

Community health volunteer training manual



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List of abbreviations

ADLs	Activities of Daily Living
AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretrovirals
BMI	Body Mass Index
BP	Blood Pressure
CAD	Coronary artery disease
CBAs	Community Based Approaches
CBM	Community Mental Health
COPD	Chronic Obstructive Pulmonary Disease
CHV	Community health volunteers
FINDRISC	Finnish Diabetes Risk Score
HIV	Human Immune Deficiency Virus
IADLs	Instrumental Activities of Daily Living
IEC	Information Education and Communication
ICOPE	Integrated Care for Older People
ISHCs	Intergenerational self-help clubs
IPC	Infection Prevention and Control
KG	Kilogram
LLITN	Long Lasting Insecticide Treated Net
M and E	Monitoring and Evaluation
NCDs	Non communicable diseases
NTDs	Neglected Tropical Diseases
PPT	PowerPoint
PrEP	Pre- exposure prophylaxis
SADDD	Sex, age, disability, disaggregated data
SRHR	Sexual and reproductive health rights
STIs	Sexually Transmitted Infections
SUNI-SEA	Scaling up NCDs Intervention in South-East Asia
OPA	Older Persons' Association
TB	Tuberculosis
WHO	World Health Organization

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Introduction to the manual



Background

Globally, populations are ageing, by 2050 nearly one in five people in lower and middle income countries will be over the age of 60. Longer life expectancy is a cause for celebration, but this new reality also brings new challenges. All communities have challenges creating healthy living environments, but community health must be inclusive of older people and engage and empower older people in their own healthy ageing.

Healthy ageing is influenced by our physical and mental abilities. Such as our ability to walk, think, see, hear and remember. As we age, these can be affected by disease, injury or general age-related changes, more than 46% of older people have disabilities. Our environment and the society in which we live also affects healthy ageing: the facilities and structures built around us, the people and relationships in our lives, the attitudes and values we and others around us hold, the opportunities available to us, and the systems and services that are there to support us.

To create an environment conducive to healthy ageing and increase healthy life expectancy community support is a must. A key component of this is properly trained community health volunteers with the capacity to promote health and wellbeing in later life.

Who is most at risk of being left behind?

Older people are not a homogenous group. Large inequalities exist both between and within countries in the extent to which all people are able to enjoy healthy ageing and their equal right to health. Although some of the diversity we see in older age reflects genetic inheritance or the choices made by people across their lives, much is influenced by factors beyond an individual's control.

Intersectionality is a concept that acknowledges that people's identities are made up of multiple dimensions, such as age, sex, gender identity, functional ability, socio-economic status, ethnicity, religion, and sexual orientation which can interact in complex ways to shape their experiences and access to resources. They intersect and accumulate across life-course, leading to compound disadvantages and inequalities in later life.

These inequalities have a profound impact on people's health and wellbeing, and often result in those with the greatest need being least able to enjoy their right to quality health and care services, facilities and goods that meet their needs. Which older people are most likely to be left behind depends on the context but is likely to include poorer older people, the oldest old, older women, older people with a disability or care and support need, older people with lower levels of education, older people from minority ethnic or religious groups, older members of the LGBTQI+ community, migrants, refugees and internally displaced persons, and those living in remote, insecure, or fragile environments, contexts or settings. An equity-based approach to healthy ageing demands that we consider the diversity of older people when designing policies and programmes and engage them to identify who is most at risk of being left behind.

Who is this manual for?

This manual is to be used by trainers responsible for training community health volunteers. The manual can also be shared with community health volunteers to enable them to return to the content when needed and should also be accompanied with the self-care manual as a job aid.

This training mainly focuses on Community health care volunteers providing community based health promotion education, screening, referrals and self-care advice.

The role and expectations of community health volunteers varies significantly from context to context. The trainers should decide which modules are most relevant to the requirements of the community health volunteers in their areas.

How to use this manual?

This manual provides content on each of the topic areas listed above. Each module comes with suggestions for structuring sessions, including tasks and activities for trainees. However, there is no requirement to stick to the suggested tasks.

A facilitators guide accompanies this manual.

What is the role of community health volunteers?

Each module of this manual includes information on the roles of community health volunteers specific to the content area.

In general community health volunteers demonstrate an interest in supporting and working with older people, maintaining a positive attitude, having some literacy and numeracy skills and basic knowledge of health. CHVs do their work voluntarily, with recognition from the community, in some cases CHV may receive an allowance or other forms of support. Community health volunteers can be of any age so long as they have the capacity to fulfil the requirements of the role.

One of the most important aspects of being a community health volunteer focusing on older people is the commitment to support the independence and dignity of older people, supporting individuals to continue to live their life as they wish. CHVs should always ensure the support they provide is based on older people's goals and preferences and promotes their engagement in their health and wellbeing.

Some characteristics of a good community health volunteer include;

- Being friendly, kind, compassionate, patient
- Treating others with respect
- Having integrity and being reliable
- Being flexible and resilient when faced with challenges
- Being committed to providing good support and willing to learn new skills

- Having a sense of humour and ability to make the best out of a situation
- Taking initiative and being enthusiastic
- Having good interpersonal and communication skills
- Knowing how to remain calm or to take a break when frustrated
- Often it is useful for community health volunteers to be recruited from the locations in which they will work.

Some key principles and practices for community health volunteers to be aware of:

- Confidentiality - when a person shares something of a private nature, this should not be discussed with anyone else. If the issue requires referral to a health professional, this process should be discussed with the older person.
- CHV should not pass judgement on an individual and should not let their own personal beliefs impact upon how care is given which should always be impartial

Summary

The global population is ageing, with nearly one in five people in developing countries expected to be over 60 by 2050.

Healthy ageing is influenced by physical and mental abilities, which can be affected by disease, injury, or age-related changes. Our environment and the society in which we live also affects healthy ageing: The facilities and structures built around us, the people and relationships in our lives, the attitudes and values we and others around us hold, the opportunities available to us, and the systems and services that are there to support us.

Older people are more likely to be disabled, which can complicate health and care needs. Consideration of adaptations or additional needs for older people with disabilities is important in providing appropriate health and home based care and support to meet all needs.

Disparities in healthy life expectancy exist globally, with community support being a key component in creating an environment conducive to healthy ageing.

This manual is designed for trainers responsible for training community health volunteers, with a focus on community-based health promotion education, screening, referrals, and home based care and support.

The role and expectations of community health volunteers vary significantly from context to context, but community health volunteers should always prioritise the dignity and autonomy of older people.

Module 1

Introduction to community-based approaches to healthy ageing



Introduction

What are community-based approaches to healthy ageing?

The overall goal of community-based approaches (CBAs) to healthy ageing is that older people are actively engaged in actions to achieve their right to health and related rights such as right to participation, and right to live independently and be included. It is important to focus on prioritising those with the greatest need for support first, such as older women or older people with disabilities. The expected results of CBAs include:

- older people's enhanced agency and dignity,
- improved physical and mental capacity and well-being,
- and increased access to affordable, age inclusive, people centred, health and care services.

An essential aim of CBAs work is to support older people's rights, prioritising those with the greatest need for support first, to be meaningfully involved in decisions around their own health care, and to shape the design of health and care services that meet their needs.

In numerous countries and contexts CBAs to healthy ageing are implemented by a variety of community-based organisations, which often include older people's associations or organisations that have a mix of age groups (intergenerational), including older people.

What interventions are included in community-based approaches to healthy ageing?

The design of community-based approaches to healthy ageing interventions is context specific and tailored to local needs, influenced by older people's health and care priorities, and the resources available to them and their communities.

Examples of CBAs activities include:

- health promotion including information and education for self-care,
- basic health screening, including for non-communicable diseases,
- peer support groups,
- home-based care services for people with long term care and support needs,
- advocacy to increase access to people-centred, integrated, age friendly health and care services (health promotion, disease prevention, treatment, rehabilitation, long-term care and support, and palliative and end of life care services)
- approaches to strengthen linkages, coordination and communication between health and care service providers and the community.
- exercise groups for health promotion
- community gardens and cooking clubs to improve nutrition

Who should be involved in community-based approaches to healthy ageing?

To achieve healthy ageing for all it is necessary to consider the underlying social determinants of health which have a strong influence on people's health and wellbeing. This is why multi-sector partnerships and linkages across sectors are important. The underlying social determinants of health are the non-medical factors that influence our health. They include the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

Often older people's associations or other community groups include a variety of interventions that address the social determinant of health such as those related to social inclusion, income security, livelihoods, health screening, home visits, exercise clubs, access to health and care services etc.

Older people's associations through mechanisms such as older citizens monitoring and stakeholder coalition building can act as strong advocates for the rights of older people as well as hold duty bearers to account on delivery of their rights and entitlements.

Community-based organisations may partner or collaborate with a variety of stakeholders working in areas that can influence social determinants of health. Stakeholders may include community leaders, cross sector government departments, health and care service providers, non-government organisations and research institutes.

Why do community-based approaches (CBAs) to healthy ageing matter?

Millions of older people in low and middle income countries are among those with the greatest need for health and care services, but the furthest behind in accessing them. This means they are unable to enjoy their right to health - which includes the right to health and care services that meet their needs, the right for their voices to be heard and to meaningfully participate.

More than 46 per cent of older people have disabilities and more than 250 million older people experience moderate to severe disability, with populations around the global ageing, this number is likely to grow and therefore health and care support for older people also needs to be inclusive of the needs of people with disability. Older people with disabilities face double discrimination and so approaches need to be designed to ensure their needs are prioritised.

As a result, older people and people with disabilities are unable to achieve their right to access health and care services that meet their needs, to have their voices heard and to meaningfully participate in decisions that affect their health and well-being. They are missing out on experiencing healthy ageing.

Community based approaches bring healthy ageing actions closer to where older people and people with disabilities, live; prioritise their inclusion and active participation, especially those who have the greatest need for support but with the least access to it, to enjoy healthy ageing, and catalyse actions towards achieving age friendly, people centred health and care services that are available, affordable, accessible and acceptable, and good quality.

A strong primary health care system which puts people and communities at the centre of health systems is the cornerstone for achieving universal health coverage (UHC). Governments are responsible for delivering health and care services that ensure people's right to health but it takes whole of society approaches to achieve longer, healthier lives lived in greater wellbeing. And while national policies are a big part of progress on health, it is at the local level that work needs to be done to ensure that all people are able to affordably access the health services they need.

What is universal health coverage?

Universal health coverage (UHC) means that everyone, everywhere is able to access the quality health and care services they need without suffering financial hardship. The health and care services provided to you should include the full continuum of community-based care from health promotion and disease prevention to early diagnosis and treatment, rehabilitation, specialist, long-term care and palliative care.

Purpose

The purpose of these two sessions on CBA approaches to healthy ageing, is to introduce the participants to CBAs to healthy ageing, and to increase their skills and confidence to actively participate in the design and implementation of inclusive CBAs to healthy ageing in their community.

Learning outcomes

By the end of the session, the participants should be able to:

- Define CBAs to healthy ageing; explain the CBA key principles and discuss why CBAs to healthy ageing matter. Discuss the social determinants of health.
- Review CBAs case studies and identify the CBAs key principles. Share examples of CBAs in their own communities.
- Discuss their responsibilities for CBAs and identify gaps in their knowledge and skills that may need further development

Session 1.1

What are community-based approaches, CBA principles and why do CBAs matter?



Training materials

Flip chart paper, marker pens, adhesive tape, pre-prepared flip charts: expected outcomes of session; summary definition of CBAs to healthy ageing; CBA key principles, why CBA approaches matter. Two case studies of CBA approaches.



Facilitation steps

Step 1: Introduce the CBA session topic, and the expected outcomes when the two CBA sessions are complete.

Step 2: Ask the participants to brainstorm this question with the person sitting closest to them, 'What does healthy ageing mean to you?' 'What supports you to enjoy healthy ageing'? Request participants to share their ideas. Write up their responses on the flip chart paper.

Step 3: Present the CBA definition (in box below) highlighting the ideas the participants contributed and the areas that have not yet been mentioned. Provide the opportunity for the participants to ask questions.



Facilitator's notes:

What are community-based approaches (CBAs) to healthy ageing? What are the CBA key principles? Why do CBA approaches to healthy ageing matter?

The overall goal of community-based approaches is that older people, inclusive of those with the greatest need for support, for example, some older people with disabilities, are actively engaged in actions to achieve their right to experience healthy ageing. The expected results of CBA include:

- older people's enhanced confidence to participate and enhanced dignity,
- improved physical and mental capacity and well-being,
- increased access to affordable, age inclusive, people centred, health and care services.

An essential aim of CBAs work is to support older people's right to be meaningfully involved in decisions around their own health care, and to shape the design of local health and care services that meet their needs.

CBAs to healthy ageing are implemented by a variety of community-based organisations, which often include older people's associations or organisations that have a mix of age groups, including older people (intergenerational).

The design of community-based approaches to healthy ageing interventions is context specific, tailored to local needs, depending on the priorities of the older people, and the resources available to them and their communities.

Examples of CBAs activities are;

- health promotion including self-care,
- basic health screening, including for non-communicable diseases.
- peer support groups,
- home-based care services for people with long term care and support needs,
- advocacy to increase access to people-centred, integrated, age friendly health and care services (health promotion, disease prevention, treatment, rehabilitation, long-term care and support, and palliative and end of life care services).
- approaches to strengthen linkages, coordination and communication between health and care service providers and the community.

These are covered in more detail in later sections of the manual.

Step 4: Community based approaches are designed and implemented based on a human right based approach to health.

Divide the group into 4 small groups to discuss the CBAs underlying principles.

Give each group a copy of the CBA case study (included below). Ask them to discuss the case study and identify which CBA guiding principles are included. Also request them to share examples of CBA approaches from their own community. Ask them to report their ideas back to the big group.

Checklist Guiding Principles for Community Based Approaches to Healthy Ageing	
1	The approach actively involves older people in decision making about the design and contextualisation of the approaches to fit with their context and needs
2	The approach protects and promotes older people's right to enjoy the highest attainable standard of physical and mental health, to participate in the design of services, to have their voices heard and to be involved in decision that affect their health and wellbeing
3	The approach holds governments responsible as duty bearers to ensure the right to health for all people, including the availability, accessibility, acceptability (physical and financial) and quality of health and care services.

4	The approach ensures that individuals, families, communities and organisations can participate and play a role in promoting health and wellbeing in older age, as part of a government driven plan to develop and strengthen health and care systems
5	The approach supports older people and communities to adopt positive practices in support of their health, wellbeing and functional ability (physical and mental capacity and supportive environments)
6	The approach advocates for health and care systems to adopt a person-centred approach, which recognises older people as participants as well as recipients, placing them at the centre of decision making about their care. In some circumstances it might also be necessary to engage an older person's primary caregiver as well.
7	The approach advocates for integrated health services, and increased linkages between health and care systems and services to enable the provision of more holistic care
8	The approach recognises the diversity of older people and avoids stereotyping, prejudice and discrimination based on age and any other grounds, and has mechanisms to promote the inclusion of all older people, irrespective of age, sex, gender identity, ethnicity, religion, level of ability, location or any other characteristic, ensuring non-discrimination and equity in access to services (prioritises reaching those with the greatest need and those who are struggling to access appropriate support)
9	The approach advocates for data disaggregation and analysis to support design, implementation and evaluation of the intervention (Sex, Age, Disability, Disaggregated Data (SADDD)- minimum standard) and considers other factors which may influence inclusion and exclusion such as location, ethnicity, education or other)
10	The approach promotes the health, care and support service providers to take a human rights-based approach to service design and delivery, and respond to older people in ways that respect their dignity, autonomy and independence
11	The approach is designed to be sustainable and replicable, using initial funding to put in place sustainable systems and structures and aiming at future wide-scale coverage



Case Study **Example of community based approaches to healthy ageing**

SUNI-SEA Project – Scaling Up Non Communicable Disease (NCDs) Interventions in South East Asia.

The aim of the SUNI-SEA project community-based approach is to strengthen the prevention and management of non-communicable diseases by reaching more people with health screening, linking people at risk of NCDs to health services, and providing health information and peer support to people in the community.

In Vietnam the SUNI-SEA project works in close collaboration with the government, and cross sector partners. The project is aligned with the priorities and strategies of the government to prevent and manage non communicable diseases such as diabetes and hypertension; and also aligned with the priority health needs of older people in the community.

The community activities to prevent and manage non communicable diseases are implemented by volunteers from the older people's associations (Intergenerational self-help clubs or ISHCs). The design of the CBAs was developed in consultation with the ISHC members, and other local stakeholders such as health care providers and managers. These activities were integrated into the health activities of the ISHCs and also linked to the other areas of ISHCs work, such as health and care activities, income generation, livelihoods, home care, rights and entitlements. This promotes ownership by the ISHCs and sustainability after the project is completed.

Training for the volunteers was provided by the local organisation. During the training the volunteers learnt about a healthy lifestyle, health promotion and non-communicable diseases. They also practised skills to conduct community health screening such as learning how to weigh and measure people, check blood pressure, ask questions and report on results. In addition, the volunteers practiced providing health information to people who received the health screening,

Since the training the volunteers have planned and facilitated screening events, health promotion and self-care activities in their community. They motivate people to participate in peer support activities, The volunteers have also referred people at risk of NCDs to the health facility and continue to monitor and report their activities to their club manager. The local organisation and NGO staff provide ongoing supportive supervision to the volunteers, during which the volunteers practice their skills, and receive feedback about their achievements.

The local organisation and NGO also works to support increased linkages and collaboration between the health facility and the community volunteers.

To share their learning and advocate for their work, the ISHC volunteers participate in meetings with local government members and other stakeholders. They share their experiences of community interventions for health ageing and advocate with decision makers for increased support for the community based volunteer activities, and for increased access to age friendly services for older people.

Step 5: Discuss why CBAs to healthy ageing matter.

Ask participants to share ideas about older people in their community who have the greatest need for support but with the least access to it, and the reasons for this. Review the underlying social determinants of health and discuss the importance of CBA approaches linking/ collaborating with stakeholders who can help influence the social determinants of health within the community.

Why do community-based approaches (CBAs) to healthy ageing matter?

- Millions of people 60 years and older, particularly those with disabilities, and those living in low- and middle-income countries have the greatest need for support are the least likely to receive it.
- This means they are unable to achieve their right to access health and care services that meet their needs, to have their voices heard and to meaningfully participate in decisions that affect their health and well-being. They are missing out on experiencing healthy ageing.
- CBAs bring healthy ageing actions closer to where the older people live; prioritise their inclusion and meaningful participation (especially those most at risk of being left behind) to shape the design of CBAs that fit their needs; and contribute to catalysing community action to achieve progress for age friendly, people centred health and care services, that are affordable, accessible and acceptable.

Session 1.2

What are the community volunteers' responsibilities for CBAs to healthy ageing? What are the gaps in their knowledge and skills that will need further strengthening to enable them to contribute to CBAs?



Training materials

Flip chart paper, marker pens, sticky tape, small cards or stick on cards for writing (2 cards per participant)



Facilitation steps

Step 1: Introduce the session topic. Ask the participants to think about the case studies they read earlier. Give each participant two small cards for writing. Ask them to write two volunteers' responsibilities for implementing CBAs to healthy ageing? Write one responsibility per card.

When everyone has finished, ask them to walk around the room and compare their small cards with other participants. Request them to share ideas with other participants about why these responsibilities are important to support CBAs to healthy ageing.

When everyone has finished discussing, request them to stick their small cards on the flip chart paper. Remind them only to stick the small cards with responsibilities that have not yet been posted. Invite volunteer participants to present back to the big group the responsibilities. Use the notes below to add new responsibilities to the flip chart. Explain that responsibilities may vary from one community to another depending on the CBA approaches selected by older people and their community members.

Step 2: Use the flip chart paper with a list of volunteer responsibilities. Make a second column on the flip chart and ask participants to suggest knowledge and skills needed for each responsibility. Write up their ideas. See notes below for examples.

Step 3: When participants have finished suggesting knowledge and skills request them to mark a tick on the flip chart next to the knowledge and skills, they think they will need to strengthen.



Facilitator's notes:

Discuss volunteers' responsibilities for CBAs to healthy ageing and identify gaps in knowledge and skills that may need further development.

Community volunteers' responsibilities for implementing CBA to healthy ageing	
Responsibility (examples)	Knowledge/ skills examples
Mobilise older people, community members and other stakeholders to take action for healthy ageing	• Knowledge about healthy ageing • Knowledge of VOICE, inclusion and gender equality • Facilitation skills • Skills for participation approaches • Community mobilisation skills • Good communication skills
Work with community leaders and older people to select and plan the CBAs activities, and develop a workplan	• Knowledge about healthy ageing • Knowledge of VOICE, inclusion and gender equality • Facilitation skills • Good communication skills • Knowledge about community-based approaches to healthy ageing • Planning skills • Communication skills
Collect and record information from the community members	• Interpersonal skills • Interview skills • Good communication skills • Writing skills
Facilitate small group discussions	• Facilitation skills • Basic counselling skills • Basic knowledge about common healthy issues for older people • Self-care knowledge and skills
Plan, conduct health promotion activities using IEC materials	• Knowledge on healthy lifestyle practices • Knowledge on common health problems in older people • Health promotion skills • Behaviour change interventions

Monitor and evaluate health promotion events Monitoring and evaluation of all other activities	• Monitoring and evaluation skills • Record keeping
Conduct home visits	• Basic counselling skills • Basic caregiver skills
Conduct health screening for older people	• Health screening skills
Measure blood pressure of people receiving health screening	• Basic information about high blood pressure • Blood pressure measurement skills
Weigh and measure people during screening	• Knowledge about overweight and obesity • Skills to weigh and measure
Record the results of health screening and report to the person responsible	• Recording and reporting skills
Provide counselling to people after screening about their health status and healthy lifestyle	• Basic counselling skills
Refer people with a health problem to the health facility	• Referral and follow up skills
Report writing	• Report writing skills
Planning and conducting advocacy activities	• Event planning • Stakeholder mapping • Community organising • Key message development
Mapping of health and care services in the community	• Mapping services skills

Network with partners and other stakeholders	• Networking skills
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Step 4: Discussing dignity and inclusion

The principles of dignity and inclusion should be considered throughout this manual.

Ask participants to discuss the terms in small groups and come up with definitions.



Facilitator's notes:

Dignity is our inherent value and worth because we are human.

We feel it in a sense of our own self-worth and of other people's respect for us. It is central to our wellbeing. Human rights instruments set out the minimum standards necessary for everyone to live a life of dignity.

Inclusion is the practice or policy of providing equal access to opportunities and resources for people who might otherwise be excluded or marginalised, such as those who have physical or intellectual disabilities and members of other minority groups.

HelpAge International has created a few games to help volunteers and staff understand the principles of dignity and inclusion, they can be accessed here:

<https://www.helpage.org/resources/practical-guidelines/games-on-inclusion/>

Pick one or two of the most relevant games and conduct them with the groups. We recommend:

- 'Why inclusion matters'
- 'What is dignity'

The case study examples used in the games can be adapted to suit the local context.

Step 5: Review of learning and summary of Community Based Approaches to Healthy Ageing



Facilitator's notes:

- The overall goal of community-based approaches (CBAs) to healthy ageing is that older people, inclusive of the people with the least access to health and care services, are actively engaged in actions to achieve their right to experience healthy ageing.
- What interventions are included in community-based approaches to healthy ageing?
- The design of community-based approaches to healthy ageing interventions is context specific and tailored to local needs, influenced by older people's health and care priorities, and the resources available to them and their communities.

Examples of CBAs activities are:

- health promotion including self-care,
- basic health screening, including for non-communicable diseases,
- peer support groups,
- home-based care services for people with long term care and support needs,
- advocacy to increase access to people-centred, integrated, age friendly health and care services (health promotion, disease prevention, treatment, rehabilitation, long-term care and support, and palliative and end of life care services).
- approaches to strengthen linkages, coordination and communication between health and care service providers and the community.

Community-based organisations may partner or collaborate with a variety of stakeholders working in areas that can influence social determinants of health. Stakeholders may include community leaders, cross sector government departments, health and care service providers, non-government organisations and research institutes.

Summary

Community-based approaches to healthy ageing aim to actively involve older people, particularly those with the greatest need for support, in achieving their right to experience healthy ageing. These approaches prioritise older women, individuals with disabilities, and other vulnerable groups. The expected outcomes of community-based approaches include enhanced agency and dignity for older people, improved physical and mental well-being, and increased access to affordable and age-inclusive health and care services. The key objective is to support older people's rights, involve them in healthcare decisions, and shape services that meet their specific needs. Community-based organisations, including older people's associations and intergenerational groups, often implement these approaches in various countries.

Interventions in community-based approaches to healthy ageing are tailored to local needs and influenced by older people's health priorities and available resources. Examples of such interventions include health promotion through education and self-care, basic health screening for non-communicable diseases, peer support groups, home-based care services for those with long-term support needs, advocacy for people-centred and integrated health and care services, and strengthening linkages between service providers and the community.

Multi-sector partnerships and linkages across sectors are crucial for achieving healthy ageing for all. Community-based organisations collaborate with various stakeholders, such as community leaders, government departments, health and care providers, non-governmental organisations, and research institutes, to address social determinants and improve health outcomes for older people.

By bringing healthy ageing actions closer to where older people and individuals with disabilities live, community-based approaches prioritize their inclusion and active participation, ensuring they have access to age-friendly and people-centred health and

care services that are affordable, accessible, and of good quality. The purpose of these sessions on community-based approaches to healthy ageing is to introduce participants to these approaches, enhance their skills and confidence to participate in their design and implementation, and address any gaps in their knowledge and skills related to healthy ageing.

Module 2

Health Promotion Skills



Introduction

Health promotion is the process of enabling people to improve their health and well-being. It involves creating supportive environments, strengthening community action, developing personal skills and shifting the focus to prevention of illness through the promotion of healthy lifestyles.

Health promotion can take many forms, such as educating individuals and communities about healthy behaviours, advocating for policies to support healthy environments and providing access to health services rather than just treating disease after it occurs. Health promotion is about empowering individuals to make positive changes in their own lives.

The goal of health promotion is to improve overall health outcomes, reduce the burden of disease and enhance quality of life for individuals and communities.

Why is this relevant for older people?

Health promotion is particularly relevant for older people, as individuals age they may become more susceptible to NCD, disabilities, and other health issues that can affect quality of life. Older adults are more likely to face challenges related to social isolation, limited access to healthcare, and a decline in functional ability.

Health promotion encourages healthy behaviours and creates supportive environments and in doing so can help older adults maintain their health, prevent chronic diseases and improve their quality of life. For example, health promotion can encourage physical activity and healthy eating. Health promotion can also help older adults stay socially connected, a key factor in good mental and emotional health. There is an ageist misconception that our older age is a time of inevitable and irreversible decline, when in actual fact there is plenty of action we can take to improve our health at any age, including at the oldest age.

By providing access to health information, services, and resources, health promotion can empower adults to take control of their health and make informed decisions about their care.

Role of community health volunteers

CHV plays a critical role in health promotion by serving as a link between individuals, communities and the formal healthcare system and wider social support.

CHV work closely with community members to promote health behaviours, provide health education and help prevent diseases. Some of the roles they play, include;

- Health education
- Community mobilisation
- Referrals

- Support for patients and families
- Screening
- Monitoring and reporting

Learning outcomes

- To understand the Role of community health volunteers in delivering health promotion interventions
- To gain knowledge and skills to empower community members in gaining a healthy lifestyle
- To discuss techniques for facilitating health promotion sessions
- Familiarity in screening

☒	Evaluation:	Group discussion
☒	Teaching method:	Lecture, group discussion, role play, activity planning
☒	Materials:	Flip chart and paper

Session 2.1

What is good health?

Introduction

Before we talk about how to promote health, it is necessary to discuss what is good health?

Health promotion should centre on the idea of 'positive health' focusing on how we keep ourselves well, rather than how we treat illness.



Facilitation steps

Step 1: Get participants into small groups - ask them to come up with a definition of good health and some things they would recommend to others to improve their health.

Discuss with key notes below:

- WHO describes health as the complete state of physical, mental, and social well being and not merely the absence of disease or infirmity.

- This means that to be in good health, we need to think beyond just being 'not sick'
- Good health means we have strong social connections and are physically and mentally well.
- For example, somebody may be diagnosed with HIV - a very serious disease, but with appropriate support and treatment, this may have very little effect on their wellbeing or life expectancy, in this sense we would still consider them a healthy person.
- Good health is about the resilience to manage the strains and stresses of life.

Step 2: In plenary, ask the group what, if anything they have learned from this session?

Session 2.2 Health education

Introduction

Health education is the process of imparting knowledge, skills, and attitudes related to health to individuals and communities. Health education can include a broad range of topics, for example many of those included in this manual.

It involves teaching people how to prevent illness and injury, maintain good health, and make informed decisions about their health.

The goal of health education is to promote healthy behaviours and empower individuals to take control of their health.



Facilitation steps

Step 1: In plenary, ask participants to discuss a time when they learned something new, and discuss what they thought helped them to take on board and remember that new information.

Step 2: Make note of key themes

Step 3: Present key information below on adult learning



Facilitator's notes:

In order to make education for adults interesting and effective, it is important to:

Be participatory: Adults are more likely to learn and retain new information when they are active participants.

Be supportive: Adults are most likely to learn in an environment where they receive praise and encouragement. Criticism is likely to disengage participants in their learning.

Build on their own experience: training will be more useful when it is designed to connect to and build on participants' existing knowledge. This approach also enables participants to connect what they are learning to real-life, which is key for embedding knowledge.

Be relevant: Adults often respond best to material that is relevant to their lives and communities. For health education this could include actions that are tangible and realistic to take. Training is usually more readily incorporated when they are able to build knowledge and skills immediately.

Step 4: In plenary, ask participants to discuss different tools they might use to share new information in their role as CHV.



Discuss using notes below:

Lectures and presentation

Presentation is the most used teaching method. If used well, it can convey key facts, concepts and principles. A framework can guide the participants through a topic and stimulate interest in a subject.

A good presentation contains:

- Clear statements with examples of what is being explained
- Organization of information
- Re-capping of key points at the end of each sub-topic
- Providing opportunity for participant involvement.

Demonstration

Demonstration is an effective method widely used for teaching skills. It is always linked in some way to other methods. For example, learners are unlikely to learn effectively from demonstration alone. They will need guided practice and feedback on how they are doing.

Group discussion

Group discussion can be an effective method when the main objective is to encourage learners to share information and compare viewpoints. It provides cooperative learning, which encourages thinking skills and triggers new ideas.

Group discussions can be started by asking questions, for example, how they perceive their health and how is it important to be healthy? How do they keep healthy? Remember that these people have their own experiences; this is why it is best for them to share and learn from each other.

Community and Individual Empowerment

Empowerment is a process by which people gain control over their lives and make their own decisions. To make this happen, people need the right information, appropriate skills and confidence, and continuous support.

Simply telling people what to do will not help them empower themselves.

Setting goals is a method to empower individuals to take control over their own health.

Share the following information:

Working with individuals to set healthy goals is a good way to make incremental change to improving health outcomes, but goals should include the following principles:

- Goals should be a positive statement - 'Eat 4 vegetables a day' is a much better goal than 'Don't eat unhealthy foods.'
- Goals should be precise - ensure goals have dates, times and amounts.
- Start with one goal and build on this - this helps people to avoid feeling overwhelmed by too many goals and helps to direct attention to the most important ones.
- Write goals down or share them with a friend or family member - this helps you stick to your goals
- Keep goals reasonable - small goals are achievable goals, when goals are large, it will be hard to see progress.
- Set goals, not outcomes - focus on behaviour and not long term outcomes, for example, "eat 1 more serving each of fruits, vegetables and grains each day" rather than 'lose 10 kilos/pounds.'
- Avoid setting goals that are too low: It is important to set goals that require a change, but not so large a change that there is no hope of achieving them.

Step 5: Setting goals

Ask participants to get into pairs - have a go at drafting a goal you could implement for a healthy change in behaviour? Use the above criteria to check on your goals.

Step 6: Using the self-care manual as a job aid – try using the health checklist as a tool to talk through your needs and aims for adjusting healthy behaviours – it is on page 11 of the self-care manual

Session 2.3

Practice session – talking about healthy ageing and supporting older people to use the self-care booklet for healthy ageing



Training materials

Copies of self-care booklets, health promotion steps, flip chart with explanation of the role play practice task.



