Age-friendly community health services in Aceh, Indonesia

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Tsunami rehabiliation programme in Aceh, Indonesia

HelpAge International's Tsunami Rehabilitation Programme in Aceh, Indonesia focuses on supporting research, analysis, technical advice, capacity building and advocacy by collaborating with government authorities, international and local non-government organisations, international agencies, the donor community, community-based organisations and academics. In partnership with local organisations, HelpAge International also supports older people in a number of communities. Its activities centre on the following three thematic areas:

- Social protection: HelpAge International aims to a) improve access to health care and enhance the age-friendliness of health services for older people and b) to strengthen community care systems and provide other forms of assistance to older people.
- Sustainable livelihoods in old age: HelpAge International aims to assist older people who would like to pursue suitable and sustainable livelihood activities.
- Disaster management: HelpAge International aims to ensure the inclusion of older people in ongoing rehabilitation efforts and disaster preparedness planning.

HelpAge International is a global network of not-for-profit organisations with a mission to work with and for disadvantaged older people to achieve a lasting improvement in the quality of their lives.

Help the Aged provides core funding to HelpAge International's global network of not-for-profit organisations.

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Summary

Older people generally experience specific problems in relation to their health. Disregarding those specific needs reduces the wellbeing of older people and increases the cost of health care for individuals, families and society. It also increases older people's vulnerability in disaster situations. This publication focuses on the health status of older people in Aceh, Indonesia in the context of rehabilitation programmes carried out during the two years following the tsunami disaster and on opportunities to improve health care for them through community-based services.

In its relief and rehabilitation experiences in general, HelpAge International staff typically observe that older people, while recognised as a vulnerable group in theory, in practice often are excluded in terms of participation and as priority beneficiaries requiring special attention. For instance, they do not receive the same attention in humanitarian programmes, policies and international laws and conventions governing the delivery of humanitarian assistance as women (often interpreted as child-bearing age) and children. This appears to be the case in Aceh. While various organisation officers interviewed for this report emphasised that older people were not actively excluded from their programmes, they also acknowledged that they were not directly targeted.[1]

However, the post-tsunami rehabilitation programmes have provided a valuable opportunity for reconstructing and strengthening community health services to be age-friendly, including expanding community-based primary health care. Community health services are central to promoting healthy and active ageing as well as ensuring better preparedness against future emergencies. To help improve the age-friendliness of those services, HelpAge International has looked at the health issues among older people in Aceh since the tsunami and at what could be done differently to improve the situation for them.

Key gaps that HelpAge International has identified in the current health care policies, services and programmes in Aceh relate to:

- Inadequate **data and information** on the health status and needs of older people, which is crucial for planning appropriate age-friendly health programmes;
- Limited **capacity and knowledge** among health providers in government and NGO health programmes on age-specific health problems and treatment, in addition to a lack of specialist equipment;
- Limited **involvement of older people** in community-based health initiatives;
- Limited **access** of older people to existing health facilities and services because of their reduced mobility, the distance and cost of travel and because of poor coordination;
- Uncoordinated or insufficient **allocation of resources** to develop age-friendly and old-age-specific health facilities/services, particularly at the community level.

[1] J Wells (2005), Protecting and Assisting Older People in Emergencies, Network Paper Number 53, Humanitarian Practice Network, Overseas Development Institute

The **recommendations** included in this report are directed to local and provincial governments and non-government organisations working on health programmes in Aceh province and focus on:

- **Data collection** on community health status that is disaggregated by age, sex, type of health need and social status/support networks, as well as the status of available health services, facilities and resource allocations;
- **Capacity building** for community health volunteers (kader), including older people, health practitioners and health administrators, with a focus on education, awareness, planning and providing age-friendly and old-age-specific community health services;
- **Increasing access** to age-friendly and old-age-specific health services, with a focus on improving the skills of primary health care providers and introducing/strengthening community models, such as mobile clinics and home care programmes;
- **Transforming policies into practical actions** by working with district and provincial health departments and the National Commission on Ageing to identify solutions and secure resources to develop age-friendly community health services.

