



Achieving Universal Health Coverage fit for an ageing world

HelpAge

International



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Overview

Universal health coverage (UHC) means that everyone, everywhere can access the health and care services they need without suffering financial hardship. Progress towards UHC is essential for promoting healthy ageing, delivering social and economic development, and building resilient and equitable societies that respond effectively in times of crisis.

The commitment of governments to achieve UHC as part of the Sustainable Development Goals aligns directly with their duty to respect, protect and fulfil all people's right to enjoy the highest attainable standard of physical and mental health, which is also indispensable for the exercise of other human rights.

By 2030, 1.4 billion people will be aged 60 or over. Yet the majority of health and care systems worldwide remain unprepared for population ageing and shifting patterns of disease and disability. Millions of older people do not have access to the health and care services they need.

We must harness the opportunity UHC presents to reorient health and care systems and services to meet the needs of an ageing world and uphold the rights of all older people. This means investing in comprehensive, integrated, inclusive and people-centred primary and community-based health and care services that empower people and communities, and promote health and wellbeing for all across the life-course. The impact of COVID-19, climate crisis and wider threats to global health security make achieving UHC for people of all ages even more urgent.

To deliver this vision, governments, service providers and global health actors at all levels must work together to ensure:

1. UHC addresses the specific barriers older people face to enjoying their right to health [↗](#)

Health and care related goods, facilities and services meeting the full continuum of older people's physical, mental, psycho-social and cognitive health and wellbeing needs must be **available, accessible, acceptable and of good quality**, including those focused on:

- Health and wellbeing promotion
- Prevention of disease and disability
- Diagnosis and treatment
- Specialist services
- Rehabilitation
- Long-term care and support
- Palliative and end of life care

2. Systems are age-, gender-, and disability- responsive and promote healthy ageing for all through integrated primary and community-based health and care services that reach the furthest behind first [↗](#)

This includes:

- **Services** [↗](#) Delivering inclusive, integrated and person-centred care through strong primary health care systems, including community-based health and care services that engage and empower people and communities.
- **Workforce** [↗](#) A well-paid, well-trained and well-resourced, multidisciplinary workforce is able to respond effectively to the diverse needs of ageing populations across the full continuum of UHC services.



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- **Medicines, vaccines and assistive technologies** [↗](#) Essential goods and products lists include the tools and technologies recommended for addressing the conditions most common in later life and for promoting older people's intrinsic capacity, functional ability and quality of life.
- **Information and data systems** [↗](#) Data includes all age groups and provides information disaggregated by age, sex, disability, location, and socio-economic status as a minimum, on all components of people's right to health and long-term care and support to inform equity-based decision making.
- **Financing** [↗](#) Those most at risk, including older people with the greatest health and care needs, are prioritised in progress towards increasing financial coverage for the full continuum of UHC services, with the ultimate goal of care being available free at the point of use for all.
- **Governance and leadership** [↗](#) There is political commitment to achieving UHC and healthy ageing at the highest levels, underpinned by legislation and a strong policy framework that protects and promotes the right of people of all ages to health and long-term care and support.

3. Models of UHC adopt a rights-based approach, ensuring the voices of all groups, including older people, are heard within system and service design, delivery, monitoring and evaluation [↗](#)

They must promote the PANEL principles of:

- Participation [↗](#)
- Accountability and transparency [↗](#)
- Non-discrimination and equality [↗](#)
- Empowerment [↗](#), and
- Legality for all at all levels. [↗](#)

HelpAge and network members are part of the solution and are supporting progress to ensure all components of UHC are fit for an ageing world from grassroots to global levels.

See how here. [↗](#)

Introduction

Healthy ageing is the process of developing and maintaining the functional ability that enables wellbeing in older age.¹ An older person's functional ability is determined by their intrinsic capacities, the environments in which they live, and the interaction between the two. 'Intrinsic capacities' are a person's physical and mental abilities. 'Environment' refers to all the elements of a person's home and community, the relationships they have, and the wider social, political, cultural, economic, environmental and physical contexts in which they are born, grow, live, work and age.

The Sustainable Development Goals (SDGs) and the blueprint they outline for creating a better future for all are directly aligned with the ambitions of healthy ageing and the United Nations Decade of Healthy Ageing. They advocate for whole-of-government and whole-of-society action across all sectors to promote strong and sustainable communities and societies. This includes SDG 3 [↗](#) focused on promoting health and wellbeing for all at all ages. A key target within that is the achievement of universal health coverage (UHC) so that everyone, everywhere is able to access the quality health and care services they need without suffering financial hardship.

Progress towards UHC as part of Agenda 2030 is essential for promoting healthy ageing, delivering social and economic development, and building resilient and equitable societies that respond effectively in times of crisis.² But to achieve its promise, models of UHC must be fit for an ageing world. Today, there are more than 1 billion people aged 60 years or older globally, with the majority (70 per cent) living in low- and middle-income countries.³ The number is set to increase to 1.4 billion by 2030 and to 2.1 billion by 2050.⁴ This increase is occurring at an unprecedented pace and will accelerate in coming decades, particularly in developing countries, while the fastest growing segment of the population is people aged 80 and over. Within the older population, women outnumber men at all ages.

While people in nearly all countries of the world are now living longer, ensuring that everyone, everywhere is able to enjoy dignity and wellbeing in later life is a challenge. The World Health Organization (WHO) estimates that at least 142 million older people worldwide today are unable to enjoy their basic rights including their right to enjoy an adequate standard of living and their right to food, clothing, suitable housing, and access to quality health and care services that meet their needs.⁵

The majority of health and care systems worldwide remain unprepared for the demographic and epidemiological transitions all countries are experiencing. Many low- and middle-income countries are experiencing population ageing whilst facing a 'double burden' of infectious and non-communicable diseases (NCDs), with rapidly increasing numbers of people who require health and long-term care and support. Millions of older people are unable to access the quality services they need, while critical opportunities to promote health and wellbeing across the life-course and to prevent or delay the onset of more acute care needs are being missed.

We must harness the opportunity UHC presents to reorient health and care systems to be fit for our ageing world and fulfil the rights of all older people. This means investing in comprehensive, integrated, inclusive and people-centred primary and community-based health and care approaches that engage and empower people and communities, respond to the diverse needs of older people, and effectively promote health and wellbeing for all across the life-course. The impact of COVID-19, climate crisis and wider threats to global health security make achieving UHC and the resilient societies that it can support even more urgent.

This briefing explores the barriers that must be addressed and the key components necessary to ensure we deliver on this vision.