Facilitation steps

Step 1: Introduce the session topic. Provide each participant with a copy of the Self Care Booklet for older people. Explain that the booklet is for older people and their families to support them for healthy ageing. The booklet is also a resource for community volunteers to support healthy education for older people. Request them to look at the topics in the booklets. Answer questions.

Step 2: Explain that the participants will practise using the self-care booklet to conduct an individual health promotion discussion with an older person. Divide the group into 4 smaller groups.

Explain the task. Each group will role play a health promotion discussion between an older person and volunteer. Everyone in the group should take a turn practising. Facilitators notes below include suggested steps for conducting a discussion.

NOTE – if it is feasible, it would be ideal to conduct an actual practice with older people, in the OPA club or community. Provide each group with the short guide about how to conduct the health promotion session. After each role play the other members of the group should ask the persons who were role playing to evaluate their role play. What went well, what needs improving.

After this other people in the group should provide constructive feedback using the 'Sandwich Method' (firstly provide a positive comment, then identify an area of the health promotion that requires strengthening, then finish feedback with another positive comment.

Step3: When all the participants have practised conducting a health promotion discussion invite them back to the big group. Ask the small groups to share back about the experience conducting the role plays – what went well? What needs improvement?



Facilitator's notes:

How do I conduct individual health promotion?

The aim of individual health communication is to increase the person's knowledge and awareness of a health issue they are concerned about, help them identify their risks for the health issue, reinforce their positive practices, and plan for making small feasible changes to reduce their unhealthy practices.

Steps for conducting an individual health promotion discussion

Remark: Choose a time and place that is convenient for the person. Try to find a private, quiet place.

1	Introduce yourself and your role as a volunteer. Explain the purpose of your visit. Ask a few friendly questions about the person and their life in the community. Assure the person that the information they share is confidential.
2	Ask open ended questions to identify the persons health and wellbeing concerns. "How are you feeling? "How is your health?" "Is there anything you'd like to talk to me about, it can be about your health or anything else?" (this final question is an example of how to open up a wider conversation, it is often the case that somethings that may not be percieved as health related may have a huge impact on health) (Check if the person has a health record book), ask about any previous health problems, medicines etc.
3	Listen carefully to what the person is saying. Show the person you are listening carefully by your body language: nodding your head, making eye contact, etc.
4	Summarize what they have said using your own words: "I hear you are worried about your weight gain."
5	Give the person time to tell you more. Ask to follow up questions for more information. Praise them for their good health practices.
6	Do not judge the person or show disapproval of what they say if they discuss poor health practices.

7	Provide health information according to the person needs (exercise, diet, smoking, drinking etc.) Use the self-care booklet to help you know what information to provide. Show the pictures in the booklet.
8	Ask about challenges they might face to change their behaviour. What is something feasible they could change to improve their health practices?
9	Help the person make their own decisions and choices. Such as “Who could support you?” “What could you do if that happens?”
10	Summarize what the person has agreed to change. Example “You have agreed to go to the health facility next week to have a health check. After the health check you will return to meet me if you would like me to provide further support Ask the person if they have questions?

Session 2.4

Communication and counselling

Introduction

As Volunteers working with older people it's important that you know what good, clear and positive communication is, and how to listen actively to them. You will also need to know how to communicate with older people and older people with disabilities who might have sight or hearing impairments, or other challenges with communication.



Facilitation steps

Step 1: Organise participants into small groups and ask them to discuss the following question: **‘What do we mean by communication?’**

Step 2: Ask representatives from each group to share a summary of their discussion

Step 3: Feedback using the key notes outlined below



Facilitator's notes:

Communication is the transfer of information from one person to another. It is a way of communicating wishes and needs, and exchanging ideas and opinions.

Communication can be divided into verbal and non-verbal.

- Verbal communication consists of two skills: speaking and listening.
- Non-verbal communication refers to gestures, facial expressions, tone of voice, posture, physical distance between communicators. Good communication involves both verbal and non-verbal communication skills.

Verbal communication can be clear or unclear, direct or indirect, positive or negative. Working with older people, including older people with disabilities, the volunteer must learn skills of good communication, i.e. clear, direct and helpful and responsive!

Good communication is the most important support skill for volunteers. Learning how to listen and pay attention to them is essential.

Listening

In contrast to everyday conversation, which is usually an active conversation for both parties, volunteers spend most of their time as active listeners rather than talkers.

Listening is a very important skill for volunteers when working with older people. The aim of listening is to provide the opportunity for the older person to express his/her thoughts and feelings in a supportive environment. Listening can be active or passive (silence).

Active listening means giving full attention to the speaker. This means not only listening to what is being said, but also listening to or being aware of body language, tone of voice and facial expressions of the older person. The skill of listening, therefore, is to be able to pick up the meaning both from what is said and how it is said.

Frequently, volunteers need to communicate with beneficiaries with impaired sight or hearing. In the case of impaired sight:

- everything needs to be explained in words, as non-verbal communication cannot be followed
- the volunteer should emphasise his/her presence
- the volunteer should explain any action or behaviour
- the volunteer should help as much as possible, by checking that spectacles are clean, and that lighting is good

In the case of impaired hearing, volunteers should:

- reduce external or unnecessary noise
- speak slowly and clearly but making sure not to patronise
- emphasise gestures
- be in front of the client
- only one person should talk at the same time

- make sure the older person is understood
- take care of any hearing aid.

Session 2.5

Community mobilisation

This section provides topline information on community mobilisation but for more detail you can look at the Community based organisation manual, which is a step by step guide to mobilising interventions at the community level.



Facilitation steps

Step 1: Discuss mobilisation with group, use questions below as prompts:

- Have you as volunteers ever organised a community activity?
- How did you get all the people involved?
- How did you get particularly marginalised groups involved?

Step 2: Describe community mobilisation using the notes below:

The process of informing people about an activity and getting them to take part in it is called community mobilisation and participation.

As a volunteer you need to understand what community, community mobilisation, and participation mean. In addition, it will help you understand the stages involved in community mobilisation. This section will help you identify the various methods used in community mobilisation and participation. The importance of knowing more about your community is discussed. Finally, you will learn skills that will help you become an effective community mobiliser.

Step 3: Organise participants into small groups. Ask the groups to write a plan for mobilising their community for a project they might implement.

Step 4: In plenary presentations, ask participants to share their plans for mobilising communities for their specific projects, prompt participants to consider how they might make their events inclusive of people who are least likely to access health and other services.

Ask the participants about anything they may need to do to prepare for an event;

- **Community mapping** - identifying different groups that you want to target, and think about what is the best way to reach those particular groups. For example, if you want to reach people who work at the local market, it makes sense to advertise at the market.

In community mapping it is important to consider how to engage the people that at hardest to reach, for example, people who are unable to leave their home without help.

- **Producing materials** - do you need to design posters or pamphlets to engage people, how will you ensure these materials are able to be viewed by people with different disabilities.
- **Methods for Community Mobilisation**

A. Awareness creation events: National immunisation day, campaigns (general as well as door-to-door)

B. Targeted events in specific areas of the community:

- Meeting on the site for community health compound, a market, school, etc;
- Information sharing on upcoming events;
- Co-sponsoring or coordinating an event - for any events that are hosted by CHV, it is important to consider the principles of **Reach, Enter, Circulate, Use** (RECU). See the information box below.

Reach, Enter, Circulate, Use (RECU) principles

Reach - being able to move around the community to get to the service you wish to use (requires accessibility of roads, transportation, signage, etc.).

Enter - being able to get inside the facility you wish to use (requires steps, ramps, handrails, wide doorways, appropriate door handles, etc.).

Circulate – being able to move about inside the entire facility, including from one building to another or one floor to another (requires wide corridors and doors, absence of high steps and thresholds, resting places, adequate light, clear and adapted signage, etc.).

Use – being able to use all services and facilities within the building (requires appropriate dimensions and design of internal furniture, equipment, information and communications, etc.)

https://www.unrwa.org/sites/default/files/content/resources/disability_inclusion_guidelines.pdf

C. Media campaigns:

- Radio announcements on national and local FM stations
- Interviews covered by newspapers
- Specific television (TV) programs Regular columns in a newspaper.

Step 5: ask participants to think about a community event that they attended and discuss – how did they hear about it? What encouraged them to attend? What did they think of the meeting? What aspects were well organised? Was it inclusive – i.e. were people with different needs – for example disabilities – able to meaningfully join and participate? [OBJ]

Step 6: Share with participants some common barriers including; poor physical access, low income, poor transport, lack of accessibility in terms of sign language or other provisions at events, lack of accessible information.



Session 2.6 Screening & Referrals

Introduction

Where services are available, individuals should be encouraged to attend regular screening. These may be provided by primary health centres, mobile medical units, or elsewhere and may be particularly useful for conditions where there may be no obvious symptoms, this includes common cancers. Screening is often accompanied with referrals or development of a plan for health and care support, this should be done in collaboration with the older people, wherever possible people should be empowered to make decisions about their health.

Please note: screening for particular conditions etc may be duplicated in separate modules.

2.6.1 Organising a screening session



Facilitation steps

Step 1: Ask members about knowledge relevant to the topic

Some prompting questions:

- Have you ever been to a health check-up organised locally?

- What is the process that you went through?
- Do you think it was organised in an age and disability friendly way? Provide details.

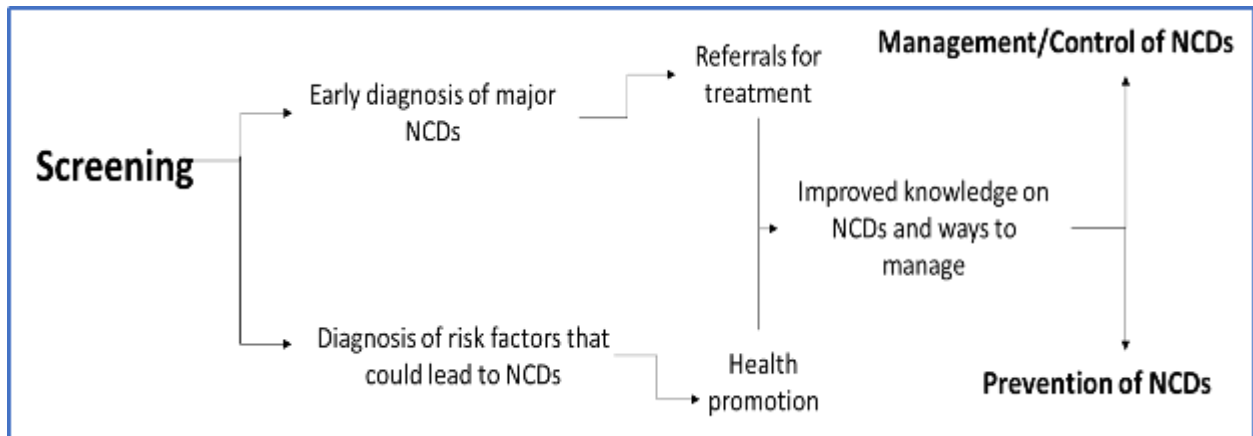
Why is screening important?

Non communicable diseases are a leading cause of illness and death among older people.

Screening and referrals can prevent and control disease and improve health outcomes

Screening can help monitor changes in intrinsic capacity and functional ability and in doing so allow for development of person centred health and care plans that maintain or improve health and wellbeing.

Draw or project the following diagram:



NCDs are largely preventable and controllable when diagnosed early, or when risk factors are reduced. For this, it is important to screen. Because by screening it is possible to diagnose a NCD (in an early stage) or to investigate personal risk factors

Screening is important, because after knowing, you can act!

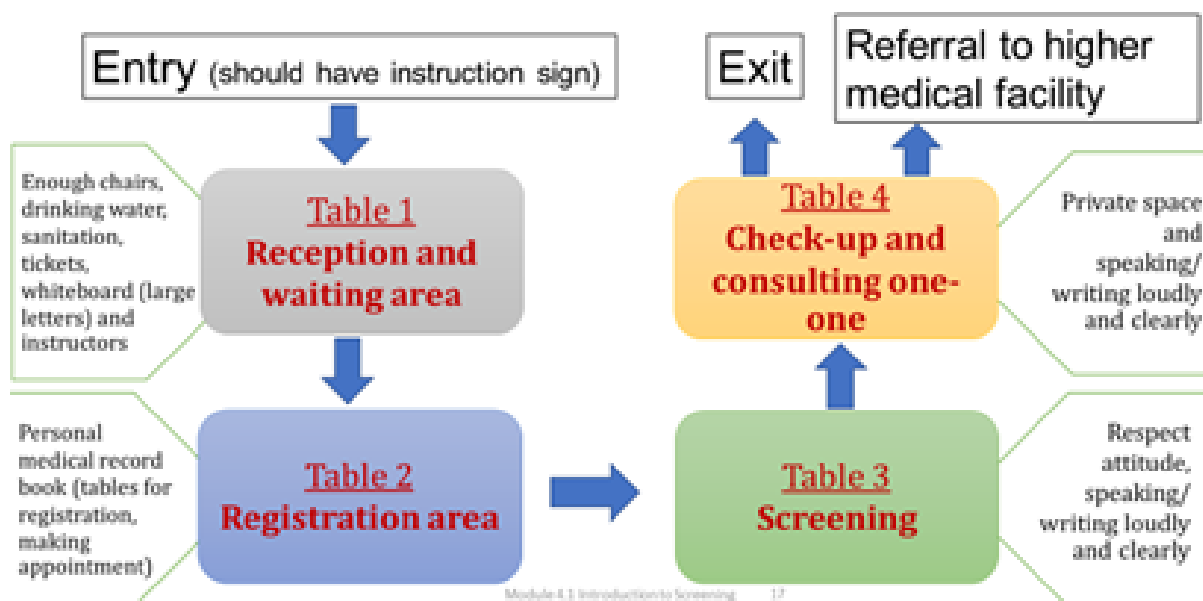
Module 9 includes information on the details of particular NCDs.

There are accompanying powerpoint slides available on the HelpAge knowledge platform that cover an introduction to screening.

Step 2: Conducting a screening session

- 1) Identify a screening room - It must be accessible for older people, and particularly older people with disabilities, so make sure there are places to sit, drinking water, hand sanitiser. Ensure all signage is clear or people are available to provide verbal instructions for people with limited sight. Community halls, religious centres, or health centres may have a space they can offer for use free of charge - remind participants about the '**Reach, Enter, Circulate, Use**' principles that were discussed in an earlier session.

Map of a health check-up friendly with older people



- 2) Ensure necessary equipment is present (BP machine, glucometer, weighing scales etc)
- 3) Registration of patients - in order to monitor screening and support with follow up, registration is necessary. However, it is crucial that people consent to their data being collected and stored and that sensitive information can be stored securely.

The purpose is to collect relevant data such as name, ID, medical records where appropriate.

(The HelpAge knowledge platform includes templates for data collection, as well as case studies of digital tools that have been developed for screening)

- 4) Screening process (questionnaire and taking measurements)
 - i) **Questionnaire.** Questions about: Diet pattern, lifestyle, diabetes risk, mobility, hearing loss, visual impairment
 - ii) **Measurements.** The following presentations include details on how to screen for a range of risk factors
 - Weight - this will require a scale and pen and paper or digital device for noting down the figures, use which system is common to the location e.g. metric (KG), imperial (Pounds)

- Height - this is how tall or short a person is, the person being measured must stand tall and flat on an even surface - lots of details are included in the presentation
- Body Mass Index (BMI) is calculated by combining weight and height information, in the presentation linked below there is a BMI table - everyone should practise using this tool to calculate BMI
- Waist circumference - this is a measurement taken from around a person's waist, for it you will need a tape measure, and to ask the person if they are happy for their top to be pulled up to as the measurement must be taken against the skin
- Blood pressure - must be screened using tools, details are in the presentation.

Screening guides - these sessions should be covered for CHV based on their job requirements.

Each of the presentations linked below provide a guide on screening for different measurements, conditions, and risk factors.

- Training PPT - Waist circumference
- Training PPT - Screening BMI
- Training PPT - Blood pressure and hypertension
- Training PPT - Oral cancer self-examination
- Training PPT - Diabetes - FINDRISC
- Training PPT - Healthy diet including mini nutritional assessment form
- Training PPT - Hearing loss
- Training PPT - Visual impairment
- Training PPT - Alcohol abuse

It is important for CHV to understand that screening is not the same as diagnosis but that high risk patients should be referred to relevant services.

Group task:

In small groups, discuss how you would organise a screening session.

Prompting questions:

- Where would you host the session?
- How would you publicise it?
- What equipment would you need?
- Who would you need to engage with?
- How would you ensure it reached diverse groups of older people, including those with the greatest health and care needs?

Ask groups to present back their plans as well as demonstrate conducting screening from one of the options linked above.

2.6.2 Screening for declines in intrinsic capacity (general screening)



Facilitation steps

Step 1: Define with participants the terms healthy ageing, functional ability, environment, intrinsic capacity and wellbeing. Either ask participants to attempt definitions or work through them and discuss.

- **Healthy ageing:** Defined by WHO as “the process of developing and maintaining the functional ability that enables wellbeing in older age.” Healthy ageing is about all of us, everywhere being able to enjoy wellbeing, dignity, and our right to health, to live independently and continue to do the things that matter the most to us, and to participate at all ages.
- **Functional ability** is about having the capabilities that enable all people to be and do what they have reason to value. It consists of the intrinsic capacity of the individual, the environment of the individual and the interactions between them.
- **Intrinsic capacity** is “the composite of all the physical and mental capacities that an individual can draw on”.
- **Environment:** in the context of healthy ageing refers to an individual’s situation or surroundings. It consists of the physical and the social surroundings.
- **Well-being:** Individual perception of life satisfaction (social, mental, physical, emotional, health), happiness and prosperity
- **Integrated Care for Older People.** WHO Integrated Care for Older People (ICOPE) guidelines on community-level interventions to manage declines in intrinsic capacity outlines how to screen and manage older people for declines in intrinsic capacity.



Facilitator’s notes:

- For the health-care system, the key to supporting healthy ageing for all is optimising people’s intrinsic capacity and functional ability, even as ageing gradually reduces capacity.
- Care-dependency can be prevented if priority conditions associated with declines in intrinsic capacity are promptly diagnosed and managed.
- Health and social care workers in the community at the primary care level can identify older people with losses in capacities and provide appropriate care to reverse or slow these losses by following this guidance. This approach is a simple and low-cost one.

- Conditions associated with declines in intrinsic capacity are interrelated and so require an integrated and person-centred approach to assessment and management.

The objective of the guidelines is to prevent, delay or reduce, care dependence in older age and assist people who support older people in communities to:

- Detect declines in physical and mental capacities,
- Deliver comprehensive and integrated care
- Prevent and delay progression of decline

ICOPE includes tests to screen against key domains of intrinsic capacity.

Full information on ICOPE can be accessed here

<https://www.who.int/publications/i/item/WHO-FWC-ALC-19.1>

There is also a comprehensive guide for ICOPE training for CHV accessible at the above link and a downloadable application (english only) accessible here -

<https://play.google.com/store/apps/details?id=com.universaltools.icope&pli=1>

We recommend conducting training in the use of the ICOPE tool using the WHO guidance.

TABLE 1.
WHO ICOPE SCREENING TOOL

Priority conditions associated with declines in intrinsic capacity	Tests	Assess fully any domain with a checked circle
COGNITIVE DECLINE (Chapter 4)	1. Remember three words: flower, door, rice (for example) 2. Orientation in time and space: What is the full date today? Where are you now (home, clinic, etc)? 3. Recalls the three words?	☐ Wrong to either question or does not know ☐ Cannot recall all three words
LIMITED MOBILITY (Chapter 5)	Chair rise test: Rise from chair five times without using arms. Did the person complete five chair rises within 14 seconds?	☐ No
MALNUTRITION (Chapter 6)	1. Weight loss: Have you unintentionally lost more than 3 kg over the last three months? 2. Appetite loss: Have you experienced loss of appetite?	☐ Yes ☐ Yes
VISUAL IMPAIRMENT (Chapter 7)	Do you have any problems with your eyes: difficulties in seeing far, reading, eye diseases or currently under medical treatment (e.g. diabetes, high blood pressure)?	☐ Yes
HEARING LOSS (Chapter 8)	Hears whispers (whisper test) or Screening audiometry result is 35 dB or less or Passes automated app-based digits-in-noise test	☐ Fail
DEPRESSIVE SYMPTOMS (Chapter 9)	Over the past two weeks, have you been bothered by – feeling down, depressed or hopeless? – little interest or pleasure in doing things?	☐ Yes ☐ Yes

Step 2: Organise participants into pairs

Step 3: Ask participants to role play each of the screening tests – details on the whisper test are available in the full ICOPE document.

Step 4: Discussion in plenary;

Prompting questions:

- How easy or difficult did you find conducting the screening tests?
- How could you incorporate this into the work/volunteering you will do?

2.6.3 Generic care pathways: Person-centred assessment and pathways in primary care



Facilitation steps

Step 1: Discuss person centred care – ask participants in small groups to discuss what they think person centred care might mean.

Step 2: Ask participants to share their thoughts in plenary and discuss using the facilitators notes below:

- WHO defines person centred care as an approach that consciously adopts individuals' perspectives, needs, and experiences, recognising them as experts, working together with health professionals to achieve the best outcome.
- This definition is important because it emphasises the partnership between healthcare professionals, which includes community health volunteers, and individuals. It emphasises the significance of the unique perspectives and expertise that individuals bring to their own health, promoting a more holistic approach to healthcare.
- A person-centred assessment starts not only with a conventional history taking, but a thorough understanding of the person's life, values, priorities and preferences for the course of their health and its management.

Step 3: Put participants into pairs and small groups – ask them to role play the development a simple care plan. Participants should start with one person completing the ICOPE questionnaire and an additional screening tools such as BMI, they do not have to answer accurately but the group should then work with the individual to identify a set of actions they will take to improve or maintain the health and wellbeing of the individual.

Step 4: Discuss in plenary using the notes below



Facilitators notes:

- CHV are typically not medically trained professionals and should not provide clinical interventions but there are a number of way CHV can support older people with their care.
- Examples include; encouraging health awareness through health promotion interventions such as goal setting and self-care

- Referring individuals for screening or health services where community screening has identified risks
- Homebased care – for example support with activities of daily living, befriending
- Providing information on other services available to them including opportunities for socialisation.
- A care plan would incorporate many of the items identified above but the most important thing is that the individual has a say in the type of health and care support they receive.

Session 2.7

Advocacy

The role of a CHV can mean advocating on behalf of an individual, with their permission and ensuring they are included in all decisions made. For example, ensuring individuals they support are aware of the services available to them, their rights and entitlements and then also engaging service providers on those individuals behalf.

Advocacy can also be focused on the group, community, or even at the national level.

As we have discussed, good health and health promotion is not just about treating disease. Individuals can take action to improve their health but wider community, societal, and structural issues also affect our health. Advocacy involves using communication, education, and taking broader actions with the aim of influencing policy or practices that affect health outcomes.

There are lots of good resources for more comprehensive training in advocacy including here: <https://disasterlaw.ifrc.org/toolbox>

Provide the below hand out to the CHV:





Reminder

- Advocacy and campaigning is a **series of organised actions** aimed at producing **political or social change** at **local, provincial, national, regional** or **global** level.
- Advocacy and campaigning puts problems on the agenda of **decision-makers**, generates **public engagement**, and aims to ultimately build the **power of rights-holders** themselves.
- Advocacy and campaign **goals** and **objectives** should be identified by those who are affected by the issue themselves. They must be at the centre of all activity.
- **Actions / tactics** must be chosen based upon what **change you are seeking** and what will **motivate the key decision-makers to act**.
- **There is power in numbers**. Working with and building support of **key constituencies** and **stakeholders** is key to effective influencing.
- Advocacy is **not a one-off** event or activity, but a **strategic and dynamic process** that requires **thorough plan for how you will achieve an identified goal**.

Summary

Health promotion involves creating supportive environments, strengthening community action, developing personal skills, and shifting the focus to prevention of illness through the promotion of healthy lifestyles.

Health education involves teaching people how to prevent illness and injury, maintain good health, and make informed decisions about their health.

Empowerment is a process by which people gain control over their lives and make their own decisions.

Good communication involves both verbal and non-verbal communication skills, and listening is a very important skill for volunteers when working with older people.

Community mobilization involves informing people about an activity and getting them to take part in it.

Screening is important for preventing and controlling non-communicable diseases among older people.

Advocacy involves using communication, education, and lobbying to influence policy or practices that affect health outcomes.

Community health volunteers play a critical role in health promotion by serving as a link between individuals, communities, and the formal healthcare system.

Additional resources

1. WHO - Health Promotion <https://www.who.int/westernpacific/about/how-we-work/programmes/health-promotion>
2. ICOPE guidance - <https://www.who.int/publications/i/item/WHO-FWC-ALC-19.1>

Module 3

How to establish and support peer support groups



Introduction

Peer support groups are groups that meet to share common experiences and challenges in a safe and supportive environment, members can learn from each other, and provide emotional support and practical assistance. They can be a positive mechanism to promote the health and wellbeing of individuals within a community. Whilst traditional peer support groups may take the form of talking circles or therapy, peer support can also be achieved through social activities that bring people together, reduce loneliness and give people an opportunity to engage with their communities.

Relevance to older people

Peer support groups may be very useful for older people. As people age, they may experience changes to social and familial networks and support systems. This can lead to increased feelings of isolation and loneliness. Peer support groups offer a way for older people to connect with others who may be experiencing similar challenges and to form new connections. As well as a form of social support, peer support groups can offer practical assistance and sources of information.

Participation in peer support groups can be an empowering experience for older people, enabling older people to gain a sense of control over their health and wellbeing, build confidence and resilience.

Role of community health volunteers

Peer support groups can be an effective way for community health volunteers to help members of their community access support and resources they need. Community health volunteers can help establish and facilitate peer support groups.

Learning outcomes:

By the end of the training, participants will increase their understanding of:

- What are peer support groups
- Establishing a peer support group
- How to support peer support groups
- Benefits of peer support group

☒	Evaluation:	Pre and Post training evaluation
☒	Teaching method:	Lecture, small group work
☒	Materials:	Flip chart and coloured markers, paper

Session 3.1

What are peer support groups?



Facilitation steps

Step 1: Describe peer support groups using the paragraph below.

Peer support groups bring people together who are facing similar challenges, have similar experiences or other important things in common. The purpose of peer support groups are typically to provide social, emotional and practical support to overcome shared challenges. Typically peer support groups are run by their members so that priorities are directly based on their needs and preferences. Peer support groups can follow a number of formats depending on the preferences of the participants.

Step 2: In small groups ask participants to think about ways peer support groups may support one another, using the three categories above (social, emotional, practical support). If they are aware of or participate in any groups already and are happy to share, ask participants to share their experience of peer support groups.

Step 3: Summarise using the notes below:

- Social: Spending time with other people & companionship
- Emotional: Sharing feelings with others, empathy
- Practical: Learning how to cope with conditions or circumstances, accessing services and advice

Session 3.2

Establishing peer support groups



Facilitation steps

Step 1: In small groups, ask participants to brainstorm things they may need to consider in establishing a peer support group.

Step 2: Ask participants to share their thoughts.

Step 3: Using a large piece of paper, blackboard, or whiteboard map out the steps as discussed.



Facilitator's notes:

- Identify a need or purpose - most groups start in response to a need, this might be identified by someone in the community or someone external to the community. CHV might recognise that a lot of people are having similar challenges and recommend a peer support group. Though peer support groups are often established around a challenging issue such as grief or addiction, peer support can cover a range of purposes including general social isolation, loneliness, and psycho-social support.
- Determine membership - should the group be closed to a small number of people, this may help facilitate trust, but a more open group might enable more people to be reached. In an open group structure, members may drop in and out as suits their own needs, one benefit of this is it enables support to be available at short notice.
- Define an aim and structure - members may wish to determine together a common aim or vision for the group, this may help in facilitation of meetings as well as provide some overall focus for the group.

Peer support groups may take many different forms, even ones with the same or similar aims. Groups may focus on formal meetings or have a more informal structure, groups may engage in recreational activities or may focus only on discussion. Members should decide collectively how they want the group to operate.

- Decide a location for group to meet - this could be anywhere but there are some key considerations to think about:
 - 1) accessibility - can people get there easily, and is it accessible for members with disabilities,
 - 2) size - can it comfortably accommodate all the members of the group,
 - 3) privacy - peer support groups may wish to discuss things in confidence and as such being sufficiently private is important,

- 4) convenience - are there suitable facilities such as toilets,
 - 5) cost - is there a charge, and if so, is it affordable.
- Set some ground rules - a useful topic for the first meeting might be the agreement upon some ground rules. Ground rules can vary and should be developed by the group members, some common rules include:
 - 1) Maintaining confidentiality. Group members should not disclose information about other members outside the group.
 - 2) No passing judgement or critique of other members
 - 3) Respecting someone's decision to share or not share, it is important that people have an opportunity to speak but equally they may not wish to participate at every meeting, and this should be accepted.
 - 4) Appreciate that each person's feelings and experience are unique and group members need to respect and accept, without discrimination, what members have in common and what is specific to each individual.
 - 5) Respect the right of all the members to express themselves, and to do so without interruption. However, people who may be in crisis may be allowed more time to talk through their issues.
 - 6) Share responsibility by taking turns in various roles such facilitator or making the refreshments
 - Promote the group - the group may begin organically but you may wish to include more members over time and for this you will require promotion. Information can be shared with community-based organisations, health centres, other locations where people access information. Your group could be advertised on social media including local Facebook groups and similar.

Session 3.3

Provision of support to peer support groups



Facilitation steps

Step 1: Introduce topic by highlighting that as discussed, peer support groups are typically run by their members, often with all members playing a role in facilitating and organising sessions. However, each group is different and some may want or need more support from community health volunteers. CHV can play an important role in setting up peer support groups.

Step 2: Discuss the three main points below, giving participants an opportunity to ask trainees what they understand by each category, and discuss the role together.

Asking for a volunteer to facilitate the discussion would enable them to practise some of the points below.

Facilitation

- If required CHV may facilitate meetings, this might include - organising a time and place, communicating with group members, providing guidance.
- Rotating facilitation between CHV and other group members can be a way to share responsibility and minimise power imbalances within the group members.
- Once a group is established and has regular participants, the facilitator may look for members who can take over if they are absent or no longer able to continue. When the group is large it is useful to have a co-facilitator.
- It is important to remember, that just because you might be facilitating the session you do not have to act as the main source of support and shouldn't be the loudest voice in the room, the intention is that members support one another.

Contributions

- As facilitator, CHV can contribute to discussion as relevant and can also play a role to mediate conversations if difficult issues are raised or there are any tensions.

Mediator

- As facilitator, CHV can help ensure everyone has time to speak, should they wish. The facilitator should emphasise the importance of listening to the diverse views of all participants and should stress that everyone brings a unique set of strengths, experience and knowledge to the table.

Session 3.4

Benefits of peer support groups



Facilitation steps

Step 1: In plenary, ask participants to discuss what they think some of the benefits of peer support groups may be.

Step 2: Summarise and complement using the information below:

- Peer support groups provide a safe environment to share thoughts and emotions. People shouldn't be afraid in these groups to ask each other how they're doing and encouraged (but not pressured!) to share their troubles, worries, concerns as well as joy as an important aspect of overall wellbeing.
- Peer support groups enable sharing of information and experience, and learning from others in similar situations
- Peer support groups offer an opportunity for working through ideas and solutions with peers who have similar experience
- Peer support groups provide an opportunity to build new relationships and to strengthen social support networks.
- Peer support groups are an important source of information about available community resources
- Peer support groups can minimise many forms of exclusion and stigmatisation by offering a safe and inclusive space, this can contribute to empowerment and resilience of their members.

Testimony

Members of Maitri, a peer support group led by and for people with psychosocial disabilities, India

"Since I started communicating my needs and desire to my peers in the Maitri group, I realize that I have been able to open up for new changes and challenges, which earlier I could not do. Now I ask for help when I need it... The Maitri group has motivated me to understand my right to stay in the community. I have also become assertive to ask for what I need because I consider it as a right to have it"

"When I come to these group meetings I feel happy because it makes me feel that I belong to some place and that I have someone to support me. I have learned that there are many other people like me."

