Concept Ageing and Health

SRC International Cooperation

Swiss Red Cross

Impressum

Graphic design and print:
Graphic-print SRC

Bern, September 2018

Picture cover page:
Moldova ©SRK, Caspar Martig

Contents

Abbreviations

CIS	Commonwealth of Independent States
DRM	Disaster risk management
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
IFRC	International Federation of Red Cross and Red Crescent Societies
National Society	National Red Cross or Red Crescent Society
NCD	Non-communicable disease
NGO	Non-governmental organisation
Movement	International Red Cross and Red Crescent Movement
OECD/DAC	Organisation for Economic Cooperation and Development / Development Assistance Committee
SDG	Sustainable Development Goal
SRC	Swiss Red Cross
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WASH	Water, sanitation and hygiene
WHO	World Health Organization

1. Introduction

Swiss Red Cross (SRC) international cooperation programmes pursue a life-course approach, engaging with people from infancy to old age, recognising critical periods of growth and development, and attempting to mitigate people's exposure to health and disaster risks. While the involvement of young people is essential to shape the lifestyle of future generations, demographic changes worldwide require a shift in focus to older people[1] , not only in high-income, but also in low- and middle-income countries. Health and active ageing, age-friendly environments and long-term integrated care for older people are becoming more important.

The SRC established that "ageing and health" is one of its thematic priorities in its Health Policy (SRC, 2016). While the Health Policy is predicated on a life-course approach, "ageing and health" looks at the health of elderly persons in particular.

The ageing and health concept defines the framework for the SRC's engagement. It considers home-based care models, healthy and active ageing, and awareness-raising within the SRC, the Red Cross and Red Crescent Movement and their countries of intervention and projects, in order to better focus on and include the elderly in disaster risk management and health. It recognises that elderly people have different needs and opportunities, depending on their social, cultural and economic background. It reflects and complements the values expressed in the SRC's "Altersleitbild" (SRC, forthcoming).

1.1 Rationale and scope: adding years to life and life to years

The rapid ageing of populations is a well-established fact and one of the principal policy issues of the twenty-first century. The United Nations forecasts that the number of individuals world-wide aged 60 years and above will have more than tripled by 2050, from 600 million in 2000 to two billion, outnumbering children under 15. Eighty per cent of old people will be living in low- and middle-income countries (UNFPA, 2012). Population ageing is a matter of serious concern to governments, which fear that revenues will be insufficient to meet the needs of an ageing population. Impossible strains may be placed on pension and social security systems, and demands on health and long-term care systems will increase.

Internationally, there is growing recognition that a longer life presents great opportunities. This involves a change of mindset and social attitudes, whereby older persons are no longer perceived as welfare recipients but rather as active and contributing members of society. There are multiple social justifications for devoting public resources to older people and the challenges that ageing brings: from fundamental human rights and ethical and humanitarian considerations to social capital investments that foster cross-generational cohesion (Beard et al., 2012). Older people are a resource for their families, friends and communities (WHO, 2002). They are ready and willing to contribute to the development of their communities, but lack opportunities to do so (UNFPA, 2012; WHO, 2016). Preparing for an ageing population is vital to achievement of the SDGs under the 2030 Agenda for Sustainable Development (UN, 2015), in particular to "leave no one behind" and SDG 3 (to ensure healthy lives and promote well-being for all ages). Ageing is also a cross-cutting consideration for other SDGs, such as those on poverty eradication, gender equality, economic growth and decent work, reduced inequalities and sustainable cities.

1 The SRC uses the UN and WHO (2002) terminology, which describes "older people" as people from age 60 up. It nevertheless recognises that other countries may have their own, different definitions of "old age".

1.2 International frameworks, standards and guidelines on ageing and health

There exist various frameworks and guidelines on healthy ageing, active ageing and ageing and health. Those considered most important for the SRC's international work are referenced in this section.

The Madrid International Plan of Action on Ageing and the Political Declaration adopted at the Second World Assembly on Ageing (UN, 2002) marked a first turning point in how the world addresses the key challenge of "building a society for all ages". They provide a resource for policymaking, suggesting how governments, NGOs and others can reorient how society perceives, interacts with and cares for older citizens. The United Nations Regional Economic Commissions conduct five-year reviews of the Madrid Plan of Action in Africa, Europe, Latin America and the Caribbean, Asia-Pacific and Western Asia. While most governments in Europe are committed to adhering to the Madrid Plan of Action's priority areas (see Annex 1), other regions have been slower to adapt and/or have developed their own protocols.

In order to further maximise opportunities for ageing populations, WHO has adopted a global strategy and action plan on ageing and health (2016–2020) that focuses on five strategic objectives:

1. Commitment to action on healthy ageing in every country;
2. Developing age-friendly environments;
3. Aligning health systems to the needs of older populations;
4. Developing sustainable and equitable systems for providing longterm care (home, communities, institutions);
5. Improving healthy ageing measurement, monitoring and research.

The SRC endorses and aligns its work on ageing and health with the Madrid Plan of Action priority areas, the WHO global strategy and the SDGs. It also works with standards, guidelines and toolkits established by WHO, UNFPA and other UN agencies, the IFRC, the Aging and Disability Resource Consortia, the African Union Protocol to the African Charter on Human and People's Rights on the Rights of Older Persons in Africa and the Inter-American Convention on Protecting the Human Rights of Older Persons (see Annex 2). The SRC strictly adheres to the national strategies, protocols and guidelines on ageing and health of the country concerned and, where applicable and desired, influences their development.

1.3 Embedding ageing and health the strategic and institutional frameworks

The SRC bases its activities on the Movement's seven Fundamental Principles – humanity, impartiality, neutrality, independence, voluntary service, unity and universality. Its work is guided by the following SRC and IFRC policy frameworks.

IFRC Strategy: In its Strategy 2020: Saving Lives, Changing Minds, the IFRC renews its commitment to humanitarian aid and calls for more action to prevent and reduce the underlying causes of vulnerability. Strategic aims include "an integrated health system with services that are more accessible, gender and age sensitive" (strategic aim 2) and help to "develop and maintain the autonomy and well-being of those made vulnerable by their disadvantage […] Elderly people are a special focus for our attention" (strategic aim 3). The IFRC also aligns its work on healthy ageing with the WHO global strategy.

SRC Strategy 2020: SRC Strategy 2020 clearly spells out that "elderly and frail people who live at home and require assistance, as well as their relatives and carers, are one of the prime target groups of the SRC". Ageing and health are tackled in three of the SRC's four core business areas: health and social integration, via SRC activities in Switzerland, and disaster management and development cooperation, via SRC activities abroad.

SRC Strategy 2020 for International Cooperation: The overall goal of SRC international cooperation work is to enable healthy and safe living for vulnerable groups and communities. Health and disasters are the two principal spheres of activity for SRC international cooperation work. Ageing and health is recognised as an important working priority for international cooperation within the health sphere of activity.

SRC Health Policy: The Health Policy identifies eight thematic priorities: reproductive health, disease control, WASH, nutrition, health in emergencies, blood safety, eye care, and ageing and health. To date, ageing and health interventions have focused on integrated home-based care models, participatory approaches to community work, and advocacy for active ageing. Ageing and health is closely linked to the SRC thematic priorities of eye care and disease control (in particular to non-communicable diseases).

SRC Disaster Risk Management Policy: The SRC's disaster management activities focus on seven thematic priorities: shelter, housing and non-food items; WASH; health; economic support; (re)construction of public infrastructure; community-based disaster risk management (DRM) and institutional preparedness. They aim to strengthen the resilience of vulnerable people, groups and communities. The policy does not, however, specifically mention elderly people's vulnerabilities, needs and potentials in disasters.