Ganesha Bista, Ageing Nepal

Box 1: The three transitions – reorientating health and care systems to be fit for an ageing world⁶



The demographic transition

- The world is ageing rapidly. By 2030, 1.4 billion people will be aged 60 years or older.
- Today, the majority (70 per cent) are living in low- and middle-income countries.
- Women outlive men around the world by an average of 5.4 years.⁷



The epidemiological transition

- The global pattern of disease is shifting towards non-communicable diseases (NCDs). NCDs already contribute to 80 per cent of all years lived with a disability globally and 74 per cent of all deaths.^{8, 9}
- NCDs have a disproportionate impact on older people – in 2019, 85 per cent of all deaths from NCDs were among people aged 55 and over.¹⁰
- Many countries face a ‘double burden’ of disease due to high levels of infectious diseases and rising rates of NCDs.



The health and care system transition

- Health and care systems must adapt to changing patterns of disease and disability, and the needs and rights of ageing populations.
- The Sustainable Development Goals, the Decade of Healthy Ageing and the global push towards UHC provide opportunities to catalyse action.



David Lomuria/HelpAge International

UHC and older people's right to health

The right to the enjoyment of the highest attainable standard of physical and mental health is a fundamental human right and is indispensable for the exercise of other human rights.¹¹ Health is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The right to health goes beyond access to health services to embrace “a wide range of socioeconomic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment”.¹²

A central component of the right to health is the right to the goods, facilities, and services necessary to support a person's enjoyment of the highest attainable standard of health. These facilities, goods and services must be available, accessible, acceptable and of good quality. The right to health also explicitly includes the right of populations to participate in all health-related decision making.

The commitment of governments towards achieving UHC as part of Agenda 2030 aligns directly with their duty to respect, protect and fulfil people's right to health. Within the Political Declaration of the High-level Meeting on Universal Health Coverage [✓](#) adopted at the UN General Assembly in 2019, Heads of States and governments committed to accelerating progress towards UHC, based on nationally determined sets of essential services, ensuring that the use of these services does not expose people to financial hardship. Within the Political Declaration on UHC 2019, Governments agreed to pursue whole-of-society and equity-based approaches that seek to meet the needs of the furthest behind first. They recognised primary health care as the cornerstone of a sustainable, people-centred, community-based and integrated health and care system and the foundation for achieving UHC.

The Declaration on UHC also included clear commitments to promoting healthy ageing. Specifically, it committed governments to *‘scale up efforts to promote healthy and active ageing, maintain and improve quality of life of older persons and to respond to the needs of the rapidly ageing population, especially the need for promotive, preventive, curative, rehabilitative and palliative care as well as specialized care and the sustainable provision of long-term care’*.¹³ To achieve these ambitions, a step change is needed in the design and delivery of health services so that they fulfil the rights and meet the needs of all older people and promote health and wellbeing across the life-course.

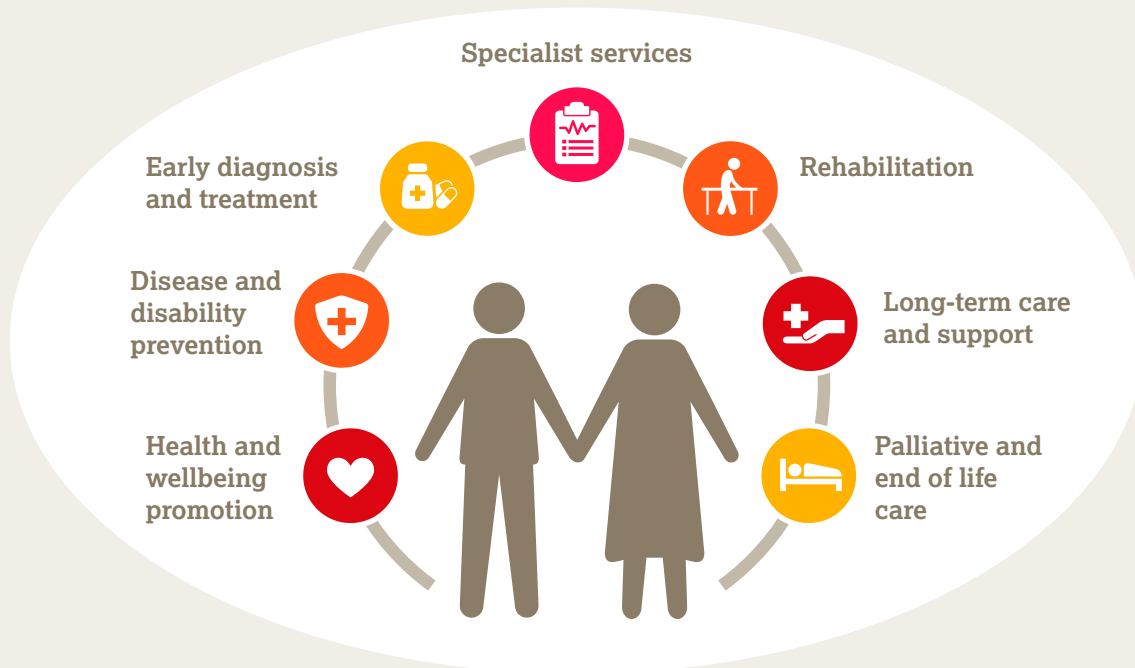


Ben Small/HelpAge International

Box 2: UHC continuum of essential integrated services

The full continuum of essential, quality and integrated health and care services includes:

- **Health and wellbeing promotion** – focused on enabling people to increase control over and to improve their health and wellbeing
- **Disease and disability prevention** – focused on reducing risk factors, preventing the occurrence of disease and disability, arresting their progress over time, and reducing their impact on health and wellbeing once established
- **Early diagnosis and treatment** – focused on diagnosis, treatment and management of health conditions
- **Specialist services** – focused on diagnosis, treatment, prevention and management of specific, rare or complex health conditions
- **Rehabilitation** – focused on optimising functioning and reducing disability in individuals with physical, mental, psycho-social or cognitive health conditions in interaction with their environment
- **Long-term care and support** – focused on enabling people who experience significant declines in capacity and their caregivers to receive care and support that allows them to live a life consistent with their rights, fundamental freedoms and human dignity
- **Palliative and end of life care** – focused on improving the quality of life of people who are facing challenges associated with life-threatening illness and their families.



Barriers older people face in enjoying their right to health

Services fail to meet the health and care needs of older people or to promote healthy ageing across the life-course

The failure to invest in primary health care means at least half of the world's population lack access to essential health services.¹⁴ Even where services are available, they often focus on addressing a burden of disease dominated by acute, time-bound conditions. They do not respond effectively to older people's health and care needs (see box) or to deliver the integrated, person-centred and community-based care across the full continuum of UHC services that effectively promotes healthy ageing and quality of life.

Failures to deliver integrated, person-centred and community-based care across the full continuum of UHC services also means critical opportunities are missed to prevent or delay the onset of more acute health and care needs and to support healthy ageing. This includes activity that promote health and wellbeing, disease and disability prevention, early diagnosis and treatment, rehabilitation, specialist, long-term care and support, and palliative and end of life care.