Source: *Peer support groups by and for people with lived experience: WHO QualityRights Guidance module*

Summary

Peer support groups provide a safe and supportive environment for individuals to share common experiences and challenges which can be beneficial for promoting the health and wellbeing of individuals within a community.

The purpose of peer support groups is typically to provide social, emotional and practical support to overcome shared challenges.

Peer support groups are typically run by their members so that priorities are directly based on their needs and preferences.

Peer support groups may be particularly useful for older people who may experience changes to social and familial networks and support systems.

They offer a way for older people to connect with others who may be experiencing similar challenges and to form new connections.

Community health volunteers can help establish and facilitate peer support groups.

Peer support groups can be an effective way for community health volunteers to help members of their community access support and resources they need.

Peer support groups can minimise many forms of exclusion and stigmatisation.

Additional resources

1. CBM - Community Mental Health Good Practice Guide: Peer Support <https://cbm-global.org/resource/community-mental-health-good-practice-guide-peer-support>

2. Peer support groups by and for people with lived experience: WHO QualityRights guidance module <https://apps.who.int/iris/handle/10665/329594>
3. PEER SUPPORT GROUP GUIDE: A tool to enhance treatment for adolescents and young people living with HIV in Lesotho <https://www.pedaids.org/resource/peer-support-group-guide/>

Module 4

Planning, monitoring and evaluation for CHV



Introduction

Monitoring and evaluation (M&E) is a crucial component of any community health programme. M&E is the process of gathering data to analyse and understand the situation in the community. M&E can help identify any health issues in the community but also can be used to assess whether a programme is working, identify areas for improvement and make good decisions based on evidence.

Role of community health volunteers

Community health volunteers play an important role in collecting data and monitoring the progress of community health programs. This session of the manual helps provide an overview of M&E methods. By understanding M&E, CHV are able to monitor the progress of programmes as well as contribute to strengthening action and ensuring interventions are responsive to the needs of the community.

Learning outcomes:

By the end of the training , participants will be able to:

- Describe and understand the four stages in an M&E system
- Explain the framework for monitoring and evaluation and describe what has changed
- Be able to distinguish between input/output/outcome/impact indicators
- Understand the basics of data collection and compilation at community level
- Explain how to use information to identify problems and implement changes

☑	Evaluation:	Pre and Post training evaluation
☑	Teaching method:	Lecture, small group work
☑	Materials:	Flip chart and coloured markers, paper

Session 4.1

What is monitoring and evaluation



Facilitation steps

Step 1: Divide participants into groups and let each group define the following:

- Monitoring
- Evaluation

Step 2: Ask participants to share their responses in the plenary.

Step 3: Summarise the activity using the key notes below.



Facilitator's notes:

- **Monitoring** is an ongoing activity that measures progress through routine data collection and helps inform real-time adjustments based on whether activities are being implemented faithfully and achieving their intended results.
- **Evaluation** is a more formal and comprehensive form of monitoring, typically done at midterm or at the end of a project. It is more rigorous and complex and focused on questions of effectiveness, relevance, and impact. Evaluation is used to make claims about the success of a program in meeting its desired outcomes.
- **Monitoring and evaluation (M&E)** is a vital part of any effective community based program. By tracking activities and community response, the M&E system facilitates accountability, learning, and adaptation. M&E helps to build the capacity of staff and community members in analysing the delivery and social dimensions of the program.
- By doing so, M&E enhances problem solving and can be used to improve program quality and effectiveness when it is combined with learning activities that are integrated with the program planning process.
- Lastly, M&E data also plays an essential role in justifying resources and investments, and in helping plan for future activities and programmes.

Session 4.2

Benefits of monitoring and evaluation



Facilitation steps

Step 1: Ask participants to brainstorm on the benefits of monitoring and evaluation

Step 2: List the responses on a flip chart.

Step 3: Summarise using the key notes below.



Facilitator's notes:

M&E systems will allow a community-based programme to:

- Improve activities and plans by learning about what is working and what is not working from the users perspective
- Improve the planning process and the design of the program
- Assess the results of the program and whether it achieved its planned objectives
- Determine the appropriateness of program elements and activities
- Make claims about effectiveness
- Demonstrate the value of community engagement
- Gain credibility and support by showing results and impact

Session 4.3

Monitoring and Evaluation Frameworks



Facilitation steps

Step 1: Explain the below program logic framework to participants - draw the framework on a large flip chart paper

Step 2: Use the key notes below to share details

Step 2: Ask participants to fill the inputs and activities section using examples from community based programs / projects they are aware of, or something they think should be implemented in their local community

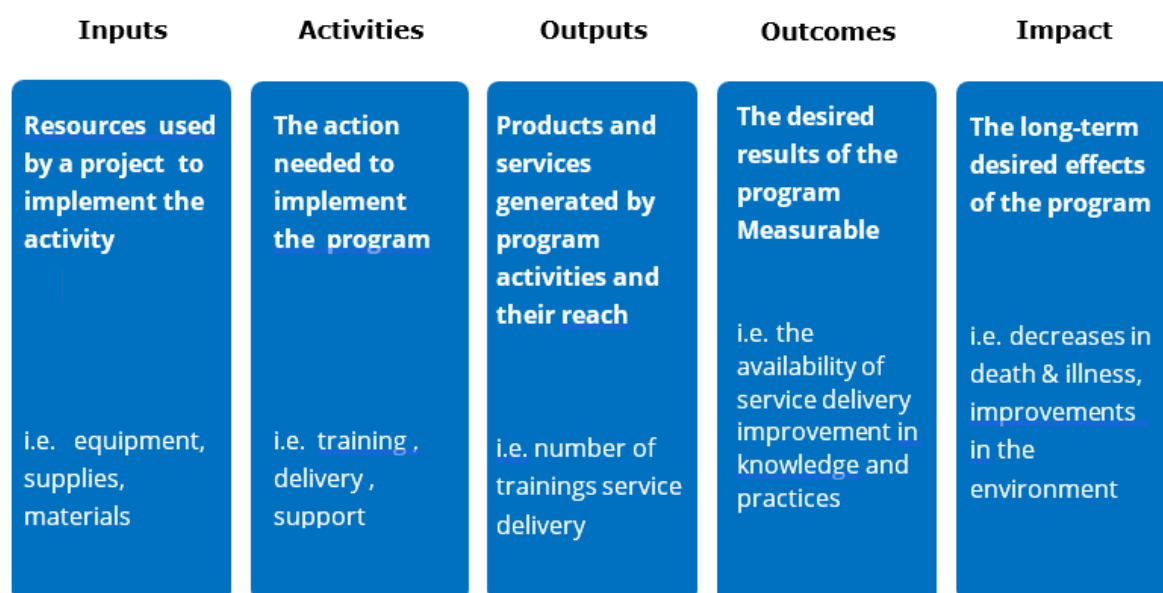
Fill in their responses on the flip chart



Facilitator's notes:

The generic model below depicts the anticipated pathways and mechanisms for how activities will bring about change. The model is a management tool that helps clarify and review the activities and results of the project against its aims and objectives. It can also be tailored to fit any community based projects.

Components of a program logic model



Session 4.4

Developing indicators that effectively identify progress toward project outcomes



Facilitation steps

Step 1: Ask participants to brainstorm on indicators for each of the activities listed in the above log framework output, outcome and impact indicators.

Step 2: Ask participants to brainstorm on the difference between output, outcome and impact indicators.

Step 3: Summarise the activity using the key notes in the table below.

Activity	Output indicators	Outcome indicators
Training of community members	Number of community members completed the training	Community members with demonstrated improved skill post training



Facilitator's notes:

Input indicators measure the contributions necessary to enable the program to be implemented (e.g., funding, staff, key partners, infrastructure).

- Output indicators: those that measure immediate results, for example, the number of people trained
- Outcome indicators measure whether the program is achieving the expected effects/changes in the short, intermediate, and long term. Some programs refer to their longest-term outcome indicators as impact indicators. Outcomes may taken many years to achieve.

Session 4.5

Developing a system to collect and compile data



Facilitation steps

Step 1: Ask participants to brainstorm on sources of data for M&E

Step 2: Summarise their response



Facilitator's notes:

- The most important principle is that participants/beneficiaries have the opportunity to provide feedback; anonymous feedback and complaints systems are a good way to receive ongoing feedback, but taking time to include people who the programme is intending to reach, in a regular and structured way, is crucial - these could include focus group discussions, or individual interviews. It is also important that data once collected is also shared with participants (ensuring confidentiality where necessary).
- Monitoring statistics can be collected from a variety of sources including participants timesheets and training records, service users, staff as well as volunteers.
- Data collection formats can be prepared based on the nature of the community based programs.

Session 4.6

Using your findings to identify problems and implement change



Facilitation steps

Step 1: Ask participants to brainstorm on sources of data for M&E

Step 2: Summarise their response



Facilitator's notes:

Once you have collected the evidence you will need to analyse and interpret it. For outputs, this might include:

- Did you meet the targets you set for volunteer recruitment?
- Are your volunteers from a wide and diverse range of backgrounds?
- Are you reaching people who are most in need of the services? Who is not being reached.
- How is the service promoting inclusive, equity-based approaches, prioritising those with the greatest need for support.
- What about your outcomes?
- Did you achieve what you set out to do, or were there some unexpected outcomes?

Summary

- Monitoring and evaluation (M&E) is important for community health programs as it can help identify health issues, assess program effectiveness, and make evidence-based decisions
- M&E is vital for effective community-based programs it helps facilitate accountability, learning, and adaptation
- Monitoring statistics can be collected from various sources, including timesheets, training records, service users, staff, and volunteers
- CHV may lead on monitoring and evaluating programmes or may be able to provide data to support others to do so.

Additional resources

1. Better evaluation - CHW evaluation toolkit
<https://www.betterevaluation.org/tools-resources/community-health-worker-evaluation-tool-kit>

Module 5

Healthy ageing and common health issues for older people



Introduction

WHO defines healthy ageing as “the process of developing and maintaining the functional ability that enables wellbeing in older age”. Ageing should not be viewed as an inevitable decline, but changes do mean we may need to adjust or prioritise different aspects of health and care. It is never too early or late to take action to achieve healthy ageing. Everyone should have the opportunity to age healthily.

Ageing is an inevitable process that starts at birth and that intensifies with age. It is the process of becoming older. In humans, ageing represents the accumulation of changes over time. The changes encompass physical, psychological, and social aspects. The most visible changes are observed on the body (hair, skin, hands, limbs, walking style, posture,) and mind (memory, reasoning, and thinking among others). Common conditions in older age include changes to hearing, vision, chronic pain, and diseases such as osteoarthritis, chronic obstructive pulmonary disease, diabetes, depression and dementia. As people age, they are more likely to experience several conditions at the same time. Some of these conditions are covered in more detail in later modules.

Ageing is also characterised by the emergence of several complex health states commonly called geriatric syndromes. They are often the consequence of multiple underlying factors and include frailty, urinary incontinence, falls, delirium and pressure ulcers. Older people are generally more likely to experience disabilities than younger people, because of physical and cognitive age-related changes. However, it is important to note that not all older people will develop disabilities. Many of these conditions or syndromes are covered in standalone modules of the manual.

The presence of the health conditions listed in this module does not say anything about the impact they may have on an older person’s life. High blood pressure in one older person may be easily controlled where medication is available, accessible, and affordable. However, without access to medication, the high blood pressure could be limiting. It is important to reiterate that not all older people experience ageing in the same ways, and just because some of the conditions discussed here are common it does not mean they are an inevitable part of ageing. Even for people experiencing declines in capacity, supportive environments can ensure that they can still get where they need to go and do what they need to do. Long-term care and support can ensure that they live dignified lives with opportunities for continued personal growth.

It is very important to understand that the group described as ‘older people’ throughout will contain a range of ages, capacities, people with different interests, needs and approaches to managing their health and wellbeing. A 65 and an 80-year-old may have very different needs but the same could be true of two 80-year-olds as well. This is in part because many of the mechanisms of ageing are random, but also because our health and wellbeing in later life is strongly influenced by our environment. CHV need to keep this in mind, whenever they are working with older people.

Role of Community Health Volunteers

Community health volunteers can provide health education and promotion to older people on common health issues, they can provide support in managing these conditions. Some community health volunteers may provide home-based care and others may ensure referrals are made to appropriate services or for appropriate assistive products. Community health volunteers can provide social support, such as companionship, helping to reduce isolation. CHVs should always ask the older people they are supporting to ensure that their needs are clarified and met.

Purpose

The purpose of this session is to impart knowledge and skills on ageing, healthy ageing and well-being, and common conditions occurring in older age.

Learning outcomes

By the end of the session, the participants should be able to:

- Define the term older person, healthy ageing, and well-being
- Describe how the body changes when we age
- Discuss the social changes with ageing in older people
- Identify challenges associated with ageing in older people

☒	Evaluation:	Pre and post discussion
☒	Teaching method:	Small group work, plenary
☒	Materials:	Pens and paper, flipchart, blackboard

Session 5.1

Definition of the terms



Facilitation steps

Step 1: Divide participants into four groups and let each group define the following; older people, ageing, healthy ageing, and well-being.

Step 2: Ask participants to share their responses in the plenary.

Step 3: Summarise the activity using the key notes below.



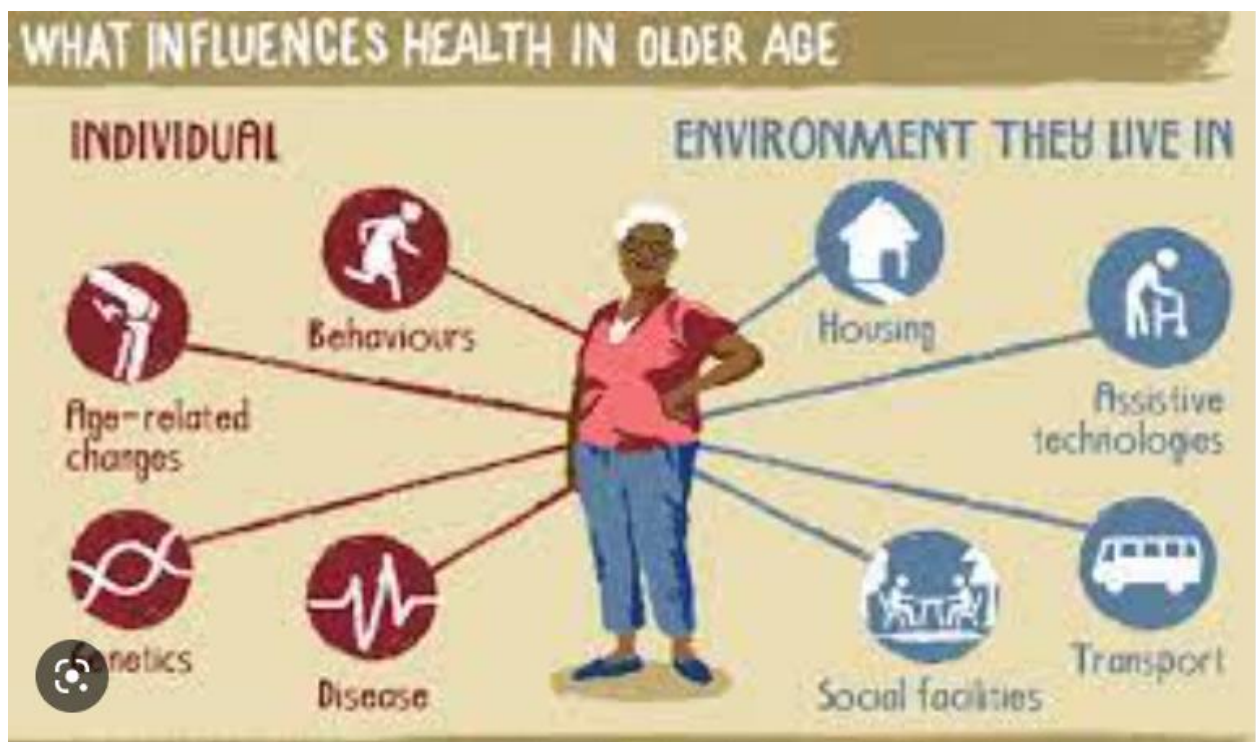
Facilitator's notes:

- An older person is defined by the United Nations as a person who is over 60 years of age. However, individuals, families and communities often use other ways to define and describe age, including family status (grandparents), physical appearance, or the presence of age-related health conditions.
- Ageing is progressive change in humans that starts at birth, gradually over the years the cells that make up our bodies age and stop replicating, and this results in a change to physical functioning. It is important to note that the speed of ageing is different among individuals and is influenced by our environment, not just our chronological age – that is how many years we have been alive.

The World Health Organisation defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

- Healthy ageing: Defined by WHO 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. It consists of the intrinsic capacity of the individual, the environment of the individual and the interactions between them.
- Intrinsic capacity is “the combination of all the physical and mental capacities that an individual can draw on”
- Environment: in the context of healthy ageing refers to an individual’s situation or surroundings. It consists of the physical and the social surroundings.
- These terms are also very important for understanding disability and how we support people with disabilities.
- Well-being: Individual perception of life satisfaction (social, mental, physical, emotional, health), happiness and prosperity

Share this infographic with participants and ask them to reflect on what it means:



Access to the full size infographic [here](#).

Session 5.2

How the body and brain changes as people age



Facilitation steps

Step 1: Ask participants to brainstorm some of the changes the body commonly goes through as people age.

Step 2: List the responses on a flip chart.

Step 3: Summarise using the facilitators notes below.

Step 4: Ask participants to name one thing they were surprised to learn



Facilitator's notes:

System/Organ	Changes
Skin	• The skin may thin and become less elastic and more fragile. • Fatty tissue just below the skin decreases. • Decreased production of natural oils makes the skin drier. • Wrinkles, age spots and small growths called skin tags are more common – we can celebrate these as a testament to a life well lived!

System/Organ	Changes
Immunity	• The immune system becomes slower in responding, increasing the risk of getting sick. • The body may heal more slowly since there are fewer immune cells in the body to bring about healing. The immune system's ability to detect and correct cell faults also declines.
Sleep	• Sleep patterns tend to change • Many older people find it harder falling asleep • They awaken more often during the night • They wake up earlier in the morning.
Cardiovascular system	• There is stiffening of the blood vessels • The heart works harder to pump blood through vessels. • Regular cardiovascular exercise can strengthen the system reducing the impact of ageing on blood vessels and the heart.
Bones and muscles	• Bones tend to shrink in size • Bones become weaker and more at risk of fracture • Fluid in the joints may decrease • Cartilage may soften though this does not necessarily guarantee joint pain or associated disease • The joints become stiffer and less flexible. • There are changes to muscle mass • Muscles can lose strength, endurance and flexibility - factors that can affect coordination, stability and balance. • Regular moderate strength and balance exercise can maintain as well as restore strength to bones and muscles.
Digestive system	• There is age-related structural changes in the large intestine • This can result in more constipation in older adults. • Adjustments to the diet can help with constipation and manage changes to the digestive system.
Bladder and urinary tract	• The bladder may become less elastic with age, resulting in the need to urinate more frequently. • Weakening of bladder muscles and pelvic floor muscles may make it difficult for one to empty their

	bladder completely or cause one to lose bladder control (urinary incontinence). • In men, an enlarged or inflamed prostate also can cause difficult emptying the bladder and incontinence.
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System/Organ	Changes
Eyes	• One might become more sensitive to glare and have trouble adapting to different levels of light. • Ageing also can affect the eye's lens, causing clouded vision (cataracts) but cataract surgery is simple and affordable in most locations. • Changes in the lens make it harder to focus on close objects as well as see in dim light. • Colours may also begin to be perceived differently • The eyes produce less fluid, making them feel dry • Glasses can rectify most decline in eyesight essentially restoring function.
Ears	• Hearing might diminish. • Difficulty following a conversation in a crowded room. • Hearing aids can restore hearing in a lot of cases, as well as environmental and social adjustments.
Teeth and mouth	• Gums might pull back from the teeth. • Certain medications, such as those that treat allergies, asthma, high blood pressure and high cholesterol, also can cause dry mouth and as a result, the teeth and gums might become slightly more vulnerable to decay and infection. • Our sense of taste and smell can change
Sexual and Reproductive System	• With age, sexual needs and performance might change. • Illness or medication might affect the ability to enjoy sex. In women: • Vaginal walls become thinner, dryer, less elastic, and can make sex uncomfortable. • The menstrual periods stop. • The external genital tissue decreases and thins, and can become irritated. • Menopause symptoms such as hot flushes, change in mood, depression, heightened anxiety, headaches, short-term memory and trouble sleeping. These symptoms can be debilitating. • Decrease in breast tissue. • May experience lower sex drive (libido) and sexual response.

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System/Organ	Changes
Sexual and Reproductive System (cont.)	In men: • Impotence might become a concern. • It might take longer to get an erection, and erections might not be as firm as they used to be. • The prostate gland enlarges with age. • Some men may have a lower sex drive (libido). Sexual responses may become slower and less intense.
Hormone production	• Hormones are also broken down (metabolized) more slowly • In women, oestrogen and other hormones decrease significantly • Testosterone levels usually decrease gradually as men age
Nails and hair	• Nails and hair may become more brittle and are more likely to break
Brain	• Wisdom is accumulated over the course of one's life and so crystallised intelligence may grow. • The brain undergoes changes as one ages that may have minor effects on one's memory or thinking - <u>this is not the same as dementia</u>. Though older people may be more likely to have dementia, it is not a normal part of ageing. • Healthy older adults might forget familiar names or words, or they may find it more difficult to multitask. • However, different people age differently • Not all cognitive functions deteriorate with age, and language features, such as comprehension, reading and vocabulary, in particular, remain stable throughout life.

Session 5.3

Social and emotional changes in older people



Facilitation steps

Step 1: Ask the participants to brainstorm potential social and emotional changes that might occur in older people

Step 2: List the responses on a flip chart.

Step 3: Summarise using the key notes below.



Facilitator's notes:

- Ageing should not be viewed as a negative experience, there are many positive aspects to growing older. It is common for happiness to increase as people age. Social roles may change, for example, an older person may adapt to a new role as a grandparent and enjoy spending quality time with grandchildren.
- Investments in meaningful relationships may increase. Research suggests that goals, motivational priorities and preferences may change as we age, with a shift from more materialistic goals, this can strengthen our emotional and social wellbeing and result in self-reported increases in well-being.
- However, social networks may narrow, this could be as a result of retirement, or a disability making mobility harder, for example. A social network is a network of social interactions and personal relationships.
- Retirement—the withdrawal from paid work at a certain age - retiring from working roles may remove older people from a network of contacts and relationships.
- Compromised functional ability may make maintaining some social interactions more challenging as people may have difficulty in leaving the home, for example. This is a problem if the environment is not supportive of people with varying functional ability. This may be particularly challenging for older people with disabilities, digital technologies bring people closer together all the time but it is important to also discuss accessible ways of physically bringing people together if that is their preference.
- Changes to our eyesight and hearing can make maintaining conversations more challenging, which can lead people to withdraw from participating.

Summary

Ageing is a normal and inevitable part of the lifecourse. The changes felt by older people do not always occur in the same order, or at all, and some may be malleable. Whilst some 70-year-olds may enjoy good health and functioning, another 70-year-old may not. This is in part because changes are strongly influenced by the environment in which they live and their unique behaviours.

The body and mind go through many changes as we age, sometimes these can be difficult to adjust to at first.

Being older doesn't mean being sick but there are a number of common conditions faced by older people.

If you do fall unwell in older age you may be at greater risk of complications.

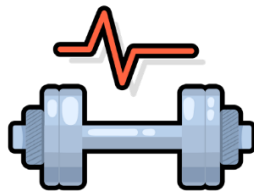
CHV can play an important role in encouraging good health and wellbeing, connecting older people to other services as well as being a source of companionship for older people.

Additional resources

1. Enabling meaningful engagement of older people - <https://www.who.int/activities/enabling-diverse-voices-and-meaningful-engagement-of-older-people>
2. UN Decade of Healthy Ageing - <https://www.who.int/initiatives/decade-of-healthy-ageing>
3. WHO Combatting ageism - <https://www.who.int/teams/social-determinants-of-health/demographic-change-and-healthy-ageing/combating-ageism>
4. National institute of ageing - What do we know about healthy ageing? - <https://www.nia.nih.gov/health/what-do-we-know-about-healthy-aging>

Module 6

Healthy lifestyle interventions



Introduction

Good health contributes to a happy and fulfilling life. It is also important to realise that people who are healthy fall sick less often.

Healthy lifestyle interventions are strategies or activities that promote healthy habits and behaviours. These interventions aim to improve health outcomes by encouraging individuals to adopt and maintain healthy lifestyle and self-care practices, such as eating a balanced diet, regular physical activity, getting enough sleep and avoiding harmful behaviours such as smoking and excessive alcohol consumption.

Relevance to older people

Healthy lifestyle interventions are highly relevant to older people because they can help prevent or delay the onset of many chronic conditions and diseases that are common in this age group. They are oftentimes simple strategies for improving one's health and wellbeing, many which can be actioned in a wide variety of contexts.

Role of community health volunteers in delivering healthy lifestyle interventions

Community health volunteers play a crucial role in promoting healthy living practices and behaviours within their community. With the rise of NCD, it has become more important than ever to educate individuals on the benefits of a healthy lifestyle. CHV will encourage older people to incorporate healthy habits into daily routines, reducing the risk of developing disease and improving quality of life. This module will cover the content needed to promote healthy lifestyle interventions within community settings. CHV can apply the content they learn in this module to the skills they developed in module 3 health promotion. In the self-care manual there are some useful tools for managing a healthy lifestyle, these can be used as training and job aids for community health volunteers and will be useful in this section.

Session 6.1

Personal hygiene and grooming

Learning outcomes

By the end of this session, participants will be able to acquire skills on how to support older people in maintaining their personal hygiene and grooming.

☑	Evaluation:	Discussion and group feedback
☑	Teaching method:	Discussion, group work
☑	Materials:	Flip chart and paper

Key messages:

Personal grooming is an important aspect of healthy ageing.

Looking their best can help older people feel good about themselves.

While most older people are able to groom themselves, others need some support to ensure that their appearance and hygiene is well cared for.

Older people with disabilities may need additional adaptations for support with their grooming.

Older people, including older people with disabilities, should wherever possible lead on personal hygiene and grooming decision making.



Facilitation steps

Step 1: Introduce the session by telling the participants that they will discuss personal grooming for older people. Ask the participants to share why they think it is important for older people to be well-groomed and maintain good hygiene practices.

Step 2: Ask the participants to think of important things to do when helping older people practise self-grooming.

Step 3: Summarise their responses by giving the information in the Facilitator's notes below.



Facilitator's notes:

When an older person takes care of their personal appearance and hygiene, it helps them feel good about themselves. It also gives them a sense of dignity and self-esteem.

What does personal self-grooming mean?

- 1) Regular baths
- 2) Clean dry clothes
- 3) Brushing teeth morning and night
- 4) Cleaned clipped nails
- 5) Neat hair
- 6) Regular shaving where applicable
- 7) Clean face after meals and on waking up
- 8) Clean bedding and making bed everyday



Tips for helping older people with personal grooming

- Talk openly about the self-grooming needs of the older person. It can be a hard experience for older people to accept assistance with bathing and grooming. It is important that older people are treated with dignity at all times.

Language - dos and don'ts

Ensure older people are able to make choices about how to be bathed "would you like a shower or a bath", "can I help wash your hair today"?

Before doing anything, always explain to the person what you will be doing next.

Use simple phrases such as "raise your arms please" or "next I will wash your legs, is that OK?" to talk to the person through what you need them to do - enabling people to continue to do as much for themselves as possible is a good way to maintain autonomy and dignity.

Your tone and body language is as important as what you are saying.

- Try not to deviate from familiar routines of self-grooming. People may have a preference for certain ways of wearing their hair for example, try not to remove the decision making from older people by discussing their needs and wants with them.
- Keep hygiene products such as water, soap, towels, toothpaste, tooth brush, nail cutters, shavers etc. within reach, in case the older person needs them.
- Protect the modesty of the older person. Agree on how to go about helping them to take a bath. You should not expose their bodies unnecessarily
- Don't neglect to clean their private areas if they are not able to do so themselves.
- Ensure that the whole body is well rinsed after a bath, to avoid soap residues on their skin,
- The final step is to ensure that the person is completely dry before dressing.

Safety first!

While helping an older person to bathe and dress up, ensure that they are safe from falls and other types of injury.

The risk of slips and falls can increase during bathing, it is important to always think of safety considerations first. If you are not confident that you can safely wash or move a person, always seek additional help first and discuss this with the older person.

Session 6.2

Skin Care

Learning outcomes

By the end of the session participants will have acquired knowledge on how to support older people with proper skin care.

☑	Evaluation:	Discussion and group feedback
☑	Teaching method:	Discussion in plenary
☑	Materials:	Flip chart and paper

6.2.1 Introduction to our skin

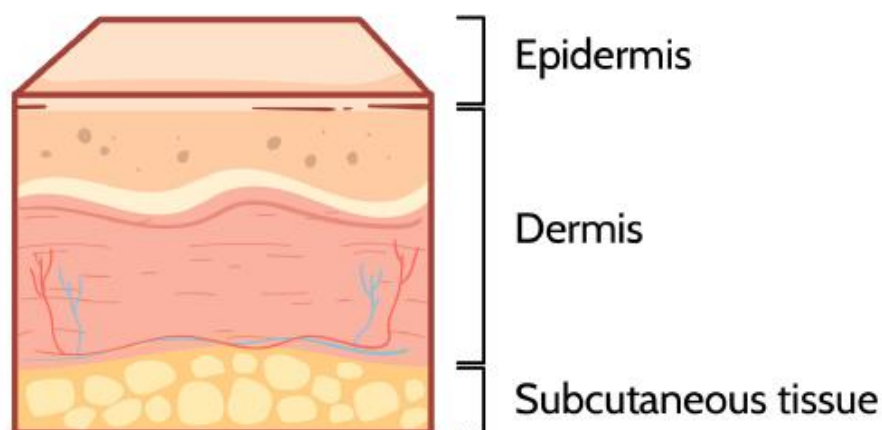
Changes to the appearance and texture of skin is normal as people age. There are certain techniques that can be shared in order to care for skin as well as identify common issues that may require referral.



Facilitation steps

Step 1: Provide background information in plenary

- Skin is made up of multiple layers, the outermost layer provides protection against infection, and accidents, and it also helps our bodies remove waste through sweating. The other layers all play an important role in the health and structure of our skin.



- As people age the skin loses fat and elasticity from the lower layers, becoming more delicate, veins can be seen more easily and scratches and wounds take longer to heal.
- Older skin is typically drier and requires more moisturising
- Older skin is also less well protected from sun damage and so older people are at higher risk from skin cancer

6.2.2 Basic skin care advice



Facilitation steps

Step 1: Ask participants to suggest ideas for good skin care and hygiene - allow group to discuss.

Provide key information below in plenary.