1.4 Definition of ageing and health

The SRC definition of "ageing and health" combines elements of different international concepts and approaches (see Annex 3). On the one hand, the SRC bases its work on the rights-based active ageing approach, which recognises the rights of people to equality of opportunity and treatment in all aspects of life as they grow older, and supports older people's responsibility to participate in the political process and other aspects of community life. On the other hand, the SRC implements the healthy ageing agenda in its projects by helping to develop and maintain older people's functional ability in age-friendly environments and healthy cities, thus enabling well-being in older age.

1.5 Building on SRC experience in ageing and health

For the past 20 years, the SRC has been actively working for and with older people in Eastern Europe in particular. Its projects initially focused on home-based care as a means of addressing specific physical, mental and social threats faced by older people, particularly those living alone and with insufficient resources. Realising that the needs of older people go beyond care issues, the SRC introduced participatory community work and advocacy and active ageing as separate components in some larger home-based care programmes from 2003 onwards. Besides Eastern Europe, it has attempted to develop and piloted projects for the elderly in Africa and Asia, but these were exceptions and ultimately discontinued.

In Switzerland, the SRC helps family members of sick and elderly people see to their own needs. Volunteers step in temporarily to care for older people, so that family caregivers can get a break and some rest. Other programmes on active ageing and home-based care are under discussion and development.

At the international level and within the Movement, the SRC is a long-standing proponent of home-based care and active ageing, and its partners and stakeholders have acknowledged its competence and impact in the various working regions. It has contributed substantially to the development of manuals and guidelines on home-based care and healthy ageing for use within the Movement (see Annex 2).

At present, the SRC is engaged for older people in Belarus, Bulgaria, Bosnia-Herzegovina, the Republic of Moldova, Kyrgyzstan and Armenia. Everywhere, its projects are implemented through its local counterparts, the National Society or local NGOs. They are the ones working directly with individual and groups of older people.

Examples of ageing and health activities to date are:

- Integrated medico-social home-care programmes carried out by professionals and volunteers for elderly and disabled people living alone in Belarus;
- Active ageing initiatives, including the formation of groups of older people who meet regularly to socialise, plan, develop and carry out activities, including advocacy work, in Bosnia-Herzegovina;
- Distribution of individual food parcels or cash and funding of soup kitchens, to assist elderly people in winter in Bulgaria;
- Advocating age-friendliness, so as to change social and physical environments with a view to including elderly people in decision-making, and intergenerational dialogue in the Republic of Moldova.

Volunteers bring added value to SRC ageing and health programmes. Their home visits improve the mental well-being of the elderly and counteract social isolation (SRC, 2014). A comparative review of the participatory community work approach in three project countries (Bulgaria, Belarus and Bosnia-Herzegovina) and its impact on older people's vulnerability clearly showed that it had reduced social vulnerability among older people (SRC, 2017). Regular evaluations have been conducted and actions taken to improve the quality of care and care models in Bulgaria, Belarus, Bosnia-Herzegovina and the Republic of Moldova.

2. Context and challenges for the SRC

2.1 Global context and trends

The SRC considers the following global context and trends relevant for ageing and health.

- **Global demographic changes:** The world's elderly population is increasing by 1 million persons every month (UNFPA, 2012). This demographic transition, until recently viewed as characteristic of more developed countries, is starting to emerge in many low- and middle-income countries. Unlike in many developed countries, where population ageing has been a gradual process spread over a long period, the population is projected to age very rapidly in a number of low- and middle-income countries. In many regions, the population is ageing at the same time as the number of children and young people falls. This places the adult population under a dual economic and care-giving onus, and reduces the volume of support available for older people in terms of finances and time. Eastern Europe, for example, is characterised by an ageing population, low fertility rates and the emigration of young workers, leading to a severe population decline in the younger generation (Bussolo et al., 2015).

- **Weak and unprepared health systems:** An ageing population places additional strain on mostly weak and unprepared health systems in low- and middle-income countries. Older people are particularly at risk of developing non-communicable diseases (NCDs) and mostly suffer from multi-morbidity, including dementia, which requires long-term care (Bussolo et al., 2015; OECD, 2017). In many countries, long-term care is not available, accessible or affordable. Structures and resources are needed to provide services and care within an already overburdened and underfinanced health system, which may not even provide adequate and equitable access to basic health services. Most countries have not adapted their health and social care systems to the needs of older populations and people with disabilities, who are often reluctant to resort to hospital care and prefer home care in a supportive environment.

- **Increasing migration and urbanisation:** Urbanisation and migration, with more young people moving to cities and towns for education and work, lead to a higher proportion of aged people living in rural areas, often alone and in inappropriate living conditions, with limited access to services and care, and in greater need of external support and an age-friendly environment. When the elderly migrate to urban areas together with their families, they may still feel isolated and lonely, often confined indoors in a new environment without their own social network. The migration of health personnel from rural to urban areas or abroad further undermines the already limited access to services and care in rural areas.

- **Social change, filial duty and ageing:** Socioeconomic challenges, migration, and changing social and cultural values and norms of solidarity have altered the family's traditional role to provide care for elderly family members. Tensions are rising in many countries as younger generations feel either less compelled, or have a reduced ability, to fulfil filial duties. The rise of smaller families and the increase in migration for work often means that fewer children are at home to share the physical, emotional and financial responsibilities of caring for ageing parents and grandparents. This has the potential to lead to social exclusion, isolation and poverty, and to a mounting mismatch in intergenerational expectations. Grandparents often take over the role of permanent caretakers of their grandchildren, for example when parents migrate for work or die because of HIV/AIDS.

- **Ageism:** The dignity of older women and men, who are increasingly confronted with negative attitudes, myths and stereotypes, is often compromised. Ageism can lead to different forms of violence, mistreatment, neglect, abuse, manipulation, the denial of proper care and services, and rights violations – in institutions, but also within families.

- **A changing political and natural environment:** More than 20 per cent of the world's population lives in conflict-affected contexts or fragile States, where access to services is particularly fraught (OECD/DAC, 2015). Some of the world's worst humanitarian crises are not at all short-lived, but rather drag on for years or decades. In addition, many predictable disasters, such as typhoons and droughts, are becoming more severe and adding to the growing number of people forcibly displaced every year. A recent report (HelpAge International, 2018) states that 14 million older people with disabilities may be affected by humanitarian disasters. These people are among those most at risk, yet little is known about their particular experiences. Their rights and needs are widely overlooked in humanitarian responses (HelpAge International, 2018; Mazurana et al., 2011; UNHCR and Handicap International, 2011). Elderly people have a disproportionately high risk of dying or being hospitalised during and after disasters (Wilson, 2006; HelpAge International, 2015).

2.2 Challenges and opportunities for international cooperation

The SRC faces the same challenges and opportunities as the international community and its members.

- **Absence of ageing policies and programmes:** In many countries, ageing is not a high priority on the political agenda. Ageing policies are not in place and programmes for and with elderly people are few and relatively uncommon. National health and social systems are vertical in nature, but healthy and active ageing programmes require interagency cooperation. This constitutes an opportunity for the SRC and its partners to encourage collaboration and an integrated working environment among different government agencies, and to foster civil society-led advocacy for policies that recognise the potentials and needs of the elderly.

- **Lack of sex- and age-disaggregated data:** In order to "leave no one behind" and be able to respond to the needs of the most vulnerable, it is essential to have data disaggregated at least by sex and age. Helping countries to manage and analyse data, and investing in data collection and disaggregation prior to a humanitarian response, helps to better target interventions.

