

PART 3: TRAINER'S GUIDE

The trainer's guide is the third of four parts contained in this module. It is NOT a training course. This guide provides guidance on how to design a training course by giving tips and examples of tools that the trainer can use and adapt to meet training needs. The trainer's guide should only be used by experienced trainers to help develop a training course that meets the needs of a specific audience. The trainer's guide is linked to the technical information found in Part 2 of the module.

Navigating your way round the guide

The trainer's guide is divided into six sections:

1. **Tips for trainers** provide pointers on how to prepare for and organize a training course.
2. **Learning objectives** sets out examples of learning objectives for this module that can be adapted for a particular participant group.
3. **Testing knowledge** contains an example of a questionnaire that can be used to test participants' knowledge at the start or at the end of a training course.
4. **Classroom exercises** provide examples of practical exercises that can be done in a classroom context by participants individually or in groups.
5. **Case studies** contain examples of case studies that can be used to get participants to think by using real-life scenarios.
6. **Field-based exercises** outline ideas for field visits that may be conducted during a longer training course.

When developing this section, the author has considered three main categories through which exercises and case studies have been selected:

- Context, mandate, inclusion, equity of access, civil society and rights;
- Vulnerability and nutritional assessment; and
- Interventions and broader programmatic response.

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¹ Adapted from Maxi, M, 2004. Report on the situation of the elderly at the Fendell and Soul Clinics, Internally Displaced People Camps, Liberia. <http://www.globalaging.org/armedconflict/countryreports/Africa/fendall.htm>

1. Tips for trainers

Step 1: Do the reading!

- Read Part 2: Technical Notes, of this module.
- Familiarise yourself with the technical terms from the glossary.
- Read through the key documents (see full references and how to access them in Part 4 of this module).
- Be sure that you take time to read the exercises and cases studies so that you can decide if they meet your training objectives.
- Decide which sessions to include and within sessions, which activities to include.

Step 2: Know your audience!

- Find out about your participants in advance of the training.
- How many participants will there be?
- Investigate their expectations for the training.
- Have any of them got experience of nutrition programming or working with older people?
- Could participants with experience be involved in the sessions by preparing a case study or contribute through describing their practical experience?
- Examine the possibility of counterpart trainers from Government and NGO stakeholders.

Step 3: Design the training!

Decide how long the training will be and what activities can be covered within the available time. In general the following guide can be used:

- A **45-60-minute** classroom-based training session can provide a very basic overview of the issues facing older people.
- A **90-minute** classroom-based training session can provide a more in-depth overview of the issues facing older people and include practical exercises to reinforce learning.
- A **half-day** classroom-based training session can provide a more in-depth understanding and include all three practical exercises or a case study.
- A **full-day** classroom-based training session is appropriate if you do Module 23 as a stand-alone one-day course. You could include the case study material in the session where participants work in groups of about four people and present back their findings in plenary. If your participants all work in one country and have contextual experience of a specific scenario, you could use the session to develop your own case study with the group by getting them to write up the scenario following the model from the case studies presented here. This will reinforce their active learning.
- A **3-5 day** classroom plus field-based training can provide a full training in order to carry out a more comprehensive training and simulation on programme intervention.

Step 4: Get prepared!

Ensuring you are prepared and ready will elevated confidence and reduce any pressure of facilitation. Some key points to consider when preparing for any length of training include:

- Check the room, lighting and set-up of helpers and tables to promote conversation and open group work.
- Check any equipment and IT hardware that may be used throughout the training. Familiarize yourself with the equipment and know the individual responsible to support you within the training facility/hosting location.
- Have all flipcharts, papers and stationery ready and available.
- Write up the schedule and agenda for each day prior to the start of the daily session to promote good time keeping and let participants be aware of breaks.
- Have all key references available within the training facility. Ensure all hand-outs and training materials are printed, bound and available for the participants from day one.

REMEMBER

People remember 20% of what they are told, 40% of what they are told and read, and 80% of what they find out for themselves.

People learn differently. They learn from what they read, what they hear, what they see, what they discuss with others and what they explain to others. A good training is therefore one that offers a variety of learning methods which suit the variety of individuals in any group. Such variety will also help reinforce messages and ideas so that they are more likely to be learned.

2. Learning objectives

Below are examples of learning objectives for a session on **'Older people in emergencies'**. Trainers may wish to develop alternative learning objectives that are appropriate to their particular participant group. The number of learning objectives should be limited: up to five per day of training is appropriate. Each exercise should be related to at least one of the learning objectives.