Introduction

In post-emergency rehabilitation interventions, many social protection, health and livelihood programmes acknowledge the vulnerability of older people but tend not to directly or adequately consider their specific needs. These age-specific needs relate to their physical and mental health, nutrition and access to services and require special consideration during and after emergencies.[2]

Health refers to physical, mental and social wellbeing. Good health is critical for a good quality of life. In HelpAge International's programme experience, older people typically cite good health and income security as their main life priorities. But for older people with modest incomes, the cost of health care can cause anxiety and threaten their income security. For those who live in poverty, poor health impacts on their ability to survive. An ageing population is susceptible to an increased risk of chronic disease and disability: hypertension, cardiovascular disease, chronic obstructive pulmonary diseases, blindness and visual impairment, mental health disorders, arthritis and diabetes, which can require life-long treatment or support (see the table on page 9 for a list of common health problems among older people in Aceh).[3]

Chronic illness and disability impose high ongoing costs on individuals, families and societies. Poor health reduces older people's capacity to actively participate in and contribute to their families, thus increasing their isolation and dependence. Individuals and families may have to sell their assets in order to purchase medicines, which thus increases their vulnerability. Family members may need to take time off from work to look after an older family relative who has a disability. Governments need to cope with increased demands for health services and increased costs to their health service providers for long-term care. And yet, much of this financial anxiety is avoidable because many chronic illnesses are preventable when healthy and active ageing is promoted, especially among people earlier in life.

Why is it important to focus on older people?

A strong community-based health infrastructure contributes towards disaster preparedness and the ability of communities to be more responsive to health needs in emergency situations. But we live in an era of rapid and unprecedented global ageing – which is a triumphant achievement for humanity. However, it presents major challenges in relation to poverty and access to appropriate health care in old age. In 2000, some 600 million (1 in 10 people) were aged 60 or older. By 2050, this figure is expected to triple to 1.9 billion, of which at least 1 billion people will live in countries with an average income of less than US$2 a day. The fastest growth in older populations will be in Asia, where the proportion of people older than 60 will rise from 9.4 per cent in 2000 to an estimated 19.1 per cent (1.7 billion) by 2040.

In Indonesia in 2005, people over the age of 60 accounted for 8.4 per cent (18.7 million) of the population. This is the tenth-largest older population in the world. In 2004, the Department of Social Welfare estimated that 18.7 per cent of older Indonesians were living on less than US$1 a day. By 2020, an estimated 11.4 per cent of Indonesians (29.2 million) will be older than 60, and by 2040 this number will increase to 19.7 per cent (55.5 million). By 2040 – in the span of three decades – the proportion of Indonesians older than 60 will be larger than the proportion of Indonesians younger than 14.[4]

> *There are proven strategies that can change the future picture from overburdened health and social systems to older people living longer, more healthily and more productively.* – World Health Organization (2004), *Towards Age-friendly Primary Health Care*

[2] J Wells (2005), *Protecting and Assisting Older People in Emergencies*, Network Paper Number 53, Humanitarian Practice Network, Overseas Development Institute

[3] M Tsao (November 2006), "Older People, Health Care and Accessibility", presentation by the Tsao Foundation at the HAI Regional Conference

[4] United Nations (2004), *World Population Prospects: The 2004 Revision*, http://esa.un.org/unpp/

One key strategy to ensure improved health quality for older people and healthy ageing is to make primary health care facilities and services at the community level age-friendly or old-age-specific.

Age-friendly primary health care

Primary health care refers to the first level of health care, which is provided in communities (the most local level) in a country. Age-friendly means that health care is accessible and appropriate to persons of all ages but in relation to their specific needs at a specific age. Thus, primary health care workers need to be sensitised and informed about the various specific needs of older people when providing care in the communities.

Age-friendly primary health care services should be available, accessible (physically, socially and financially), appropriate (facilities and staff, appropriate knowledge, skills and attitudes), affordable (equitably financed) and integrated with other health and social service providers (M.Tsao, 2006).

Community-based health care refers to health services, staff, volunteers and facilities located within a community. Community-level health care refers to health services provided for – but not necessarily located in – the community (for example, health providers in mobile clinics).