- **Ageing and disasters:** Disasters exacerbate older people's vulnerability because it is harder for them to maintain their housing and prepare for a potential disaster (such as a hurricane), and to evacuate and protect themselves. Limitations in vision and hearing make it particularly difficult to cope. Humanitarian players have opportunities to involve and target older people in innovative ways to prepare for and obtain care during and after a disaster or crisis.

- **The rise of NCDs and multi-morbidity in old age:** As people grow older, they become increasingly likely to develop multiple health problems, including NCDs. NCD prevention and treatment often go hand in hand with ageing and health, and provide a good entry point and funding opportunity for improving the health of elderly men and women.

- **Financing health care and social services:** The lifetime costs of long-term care services can be substantial. In most countries, the cost of a prolonged stay in a long-term care facility will consume the patient's personal assets, in particular when financial and social protection schemes are not in place. Integrating care for the elderly into universal health coverage helps to protect the financial resources of older people in need. Long-term care can also be perceived as an opportunity for socioeconomic development, in that it serves to secure human resources in health.

- **Experience, knowledge and skills of older people:** In countries and programmes that emphasise civic participation and accountability, the involvement of older people provides a great opportunity to tap their knowledge and ensure their voices are heard. Older women and men bring traditional and other valuable skills with them; they can draw on a wealth of experience and environmental knowledge, which is important for mitigating, for example, the impact of emergencies or local conflicts. Building on the contributions of older people offers potential gains for them, the local community, and service providers and organisations.

- **Big needs, but few workers:** Only a few entities involved in international cooperation are prioritising elderly people. Investing in the elderly is less attractive and yields far fewer quality-adjusted life years than investing in the young. This makes ageing and health an area with plenty of scope for work on policy and practice.

3. Guiding principles

SRC programmes follow the guiding principles set out in the SRC Strategy 2020 for International Cooperation and the Health Policy for International Cooperation.

Focusing on marginalized and most vulnerable people: The SRC considers elderly people, who are prone to exclusion, solitude, poverty, poor health and ageism, as most vulnerable. It assesses their individual situations and promotes and creates conditions that support care, income and capacity-building opportunities, in order to mitigate their vulnerability and improve their quality of life and well-being.

Promotion of local resources and self-help potentials: Older women and men are great contributors to development. They bring unique capacities gained through life-long learning and life experience, and are thus of great value to society. These resources are tapped by empowering elderly people to realise their self-help potential.

Empowering people for health: Empowering communities and individuals of all age groups to manage their health and claim their right to health is at the core of the SRC's work. SRC projects aim to capacitate and empower elderly people to participate in social activities, engage in civil society and advocate for their needs and rights. This is an important driver of reduced social isolation and greater mental well-being.

Working in a gender-sensitive manner: SRC projects endeavour to take account of country-specific differences between older women and men in terms of life expectancy, health and social profiles. These differences and resulting specific needs are reflected in the planning and implementation of ageing and health interventions. Older men are particularly encouraged to participate in active ageing groups and to use home-care services.

Promoting voluntary work: Local volunteers play an important role in SRC health programmes. In ageing and health projects, they are valuable resources for home visits and for helping elderly people to manage their daily activities. Likewise, elderly men and women are engaged as volunteers in different National Society programmes.

Working in partnerships, fostering alliances and the multi-stakeholder approach: The SRC works with local partners, in particular the local National Society, other NGOs specialised in working with elderly people, and ministries of health and social affairs. A close partnership with stakeholders in the medical and social care arena is a pivotal aspect of providing integrated and person-centred services. The formation of alliances and large networks of active ageing groups increases leverage at local and national level. Ultimately, strong policy dialogue and advocacy are conducive to sound and influence ageing policies and the creation of a legal and regulatory environment.

Conflict-sensitivity and do no harm: Ageing and health projects emphasise the inclusion of all elderly and disabled people, irrespective of their socioeconomic situation. Food assistance and delivery of supplies (e.g. during disasters or in winter) are always preceded by careful needs and context assessments, in order to ensure transparent beneficiary selection and thus avoid conflict.

4. Objectives

4.1 Goal

The SRC aims to ensure healthy and safe living for vulnerable groups and communities. In terms of ageing and health, this means improving the health and well-being of elderly people. Ageing and health interventions are implemented in rural and urban settings with a view to improving and/or maintaining the health status of the elderly and the disabled, ensuring their independence, preventing social isolation and empowering them to claim their rights.

4.2 Outcomes

The SRC targets four specific outcomes in ageing and health:

1. Access to good-quality home-based care services is improved;
2. The participation and social inclusion of elderly people are increased and age-friendly environments are supported;
3. The DRM cycle takes account of and meets the needs of older people;
4. Commitment to action on ageing and health is advocated.

The outcomes are explained below. Annex 4 depicts the results chain for Outcomes 1 and 2.

Outcome 1: Access to good-quality home-based care services is improved

SRC programmes focus on enhancing access by older women and men and disabled people from different ethnic and social groups, irrespective of their medical and social condition, to person-centred home-based care with adequate quality of services. Home-care models vary widely depending on the context, are nearly impossible to replicate and can only be successful if they take account of the unique needs and characteristics of the population they serve. SRC models for elderly care may therefore look different in each country, depending on the context, the strategies, capacities and abilities of the local implementing partner organisation, and the level of deinstitutionalisation of care in each country. A thorough assessment can serve as the basis for the flexible combination of the elements of home care, helping to meet the needs of the elderly and fill any gaps in the country's present system (see Annex 5). Home-care models promoted by the SRC range from simple and low-cost volunteer-based home visits to complex and more costly integrated home-based care systems embedded in the State public health system (see Annex 6). They can be freely combined with active ageing intervention models.

The SRC supports its implementing partners' efforts to develop and establish home-care models using a participatory multi-stakeholder approach that emphasises financial and operational sustainability from inception. It builds their organisational capacity to run, manage, sustain or even expand their model and advocate its institutionalisation in the country, including through licensing, activity standardisation, and resource planning and mobilisation that comprises diversified financing mechanisms and cost contributions while bearing in mind service affordability.

Depending on the needs, context and available local resources, the SRC provides support for infrastructure, facilities and equipment. It invests in development and capacity building for volunteers, caregivers, home helpers, trained nurses and professionals from different sectors, providing general and specific trainings (i.e. in palliative care, dementia, bedsores and chronic wound management, kinaesthetic). It further improves the quality of care by organising visits

in-country and abroad to other practitioners, arranging exchanges of experience, developing quality-management systems and care guidelines, and engaging external experts to provide regular quality monitoring and supervision.

Outcome 2: The participation and social inclusion of elderly people are increased and age-friendly environments are supported

The SRC supports the efforts of its implementing partners to develop and carry out active ageing programmes that foster access, inclusion and participation of older women and men by engaging them in social networks and having them practice an active lifestyle. Key strategies include strengthening local groups committed to the needs and rights of older people and developing the capacity of elderly citizens to initiate and take action in cooperation with other relevant local partners and institutions. Activities span from physical fitness to maintaining social networks, doing flash mobs and advocating a safer living environment. Active ageing groups are encouraged to build partnerships and to join movements or networks promoting elderly people's rights and enabling their autonomy. In the groups, the SRC stimulates intergenerational solidarity, bringing young people and older women and men together. These actions raise awareness about ageing and combat age-related discrimination and stereotyping.

