings in all five steps of ICOPE.** This could include: i) establishing a common data platform among all key stakeholders including social care workers to identify, monitor needs and deterioration of older people; ii) empowering community health workers including volunteers by training and dissemination of IC and functional ability concepts; iii) identifying the gaps between current health and social services and ICOPE, and adapt ICOPE to address those gaps, as it is adapted to the local context; iv) identifying and expanding existing human resources for implementation of each step of the ICOPE care pathway; and v) identifying vertical (primary care to tertiary care) and horizontal networks in primary care and community, resulting in integrated care around an individual’s needs within the context of a service- and system-level approach.

- **Implementing in clinical practice versus running ad hoc research.** The group indicated that in a first stage, while evidence is accumulating in parallel, the focus should be on integrating the principles of ICOPE (person-centred care, involve multi-disciplinary team, objective to optimize IC and functional ability), rather than implementing ICOPE as a new whole public health programme within UHC (the latter is the final aim but will take some time). Initial experience (e.g. in Mexico) shows that optimizing available resources can generate a positive movement (e.g. primary care providers are happy to find a solution for their problems through an ICOPE approach).

- **Validation of the tools.** This step is critical to ICOPE uptake. Integral to this is determining which tools are implementable in different countries/cultural contexts. Small pilot projects in different countries, such as those discussed in this report, will confirm the feasibility or identify eventual solutions/adaptations needed.
**Fig. 9.** The five steps involved in the care pathways

1. **SCREEN FOR LOSSES IN INTRINSIC CAPACITY**

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**
Development of WHO guidelines on low back pain management for adults

WHO guidelines on chronic low back pain management for adults

WHO is developing guidelines on low back pain (LBP) management for adults. LBP is being singled out due to its disease burden: ~577 million people affected, and it is the leading cause of years lived with disability (YLD) globally (15). In addition, LBP peaks in mid-life and remains a common symptom in older people with one-year prevalence estimates ranging from 13% to 50%. It is also an important contributor to declines in physical and mental capacities and limiting functional ability and pain is a critical cause of care dependence in older age.

The guidelines will focus on primary (non-specific) chronic/persistent LBP in adults aged 20 years and older, with a separate recommendation for older people. Interventions will include non-surgical (pharmacological and non-pharmacological) management. Pain management is part of the ICOPE care pathways in the domains of mobility and depressive symptoms, but which currently lack evidence-based recommendations; a WHO guideline in this area will therefore provide this evidence base.

It is envisaged that the LBP guidelines will provide recommendations so health-care providers will be able to deliver evidence-based high-quality and person-centred interventions to manage LBP. This will link to ICOPE interventions. The CCHA Secretariat would be happy to engage CCHA members who have expertise in this area, particularly those in low- and middle-income countries.
Low back pain for adults

Disturbingly, disability associated with LBP has increased by over 50% between 1990 and 2015 across the life course, and particularly in low- and middle-income countries (16). In most people LBP is an episodic condition (16). In addition, many people with back pain have multisite musculoskeletal pain and a range of other physical and mental comorbidities (17).

New research has yielded insights into the social factors (e.g. limited education, low income and poor access to health care predispose one to back pain) and genetic factors (e.g. that between 21% and 67% of people have an underlying disposition to back pain) that contribute to LBP (18). Data also show that those with chronic back pain have more comorbidities than those without such pain, and that persistent pain can result in functional and anatomical changes in the central nervous system (19). In addition, those with more positive attitudes about LBP and their treatment lead to better outcomes.

Many traditional interventions including pharmacological and non-pharmacological treatments for persistent LBP have been shown to have either small to moderate or no effect in treating LBP, leaving health-care providers with little to suggest in the way of evidence-based interventions (20–22). Promisingly, a 40% reduction in recurrence of LBP is seen when education about the condition and exercises to address it are shared (23). Non-pharmacological therapies are increasingly being recommended, which represents a paradigm shift in treatment (24). However, there is a dearth of evidence focusing on older people with LBP. Incorporating consideration of LBP into the Decade of Healthy Ageing will therefore advance progress in treating this condition.

Road map for guideline development

The WHO guideline development process was shared. The steps are detailed in the WHO handbook for guideline development, 2nd edition (25). The process is robust and it requires a lot of time and resources. It starts with the formation of a guideline development group (GDG) by a WHO steering group. The GDG will formulate the key questions and outcomes to be reviewed (following the population, intervention, comparator and outcome (PICO) format).