The Indonesian Government needs to adapt its health infrastructure to address the future demands of ageing, and it must start now. The rehabilitation process ongoing in Aceh, supported by a generous allocation of resources, presents an ideal opportunity to improve health infrastructure and to make health services responsive to the specific needs of older people. This moment in time, when the number of people older than 60 accounts for 8.4 per cent of Indonesia's population, provides a demographic window of opportunity to plan and develop health programmes that anticipate and address the challenges that ageing creates.

The Government has committed itself to respond to the needs of older people through a National Plan of Action for Older Persons (2003). The objectives outlined in that action plan are supported by a number of laws, decrees and regulations on older people's welfare and programmes related to poverty, health, participation and empowerment.[5]

This document is based on the results of research that HelpAge International initiated to examine the current status of health facilities and gaps in service provision in Aceh Besar district in Aceh province. The study aimed to identify ways to better utilise available rehabilitation resources to improve the health care system for older people's needs now and in the future.

The recommendations offer practical advice for helping the Indonesia Government realise its policy commitments to older people within the context of community health care and health services. They are primarily intended for local and provincial government and non-government organisations working on health programmes and focus on strengthening the health system to be more responsive and age-friendly.

Research methodology

The study was conducted in four communities – Lambaro Neujid, Lamnga, Lamreh and Garot – affected by the earthquake and tsunami disaster of December 2004, with 4 focus group discussions (48 older men and 81 older women) and 63 individual interviews (26 older men and 37 older women). Interviews also were conducted with HelpAge International team members, community leaders, local and international NGO staff, multilateral and bilateral organisation staff, government health representatives and medical doctors.

[5] N Abikusno (June 2006), Ageing Policy and Program Development in Indonesia: An Update, http://komnaslansia.or.id

Low levels of data on government programmes and community health status limited the breadth of the research. Thus, the data used as the basis for the observations and recommendations are drawn mainly from the group discussions. Differences in language used between the consultant hired to conduct the study and government health representatives made communication difficult at times. As well, the study coincided with the month-long Muslim Ramadan period of fasting and praying, which is of special significance in the targeted communities. It was thus difficult for some people to participate as fully as others in the focus group discussions.

Health care provision in Aceh: Gaps and limitations

The Ministry of Social Affairs and the Ministry of Health share responsibility for older people's policies and programmes. The Usia Lanjut (Usila), within the Family Health Department in the Ministry of Health, has responsibility for old-age care, health education and age-friendly health services for older people (Puskesmas Santun Usila). Government health programmes are planned in five-year cycles.

The National Commission on Ageing reports to the country's president on issues related to older people in Indonesia. However, for that body to be effective at the local level, each province has to form a Provincial Commission for Older Persons. But the possibility of that is, to a large extent, dependent on the local political situation. In Aceh, there is as yet no functioning provincial commission to work with local government officials on issues relevant to older people.

At the community level, the key structures providing health care include the Puskesmas (subdistrict health centre), Puskesmas Pustu (health centres located in villages and linked to subdistrict health centres), Polindes (village midwife clinic) and Posyandu (health posts at the village level). Community-based health volunteers (kader) are the primary contact for community members. Kader receive support from Puskesmas and Posyandu staff (doctors, nurses, pharmacists, etc). There are also a number of traditional healers in communities, some of whom are trained by Puskesmas and Polindes staff to serve their community.

Prior to the tsunami disaster, Aceh's health services and infrastructure were considered poor. Many community facilities were understaffed and poorly resourced, and many were unable to function. The tsunami caused considerable damage to the existing, limited services, thus further weakening their ability to respond immediately to health needs. However, the concentration of resources in Aceh brought on by the disaster has allowed investment in health service provision to increase. New staff have been recruited to replace those lost in the tsunami and to help increase local health facilities to better address the needs of Acehnese.[6] Many survivors report that the level of health care being provided by the Government and local and international NGOs is a considerable improvement.

However, in the current phase of rehabilitation and long-term health system development, there are still a number of identified limitations and gaps in health care provision related to older people that need to be addressed. These centre largely on age-friendly health services and promoting good health and active ageing:

[6] World Bank (2006), *Aceh Public Expenditure Analysis: Spending for Reconstruction and Poverty Reduction*

Inadequate data and information

There is a lack of age-sensitive, disaggregated health data on communities, the types of health problems identified in different community groups, existing health care facilities and services and government resource commitments to old-age-specific or age-friendly health provision at the community level. Existing data tends to be inconsistent, incomplete or limited to focused studies in selected communities or parts of the country. This lack of appropriate data makes developing and coordinating policies, programme planning and resource allocation difficult for various government and non-government agencies and organisations.