The SRC promotes participatory community work, which changes the paradigm from older people as "aid recipients" to women and men as "organisers, initiators and change-makers" in actions with and by them. It aims to achieve improvements that involve local resources and solutions and are thus locally owned and long-lasting. By owning the process, older people take leading roles and at the same time develop confidence and skills. Their capacity to use modern technologies is bolstered, enabling them promote their group's work to a wider audience.

SRC projects increasingly use the age-friendly environment and communities approach as a new way of empowering older people. This approach enables older people to articulate their requests, opinions, interests and needs to the local public authorities. It also makes local governments and communities aware of the need to actively engage elderly citizens in public affairs and fosters intergenerational dialogue. When the age-friendly communities approach is used to ensure that older people are active and engaged participants in society, the elderly cease to be viewed as burdens.

Where the SRC's implementing partner is the National Society, older people are encouraged to become volunteers and engage actively in same-age or intergenerational activities, fostering social cohesion and solidarity between generations. SRC active ageing projects can complement and be linked to home-based care interventions (see Annex 6).

Outcome 3: The DRM cycle takes account of and meets the needs of older people

The SRC applies an integrated multi-sector approach to DRM, in line with the Sendai Framework for Disaster Risk Reduction 2015–2030 and covering the entire spectrum of response, recovery and development. In disaster response, the SRC works with a comprehensive emergency relief and early recovery system, enabling an efficient response in bilateral and multilateral operations. In future, it will advocate and focus on age-sensitive needs assessments to make sure that elderly people receive appropriate assistance. It is important to take active steps to locate and identify the elderly, and to include them in direct interviews and focus group discussions, in order to address their immediate needs and understand their vision for recovery. To that end, it is vital to collaborate and coordinate with existing social networks and institutions, if any, as they can provide the information needed to target beneficiaries. If goods and services are available and functioning, cash transfer programming can be a good option for elderly people. The SRC will therefore include specific sessions in the training of disaster management pool members, to make them even more aware of the particular problems, obstacles and needs elderly people face before, during and after disasters.

Restoring shelters, incomes and livelihoods plays a critical role in helping older people recover, become self-supporting and contribute to their families, especially where there is no other form of income support, such as pensions. Elderly people who have been displaced or dispossessed of their land need legal and practical help, which is also required to address legal rights, health issues, and questions of repatriation, trespass and inheritance. Elderly people who have been separated from their families will be given priority access to tracing and restoring family links services.

Recognising, and facilitating the sharing of, older people's knowledge, experience and strategies are important parts of disaster preparedness and mitigation. Active ageing groups can serve as functioning exchange platforms for raising awareness and ensuring access to timely and accurate information on how to reduce and transfer risks and react in an emergency. When disaster strikes, previously collected secondary data can give an idea of how many elderly people are potentially affected and what their likely needs for assistance will be. Earlier experiences, coping strategies, traditional skills and local environmental knowledge are important in mitigating the impact of disasters. The SRC's goal is to involve older people in disaster prevention, preparedness and management.

Outcome 4: Commitment to action on ageing and health is advocated

There is scope for more action on ageing and health in existing and future SRC programmes. Within its ongoing programmes, the SRC will work in a more age-sensitive manner to reach out to and include elderly people in community groups and ensure that they have access to health services. Where possible and necessary, assessments focusing on the needs of elderly women and men will be conducted. Age-disaggregated data analyses will enhance understanding, for example, of how health services are used or of health behaviours by age group, and help to identify possible gaps. The thematic priorities of eye care and NCDs will provide further entry points to work with elderly people.

The SRC will heighten the awareness of National Societies and government ministries of the significance of population ageing, in particular its implications for health and disaster management. In the future, the SRC will support the efforts of interested National Society partners to strengthen local capacities and explore national opportunities. It may engage in a partnership once it receives a request for assistance from a National Society that has placed ageing and health on its strategic agenda, and it will encourage small-scale pilot projects or activities in other SRC priority countries outside Europe and the CIS.

As the realities with regard to policies and practice on ageing and health in the global North and South vary greatly, there is no magic bullet for moving the concerns of older population groups higher on the agendas of key ministries and authorities. Depending on the specific programme context, tailor-made advocacy activities are needed on different levels, i.e. from community to national policy level. Advocacy levels may include:

- Fostering the exchange of good practice within the Movement, in particular among National Societies;
- Supporting forums and mechanisms for exchange and learning, within and beyond the Movement;
- Promoting an "age-inclusive health systems approach" in SRC projects, to contribute to universal health coverage;
- Participating in policy debates and promoting the right of older people to access adequate health services and care;
- Advocating the recognition of population ageing as a socioeconomic opportunity and not merely a burden; Mobilising and supporting the efforts of older people to advocate for their right to health;

- Supporting and engaging in research activities to consolidate and broaden the evidence base;
- Adapting data management systems to make elderly beneficiaries of SRC projects more visible, e.g. by disaggregating health data in reporting.

4.1 Cooperation, partnerships and alliances

It is essential to establish partnerships and linkages between stakeholders, in order to deliver efficient and effective ageing- and health-related activities and to include elderly people in all stages of the humanitarian continuum. The SRC's main partner is the National Society in the country concerned. Working in partnership includes organisational development to anchor the activity in the local context over the long term, and fostering operational and financial sustainability through the creation of diversified financing mechanisms and cost contributions from the different stakeholders right from the project start.

Within the Movement

- **The SRC Health and Integration Department and SRC cantonal branches:** Various cantonal branches are about to develop home-based care programmes. SRC international cooperation programmes will seek partnerships to align concepts and exchange knowledge and lessons learnt.

- **The IFRC:** The SRC strives to thematically position itself within the Movement. Experiences from different projects have shaped the IFRC's healthy ageing toolkit, including the facilitator and volunteer guides (see Annex 2). As part of the IFRC, the SRC works closely with and supports the IFRC Health Department to develop, pilot and roll out guidelines and toolkits on ageing and health. SRC staff continue to participate in the technical working groups on this subject.

- **Partner National Societies:** The SRC and its partner National Societies are well recognised for their work on ageing and health within the Movement. They are embedded in different working groups and exchange platforms within the Movement and have made essential contributions to the development of curricula, guidelines and standards for the Movement's home helpers and volunteers (see Annex 2).

Coordination between the SRC and the Movement on ageing and health is very strong in the Europe and CIS region. Within the existing Europe and CIS Network (see section 5.3.), the SRC has fostered partnerships and exchanges between like-minded National Societies, an activity that it plans to continue and expand to other interested National Societies.

Other regions are lagging behind, yet offer ample scope to place ageing and health higher on the agendas of the Movement and its partners. The SRC can draw on its vast experience in Europe to play a pivotal role in the roll-out of ageing and health activities in the Africa, Latin America, Middle East and Asia-Pacific regions.

With other stakeholders

The SRC involves and maintains alliances with different stakeholders at various levels.

- **Ministries of health and related national authorities:** The SRC explicitly seeks the cooperation of the Ministry of Health and other national authorities relevant for the health of the elderly. Its interventions strictly adhere to and support national policies, rules and regulations related to elderly care in institutions and at home. Likewise, the SRC promotes recognition of the needs of elderly people in laws and the development of a health system that provides person-centred integrated care and meets active ageing needs in an age-friendly environment.

- **Ministries of social affairs and related national authorities:** SRC activities adhere to the social laws of the country. Striving for an integrated care approach requires a close partnership with the Ministry of Social Affairs. Within its role, the SRC facilitates closer cooperation between ministries of health and social affairs, with a view to having them work together more effectively and efficiently as a "medico-social" team caring for the elderly.

- **Multilateral organisations:** The SRC, together with the IFRC, will engage in a stronger partnership with UNHCR in emergency settings, to better meet the needs of older people.