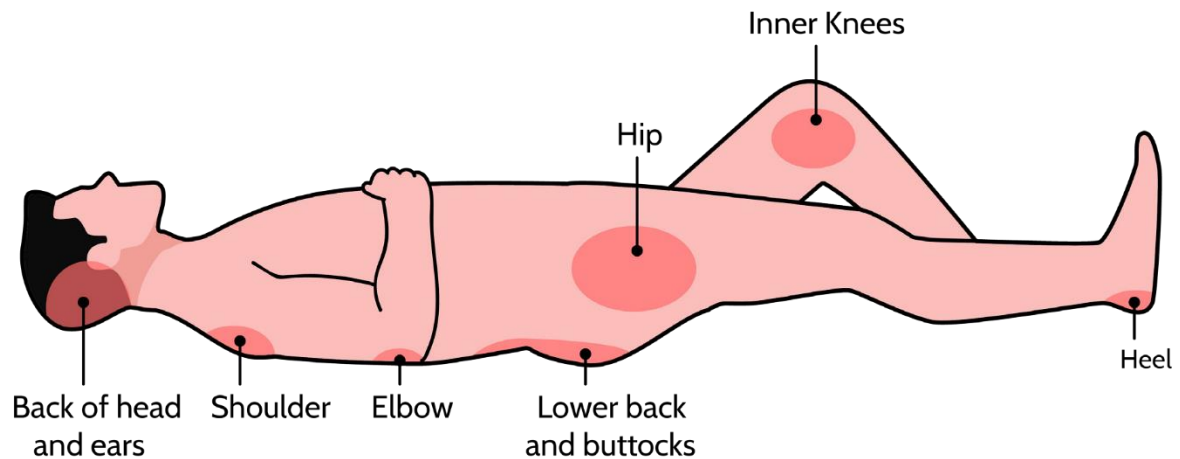
- To care for skin, it should be cleansed, moisturised and protected from the sun regularly.
- Skin should be gently cleansed with soap and water, or some other form of cleanser - avoid those containing alcohol as this can be drying.
- It is advised to avoid vigorous scrubbing as skin can be weaker
- It is important to target areas that may be susceptible to retaining dirt such as under folds of skin.
- Because older skin is more susceptible to drying it is particularly important to moisturise as this may prevent sores and rashes from developing
- To protect against skin cancer and sun damage it is important that skin is protected with sunscreen. It is also recommended, where possible to avoid sunshine at the hottest part of the day, wearing a hat or staying indoors can help with this.
- When skin is very dry avoid taking hot showers or baths and use only mild cleansers
- Treat cracked skin with antibiotic ointment to prevent infection
- Skin should be properly dried before dressing

[This information may need contextualising depending on how CHV will be working with and means to purchase and availability of sometimes costly products such as sunscreen - this information could be utilised either for CHV to deliver care or to provide health information during sessions]

6.2.3 Specialist skin care advice

Explain that you will now provide some further details on specialist skin care and/or skin care issues.

Bedsores

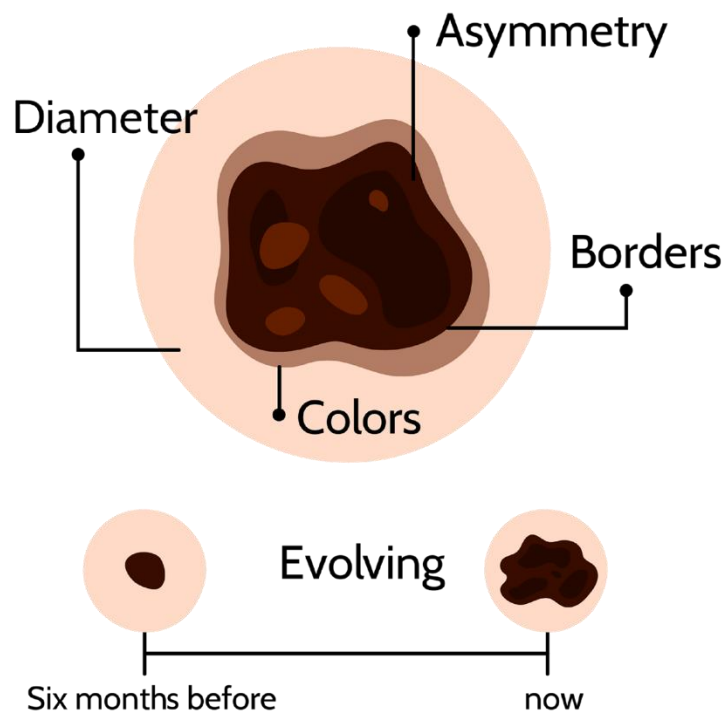


- People with limited mobility, including older people with disabilities, may develop bedsores, also known as pressure ulcers.
- When parts of the body are under pressure for long periods of time, for example because you spend a lot of time laying down in bed or seated in a wheelchair, circulation can be limited and this causes damage to the skin and underlying tissue
- Bedsores are measured from stages 1-5
- Stage 1 bedsores are red, hot patches that will heal quickly if the pressure is relieved
- Stage 5 bedsores are deep wounds that may penetrate through the layers of the skin to the bone and cause life threatening infections
- Infections need treatment with appropriate medication and dressing and anyone with serious bedsores should be referred to a health centre.
- Once bedsores have formed the individuals must not apply any pressure in those areas which may mean adapting sleeping and sitting positions
- People must be moved, safely, regularly to avoid further sores forming

Skin cancer

- Over 1 million cases of skin cancer are diagnosed every year
- There are three types of skin cancer: Basal cell carcinoma and squamous cell carcinoma grow slowly and rarely spread to other parts of the body. Melanoma can spread to other organs and be fatal.
- People should be advised to regularly check their skin for changes that might indicate skin cancer. Things to look out for include: asymmetry of moles, irregular borders, colour changes, increased diameter, evolving change in size, shape, sensitivity, itchiness, bleeding, and variations in shades of colour.
- **CHV should encourage older people to seek medical help if they notice any of these changes.**

SIGNS OF MELANOMA



Session 6.3

Eye and ear care

Learning outcomes

By the end of the session participants will have acquired knowledge on eye and ear care and common eye and ear conditions among older people.

✓	Evaluation:	Discussion and group feedback
✓	Teaching method:	Presentation
✓	Materials:	Flip chart and paper

6.3.1 Eye care

Older people often start having issues with their eyesight as their age progresses. However, it is not the case that every older person will have weakened eyesight.

It is important that older people do not simply accept failing eyesight as part of becoming old; they should consult a doctor or a health worker and have their eyes examined. Treatment may include having a pair of spectacles or they may need medicines, eye drops, ointments or an operation, but many conditions are curable or at least treatable which will prevent any further worsening in eyesight.

Blurred/weakened vision can limit mobility of older people, affect interpersonal interactions. It may be a trigger for depression. It often becomes a barrier to accessing information, increases the risk of falls and accidents, and makes driving dangerous.

Uncontrolled diabetes and increased blood pressure can lead to issues related to eyesight.

least treatable which will prevent any further worsening in eyesight.

Blurred/weakened vision can limit mobility of older people, affect interpersonal interactions. It may be a trigger for depression. It often becomes a barrier to accessing information, increases the risk of falls and accidents, and makes driving dangerous.

Uncontrolled diabetes and increased blood pressure can lead to issues related to eyesight.

Common eye problems in older people

- **Difficulty in seeing the objects nearby:** Presbyopia - This is common among older people. It is a condition that is age related and commonly starts after the age of 40.

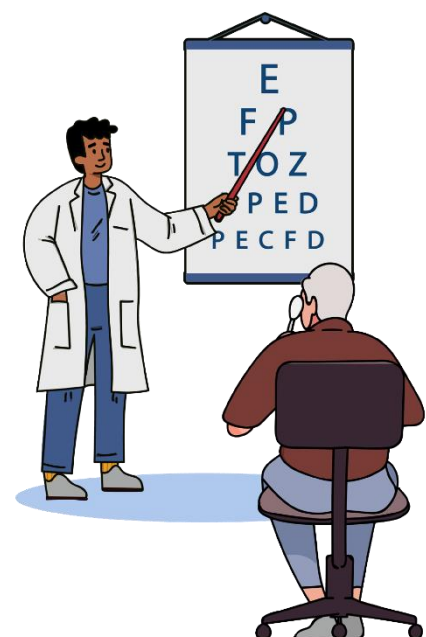
In presbyopia, the person is not able to view near objects properly and may find difficulty with tasks such as reading. It can be easily corrected by use of spectacles. There are ready made spectacles available which provide correction for near vision. People with difficulty seeing should be advised to seek support from an optometrist or ophthalmologist

- **Difficulty in seeing objects far away:** myopia or short-sightedness is difficulty seeing objects in the distance, while close-up vision is usually unaffected (though it is possible to have both!). People with short-sightedness may squint or strain their eyes to try and see faraway objects clearly. It typically begins during childhood and continues to worsen over the lifetime. Corrective measures for short-sightedness include wearing spectacles or contact lenses. It is important to have regular eye examinations to monitor and manage short-sightedness, as uncorrected, it can lead to eye strain and headaches. An optician can provide information on the strength of eyeglasses necessary to correct sight.
- **Cataracts** is the most common eye problem among older people. It is a leading cause of blindness across the world. Cataract usually causes gradual loss of sight. The pupil, black circle of eye, shows chalky white or greenish-grey colour. Cataracts can be easily reversed with small and safe surgery meaning that eyesight affected by cataract need not be permanent or debilitating. During surgery, the damaged part (lens) is removed and replaced with a new artificial lens. Eye drops or glasses/spectacles cannot cure cataracts.

Screening - eyecare

A simple screening for eyecare through the ICOPE questionnaire is covered in module 3 and in the accompanying screening presentation slides.

An alternative approach, if useful is to use an eye chart, community health volunteers can test for vision loss.



6.3.2 Hearing

As a part of ageing, people may start gradually losing their hearing. Many older people may complain about not being able to hear clearly and may require others including healthcare volunteers to speak loudly and clearly.

Because deafness is an unseen impairment, less sympathy may be given to the sufferer than for more obvious disabilities such as blindness. Many people are ill informed of the needs of hearing impaired people and do not understand how, in very simple ways, they could help considerably.



Facilitation steps

Step 1: Group work

We can broadly think about three types of noise:

- 1) Background noise
- 2) Warning sounds
- 3) Sounds we actively listen to

Think about these categories and come up with some examples. Describe why they might be important and what the repercussions of poor hearing may be.

Plenary: Report back in plenary



Facilitator's notes:

- a. Background noise: This is nearly always around us - we hear it in the background, but we are concentrating on other things. However, it gives us a sense of reality and keeps us in touch with our surroundings.
- b. Warning sounds: These come out of the background because they have a particular significance - they help us to react consciously to situations (eg. a warning bell).
- c. Sounds we actively listen to: These include speech and music; they provide communication and are important for social interaction and enjoyment.
 - Loss of hearing can be a cause of great frustration as well as inhibit older people from accessing important information.
 - Untreated hearing loss affects communication and thus may also contribute to social isolation and loss of autonomy.
 - It can put the sufferer at risk because they cannot hear alarms in buildings or traffic in a busy street; it can leave a person with a sense of unreality,

of being apart from the world around them - it can make them distrustful and suspicious.

- Inability to hear properly is often associated with anxiety, and depression.
- This may not be understood quickly by the family members and also could be seen as older people 'being slow'.
- Some hearing issues may be the result of ear infection or blockages which can be remedied. However, it is important that older people see a nurse to remedy these.

Screening for hearing loss is covered using the ICOPE questionnaire in module 3 alongside slides for delivering screening for hearing loss. The whisper test does not require access to a phone or any additional equipment.

Step 2: Role play using the whisper test instructions, as outlined below.

Stand about an arm's length away behind and to one side of the person.

Ask the person or an assistant to close of the opposite ear by pressing on the tragus. (The tragus is the projection in front of and partly covering the opening of the ear.)

Breathe out and then softly whisper four words. Use any common, unrelated words.

Ask the person to repeat your words.

The words should be spoken one by one, and wait for the response to each one at time. If the person repeats more than three words and you are sure that the s/he can hear you clearly, then the person is likely to have normal hearing in this ear. Move to the other side of the person and test the other ear. Use different words.

Session 6.4

Oral hygiene

Learning outcomes

By the end of the session participants should understand what is meant by good oral hygiene and be equipped with information to teach others how to maintain oral hygiene.

☒	Evaluation:	Discussion and feedback
☒	Teaching method:	Group work and discussion
☒	Materials:	Flip chart and paper

6.4.1 Background

The subject of teeth and mouth care is often ignored with older people in the mistaken belief that loss of teeth is inevitable with ageing and that mouth care is unnecessary. This is unfortunate as it results in discomfort and sometimes ill health for older people.

Dental care should be a part of daily hygiene for all age groups and older people are no exception.

Teeth are obviously important for eating, for biting and grinding food. But they also play a part in the production of clear speech and they are important for appearance. As we have seen with other aspects of health, prevention of problems is always better than having to cure the results of a lack of care.

Many older people suffer or are at risk of poor oral health. In some locations older people may rely on traditional methods for practising teeth cleaning which may be inadequate to maintain oral hygiene.

Diseases of other parts of the body may also lead to increased risk of oral disease or discomfort. In addition, adverse side effects of some treatments may also lead to dry mouth, altered sense of taste and smell.

Poor oral health status may result in impaired nutritional status, reduced self-esteem and wellbeing.



Facilitation steps

Step 1: In groups:

- Spend 10 minutes brainstorming some signs and symptoms of poor oral hygiene;
- Present back in plenary

Key notes/signs and symptoms of poor oral hygiene

- Dry mouth
- Tooth pain
- Tooth infection
- Discolouration of tooth
- Swelling/infection of gums
- Bleeding of gums
- Inability to fully or partially open mouth.

6.4.2 Maintaining healthy mouth and oral hygiene

Individuals should be encouraged to brush and floss daily:

- Gently brush your teeth on all sides with a soft-bristle brush and fluoride toothpaste. Replace your toothbrush every 3 to 4 months.
- Use small circular motions and short back-and-forth strokes.
- Brush carefully and gently along your gum line.
- Lightly brush your tongue or use a tongue scraper to help keep your mouth clean.
- Clean between your teeth with dental floss, pre-threaded flossers, a water flosser, or a similar product. This removes plaque and leftover food that a toothbrush can't reach. If these products aren't available, gentle use of a toothpick can help remove food that has been left behind - these shouldn't be forced in between teeth as this can damage gums.
- Rinse after you floss.
- Self-screening for oral cancer is available in module 3 including training slides



Session 6.5

Healthy nutrition

Older people may face age-related challenges such as inability to chew food, reduced breakdown and absorption of food, and increased demand for nutrients. These challenges may interfere with the maintenance of good nutritional status. Older people are also at an increased risk of nutritional deficiency due to the number of prescription medicines that they typically may take.

Learning outcomes

By the end of the session, participants should be able to;

- Explain the functions of different foods in the body
- Explain factors affecting older peoples' nutrition
- Discuss various food portions for older people
- Explain the differences between healthy and unhealthy foods
- Discuss the effects of unhealthy diet on an older person
- Highlight common unhealthy eating habits
- Describe healthy nutritional planning for older people
- Discuss assessment of nutrition status of older people

☒	Evaluation:	Discussion
☒	Teaching method:	Exercise, brainstorming, Discussion
☒	Materials:	Flip chart, paper, pens.

6.5.1 Definition of basic nutrition terms



Facilitation steps

Step 1: Divide participants into 3 groups and let each group define "food", "nutrition" and "nutrients".

Step 2: Ask participants to present in the plenary

Step 3: Summarise using the notes below



Facilitator's notes:

- **Nutrition:** Process of taking in food, breaking it down and utilising it for growth and good health
- **Food:** Any substance (liquid or solid) that people eat or drink to provide energy for bodily functions and to satisfy hunger.
- **Nutrient:** A substance found in food that provides nourishment required for the maintenance of life

6.5.2 Categories of foods and their functions in the body



Training materials

In preparation for this session, on separate pieces of paper write down the food groups (paper 1) and function in body (paper 2).



Facilitation steps

Step 1: Share these pieces of paper with small groups and ask them to match the function to the food group.



Cut the cards below.



Food group	Function in the body
Grains, tubers, and plantains	• Supplies the body with energy for movement • Varying amounts of micro- nutrients such as Iron and Calcium, • Provide fibre for digestion.
Pulses (beans, peas and lentils)	• Provide protein, vitamins such as vitamin B • Provide minerals such as folate and iron which help to prevent anaemia; • Potassium and Magnesium which are important for muscle and nerve function.
Nuts and seeds	• Provide a source of dietary fibre which helps in digestion • Provide healthy unsaturated fats good for health. • Help reduce levels of inflammation in the body e.g. risk of heart disease and reduce risk of type 2 diabetes

Dairy (milk and milk products)	• Essential for healthy bones and teeth. • Help in muscle function and connective tissue. • Help in growth and repair of tissues. • Improve immunity. • Regulate the body's rate of metabolism. • Required for release of energy.
Meat, poultry, eggs and fish	• Important sources of high-quality protein. • Provides Vitamin A, B-complex vitamins and vitamin K necessary for proper function of the immune system. • Vitamin B12 and a range of bio-available micronutrients notably iron and zinc.
Leafy vegetables and other vegetables	• Rich in folate which supports bones and blood formation. • Rich in vitamin A,C,E and K which strengthen the immune system • Improve blood circulation • Help in detoxification. • Improve the skin texture • Purify the blood. • Act as an anti-inflammatory agents
Fruits	• Help reduce levels of toxic chemicals in the body. • Help to prevent heart disease • Help maintain healthy blood and prevent iron deficiency. • Great anti-aging agents.

Sugars, salts	Provide quick energy to the body
Oils/Fats	Source of energy when added to food
Seasonings	Improve taste of food, making it more enjoyable to eat

6.5.3 Factors affecting nutrition in older people



Facilitation steps

Steps 1: Ask the participants to discuss factors that may prevent older people from eating well

Step 2: Discuss cultural, traditional and religious factors that influence diet and nutrition

Step 3: List them on the flip chart

Step 4: Summarise the session using the points below:

Factors that affect older person's nutrition

- **Taste:** As one grows older, there is diminished taste in food as a result of decrease in taste buds. This may make food taste sour or bitter or less interesting and motivation to eat may drop.
- **Smell:** A loss of smell may lead to loss of satisfaction with food and diminish the ability to enjoy a meal or choose certain types of foods.
- **Vision:** As one ages, there is reduced vision and this can discourage them from eating something that they cannot see. Seeing food attracts appetite. Thus, reduced vision may cause reduced food intake. Older people with sight impairments may need additional support in shopping for food they enjoy, and eating.
- **Financial Issues:** Older people living on no fixed income may not be able to afford the amount of nutritious food needed to maintain good health. It is important to discuss with older people about substitutes for expensive foodstuffs. For example, meat and fish provide good amounts of protein but so too do milk, eggs, and pulses such as lentils and beans.
- **Nutrient Absorption:** Older adults may not absorb nutrients well because of age-related changes in metabolism. Vitamin B12 deficiency is particularly common because the digestive tract of an older adult doesn't absorb this vitamin well.
- **Body organs:** As one ages, the body organs such as kidney, liver, lungs and nervous system may decrease in their functions.
- **Energy:** With advancing age, there is a decrease in physical activity and energy levels required by the body.
- **Gastrointestinal Changes:** Constipation, gastritis and problems emptying the stomach may cause some older people to avoid certain types of food such as vegetables and fruits.
- **Dentition:** Loss of teeth which is common among older people or ill-fitting dentures may lead to avoidance of sticky or hard foods. They may also experience difficulty in chewing.
- **Loss of Appetite:** Older peoples' experience diminished appetite and eat less food than younger people.

- **Lack of Mobility:** Older people may have difficulty in movement thus reducing access to nutritious food.
- **Difficulty swallowing:** this is called dysphagia, and is caused by muscle weakening making it harder to swallow. It can cause multiple issues, including malnutrition, dehydration and pneumonia (caused by food entering the lungs by mistake). Anybody with issues swallowing should seek medical attention.

Step 5: Ask participants to feedback something new that they learned.

Step 6: Discuss with participants advice they can provide linked to the above, you can ask participants to match the area of concern with the advice.

Taste	Explore a variety of herbs and spices to enhance flavour without relying on excessive salt or sugar. Experiment with different textures and temperatures to make meals more enjoyable. Regularly include a diverse range of fresh fruits and vegetables in your diet.
Smell	Engage in activities that stimulate the sense of smell, such as cooking aromatic meals
Vision	Schedule regular eye check-ups and follow your eye care professional's recommendations.
Financial issues	Cook and shop in bulk if this is possible, grow a kitchen garden to supplement your shopping – a community garden is a good way to socialise whilst providing food and/or a source of income. Discuss with your CHV options for other forms of financial support available to you, such as entitlements, pensions, or food banks and vouchers.
Nutrient absorption	Consume a balanced diet rich in vitamins and minerals. Consider dietary supplements if recommended by a healthcare professional. Stay hydrated to support nutrient absorption. Discuss any concerns about nutrient absorption with your healthcare provider.
Body organs	Prioritize a healthy lifestyle with regular exercise and a balanced diet to support organ health. Schedule regular check-ups to monitor organ function. Avoid excessive alcohol consumption and tobacco use. Stay hydrated to promote overall organ function.
Energy	Maintain a consistent sleep schedule and prioritize quality sleep. Engage in regular physical activity to boost energy levels. Stay hydrated and consume a balanced diet with a mix of complex carbohydrates, proteins, and healthy fats.
Gastrointestinal changes	Include fibre-rich foods in your diet to support digestive health. Stay hydrated to prevent constipation. Consider probiotics for gut health.

	Discuss any persistent gastrointestinal issues with a healthcare professional.
Dentition	Practice good oral hygiene with regular brushing and flossing. Schedule regular dental check-ups including for fit of dentures. Consider a diet rich in calcium and vitamin D for strong teeth. Use fluoride toothpaste. Address dental issues promptly to prevent further complications.
Loss of appetite	Choose smaller, more frequent meals. Include a variety of colourful and flavourful foods. Engage in social meals to make dining a positive experience. Consult a healthcare professional if loss of appetite persists.
Lack of mobility	Talk with family and other caregivers about support in shopping and cooking.
Difficulty swallowing	Modify the texture of foods and liquids as advised by a healthcare professional. Sit upright while eating and take smaller bites. Stay hydrated to facilitate swallowing. Consult a speech therapist for specialized exercises if needed.

Step 7: Discuss screening for malnutrition among older people – remind participants of the ICOPE screening tool covered in module 3 which includes a section on malnutrition. If this module has not been covered, two simple questions to detect if there are risks of malnutrition are:

1. Weight loss: Have you unintentionally lost more than 3 kg over the last three months?
2. Appetite loss: Have you experienced loss of appetite?

However, we recommend completing module 3 in order to discuss in more detail screening and pathways for care.

6.5.4 Food Portions and the Healthy Plate



Facilitation steps

Step 1: In groups ask participants to use paper or flipchart to draw a healthy plate of food. Each group describes in plenary what they have included in the plate, and ask them to list what considerations they made in planning the healthy plate - remind them of the previous sessions if necessary.

Step 2: Give an overview on what a healthy plate should contain and look like.

Step 3: Summarise using the below healthy plate.



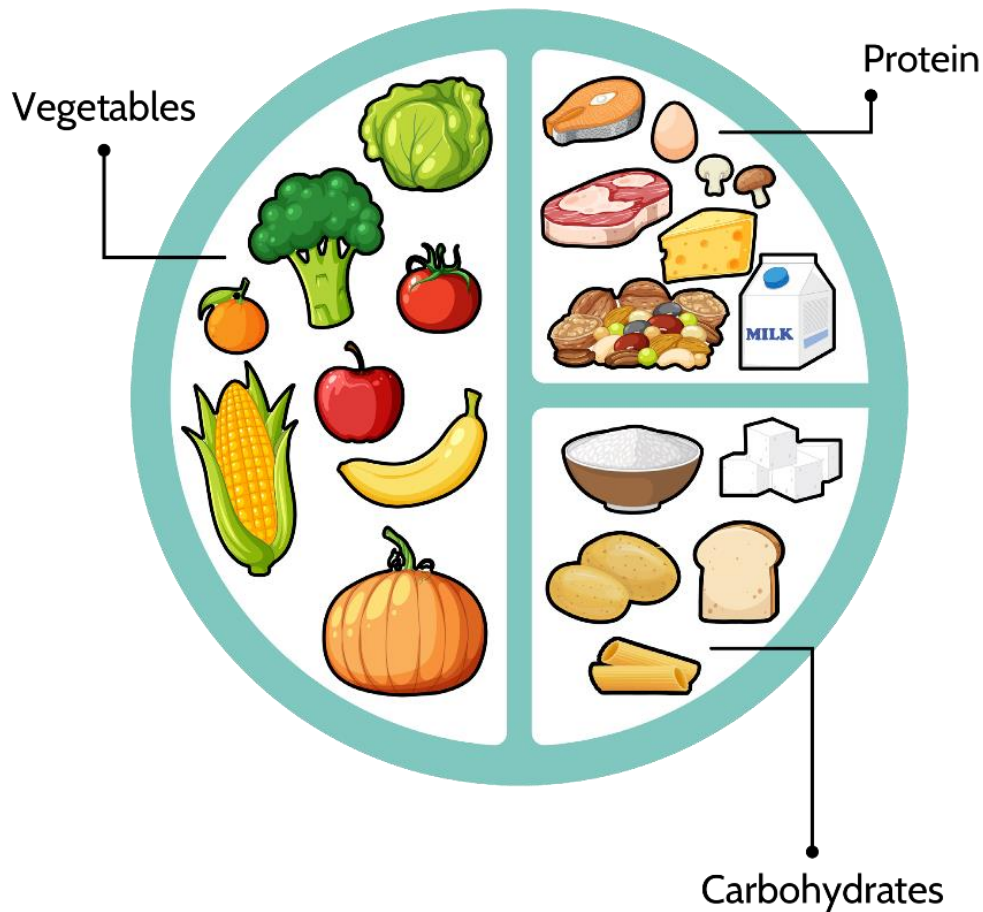
Facilitator's notes:

- Vegetables should take half of the plate while proteins and carbohydrates should each be a quarter of the plate.
- Ensure to have a variety of vegetables and fruits for each meal. It is best for vegetables to be baked, steamed or eaten raw rather than deep fried or cooked in lots of oily sauces.
- Fill a quarter of your plate with proteins. Proteins such as [insert locally available options]
- Fill a quarter of your plate with carbohydrates such as [insert locally available options]
- Ensure you drink at least eight glasses of clean water daily.

Considerations:

- Varieties of food
- Any health condition the individual may have
- Locally available foods
- Level of physical activity of the individual
- Affordability of food
- Cultural preferences
- Individual preferences
- Social circumstances
- Teeth and gum status may also affect an older adult's interest in food
- Medication that older persons may be on.
- Support requirements with cooking and eating, i.e. whether a person is able to do these things alone and their impact on nutrition if not

EXAMPLE OF A HEALTHY PLATE



6.5.5 Healthy vs unhealthy foods



Facilitation steps

Step 1: Ask participants to each reflect on and mention foods, snacks and drink that they think are healthy or unhealthy

Step 2: Divide flip chart paper in half - on one side list all healthy food and other side list all the unhealthy foods

Step 3: Summarise the activity in plenary. Examples:

Unhealthy food

Diets high in sugars, saturated and trans-fats, low fibre foods and high-sugar drinks that contribute to non-communicable diseases (NCDs) and other health problems.

Examples of Unhealthy foods

- Processed and refined foods such as: [insert locally available options]
- Deep fried foods such as [insert locally available options]
- Sugary foods such as [insert locally available options]
- Soft drinks such as sodas, energy drinks, pre-bottled smoothies, processed juices, sweetened ice tea

Healthy foods

- Foods that grow naturally such as vegetables cooked or eaten raw
- Animal protein cooked fresh
- Whole fruits or fruit juice produced organically are considered healthy

Examples of Healthy foods

- Fresh fruits and vegetables
- Dried fruits and vegetables
- Homemade food with little added salt or sugar
- Nuts

6.5.6 Common unhealthy eating habits



Facilitation steps

Step 1: Have a basket of papers with written common nutritional behaviours (as listed below).

Step 2: Ask each participant to pick a piece of paper.

Step 3: Let each participant read out their piece of paper at a time, and state whether the behaviour is a healthy or unhealthy eating behaviour.

Step 4: Summarise with the key points below.



Unhealthy eating habits	Healthy eating habits
Skipping meals	Drinking plenty of water throughout the day
Overeating – eating more than the body needs	Ensuring each meal is the right balance of vegetables, carbohydrates, and protein
Eating mostly carbohydrates	Eating regularly every day
Eating vegetables a few times a week	Limiting salt
Adding lots of sugar to food and drinks	Limiting sugar
Adding lots of salt to food	Avoiding deep fried products
Using a lot of oil when cooking	Avoiding highly processed foods.

Session 6.6

Keeping fit and physically active

Learning outcomes

By the end of the session, participants should be able to;

- Describe physical activity, exercise and sedentary behaviour
- Explain the health benefits of physical activity and exercise
- Distinguish between different forms of activity
- Explain the risks of sedentary behaviour
- Challenge myths about exercising in older age.
- Challenge myths about people with disabilities and exercise

✓	Evaluation:	Discussion
✓	Teaching method:	Brainstorming, discussion, group work
✓	Materials:	Flip chat, pens, writing pads

6.6.1 Physical activity, exercise and sedentary behaviour

Physical activity in older people is critically important in the prevention of disease, maintenance of independence and improvement of quality of life. Regular physical activity can bring significant health benefits to people of all ages and the need for physical activity does not end in later life with evidence increasingly indicating that physical activity can extend years of active independent living, reduce disability and improve the quality of life for older people.

Most older people with disabilities can also participate in and benefit from exercise but may need support and adaptations to do so. There are no major risks if you have a disability and engage in physical activity if the activity is appropriate to your current health status.



Facilitation steps

Step 1: Ask participants to form groups and ask each group to discuss and define physical activity, exercise and sedentary behaviour

Step 2: List the participants' responses on a flip chart

Step 3: Summarise using notes below



Facilitator's notes:

- **Physical activity:** Physical activity is defined as any bodily movement, this could be walking, running, swimming, sweeping the house, gardening, cycling.
- **Exercise:** A subset of physical activity that is planned, structured, and repetitive and has as a final or an intermediate objective of the improvement or maintenance of physical fitness. Physical fitness is a set of attributes that are either health- or skill-related.
- **Sedentary behaviour:** Sitting or lying down, (with the exception of sleeping), one can be sedentary at work, at school, at home, when travelling or during leisure time. Sedentary behaviour requires little energy expenditure. Examples of sedentary behaviour include:
 - Sitting or lying down while watching television or playing electronic games.
 - Sitting while driving a vehicle, or while travelling.
 - Sitting or lying down to read, study, write, or work at a desk or computer or on a phone or tablet

Step 4: Explain you will now discuss exercise in more detail – describe the categories of exercise below (you could also have them written up on 4 pieces of flip chart paper and stuck to the walls)

- A. Endurance:** often referred to as aerobic, increases your breathing and heart rates. These activities help keep you healthy, improve your fitness, and help you perform the tasks you need to do every day.
- B. Strength:** Muscular strength can make a big difference. Strong muscles help one to stay independent and make everyday activities feel easier, like getting up from a chair, climbing stairs, and carrying shopping. Keeping one's muscles strong can help with their balance and prevent falls and fall-related injuries
- C. Balance:** Balance exercises help prevent falls, a common problem in older adults that can have serious consequences.
- D. Flexibility:** Stretching can improve one's flexibility. Moving more freely will make it easier for one to reach down to tie their shoe

Step 5: Ask the participants to brainstorm types of physical activity under each category

Step 6: List the participants' responses on a flip chart/on each piece of flip chart paper

Step 7: Summarise using information below



Facilitator's notes:

- A. Endurance examples include** brisk walking or jogging, yard/garden work (mowing, raking), dancing, swimming, [activities should be adapted to context]. Many people with mobility issues find exercising in water especially beneficial as it supports the body and reduces the risk of muscle or joint discomfort. Even if you're confined to a chair or wheelchair, it's still possible to perform

cardiovascular exercise. It is recommended to build up to at least 150 minutes of activity a week.

(There is lots of information available on exercise for people with impaired mobility here – <https://www.nhs.uk/live-well/exercise/strength-and-flexibility-exercises/sitting-exercises/>)

- B. Strength exercises examples include** lifting weights, even one's own body weight, and using a resistance band. It is recommended that everyone engages in strength exercises for all of their major muscle groups at least 2 days per week. However, if you have limited mobility in your legs, your focus will be on upper body strength exercises. If you have limited mobility in your arms or upper body, for example, your focus will be more on strength training your legs and core.
- C. Balance examples include:** Many lower-body strength exercises also will improve one's balance. Examples include; standing on one foot, then the other, heel-to-toe walk, yoga
- D. Flexibility:** Examples include, calf muscle stretch, ankle stretch, yoga

Activities may also help across a range of these categories, for example yoga helps support flexibility and balance but it also builds strength.

- Exercise should be fun, people should participate in physical activities they find enjoyable, for some people this may be dancing and for others it could be a walk with a friend. It is important that older people are encouraged to identify physical activity or exercise that interests them.
- People with disabilities should not be excluded from opportunities to participate in exercise clubs or physical activity, simple adaptations can improve participation from older people with disabilities, some examples are included in the box below which can be used as a handout.