One possible way to fill the gap: In Bireuen district, where HelpAge International works with the international health NGO Merlin, the local health department has started issuing a set of health cards to older people from a selected number of subdistricts. These health cards could be a useful mechanism for collecting, monitoring and assessing data on older people's health status throughout Aceh.

Limited capacity, knowledge and equipment

At the community level, there is a visible lack of age-friendly or age-sensitive health facilities and staff. Community-based health centre staff and community health volunteers (kader) have limited awareness and knowledge of older people's health needs and of appropriate ways to treat these illnesses or conditions either, directly or through referrals. In the interviews and discussions for this report, some older people commented on the difficulties they experience in terms of how they are treated by health centre staff, describing disrespectful attitudes and ineffective treatment.

> *The health centre officials do not speak to us in a nice way.* – Nurma, aged 60

> *Before the tsunami, when I went to the health centre, I had to stand in a long queue to register. The doctor didn't give me special attention and sometimes the medicines did not treat my illness.* – Syarifudden, aged 63

In 2006, HelpAge International and two of its partners, the Tsao Foundation and Yayasan Emong Lansia (YEL), conducted a series of capacity-building training sessions for local and international NGO staff, government medical staff, community health volunteers and medical students. In Bireuen district specifically, training sessions were organised for government health practitioners and Merlin staff on geriatric health management at the field level. In their evaluations of the workshop, participants noted their appreciation for the insight on medicine management, using community resources for older people and different models of community-based social services available or suitable for older people.[7]

In the interviews and discussions for this study, many older people also reported that subdistrict health centres (Puskesmas Pustu) are not equipped to treat their chronic conditions. For example, older people requiring treatment for cardiac conditions must go some distance to Banda Aceh town to find the necessary facility because it is not available locally. According to Dr Titin, who works with a mobile service supported by the NGO Yakkum, "In critical cases, we are ill-equipped to diagnose and treat many illnesses, so we refer patients to Banda Aceh."

Deteriorating eyesight and eye conditions are also common maladies that many older people mentioned as having difficulty finding treatment locally. As pointed out in the table on page 9, 55 per cent of older people interviewed for this report said they have eye problems. Common among them is cataracts, which is easily treatable. But there is a lack of appropriate facilities at the community level. HelpAge India found one way to address this gap by setting up regular screening camps to detect eye diseases in older people. When required, it then organises surgical operation with eye specialists. Similar activity could easily be integrated into existing community-level health programmes in Aceh.

[7] Capacity Building of Health Professionals for Health Issues of Older People in Banda Aceh: An Exposure Programme in Singapore, 1–3 November 2006, Evaluation Report.

Limited involvement of older people

Existing health facilities in Aceh seem to focus more on treating diseases and illnesses rather than on providing long-term primary health care that would help reduce the incidence of chronic problems in old age. There is a need to strengthen community-based care and health facilities to enable older people to prevent or delay disabilities related to chronic conditions and to promote healthy and active ageing in the entire community.[8] To address the gap: Older people can play an active role in this process by organising and promoting health education and awareness projects in their communities.

A vision for healthy and active ageing

> *Active ageing is the process of optimising opportunities for health, participation and security in order to enhance the quality of life as people age.* – World Health Organization

"Active ageing" aims to extend a healthy life expectancy and the quality of life for all people as they age, including those who are frail or have a disability and are in need of care. In an active ageing framework, policies and programmes that promote mental health and social connections are as important as those that improve physical health status. In this vision, maintaining autonomy and independence in the ageing process is a key goal for individuals and is reflected in health care policies.

As individuals age, noncommunicable diseases become the leading causes of morbidity, disability and mortality. Many of these noncommunicable diseases can be prevented or postponed; failure to prevent or manage the growth of noncommunicable diseases leads to high human and social costs, which in turn lead to high levels of economic costs for individuals and governments.

It is not ageing that results in higher medical costs but rather disability and poor health associated with old age, which increase individual and public expenditure on health care.