- **International and local NGOs:** HelpAge International is a major global player in ageing issues and the SRC is already implementing joint projects with it. The SRC may explore other opportunities to work with HelpAge International and other global partners, so as to move the ageing and health global and regional agenda forward.

- **Alliances with Swiss NGOs, private and corporate players:** Partnerships and knowledge exchange with Caritas, the Careum Foundation and the Swiss Spitex Organisations will be further strengthened, particularly in new areas of work (e.g. dementia, palliative care). Alliances complementing efforts in the field will be enhanced.

- **Partnerships with academic and research organisations:** Partnerships will be sought with national and international academic research institutions to capitalize and publish experiences and conduct implementation research to further issues in ageing and health.

5. Quality management

5.1 Relevance and impact

Demographic changes worldwide make SRC programmes on ageing and health highly relevant in all countries, even though the magnitude of relevance has not yet been equally recognised in all regions of the world.

SRC ageing and health activities are designed in such a way that they contribute to and put into practice existing local, national and global ageing and health policies and strategies. In countries where no local or national policies are in place, the SRC, together with its implementing partner, can pilot projects that translate global policies and strategies into practice. These pilots aim to influence the local and national policy dialogue.

SRC projects on ageing and health are having an impact on the health and well-being of older people, who as a result live dignified lives in good conditions in which they can realise their full potential. Thanks to its inclusive, life-course approach, the SRC contributes substantially to the goal of "leaving no one behind".

5.2 Monitoring, evaluation and operational research

The results chains for home-based care and active ageing (see Annex 4) indicate the outcomes and outputs reflected in the monitoring and evaluation framework. They also contain a set of indicators for project monitoring.

Regional thematic research on active ageing approaches and impact has yielded valuable lessons for scaling up. Cost-effectiveness studies on home-based care have been important drivers of policy dialogue, prompting governments to invest in home-based care models. Further regional and sub-regional thematic operational research and assessments in these areas will help enhance understanding of the effectiveness of different approaches and the role of the socioeconomic context, and will provide insights for possible multi-country projects. Ageing and health projects are evaluated at regular intervals, using a mix of qualitative and quantitative methods to gauge relevance, effectiveness and impact.

5.3 Capacity development and knowledge management

The SRC is committed to developing and improving its capacity in the area of ageing and health by providing thematic training to staff and partners, exchanging experiences within and between regions, conducting research and sharing the results within and outside the organisation. SRC staff will be trained to work in an age-sensitive manner in all emergency, recovery and long-term development programmes.

The SRC plays a major role in shaping IFRC approaches, methodology and human resource capacity in the area of healthy and active ageing, participating in the working groups developing tools, supporting ageing focal points and sharing best practices and effective tools via IFRC thematic networks and platforms.

The SRC Europe and CIS network, which was established in 2013, has proved to be an excellent knowledge management platform. Apart from encouraging knowledge transfers and experience exchanges between countries and network members, it also disseminates SRC expertise and results at international conferences and through peer reviews, maintains a resource library and facilitates thematic online and face-to-face discussions among SRC staff and national partner representatives. The network's knowledge and expertise can be used and expanded to other interested countries and regions working on ageing and health, and to the SRC cantonal branches.

6. Resources

6.1 Human resources

The SRC working group on health comprises focal persons for different thematic priorities, including one person for ageing and health. This resource person also convenes the network of National Societies on ageing and health. The SRC employs various professionals in the field who are experts on the subject and valuable resource persons.

6.2 Financial and material resources

Ageing and health projects are generally financed from the sources listed below:

- Contributions from the Swiss Government, in particular the Swiss Agency for Development and Cooperation;
- Contributions from foundations, companies, public authorities and other institutions;
- Earmarked private contributions;
- Contributions from Swiss Solidarity and the SRC Disaster Relief Emergency Fund for interventions related to the DRM cycle.

Annexes

Annex 1: The Madrid International Plan of Action

Under each of the priority directions there are a number of issues, objectives and recommendations for action – as follows:

Priority direction 1: Older persons and development

Eight issues are:

- Active participation in society and development
- Work and the ageing labour force
- Rural development, migration and urbanization
- Access to knowledge, education and training
- Intergenerational solidarity
- Eradication of poverty
- Income security, social protection/social security and poverty prevention
- Emergency situations

Priority direction 2: Advancing health and well-being into old age

Six issues are:

- Health promotion and well-being throughout life
- Universal and equal access to health-care services
- Older persons and HIV/AIDS
- Training of care providers and health professionals
- Mental health needs of older persons
- Older persons and disabilities

Priority direction 3: Ensuring enabling and supportive environments

Four issues are:

- Housing and the living environment
- Care and support for caregivers
- Neglect, abuse and violence
- Images of ageing

from: United Nations (2002), Political Declaration and Madrid International Plan of Action on Ageing; New York.

Annex 2: Ageing and health standards, guidelines and toolkits

Protocols and Positions:

The Protocol To The African Charter On Human and Peoples' Rights On The Rights Of Older Persons In Africa. Available at.https://au.int/en/treaties/protocol-african-charter-human-and-peoples%E2%80%99-rights-rights-older-persons (accessed 28.09.2017)

African Union Common Africa Position (CAP) on long-term care systems for Africa The CAP was formally adopted by the African Ministers of Social Development, Labour and Employment during the second session of the AU Specialised Technical Committee on Social Development Labour and Employment (STC-SDLE-2), 24-28 April, 2017 in Algiers.

Convención interamericana sobre la protección de los derechos humanos de las personas mayores. Available at: http://www.oas.org/es/sla/ddi/tratados_multilaterales_interamericanos_A-70_derechos_humanos_personas_mayores_firmas.asp ; 2015

Standards and guidelines:

Organisation and provision of community based home care– Volume 1 ; IFRC
Basic Skills and knowledge in community based home care – Volume 2; IFRC
Training programme for home care volunteers – Volume 3; IFRC
Training curriculum for home helpers - Volume 4; IFRC

Minimum Standards for Age and Disability Inclusion in Humanitarian Action – Age and Disability Capacity Capacity Programme (ADCAP)

Toolkits and Resource Books:
IFRC Healthy Ageing facilitator guide
IFRC Health Ageing Toolkit
IFRC Healthy Ageing volunteer guide
Ageing and Disability in Humanitarian Response- Ageing and Disability Task Force (ADTF)

SRC IC net link to ageing and health indicator toolbox
Ageing and health (Home based care) Indicator Toolbox

Annex 3: International Definitions and Concepts related to Ageing and Health

Active Ageing:

The term "active ageing" was adopted by the World Health Organization in the late 1990s. The WHO developed the "Active Ageing Policy Framework" in 2002. The active ageing approach is based on the recognition of the human rights of older people and the United Nations Principles of independence, participation, dignity, care and self-fulfillment. It shifts strategic planning away from a "needs-based" approach (which assumes that older people are passive targets) to a "rights- based" approach that recognizes the rights of people to equality of opportunity and treatment in all aspects of life as they grow older. It supports their responsibility to exercise their participation in the political process and other aspects of community life.

The WHO has replaced the "Active Ageing Policy Framework" with "Healthy Ageing" in 2015.

Healthy Ageing:

Healthy Ageing is about creating the environments and opportunities that enable people to be and do what they value throughout their lives. Everybody can experience Healthy Ageing. Being free of disease or infirmity is not a requirement for Healthy Ageing as many older adults have one or more health conditions that, when well controlled, have little influence on their wellbeing.