Examples of learning objectives

- Show the importance of involving older people from the outset.
- Understand their existing decision-making structures, the importance of partnerships with appropriate groups, acknowledging their roles in future steps such as assessments and implementation.
- Understand older people as a vulnerable group, outline the variety of risk factors, understand older people's roles and responsibilities. Examine the process through which to influence for inclusion in assessments.
- Allow participants to examine the results and main findings of an actual assessment and prioritise objectives and methods for intervention.
- Understand the shelter and physical needs of older people. Examine how to target this group.
- Allow participants to consider the layout and design including accessibility and location, safety and fall prevention, weather proofing and lighting.
- Generate awareness of psychosocial components within planning and design of interventions.

3. Training exercises from other key modules

Quiz: 'True' or 'False' statements² about older people in humanitarian emergencies. This includes key discussion points around each statement.

Q: Older people are not affected by humanitarian emergencies. Children are.

A: FALSE

26 million people of all age groups are affected by disasters every year.

Q: The numbers of older people in developing countries is roughly static.

A: FALSE

Low life expectancy figures mask the fact that there are millions of older people in developing countries. The most rapid increase in the 60+ population is occurring in the developing world, which will see a jump of 225% (to over 1.5 billion people) between 2010 and 2050.

Q: Age specific interventions for older people do exist.

A: TRUE

Interventions that consider the needs of older people in terms of social and physical requirements do exist. Vulnerability analysis focused on older people and conducted in conjunction with that group, will allow the design and content of interventions to be age-specific and appropriate to older people.

Q: The extended family and community protects their older adults and older people.

A: FALSE

Migration and urbanisation mean that the extended family is no longer as common as it once was. Some older people do not have families, others are caring for orphaned grandchildren. People may not have the resources or ability to help others at a time when they are also suffering.

Q: There are methods available to measure the nutritional status of older people

A: TRUE

Whilst there remains some ambiguities and contention over the accepted international standards for the measurement of older people's nutritional status within emergency settings, guidance is available, methods and standards have been recommended, if not fully ratified, and national level settings have to be established through a peer reviewed and coordinated mechanism.

Q: Older people's needs will automatically be covered by general aid distributions.

A: FALSE

Older people have particular nutritional, cultural and health needs that are often not met by a general relief distribution. Sick and frail people might find it difficult to queue at, or walk to, relief distribution points, and they may not be able to access general aid distributions in the first place.

² **Sources:** HelpAge UK/HelpAge International, 2011. On the Edge: why older people's needs are not being met in humanitarian emergencies. Humanitarian Emergency Response Review (an independent review published by the UK's Department for International Development).

Q: Older people only have themselves to worry about.

A: FALSE

Many older people are looking after grandchildren as their children migrate in search of work or die through conflict and illness. HelpAge International estimates that up to half of the world's children orphaned by AIDS are cared for by a grandparent.

Q: Older people can play a crucial role in the design, implementation and monitoring of programming.

A. TRUE

Their role and importance in gaining a comprehensive situational analysis as well as ensuring credibility and accuracy of subsequent responses has been well detailed within the literature, the details of which are included within Part 2 of this module.

Q: There are agencies that specialise in older people and who are responsible for their needs.

A: FALSE

Whilst there are a number of agencies and bodies that would be responsible, represent or focus on older people within emergency programming, it is important to establish that all actors should be aware of the vulnerability, inclusion and benefits of targeting older people within the design and implementation of responses.

4. Classroom exercises

Exercise 1: Exploring MIPAA and generating awareness

Activity: Using the Madrid International Plan of Action (MIPAA), which you will find on p.16 in Part 2 Technical Notes, hand out the General Principles, MIPAA Priorities and Priority 1, Issue 8. Ask the group to understand and summarise the evolution and key content of MIPAA. Provide the group with 30 minutes to read the documents and prepare a presentation or feedback to the rest of the participants.

Additional Questions and Group Discussion

Q1. Having read the documents, what experience have you faced with regard to age discrimination in certain settings and the implications for planning?

Q2. How would the group define the difference between ageism and age discrimination?

Exercise 2: Match the Guiding Principles and Activities

Use the sheet below to allow participants to match the principles to the activities. This sheet can be printed off and cut up so the activities and principles have to be matched by the groups. This is a quick activity that can be used as an introduction to an afternoon session for example. The matching of activities and principles can stimulate a discussion that can be examined and elaborated upon in a subsequent plenary session.