World Health Organisation recommends:

[pic]

[pic]

At least 150 minutes a week (for example, 30 minutes a day, 5 days a week) of moderate-intensity activity such as brisk walking or wheeling yourself in a wheelchair or 75 minutes a week of vigorous-intensity activity such as hiking, jogging, or running. At least 2 days a week of activities that strengthen muscles.

Older people with limited mobility

If the person you are working with is less mobile, encourage them to do a mix of chair-based exercises and getting up from their chair if they are able. If the person wants to try some specific chair-based exercises, you could help them to learn the exercises described below. Try to support the person by:

- Suggesting they get up once an hour. You could set a timer to remind them
- Helping them to set goals to work towards, like pushing up from sitting in a chair to standing position without using an aid or leaning on someone
- Encouraging the person to discuss chair-based exercises with a health worker before starting
- Making sure you guide the person through each step of the exercise
- Making sure the person uses a sturdy and stable chair, without wheels or arms
- Making sure they can sit with their feet flat on the floor with their knees bent at right angles
- Looking out for any signs of discomfort, weakness or dizziness and telling the person to stop

Chest stretch: This stretch is good for posture

- Sit upright and away from the back of the chair. Pull your shoulders back and down. Extend your arms out to the side
- Gently push your chest forward and up until you feel a stretch across your chest
- Hold for 5 to 10 seconds and repeat 5 times.

Upper-body twist: This stretch will develop and maintain flexibility in the upper back

- Sit upright with your feet flat on the floor, cross your arms and reach for your shoulders
- Without moving your hips, turn your upper body to the left as far as is comfortable. Hold for 5 seconds
- Repeat on the right side
- Try 5 times on each side.

Hip marching: This exercise will strengthen your hips and thighs, and improve flexibility

- Sit upright, do not lean on the back of the chair. Hold on to the sides of the chair
- Lift your left leg with your knee bent as far as is comfortable. Place your foot down with control
- Repeat with the opposite leg
- Try 5 lifts with each leg.

Ankle stretch: This stretch improves ankle flexibility and lowers the risk of developing a blood clot

- Sit upright, hold on to the side of the chair and straighten your left leg with your foot off the floor
- With your leg straight and raised, point your toes away from you
- Point your toes back towards you
- Try 2 sets of 5 stretches with each foot.

Arm raises: This exercise builds shoulder strength

- Sit upright with your arms by your sides
- With your palms forwards, raise both arms out and to the side, and up as far as is comfortable
- Return to the starting position
- Keep your shoulders down and arms straight out
- Breathe out as you raise your arms and breathe in as you lower them
- Repeat 5 times

Step 8: Ask the participants to brainstorm about the health effects of sedentary lifestyle on older persons

Step 9: List their responses on a flip chart

Step 10: Summarise using notes below



Facilitator's notes:

Higher levels of sedentary lifestyle are related to an increased risk of:

- Premature death
- High cholesterol
- High blood glucose
- Glucose intolerance
- Larger waist circumference,
- Obesity/overweight

6.6.2 Health benefits of physical activity and exercise



Facilitation steps

Step 1: Ask the participants to get into groups

Step 2: Ask participants to brainstorm the health benefits of physical activity

Step 3: Ask participants to present back their discussion, list the responses on a flip chart

Step 4: Summarise with the notes below



Facilitator's notes:

Health benefits of physical activity

- Improves one's mood and decrease feelings of depression, anxiety and stress
- Can reduce one's risk of NCD
- Can help to achieve weight loss
- Plays an important role in building and maintaining strong muscles and bones
- Can increase one's energy levels
- Can help one's brain health and memory
- Can help with relaxation and improve sleep quality
- Can reduce chronic pain
- Can be a fun way to socialise

Older adults who are physically active:

- Have lower rates of premature deaths, coronary heart disease, high blood pressure, stroke, type 2 diabetes, colon cancer and breast cancer.
- They have a higher level of cardio-respiratory and muscular fitness, healthier body mass and composition;
- Are less likely to develop cardiovascular disease, type 2 diabetes and have improved bone health
- Show higher levels of functional health, a lower risk of falling, and better cognitive skills
- You don't need to have full mobility to experience the health benefits of exercise. If disability, illness, or weight problems have limited your mobility, there are still plenty of ways you can use exercise to maintain and improve your health

6.6.3 Myths and misconceptions about physical activity for older people



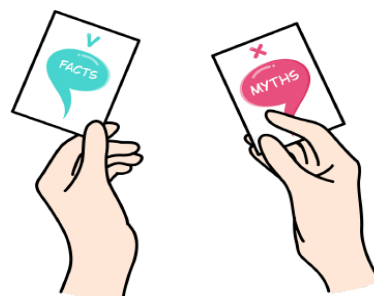
Facilitation steps

Step 1: Ask the participants to get into two groups

Step 2: Share flash cards that include the myths listed in table below

Step 3: Ask the participants to decide whether it is a myth or a fact

Step 4: Discuss and make corrections where necessary, use the information in the fact column to discuss in more detail.





Facilitator's notes:

	Myth	Fact
1	"I'm 70 years old and have never exercised— it's too late to start."	Older people who have led a sedentary lifestyle can benefit from beginning a regular program of fitness activities, even if they start at age 65, 70, 80 or older.
2	"Heart health is the only benefit of exercise."	Leading an active lifestyle slows physical decline. It protects the lungs, muscles, bones and joints. It reduces stress and boosts the immune system. It helps delay or manage many common health conditions, such as arthritis, diabetes, stroke, kidney disease and depression. It helps maintain a healthy weight. And it even reduces the risk of some cancers.
3	"Going for a brisk walk every day pretty much covers my exercise needs."	A complete exercise program for older people should include aerobic activities (those that make the heart pump faster, such as brisk walking, swimming, dancing or aerobics- type classes); muscle strengthening activities, such as lifting weights or using a resistance band; flexibility exercises such as stretches or yoga; and exercises that improve the sense of balance,
4	"Avoiding activity is the best way to prevent falling."	Inactivity increases the risk of falling.
5	"If I have arthritis or osteoporosis, I should exercise only sparingly."	Exercise is one of the best ways to build strong bones and protect the joints. Exercise increases one's muscle mass, which reduces pain and improves function.
6	"It's not safe for people with Alzheimer's disease to exercise."	When a loved one has Alzheimer's disease or a related condition, their exercise routine may need to be modified to keep them safe. But physical activity is of great benefit to people with memory loss. It reduces pain, improves sleep, increases the appetite, and decreases agitation and wandering.
7	"I'm not fit enough to attend an exercise class!"	Exercising at home is fine, but working out with others can be much more motivating, many classes have no requirements for a certain level of fitness and provide modifications if you are not physically capable of doing everything the instructor suggests.
8	"Trying to exercise and get healthy is pointless -- decline in old age is inevitable"	A lot of the symptoms that we associate with old age - such as weakness and loss of balance - can be improved with activity. Exercise improves more than one's physical health. It can also boost memory. And it can help one maintain their independence and way of life. If one stays strong and agile as they age,

		they'll be more able to keep doing the things they enjoy and less likely to need help.
9	"People with disabilities shouldn't exercise, it is not safe"	Exercise is just as important for people with disabilities as for those without. Sometimes it may be necessary to make adjustments for people with disabilities. People with disabilities should decide for themselves what sorts of activities they find fun and engaging.



Cut the cards below

I'm 70 years old and have never exercised— it's too late to start.	Heart health is the only benefit of exercise.
Going for a brisk walk every day pretty much covers my exercise needs.	Avoiding activity is the best way to prevent falling."
If I have arthritis or osteoporosis, I should exercise only sparingly.	It's not safe for people with Alzheimer's disease to exercise.

I'm not fit enough to attend an exercise class!	Trying to exercise and get healthy is pointless -- decline in old age is inevitable.
People with disabilities shouldn't exercise, it is not safe.	

6.6.4 Encouraging and engaging older people to be physically active



Facilitation steps

Step 1: Ask the participants to form groups of four

Step 2: Ask the participants to design role plays on ways of motivating older people to be physically active.

Step 3: Ask the participants to show their role play with the wider group

Step 4: Invite discussion from other groups

Step 5: Summarise using notes below



Facilitator's notes:

- Having someone to exercise with makes it more enjoyable. "The main pitfall for most people is accountability; having someone that is counting on you being there - exercise is more fun with a friend".

- Make exercise a priority and set time aside during the day. "Schedule it into one's day, just like brushing your teeth,"
- Identify activities that they enjoy. Older adults are more likely to perform exercises they deem pleasurable. By selecting an activity that they like to do the chances are greater that they will continue doing it.
- Start slowly and advance the physical activity program gradually. It is recommended starting off at two to three times per week, then move up to three to five times per week.
- Set realistic expectations. "You never want to set an expectation you can't meet,"
- Keep records to assess progress
- Be supportive. Older adults need to receive regular encouragement from friends and family.

Session 6.7

Sleep

Learning outcomes

By the end of the session, participants should be able to:

- Describe some common sleep disorders
- Be able to provide simple recommendations for improving sleep

☒	Evaluation:	Discussion and feedback
☒	Teaching method:	Group discussion
☒	Materials:	Flipcharts, pen and paper

6.7.1 Common sleep disorders and simple interventions

Step 1: Ask participants to suggest answers to the following question.

- What is a sleep disorder?

Step 2: Discuss with participants using the notes below:

Sleep disorders in adults involve any disrupted sleep pattern. This can include problems with:

- Falling or staying asleep,
- Too much or abnormal behaviour with sleep.

Difficulty sleeping is commonly referred to as **insomnia**, insomnia is categorised by;

- Difficulty falling asleep
- Difficulty staying asleep
- Premature awakening

Insomnia is the most common sleep problem in adults aged 60 and older. Insomnia can last for days, months, and even years.

Step 3: Ask participants to share with the group their ideas about **what might be the causes of poor sleep?**

Discuss using the following notes:

There are many potential causes of poor sleep,

- Nasal and sinus inflammation.
- Asthma.
- Diabetes.
- Parkinson's disease
- High blood pressure
- Anxiety.
- Stress
- Uncomfortable sleeping environment
- Clinical depression
- Medicines for above and other conditions
- Drug and alcohol use
- Changes in hormones
- Impact of menopause

Step 4: Ask participants to share with the group their ideas about **what might be the results of poor sleep disorders?**

Discuss using the following notes:

- Impaired sleep may results in:
- Daytime sleepiness
- Lack of concentration
- Poor nutrition
- Mood shifts
- Falls
- Increased likelihood of cardiovascular disease, high blood pressure, diabetes, depression, and obesity.

Step 5: Ask the participants to brainstorm ideas for improving sleep?

Discuss using the following notes:

- Follow a regular sleep schedule. Go to sleep and get up at the same time each day, even on weekends or when you are travelling.



- Avoid napping in the late afternoon or evening, if you can. Naps close to bedtime may keep you awake at night.
- Develop a bedtime routine. Take time to relax before bedtime each night. Some people read a book, listen to soothing music, or soak in a warm bath.
- Try not to watch television or use your computer, cell phone, or tablet in the bedroom. The light from these devices may make it difficult for you to fall asleep. And alarming or unsettling shows or movies, like horror movies, may keep you awake.
- Keep your bedroom at a comfortable temperature, not too hot or too cold, and as quiet as possible.
- Use low lighting in the evenings and as you prepare for bed.
- Exercise at regular times each day but not within 3 hours of your bedtime.
- Avoid eating large meals close to bedtime—they can keep you awake.
- Stay away from caffeine late in the day. Caffeine (found in coffee, tea, soda, and chocolate) can keep you awake.
- Remember—alcohol won't help you sleep. Even small amounts make it harder to stay asleep.

6.8 Using the self-care checklist

Learning outcomes

By the end of the session, participants should be able to:

- Use the self-care checklist as a tool to discuss healthy lifestyle planning

☒	Evaluation:	Discussion and feedback
☒	Teaching method:	Role play
☒	Materials:	Flipcharts, pen and paper, printed copies of self-care checklist

This section conclude modules 6 with an opportunity to practice using a checklist as a healthy lifestyle planning tool.

Step 1: Handout copies of the self-care checklist, one for each participant (included on the next page). If this is the first time you've used the self-care manual as part of the training, explain that it is an accompanying guide that can be shared with individuals to help understand their own health and wellbeing. Explain it is also a useful tool for CHV to use when conducting health promotion activities and other tasks.

Step 2: Break participants into pairs or small groups – ask them to go through the checklist, answering for themselves if they are comfortable doing so, and inputting some potential actions.

Step 3: Bring group back together to discuss the tool, answer any questions and ask participants to reflect.

Use this checklist to reflect on your lifestyle choices						
#	Healthy behaviour	Page	Question	Response		What action will I take?
				YES	NO	
1	Stay active		Do I take at least 30- 60 minutes of light/ moderate exercise a day?			
2	Eat well		Do I eat a portion of protein foods at each meal?			
			Do I eat 5 or more servings of vegetables or fruit every day?			
			Do I restrict my daily intake of salt to not more than one teaspoon?			
			Do I restrict my intake of sugar to no more than the equivalent of 6 teaspoons of sugar per day?			
			Do I drink at 6- 8 glasses of water/ other liquids per day?			
			Do I restrict my daily intake of oil to no more than 6 teaspoons of healthy oil in my food?			
3	Sleep well		Do I have a good sleep routine?			
4	Reduce and manage stress		Do I stay in touch with family and friends?			
			Do I make time to do things that I enjoy?			
			Do I try to do or learn new things too?			
5	Maintain your brain		Do I continue to learn new skills?			
			Do I meet friends or family members regularly?			
			Do I participate in community decisions about things that matter to me?			
			Do I participate in social groups or clubs?			
6	Quit smoking		Do I smoke?			
7	Avoid harmful use of alcohol		Do I drink alcohol over what is recommended?			
8	Medications		Do I take my medication correctly?			
9	Health check/ vaccinations		Did I have an annual health check?			
			Am I up to date on my vaccines?			

Summary

Chapter 6 discusses healthy lifestyle interventions for older people to prevent or delay chronic conditions and diseases and promote good health and wellbeing.

Personal hygiene and grooming are important for older people's self-esteem and dignity.

Presbyopia and cataracts are common eye problems among older people, but they can be corrected with spectacles or surgery.

Hearing loss is a common issue among older people and can lead to social isolation and loss of autonomy.

Older adults who are physically active have lower rates of premature deaths and chronic diseases, improved bone health, and better cognitive skills.

Dental care should be a part of daily hygiene for all age groups - many older people suffer from poor oral health and may rely on inadequate traditional methods for teeth cleaning.

Some older people face challenges in maintaining good nutritional status, this may be a result of a number of factors including changes to taste, smell, vision, as well as financial issues, nutrient absorption, dentition, loss of appetite.

A healthy plate should contain half vegetables, a quarter each of proteins and carbohydrates, and at least eight glasses of water daily.

Physical activity can reduce the risk of chronic diseases, improve mood, help achieve weight loss, and increase energy levels.

Physical activity is critically important in the prevention of disease, maintenance of independence, and improvement of quality of life for older persons.

Most older people with disabilities can participate in and benefit from exercise but may need support and adaptations to do so.

Community health volunteers play a crucial role in promoting healthy living practices and behaviors within their community.

CHV can support older people to make their own healthy choices that suit their lifestyle, capacity and interests. CHV should not be judgemental of the way people live their lives.

Additional resources

1. Primary ear and hearing care training manual - <https://www.who.int/teams/noncommunicable-diseases/sensory-functions-disability-and-rehabilitation/primary-ear-and-hearing-care-training-manual>
2. WHO Guidelines on a health diet <https://www.who.int/news-room/fact-sheets/detail/healthy-diet>
3. WHO A health diet - sustainably produced <https://apps.who.int/iris/bitstream/handle/10665/278948/WHO-NMH-NHD-18.12-eng.pdf?ua=1>
4. National institute on ageing - A good night's sleep - <https://www.nia.nih.gov/health/good-nights-sleep>
5. WHO Healthy lifestyle recommendations - <https://www.who.int/europe/news-room/fact-sheets/item/a-healthy-lifestyle---who-recommendations>
6. HelpAge International - Caregiver manual (link to knowledge platform)

Module 7

Mental health and psychosocial wellbeing interventions



Introduction

Mental health and psychosocial wellbeing are essential components of overall health. They refer to a person's emotional, psychological, and social well-being. Good mental health and wellbeing enable individuals to cope with daily challenges and enjoy a fulfilling life. Mental health issues can be taboo in some places. It is important to tackle stigma and misconceptions around mental health, this can be helped by emphasising that mental health is as important as physical health, by educating ourselves and others about mental health conditions and their causes and by promoting and providing safe spaces to discuss mental health.

Relevance to older people

Older adults who experience poor mental health are more likely to have chronic physical health conditions, experience disability and have reduced quality of life. As individuals age, significant life changes such as retirement, loss of loved ones, or physical changes can be stressful and can result in mental health challenges such as depression, anxiety, and social isolation.

Older adults are often underserved when it comes to mental health care, barriers such as a lack of access, stigma and lack of awareness can prevent older people from receiving the care they need.

Good mental health is vital for maintaining social connections and preventing isolation, which can be a significant issue for older people.

Role of community health volunteers

Community health volunteers will play an essential role in promoting mental health and wellbeing in the community. The Role of community health volunteers is to provide education, support, opportunities for social interaction, and resources as well as recommend referrals for older people in the community. CHV should reassure individuals that their discussions will be kept completely confidential and it is safe to discuss with them how they are feeling. A CHV should be open and non-judgmental.

Learning outcomes

By the end of the session Participants will be able to;

- Explain what is meant by 'mental health' and 'mental health conditions' and discuss some common causes
- Feel confident in addressing stigma and misconceptions surrounding mental health
- Identify normal reactions to distressing events and/or stress and how to manage them

- Identify types of mental health conditions in older persons
- List down problems related to mental health conditions.
- Discuss promotion of good mental health and wellbeing

☑	Evaluation:	Pre and post session discussion
☑	Teaching method:	Discussion, small group work
☑	Materials:	Flipcharts, pen and paper

Session 7.1

Mental health, mental health conditions and their causes



Facilitation steps

Step 1: Ask the participants to get into groups

Step 2: Ask them to explain their understanding of mental health and mental health conditions

Step 3: List their responses on a flip chart

Step 4: Summarise their responses with the following notes



Facilitator's notes:

Mental health is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”.

Source: World Health Organization (WHO)

- Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.
- Mental health conditions are disorders involving changes in emotion, thinking and behaviour.
- They are associated with distress or problems of functioning in social, work or family activities.

Step 5: In small groups, ask participants to discuss what circumstances might affect someone's mental health.

Step 6: Ask groups to share in plenary

Step 7: Discuss using the notes below.

Exact cause of mental health problems in any person, including older people, may not be known. These conditions are caused by a combination of biological, psychological, and environmental factors.

Causes		
Biological	Psychological	Environmental
- Genetics (heredity) - Infections - Brain defects or injury - Prenatal damage - Substance abuse - Poor nutrition	- Severe psychological trauma suffered as a child, such as emotional, physical, or sexual abuse - Loss of a loved one, - Older adults are at risk of elder abuse - including physical, verbal, psychological, financial and sexual abuse; abandonment; neglect; and serious abuses due to not being treated with dignity and respect.	- Death or divorce - A dysfunctional family life - Feelings of inadequacy, low self- esteem, anxiety, anger - Social or cultural expectations - Substance abuse by the person or the person's children - Loss of work - Retirement and the stress of transition - Social isolation and loneliness - Financial stress - Physical inactivity - Substance abuse - Sleep deprivation - Pollution - Exposure to toxins, such as lead

Step 8: Remind participants of the ICOPE screening tool: Screening for depressive symptoms – the ICOPE screening tool covered in module 3 covers two simple screening questions for depressive symptoms, these are:

Over the past two weeks, have you been bothered by

- feeling down, depressed or hopeless?
- little interest or pleasure in doing things?

If they answer yes to either question they should be referred for proper diagnosis, if possible.

(If module three hasn't been covered participants can now role play asking these questions in pairs)

Session 7.2

Tackling stigma

Now that you have had a chance to discuss definitions of mental health and mental health conditions, it is important to break down some stigma and misconceptions around mental health.



Facilitation steps

Step 1: As a group use the information in the table below to discuss myths and counter them with the facts. You could read out the myths and see if the participants agree or disagree and then discuss utilising the information in the fact column.

Myth	Fact
Your physical health is all you need to prioritise	Both your physical and mental health play a key role in health and wellbeing and there are steps we can take to promote good mental and physical health.
You only need to take care of your mental health if you have a mental health condition.	Everyone can benefit from taking steps to promote their well-being and care for their mental health.
Nothing can be done to protect people from developing mental health conditions.	There are many things we can do to protect people from developing mental health conditions, including developing social and emotional skills, building supportive networks, seeking help and support. Some people will still go on to develop mental health conditions and there is no shame in that.

	Sometimes difficult situations can trigger mental health conditions. Our ability to respond to and manage difficult situations relies on a combination of protective factors.
Myth	Fact
Nothing can be done to protect people from developing mental health conditions. (cont.)	People who do well in the face of adversity typically have biological resistance as well as strong, supportive relationships with family, friends and other people around them, resulting in a combination of protective factors to support well-being.
People with mental health conditions have been cursed	There is no evidence that mental health conditions are caused by witchcraft or curses, these kinds of accusations can prevent people from seeking support.
A mental health condition is a sign of weakness; if the person were stronger, they would not have this condition.	A mental health condition is not related to weakness or willpower. It is not a matter of choice. Recognising the need to accept help for a mental health condition requires great strength and courage. Anyone can develop a mental health condition.
People with mental health problems can't function properly in society	There is great diversity among people with mental health problems. People with mental health problems have skills, strengths and lots to offer the community and society.
People with mental health problems are dangerous and should be avoided.	Mental health problems should not be feared. There is no reason to assume that someone with mental health problems is a risk to others.

There is nothing I can do to help someone who is worried about their mental health, they need to see a professional.	Everyone has a role to play in understanding mental health, and everyone can offer support to someone experiencing mental health problems.
--	--

Myth	Fact
Depression is just a normal part of ageing	Depression is not a normal part of ageing. Older people are more likely to experience events associated with depression, such as loss, loneliness, or major health diagnoses but that does not mean that depression is inevitable and if it does occur older people have the right to the same level of respect and care as any other age group.
Therapy is only for young people, once you are old it is too late.	Treating depression in older people has no different success rates than in younger people, and can vastly improve the quality of life.
Older people grow out of things like anxiety which only affects younger age groups.	There are many types of anxiety disorders, and they can affect anyone regardless of age.

Step 2: In plenary, ask participants to reflect on any local assumptions or myths related to mental health in their communities - having participated in this training so far, ask them to reflect on some of these assumptions.

Session 7.3

Common mental health conditions and their symptoms among older people



Facilitation steps

Step 1: Using the table of information below, ask participants in small groups to match the types of mental conditions with the signs and symptoms.

Step 2: Ask the participants to present their group work in the plenary.

Step 3: The facilitator summarises their responses with the following key notes

 Facilitator's notes:

Common types of mental health conditions among older people include:

Types	Signs & Symptoms
Depression	Feelings of sadness, hopelessness, helplessness
Substance abuse	Excessive use of drugs such as alcohol, prescription medication
Anxiety disorders	Feelings of panic, restlessness, terror and fear. Range from hoarding syndrome (difficulty parting with possessions), obsessive compulsive disorders (recurring, unwanted thoughts, ideas of sensations that make people feel driven to do something repetitively), to phobias (persistent and excessive fear of an object or situation) and post traumatic stress disorder (Frightening thoughts, flashbacks and nightmares)
Suicidal behaviour	Thinking about dying, overdose on medication and attempted suicide.

Session 7.4

Promotion of mental health and wellbeing of older people

Our mental health is very important, and can be improved with simple action and support but it can also be a very difficult topic to discuss. Some mental health conditions will need to be assessed and supported by specialist health practitioners. It is important to reiterate that community health volunteers can help with coping mechanisms, provide some advice and a safe space for discussion but should also sign post to professional services where necessary.



Step 1: Ask participants to discuss promotion of mental health and management of mental health conditions in small groups. A prompt could be to ask participants what they like to do to improve their own mental health?

Step 2: Ask the participants to present their group work in the plenary.

Step 3: The facilitator summarises their responses by complementing their responses with the following information.



Facilitator's notes:

- Staying socially connected
- Engage in hobbies or interests that you find stimulating or value
- Keeping physically active
- Eating a healthy diet
- Getting enough sleep
- Seeking help when you have concerns - early diagnosis promotes early and optimal management
- Detecting and managing challenging behaviour;
- Providing information and long-term support to carer - it can be stressful to provide care to another person and older people are often caregivers themselves. It is important to know when you need to take a break, and identify support services to allow you to do this.
- Journalling - the process of writing your thoughts each day or a couple of times a week is a good way to manage stress.
- Relaxation techniques: walking, listening to music, meditation, prayers, dancing, yoga, art and crafts etc

Step 4: share information from the flyer below on positive and negative coping mechanisms. CHV should encourage older people to use positive coping mechanisms



Download the pamphlet [here](#).

Session 7.5

Psychological first aid and management of distressing situations



Facilitation steps

Step 1: Ask participants to share what they think of when they hear the term “psychological first aid”.

Step 2: Reinforce accurate aspects people have shared, such as:

- Giving emotional support,
- Helping people with practical needs,
- Listening to people.

You may also receive some incorrect answers such as counselling, medication and psychotherapy. Explain that whilst these may be used to treat some mental health conditions, they are delivered by specialist doctors, nurses, and therapists and not within the remit of the community health volunteer

Use the key notes below to discuss what psychological first aid is in more detail:

- Assessing needs and concerns
- Practical care and support
- Listening when people feel comfortable talking, but not pressing people to talk if they are not willing
- Comforting people and helping them to feel calm
- Helping people connect to information, services and social supports
- Protecting people from further harm

Step 3: Discuss distressing situations: distressing situations may affect our wellbeing including our mental health, at different times of life. This is a normal part of life. Both older people and their caregivers, including community health volunteers may experience stress and other mental health conditions. It is always important to care for our own wellbeing, so that we can also support others.

There is not one normal reaction to highly stressful events, people may respond very differently. However, some common reactions include feeling overwhelmed, crying, becoming agitated, angry, helpless or hopeless.

It can be difficult to support someone experiencing a distressing situation. The way you respond may make a difference to the person, and whilst distress may be expressed differently, you can use the same approaches to respond.

Step 4: In plenary ask participants to brainstorm their ideas for responding to people in distress.

Step 5: Discuss using the following notes.



Facilitator's notes:

- **Respond calmly** - it is easy to mirror the feelings of a person in distress but this is not a helpful response, attempt to remain calm, take long deep breaths and encourage the person in distress to also slow their breathing down.
- **Listen and acknowledge feelings** - listen carefully to what the person is saying, ensure to avoid interrupting them, and repeat back what they have said to ensure they are understood and for them to know you are taking their concerns on board. Be warm and non-judgmental - remember your tone and body language is just as important as what you are saying.
- **Support simple problem solving** - when appropriate, ask one simple question at a time, help assess the most urgent needs at that time.

Step 6: In pairs or small groups, ask participants to role play supporting someone in distress. Share the phrases below for pairs to use in conversation.

Useful phrases for distressing conversations

"It sounds like you are feeling [insert emotion] and that you want/plan to [action]. Have I understood correctly?"

"I am here for you, you are not alone"

"It is perfectly normal to feel this way"

"It is OK to ask for help, it is a sign of strength"

Phrases to avoid

"*It's not that bad.*" - whilst you may think this might reassure a person, it may cause the person to feel ashamed or misunderstood. It also might mean they choose not to reach out in the future.

"*I know how you feel.*" - whilst you might have a similar experience nobody knows exactly how someone else is feeling. This statement can also make people feel misunderstood or seem as though you are trying to bring attention to yourself.

"*You're making me feel bad.*" - having difficult conversations can be distressing or overwhelming for the caregiver as well, however it is important not to blame the individual for this. However, it is important to set boundaries or to reach out for help if you are struggling to support somebody.

Session 7.6

Support for older people living with dementia

Dementia is a neurological or cognitive health condition but is sometimes confused with mental health conditions. It is included in this section because some of the symptoms of dementia present in similar ways to other mental health conditions.



Facilitation steps

Step 1: Ask participants whether they have heard of dementia and discuss in a large group?

Step 2: Reflect on their contributions and share definition for common understanding:

Dementia is an umbrella term for a collection of symptoms that are caused by disorders affecting the brain and impact on memory, thinking, behaviour and emotion, and the ability to perform daily activities. (WHO)

A useful resource for identifying 10 common signs of Alzheimer's and dementia could be printed and shared with participants. Other excellent resources are available via the same link.

https://www.alz.org/alzheimers-dementia/10_signs

Dementia is more common among older people but it is not a normal part of ageing.

A medical professional needs to provide a diagnosis for dementia.

There is a lot of stigma around dementia and memory loss, but dementia does not mean someone is 'crazy' or should be avoided.

There are lots of great resources for CHV and other carers providing support to people with dementia, so further learning can take place if it is of interest or relevant to the role of CHV.

Caring for people with dementia can be challenging and benefits from expert training. The iSupport modules from WHO are an excellent place for additional training:

<https://www.who.int/publications/i/item/9789241515863>

Summary

Mental health and wellbeing are essential components of overall health. They refer to a person's emotional, psychological, and social well-being. Good mental health and wellbeing enable individuals to cope with daily challenges and enjoy a fulfilling life.

There are many biological, psychological, and environmental reasons for changes to our mental health and causes of mental health conditions.

There is a lot of stigma attached to our mental health, and this can make it harder for people to seek out support when they need it.

Everyone can benefit from taking steps to promote their well-being and care for their mental health. There are many things we can do to protect people from developing mental health conditions, including developing social and emotional skills, building supportive networks, seeking help and support. Everyone has a role to play in understanding mental health, and everyone can offer support to someone experiencing mental health problems.

Older adults are often underserved when it comes to mental health care, barriers such as a lack of access, stigma and lack of awareness can prevent older people from receiving the care they need. Good mental health is vital for maintaining social connections and preventing isolation, which can be a significant issue for older people.

Community health volunteers will play an essential role in promoting mental health and wellbeing in the community. The Role of community health volunteers is to provide education, support, opportunities for social interaction, and resources as well as recommend referrals for older people in the community.

Additional resources

1. 5 steps to promote good mental health and wellbeing - <https://www.nhs.uk/mental-health/self-help/guides-tools-and-activities/five-steps-to-mental-wellbeing/>
2. WHO - Mental health among older adults <https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults>
3. Mental Health Gap Action Programme (mhGAP) <https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme>
4. Dementia friendly community resources - <https://www.alzint.org/resource/dementia-friendly-community-resources/>
5. iSupport training for carers of people with dementia - <https://www.who.int/publications/i/item/9789241515863>
6. WHO Dementia overview - https://www.who.int/health-topics/dementia#tab=tab_1

Module 8

Prevention and management of common communicable diseases



Introduction

Communicable diseases are illnesses that spread from one person to another or sometimes from animals, such as mosquitoes, to humans. They may also be referred to as infectious or contagious diseases. Examples of communicable diseases include influenza, tuberculosis, measles, and COVID-19.

Relevance to older people.

Communicable diseases are highly relevant to older people for many reasons.

- Many older people have increased susceptibility, as people age, their immune systems may weaken. This can increase the chances of catching a communicable disease but it also makes it harder to recover.
- Older adults are more likely to experience complications, which can be serious and sometimes life-threatening.
- Communicable diseases can have a significant impact on the quality of life of adults, illness can result in hospitalisation, isolation, and loss of independence, it can contribute to development of depression and other mental health issues.

Role of community health volunteers

It is important for community health volunteers to understand communicable diseases and how they are transmitted in order to support communities in preventing and controlling their spread. This session of the health volunteer manual includes content that will help CHV develop a basic understanding of communicable diseases and prevention and treatment strategies.

Learning outcomes:

The purpose of this session is to impart knowledge and skills about common communicable diseases that affect older people.