WHO defines "Healthy Ageing "as the process of developing and maintaining the functional ability that enables wellbeing in older age". Functional ability is about having the capabilities that enable all people to be and do what they have reason to value. This includes a person's ability to:

- meet their basic needs;
- to learn, grow and make decisions;
- to be mobile;
- to build and maintain relationships; and
- to contribute to society.

Functional ability is made up of the intrinsic capacity of the individual, relevant environmental characteristics and the interaction between them. Intrinsic capacity comprises all the mental and physical capacities that a person can draw on and includes their ability to walk, think, see, hear and remember. The level of intrinsic capacity is influenced by a number of factors such as the presence of diseases, injuries and age-related changes.

Environments include the home, community and broader society, and all the factors within them such as the built environment, people and their relationships, attitudes and values, health and social policies, the systems that support them and the services that they implement. Being able to live in environments that support and maintain your intrinsic capacity and functional ability is key to Healthy Ageing.

Age-friendly environments and healthy cities:

WHO raises awareness on the importance of environments in determining Healthy Ageing and encourages the creation of age-friendly environments by:

- compiling evidence based guidance on age-friendly environments;
- providing an information platform for sharing of information and experience; and
- nurturing and developing the WHO Global Network for age-friendly cities (2007) and communities.

Cities and communities around the world are working towards becoming more age-friendly. The WHO Global Network consists of more than 500 cities and communities in 37 countries, working to improve their physical and social environments to become better places in which to grow old.

Creating environments that are truly age-friendly requires action in many sectors: health, long-term care, transport, housing, labour, social protection, information and communication, and by many actors – government, service providers, civil society, older people and their organizations, families and friends. It also requires action at multiple levels of government. The following key approaches are relevant to all stakeholders:

- combat ageism;
- enable autonomy;
- support Healthy Ageing in all policies at all levels.

Integrated Home Based Care:

In the absence of a unifying definition and an overarching approach to integrated home based care, the WHO Europe has attempted to consolidate and align evidence on integrated care. The WHO working document (2016) provides an analysis of definitions and components that challenge or support integrated care. In doing so, it delivers a synthesis of generic considerations when designing and implementing integrated care models.

In respect to the definition of integrated care, the reviewers state that the concept of integrated care is strongly shaped by perspectives and expectations of various users in the health system, making a unified definition difficult. Interestingly, all definitions converge around highlighting the central role of population and individual needs. De Cavalho et al. (2017) as part of the WHO Integrated Care for Older People programme talk about the following levels of integration:

Micro-level integration at the level of

Clinical care: Integration at the clinical care level is especially important for older people and should include: (i) comprehensive assessment; (ii) a common treatment or care goal based on the individual's intrinsic capacity and functional ability; and (iii) a care plan that is shared among all care providers.

Meso- and macro-level integration at the level of

Service delivery: Important aspects of service delivery for older people include: (i) active case-finding and management; (ii) community-based care; and (iii) home-based interventions. In addition, service delivery must be anchored to a strong and well-performing primary health-care system. Support for self-management provides older people with the information, skills and tools they need to manage their health conditions, prevent complications, maximize their intrinsic capacity and maintain their quality of life. Community engagement enables existing resources to be employed and helps provide support for older people and their families.

Health workforce: Health-care workers require several key competencies to provide good-quality care for older people. Training reforms are necessary to ensure they have these skills. In addition, a critical mass of specialist geriatric expertise is needed for more difficult and complex cases. Moreover, health-care workers should be deployed in a manner consistent with the objective of providing person-centred, integrated care for older people – for this purpose, multidisciplinary teams are essential. In some contexts, care coordinators and self-management counsellors might be needed.

Information and data: Electronic health records and shared data platforms can capture, organize and share information about individuals and clinical populations. This information can help identify older people's needs, plan care over time, monitor responses to treatment

and assess health outcomes. Information systems can also facilitate collaboration between different health-care workers and between health-care teams and their patients, who may be located in a range of settings or geographic locations. Standard assessment measures should be reviewed to ensure they are assessing outcomes important to older people, namely intrinsic capacity and functional ability.

Health-care infrastructure, products and technology and vaccines: The physical infrastructure of health centres and hospitals should be designed in an older age-friendly manner. In addition, older people should have access to essential medicines and to assistive and medical devices that will enable them to remain healthy, active and independent as long as possible.

Financing: Policy on health financing should be aligned with the goals of universal health coverage for ageing populations, which is defined by WHO as all people having access to the health services needed without risking financial hardship by accessing them. Joint funding across health and social care sectors would help ensure coordination and efficiency and is particularly important for ageing populations.

Concepts and models of (integrated) Home Based Care are manifold. There are models designed to integrate care for individuals with chronic conditions, disease-specific models and population-based integrated models. Individual integrated care models include case management, individual care planning, person-centred medical home and personal health budgets. Group and disease specific models include chronic care models, disease management programmes and integrated care models for elderly and frail.

The working document explains that while it has been possible to identify general principles and core components, it cannot be concluded that one model best supports integrated care. Any integrated model development is strongly contextually-bound, nearly impossible to replicate and can only be successful if it does account for unique needs and characteristics of the population it serves. In the population based model, the population receives promotion and prevention services with the aim to control exposure to risk factors; the majority of chronic care patients receive support for self-management of their illness and high-risk patients receive disease and case management, which combines self-management and professional care.

Evidence based guidelines on integrated care for older people:

The WHO, with support from 30 experts in geriatric medicine, has developed of evidence-based guidelines on integrated care for older people with a particular focus on less resourced settings (WHO 2017). This document aims to guide health care providers on the appropriate approaches at the community level to detect and manage important declines in physical and mental capacities, and to deliver interventions in support of caregivers. These standards can act as the basis for national guidelines and for the inclusion of older people's health care in primary care programmes, using a person-centred and integrated approach.

The guidelines encompass the following key elements of WHO's approach to integrated health care for older people (1991-2015)

- Focus on intrinsic capacity, i.e. the combination of the individual's physical and mental (including psychosocial) capacities
- Comprehensive assessments and care plans to harmonize clinical management across different care providers and unite providers around a common goal
- Case management to improve intrinsic capacity, various aspects of medication management and the use of community services.
- Support for self-management to improve a wide range of outcomes in older adults. Improvements have been observed in physical activity, self-care, chronic pain and self-efficacy.
- Home-based interventions