The process follows the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach – a systematic approach to rating the certainty of evidence in systematic reviews and other evidence syntheses. A systematic review team reviews the evidence for each key question and evaluates the quality of the evidence using GRADE. The WHO steering group then drafts the recommendation based on the evidence synthesis, then the GDG will finalize the recommendations. An independent external review group will review the draft along the process. Ideally the guidance would be published in 2023. CCHA members should contact the Secretariat if they wish to get involved in this process.
Discussion summary

New data in the areas of LBP were discussed. Among the points mentioned were data related to non-specific and specific LBP and psychosocial factors contributing to LBP (e.g. the Cultural and Psychosocial Influences on Disability (CUPID) Study (26)).

As evidence suggests that pharmacological interventions might not be most appropriate to treat LBP, researchers are revisiting recently published meta-analyses to draw conclusions based on the latest available evidence. This will inform the guideline development process.

The diagnostic complexity of LBP becomes more challenging with increasing age due to comorbidities; this then would warrant creating separate recommendations for older adults.

It was stressed that back pain guidelines should be established in collaboration with multiple stakeholders, as part of an integrated health care system that considers conditions like frailty and osteoporosis alongside LBP. As ICOPE guidance already addresses pain in multiple domains, its use with the new guidelines on back pain should prevent so-called silo approaches.

Packages of care are generally how LBP is treated, so any systematic reviews will consider packages of interventions in their search criteria.
COVID-19 and older people

WHO convened the meeting “Learning from COVID-19 to strengthen care for older people” to share experiences and lessons from the current COVID-19 pandemic on care for older people and identify the gaps in health and long-term care services and systems. During the two-day meeting, held virtually on 26 and 27 October 2020, over 100 experts shared challenges and lessons learned that health systems and service providers in countries had experienced since the beginning of the COVID-19 pandemic.

Some of those lessons include extending telemedicine services and leveraging younger household members in intergenerational households to assist older ones in navigating the digital interface; review of daily reports of COVID-19 infections cross-referenced with a database of diabetes patients to contact high-risk (older) people and proactively offering them care and support; and the role of UHC in mitigating the impacts of COVID-19.

COVID-19 outbreaks in long-term care facilities

Mounting evidence (as available on 8 September 2020) suggests that the COVID-19 disproportionately affected long-term care facilities (LTCFs) worldwide, with high rates of morbidity, mortality and substantial health care costs. Most countries with large numbers of LTCFs experienced a greater than 50% rate of their total COVID-19 deaths within LTCFs, and 25% of individuals infected in LTCFs died from COVID-19 (27).

Contributing factors to high burden across LTCFs include high susceptibility to severe COVID-19 due to old age and multimorbidity. Compounding the problem were a lack of personal protective equipment, lack of adequate surveillance systems, difficulty implementing infection prevention and control (IPC) measures and a lack of IPC training of staff and caregivers.

Long-term care: activities to ensure that people with, or at risk of, a significant ongoing loss of IC can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity.
How COVID-19 affects IC (mood)

An ongoing community-based longitudinal study, called the Barcelona Brain Health Initiative (28) in Barcelona, Spain, allowed researchers to study the effect the COVID-19 lockdown had on mental health. The Barcelona Brain Health Initiative study, begun in 2017, seeks to assess the lifestyle, social, psychological and biological determinants of brain and mental health performance. Data from the original cohort of 5000 participants of the Barcelona Brain Health Initiative study were used in what became known as the Barcelona Brain Health Initiative COVID-19 study. Researchers had two time points of data on anxiety and depression from the cohort before the COVID-19 outbreak. During the lockdown, researchers queried the cohort (n > 3800) five more times (March–October 2020) with questionnaires through continuous sampling at different moments of health and societal impact.

Preliminary results indicate that there was a 25% increased relative risk of depression after the COVID-19 outbreak. When reviewing the data by socioeconomic metrics, poverty had a strong influence on the level of anxiety experienced by study participants (Fig. 10). Data also showed a small decrease in loneliness among participants in the first weeks of the lockdown, perhaps due to a feeling of solidarity with the collective effort to slow the infection rate. By the next time point studied, however, loneliness had increased again.

Data with respect to how the pandemic has affected economic status of the cohort – and its knock-on effect on depression – have not yet been analysed.