7 Guiding Principle For Nutrition Programmes Targeting Older People In Emergencies

The guiding principles that apply to working with older people in emergencies are given below. These provide a framework for specific programme design issues that are considered in Section 8.

In 1982, UN General Assembly endorsed the 'International Plan of Action on Ageing' (resolution 37/51) – designed to guide the thinking and formulation of policies and programmes on ageing. Nine years after endorsing the Plan, the General Assembly adopted the UN Principles for Older Persons (resolution 46/91) addressing issues of independence, participation, care, self-fulfillment and dignity (Annex 4).

Although the UN Principles for Older Persons and the International Plan provide a framework for action, more specific nutritional principles and approaches are required. Therefore, for the purpose of guiding programme design for nutrition intervention, HAI recommends that the following guiding principles be used. These principles, specific to food and nutrition interventions in emergencies, reinforce the broader Vienna (Nutrition) Recommendation for the Plan of Action on Ageing (1982).

Guiding Principles for Nutrition Interventions for Older People in Emergencies

1. Older people should have physical access to an adequate general ration that is suitable in terms of quantity and quality that are easily digestible and culturally acceptable.

- Older people should have access to milled cereal and legumes that they are familiar with or alternatively, to milling facilities in situations where whole grain cereal is provided.
- Measures should be taken to ensure that older people are (i) informed of their eligibility and (ii) have physical access to the general ration.

2. The physiological changes associated with ageing and its consequences for nutrition requirements and special needs should be reflected in programme design.

- Older people should be supported and encouraged to access and consume nutrition-dense food, adequate fluid volumes and easily digestible foods.
- A fortified blended food should be included as part of the basic general ration. Where this is not available, older people (in addition to young children) should be prioritized to receive a supplement of blended food or other nutrition-dense food.

3. Older people should be involved in the assessment, design and implementation of the programme.

- The nutritional status and nutritional needs of older people should systematically be evaluated during emergency nutrition assessments.
- Older people should be involved in all stages of the emergency programme.

4. The chronic nature of their needs should be reflected in the programme design.

- Until livelihoods are restored, community support structures are re-established or families reunited, older people are likely to remain relatively food insecure. Provision of community-based follow-up support for older people should be ensured until such a time as appropriate structures are in place which provide secure and adequate support.

5. Existing community support structures should be rebuilt and strengthened as the most important strategy of food and nutrition assistance programmes for older people.

- Where possible, older people should be given the opportunity to continue to live normally in their communities, engage and contribute activity in daily activities with the help of community support where needed.
- Every effort should be made not to create institutional structures for older people, especially where such institutions are not considered the norm.

6. Malnourished older people should have equal access to selective feeding programmes for nutritional rehabilitation.

- Out-reach activities, referral mechanisms and information dissemination should be addressed.

Exercise 3: Considering assessment and vulnerability information in designing response

Activity: Using the Handicap International Individual Assessment form (Part 2 Technical Notes, Annex D) and the Risk Factor for Nutrition Vulnerability Diagram (Part 2, p.43), consider this key question:

In what way would you adapt or improve the design of a feeding programme to address different aspects and needs that are highlighted within these documents? Make sure to consider a key design adaptation from each component of the Nutrition Vulnerability Diagram.

Exercise 4: Composition of the food ration in Dadaab, May 2011

Item	Amount (in grams)	Frequency	Grams per month
Maize	3,150	Twice a month	6,300
Wheat flour	3,150		6,300
Pulses	900		1,800
Fortified oil	450		900
Corn soya blend (CSB)	675		1,350
Salt	75		150

Source: Care International, Dadaab, June 2011; and UNHCR, Dadaab, November 2011.