Annex 4: SRC Result chains Ageing and Health

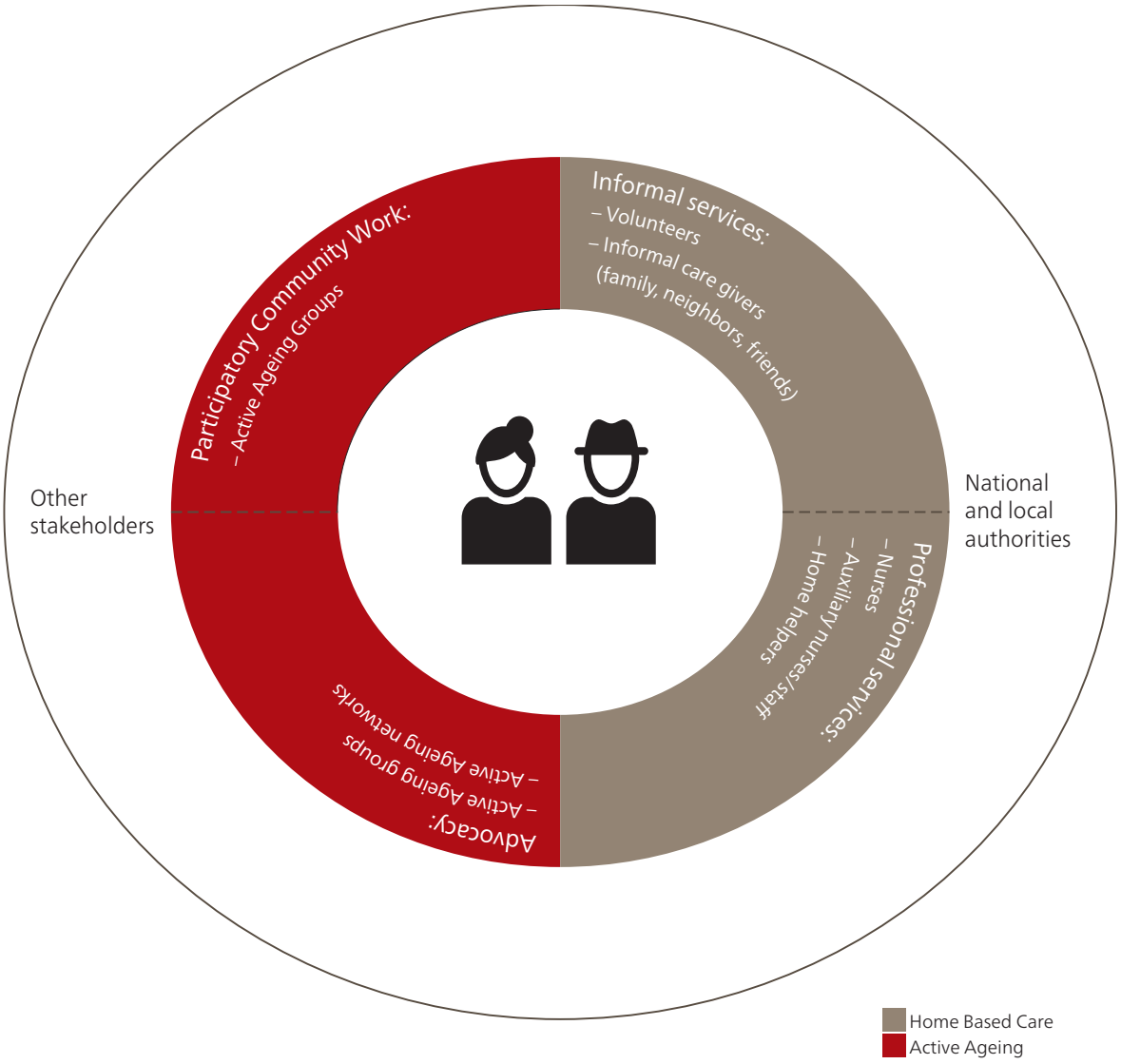
Results chain home based care services (HBC)						
Output		**Intermediate Outcome**		**Long term Outcome**		**Impact**
Facilities infrastructure improved and equipped						
No. of facilites for HBC newly established/renovated						
No. and type of specific equipment bought						
Services provided		**Service delivery is enhanced**		**Improved quality of HBC**		
No. elderly people with disability status enrolled in programme		% of clients receiving integrated medical-social care		Quality standards are fulfilled by 100% (must have indicator)		
No. of palliative care services given per month		Integrated health management system for client data is in place		% of clients are satisfied with the service		
No and type of services provided by HBC staff		Staff : Client ratio is optimised with highest possible efficiency				
No. and type of services provided by HBC volunteers						
A system for regular client feedback is exisiting in all HBC centres						
Quality standards are in place (internal/national)						
Procedures for monitoring and evaluation are existing						
Financing and human resources secured		**Sustainability of HBC is achieved**		**Increased access to HBC for elderly people**		**To contribute to the improved health and well being of vulnerable elderly people**
Financial mechanism for cost coverage is in place		Amount and % contributed through multi-funding (i.e. different internal and external resources)		% increased number of clients benefitting from the services (must have indicator)		Increased self-stated wellbeing by at 20% (based on standard self-assessment questionnaire (e.g. Quality Metrics), covering complete target group
No. of nurses and other staff employed		% of contribution to services paid by the state/ others		Coverage of services, i.e. people in need for HBC actually receive care.		
No. of home based care volunteers in place and working		% of contribution to services paid by the clients themselves		Number of days on waiting list for new admissions		
Staff and authorities sensitized, trained and linked		**Local decision making and policy influenced**				
No. of trainings done for staff on HBC (i.e. palliative care, dementia other topics)		Legal acts are in place				
No. of remunerated staff trained on these specific topics		Types of decisions taken in favour of HBC services				
No. and type of multi-disciplinatory trainings done involving medical and social staff		The HBC model is replicated (or planned to be replicated) in x number of towns/districts/regions				
No. of MoUs signed with relevant stakeholders		Legal frame work is adopted				
No. of collaborations established.						
No. of representatives of relevant institutions participating in the awareness events						
Community workers and volunteers trained and linked		**Knowledge/awareness about HBC services improved**				
No. volunteers / non-remunerated staff trained		% of population know about HBC services				
Type and number of trainings conducted		No. of beneficiaries directed to HBC by other stakeholders				
Communities sensitized						
No. of media and other publications						
No. of awareness events and no. of people participating in the events						