Fig. 10. Effects of the COVID-19 pandemic on mental health outcomes, by income and age, in a cohort in Spain

A score <1 (red) means below poverty threshold. MIDDLE&RIGHT: Point estimates and confidence intervals of probability of diagnosis according to GAD-2 using Binomial Mixed Linear Models. Comparison for different income groups.
Discussion summary

Several participants noted the opportunity that the pandemic has provided in capturing the attention of policy-makers with respect to older people and long-term care. As WHO publishes guidance responding to the COVID-19 pandemic and long-term care, this information can be used to drive advocacy efforts and a narrative about person-centred care and long-term care. This guidance (1) includes among others an IPC checklist for health care facilities (but which can be applied to LTCFs), guidance on clinical management of COVID-19 and a training course related to IPC strategies available on OpenWHO (29).

Roll out of COVID-19 vaccines was also discussed. Advocacy is necessary to maintain the focus on equitable access to the vaccine as well as prioritization of health workers and caregivers as well as recognizing that older people are also considered a priority group. This is part of the Access to COVID-19 Tools (ACT) Accelerator (30), a ground-breaking global collaboration to accelerate development, production and equitable access to COVID-19 tests, treatments and vaccines. Ensuring uptake of the vaccine among the population, particularly older people, will require a multi-pronged approach, which addresses vaccine hesitancy/misinformation, new approaches to increase uptake, such as mobile teams visiting the homes of older people.
WHO integrated continuum of long-term care

Introduction of the WHO integrated continuum of long-term care

WHO articulated a vision for healthy ageing as “the process of developing and maintaining the functional ability that enables well-being in older age” (5). A public health framework for healthy ageing has two components: IC and functional ability, across the life course (shown in Fig. 11). This marks a shift from point-in-time disease detection addressed by fragmented treatments, to person-centred assessment across the life course as a continuous trajectory.

WHO defined long-term care as activities “to ensure that people with, or at risk of, a significant ongoing loss of IC can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity” (5). Such long-term care services would aim to compensate for IC loss to maintain functional ability at an optimal level as long as possible, while working to prevent further loss of declining capacity. For long-term care services, the outcome would mainly focus on gains in functional ability.

Long-term care services include traditional health services such as management of chronic geriatric conditions, rehabilitation, palliation, promotion and preventative services. However, long-term care services should also include assistive care services such as caregiving and social support for older people. All these services must be integrated and provided in a continuum with the underlying core principles of person-centred care and with the goal of enabling older people to do the things that have meaning to them.

The WHO integrated continuum of long-term care will uphold these principles of integration, non-fragmentation and being person-centred to support countries to develop high-quality long-term care programmes. The WHO integrated continuum of long-term care emphasis on integration of health and social care services for older people and support for family caregivers (as part of a focus on home and community), will be fundamental in advancing activities to transform long-term care systems throughout the Decade.

**Fig. 11.** WHO public health framework
Introduction of the Global Network on Long-Term Care

The GNLTC is a multidisciplinary, multi-institutional network of experts that provides strategic and technical advice to WHO in developing norms and guidelines necessary for the implementation of the WHO global strategy and action plan on ageing and health in the area of long-term care.

The GNLTC will advise WHO in developing concrete normative products to support countries in achieving sustainable and equitable long-term care, throughout the Decade of Healthy Ageing. In addition it will advise WHO on ways to create equitable and sustainable long-term care models for older people, with a focus on optimizing functional ability and achieving healthy ageing.

There are currently four workstreams with which the Network is engaged.
- Health policy and systems for long-term care.
- Service provision of long-term care (inclusive of caregiver support).
- Assessment of the need for long-term care.
- Financing mechanisms for long-term care services.

WHO will work with the GNLTC on the following actions.
- Provide technical support for national situation analyses of long-term care.
- Design tools and guidance for a minimum package of long-term care as part of UHC.
- Provide online resources for informal caregivers.
- Improve the working conditions of care workers.
- Assess the health impact of social protection programmes, including pensions.

Timeline of GNLTC activities already envisaged include the following.
- Expand online platform for caregivers and provide competency-based training programmes: 2021–2023.
UHC service package of long-term care

A literature review was conducted for long-term care interventions in 2020, with the goal of identifying and describing long-term care interventions for older adults; to deliver a comprehensive list of long-term care interventions; to attempt a categorization of the identified long-term care interventions that can be used as a framework for the development of a UHC long-term care services package; and to identify the gaps regarding long-term care interventions. The time period for the review was publication between January 2010 and February 2020. Following rigorous criteria for inclusion, a total of 272 interventions were selected (62 clustered, shown below) across eight domains.