Box 3: 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.¹⁵ The impact of unequal power relations, inequalities and discrimination experienced by people on the grounds of age, sex, gender identity, functional ability, socio-economic status, ethnicity, religion, sexual orientation or other grounds, intersect and accumulate across life-course, leading to compounded disadvantage 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. For more exploration of who is most at risk in being left behind in UHC, see HelpAge's report, *Older people's perceptions of health and wellbeing in rapidly ageing low- and middle-income countries*. [↗](#)

An equity-based approach to UHC 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 and how we can most effectively tailor UHC to meet their needs and fulfil their rights.

"The truth is current programmes or provisions of the government are unfit and incompatible or inappropriate for the needs of older persons."

Older person, Philippines

“There are no support services available to older people in my community. Only family members are taken as or believed to provide assistance with daily activities. But this does not happen for all.”

Older woman, Nepal

“There is no service for palliative care in the community, the health centre is at a distance of 10 km and the nurse performs care once a month.”

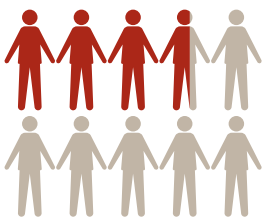
Older person, Bolivia

“[The health clinic] is too far for me to walk to. It takes a day to get there on foot and I don’t have enough money to go by bus.”

Older woman, Mozambique

“The infrastructure is not friendly at all. There are no proper toilets at the hospital and also no ramps for older and disabled people.”

Older person, Kenya



Over a third of 3,658 older people said they faced difficulty in accessing health services.

Box 4: Older people’s physical, mental, psycho-social and cognitive health and care needs

There is great diversity in how people age. Many older people maintain high levels of intrinsic capacity and functional ability well into later life. However, as people age, they are generally more likely to develop a health and care and support need.

Common conditions experienced in later life including hearing loss, cataracts and other eye disorders, back and neck pain and osteoarthritis, and leading non-communicable diseases (NCDs), including chronic obstructive pulmonary disease, hypertension, diabetes, cancers, depression, and dementia. As people age, they are also more likely to experience several conditions at the same time (‘multi-’ or ‘co-’ morbidity). These conditions are often a result of multiple underlying factors and include frailty, urinary incontinence, falls, delirium and pressure ulcers.¹⁶ The presence of these conditions, coupled with ageing immune systems, means many older people are also at greater risk from infectious diseases.

The presence of a long-term condition or co-morbidity is closely associated with limitations in a person’s intrinsic capacity and disability (see box 5). This may affect someone’s ability to perform activities of daily living (ADL) and increase their likelihood of needing care and support.

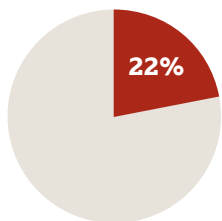
However, with the right interventions, delivered in the right place, at the right time, it is possible to prevent, delay or reverse the onset of more acute health and care needs and ensure older people can maintain the functional ability that enables wellbeing in older age.¹⁷

Poor physical access

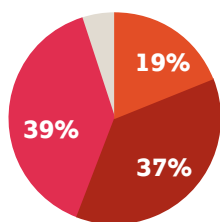
With a lack of primary health care delivered close to home, accessing services for many older people in low- and middle-income countries is impossible. In Sub-Saharan Africa, approximately 10 per cent of people aged 60 years and over across the region have an estimated travel time to the nearest hospital of 6 hours or longer.⁶ A study in Tanzania found the most common means of reaching health facilities for older people was walking, with journeys taking up to four hours. For many older people with mobility issues, these facilities are simply out of reach. In one study in Thailand, researchers found that the likelihood of an older person not using a health care service increased by about 30 per cent with each additional kilometre they had to travel to the health care service.¹⁸

Many older people with disabilities find that, even if they can reach health services, they are not accessible. This might be due to lack of ramps, long queues, lack of suitable toilet facilities, or due to services not meeting the needs of different groups, including needs related to the provision of information and communication.

During COVID-19, rapid needs assessment carried out by HelpAge and partners in 12 low- and middle-income countries during 2020, found that over a third (37 per cent) of 3,658 older people surveyed faced difficulty in accessing health services.¹⁹



Less than a quarter (22%) of survey respondents in Mozambique were able to get the medication prescribed to them during their last visit to a health centre. The main reasons were:

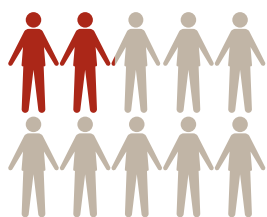


39%: medication was not available at the health facility

37%: the patient could not afford it

19%: the patient could not afford the transport costs to collect the medicine from another health facility

Source: HelpAge International, *Cash transfers and older people's access to healthcare*, 2017



One fifth of 3,658 older people said they faced barriers in accessing COVID-19 information.

Lack of access to medicines, vaccines, and assistive technologies to promote healthy ageing

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 in low- and middle-income countries.

In a study conducted in Ethiopia, Mozambique, Tanzania and Zimbabwe, older people reported being unable to access medicine either because it was not available free of charge or, in many cases, not available at all.²⁰

WHO estimates that 2.5 billion people – or 1 in 3 people – need one or more assistive products, such as wheelchairs, hearing aids, or apps that support communication and recognition,²¹ but that nearly one billion of them are denied access, particularly in low- and middle-income countries, where access can be as low as 3 per cent.

WHO also advises annual vaccination against influenza for people aged 65 and over and yet less than half of the countries around the world have a national immunisation programme targeted at older people.²² During COVID-19, despite older people being the age group most at risk of severe disease and death from the virus, millions of older people in low- and middle-income have faced barriers to accessing COVID-19 vaccines, tests and treatments.²³ As late as May 2022, less than 5 per cent of older people were vaccinated against COVID-19 in some countries, and were less likely to be vaccinated than younger age groups in some settings.²⁴

Lack of accessible information and health education

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. This includes information and education on: health promotion and disease prevention; self-care and the effective management of long-term conditions; older people's health rights and entitlements; and how to access services and support.

Where information is available, it is often not provided in a variety of languages, channels or formats to meet the communication needs of different groups, including offline, in easy-to-read versions, spoken word, picture format or braille.

Literacy levels, including levels of health literacy, are lower among older age groups than younger sections of the population.²⁵ The World Health Survey found that 1 in 10 older people did not know where to go to access healthcare when they needed it.²⁶ This is lower for certain groups of older people, including but not limited to older women, older people with disabilities and/or older people who have a lower level of educational attainment

Rapid needs assessment carried out by HelpAge and partners in 12 low- and middle-income countries during 2020, found that one fifth (21 per cent) of 3,658 older people surveyed said they faced barriers in accessing COVID-19 information, despite being the age group most at risk.