Source: World Health Organization (2002), *Active Ageing: A Policy Framework*, pp12-18

Limited access

Limited access to health centres at the community level is a problem for older people and other community members with reduced or little mobility. Transportation to health centres can also be expensive or time-consuming.

> *If you go to remote areas, you will see health centres located in very difficult places. I cannot imagine how older people could reach there unless supported by someone.*
> – Dr. Tahmina, International Mercy Corps

In Aceh, limited health awareness and reluctant health-seeking behaviour is most common among older women. This, combined with the limited access to facilities, the lack of coordination between service providers, the lack of integration of services and the poor allocation of resources to health services, staff and facilities, means that older women are among the most vulnerable community members.

Initiatives such as the mobile clinics (Puskesmas Keliling) are innovative ways in which accessibility can be increased and the gap addressed. Many of these mobile facilities have been established and funded by international or local NGOs working in Aceh. For example, Yakkum currently provides mobile services to communities in Lamrah and Lamnga. However, the mobile clinics operated by the government health departments lack funding and thus operate irregularly and with limited resources. The lack of resources also prevents government health workers, such as nurses, from making regular visits to remote communities. And of the mobile units that are operational, many lack the knowledge and facilities to address the specific health needs of older people.

[8] World Health Organization (2004), *Towards Age-friendly Primary Health Care*, http://www.who.int/ageing/projects/age_friendly_standards/en/index.html

Uncoordinated or insufficient allocation of resources

Aceh's reconstruction budget is estimated to be US$8 billion. Despite that influx of aid, Aceh's health system is underfunded, with inadequately staffed and resourced (medicine and equipment) facilities, particularly at the community level. In addition, it appears among existing community-level health services that few resources are directed to providing older-people-sensitive health care. The amount of expenditure allocated to health and social welfare more than doubled between 1999 and 2006. However, the proportion of expenditure fell from 12 per cent in 1999 to 6.7 per cent in 2006.

To address the gap, there is a need to ensure that resources are better allocated towards developing an age-friendly health system. HelpAge International believes that at least 6 per cent of resources should be directed to meeting the health, social protection and livelihood needs of vulnerable older people. This minimum of 6 per cent is based on the average proportion of people over age 60 in a population, and decision makers should take into account the actual proportion of older people when allocating resources.

In addition, the Indonesian Government has established funds for Aceh that could be directed towards developing a strong, sustainable and age-friendly community-level health care system. For example, priorities for funding under the Special Autonomy Fund (Otsus Fund), which is managed at the provincial level, include development and maintenance of infrastructure as well as education, health and social sectors at the regional level. Thus, part of the Otsus Fund could be used to develop or strengthen age-friendly and old-age-specific primary health care services in Aceh.[9]

Health problems among older people in Aceh

As well as suffering from physical injury and emotional distress as a direct result of the tsunami disaster, many older people cited during the interviews and discussions for this report symptoms of chronic conditions such as cardiac disease and systemic hypertension or disability – which increased their vulnerability during the disaster and were made worse as a result. Health and aid workers increasingly observed psychosocial disorders in communities that struggled to come to terms with the dramatic devastation caused by the tsunami. Many organisations recognised the need for psychosocial support and offered counselling, for example; however, many older people in the study discussions reported that these services were not available in their area.

Coping with trauma: The case of Juned

Juned lives in Desa Laminga village in Aceh province. His memories of the destructive rage of the tsunami and his struggle to survive are still fresh. His sons helped their 73-year-old father scramble to safety up a nearby mountain as the tsunami attacked their village on the morning of 26 December 2004. Juned stayed there for three days with many other displaced people and returned to his village only after the water level receded. But his home had been destroyed and he and his children found shelter in a displaced persons camp. There Juned received food and clothes, but medical help arrived late.

Prior to the disaster, Juned suffered from osteoarthritis and severe lower back pain. Since the tsunami, he says, he has been troubled with insomnia and is uninterested in eating, suggesting that he also suffers from anorexia as possible symptoms of anxiety and/or depression. "There should be better health care facilities for people like us here," he says. "I hope I will not face another disaster in my remaining life."

[9] For further information on available sources of funding, please see: *World Bank (2006), Aceh Public Expenditure Analysis: Spending for Reconstruction and Poverty Reduction*

Common health problems reported by older people in Aceh

The analysis in the following table is based on field interviews, conducted in October 2006, with 63 older people (26 men and 37 women) and indicates the types of common health problems that older people have experienced in general in Aceh.