CLUSTERED INTERVENTIONS INCLUDED THE FOLLOWING.

1. Caregiver support (n=13)
   - Care provider (e.g. health care workers, social care workers, caregivers) support & training

2. Person-centred assessment and care planning (n=4)
   - Person-centred assessment and care plan development

3. Prevention of IC decline (n=26)
   - Vitality (nutrition and hydration) (n=4)
   - Oral care (n=1)
   - Skin care (n=2)
   - Vaccination (n=1)
   - Visual capacity (n=2)
   - Hearing capacity (n=2)
   - Cognitive capacity (n=3)
   - Psychological capacity (n=3)
   - Locomotor capacity (n=4)
   - Management of NCDs (n=2)
   - Bladder and bowel capacity (n=2)

4. Optimization of functional ability (n=7)
   - Sleep hygiene (n=1)
   - Basic need (n=2)
   - Moving around (n=1)
   - Building and maintaining relationships (n=1)
   - Learn grow and make decisions (n=2)

5. Environmental interventions (n=2)
   - Environmental adaptation (n=2)

6. Cross-cutting (n=5)
   - Fall prevention (n=3)
   - Pain management (n=1)
   - Polypharmacy (n=1)

7. Palliative care (n=1)

8. Digital health technology & innovation (n=4)
   - Digital health interventions for long-term care strengthening (n=4).

The majority of published studies that met the search criteria were conducted in high-income countries.
Next steps

A Delphi consensus-based process began in early 2021, to which CCHA members are being asked to contribute. The main objective of this process is to reach consensus on a minimum list of long-term care interventions for older people to be included in the WHO integrated continuum of long-term care service package, to be provided to low-, middle- and high-income countries. This includes defining which services are truly relevant and evidence based.

The heterogeneity of LTCFs will be addressed in the next phase of the process of developing a UHC service package.

Discussion summary

- The literature review was the first topic discussed. In the literature review, less than 1% of studies included in the review came from five low- and/or middle-income countries.

- It was noted that studies rarely focus on quality of life end-points, such as “retaining a sense of purpose in life”, which is known to be an important component of healthy ageing. Such qualitative end-points should be borne in mind while considering outcomes.

- WHO promotes ageing in place and community/home-based care: some data show that community care by families and community caregivers is more cost-effective and leads to better outcomes for older people than care in LTCFs. These data need to be collected systematically and reviewed to inform a definitive position by WHO, which will be addressed during the Decade of Healthy Ageing.

- Worldwide stakeholders conduct programmes and interventions locally and nationally but often they lack the capacity to evaluate them systematically – that capacity therefore needs to be built and/or expanded. Alongside, a more heterodox approach to capturing these experiences should be considered to more fully understand and document these experiences and fully leverage stakeholder efforts.
The way forward

Next steps

A series of short- and long-term next steps were shared from each of the four break-out groups. A selection of the points is below.

Health workforce

**Short term:**
- Develop modalities for quality assurance in training and programme implementation.
- Identify a list of “master” multidisciplinary trainers from the health system.
- Contact IAGG and other professional bodies to engage them to promote ICOPE as the tool for community-based assessment.

**Long term:**
- Adapt ICOPE tools and generic training materials to different country settings.
- Advocate Member States adopt the ICOPE tools and conduct training in its use.

Data governance

**Short term:**
- Assess if a consent form can be added to the WHO ICOPE handbook app.
- Outline a standard framework for data privacy.
- The ICOPE app should have a provision to ensure data quality, in keeping with the WHO data principles framework.
- Assess ways to improve and speed up the process of getting access to data.

**Long term:**
- Provide guidance on the governance framework needed to link the ICOPE handbook app with other electronic medical record or health information systems.

ICOPE interventions in UHC

**Short term:**
- Involve government ministries and stakeholders in highlighting the ICOPE approach.

**Implementation of ICOPE care pathways (at the clinical level)**

**Short term:**
- Identify the common models of care pathways, learning from locally adapted models through ICOPE pilot studies.
- Empower community health workers including volunteers by training and dissemination of IC and functional ability concepts.
- Identify the gaps between current health and social services and ICOPE, as part of adapting ICOPE to local contexts.