Analysis of this food ration:

	Daily Portion	% of recommended daily ration
Energy	1,866.9kcal	98.3%
Protein (9%)	43.9g	91.4%
Fat (19%)	40.0g	51.9%
Carbohydrate (72%)	335.4g	95.6%
Dietary fiber	24.8g	82.8%
Phytic acid	2,642.4mg	–%
Calcium	60.9mg	6.1%
Calcium absorption	16.8mg	–%
Magnesium	339.9mg	109.6%
Zinc	5.9mg	84.4%
Zinc absorbed	0.9mg	–%
Iron	11.6mg	77.4%
Iron absorbed	0.8mg	–%
Vitamin B1	1.1mg	112.5%
Vitamin B2	0.5mg	45.0%
Niacin equivalent	17.8mg	–%
Vitamin B6	0.8mg	65.5%
Pantothenic acid	1.9mg	30.9%
Folic acid equivalent	168.3µg	–%
Vitamin B12	0.0µg	0.0%
Vitamin C	0.6mg	0.6%
Retinol equivalent	0.0ug	–%
Grains and roots	420.0g	–%
Legumes nuts	60.0g	–%
Dairy products	0.0g	–%
Flesh food	0.0g	–%
Eggs	0.0g	–%
Vitamin A from fruit/veg	0.0g	–%
Other fruits/veg	0.0g	–%
Fats/oils	30.0g	–%

This ration provides the 2,100kcal/day (recommended by HelpAge International guidelines for older people, HelpAge International 2001). According to the same standards, the protein content of the ration is adequate (12% of the ration), as well as the fat content (19% of the ration – i.e., at least 17% of the ration).³ There is not enough fibre, and some micronutrients (including calcium, Vitamin C and Vitamin B12) are insufficient.

Questions:

Q: List the existing and potential micronutrient deficiencies resulting from this food package?

Q: Using NutVal, how would you improve the quantity and quality of the package?

Q: How would you then advocate for these improvements?

³ These standards differ slightly from the 2011 Sphere standards for minimum nutritional requirements. The global energy intake is similar, as well as the percentage of energy provided by fat, but older people need more protein intake. They also need more calcium, Vitamin D, B6 and B12.

5. Case studies

Case study 1: Engaging with and involving older people in situation setting and planning⁴

Learning objectives: To show the importance of involving older people from the outset. Understanding their existing decision making structures, the importance of partnership with appropriate groups, acknowledging their roles in future steps such as assessments and implementation.

Methods: Handout, provide sufficient time for comprehension.

It is August 2011 in Dadaab, Kenya – the largest refugee camp in the world. More than 400,000 people have fled their country to settle in this hot, sandy and windy place. It has not rained for months, but there are some cows, sheep and goats surviving on a few green bushes and pockets of pasture. The influx of new arrivals from Somalia does not stop. They are fleeing the insecurity, but mostly they could not stay in their homes because of the persistent drought.

Abdullahi is about 70 years old, although he has no documentation to prove this. He has just been through Hagadera reception centre. A red plastic bracelet has been tied around his wrist as proof of his having been processed. This gives him access to a ration of food for three weeks (wheat flour, oil, cornmeal, sugar, beans, corn-soya blend, salt) as well as a cooking kit, a blanket, a mat, a 10-litre jerry can and soap. Arriving from Somalia after fifteen days of travelling, he says:

"I am one of the lucky ones who were transported by truck from the border to Dadaab. I used to live alone and work on my small piece of land. I have been a widower for seven years. My sons disappeared and my only daughter is married and looks after her own family. The drought took away my only means of livelihood, and I was forced to leave."

Now Abdullahi has to find a place to live before being officially registered by the Directorate of Refugee Affairs (Government of Kenya), and UNHCR. The registration can take up to two months, and Abdullahi has received food for only three weeks. Being registered allows refugees to have access to food distribution, and to be given an official plot with a tent, a real shelter. However some refugees have to wait for several months before being allocated a definitive plot.

There are 13,000 older people in Dadaab, and the number is growing every day. Some arrived twenty years ago while others are new arrivals. Some are alone, some are with families and others are the sole care providers for their family. They all have to adapt to harsh environmental conditions and heavy bureaucratic procedures. They are not used to food rations and often cannot consume them as they are too hard to chew. Being allotted shelter and a place to live is also uncertain.

⁴ Adapted from Fritsch P, 2011: East Africa crisis: older refugees arrive at Dadaab in search of better life. Blog, HelpAge International. 5 August 2011. For full article: www.helpage.org/blogs

Questions:

You arrive in Dadaab with an international aid agency and have to assess the immediate nutritional needs and vulnerability of people over 50 years old.

Q: What nutritional status indicators would you use?

Q: What particular challenges would you face from the community, as well as your own organization?

Q: How would you investigate vulnerability?

Q: How would you involve older people in this work?

Case study 2: Identifying nutritional risk vulnerability factors and influencing for assessment; camp for Rwandan refugees, North West Tanzania (1998)

Learning objectives: Understand older people as a vulnerable group, outline the variety of risk factors, understand older people's roles and responsibilities. Examine the process through which to influence older people's inclusion in assessments.