Health problem	What older people reported experiencing
Emergency health problems	
Epidemics ▪ malaria and dengue ▪ water-borne	14% had malaria and dengue at the start of the relief period[10]
Injuries ▪ wounds ▪ musculo-skeletal (fractures, dislocation, etc.)	38% were injured while escaping the tsunami 13% have severe musculo-skeletal injuries
Chronic/long-term health problems	
Psychosocial disorders ▪ including intellectual impairment, depression, trauma, anxiety, anorexia, other eating disorders, insomnia	53% reported symptoms associated with psychosocial health disorders
Cardiac diseases and systemic hypertension ▪ symptoms such as shortness of breath, chest pain, palpitations and swelling/fluid retention	34% reported systemic hypertension
Pulmonary diseases ▪ symptoms such as shortness of breath and persistent coughs	70% reported respiratory tract infections A majority of those interviewed complained of dyspnoea and coughing. The most common pulmonary diseases among older people in Aceh are bronchial asthma and chronic obstructive pulmonary disease. While air pollution and allergies considerably trigger these conditions, smoking is a big concern too: In Aceh, an estimated 75% of older men smoke. Respiratory tract infections also have a high prevalence rate in Aceh. According to Dr Thomas Starega, World Health Organization representative in Banda Aceh, they account for about 70% of all diseases.
Musculo-skeletal disorders ▪ includes lower back pain, joint pains and reduced mobility ▪ arthritis and osteoporosis	Many reported conditions have been aggravated by the tsunami disaster conditions. 60% displayed signs of arthritis and osteoporosis, including rheumatoid arthritis.
Metabolic diseases ▪ including diabetes and gouty arthritis	No specific data on diagnosed cases available, however, the majority of older people reported symptoms associated with diabetes and gouty arthritis.
Eye conditions ▪ including cataracts, short-sightedness, long-sightedness and blurred vision	55% reported diminished vision
Disabilities ▪ including poor mobility, loss of sight, hearing	Many people reported losing disability aids (crutches, wheelchairs, hearing aids) in the disaster, which reduced their mobility and made access to services more difficult.

[10] Indonesia has the highest incidence of dengue fever in Southeast Asia. In 2005, 53 per cent (95,279) of all dengue cases in Southeast Asia were in Indonesia and 74 per cent (1,298) of all dengue fatalities in the same region were in Indonesia, according to the World Health Organization in Dengue, August 2006, http://www.searo.who.int/en/Section10/Section332.htm
Data on malaria cases is limited and concentrated in Java/Bali; however, in 2004, Indonesia had an estimated 2.46 million cases of malaria.

The relevance of primary health care in communities

Establishing age-friendly community primary health care that utilises local resources and inter-generational approaches is critical in a strategy to achieve good health and good ageing conditions. And it is more cost-effective than treating illnesses once they have occurred. In addition, encouraging older people to participate as kader or health educators focused specifically on age-related illnesses is a useful strategy to complement community health care services.

> *I have seen the work of community health volunteers in rural areas. It is very impressive and effective. We must promote it further.* – Dr. Lidia, International Medical Corps

Older people are aware of their conditions and/or are able, through a model of home-based care, to look after other older people who are more vulnerable. HelpAge International is working with its NGO partner Yayasan Emong Lansia on a pilot programme for home-based care in Aceh to demonstrate its effectiveness for vulnerable older people. The purpose of the project is to improve the quality of life for vulnerable, sick, lonely or isolated older people by providing them care at home. Home care volunteers from within each community have been identified and trained to assist older people. Each volunteer cares for at least two older people. The volunteers visit their "patients" at least one hour every week and write a report after each visit. They provide many types of support, including companionship, emotional relief, personal care, basic health care, referrals and access assistance to health centres and hospitals if necessary or other daily activities, such as housekeeping and shopping.

Associations of older people is also an effective way in which they can gain confidence to participate in their communities or seek outside help with their priorities, as well as enable them to provide support to other more vulnerable older people. For example, in Bangladesh, during the 2004 floods in Pubail Union of Gazipur district, members of an older people's association, on their own initiative, provided support to older people badly affected by the floods by organising relief packages and by establishing a system of home-visiting to those most vulnerable.