**Long term:**
- Develop the narrative that ICOPE is beneficial for health and well-being and good value for investment with measurable outcomes and impact including cost-effectiveness (aligns with a long-term action of the ICOPE interventions in UHC).
- Develop a common data platform to connect all key stakeholders involved in ICOPE care pathways (including social care workers) and monitor the needs and care plans for older people.
Discussion summary on the way forward for the CCHA

The WHO Academy (31) will bring a single, digital learning experience platform featuring innovations such as artificial intelligence and virtual reality technology to connect devices, users and data in the learning environment and to support learning through simulations. Learners will be able to access the full scope of courses developed and curated by the WHO Academy via desktop computer, laptop, tablet and mobile phone – through a single profile and login. It was also explored whether stakeholders and collaborators such as IAGG and CSOs could collaborate with the WHO Academy.

CCHA members are encouraged to consider how to engage stakeholders in local and national governments in low- and middle-income countries to increase participation and representation of those countries. For example, policy-makers in many countries in Africa see the need and would like to implement ICOPE, though there are financial challenges due to competing priorities in those countries.

It was requested to consider discussion of the oral care pathway as a part of ICOPE in 2021 (discussed in the CCHA 2018 report (32)).

ICOPE is not about disease minimization. Rather its goal is to promote IC and functional ability of older people. This message should be promoted as part of global campaign and advocacy to reach policy-makers, such as those in government ministries, and other stakeholders. So using standardized metrics to measure functional ability, including ADLs or Instrumental Activities of Daily Living (33), is the next step.

It was noted by several participants that resource allocation within WHO needs to be commensurate with conducting this and other tasks of the Decade of Healthy Ageing.

The activities of the CCHA and those linked with the decade of Healthy Ageing need to be more widely disseminated. Establishing a repository, a webpage containing the knowledge, studies, lessons and experiences of CCHA activities, was suggested. This could facilitate engagement at local levels of countries, too. Creation of a Community of Practice might be a way to address this issue as well. The baseline report for the Decade of Healthy Ageing (4) highlights many lessons learned with respect to IC and functional ability.

It was queried if WHO could assist further with assisting countries with ICOPE projects (including collating data, etc.). Alongside, it was suggested to draw on the lessons learned from stakeholders who had already started ICOPE pilot projects to share with those getting started in other countries. To that end, it was suggested to develop a platform of information about this, which could be easily evaluated, to be shared with stakeholders in countries wanting to begin ICOPE pilot projects.

While a real-time dashboard of data from ICOPE projects is too ambitious at the moment, a simple server and repository could be established for an audience of policy-makers, with, for example, lessons learned. Legal provisions about data privacy differ across countries, which would add to the challenge of a dashboard.

The roles that other influential organizations play in disseminating message about IC and functional ability were discussed. It was suggested that the Decade of Healthy Ageing should provide a platform (34) to broadcast messages about these topics and inform CSOs, many of which have expressed interest in assisting with broadcast and advocacy of healthy ageing in general.
Closure of the meeting

Following a list of action points to take in the coming year, Dr Banerjee closed the meeting by thanking CCHA members for their continued participation and passion in promoting healthy ageing. He then asked members to honour Dr Araujo de Carvalho’s contribution to ICOPE and healthy ageing, by carrying that spirit forward and making it a reality.

As exemplified by Dr Araujo de Carvalho, it is hoped that Consortium members continue to listen to each other, learn from each other and take this concept forward, for example by integrating ICOPE into primary health care systems and achieving the goals of the Decade of Healthy Ageing.

The United Nations Decade of Healthy Ageing (2021–2030) is a global collaboration, aligned with the past ten years of the SDGs, that brings together all stakeholders to improve the lives of older people, their families, and the communities in which they live.
References


# Annex. Meeting programme and list of participants

## Meeting programme

**WHO Clinical Consortium on Healthy Ageing**  
**ANNUAL MEETING, 18–19 NOVEMBER 2020 13:00–16:30 CET**

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12:45 – 13:00 **Welcome**

12:45 – 13:00 **Introduction and objectives of the meeting**

13:00 – 13:07 **Welcoming remarks**  
Anshu Banerjee

13:07 – 13:15 **Keynote**  
Yuji Kuroiwa

13:15 – 13:20 **Objectives of the meeting**  
Yuka Sumi

*Chair: Etienne Krug*

13:20 – 13:25 **Decade of Healthy Ageing**  
Anshu Banerjee

13:25 – 13:30 **Baseline report**  
Ritu Sadana

13:30 – 13:40 **Q&A**

13:40 – 14:25 **PANEL 2: Monitoring Intrinsic Capacity (IC)**  
*Chairs: John Beard, Somnath Chatterji*