Methods: Listed questions and role play.

Before the war in Rwanda, Mr Musirikare (aged 74) and his wife (aged 72) were quite wealthy. They had 10 children: five of them died before the war, four were killed by rebel soldiers. They managed to escape with their daughter-in-law and her three children. Arriving in Chabalisa, Tanzania, they registered in the refugee camp and received food, a plot of land and a plastic sheet to make their hut. Their daughter-in-law now lives in Chabalisa and comes to visit them regularly. However, their surviving son lives far away and has a family of 12 to take care of.

Mr and Mrs Musirikare are both undernourished. Mr Musirikare is in the red zone of the BMI chart and his wife in the yellow zone. They receive two shares of food (maize, oil and sometimes beans) from the food distribution and this is enough to eat porridge in the late morning and dinner. Mr Musirikare says: "it is not enough. We digest the porridge quickly and then feel hungry until dinner." They both find it difficult to eat grain because of their teeth but are forced to do so when they run out of money. Occasionally they receive some food from the HelpAge garden, and sometimes bananas from their daughter-in-law who has a salary. Mrs Musirikare says: "We only eat maize porridge to survive. Food I really like is rice and milk."

Mr Musirikare rates his health as being poorer than it was in Rwanda: "Since I'm here I always feel sick. I'm becoming weaker each day due to lack of vegetables and milk. In Rwanda I did heavy work, but I lost my strength since I had dysentery in the camp and remained weak because of the poor diet. I also suffer horribly from malaria attacks and the horrible memories of what happened in the war." He perceives himself as a burden to his wife as he is no longer able to support her and provide the household with what is needed. He says: "I feel like a flat bicycle tyre." He mentions that older people in the camp feel rather bored, as they are less active due to poor health and lack of land for cultivation. His main concern is better food so that he will revive.

Questions:

Q: What risk factors for nutritional vulnerability do you notice?

Q: Are there gaps in understanding vulnerability that may need further investigation?

Q: How would you convince your line manager/organisation to include older people in a more comprehensive vulnerability assessment and if necessary, within an anthropometric survey?

Case Study 2 Option 2, Role Play: You are Mr Musirikare and you need to describe your situation to an interviewing assessor. Make good use of the case study description as well as the risk factors.

These risk factors are given to the audience: Death of loved ones, witnessed traumatic events, poor health, poor strength, unable to work, low income, missing meals, not enough land to cultivate food, unable to obtain sufficient food, problems chewing, prefers other foods (from HelpAge/LSHTM Handbook 1999, page 43).

Questions:

Q: What risk factors for nutritional vulnerability do you notice?

Q: Are there gaps in understanding vulnerability that may need further investigation?

Q: How would you convince your line manager/organisation to include older people in a more comprehensive vulnerability assessment and if necessary, within an anthropometric survey?

Case study 3: Assessment of the nutritional status, food security, socio-economic status and care of older people in Lokitaung Division, Turkana District

Learning objectives: Allow participants to examine the results and main findings of an actual assessment and prioritise objectives and methods for intervention.

Under an Oxfam Great Britain/UNICEF-led health and nutrition subcommittee, a nutrition assessment of older adults took place in Lokitaung, Turkana district. This assessment took place at the same time as Oxfam was undertaking their regular six monthly assessment of children younger than five years. Older people are considered the custodians of the Turkana culture and they care for young children. They are highly respected and receive care from the community and family members, but due to the loss of their cattle, caregivers are threatened. Unlike children, older persons are not targeted for supplementary feeding schemes. The assessment was an effort to gather information for advocacy of the needs of older people in emergencies since older persons had previously been excluded from regular assessments by aid agencies.

Objectives of the assessment

- To describe the situation of older people in emergency situations, with a special focus on their nutritional and socio-economic status;
- To test tools used to identify malnourished older people in emergency situations; and
- To identify risk factors for older people in Lokitaung Division, to make recommendations for targeting older people in emergencies.

Methods

A total of 457 older people were assessed. Key indicators for health and nutritional vulnerability in older people including morbidity, functional ability, psychosocial problems, changes in economic and social risk factors were identified. These indicators were assessed at household level, plus individual anthropometric measurements and observation of clinical signs.