By the end of the session, the participants should be able to:

- Define communicable diseases
- Understand the relationship between communicable diseases and older people
- Explain the common communicable diseases that affect older people
- Demonstrate the common behaviours to practise in prevention of communicable diseases
- Explain ways of taking care for an older person suffering from communicable diseases

☒	Evaluation:	Discussion
☒	Teaching method:	Lecture and group work
☒	Materials:	Flip charts, pens and paper

Session 8.1 Introduction to communicable diseases



Facilitation steps

Step 1: Start the session by telling the participants that they will now discuss communicable diseases and explain that communicable diseases are caused by germs that can be transmitted to other people from an infected person, animal or a source in the environment.

Step 2: Ask participants to share examples of communicable diseases that they know

Step 3: Ask them to discuss examples of how the diseases are transmitted

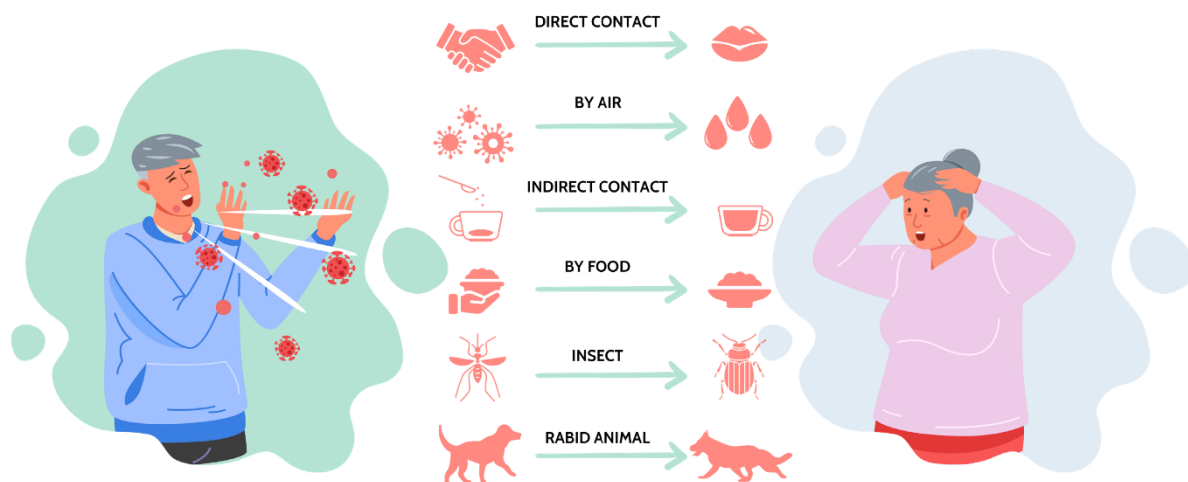
Step 4: Summarise the session by sharing the information in the facilitators notes below



Facilitator's notes:

- The germs can be bacteria, viruses, parasites and fungi that can be spread, directly or indirectly, from one person to another.
- Common forms of transmission include insect bites, inhalation, physical contact, injection and ingestion of contaminated food or water.
- A variety of disease-causing bacteria and viruses are carried in the mouth, nose, throat and reproductive tract.
- Illnesses such as common cold, tuberculosis (TB), COVID-19 and different strains of influenza (flu) can be spread by coughing, sneezing, and saliva or mucus on unwashed hands.
- Other illnesses like Malaria are transmitted through mosquito bites
- Sexually transmitted infections (STIs) such as HIV and viral hepatitis are spread through the exposure to infectious bodily fluids such as blood, vaginal secretions and semen. HIV/AIDS is covered in more detail in the section on sexual and reproductive health.

TYPES OF DISEASE TRANSMISSION



The following all increase the risk of spread of communicable disease:

- Poor hygiene/infection prevention control (IPC) practices
- Risky sexual behaviour
- Consumption of contaminated food
- Consumption of untreated water (unsafe)
- Poor sanitation practices e.g. improper disposal of faecal matter
- Not correctly using Long Lasting Insecticide Treated Net (LLITN)
- Poor housing and overcrowding

Session 8.2

Communicable diseases that affect older people



Facilitation steps

Step 1: Ask participants to share examples of communicable diseases that they know

Step 2: Guide the participants to identify communicable diseases that affect older people

Step 3: Ask them to indicate whether these communicable diseases are preventable or curable

Step 4: Summarise the session by sharing the information in the facilitator's notes below



Facilitator's notes:

- Urinary Tract Infections are infections of the urinary tract system. They are characterised by frequent strong urge to urinate, cloudy urine and pain in the lower abdomen. In older people it may also lead to sudden changes in behaviour, such as confusion or worsening of dementia, or onset of urinary incontinence
- Skin Infections - As people grow older, they experience changes on the skin. The skin may not be able to heal or resist disease. This can lead to viral infections (e.g. herpes zoster), bacterial infections (e.g. boils) and fungal infections (e.g. ringworms). Unusual itching, lesions or pain characterise skin infections.
- Pneumonia is an infection of the lungs, which leads to build up fluid in the lungs. Symptoms include high fever, coughing, chills, difficulty in breathing, fatigue and confusion.
- Tuberculosis (TB) is caused by a bacterium (*Mycobacterium tuberculosis*) that most often affects the lungs. TB is spread from person to person through the air especially in overcrowded, poorly ventilated dwellings. When people with TB cough, sneeze or spit, they propel the TB germs into the air. A person needs to inhale only a few of these germs to become infected. Symptoms include cough, fever, night sweats and weight loss. TB is preventable and curable.
- Cold and Flu are infections of the upper respiratory tract (throat, nose) by viruses. Symptoms include cough, chills, running nose, sneezing and fever.
- Gastrointestinal Infections are viral, bacterial, fungal or parasitic infections that cause inflammation of the stomach or intestines. They are characterised by

vomiting, diarrhoea and abdominal pain. This may also lead to dehydration which is a serious health condition.

- Cholera is an infectious disease that causes watery diarrhoea which can lead to dehydration and death. The disease is spread via consumption of contaminated drinking water.
- Typhoid is a bacterial infection that spreads through eating food or drinking water that has been contaminated with infected human faeces. Symptoms include prolonged high fever, fatigue, headache, nausea, abdominal pain, and constipation or diarrhoea. Some patients may have a rash.
- Malaria is caused by a parasite in the bloodstream spread via the bite of a female anopheles mosquito. Symptoms of malaria include chills, fever, headache, vomiting, diarrhoea, seizures, sweats, and fatigue.
- Sexually Transmitted Infections (STIs) are infectious diseases that are passed from one person to another during vaginal, anal, and oral sex. STIs have significant effects on health thus need to be diagnosed and treated appropriately and in a timely manner.
- HIV is a virus that suppresses the immune system and can lead to AIDs. It is transmitted through bodily fluids that include; blood, semen, vaginal fluids, rectal fluids and breast milk. HIV is preventable and with medical care, including treatment called antiretroviral therapy, it's possible to manage HIV and live with the virus for many years. Without treatment, a person with HIV is likely to develop a serious condition called Acquired Immune Deficiency Syndrome (AIDS).
- Neglected Tropical Diseases (NTDs) are a group of parasitic and bacterial diseases that generally afflict the world's poor and historically have not received as much attention as other diseases. They cause substantial illness which impairs physical and cognitive development.
- Parasitic infections are caused by different species of parasitic worms. They are transmitted by eggs present in human and animal faeces, which contaminate food, soil and water in areas where sanitation is poor. Control is based on periodical deworming to eliminate infecting worms, health education to prevent re-infection, and improved sanitation to reduce soil, water and food contamination with infective eggs. Safe and effective medicines are available to control infection.

Step 5: Ask participants to list reasons why older people might be more vulnerable to communicable diseases?

Step 6: Summarise the session by sharing the information in the facilitators notes below.



Facilitator's notes:

Older people are at greater risk of infection with communicable diseases due to the following reasons:

- Decline in the strength of their immunity
- Pre-existing NCD like diabetes, hypertension
- Nutritional deficiencies leading to a lower immunity

Session 8.3

Prevention and control of common communicable diseases among older people



Facilitation steps

Step 1: Start the session by telling the participants that they will now discuss the prevention and control of communicable diseases among older people

Step 2: Ask participants to share examples of preventive measures that would help prevent communicable diseases.

Step 3: Share the case study on COVID-19 below, and ask participants to reflect on what actions were taken?



Facilitator's notes:

Key actions include:

- Information sharing accessible to people in their own languages, on both COVID itself but also on available services
- Provision of protective equipment such as masks and hand sanitisers
- It would also be good to note that though not included in this case studies, vaccinations were an important intervention for limiting COVID-19 and this was included in the service information sharing.



Case Study HelpAge International responding to COVID-19

Older people, people with disabilities, and people with pre-existing conditions are more susceptible to serious complications from COVID-19.

In Cox's Bazar, home to about 855,000 refugees displaced from Myanmar, severe overcrowding, poverty and a chronic lack of health care facilities fueled concerns that COVID-19 could quickly spread, exacerbating an already dire humanitarian crisis. HelpAge International broadcast information in Rohingya language in partnership with BBC media action via loudspeakers, informing older people and people with disabilities about COVID-19 and available services.

In Ukraine, HelpAge provided home-base care support, COVID-19 health information and hand sanitiser to 2000 older people, through a network of community volunteers.

In Ethiopia, as part of a health promotion response, HelpAge International developed a radio programme on COVID-19 which aired nationally and reached at least 20,000 people.

Step 4: Using the diagram on hand washing below, ask participants to practise good handwashing practices and then demonstrate this in pairs.



Source: [NHS](#)

Step 5: Summarise the session by sharing the information in the facilitators notes below



Facilitator's notes:

1. Handle and Prepare Food hygienically: food can carry germs.

- Use soap or disinfectant to wash hands, utensils, and surfaces often, when preparing any food, especially raw meat
- Always wash fruits and vegetables with clean and safe water.
- Do not leave food out - preserve promptly if possible.
- Ensure water used for drinking, cooking and washing is clean and safe.

2. Waste management

- Accessible, utilisable and functional latrines (facilities)
- Practise safe disposal of domestic waste

3. Vector control

- Use Long Lasting Insecticide Treated Net (LLITN)
- Practice vector control measures (ensure clean home, compound, residual spraying, drain stagnant water, clear bushes etc.)

4. Personal hygiene

- Wash hands at all critical times (After visiting the toilet, before handling food, before eating and after changing a baby)
- Wash your hands with clean water and soap before handling food items
- Always wash your hands with clean water and soap before providing care to an older person.
- Practice cough & sneeze hygiene - If you have a cough, cough into your sleeve or elbow crease, and not into our hands, as coughing into your hands exposes people you greet to infection. Do not cough into the open, because this causes the spread of germs into the environment and other people.

5. Don't Share Personal Items

- Avoid sharing personal items that cannot be disinfected, like toothbrushes and razors, or sharing towels between washes. Needles should never be shared, should only be used once, and disposed of properly.

6. Clean & Disinfect Commonly Used Surfaces

- Germs can live on surfaces. Cleaning with soap and water is usually enough. However, you should disinfect your bathroom and kitchen regularly. Disinfect other areas if someone in the house is ill. You can use a locally available disinfectant, bleach solution, or rubbing alcohol.

7. Vaccination

- Vaccines can prevent many infectious diseases. There are vaccines for children and adults designed to provide protection against many communicable diseases.

There is a vaccination checklist available in the self-care manual, these can be provided as a handout.

Spotlight on vaccinations

[pic]

Vaccinations and immunizations are crucial for older people to help protect them from a variety of diseases that become more common with age. As we age, our immune system can become weaker, making us more susceptible to infections and illnesses. Vaccines are a safe and effective way to boost the body's immune response to specific diseases, helping to prevent infection and reduce the severity of illness if infection does occur. For older adults, getting vaccinated is particularly important as they are more likely to experience complications from vaccine-preventable diseases.

There are several types of vaccines that are recommended for older adults, including the flu vaccine, pneumococcal vaccine, and shingles vaccine. Specific vaccination needs will also be context specific. It is always important to check with a local health provider.

In many places, the flu vaccine is recommended annually for all adults over the age of 65 to protect against seasonal influenza. By staying up-to-date with recommended vaccinations, older adults can help protect themselves against a variety of illnesses and maintain their health and well-being.

Session 8.4

Supporting older people with management of communicable diseases.



Facilitation steps

Step 1: Start the session by telling the participants that they will now discuss how to take care of an older person who has a communicable disease and how to enable older people to care for themselves.

Step 2: Ask participants to share how they would take care of an older person suffering from a communicable disease.

Step 3: Summarise the session by sharing the information in the facilitators notes below.



Facilitator's notes:

- Take the older person to hospital, once you notice any of the symptoms indicated in the facilitators notes in session 8.2
- Ensure that the older person adheres to the prescribed medication
- Ensure that the older person takes their meals as advised
- Ensure that the older person stays in a clean well ventilated room
- Ensure that as the caregiver, you prioritise your own safety, wearing protective equipment, handwashing or using a hand sanitiser

Summary

Communicable diseases are caused by germs, viruses or bacteria, some are deadly.

Communicable disease can be transmitted through various means, including insect bites, physical contact, and ingestion of contaminated food or water.

Older persons are more vulnerable to communicable diseases due to a decline in immunity, pre-existing chronic illness, and nutritional deficiencies.

Examples of communicable diseases that affect older persons include urinary tract infections, skin infections, pneumonia, tuberculosis, cold and flu, gastrointestinal infections, cholera, typhoid, malaria, sexually transmitted infections, HIV.

Preventive measures include handling and preparing food hygienically, waste management, vector control, personal hygiene, not sharing personal items, cleaning and disinfecting commonly used surfaces, and vaccination.

Community Health Volunteers have a role in sharing information about common communicable diseases, how to minimise risk and what you should do if you believe you are sick.

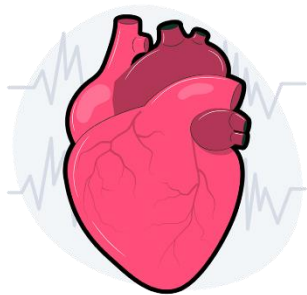
Additional resources

CDC vaccine recommendations for adults - <https://www.cdc.gov/vaccines/adults/rec-vac/index.html>

Self-care manual

Module 9

Prevention and management of common non-communicable diseases



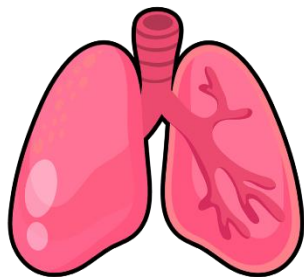
Cardiovascular
diseases



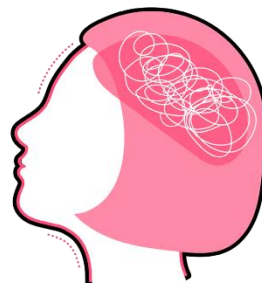
Diabetes



Cancer



Chronic respiratory
diseases



Mental health

Introduction

Non-Communicable Diseases are diseases which tend to be of long duration and are a result of a combination of genetic, biological, environmental and behavioural factors. They are not transmissible from one person to another. Their effects are often long-term and can cause death, loss of work ability and impaired quality of life over a prolonged period.

Relevance to older people

NCDs are particularly relevant to older people for several reasons:

- Higher prevalence - older people are more likely to have NCDs than younger people.
- Increased risk of complications - older people with NCDs are at high risk of experiencing complications, such as heart attack, stroke, and kidney failure.
- Impact on quality of life - NCDs can have a significant impact on the quality of life of older adults, for example chronic pain, disability and loss of independence can all affect a person's ability to carry out daily activities.
- Can worsen other conditions such as communicable disease and disabilities.

Role of community health volunteers

It is important for community health volunteers to understand NCDs and their impact on individuals and communities. This section of the community health volunteer manual is designed to provide training in basic understanding of NCDs, their risk factors, and prevention strategies.

CHV can help educate community members on how to make healthier lifestyle choices. CHV can also help identify individuals through screening who may be at risk of NCDs and refer them to appropriate services. More training on screening is available in module 3.

Learning outcomes:

The purpose of this session is to impart knowledge and skills on common non-communicable diseases that affect older people.

By the end of the session the participant should be able to:

- Define NCDs
- Discuss common risk factors for NCDs and prevention of NCDs
- Describe the common NCDs that affect older people (Cardiovascular diseases, diabetes, cancers, chronic obstructive pulmonary disease, arthritis, Eye problems, dental problems etc.)
- Describe management of NCDs

✓	Evaluation:	Pre and post session discussion
✓	Teaching method:	Lecture and discussion in small groups
✓	Materials:	Flip charts, pens and paper

Session 9.1

Definitions and burden of non-communicable diseases



Facilitation steps

Step 1: Ask the participants to get into small groups and discuss what they understand by non-communicable disease

Step 2: Ask participants to present in plenary

Step 3: Summarise the session using the notes below.



Facilitator's notes:

- A non-communicable disease (NCD) is a disease that is not transmissible directly from one person to another.
- They tend to be of long duration and are the result of a combination of factors which include; genetic, biological, environmental and behavioural.

Burden of non-communicable diseases

Step 4: Ask participants to discuss whether they think the following statements are true or false - you can use flash cards or write them up on a flipchart or black/white board.

Statement	True or false
Non-communicable diseases (NCDs) kill 41 million people each year, equivalent to 74% of all deaths globally.	True
Each year, 17 million people die from a NCD before age 70; 86% of these deaths occur in low- and middle-income countries	True
NCDs are responsible for 80% of years lived with disability globally	True

NCDs are only a problem for countries in Europe and North America	False Of all NCD deaths, 77% are in low- and middle-income countries
Tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diets all increase the risk of dying from an NCD	True
Detection, screening and treatment of NCDs, as well as provision of palliative care, are key components of the response to NCDs. If you catch an NCD early it is easier to manage	True

Step 5: Ask participants to rank the following disease categories from high to low in terms of their contribution to global deaths.

- Cardiovascular diseases such as heart attack (17.9 million people annually)
- Cancers (9.3 million)
- Chronic respiratory diseases (4.1 million)
- Diabetes (2.0 million including kidney disease deaths caused by diabetes).

1 in 8 people also live with mental health condition, making up a significant burden of disease.

Session 9.2

Common risk factors for NCDs



Facilitation steps

Step 1: Ask the participants to discuss in a large group what they understand by the phrase **risk factors** and how it might relate to NCD

Step 2: Ask participants to list what they consider to be risks or unhealthy behaviours.

Step 3: Explain that some risk factors cannot be changed with behaviour (non-modifiable), some can be reduced or removed by adopting healthy behaviours (modifiable), some are related to our physical traits (metabolic) and some are based on our environment or other external factors.

Step 4: Using flashcards or pieces of paper list out all the risk factors below. In small groups ask the participants to organise into the three categories. (You may need multiple copies of the flashcards, one set for each group)

Step 5: Ask groups to present back, support participants by organising all into correct piles as a wider group.



Facilitator's notes:

Risk factors can either be non-modifiable, modifiable or metabolic;

Non-modifiable risk factors:

- Age: Ageing has been recognized as the first of four key drivers of NCDs in developing countries.
- Genetics
- Gender

Modifiable risk factors include;

- Tobacco use (including from the effects of exposure to second-hand smoke),
- Physical inactivity,
- Unhealthy diet
- Harmful use of alcohol,
- Ambient air pollution

Metabolic risk factors including;

- Raised blood pressure
- Overweight/obesity
- High blood glucose levels

- High levels of fat in the blood

Others

- Underlying medical condition
- Environmental pollution and exposure to carcinogenic substances

Session 9.3 Common NCDs that affect older people



Facilitation steps

Step 1: Having had a chance to define and discuss NCD, ask groups to suggest any common NCD they are aware of that may impact older people.

Step 2: Ask participants to present in plenary.

Step 3: Summarise the session using the notes below.



Facilitator's notes:

(These can also be printed and shared as a handout as there is a lot of content.)

High Blood Pressure (Hypertension)

High blood pressure, also known as hypertension, is a condition in which the force of blood against the walls of the arteries is consistently too high. Blood pressure is measured using two numbers: systolic pressure, which is the pressure when the heart beats, and diastolic pressure, which is the pressure when the heart is at rest between beats.

According to the International society of hypertension global hypertension practice guidelines (ISH) of 2020, blood pressure (BP) is classified into four categories:

	Normal <130/85 mmHg
	High-normal 130–139/85–89 mmHg
	Grade 1 hypertension 140–159/90–99 mmHg

 Grade 2 hypertension $\geq 160/100$ mmHg
--

High blood pressure is a common condition and can increase the risk of heart disease, stroke, and kidney disease.

Some common causes of high blood pressure include being overweight, smoking, stress, and a diet high in salt and saturated fat. Some medical conditions, such as diabetes and kidney disease, can also increase the risk of developing high blood pressure.

Treatment for high blood pressure may involve lifestyle modifications, such as regular exercise, a healthy diet, and reducing stress. In some cases, medications such as diuretics, beta-blockers, or ACE inhibitors may also be prescribed to help lower blood pressure.

Prevention strategies for high blood pressure include maintaining a healthy weight, avoiding tobacco and excessive alcohol consumption, reducing salt intake, and getting regular physical activity. It is important to monitor blood pressure regularly, as high blood pressure often has no noticeable symptoms but can still cause serious health problems if left untreated.

Diabetes

Diabetes is a condition in which the body is unable to properly use and store glucose (a type of sugar), leading to high levels of glucose in the blood. There are two main types of diabetes: type 1 diabetes and type 2 diabetes.

Type 1 diabetes is an autoimmune disease in which the body's immune system attacks and destroys the cells in the pancreas that produce insulin. Insulin is a hormone that helps regulate glucose levels in the blood. People with type 1 diabetes need to take insulin injections or use an insulin pump to regulate their blood sugar levels.

Type 2 diabetes is a condition in which the body becomes resistant to insulin or does not produce enough insulin to properly regulate blood sugar levels. Type 2 diabetes is often linked to lifestyle factors such as being overweight or obese, lack of physical activity, and an unhealthy diet.

Symptoms of diabetes may include frequent urination, excessive thirst and hunger, unexplained weight loss, fatigue, blurred vision, and slow healing of cuts and bruises.

Treatment for diabetes may involve lifestyle modifications such as regular exercise, a healthy diet, and weight management. Medications such as insulin, oral medications, or injectable medications may also be prescribed to help regulate blood sugar levels. Monitoring blood sugar levels regularly is also important for managing diabetes and preventing complications such as nerve damage, eye damage, and kidney damage.

Prevention strategies for diabetes include maintaining a healthy weight, engaging in regular physical activity, and eating a healthy diet low in sugar and processed foods. It is

important to receive regular check-ups and screenings for diabetes, especially if there is a family history of the disease or if you have other risk factors such as high blood pressure or high cholesterol.

Alzheimer's Disease and other forms of dementia

Alzheimer's and other forms of dementia are neurological disorders that affect the brain and cause a decline in cognitive abilities, such as memory, thinking, and communication.

Alzheimer's is the most common form of dementia, but other forms include vascular dementia and Lewy body dementia.

Symptoms of dementia can vary depending on the type and stage of the disease, but common symptoms include memory loss, confusion, difficulty with language or communication and changes in behaviour.

Cancer

Cancer is a disease caused by the uncontrolled growth and spread of abnormal cells in the body. Normally, cells in our bodies grow and divide in an orderly way, but cancer cells grow and divide uncontrollably, forming masses of cells called tumours.

There are many different types of cancer, and each type is characterised by the specific cells that are affected and the way in which they grow and spread. Some common types of cancer include breast cancer, lung cancer, prostate cancer, and colon cancer.

Osteoarthritis

Osteoarthritis is a degenerative joint disease that affects the cartilage in our joints. In osteoarthritis the cartilage gradually wears away, which can cause pain, stiffness, and a loss of mobility.

Osteoarthritis can affect any joint in the body, but it is most commonly found in the hands, hips, knees, and spine.

Exact causes of osteoarthritis are not known, but factors that can contribute to its development include genetics, joint injury, and obesity. People who have jobs or hobbies that involve repetitive motions or overuse of a joint may also be at a higher risk for developing osteoarthritis.

Treatment for osteoarthritis usually involves a combination of lifestyle modifications, such as weight loss and exercise, as well as medications to manage pain and

inflammation. CHV can help guide people to suitable exercises and make suggestions about healthy food choices to aid with weight loss.

Osteoporosis

Osteoporosis is a medical condition in which the bones become weak and brittle, making them more likely to break or fracture. It occurs when the body loses bone mass faster than it can replace it, which can lead to thinning of the bones and an increased risk of fractures, especially in the hip, spine, and wrist.

Osteoporosis can develop over many years before people notice symptoms, as the disease becomes worse, people may experience back pain, loss of height, and a stooped posture.

Women are at greater risk of developing osteoporosis than men, because of changes in oestrogen levels after menopause. There are many other factors that can contribute to its development, including age, gender, and lifestyle factors such as smoking and a lack of exercise.

Strength exercises such as those described in module 4 and a diet rich in calcium and vitamin D can help slow down bone loss. Preventative measures, such as bone density screenings and fall prevention strategies, can also help reduce the risk of fractures.

Cerebrovascular Disease (Stroke)

Stroke occurs when blood flow to the brain is disrupted, either by a blockage or a ruptured blood vessel. This can lead to brain damage.

Symptoms of stroke vary depending on the type and location of the stroke, but some common symptoms include sudden weakness or numbness in the face, arm, or leg, difficulty speaking or understanding speech, sudden confusion or trouble with vision, severe headache, and a difficulty walking or maintaining balance.

Immediate medical attention is crucial for a stroke, as early treatment can help minimise brain damage and improve chances of recovery. If you think somebody is having a stroke it is important to call for help from a medical professional immediately.

CHV can encourage prevention strategies for stroke, using some of the skills and information already covered in this training. For example, a healthy diet, regular exercise, avoiding tobacco and excessive alcohol consumption.

Chronic Obstructive Pulmonary Disease (COPD)

COPD is a chronic lung disease that makes it difficult to breathe. COPD is typically caused by long term exposure to cigarette smoke, air pollution, or other harmful chemicals.

The two most common types of COPD are emphysema and chronic bronchitis.

Emphysema is a condition in which the air sacs in the lungs become damaged, making it difficult to breathe out.

Chronic bronchitis is a condition in which the bronchial tubes in the lungs become inflamed and produce excess mucus, making it difficult to breathe in.

Symptoms of COPD may include shortness of breath, coughing, wheezing, and chest tightness. These symptoms may worsen over time, making it more difficult to perform daily activities and leading to disability and a reduction in quality of life.

There is no cure for COPD, but treatments can help manage symptoms and slow the progression of the disease. Treatments include medications. Rehabilitative exercise and breathing techniques can also improve breathing and quality of life for people with COPD.

Prevention strategies for COPD include avoiding exposure to tobacco and air pollution and receiving vaccinations for respiratory infections.

Coronary Artery Disease

Coronary artery disease (CAD) is a condition in which the coronary arteries that supply blood to the heart become narrow or blocked due to a buildup of plaque (a fatty substance) on the inner walls of the arteries. This can reduce blood flow to the heart, which can lead to chest pain, heart attack, or heart failure.

Some common risk factors for CAD include high blood pressure, high cholesterol, smoking, diabetes, obesity, and a family history of heart disease. Lifestyle factors such as a poor diet and lack of exercise can also increase the risk of CAD.

Symptoms of CAD may include chest pain or discomfort, shortness of breath, fatigue, and weakness. However, some people with CAD may not have any symptoms.

Treatment for CAD may involve lifestyle modifications such as regular exercise, a healthy diet, and quitting smoking. Medications such as aspirin, beta-blockers, and cholesterol-lowering drugs may also be prescribed to help manage the condition. In some cases, surgical procedures such as angioplasty or coronary artery bypass grafting (CABG) may be recommended to restore blood flow to the heart.

Prevention strategies for CAD include maintaining a healthy weight, engaging in regular physical activity, eating a healthy diet low in saturated and trans fats, and managing other health conditions such as high blood pressure and diabetes. It is important to receive regular check-ups and screenings for CAD, especially if there is a family history of the disease or if you have other risk factors.

Session 9.4

Prevention and management of NCDs



Facilitation steps

Step 1: Introduce the session by explaining a key role for community health volunteers is health promotion, which is support and education on managing one's health and wellbeing - as discussed in module 3. Remind participants about their potential role in screening services.

Step 2: Put participants into small groups, ask them to reflect back on the risk factors and to brainstorm any potential actions they could take to limit the risk. In the previous section, we discussed common NCD, ask participants to reflect on their causes as well as prevention strategies to help suggest actions.

Step 3: Ask participants to present in plenary.

Step 4: Summarise the session using the notes below.



Facilitator's notes:

Screening is key to early detection of NCD (and is covered in module 3 of this manual), there are simple screening tools that CHV can use to help older people identify whether they are at risk of developing an NCD.

Most NCD diseases can be managed with medication and/or behaviour modification and people can live fulfilling lives with NCD. However, untreated NCD diseases are a leading cause of disability in later life.

If untreated the complications and consequences of NCD diseases can be serious.

A person with a NCD can continue to live a fulfilling life!

There are some things people with a NCD can do to optimise their quality of life:

- Live healthily: Especially for people with a NCD it is important to pay attention to healthy living. Healthy living can contribute to prevention of NCD but can also help us feel better after we have been diagnosed with a NCD.
- If we reduce salt and sugar in our diets, we reduce our chances of developing an NCD
- If we limit the amounts of alcohol we drink, we reduce our chances of developing an NCD
- If we stop smoking or using tobacco, we reduce our chances of developing an NCD
- Physical exercise is a fun way to help reduce our chances of developing an NCDs

- Going to doctor appointments, frequent screening and taking prescribed medicines and routine vaccines are important.
- Reducing ambient and indoor air pollution for example by using energy efficient and clean burning stoves indoors.

For lifestyle adjustments, remember ABCDE:



Source: [WHO](http://www.who.int)

CHV can provide support with;

- Making suggestions for small adjustments to lifestyle to improve health
- Adherence to medication
- Screening of other NCDs
- Psychosocial support
- Referrals

Summary

NCD are chronic disease resulting from a combination of genetic, biological, environmental, and behavioural factors

NCD are responsible for 74% of all deaths globally and 80% of years lived with disability

Risk factors can be **non-modifiable** - such as our age or gender, **modifiable** - such as what we eat, how much we exercise and whether we drink or smoke, or **metabolic** such as our blood pressure, or amount of cholesterol in our blood. Other risk factors include things like air pollution.

The most common NCDs are cardiovascular disease such as heart attacks, diabetes, hypertension, cancer, and chronic obstructive pulmonary disorders.

Prevention and management of NCDs includes adopting healthy behaviours, going to regular screening sessions, good adherence to medication and psychosocial support.

CHV can support people in the prevention and management of NCD by facilitating basic screening, referring high risk individuals to doctors and sharing information on how to live healthily.

Additional resources

WHO NCDs and Healthy ageing -

<https://www.who.int/westernpacific/about/governance/regional-director/ncds-and-ageing>

Module 10

Prevention of falls and accidents



Introduction

Falls are a significant health concern, particularly for older adults. Falls can result in serious injuries, hospitalisations, and even death. Preventing falls can help older adults avoid these negative consequences.

Falls can have a significant psychological impact on older adults. A fall can lead to fear and loss of confidence, which can limit an individual's ability to participate in activities they enjoy, lead to social isolation, and impact their mental health. Falls prevention can help older adults maintain their independence, mobility, and social connections.

By promoting safe and healthy ageing, falls prevention can help older adults maintain their independence, engage in activities they enjoy, and stay connected to their communities. Falls prevention is essential for promoting healthy ageing. By addressing risk factors for falls, such as physical inactivity, medication use, and environmental hazards, falls prevention can help older adults maintain their health and wellbeing as they age.

Role of community health volunteers

Community health volunteers have a vital role to play in falls prevention in communities. CHV can equip communities with practical actions for reducing falls as well as how to respond in cases where a fall takes place.

Learning outcomes

By the end of the session - participants should be able to identify risk factors for falls and strategies for prevention and provide care for someone who has had a fall.

☒	Evaluation:	Group discussion
☒	Teaching method:	Individual work, group work
☒	Materials:	Flipcharts, pen and paper

Session 10.1

Prevention of falls



Facilitation steps

Step 1: Ask participants to discuss fall risk factors - make note of these on white board/flip chart etc.