Prohibitive cost

Poverty is one of the main threats to people's health, wellbeing and dignity worldwide and, in most countries, the risk of poverty increases with age.²⁷

It is estimated that in 2017, between 1.4 billion and 1.9 billion people globally faced catastrophic or impoverishing health spending, meaning that more than 10 per cent of their household income was spent on health related costs or that health care spending pushed them below the poverty line.²⁸ This is likely to increase as a result of COVID-19 which estimates suggest could lead to a quarter of a billion more people crashing into extreme levels of poverty in 2022,²⁹ with a dire impact on the incidence of catastrophic health spending and impoverishment due to out-of-pocket health care costs.³⁰

“I spend most of my pension on the medication I need. I am lucky to have children who support me but others have to choose between buying food, having the gas or electricity at home or buying medicine.”

Older woman, Kyrgyzstan

Data shows that people living in older households face the highest incidence of catastrophic health spending.³¹ In 2017, catastrophic health spending was highest in Asia, where the median incidence rate is 38 per cent among older households. Where out-of-pocket payments are high, older people are less likely to seek medical help. The WHO World Health Survey found that 60 per cent of older people in low-income countries did not access health care either because of the cost of the visit, not having transportation, or because they could not pay for transportation.³²

Workforce challenges

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. A 2012 study found that of 40 countries in Africa, 35 had no formal undergraduate training for medical students in geriatrics and 33 reported no national postgraduate training scheme for geriatrics.³³ A key challenge for older people is also the failure to provide adequate support and training to the mainly female unpaid and volunteer caregivers who provide the vast majority of health and care support to older people in all countries.

Ageism and intersectional discrimination

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.

Structural failures in responding to older people’s health and care needs and to ensure their inclusion in policy, services and data systems (see below), are often reinforced by more explicit ageism.

Older people frequently report that the behaviour of health workers is a barrier to accessing the services they need.³⁴ They say their health issues are often dismissed as ‘old age’ or that they are treated like a burden. Ageism is particularly prevalent within some services. For example, within sexual and reproductive health (SRH) where the needs of older women (see box below) and men are often neglected, and older people struggle to access appropriate advice or care. In East and Southern Africa, this is contributing to a growing burden of sexually transmitted infections (STIs) and HIV and AIDS in older people.³⁵

During COVID-19, older people’s right to health has been denied where age has been used as a basis for deciding who has access to scarce COVID-19 treatment, or when non-COVID-19 related health and care services which they rely on have been suspended, leaving them with unmet needs.^{36, 37, 38, 39}

“The hospitals say ‘We have no pill to treat old age’. We are not made to feel welcome.”

Older woman, South Africa

“People who provide these services have a negative attitude towards older persons so we just avoid them.”

Older woman, Uganda

“The employees of the health system or public servants are imposing; they do not have the attitude of listening to us to know what we want or need. They simply decide for us and give orders.”

Older person, Columbia

“There are various levels of committees that are being initiated by government from grassroot to top-level but there are no older people representatives on them.”

Civil society representative,
India

Failures to support older people’s engagement, empowerment, independence and autonomy in their health and care

Older people are often not engaged and empowered effectively in the health and care they receive or given a voice in decision making processes. This denies them their right to participation and autonomy, and also leads to poorer individual and service level outcomes.

Older people often report that health and care professionals and family and friends exclude them from decision making about their health and care, or fail to support their engagement and empowerment in their health and wellbeing.⁴⁰ At the policy level, older people and those working with them are often excluded or not given the opportunity or support they need to meaningfully engage in the design, planning and delivery of health and care services.

On the one hand, this misses valuable opportunities to ensure older people have the right knowledge, skills and confidence to take action on their own health, in partnership with health and care professionals and informal caregivers, which can help avoid or delay the onset of more acute care needs and promote quality of life. On the other, failing to engage and empower older people in decision making denies them their right to choice, independence and autonomy. Failing to support older people’s meaningful participation in decision making also leads to poorer service design and outcomes. Such failures have been seen during the COVID-19 pandemic where older people and organisations working with them have been excluded from key decision making processes, despite them being the age group most at risk from the virus.⁴¹

Older people are not counted

For older people to be included they must also be counted. However, older people are often excluded from official statistics at local, national and global levels and data is not disaggregated to capture the diversity within older age groups.

Current measures of UHC, including the ‘access’ indicator (3.8.1) in the SDG indicator framework, do not include indicators such as physical access to health facilities, or staff skills, knowledge and attitudes – factors that are critical to understanding the barriers faced by older people. The indicator includes measures of a number of essential health services of relevance to older people’s health needs, including for hypertension and diabetes. However, this indicator relies on age-limited data sources, including the WHO STEPS NCD Risk Factor Survey (STEPS), which usually only includes people up to the age of 64, and the Demographic and Health Surveys (DHS), which usually exclude women over the age of 50 and men over the age of 55. Similarly, despite NCDs having a disproportionate impact on people in older age, SDG 3.4 on NCDs focuses on the ageist target of reducing ‘premature mortality’ by one third by 2030, defined as death between the ages of 30 and 70.

Even where data is collected on older age groups, it is rarely adequately disaggregated. Systems often fail to collect, analyse, report and use sufficiently disaggregated data for capturing the diversity of older people and understanding inequalities in access and outcomes to inform system and service design.

Box 5: Disability, ageing and the right to health

More than 46 per cent of people aged 60 and over globally have some form of disability and this rises with age, with more than 250 million older people experiencing moderate to severe disability.⁴² The greatest burden of disability is estimated to come from sensory impairments (particularly in low- and lower-middle-income countries), back and neck pain, chronic obstructive pulmonary disease (particularly in low- and lower-middle-income countries), depressive disorders, falls, diabetes, dementia and osteoarthritis.⁴³

Disability prevalence is increasing due to ageing populations and an increase in NCDs, including diabetes, cardiovascular diseases, cancer, respiratory illnesses, and mental, psycho-social and cognitive health issues, including dementia. Globally, it is estimated NCDs contribute to 80 per cent of all years lived with disability.

Despite people with disabilities often, though not always, having greater health and long-term care and support needs, people with disabilities face multiple barriers to enjoying their right to health, including access to quality health and care services that meet their needs without suffering financial hardship. Physical, communication, attitudinal, social, structural and financial barriers experienced by people with disabilities mean they are three times more likely to be denied health care, four times more likely to be treated badly in the health care system, and 50 per cent more likely to suffer catastrophic health expenditure.⁴⁴ These barriers can be exacerbated due to intersecting discrimination and exclusion on the grounds of age, gender, poverty, ethnicity, as well as other characteristics.

Delivering disability responsive UHC means understanding and responding to the rights and needs of people with a disability, recognising how disability intersects with other characteristics including but not limited to age and gender, and ensuring equity-based models of UHC that fulfil the equal right of everyone to health.⁴⁵



Ben Small/HelpAge International

Box 6: Delivering gender-responsive UHC across the life-course

The Political Declaration on UHC committed governments to ‘mainstream a gender perspective on a systems-wide basis when designing, implementing and monitoring health policies, taking into account the specific needs of all women and girls, with a view to achieving gender equality and the empowerment of women in health policies and health systems delivery’. To leave no one behind, UHC must respond to the needs and rights of women and girls across the life-course, including those of older women.