A total of 12 focus group discussions (FGD) of older people and their caregivers were held. Focus groups were randomly chosen from the 30 clusters identified for the nutrition assessment based on their livelihood activities. Four of these clusters were from a fishing area, four from a pastoral zone and four from peri-urban centres. Discussions were participatory, and gender balance was observed in each group. Data was analysed using Epi Info 6.04 with the nutritional analysis performed by the EPINUT programme.

Major findings

22.9% and 20.5% of older persons had a BMI indicative of respectively moderate (BMI = 16-16.9) and severe (BMI <16) malnutrition. The prevalence of malnutrition assessed using a MUAC reference value of less than 22cm was 19.5% for men and 17.7% for women. No significant association between age and nutritional status (assessed using either BMI or MUAC) was found.

Loss of economic livelihood negatively affects the nutritional status of older people. Older people who reported having received gifts from their family (in the form of livestock products, money, indigenous fruits and part of the food ration given by humanitarian agencies) had a better nutritional status (higher MUAC and frequency of meals/day) than those who did not receive donations.

Other factors that were found to adversely affect the nutritional status of older people, based on MUAC assessment, were loss of a caregiver, loss of formal employment (during the first year of retrenchment), and evidence of symptoms of severe depression and reporting of raids by Karamojong neighbours in Uganda. During raids, younger people escape, leaving behind older persons and the livestock.

The presence of dehydration, extreme weakness, oedema, vomiting, immobility and kyphosis (extremely bent backs) were entered into regression models to determine predictors of poor nutritional status (MUAC <22cm). Oedema, dehydration, immobility and extreme weakness were found to predict the nutritional status of older people, followed by vomiting. Musculoskeletal conditions, such as arthritis (53.8%) and backache (43.3%), as well as abdominal pains (37.2%), loss of teeth/dental problems (28.7%), poor eyesight (43.9%), having child-care responsibilities (12.7%), and impaired mobility (3.1%) adversely affected older people's nutritional status.

During focus group discussions, older adults claimed that the transition from livestock-trading to a cash economy had negatively affected their well-being and ability to cope. Being a predominantly pastoralist community, with little or no literacy skills, the repeated droughts and political unrest had diminished grazing opportunities for their livestock, and had depleted the availability of indigenous fruits. Older people measure their food security in terms of the number of animals they own, and were thus experiencing severe food insecurity. They had learnt to eat maize and beans, provided by food relief agencies, in order to survive. Older adults reported that they felt powerless and depressed in their current circumstances, but that the church met their emotional needs.

Since 1999, registration for food aid has depended on the presence of a child, pregnant or lactating women or a caregiver. Thus, a group of older people was unable to register for aid. Many agencies do not have the skills to screen older people for selective feeding programmes. The general food ration, comprising yellow maize and beans, was not appropriate for older people. 81% reported disliking the yellow maize because of chewing difficulties (60%), tastelessness (32%), and difficulty to mill (19.3%). Unimix (a corn, soya bean and powdered milk supplement, with added vitamins and minerals) was commonly provided to children under five, and was occasionally given by the World Food Programme to older people in supplementary and therapeutic feeding schemes. Unimix was preferred to the maize and beans by the older adults.

Older people had no access to health facilities due to lack of money. Some obtained income by selling part of their food ration. Among the various groups, malnutrition among older persons was highest in the peri-urban community (18.8%), followed by the fishing community (15.3%) and then pastoralists (11.5%).

In children, the prevalence rate of global acute malnutrition (wasting: WFH <-2 and >-3 Z score) was 19.1% (95% Confidence Interval = 16.6-21.9%). Severe acute malnutrition (WFH <-3 Z score) was 2.6% (95% CI = 1.7-3.9%). The situation had rapidly deteriorated from March 2001, when global and severe malnutrition was found in 9.9% and 1.0% of children, respectively.

Questions:

Q: What are the main reasons for malnutrition in older people?

Q: What are the key interventions that are required by the humanitarian actors when targeting older people?

Q: What specific design considerations would be needed to ensure an effective intervention in these circumstances?

Case study 4: General food ration and related equipment for older IDPs in Liberia, 2004⁵

Learning objectives: Understand the shelter and physical needs of older people. Examine how to target this group. Allow participants to consider the layout and design including accessibility and location, safety and fall prevention, weather proofing and lighting.