Some likely risk factors include;

- Poor vision - may make people more likely to trip and fall
- Hearing loss - response times to falling or moving objects may be slower which can then become hazards for falls
- Muscle strength - often in older age our muscle strength may deteriorate which can result in an increase in falls
- Flexibility & balance - we may also become less flexible and lose our ability to balance in older age which is a risk factor for falls, particularly poor balance
- Medication - medication may include side effects such as dizziness, loss of balance.
- Polypharmacy which is when patients are on multiple medications may be particularly risky as side effects may accumulate
- Medical conditions - some conditions are particularly high risk for falls, these include; epilepsy, stroke, Parkinson's,
- Dizziness and feel faint - we may feel faint for a number of reasons including dehydration, or high temperature.

Step 2: Ask participants to brainstorm how we may prevent falls and discuss in plenary (the image below can be printed and used as a handout)

Some prevention strategies include;

- Encouraging vision tests and use of spectacles
- It may be possible for individuals to discuss use of different medication with their doctor if the side effects are particularly bad
- Discuss use of mobility aids, if an individual has a mobility aid ensure they have received instructions on correct use of the aid, if they have not see if it is possible to refer to a nurse or someone with experience in the use of that particular aid.
- Limit alcohol which can affect balance and decision making
- Consider use of appropriate footwear - shoes should have good grip, in addition sandals and other open toe shoes may be more likely to be caught on something and result in a slip
- Think about a safe home environment - for example, rugs and other loose items on floors may be trip hazards. It is advisable to have handrails on staircases and in hallways. Bathrooms can be fitted with grab rails in showers. Stairs and

uneven surfaces can be highlighted with tape. Use non-slip mats in the bathroom. Do not use chairs to reach things on high shelves, move items you need to use regularly into easy reaching distance

- Good lighting can prevent falls by ensuring better awareness of one's surroundings
- Strength and balance training - these could be simple activities such as daily walks, there are also a range of chair exercises that can be done safely for people with limited mobility.



Source: [MobileHelp](#)

Session 10.2

Falls evaluation



Facilitation steps

Step 1: Role play - in pairs ask participants to take it in turns to conduct a brief falls evaluation

In order to evaluate falls, CHV should ask the following questions:

- Have you fallen in the past year? (f yes: frequency, injury, if any)
- Are you afraid of falling?
- Do you feel unsteady when standing or walking?
- Do you have difficulty in your vision?

The person is at high risk of falling if they answer yes to any of the questions. (encourage participants to role play from the perspective of an older adult), spend 5 minutes taking them through some of the recommendations outlined in step 2.

Step 2: Discuss with the group key principles for caring for someone who has recently had a fall

- In the immediate aftermath of a fall, it is important to identify any immediate danger, this includes some injuries discussed further in module 16 such as bleeding from a wound, unconsciousness, and shock.
- A fall can also be the result of a serious emergency such as a heart attack
- The first thing to do in these scenarios is always to call for help
- Injuries from falls may not always be obvious; these include concussion - you should stay with the older person and monitor them for any deterioration in their wellbeing. If you cannot stay, make sure they have someone with them
- As previously mentioned, falls may also result in increased fear and anxiety, take time to discuss these fears and see if there are any preventative actions you can implement in the home in order to reduce risk and reassure people. Discuss all the options from preventative action using the list above.
- People who have recently fallen may be less inclined to exercise, though strength and balance exercises can help prevent future falls. Share examples of safe exercises and offer to support older people with their exercise.

Session 10.3

Common injuries from falls



Facilitation steps

Step 1: Ask participants to discuss in pairs some common injuries that might occur when a person falls

Step 2: Each pair to share their discussion

Step 3: Summarise using facilitators notes below:

- Fractures - falls can result in fractures, or breaks, in bones throughout the body. Most often these are hip fractures, but other common fractures include the wrists, arms, ankle, and pelvis
- Head injuries - falls can result in concussions, skull fractures, and bleeding in the brain.
- Soft tissue injuries - bruises, sprains and strains
- Back injuries - back injuries can cause significant pain and limit mobility
- Dislocations - falls can cause joints to become dislocated, often the shoulder, hip, or elbow

Serious falls should always be treated by a medical doctor or nurse but there are some actions you can take, and more information is provided in the first aid module.

Summary

Falls are a significant health concern, particularly for older adults.

Falls can have a significant psychological impact on older adults. A fall can lead to fear and loss of confidence, which can limit an individual's ability to participate in activities they enjoy, lead to social isolation, and impact their mental health.

Risk factors for falls include; Poor vision, hearing loss, decreased muscle strength, poor flexibility and balance, medication and particularly multiple medications, and some medical conditions such as epilepsy, stroke, and Parkinson's.

Fortunately there are some simple preventative measures we can take to reduce likelihood of falls, these include; Encouraging vision tests and use of spectacles, discussing medication options with doctors, use of mobility aids, limiting alcohol, wearing appropriate footwear, ensuring a safe home environment and participating in strength and balance training.

Community health volunteers can promote safe and healthy ageing, evaluate older people for falls and help put in place fall prevention plans enabling older adults to maintain their independence, engage in activities they enjoy, and stay connected to their communities.

Additional resources

CDC checklist for assessment of risk - <https://www.cdc.gov/steady/pdf/STEADI-Brochure-CheckForSafety-508.pdf>

CDC - chair exercise handout and instructions - <https://www.cdc.gov/steady/pdf/STEADI-Brochure-ChairRiseEx-508.pdf>

NHS UK - sitting exercises for building strength <https://www.nhs.uk/live-well/exercise/strength-and-flexibility-exercises/sitting-exercises/>

Module 11

Supporting people living with a disability



Introduction

Disability is part of being human. Almost everyone will temporarily or permanently experience disability at some point in their life.

Disability results from the interaction between individuals with a health condition or impairment, with personal and environmental factors including; *negative attitudes*, or stereotypes about people living with a health condition or impairment, *inaccessible transportation* and public buildings, and *limited social support*.

A person's environment has a huge effect on the experience and extent of disability. Inaccessible environments create barriers that often hinder the full and effective participation of persons with disabilities in society on an equal basis with others. Progress on improving social participation can be made by addressing these barriers and facilitating persons with disabilities in their day to day lives.

Relevance to older people

Disability is particularly relevant to older people.

- Older people are more likely to experience either a temporary or permanent disability due to age-related changes in physical and cognitive capacity. For example, mobility impairments, vision or hearing loss, or dementia.
- Older people are more likely to have NCD which can contribute to the development of disabilities
- Older people with disabilities may face barriers to accessing healthcare and other services they need, for example due to inaccessible facilities.

Role of community health volunteers

It is important for CHV to understand disability and how to support people with disabilities in the community. This section of the manual is designed to share basic information on common types of disability and simple interventions to support older people with disability.

By being aware of needs and challenges faced by older people with disabilities, CHV can help promote inclusion and accessibility in the community.

Learning outcomes

By the end of this session participants should be able to confidently discuss disability in relation to ageing and older people. Participants should be able to:

- Identify causes and types of disability
- Identify risks for developing disability

- Identify risks associated with having a disability
- Use the Washington short group of questions in order to screen for disability
- Provide recommendations for supporting older people with management of disabilities including the use of assistive products.

✓	Evaluation:	Group discussion
✓	Teaching method:	Lecture and group discussion
✓	Materials:	Flip chart, paper and pens.

Session 11.1

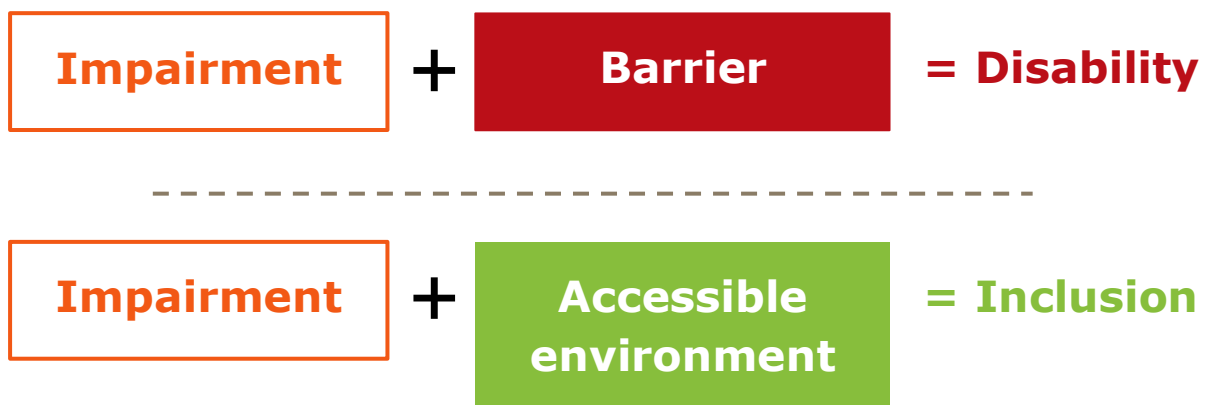
Introduction to disability



Facilitation steps

Step 1: Discuss the following bullets with participants.

- Disability results from the interaction between individuals with a health condition or impairment, with personal and environmental factors including negative attitudes, inaccessible transportation and public buildings, and limited social support. Drawing the diagram below on a flipchart may help visualise how disability is understood.



- Disability may restrict functional performance such as walking or eating. It can affect a person's ability to communicate, interact with others and get about independently.
- Disability can be permanent or temporary.

- As people get older, they are likely to experience one or more different forms of disability.
 - Disability does not mean poor quality of life but can lead to it if an enabling and supportive environment is not in place.
 - Disability is not always immediately noticeable e.g. hearing loss.
 - An accessible environment can be achieved by adjusting home or workplace, by providing assistive devices, and by getting the correct support and respect from people around us. There is more information on assistive devices in section 11.6.
- Step 2:** Ask participants to discuss the following case study in pairs or small groups, does the new information and the case study below, change the way they think about disability? If so, in what ways?



Case Study "David"

David is a 65 year old man, he has lost the use of his legs and so cannot walk. (impairment)

Fortunately, David has a wheelchair designed for his specific needs and with it he can get around his home and live independently (functional ability), he enjoys spending time with his family and socialising with friends.

However, David is sometimes limited by the environment outside of his home, for example, the health centre near his house doesn't have a ramp (barrier), so he can't enter without being carried, this results in a disability.

Session 11.2

Types of impairments common among older people



Facilitation steps

Step 1: Ask the participants to form groups

Step 2: Ask the participants to list types of impairments which they know

Step 3: Ask the participant to present in plenary

Step 4: Summarise with key notes below



Facilitator's notes:

- **Physical impairment:** Difficulty in movement, and challenges with coordination of the body parts and movements. For example, difficulty walking, loss of body parts, difficult using hands, etc.
- **Sensory impairment:** Difficulty in hearing (deafness}, vision (blindness), loss of taste, smell, or touch. It can be partial or complete loss of the senses.
- **Cognitive impairment:** Challenges in thought process, communicating, memory, problem solving, making judgements. For example, memory loss, confusion, walking aimlessly (wandering), odd behaviour and disorganised speech.
- **Intellectual/Learning impairment:** it is characterised by significant limitation in ability to obtain, adapt and apply new information which covers many everyday social and practical skills.
- **Mental (emotional & behavioural) impairment:** Also called emotional and behavioural disability, a person with mental disability presents with one or more of the following; Does not internalise things easily, does not answer questions appropriately, Difficulty thinking in a logical or sequential manner, often requires a great deal of clarification and one to one support.
- **Speech Impairment:** This indicates persons with difficulty in oral or spoken communication. It can range from difficulty speaking or being understood because of a long- term condition or health problem to total inability to talk
- **Multiple impairments:** A combination of several impairments.

Session 11.3

Risk factors for disability among older people



Facilitation steps

Step 1: Ask the participants to take 10 minutes to brainstorm risk factors for disability among older people

Step 2: List their responses on a flip chart

Step 3: Summarise their responses with the following key notes



Facilitator's notes:

Factors most associated with disability can be categorised into:

- **Non-modifiable risk factors:** Age, gender, genetics

- **Modifiable risk factors:** age-related diseases (modifiable to an extent), impairments, functional limitations, poor coping strategies, sedentary lifestyle, other unhealthy behaviour (e.g. physical inactivity, smoking, harmful consumption of alcohol and unhealthy diets), other disease, socioeconomic status and environment.

Session 11.4

Screening for disability using the Washington group of questions



Facilitation steps

Step 1: Introduce the session by introducing the Washington group of questions as a screening tool, write all questions on a flip chart or white/black board.

The Washington group of questions are a set of simple questions that can be used to screen for disability as well as monitor prevalence of people with disability in the community.

Step 2: Organise the participants into groups of 2 or 3 and have them practise using the questionnaire. Taking it in turns to ask the questions and noting down the answers.

Step 3: Call the participants to plenary and let them discuss their experience.

Step 4: Summarise in plenary by reminding the participants the six questions referring to the key notes below.



Question	Scoring <i>A person is identified as having a disability if they answer C or D to any single question.</i>
1. Do you have difficulty seeing, even if wearing glasses?	a. No - no difficulty b. Yes – some difficulty c. Yes – a lot of difficulty d. Cannot do at all
2. Do you have difficulty hearing, even if using a hearing aid?	a. No- no difficulty b. Yes – some difficulty c. Yes – a lot of difficulty d. Cannot do at all
3. Do you have difficulty walking or climbing steps?	a. No- no difficulty b. Yes – some difficulty c. Yes – a lot of difficulty d. Cannot do at all
4. Do you have difficulty remembering or concentrating?	a. No – no difficulty b. Yes – some difficulty c. Yes – a lot of difficulty d. Cannot do at all
5. Do you have difficulty (with self-care such as) washing all over or dressing?	a. No – no difficulty b. Yes – some difficulty c. Yes – a lot of difficulty d. Cannot do at all
6. Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?	a. No – no difficulty b. Yes – some difficulty c. Yes – a lot of difficulty d. Cannot do at all

Note: there is an extended questionnaire as well but typically the short set of questions are used to assess disability.

Session 11.5

Common challenges and effects of disability on older people



Facilitation steps

Step 1: Ask the participants to list down common effects of disability that they know

Step 2: List their responses on a flip chart

Step 3: Summarise their responses with the following key notes



Facilitator's notes:

Older people may experience difficulties as a result of disability. These can be categorized into:

1. Difficulties of Activities of daily living (ADLs)	• Challenges in dressing • Challenges in managing one's personal appearance • Difficulty in toileting • Challenges in bathing
2. Difficulties of Instrumental Activities of Daily Living (IADLs)	• Challenges in carrying out household activities • Challenges in preparing meals • Challenges going around e.g. shopping • Challenges in using phone • Challenges in taking medication • People with disabilities may find getting jobs harder because proper adjustments aren't made or as a result of stigma and discrimination.
3. Socioeconomic difficulties	Where there aren't social protection schemes in place to provide financial support to older people with disabilities they may find themselves living in poverty or more difficult circumstances. People with disabilities may face higher costs, as a result of higher medical bills, need for assistive devices, and specialist equipment.

Session 11.6

Support for older people with disabilities



Facilitation steps

Step 1: Ask the participants to discuss how to support an older people with a disability/ies

Step 2: Give a summary of the discussion with additional points from the facilitator's notes



Facilitator's notes:

Supporting people with disabilities

- Having a good understanding of the disability
- Refer the older person with disability to the nearest health facility for further management
- Screening and identification of suitable assistive technologies – see session below for more detailed introduction to assistive technologies and products.
- Assist the older person with disability to acquire appropriate assistive devices, more information is available below.
- Conduct a home assessment, to provide advice and assist in modify the home environment to avoid falls e.g. avoid slippery floors, minimizing obstructing objects; structural modifications e.g. sanitary facility, kitchens, utensils, furniture, doors, fix supporting rails
- Adjust living arrangements where feasible e.g. live downstairs, move to a conducive neighbourhood, supported housing etc.
- Referral and navigating services are also key. I.e. health and social service referrals, helping them to get to appointments, other community based organisations that might help, applying for any benefit that might be available etc.

Providing care for older people with disabilities

- Advice on acceptance and adaptation
- Educate the family and caregiver on type of disability, care and rehabilitation
- Encourage older people to be physically active
- Advise on support and services available and how to access them, including assistive products.

Assistive technologies

- Assistive technology is an umbrella term covering the systems and services related to the delivery of assistive products and services.
- Globally, more than 2.5 billion people need one or more assistive products.
- With an ageing global population and a rise in noncommunicable diseases, more than 3.5 billion people will need at least one assistive product by 2050, with many older people needing two or more.
- Use of assistive technology can be particularly challenging for older people who may find their needs for assistive technology changing rapidly.

(<https://www.who.int/news-room/fact-sheets/detail/assistive-technology>)

Access to assistive technologies contributes to ensuring the inherent dignity and worth of every person is achieved, in doing so aligning with international frameworks such as the United Nations Convention on the Rights of Persons with disabilities (CRPD). Individuals with disabilities have the right to live independently, participate actively in their communities, and enjoy the highest attainable standard of health and well-being.

Assistive technologies and products play a crucial role in translating these rights into tangible opportunities for empowerment. Assistive technologies and products aim to break down barriers and enable individuals with disabilities to exercise their rights on an equal basis with others. Whether it be in education, employment, or daily living, the deployment of assistive technologies contributes to fostering an inclusive society where diversity is celebrated, and everyone can reach their full potential.

Assistive technologies are one example of ways in which to influence healthy ageing and functional ability.

WHO provides advice and training in the use of assistive products, if this is a priority area for the training you are conducting, we recommend reviewing, translating and utilising the training resources available here - <https://www.gate-tap.org/>

A short introduction to assistive products module is included below:



Facilitation steps

Step 1: Introduce the topic using the information below.

Assistive products are products used by people to carry out tasks they may not otherwise be able to do well, or at all. People with disabilities may benefit from assistive products as they play a role in improving the accessibility of the environment in which everyone lives. Assistive products contribute towards enhancing the independence and quality of life for individuals with disabilities.

In an earlier module, we practiced using the Washington short set of questions, this screening tool could also help in identifying needs for assistive products. For example, if someone has stated they have difficulty seeing, we could suggest they see an optometrist and provided with spectacles.

Top facts:

- Assistive products can be used by people of all ages.
- There are many types of assistive products that help people in different areas of their life, such as: thinking, communicating, hearing, seeing, moving around, and self-care.
- Examples of assistive products include; hearing aids, wheelchairs, communication aids, spectacles, prostheses, pill organizers and memory aids.

Question for participants in pairs/small groups – how might a community health volunteer play a role in supporting somebody to receive and use an assistive product?

Step 2: Discuss answers – some key points for consideration could include;

- Talking to the individual about their wants and needs.
- Providing information on the sorts of assistive products available.
- Discussing with individuals about the issues they are facing.

Though many assistive products should be recommended and fitted by a professional, lots of people have a role to play in providing assistive products, including:

- o the person who needs an assistive product
- o Their family and friends
- o People who refer those who need assistive products to a service
- o Trained service providers
- o People in the community

Step 3: Provide this short quiz (answers included below) - take time to discuss the answers following the quiz. (quiz questions are taken from WHO gate-tap website)

Question 1:

John uses glasses to help him read.

Anita has had a stroke and uses a walking stick to help her move around independently.

Anya has a hearing impairment and uses a hearing aid.

John, Anita, and Anya are all using assistive products.

Is this statement:

- A. True

- B. False
- C. Do not know

Correct answer: true – discussion point – there are a wide range of assistive products available, and many people use assistive products in their day to day lives.

Question 2:

Maria has become forgetful. She often forgets what day it is, which makes her feel confused and anxious. Maria could benefit from an assessment for assistive products to help her remember things, such as a whiteboard where her husband can write what day it is.

Is this statement:

- A. True
- B. False
- C. Don't know

Correct answer: true – discussion point – a range of individuals are involved in the identification for and use of assistive products. For example, Maria may have noticed she is feeling confused and forgetful and want to reach out to her doctor for support. Maria's husband could also have noticed and discussed this with her but is also able to support Maria with the use of a whiteboard (assistive product). To get properly assessed Maria will need to discuss with a professional. When determining which assistive product is appropriate, it is important that Maria makes the decision about what she would like to use to assist her, having been presented with suitable options.

Question 3:

A person may use more than one assistive product?

Is this statement:

- A. True
- B. False
- C. Don't know

Correct answer: true – discussion point – any individual may use a range of products to suit their individual needs.

Summary

Disability is a part of being human and almost everyone will experience it at some point in their life.

Disability results from the interaction between individuals with a health condition or impairment, with personal and environmental factors.

Inaccessible environments create barriers that often hinder the full and effective participation of persons with disabilities in society on an equal basis with others.

Disability is any condition that restricts everyday activities, it can affect a person's ability to communicate, interact with others and get about independently.

Disability can be permanent or temporary.

As people get older, they are likely to experience one or different forms of disability.

The Washington group of questions is a set of simple questions that can be used to screen for disability as well as monitor prevalence of people with disability in the community.

Assistive technology and products play a crucial role in enhancing the independence, functionality, and overall quality of life for individuals with disabilities. Assistive products are able to address a range of challenges associated with mobility, communication, sensory impairments, and others. The significance of assistive technology lies in its ability to break down barriers, providing people with disabilities the means to actively participate in education, employment, and social activities. Assistive products promote inclusivity and equal opportunities, fostering a more accessible and accommodating environment.

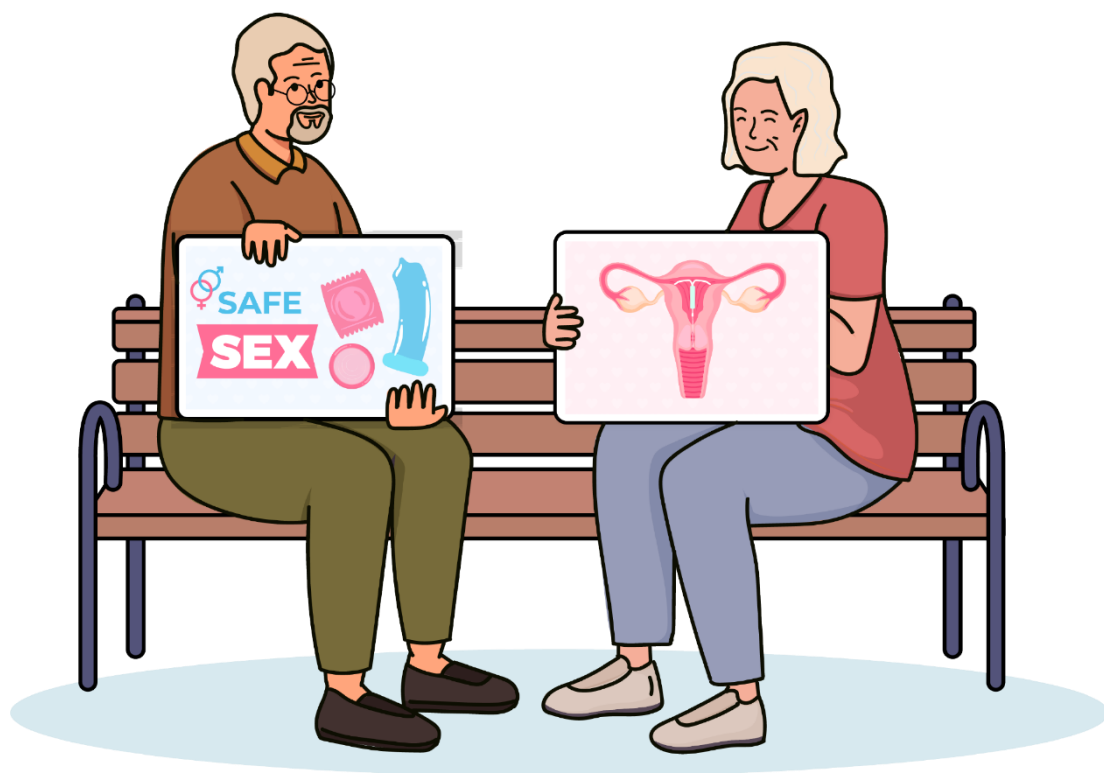
It is important for CHV to understand disability and how to support people with disabilities in the community. By being aware of needs and challenges faced by older people with disabilities, CHV can help promote inclusion and accessibility in the community.

Additional resources

1. More information on Washington Group Questions - <https://www.washingtongroup-disability.com/>
2. Further information including on assistive technology - <https://www.who.int/news-room/fact-sheets/detail/assistive-technology>
3. WHO -Disability overview - https://www.who.int/health-topics/disability#tab=tab_1
4. Training in safe and effective provision of assistive products - <https://www.gate-tap.org/>

Module 12

Sexual and reproductive health



Introduction

Sexual and reproductive health is a crucial component of health that encompasses the right to access information, services, and resources related to sexual and reproductive health and care services. In many contexts, cultural and social norms make discussing sexual health and sexual activity difficult and this has repercussions for people's health as conditions may go ignored, it may also affect people's mental health. It is possible to encourage open conversations about sexual and reproductive health whilst being respectful of cultures and beliefs, and this can help breakdown barriers and stigma.

Relevance to older people

Sexual and reproductive health and rights (SRHR) issues for older people remain a "taboo" in many societies and as such can be ignored or avoided. Improved awareness, education, and conversation is necessary to improve the sexual and reproductive health and wellbeing of older people.

Role of community health volunteers

It is important for CHV to understand the sexual and reproductive needs and rights of older people. CHV play a role in supporting community in accessing information and services they need to make informed decisions.

CHV can play an important role in challenging stigma and breaking down discrimination when it comes to sexual and reproductive health, particularly for older people. CHV can encourage older people to speak openly about their sexual and reproductive health and provide safe spaces for them to do so in a non-judgmental environment. This can help to reduce the taboo and promote greater awareness and mutual understanding.

CHV can help promote access to information and resources that support health and wellbeing as well as make referrals to specialist health providers.

Learning outcomes

By the end of the session participants should be able to;

- Discuss sexual and reproductive health needs of older adults
- Identify and oppose common myths around older adults and sexual and reproductive health
- Discuss human sexuality and SRHR (including values, beliefs and rights) confidently
- Explain physical, hormonal, psychological and emotional changes related to SRHR in old age.
- Discuss sexually transmitted infections (STI) including HIV&AIDS, Hepatitis B virus (HBV) among older people.

- Discuss SRHR challenges and population health interventions

☒	Evaluation:	Pre and post session discussion
☒	Teaching method:	Lecture, small group work,
☒	Materials:	Flipcharts, pen and paper

Session 12.1

Sex, gender, and sexuality



Facilitation steps

Step 1: Ask the participants to get into small groups

Step 2: Ask the groups to write down their definition of; sex, gender and sexuality on a flip chart

Step 3: Ask each group to present their findings in plenary

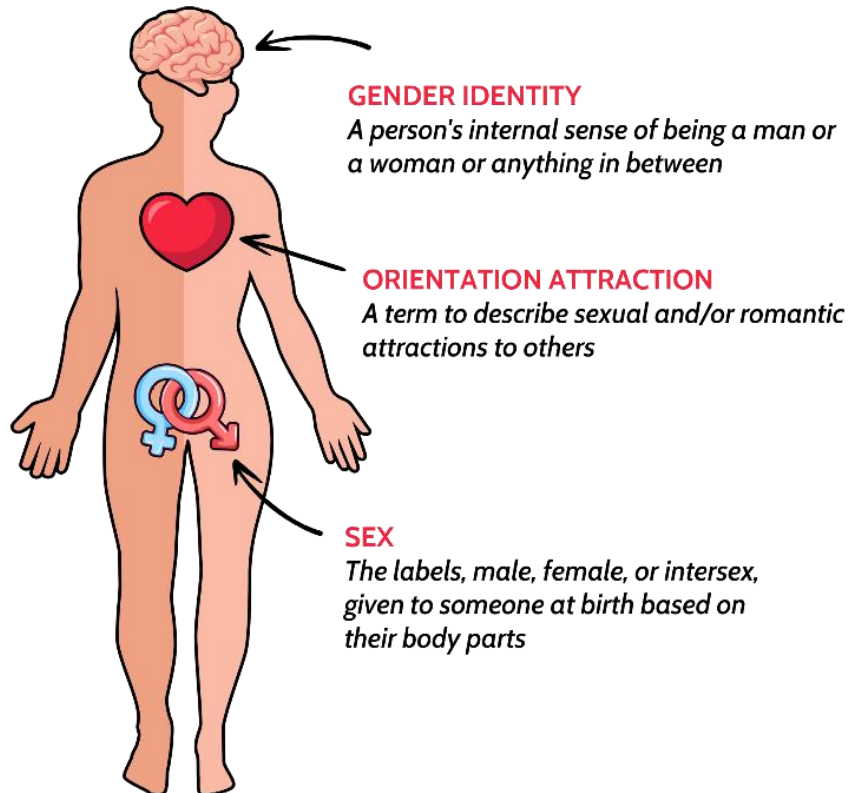
Step 4: The facilitator summarises their responses with the following key notes



Facilitator's notes:

- **Sex:** The distinguishing property, quality, or grouping of properties by which organisms are classified as female, male, or inter-sex on the basis of their reproductive organs and functions.
- **Gender:** The sociocultural phenomenon of the division of people into various categories according to their biological sex, with each having associated roles, clothing, stereotypes, etc.; those with male sex characteristics are perceived as "boys" and "men," while those with female sex characteristics are perceived as "girls" and "women."
- **Sexuality/Orientation/Attraction:** People's sexual interest in and attraction to others; their capacity to have erotic experiences and responses.

SEX, GENDER and SEXUAL ORIENTATION



Sexuality and ageing

As people age, all the systems in the body age including the reproductive health system and organs. The functioning of the reproductive system slows down and this brings about changes for all older people. This does not mean that older people do not or should not continue to enjoy sex.

What do you expect as you age?

Many people enjoy their sexual relationships into their eighties and beyond. Everyone's sexual experiences differ.

- Normal ageing also brings physical changes that can sometimes interfere with the ability to have sex.
- As people age, bodies change including weight, skin and muscle tone
- Some older people do not feel comfortable in their ageing bodies. They worry that their partner will no longer find them sexually attractive.
- Health problems can affect and decrease sex drive. This may also affect one's ability to become sexually aroused.

Session 12.2

Myths about sex and ageing



Facilitation steps

Step 1: One by one read out the statements in the **Myth** column below - ask participants to share whether they think it is true or false - ask them to share why.

Step 2: Responding using the information in the **Fact** column



Facilitator's notes:

Myth	Fact
Sex is for the young.	Sex does not belong solely to the young. People don't "age out" of being sexual. It is inherent throughout the aging process and even associated with good health! Sexual expression fulfills a natural desire and can connect people, provide opportunities for affection and passion and build or enhance relationships. Changes within the aging body can alter or complicate sexual expression and declines in sexual functioning may occur, but desire and interest remain. The use of medications to treat sexual dysfunction in both men and women has made it possible for people to remain sexually active late into life.
Residents of nursing facilities can't have sex.	Relocation to a nursing facility doesn't result in the end of a sex life. Residents should be guaranteed certain rights. Facilities must promote these rights in a manner that enhances residents' quality of life and ensures dignity, choice and self-determination, while affording them privacy and opportunity to engage in safe and consensual sexual expression.

Nursing facility residents with dementia or Alzheimer's shouldn't have sex.	Residents with cognitive impairments, such as dementia and Alzheimer's, have the same rights as other nursing facility residents. When a cognitively impaired resident indicates the desire to be sexually expressive, it becomes necessary for the resident's interdisciplinary care team to assess the level of capacity to determine the benefits or potential harm associated with the expression. Each sexually related occurrence is unique and should be looked at individually.
Sexuality in later life is undignified.	It's healthy for older adults to express their sexuality. People are living longer and remaining healthier. And they are more vigorous than ever before. Unfortunately, society is inclined to desexualize older adults, when older adults do express their sexuality, it's often viewed with disdain.
People with disabilities can't have sex	People with disabilities can enjoy sex, just like anybody else. They have the same rights and desires to express their sexuality. Depending on the disability, there may be additional challenges such as physical limitations. It is important to recognize that individuals with disabilities have the right to make their own choices regarding their sexual activity and should be supported with the access and resources they need to do so in a safe way.

Session 12.3

Physical, hormonal, psychological and emotional changes related to SRHR during old age.