The consequences of not preparing for population ageing and the demands on the health system include high costs to individuals, families and government in terms of treatment and long-term care provision.[11] Poor health increases older people's vulnerability and reduces community preparedness to deal with disasters adequately. By investing in primary health care at the community level now, governments can avoid a situation where there is an unmanageable increase in the incidence, prevalence and complications of age-related chronic diseases that divert resources from other priorities.[12]

Recommendations for strengthening age-friendly community health services in Aceh

Recommendation 1: Improve data collection on community health status, available health services and facilities, and increase resources

1.1 *Increase the collection and documentation of disaggregated data on community health status, with a focus on the specific health needs of older people.*

Data collection should be disaggregated by age, sex, type of health need (chronic conditions, functional disabilities, nutrition status), social status (living and care arrangements, access to health care, facilities and medication). This serves to better inform age-friendly and old-age-specific health programme planning and resource allocation. One mechanism for collecting data is the older people's health card system introduced in Bireuen district.

1.2 *Increase the collection and documentation of data on the status of health facilities, staff and resource allocations made for older people at the community level in order to promote coordinated age-friendly policy making, service provision and planning of long-term health programmes, as well as age-sensitive responses in the event of a disaster*

Recommendation 2: Increase community capacity to provide age-friendly and old-age-specific health services

2.1 *Improve the capacity and attitudes of community health volunteers (including older people), health practitioners and health administrators and available information so that they provide age-friendly and old-age-specific services. This requires regular training and education packages appropriate to people's functions and the services they provide.*

- Increase the capacity of older people to organise themselves and provide support to each other through the formation of community-based older people's associations.
- Increase the capacity of older people as educators through training as kader to promote active and healthy ageing in their communities and to operate as an integrated member of the team of community health volunteers.
- Increase the capacity of kader to conduct community-needs assessments and health monitoring, health education and self-care and to identify common age-specific health problems and respond appropriately (treatment or referrals to medical and social services).
- Increase the capacity of health practitioners at Posyandu, Puskesmas, district and provincial levels (doctors, nurses, pharmacists, traditional medicine practitioners) to detect age-related health problems, manage geriatric diseases and syndromes and promote patient and carer health education at the community level.
- Increase the capacity of health administrators to incorporate the special needs of older people into their health policies, planning and recommendations on resource allocation and to strengthen age-friendly health services through the use of better data and models of good practice.
- Increase the capacity of health administrators to use standard age-sensitive criteria to assess health service provision and responsiveness at the community level.

2.2 *Develop and disseminate a toolkit or guidelines on including older people in community health and vulnerability assessments, nutrition assessments and drug requirements in community emergency response strategies.*

Recommendation 3: Increase access to age-friendly and old-age-specific health services

Increase vulnerable older people's access to community health services by strengthening or creating opportunities for outreach.

- Strengthen the Posyandu model to be age-friendly and operate regularly by providing training and increased government resources.
- Promote inter-generational approaches to community-based health care using home care models that involve other community members (including older people), with support from grassroots organisations.
- Strengthen mobile clinics to incorporate older people's health needs by providing appropriate age-friendly health training, medications and access to resources to facilitate their operation.
- Extend models of mobile clinics as a cost-effective approach that is integrated into the health care system to reach communities with limited access to health care.

Recommendation 4: Transfer policies into practical actions

Increase the capacity of district and provincial health departments and the National Commission on Ageing to identify and secure government resources in Aceh to develop age-friendly and old-age-specific community health services, with a focus on primary health care.

- Increase the proportion of resource allocation to old-age-specific health interventions for older people to at least 6 per cent.
- Promote the inclusion of older people's health needs in disaster preparedness plans and relief responses.
- Support the formation of a Provincial Commission on Ageing in Aceh.

Key resources

Older people and emergencies

J Wells, (December 2005), *Protecting and assisting older people in emergencies*, Network Paper Number 53, Humanitarian Practice Network, Overseas Development Institute

HelpAge International (July 2006), *Protecting and assisting older people in emergencies*, Briefing paper for the Inter-Agency Standing Committee working group, Geneva

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