Women have a longer life expectancy than men and, partly as a result of this, are likely to spend a greater proportion of their lives in ill health or with a disability. As a result of inequalities in power relations, unequal distribution of care responsibilities, discrimination and exclusion on the grounds of gender across the life-course women are also more likely to face multi-dimensional poverty in older age.^{46, 47} This has a profound effect on health and wellbeing and on women’s access to health and care services.

Even when older women are able to access services, many do not meet their specific needs, including but not limited to those related to menopause and post-menopause, higher rates of heart disease, risk of stroke and osteoporosis.⁴⁸ Older women are nearly always excluded from sexual and reproductive health programmes which focus on women of reproductive age. Yet 15 to 50 million women per year are injured or seriously disabled during childbirth, suffering from conditions such as severe anaemia, incontinence, damage to the reproductive organs or nervous system, chronic pain, and infertility. These conditions can worsen in later life, leading to greater dependence, lower quality of life, increased marginalisation and vulnerability, and overall reduced capacity.⁴⁹

At the same time as facing a higher risk of experiencing disease or disability, women of all ages – including older women – are also more likely to be providers of health and care, both formally and informally.⁵⁰ As many as 70 per cent of the global healthcare workforce is female.⁵¹ Women and girls of all ages, including older women are also estimated to do at least two and a half times more unpaid household and care work than men, including care for older people.⁵² The level of unpaid care women and girls provide has been further increased during the COVID-19 pandemic with people stuck at home and with key services and external support disrupted. This has had a profound impact on caregivers, including in terms of income and physical and mental health and wellbeing.

Women of all ages therefore stand to gain the most from the development of comprehensive, integrated and community-based approaches to UHC that meet the continuum of health and care needs of older people – including older women. This critically must include long-term care and support systems which have a transformative role to play in recognising, reducing, redistributing and rewarding the unpaid care work carried out by women and girls of all ages. A rights-based approach to UHC system and service design, delivery, monitoring and evaluation (see below) is also critical for ensuring the representation of women and girls of all ages in UHC.



Achieving UHC fit for an ageing world

Below, we outline the three key components needed to achieve UHC fit for an ageing world and uphold the rights of all older people.

1. UHC addresses the specific barriers older people face to enjoying their right to health

Health and care related goods, facilities and services that meet the needs and fulfil the rights of older people must be:

- **Available** – with goods, facilities and services covering the full continuum of health and long-term care and support
- **Accessible** – to all older people without discrimination of any kind, including physical accessibility, affordability, and information accessibility for all groups
- **Acceptable** – to people of all ages, including older people; appropriate and respectful of the culture of all individuals, minorities, peoples and communities; and responsive to the diverse needs and preferences of older people, including but not limited to older women and older people with a disability
- **Good quality** – including being safe, effective (evidence-based), timely, equitable, integrated, efficient and person-centred

2. Systems are age-, gender-, and disability- responsive and promote healthy ageing for all through integrated primary and community-based health and care services that reach the furthest behind first

All health and care system building blocks must respond to the rights and needs of all older people, including:


Services

Services must deliver inclusive, integrated and person-centred care that responds to older people's needs in a holistic way and is delivered through strong primary health care systems, including community-based health and care services, that engage and empower people and communities.

Services must be delivered as close to home as possible and founded upon strong public and primary health care systems that engage and empower people of all ages and communities, tailoring approaches to meet the needs of the furthest behind first. Services should focus on effective promotion of people's intrinsic capacity, functional ability and quality of life across the life-course. UHC service coverage must progress towards delivering the full continuum of essential health and long-term care and support services that respond to the needs of older people, including those related to communicable and non-communicable disease and disability. Care must be person-centred, integrated, well-coordinated and inclusive, responding to older people's needs and preferences in a holistic way and promoting a human rights-based approach to care at all levels (see below).



Box 7: Primary health care approach⁵³


Primary Health Care (PHC)  is the foundation for achieving Universal Health Coverage and the most effective approach for delivering comprehensive, accessible, integrated and person-centred services that promote people's intrinsic capacity, functional ability and quality of life at all ages. Evidence suggests that PHC can produce a range of economic benefits through its potential to improve health outcomes, health system efficiency and health equity. It is also critical for ensuring strong and resilient systems and communities that respond effectively in times of crises.

A primary health care approach includes three components: meeting people's health and care needs throughout their lives; addressing the broader determinants of health through multisectoral policy and action; and empowering individuals, families and communities to take charge of their own health.

At the World Health Assembly in 2022, WHO Director General, Dr Tedros' report to Member States highlighted that at present, health spending in most countries is imbalanced towards secondary and tertiary care, with huge amounts spent on expensive equipment and medicines that often deliver modest gains. By contrast, it is estimated that 90 per cent of essential services can be delivered through primary health care.⁵⁴



Box 8: Integrated Care for Older People (ICOPE)

WHO's Guidelines on Integrated Care for Older People (ICOPE)  provide evidence-based recommendations for improving the health and wellbeing of older people and moving closer to the achievement of universal health coverage for all at all ages. ICOPE promotes a person-centred and coordinated model of care founded upon a primary health care approach and focused on optimising older people's functional ability. ICOPE involves holistic, person-centred assessment, including screening for losses in intrinsic capacity and understanding a person's life, values, priorities and social contexts. A personalised care plan is then developed to ensure seamless referral and coordinated services are delivered to enable an individual to achieve their self-identified goals. Interventions are delivered in the home and community by multidisciplinary teams that work together to optimise care. Interventions include managing declines in intrinsic capacity, providing care and support, promoting self-management, and provision of support to caregivers. Key domains of intrinsic capacity the interventions address include: mobility, nutrition, vision, hearing, cognitive capacity and psychological capacity.



Mobility Impairment



Malnutrition



Visual loss



Hearing loss



Depressive symptoms



Cognitive impairment

Source: World Health Organization

Workforce

A well-paid, well-trained and well-resourced multidisciplinary health and long-term care and support workforce must be able to respond effectively to the diverse needs of ageing populations through the provision of high quality care across the full continuum of UHC services.

The workforce must be able and equipped to provide integrated and person-centred care that addresses people's physical, mental, psycho-social and cognitive health and long-term care and support needs holistically. It must promote a human rights-based approach to service delivery, including by promoting autonomy, dignity and effectively engaging and empowering older people in their health and wellbeing. The workforce must have the knowledge and skills to be able to deliver medicines, vaccines, and assistive technologies that support healthy ageing. Policy must promote decent work and gender equality, ensuring all health and care professionals have the support they need to deliver good quality care. It must also address how unpaid care work, carried out mostly by women and girls of all ages, can effectively be recognised, reduced, redistributed and rewarded, ensuring those providing care are represented in decision making spaces and supported to deliver high quality care and support.