Facilitation steps

Step 1: Provide introduction to the topic - older age is a period that is characterised by physical, hormonal, psychological and emotional changes. The changes occur at different times for different people. The changes don't happen the same way with everyone. Individuals adjust to ageing differently, those who fail to adjust 'successfully' might develop various emotional problems.

Step 2: Describe for participants the changes outlined in the table below.



Facilitator's notes:

Physical changes	
Older Women: • Reduced self-lubrication of the vagina during sexual activity • Vaginal walls are less elastic • Reduced sex drive • Reduced muscle mass which results in shrinking and sagging of sexual organs including breasts • Menstrual flow declines and stops all together • Inability to conceive after menopause	Older Men: • Difficulty in getting and sustaining an erection • Lower sperm production • Reduced sex drive • Less strong erections • Enlargement of the prostate Note: An older man is still able to reproduce children

Emotions associated with changes related to SRH in older people

Times of significant change can be difficult for people to process, this may result in a number of emotions and coping mechanisms. Older people should be reassured that these are all normal.

Some things to look out for...

- Denial; Some older people cope by refusing to acknowledge that changes have occurred in themselves and fail to seek appropriate care.
- Guilt; some older people may blame themselves and suffer social isolation and depression.
- Loneliness; Older people might isolate themselves as a way of coping, but this might cause loneliness and lead to more severe emotional or mental health problems.
- Sense of helplessness; some older people might feel that they are useless, helpless and at the mercy of their physical problems, changes in living arrangement or negative events. This sense of hopelessness and helplessness might manifest in strained relationship challenges with partners, including sexual relationships.

Session 12.4

Common sexually transmitted infections, prevention and care

12.4.1 Background



Facilitation steps

Step 1: Explain to participants that it is possible to get a sexually transmitted infection at any age, and it is important that older people are aware of how to recognise symptoms, take preventative measures and seek care or medical treatment where necessary.

It will be important to reiterate that this topic can be particularly difficult for anyone to talk about, and that it is necessary to reassure individuals of their confidentiality, how these conditions are very normal and not something to be embarrassed about, but that it is important to see a doctor or nurse.

Step 2: Ask participants if they are aware of any common symptoms of STI. People may not be forthcoming with this topic because of internalised stigma, so it may be necessary for the facilitator to lead the discussion.



Facilitator's notes:

Common signs of STIs include:

- redness or soreness of the genitals,
- pain during urination,
- cloudy urine,
- strong-smelling urine,
- a sore or blisters (painful or painless) on or around the genitals, near the anus, or inside the mouth,
- excessive itching or rash,
- abdominal cramping/pain,
- slight fever, and,
- general sick feeling.

Step 3: Ask participants if they are aware of any STI. People may not be forthcoming with this topic because of internalised stigma, so it may be necessary for the facilitator to lead the discussion.



Facilitator's notes:

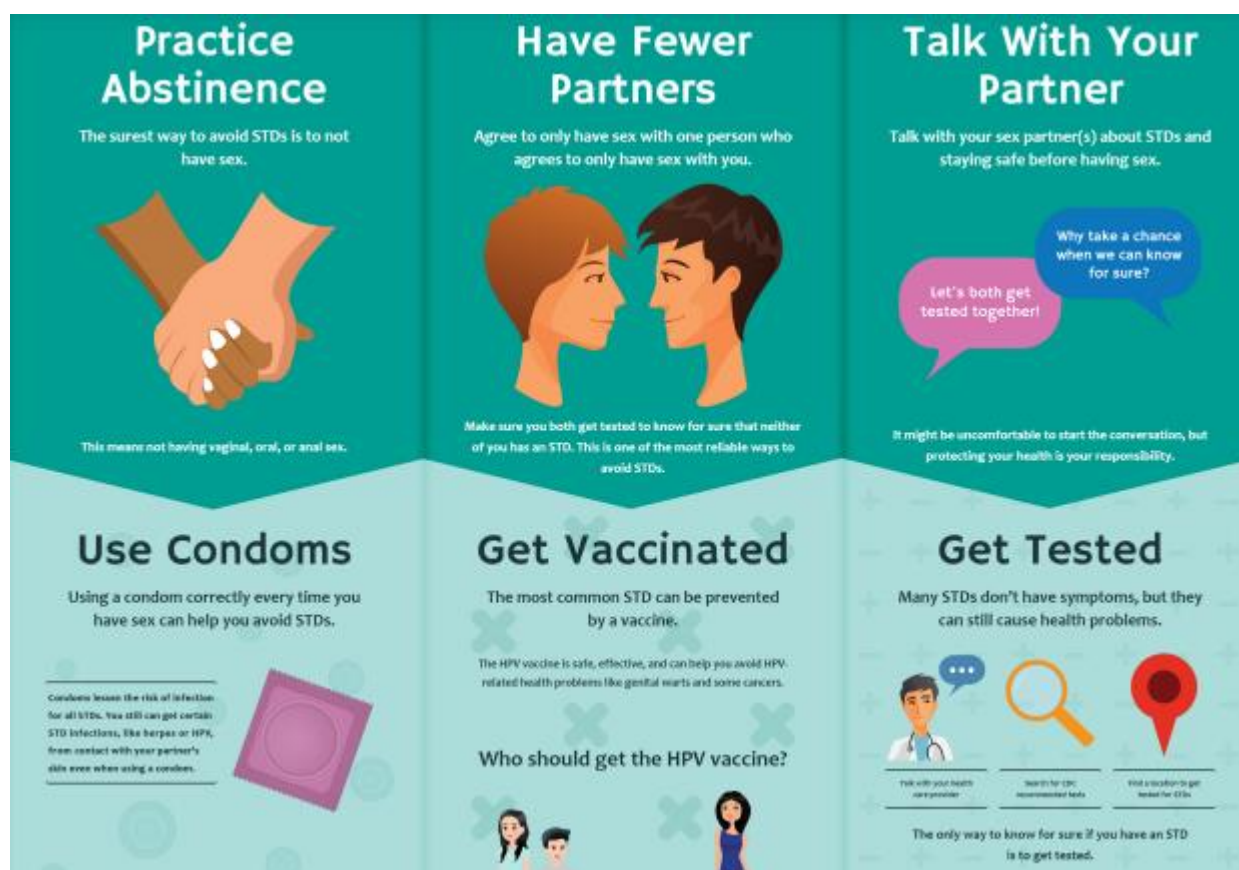
Common STI include;

- **Chlamydial Infection;** abnormal vaginal discharge burning during urination
- **Genital Herpes;** No or only minimal signs or symptoms - one or more blisters on or around the genitals or rectum
- **Genital Warts;** Small, hard painless bumps in the vaginal area or around the anus
- **Gonorrhoea;** Vaginal discharge or vaginal bleeding between periods
- **Syphilis Chancre;** a painless open sore that usually appears around or in the vagina
- **Hepatitis B;** Presents as acute and chronic phase, with acute symptoms and signs including general fatigue, loss of appetite, nausea, vomiting, abdominal pain, low-grade fever, jaundice, enlarged liver and spleen, anaemia and skin rash. The chronic phase manifest as liver cirrhosis, jaundice and varied manifestation of liver failure

Important note 1: many sexually transmitted disease or infections are highly stigmatised, CHV should take away from this session that they should challenge negative stigma around STD.

Important note 2: Some STI may have minimal or no symptoms and therefore testing is important, particularly after unprotected sex with a new partner.

12.4.2 Prevention



Source: [CDC](#)

Step 1: Ask the participants whether SRHR information and advice is provided in communities where they live or work? Ask them to reflect how likely it is that older people would have received SRHR education?

Step 2: Ask the participants to discuss what they know about prevention of STIs.

Step 3: Ask participants to report back in plenary.

Step 4: The facilitator summarizes their responses with the following key notes



Facilitator's notes:

- Abstinence
- Having fewer sexual partners lowers risk
- Use of condoms
- Vaccination
- Screening, Early diagnosis and treatment
- Contact tracing
- Compliance to treatment

Myths	Facts
STIs are all curable	Some STIs such as HIV and some forms of Herpes are not curable though people taking appropriate medication can live long and healthy lives with no symptoms, depending on availability of treatments. Many STIs are curable, depending on the availability of treatment.
It is not important to discuss sexual health with my doctors	It is important to tell the truth to your caregiver/ doctor/ trusted person when you experience any signs and symptoms of STIs so that you can get help.
I can stop taking my medication as soon as I feel better	If you are given medication, make sure you finish all the medicines that you have been given by the doctor. Do not prescribe medicine for yourself.
Condoms don't work	Condoms are effective in reducing the risk of STIs as well as unwanted pregnancies. If you suspect that you have an STI, seek support from your health care provider/counsellor.

Session 12.5

HIV & AIDS

(Page 1 is in English, Page 2 is in Spanish) June 2021

HIV 101

Without treatment, HIV (human immunodeficiency virus) can make a person very sick and even cause death. Learning the basics about HIV can keep you healthy and prevent transmission.

HIV CAN BE TRANSMITTED BY



Sexual Contact



Sharing Needles to Inject Drugs



Mother to Baby During Pregnancy, Birth, or Breastfeeding

HIV IS NOT TRANSMITTED BY



Air or Water



Saliva, Sweat, Tears, or Closed-Mouth Kissing



Insects or Pets



Sharing Toilets, Food, or Drinks

PROTECT YOURSELF FROM HIV

- Get tested at least once or more often if you are at risk.
- Use condoms the right way every time you have anal or vaginal sex.
- Choose activities with little to no risk like oral sex.
- Don't inject drugs, or if you do, don't share needles, syringes, or other drug injection equipment.



- If you are at risk for HIV, ask your health care provider if pre-exposure prophylaxis (PrEP) is right for you.
- If you think you've been exposed to HIV within the last 3 days, ask a health care provider about post-exposure prophylaxis (PEP) right away. PEP can prevent HIV, but it must be started within 72 hours.
- Get tested and treated for other STDs.



KEEP YOURSELF HEALTHY AND PROTECT OTHERS IF YOU HAVE HIV

- Find HIV care. It can keep you healthy and help reduce the risk of transmitting HIV to others.
- Take your HIV medicine as prescribed.
- Stay in HIV care.



- Tell your sex or injection partners that you have HIV. Use condoms the right way every time you have sex, and talk to your partners about PrEP.
- Get tested and treated for other STDs.

For more information, please visit www.cdc.gov/hiv.



Source: CDC



Facilitation steps

Step 1: Split into small groups and provide each group with a piece of flipchart paper

Step 2: Ask the participants to divide the paper in 4 and discuss and make notes on;

1. cause and transmission,
2. prevention,
3. testing and screening

4. care and treatment

Step 3: Let the participants present what is written in flip charts in the plenary.

Step 4: The facilitator summarises their responses with the following key notes



Facilitator's notes:

Cause and transmission

- The HIV infection is caused by the human immunodeficiency virus (HIV)
- Acquired Immune Deficiency Syndrome (AIDS) is a collection of diseases that a person gets when their immune system weakens as a result of HIV
- HIV is spread when blood, semen, or vaginal fluids from an infected person enter another person's body, usually through sexual contact, from sharing needles when injecting drugs, or from mother to baby during birth.
- The person-to-person spread of HIV is called HIV transmission. HIV is spread only in certain body fluids from a person who has HIV: Blood, Semen, Pre-seminal fluids, rectal fluids, vaginal fluids, Breast milk.
- Mother to baby transmission of HIV is during pregnancy, labor, delivery or breastfeeding

Prevention

- Being faithful to one uninfected partner
- Get tested and know your partner's HIV status
- Choose less risky sexual behaviours, limit the number of sexual partners, get tested and treated for STDs.
- Correct and consistent use of condoms - unprotected sex with an infected person can lead to HIV infection. Other forms of contraception such as the pill do not provide any protection against HIV/AIDs or other STI.
- Talk to your health care provider about pre-exposure prophylaxis (PrEP) and post exposure prophylaxis
- Don't share needles
- Anyone, including older people, can contract HIV
- Knowing one's HIV status is important because if one is negative, they can use protection to stay HIV negative, and if one is positive they can enrol for treatment
- Both males and females are vulnerable to HIV infection
- Abstain

Testing and screening

- Health facilities or mobilisation centres
- Door to door testing
- Self-testing

Care and treatment

- Proper HIV care and treatment enables one to live a healthy and productive life
- Antiretrovirals (ARVs) - medications used to treat HIV.
- Counselling and support
- Adherence to treatment

Session 12.6 **Challenges of SRHR among older people**



Facilitation steps

Step 1: Divide participants into groups

Step 2: Pin the flip charts on the wall

Step 3: Ask participants to list and discuss challenges related to SRHR faced by older people

Step 4: Ask the participants to present what is written in flip charts in the plenary.

Step 5: The facilitator summarises their responses with the following key notes



Facilitator's notes:

- The neglect of SRHR is seen across the health system spectrum right from policy and programmatic levels to health care delivery.
- With increasing women empowerment and acknowledgment of their rights there is increased respect for women's autonomy in sexual and reproductive health decisions. Such rights include seeking and enjoying sexual intimacy. This is sometimes viewed as challenging the traditional male role of dominance, resulting in interpersonal gender conflict.
- Reproductive Health programs recognize that "older women and men have distinct reproductive and sexual health issues which are often inadequately addressed"
- There has been a narrow focus on medical aspects of erectile dysfunction
- Ageism and sexism contributes to older women's invisibility and the neglect of their needs
- Research on the sexuality of older sexual minority groups is very limited, and their needs ignored, with persistent societal SRHR biases.
- The neglect of SRHR is seen across the health system spectrum right from policy and programmatic levels to health care delivery.

Interventions

- A holistic, integrated care and multidisciplinary life cycle approach to health services is required to meet the SRHR needs of older people
- Specific elements include education, advocacy, ensuring safer sex e.g. through correct and consistent use of condoms), appropriate use of contraception etc.

Step 6: Ask participants to return to their groups and discuss ways of addressing sexual concerns, amongst older people.

Step 7: Ask a representative from each group to report back in plenary



Facilitator's notes:

Ways of addressing sexual concerns amongst older people

- 1) It is important for one to recognize and accept ones condition as a natural way of ageing and learn how to live and manage it.
- 2) Seek for support where possible.
- 3) Change lifestyle;

- **Communicate with your partner;** to discuss both partners' desires and limits to having a healthy and fulfilling sex life.
- **Practise safe sex;** prioritise sexual health free of STIs/STDs.
- **Expand your own definition of sex;** as people age, it's normal to have to adjust to new physical and sexual abilities. Adopt several ways to be intimate—sex is only one of them, including touching, holding, and kissing as intimate aspects of a relationship.
- **Change your own routine;** making a few changes to your usual sexual routine could improve your sex life. For instance, if it is taking longer for you or your partner to get aroused, consider concentrating on foreplay or setting a romantic scene before having intercourse.
- **Maintain healthy habits;** Taking care of every part of your health could help you perform at your best sexually. Eating a healthy diet, exercising and bathing regularly, avoiding too much alcohol, and not smoking are all ways you can maintain your health and libido.
- **Consider counselling/sex therapy;** to help both partners communicate their sexual needs and concerns more effectively.
- **Talk to a health worker:** to figure out if any underlying health conditions (chronic conditions and medications) are impacting on sexual ability or sexual desire.

Step 8: Role play – it is particularly useful for CHV to have an opportunity to practice discussions which may be more difficult to have, role play during these sessions is a good way to achieve this.

Ask participants to split into pairs, in these pairs one person should be assigned the role of an older person with a sexual health concern, and the other person the CHV. Ask

them to practise what they may say or how they may discuss the issue. They should switch so both participants get an opportunity to play the role of CHV.

Step 9: Ask participants to feedback in plenary how they found the role play, if any parts were particularly challenging, and discuss as a group how to have these conversations.

Summary

Sexual and reproductive health is important for all ages

Physical and emotional changes occur during old age that can affect sexual health

Older people can still enjoy sexual relationships and should be reassured about changes in their bodies

It is important for older people to be aware of sexually transmitted infections and how to prevent and seek care for them.

There is a lot of stigma related to sexual health among older adults, and discussing these topics and sharing information is important for breaking down some of these barriers.

Community health volunteers can play a role in promoting sexual and reproductive health for older people.

Additional resources

1. Sexual health and wellbeing in later life
<https://extranet.who.int/agefriendlyworld/afp/sexual-health-and-wellbeing-in-later-life/>

Module 13

Palliative Care



Introduction

Palliative care is an aspect of healthcare that aims to improve the quality of life of individuals with life-limiting illnesses, including but not only at the end of life. It involves the management of physical, emotional, and spiritual symptoms, as well as the provision of psychosocial support for individuals and their families.

Relevance to older people

Palliative care is particularly relevant to older people, because;

- Older people are more likely to have life-limiting illnesses
- Older people have an increased need for symptom management. Older people may experience a range of physical and psychological symptoms associated with their illness, these can include pain, fatigue, anxiety, and depression. Palliative care can help with the management of these.
- Palliative care should prioritise respect, and the autonomy and dignity of older people. Older adults may have unique needs and preferences related to their care, which should be respected. At the centre of good palliative care is ensuring older people take the lead in making decisions related to their care, where this is possible.

Role of community health volunteers

Community health volunteers play an important role in supporting individuals in communities with life-limiting illnesses or in supporting people at the end of life. CHV may also provide practical and emotional support to the families of older people who are in need of palliative care. This section of the manual focuses on a basic understanding of palliative care, common palliative care needs, and interventions that can help support individuals and families. Crucial to the Role of community health volunteers is ensuring individuals are able to end their lives with dignity and in comfort. Some specific tasks a community health volunteer might do, could include;

- Identify older people with palliative care needs
- Provide emotional support throughout the course of a terminal illness.
- Provide continuum of palliative care from hospital to home.
- Regularly assess the needs of family members helping to care for an older person with life limiting or terminal illness.
- Deliver material support to at risk or poor families such as food, fees, household items etc.
- Refer older people for palliative care in a timely fashion.

Learning outcome:

By the end of the session, participants will be able to;

- Confidently define palliative care and end of life care
- Discuss key elements, principles, types and benefits of palliative care.
- Describe the role of a CHV in delivering palliative care
- Understand the basics of advance directives and care planning
- Understand the importance of dignity and autonomy of older people in their palliative care decisions

☒	Evaluation:	Pre and post session discussion
☒	Teaching method:	Discussion, small group work
☒	Materials:	Flip chart, pen and paper

Session 13.1

Definition and types of palliative care



Facilitation steps

Step 1: Ask the participants to discuss their understanding of palliative care

Step 2: List their responses on a flip chart

Step 3: Summarise with the notes below



Facilitator's notes:

- Palliative care is care that improves the quality of life of patients and their families facing the problems associated with life-limiting illness or at the end of life, through the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychosocial and spiritual.
- Palliative care offers a support system to help the family cope during the patient's illness and in their bereavement;
- Palliative care uses a team approach to address the needs of patients and their families, including bereavement counselling
- Palliative care will enhance the quality of life, and will also positively influence the course of illness;

Principles of Palliative care

1. To relieve pain and other distressing symptoms associated with the disease or its treatment
2. To recognize death and dying as a natural process
3. To neither prevent nor promote death each persons' timeline is different
4. To inform the persons care through spiritual and psychological principles
5. To support the patient so they may continue to live their best life

Step 4: List the following six essential elements of quality palliative homecare, ask participants to reflect on what they understand each area (facilitators notes for discussion are included in brackets after each element).

1. Integrated teamwork;
(**facilitators notes:** palliative care is usually provided by a team, which includes doctors, nurses, social workers and other specialists. Teams need to work together to provide care across the spectrum of needs, which can be physical, emotional, and spiritual)
2. Management of pain and physical symptoms;
(**facilitators notes:** pain and other physical symptoms are common in patients with serious illness. Palliative care providers are trained to care for these needs via medication, physical therapy, and other methods, with the goal of helping patients feel as pain-free as possible. CHV should not attempt to prescribe medication, but they can suggest patients see a doctor if they are in any pain or refer them to other services, reassuring people that they don't have to live in pain is also a role a CHV can play).
3. Holistic care (spiritual, religious, cultural and traditional practices)
(**facilitators notes:** palliative care is more than just treating physical conditions, it recognises that people have physical, emotional, and spiritual needs. CHV can help people by discussing with them their spiritual, religious, and cultural practices that they may want to incorporate into their package of treatment)
4. Caring, compassionate, and skilled providers;
(**facilitators notes:** palliative care providers are trained to provide care that is compassionate, empathetic, and respectful. Important skills for palliative care providers are active listening and communication (as covered in Module 3).)
5. Timely and responsive care;
(**facilitators notes:** they are available to answer questions, provide support, and adjust care plans as situations evolve, CHV can provide flexible support and be available at short notice, but CHV must also take careful measures to care for themselves as well; providing palliative care can mean confronting difficult situations and topics and so it can be mentally and physically challenging)
6. Patient and family preparedness;
(**facilitators notes:** palliative care providers work with patients and families to

help prepare them for the future, this can include things like discussing advance care planning and making sure patients and families understand their options. CHV are trusted members of the community and people may feel more comfortable talking to them, as such CHV can help communicate the wishes of people under palliative care, ensuring their needs are met, and help ensure they feel empowered and informed throughout their care journey.

Step 5: Discuss volunteer roles - ask participants to think about what kind of roles volunteers could play in providing palliative care.

Discuss using key notes below:

- Visiting the home to provide companionship and psychosocial support.
- Relaxation techniques: Teach the older people' various methods of relaxation like walking, listening to music, meditation, prayers, dancing, yoga, art and crafts etc
- Emotional and spiritual support: Help patients express their emotions and how to cope with their emotions. Spiritual support is in the form of an individual's faith community that they belong to.
- Assistance with medical appointments and access into the community for shopping or other errands.
- Social support at home including assistance with the support of children.
- Respite support by attending the home while formal carer is away or on break.
- Assistance where socio-demographic or cultural barriers exist.
- Visits to a person when they attend hospital as an inpatient.
- Bereavement support

Benefits of palliative care

- Allows patients to spend more time at home and reduces the number of hospital inpatients days
- Improves symptom management
- Provides patient, family and caretakers satisfaction
- Reduces overall cost of care.
- Supports survivorship.
- Improves quality of life of patients and family

Session 13.2

Advanced care planning



Facilitation steps

Step 1: Ask this question to the group 'Hands up everyone in the room who is going to die?'

Step 2: Ask the question 'Hands up who has had a conversation or made plans about their death and dying?'

The point of asking these two questions is to get the conversation started, and encourage the understanding that death is something that affects everyone.

Step 3: Introduce the concept of advanced care planning:



Facilitator's notes:

In simple terms, advanced care planning is a process that helps individuals think, talk about and make decisions about the kind of care they would like to receive should they become seriously unwell or unable to make decisions for themselves.

Advanced care planning involves discussing your values, goals, and preferences with your loved ones and healthcare providers, and documenting these into a legal document. This is called an **advanced directive**.

Advanced care planning enables somebody to ensure they receive the care they want and helps maintain autonomy even in the final stages of life. It also helps families to ensure they support their loved ones at the end of life according to their wishes and preferences.

Step 4: Describe in more detail the steps involved in advance care planning:

- Getting information on the types of life sustaining treatments that are available.
- Deciding what types of treatments you would or would not want should one be diagnosed with life limiting illness or an illness that limits one's capacity to make decisions.
- Sharing personal values with the older person's loved ones.
- Completing advance directives to put into writing what types of treatment you would or would not want- and who you choose to speak for you- should you be unable to speak for yourself - as CHV you may want to help an older person identify legal support or similar who can help with these sorts of documents.

Step 5: Ask participants to discuss outcomes of advanced care planning



Facilitator's notes:

- Higher satisfaction with the quality of care which is likely due to improved communication between patient, family or other decision-makers, and the patient's clinicians resulting in shared decision-making;
- Better preparation on what to expect during the dying process.
- Lower risk of stress, anxiety, and depression in surviving relatives of deceased persons likely because most patients and families/loved ones welcome these discussions and feel better prepared to make decisions for their loved one

Step 6: Ask participants to discuss what role they think CHV could play in advanced care planning.

Discuss with facilitator's notes:

- CHV can promote the importance of planning for end of life care
- CHV can provide information about advanced care planning, including the benefits of planning ahead and what to consider
- CHV can facilitate conversations between individuals and their families or healthcare providers
- CHV can follow up with individuals and families to ensure that their wishes and goals are being cared for and respected.

Summary

Palliative care aims to improve the quality of life of individuals with life-limiting illnesses.

It involves managing physical, emotional, and spiritual symptoms and providing psychosocial support for individuals and their families.

Palliative care offers a support system to help the family cope during the patient's illness and in their bereavement.

Palliative care should prioritize respect, autonomy, and dignity of older people.

Benefits of palliative care include allowing patients to spend more time at home, improving symptom management, providing patient, family, and caretaker satisfaction, reducing overall cost of care, supporting survivorship, and improving the quality of life of patients and families.

Advance care planning enables individuals to identify their values, reflect upon the meanings and consequences of serious illness scenarios, define goals and preferences for future medical treatment and care, and discuss these with family and healthcare providers.

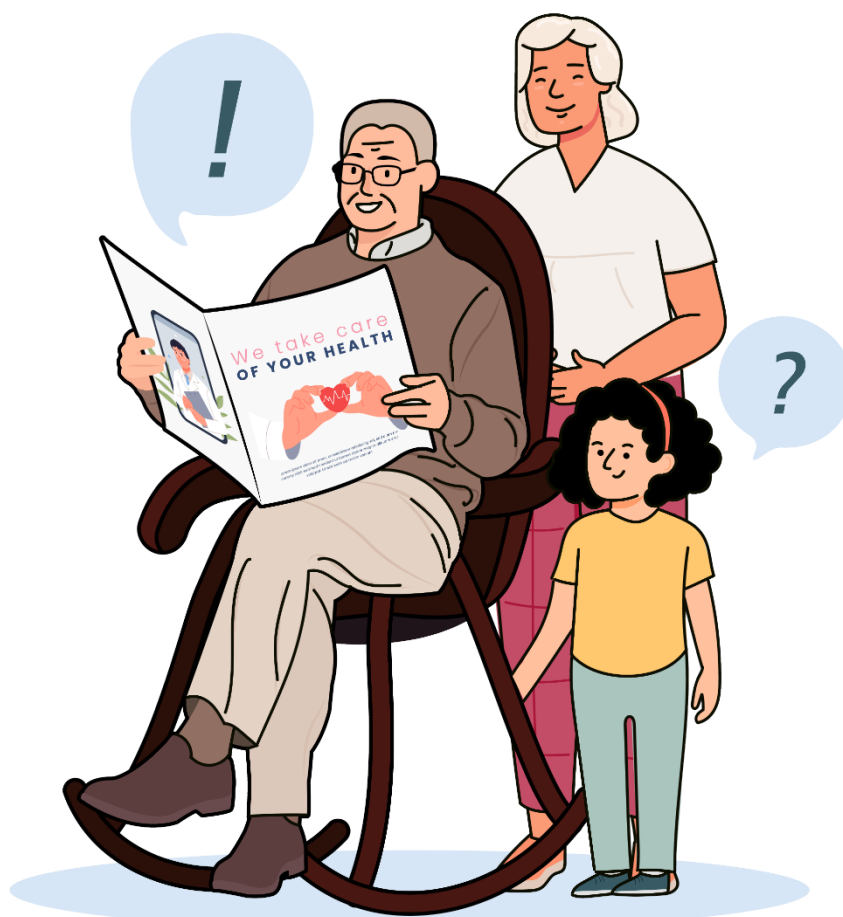
Community health volunteers play an important role in supporting individuals in communities with life-limiting illnesses by providing practical and emotional support to individuals and families of people in need of palliative care.

Additional resources

1. Palliative care in emergencies:
<https://www.google.com/url?q=https://academic.oup.com/book/33118/chapter/284160912&sa=D&source=docs&ust=1683712714210218&usq=AOvVaw1CIOTfJgLV6xQBjekm8Zr>
2. Palliative care toolkits and training manual (available in Bengali, Portuguese, Spanish, French, Vietnamese, Russian):
https://thewhpca.org/resource_category/palliative-care-toolkits-and-training-manual/
3. Standards, clinical guidelines and protocols -
https://thewhpca.org/resource_category/standards-clinical-guidelines-and-protocols/

Module 14

Useful care and support services and health information



Introduction

Community Health Volunteers play a critical role in connecting individuals in the community to the care and support services they need to stay healthy. CHV should have some awareness of useful care and support services available in the community, including healthcare facilities, social services and community organisations.

Learning outcomes

After 60 minutes, CHV will understand:

- Older people's rights and entitlements
- Services available in the nearest health station and district health centres [or equivalent]
- The list of health directory and services for reference
- Trusted sources of health Information

☒	Evaluation:	Group discussion
☒	Teaching method:	Group discussion
☒	Materials:	Flip chart, pen and paper

Session 14.1

Accessing health services



Facilitation steps

Step 1: Discuss in groups:

1. To your knowledge which health and social services are older people entitled to according to the government?
2. Are there any other services provided by NGOs or CBO that older people can access?
5. If you have health insurance, what services can you use at the local health station and district health centers that are free of charge?

6. If you don't have health insurance, what services can you use at the local health station and district health centers that are free of charge?

Main contents:

1. Older people rights and entitlements

Older people are entitled to: [Insert local rights and entitlements]

2. What services are available in your area?

[Insert list of commonly available services local to area in which CHV will be operating]

3. What common barriers exist to accessing healthcare services?

Step 1: Ask participants to discuss what they anticipate to be some of the biggest barriers for older people in accessing healthcare.

Step 2: Share the following and ask participants to consider whether these are relevant in their context?

- Services fail to meet the health and care needs of older people or to promote healthy ageing across the life-course
- With a lack of primary health care delivered close to home, accessing services for many older people in low- and middle-income countries is impossible
- Many older people with disabilities find that, even if they can reach health services, they are not accessible
- Medicines, vaccines and assistive technologies are essential for supporting people's intrinsic capacity, functional ability and quality of life. Yet they are often unavailable to older people.
- Access to health-related information and education is a critical determinant of health and wellbeing and a key component of the right to health itself. But older people often lack accessible information and education about their health
- In many countries, the general training for the health and care workforce fails to include geriatrics or gerontology and, in some places, even a basic focus on the types of physical, mental, psycho-social and cognitive health issues faced in older age is missing.
- Older people often face age discrimination that violates their right to access health and care related goods, facilities and services on an equal basis with others. Where discrimination on the basis of age intersects with discrimination on the grounds of other characteristics the impact is compounded

Session 14.2

Accessing health information



Facilitation steps

Step 1: In groups, discuss;

- Where do you get your health information from?
- What ensures you that the information is reliable?

Step 2: Report back in plenary.



Facilitator's notes:

- Not everything we read online, including through google searches, facebook posts, whatsapp messages can be trusted as accurate
- Online content includes a lot of misinformation and so should be believed with caution
- The best thing one can do is consult medical professionals but there are some ways to access high quality information online. For example, Government websites, these can be local to you or elsewhere. The WHO is a good source of reliable information.
- It is important to remember that one's individual health is impacted by many external and internal factors. As such, not everything you read online, even from a reputable source may be related specifically to your circumstances.

Session 14.3

First Aid services

Whilst first aid is one skill it would be useful for community health volunteers to have, first aid techniques should be delivered by a qualified first aid trainer due to the risk of doing more harm than good through improper delivery of lifesaving measures, such as CPR or moving somebody where there is a risk of serious spinal damage.

Organisations such as the International Federation of the Red Cross and national branches of the red cross often provide training free of charge.

The IFRC have an online learning platform with courses that can be completed free of charge – <https://ifrc.csod.com/>

The most important thing for CHV to be aware of is how to call for emergency help when it is needed.

Summary

- Community Health Volunteers (CHV) play a critical role in connecting individuals in the community to the care and support services they need to stay healthy.
- CHV should have awareness of useful care and support services available in the community, including healthcare facilities, social services, and community organizations.
- Online content including that shared by friends may include a lot of misinformation and so should be believed with caution.
- The best thing one can do is consult medical professionals, but there are some ways to access high-quality information online. For example, Government websites, or the WHO
- It is important to remember that one's individual health is impacted by many external and internal factors and that not everything you read online, even from a reputable source may be related specifically to your circumstances.

Index of additional resources