13:40 – 13:45 **Intrinsic capacity score: Implications for clinical research**  
Kelly Virecoulon Giudici

13:45 – 13:50 **Statistical methodology and output**  
Suzanne Hendrix

13:50 – 13:58 **Process for developing IC score**  
Jotheeswaran Amuthavalli Thiagarajan

13:58 – 14:25 **Plenary discussion**

14:25 – 14:35 **Virtual coffee break**

14:35 – 16:25 **PANEL 3: ICOPE pilot programme & scale up implementation**  
*Chairs: John Beard, Somnath Chatterji*

14:35 – 14:40 **ICOPE pilot protocol**  
Yuka Sumi

14:40 – 15:05 **ICOPE tool validation**  
Piu Chan  
Luis Miguel Gutierrez Robledo  
Eva Heras Muxella

15:05 – 15:35 **Scale up implementation**  
Ninie Wang  
Arvind Mathur  
Bruno Vellas  
Thi Kim Phuong Nguyen

15:35 – 15:45 **ICOPE pilot phase 1 (enablers and barriers)**  
Michael Valenzuela

15:45 – 16:30 **Break out discussions**

1. Training of health workforce  
Enrique Vega  
Michael Valenzuela

2. Data governance  
Leocadio Rodriguez Manas

3. ICOPE interventions in universal health coverage  
Yuka Sumi

4. Implementing ICOPE care pathways
### THURSDAY, 19 NOVEMBER 2020 (DAY 2)

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<tr>
<th>Time</th>
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<td>12:45 – 13:00</td>
<td><strong>Tribute to Dr Islene Araujo De Carvalho &amp; welcome</strong></td>
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<td>13:00 – 13:20</td>
<td>Report from break up discussion on Day 1 (5 min each group)</td>
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<tr>
<td>13:20 – 13:45</td>
<td>Plenary discussion</td>
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<td>13:45 – 14:30</td>
<td><strong>PANEL 4: Development of WHO guidelines on low back pain management for adults</strong></td>
<td>Cyrus Cooper, Alarcos Cieza</td>
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<tr>
<td>13:45 – 13:50</td>
<td>WHO guidelines on low back pain management for adults</td>
<td>Yuka Sumi</td>
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<tr>
<td>13:50 – 13:58</td>
<td>Low back pain for adults</td>
<td>Jan Hartvigsen</td>
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<td>13:58 – 14:06</td>
<td>Roadmap for guideline development</td>
<td>Jean-Yves Reginster</td>
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<td>14:06 – 14:30</td>
<td>Plenary discussion</td>
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<td>14:30 – 15:20</td>
<td><strong>Virtual coffee break</strong></td>
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<td>14:40 – 15:20</td>
<td><strong>PANEL 5: COVID-19 and older people</strong></td>
<td>Matteo Cesari, Edward Kelley</td>
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<tr>
<td>14:40 – 14:50</td>
<td>Report from “Learning from COVID-19 to strengthen care for older people”</td>
<td>Yuka Sumi, Zee-A Han</td>
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<td>14:50 – 14:58</td>
<td>How COVID-19 affects intrinsic capacity (mood)?</td>
<td>David Bartres-Faz</td>
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<td>14:58 – 15:20</td>
<td>Plenary discussion</td>
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<tr>
<td>15:20 – 15:28</td>
<td>Introduction of WHO integrated continuum of long-term care and Global Network on Long-Term Care</td>
<td>Zee-A Han</td>
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<tr>
<td>15:28 – 15:36</td>
<td>UHC service package of LTC</td>
<td>Natalia Arias Casais</td>
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<td>15:36 – 15:55</td>
<td>Plenary discussion</td>
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<td>15:55 – 16:30</td>
<td><strong>The way forward</strong></td>
<td>Finbarr Martin, Anshu Banerjee</td>
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<td>15:55 – 16:25</td>
<td>Plenary discussion on the CCHA way forward</td>
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<tr>
<td>16:25 – 16:30</td>
<td>Closure of the meeting</td>
<td>Anshu Banerjee</td>
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</tbody>
</table>
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