Ben Small/HelpAge International

Medicines, vaccines and assistive technologies

UHC essential medicines, vaccines and assistive products lists must include the tools and technologies recommended for addressing the conditions most common in later life and for promoting people's intrinsic capacity, functional ability and quality of life at all ages.

Medicines, vaccines and assistive technologies must be available and accessible to people of all ages to support healthy ageing, including those which address NCDs, age-related conditions and disability. Health and care professionals must have the knowledge and training needed to appropriately prescribe and support the use of health and care related goods, and be trained to effectively support people with multiple conditions, including being able to manage polypharmacy in older age groups.

Information and data systems

Data systems must include all age groups and provide information disaggregated by age, sex, disability, location and socio-economic status, as a minimum, on all components of people's right to health and long-term care and support to inform equity-based decision making.

Data systems must provide the information and research needed to understand and address older people's diverse physical, mental, psycho-social and cognitive health and care needs, and healthy ageing more broadly, and to make evidence-based and equity-based decisions about system and service planning. Data must provide evidence on and support the delivery of high-quality, person-centred and integrated care across the full continuum of essential services in line with people's right to health. It should also aim to provide information on the extent to which people are engaged and empowered in their health and long-term care and support. At global levels, measures of UHC must include older people by removing age-caps in indicators, including ageist concepts such as 'premature mortality', and by ensuring the services needed to fulfil their right to health and care are captured.

Box 9: WHO's Priority Assistive Products List and Training in Assistive Products

The Priority Assistive Products List [\[1\]](#) was the first step of WHO's GATE initiative [\[2\]](#) towards improving global access to assistive products for everyone, everywhere. The list includes essential items for many older people and people with disabilities to be able to live a healthy, productive and dignified life, including hearing aids, wheelchairs, communication aids, spectacles, artificial limbs, pill organizers, memory aids and other essential items.

WHO also recently launched open access online training resource to increase the assistive technology workforce. Training in Assistive Products (TAP) [\[3\]](#) is targeted at the primary health care and community workforce, as well as those providing services to people who need assistive products within other sectors. TAP has been developed over a number of years and with a range of partners, including HelpAge and our network. It is currently available in Arabic, Chinese, English, French, Georgian, Kiswahili, Portuguese, Russian, Spanish and Ukrainian.

Box 10: Minimum Standards for Sex, Age and Disability Disaggregated Data

HelpAge has developed Minimum Standards for Sex, Age and Disability Disaggregated Data Minimum. [\[4\]](#) This sets out HelpAge International organisational standards regarding when, how and some of the reasons why Sex, Age and Disability disaggregated data should be collected. It also provides a step-by-step example of how to code and analyse this data.

Financing

Those most at risk, including older people with the greatest health and care needs, are prioritised in progress towards increasing financial coverage for the full continuum of UHC services, with the ultimate goal of care being available free at the point of delivery for all.

Current funding levels are insufficient to achieve UHC by 2030. There is an urgent need for governments to invest more and invest better. They must commit to mobilising public resources for health and care through equitable and mandatory resources as part of prioritising health and care, and healthy ageing, within a sustainable macroeconomic framework, including committing to spend at least five percent of Gross Domestic Product (GDP) on health and moving progressively towards this target.⁵⁵ Governments must also work to improve efficiency and equity in the use of existing resources, increasing pooling mechanisms and reducing reliance on impoverishing out-of-pocket payments. Purchasing arrangements should drive quality of services and incentivise health promotion and disease and disability prevention, including through prioritising primary and community-based services.

Governments should progressively move towards financial coverage for the full range of essential services, medicines, vaccines and assistive technologies needed to promote people's intrinsic capacity, functional ability and quality of life at all ages, ideally with services being available free at the point of delivery. To ensure equity in progress towards this goal, focus must be given to extending services and financial coverage to meet the health and long-term care and support needs of those furthest behind first, including the most at risk older people with the highest levels of needs. Progress should be informed by data and analysis on equity in health and care service access and financing.

Governance and leadership

There must be political commitment to achieving UHC and healthy ageing at the highest levels underpinned by legislation and a strong policy framework that protects and promotes the right of people of all ages to health and long-term care and support.

UHC must be driven through whole-of-government, whole-of-society and health-in-all policies approaches that promote health and wellbeing for all at all ages and address social determinants of health, including by adopting a One Health approach and promoting global health security. There must be strong political leadership for achieving age-, gender-, and disability-responsive UHC, founded upon a human rights-based approach to system and service design and delivery (see below). The right to health and to long-term care and support should be incorporated into national law and accompanied by comprehensive and fully funded policy frameworks that support strong coordination and integration within and across the health and care system and with other sectors.

3. Models of UHC adopt a rights-based approach, ensuring the voices of all groups, including older people, are heard within system and service design, delivery, monitoring and evaluation

Human rights principles must be upheld in all areas of service design, delivery, monitoring and evaluation, including:

Participation

Health and care systems are everybody's business and must engage individuals, communities, civil society and private sector. All groups of older people must be able to participate in system and service design, with support if necessary, to ensure that their voices are heard and that they have agency and influence in decision making processes at all levels.

Accountability and transparency

Those involved in provision, commissioning and policy-making for health and care must be accountable and transparent in all areas of system and service design, delivery, monitoring and evaluation. Effective and transparent feedback, complaints and redress mechanisms must be in place and accessible to all.


Non-discrimination and equality

All older people must be able to enjoy equitable access to services which meet their specific needs without discrimination of any kind. Older people have intersecting identities based on their age, gender, functional ability, ethnicity, religion and many other grounds. Each of these identities must be considered and respected, and the needs of different groups of older people must be responded to effectively in system design and in service delivery. An equity-based approach to UHC means reaching the furthest behind first. This demands that we consider the diversity of older

An equity-based approach to UHC means reaching the furthest behind first. This 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 and how we can most effectively tailor UHC to meet their needs and fulfil their rights.

people when designing policies and programmes and engage them to identify who is most at risk of being left behind and how we can most effectively tailor UHC to meet their needs and fulfil their rights.

Empowerment

All older people must have the information and support they need to understand their rights in relation to health and care and how to claim these rights. Older people must be given a voice in decision making processes at all levels and be informed and empowered to exercise their rights in relation to the care they receive, including their right to choice, independence and autonomy. Where they exist, substitute decision making regimes  must be abolished and systems and policies for supported decision making should be developed to ensure that all groups have appropriate information, training, advocacy and support, in line with their rights, needs and preferences.⁵⁶

Legality

The right to health and the right to long-term care and support should be included in legislation. A human rights-based approach to policy and practice should be embedded into the work of all public authorities and all health and care providers. Legislation and regulation should be in place to ensure services are delivered in line with human rights law, with explicit prohibition of discrimination on the basis of age or any other grounds, and clear processes for taking effective action against any breaches of these rights. This includes but is not limited to UN Declaration of Human Rights; Covenant on Economic, Social and Cultural Rights; the Convention on the Rights of Persons with Disabilities (CRPD); and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).