Standard Outcome Indicator

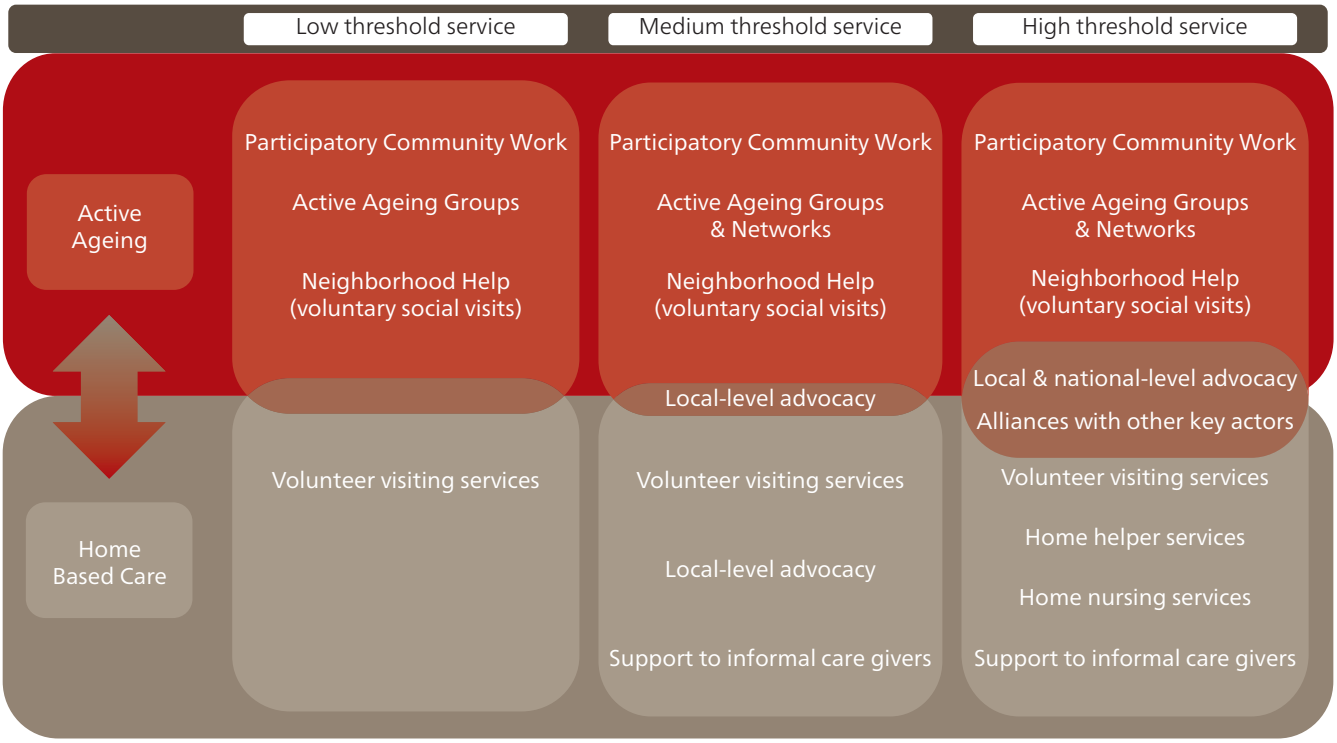
Results Chain Active Ageing

Output		Intermediate Outcome		Long Term Outcome		Impact
Age-friendly communities established		**Age-friendly policies/plans are in place**				
No. of age-friendly communities		% of communes with age-friendly action plans/ strategies (core)				
No. and type of Intergenerational social and recreational programmes started and available		Level of implementation of the age-friendly action plan / strategy				
Availability of age-friendly information and communication (Availability of info on available services; Availability of assistance to seniors for filling out forms; availability of non-automated help lines, etc.)		No. and type of policy/practice changes as a result of advocacy activities by older people				
No. and types of volunteering programme(s) for older people developed and available						
No. and type of educational programmes for older people developed and available						
Public relation events / campaigns carried out		**Image of older people has improved (image is positive)**		**Social inclusion/integration of elderly population increased**		**To contribute to improved health and well being of elderly people**
No. of information campaigns organised		% increase in no. of publications/plots with positive image of older people		Increased self stated integration of older people in the local society		Increased self-stated wellbeing by at 20% (based on standard self-assessment questionnaire (e.g. Quality Metrics), covering complete target group)
No. of persons covered by the information campaign		% decrease of people expressing ageistic views/supporting age-based stereotypes		% increase in group members in AA groups (must have)		
No. of persons involved in carrying out the information campaign						
No. of publications done						
Local interest groups (IG) formed, trained and linked		**Communities /IG empowered for self-help**		**Social Participation of older people in the Society increased**		
No of IG groups		Level of implementation of the vision of the IGs based on the self-generated resources		% of older people who are actively involved in local decision-making processes and actions		
No. of active group members		% of actions carried out (No. of initiatives started versus number of implemented and completed initiatives)		% of older people who are engaged in social activities (must have)		
No. of new group members per year		% of elderly people who know about their rights and entitlements				
No. and type of trainings completed		Amount of resources generated by Igs				
No. of people trained in advocacy						
Workplans of IGs elaborated						
Advocacy actions/ campaigns carried out		**Local decision making processes and local policy influenced**				
No of Advocacy actions/campaigns planned and completed by older people		No. of issues placed by older people to stakeholders (core) / or with decision making mechanisms / bodies				
		No. and type of local decisions influenced by IGs				
Partnership established						
No of partnership agreements signed						

Annex 5: Elements of Home Based Care and Active Ageing



Annex 6: SRC service models on Active Ageing and Home Based Care



References

Beard, J.R.; Biggs, S.; Bloom, D.E.; Fried, L.P.; Hogan, P.; Kalache, A.; Olshansky, J.S. (eds) (2012). Global Population Ageing: Peril or Promise. Geneva: World Economic Forum.

Bussolo, M., Koettl, J.; Sinnott, E. (2015). Golden Aging: Prospects for Healthy, Active and Prosperous Aging in Europe and Central Asia. Washington, DC: The World Bank Group. Available at: https://openknowledge.worldbank.org/handle/10986/22018.

HelpAge International (2015). Nepal earthquake: Longer-term plan to support older people [Blog post]. Retrieved from: http://www.helpage.org/blogs/toby-porter-20545/nepal-earthquake-longerterm-plan-to-support-older-people-852/.

– (2018). Missing millions. How older people with disabilities are excluded from humanitarian response. London: HelpAge International and London School of Hygiene and Tropical Medicine.

OECD/DAC (2015). States of Fragility 2015, Meeting Post-2015 Ambitions. Paris: OECD Publishing. Available at: http://www.oecd.org/dac/states-of-fragility-2015-9789264227699-en.htm.

OECD (2017). Health at a glance 2017. OECD Indicators (Chapter 11). Paris, OECD. Available at: http://www.oecd.org/health/health-systems/health-at-a-glance-19991312.htm

De Carvalho, I.; Epping-Jordan, J.; Pot, A.; Kelley, E.; Toro, N.; Thiyagarajan, J.; Beard, J. (2017). "Organizing integrated health-care services to meet older people's needs", Bulletin of the World Health Organization, Vol. 95, pp. 756-763. Available at: http://dx.doi.org/10.2471/BLT.16.187617.

Mazurana, D.; Benelli, P.; Gupta, H.; Walker, P. (2011). Sex and age matter. Improving humanitarian response in emergencies. Boston: Feinstein International Center, Tufts University. Available at: http://fic.tufts.edu/publication-item/sex-and-age-matter/.

SRC (2014). Volunteering for better health. A qualitative study of the impact of volunteers on health in development cooperation programmes, Issue Paper on Health series, No. 4.

– (2016). Health Policy for International Cooperation. Bern, Switzerland.

– (2017). Active, empowered and young at heart: implications of participatory community work with older people. A comparative study of Swiss Red Cross projects in Belarus, Bosnia-Herzegovina and Bulgaria, conducted by Raisa Sinelnikova and Andrew Humphreys; edited by Christine Rutschmann and Monika Christofori-Khadka. Bern, Switzerland.

– (forthcoming). Altersleitbild (guiding principles on ageing), commissioned from Klaus Vatter.

UNFPA (2002). Political declaration and Madrid International Plan of Action on Aging. New York: United Nations.

– (2012). Ageing in the 21st century: A celebration and a challenge. New York: United Nations.

UNHCR and Handicap International (2011). Working with Persons with Disabilities in Forced Displacement, Need to know guidance 1. Geneva: UNHCR.
Available at: http://www.unhcr.org/4ec3c81c9.pdf.

United Nations (2015.) The Sustainable Development Goals. Available at: http://www.un.org/sustainabledevelopment/sustainable-development-goals/ (accessed on 12 November 2017).

Wilson, Karen (2006). Public Policy and Ageing Report 2006. Washington, DC: National Academy on an Aging Society.

WHO (2002). Active ageing: A policy framework. Geneva: WHO.
Available at: http://apps.who.int/iris/bitstream/handle/10665/67215/WHO_NMH_NPH_02.8.pdf;jsessionid=9D95F1E8428010C5DC33BB9155E95C92?sequence=1.

– (2007). Global Age-friendly Cities: A Guide. Geneva: WHO. Available at: http://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf.

– (2015). World Report on Ageing and Health. Geneva: WHO. Available at: http://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf?sequence=1.

– (2016). Global strategy and action plan on ageing and health (2016–2020). A framework for coordinated global action by the World Health Organization, Member States, and Partners across the Sustainable Development Goals. Geneva: WHO.
Available at: http://www.who.int/ageing/GSAP-Summary-EN.pdf.

– (2017). Integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity. Geneva: WHO.
Available at: http://apps.who.int/iris/handle/10665/258981.

Swiss Red Cross
Rainmattstrasse 10
P.O. Box
CH–3001 Berne
Phone +41 31 387 71 11
info@redcross.ch
www.redcross.ch
PC 30-4200-3

Swiss Red Cross