Ben Small/HelpAge International

How HelpAge and partners are driving progress on achieving UHC fit for an ageing world

HelpAge and its global network members in over 90 countries work together with health and care stakeholders at all levels to promote healthy ageing and older people's right to health in both development and humanitarian settings. We engage in broad based advocacy, conduct research, provide technical expertise, deliver projects and programmes, and work with older people and their communities from grassroots to global levels to effect change. We are a non-state actor in official relations with WHO and an active collaborator within all areas of the UN Decade of Healthy Ageing. [↗](#)

Below are some examples of how the HelpAge network is supporting progress on key components of achieving UHC fit for an ageing world at different levels.

Community-based approaches to promote healthy ageing and older people's right to health

Our community approaches promote older people's role in healthy ageing and their enjoyment of their right to health. We implement evidence-based interventions for promoting self-care and supporting older people's access to quality health and care services. We work with governments, UN agencies, researchers and other civil society actors to support the development of older people led community-based groups (CBGs) and older people's associations (OPAs). These groups become equal partners in the design, implementation, monitoring and evaluation of community healthy ageing approaches. This includes activity focused on addressing demand and supply side barriers to the enjoyment of their right to health, and supporting all groups of older people to access good quality health and care services that meet their needs.

HelpAge's VOICE framework [↗](#) reflects our community-based approach. It outlines the way we work across regions and countries to support older people's to be heard at all levels and for key PANEL principles (see above) to be promoted in all sectors – including within health and care systems and services.

One example of this work is the SANAAII project that HelpAge delivered from 2018–2021 in partnerships with country offices and network members, including HelpAge Bangladesh, HelpAge Vietnam, HelpAge Cambodia and YAKKUM Emergency Unit (YEU) in Indonesia. Project activity focused on engaging older people and their communities in health promotion activity; supporting them to be informed and empowered to take action to demand their right to health at local, regional and national levels; and creating spaces for barriers to service access to be identified and solutions to be discussed collectively. It led to older people and communities taking action to amplify their voices and created opportunities for state-citizen interfaces allowing different groups of older people to raise their needs and rights with service deliverers. Overall, the project successfully contributed to older people's health and wellbeing through improving health promotion and health-seeking behaviour, and through strengthening supply-side health and care service responsiveness and accountability to older people.

Read more about our community-based approaches and our VOICE work here. [↗](#)

“Now we know many things about services, how to keep good health, about rapport building, [and how] to identify the problems of the community people and find ways to resolve the problems together.”

Older man, Bangladesh



Scaling up primary health care interventions for non-communicable disease

The Scaling up Non-Communicable Disease Interventions in Southeast Asia (SUNI-SEA Project) 2019–2023, is an operational research project implemented in Vietnam, Myanmar, and Indonesia, through a consortium of partners, including research institutes based in Europe and in Vietnam, Indonesia and Myanmar. The aim of the project is to inform policy and strategy for evidence-based, effective, efficient, and feasible scale up of NCD interventions to reach more people. The project works in close collaboration with and builds upon the work of government and other sectors.

Community NCD interventions are implemented by community-based organisations with the support of volunteers in Vietnam and Myanmar. Following skills building, the volunteers conduct community level screening for NCDs, plan and facilitate health promotion sessions, motivate people for peer support and self-care activities, refer people at risk of NCDs to the health facility and monitor, report and evaluate their activities. In Vietnam, the project activities are implemented at primary health care facility level by government partners with support from the in-country research institutes. Activities include quality strengthening of NCD care and treatment services through health centre management training, capacity building, update of service guidelines, development of user-friendly job aids, supportive supervision, and strengthening the linkages between the community and local health facility. Digital technology is being used to support stronger community-based NCD screening, management and data in Vietnam, and for self-screening and health promotion in Myanmar.

Read more here. [↗](#)

Promoting age-friendly health and care systems and services in Kenya and Mozambique

The Better Health for Older People in Africa Project (BHOPA) 2019–2022, was a comprehensive health system strengthening project implemented by HelpAge Kenya and HelpAge Mozambique in collaboration with network members. The project's objective was to make health systems more inclusive, responsive, and accountable to the needs of older people, particularly those with chronic diseases and disabilities. Activities focused on (i) strengthening and improving integration of formal and informal health systems and services in Kenya and Mozambique; (ii) national and regional level progress in the development, adoption and domestication of key policies influencing older people's health and inclusion in the health system; and (iii) robust evidence and lessons generation to support advocacy and health system strengthening.

The project strengthened integration and coordination between formal and informal health care systems through capacity building of the health workforce, both at health system level (clinical officers, nurses) and at community level (home-based care volunteers and community health workers), using WHO standard training materials for integrated care for older people (ICOPE). A total of 220 community health workers were trained on healthy ageing and supported to provide healthy ageing services, while 50 clinical officers and 220 nurses were trained on ICOPE.

At the community level, the project reached 29,000 older people with health and care information and services, including through referrals, while 1000 OPA members were trained on healthy ageing and 360 older citizen monitoring groups (OCMGs) received capacity building (see below). This activity successfully strengthened older people's leadership, participation and voice within health and care activity, and their skills for promoting healthy ageing, monitoring the access and quality of health and care services, and advocating for more inclusive and age-friendly systems. In Mozambique, the project contributed to improved access to free care in public hospitals for older people, covering consultation, treatment and medicines, by raising awareness of the policy of free medical services for older people in public hospitals among older people themselves and health workers. In Kenya, the work contributed to increased numbers of older people registering as members of National Health Insurance Fund (NHIF). Training of health and care staff and volunteers also led to more responsive services, outreach programmes, and referral processes. The project contributed to advancements at national policy level, particularly in Kenya where there was limited health and care policy for older people before the project. A draft national healthy ageing strategy is now in place and the development of national ICOPE guidelines will be rolled out in the coming year.

“Before HelpAge came with this project, all the training we received as community health volunteers (CHVs) was not inclusive of older persons. We would mostly attend to women and children. But now, we are able to help older persons to access and get the services they need from hospitals. At the same time, we advocate for our health centres to have special places for attending to them.”

Community health volunteer,
Mozambique

“We aired our opinion, worries, and the challenges that we encounter while we visit the health facilities, like the unavailability of medicines. You know, back in the days, even the health system would neglect older persons by telling them that they are suffering from old age, but after the implementation of the project, they can now access and get medical attention.”

Older man, Kenya



Eva-Lotta Jansson/HelpAge International

Strengthening data and accountability for age-, gender- and disability-responsive services

Older citizen monitoring (OCM) involves older people at grassroots level monitoring the implementation of policies and services affecting their lives and using evidence they gather to advocate for change at local, national and international levels. Developed by HelpAge International and originally piloted with funding from the UK Department for International Development (DFID) in five countries in 2002, OCM has helped some of the most disadvantaged people hold government to account for the fulfilment of their human rights, enabling them to communicate directly with decision makers – sometimes for the first time in their lives. OCM aims to: (i) empower older people to claim their rights, (ii) help older people access existing services and schemes, and (iii) to use monitoring data for influencing policy, legislation and service delivery so they better respond to the needs of older people.

To date, over 3,000 older people's associations in 27 countries have engaged in OCM. Data has been collected and used for advocacy on a range of issues, including access to health and services and social protection, the inclusion of older people in local planning and budgeting, and in humanitarian responses. In Tanzania local advocacy has led to funding being allocated for NCD drugs, geriatric health units, identity cards used to access free health services, consulting rooms dedicated to older people in clinics, and access to counselling. In Bolivia, network member Fundación Horizontes worked with the National Older People's Association of Bolivia (ANAMBO) and used OCM to increase registration of older people to the health insurance, Older People's Health Insurance Scheme (SSPAM) which entitles Bolivians over 60 years of age, and with no other insurance, to receive free healthcare. In Pakistan, OCM has been used to support local OPAs and support organisations to collect sex-, age-, and disability- disaggregated data, make referrals and advocate for better access to assistance for those most at risk within emergency responses. An external evaluation of the programme highlighted the efficiency of the OPAs in responding quickly and cost-effectively, and their strong capacity for advocacy and identification of those who are most at risk of being left behind.

Read more about HelpAge's OCM work here. [↗](#)

Delivering home-based care and support in Vietnam

Intergenerational Self-Help Clubs (ISHCs) are a ground-breaking model, pioneered by HelpAge International in Vietnam working with local partners, including the Vietnam Association of the Elderly, the Vietnam Women's Union, and the Centre for Ageing Support and Community Development (CASCD). Having launched the model in 2006, Vietnam now has over 3,000 ISHCs nationwide with a total membership of over around 160,000 people. Roughly 70 percent of the members are older people, and many are among the more at risk groups.

The ISHC takes a comprehensive and inclusive approach that promotes healthy ageing through multi-sectoral interventions. This includes promoting physical and mental health and psychosocial wellbeing, as well as delivering home based care (HBC) and support. The HBC services are offered through trained homecare volunteers, each of whom works with 10 individuals to design joint care plans based on their needs, preferences and goals, which are then delivered through regular visits. Today, ISHCs are the largest care providers in the country with more than 16,000 caregivers providing regular and ongoing care to 10,000 plus clients. The work of the volunteers can include everything from providing a friendly ear, helping with housework, and taking the individual out for a walk, to helping with personal hygiene, monitoring blood pressure, and supporting with referrals.

In 2020 the work of the HelpAge team in Vietnam was awarded for its work in developing ISHCs by Asia Health and Wellbeing Initiative with the Healthy Ageing Grand Prize for Asian Innovation.

Read more here. [↗](#)



Improving the health and protection of at risk populations in Venezuela

HelpAge network member, Convité, is an NGO based in Venezuela focused on promoting human rights and social justice for groups most at risk, including vulnerable women, young people and older people. Between 2020-2022, Convité, with the support of HelpAge, carried out a project focused on supporting older people and people with disabilities most at risk from COVID-19. The ECHO-funded project delivered interventions in five municipalities focused on improving health and protection interventions for at risk older people and people with disabilities, and strengthening the responses of local authorities, humanitarian actors and UN cluster system.

The project provided assistance to 1,216 older people, 73 per cent of whom were women and 61 per cent people with disabilities. Interventions included Psychosocial Support (PSS) through volunteers, home-based care provision and individual protection assistance (IPA). IPA included provision of medicines; provision of assistive products including, walking canes and frames, crutches, wheelchairs, urine flasks, toilet chairs, incontinence kits, pill organizers, glasses and pressure relief mattresses; provision of hygiene kits; delivery of hot meals; and referrals. An endline survey found 95 per cent of 455 sampled beneficiaries reported an improved feeling of safety and dignity, 97 per cent improved independence and/or ability to carry out daily tasks, 47 per cent general emotional wellbeing, 94 per cent reported feeling safer, and 96 per cent indicated that their lives were more dignified.

In addition, the project included strategic advocacy and coordination with humanitarian actors, including the UN cluster system, NGOs, local authorities and service providers. A key success was the establishment of an Age and Disability Technical Working Group within the Protection cluster led by UNHCR, to ensure the inclusion of the needs and rights of older people and people with disabilities within the humanitarian response.

Supporting access and uptake of COVID-19 vaccination in Tanzania

In September 2021, only 1.6 per cent of older people in Tanzania had been vaccinated against COVID-19, as a result of misinformation, ageism, limited exposure to reliable news in mainstream media and service access barriers. Working alongside UNICEF, HelpAge Tanzania embarked on a holistic programme to promote vaccine access and uptake. HelpAge staff spoke with older people, leaders and communities; they worked with volunteers and government health workers to spread the message; distributed clear, accurate information through their network of home-based care providers and Active Ageing Clubs; and held community intergenerational dialogues to share information and address questions and concerns. When they then organised eight mobile vaccination clinics in the most remote areas, almost 7,000 older people in the project area received their vaccination, while demand in other age groups increased by 88 per cent.

Read more about our work on COVID-19 vaccine equity here. [↗](#)

Research to support global and national evidence-based advocacy and policy on UHC

Ahead of the high-level meeting (HLM) on UHC in 2019, our *Global AgeWatch Insights* report [✉](#) presented data and analysis on the progress being made in realising the right to health of older people around the world, outlining how health systems and universal health coverage must adapt as the global disease burden shifts towards NCDs. The report was launched in Columbia, Myanmar, Pakistan, Serbia, Tanzania, Vietnam and the United States, engaging with key government and global health stakeholders at all levels.

The Global AgeWatch Insights report was accompanied by the findings from HelpAge's health outcome tool, Older people's perceptions of health and wellbeing in rapidly ageing low- and middle-income countries. [✉](#) This report presented data from over 3,000 older women and men, collected between 2015 and 2018 in nine low-and middle-income countries across Africa, Asia and Latin America. The report highlights how particular groups of older people are being left behind, including the oldest old, those in rural areas, those with the lowest levels of education, and those least able to meet their basic needs. It provides a basis for recommendations to governments and service providers on how to meet the needs and fulfil the rights of the most at risk or marginalised older women and men.



YAKKUM Emergency Unit/HelpAge International

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HelpAge International is a global network of organisations promoting the right of all older people to lead dignified, healthy and secure lives.


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Design by Wajee Ruangphornwisut

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