Methods: Refer to the HelpAge shelter guidelines, p.108 to allow participants to enhance and improve the case study response. Access document here: <http://www.helpage.org/resources/practical-guidelines/emergency-guidelines/>

The situation for older people at the Fendell and Soul Clinic for Internally Displaced People (IDP) in Monrovia is critical. In the last six months, 15 have died in Fendell due to hunger and lack of medical care. The majority of these older people come from Lofa and Bong Counties. About 30% come from other counties. Most have spent the last five years running from one place to the other in search of shelter from the war. In June 2003, during the height of the conflict in Liberia, many of these older people arrived at the Camp, resolving to stay and never to run anywhere again.

There are now 3,259 older people in Soul Clinic's Last Displace Camp, and 551 in Fendell between the ages of 60 and 98. The older people have no relative to take care of them nor is the government in a position to do so. Many of the older displaced people do have children but do not know their whereabouts. Often the children that are with them are not capable of taking care of them.

The old people are subsisting only on the food rations provided by the World Food Programme. Each month, an individual receives:

6.9kg maize meal	0.45kg vegetable oil
1.05kg beans/lentils	1.8kg corn soybean
0.15kg salt	

Liberia's staple food is rice. The older people find it difficult to get adjusted to this new diet, so different from their own.

UNHCR distributed cooking utensils to family heads only. Since most of these old people came to the camp unaccompanied, they did not receive pots or pans. Instead, they are using empty oil tins as cooking utensils and as buckets to do their laundry or take bath. They no longer have footwear. Soap, toothpaste, toothbrush and other basic necessities are just not available to these older people. The blankets, and other clothing received from UNHCR in July 2003, have worn out.

How do they support themselves? Those who can still move around, walk for miles in the bush gathering palm branches to make house brooms that are sold for 5 Liberian dollars, which is less than 10 US cents. A 98 year-old woman making a broom says:

"If I can sell four of these brooms, I will buy one cup of rice and palm oil to eat today."

Having no source of income, or any relatives to assist them, many older people say that they are spending their last few days on earth in misery.

As the manager of these two IDP camps, UMCOR has been doing all in its power to alleviate the hardship these older people are facing by setting up a special group in Fendell to cater to their chores on a 24-hour basis. Plans are underway to have a similar group organised in Soul Clinic. The group comprises eight IDPs who have volunteered to help the old and vulnerable. The head of the group is given a small token at the end of each month. Taking full responsibility of such a volunteer group is not an easy job.

⁵ Adapted from Maxi, M, 2004. Report on the situation of the elderly at the Fendell and Soul Clinics, Internally Displaced People Camps, Liberia. <http://www.globalaging.org/armedconflict/countryreports/Africa/fendall.htm>

Questions:

Q: What are the issues that older people face in their use of the ration and how can they be overcome?

Q: What improvements in the general ration would you advise to ensure improved quality and accessibility of the ration for older people?

Q: What suggestions do you have for ensuring that distribution mechanisms include and account for the specific needs of older people?

Case study 5: Selective feeding programmes by Action Contre la Faim and HelpAge International in Juba, Sudan

Background

During the International Year of Older Persons in 1999, HelpAge International (HelpAge) undertook awareness-raising activities on the situation of older persons in Juba, Sudan. In the process, it was recognized that many older persons had no access to feeding programmes due to lack of family support or neglect.

In August 1999, community mobilisation efforts began to identify housebound older persons with severe malnutrition who required therapeutic feeding. By April 2000, 100 cases had been assisted and recovery was observed to be successful with no individuals regressing back into the state of severe malnutrition.

In August 2000, HelpAge began implementing a community-based programme designed to improve older people's access to health and nutrition services. Further cases of severe malnutrition, particularly amongst housebound older people or those with poor mobility, were identified.

In October 2000, at the request of HelpAge, Action Contre La Faim (ACF) agreed to increase its capacity at the Therapeutic Feeding Centre (TFC) to admit severely malnourished older people referred by HelpAge community workers.

The project was aimed at providing therapeutic feeding facilities to older persons with severe malnutrition in Juba and surrounding accessible areas and to provide supplementary feeding to patients who were discharged from the therapeutic feeding programme.

Objective

To document the feeding programmes provided to severely malnourished older persons admitted to an NGO-operated therapeutic feeding centre in Juba, Sudan.

Major findings

Between October 2000 and February 2001, 103 adults and older people were admitted into the ACF Therapeutic Feeding Centre and treated as follows:

The nutritional treatment of severe malnutrition in adults and older persons is based on the same formula used to treat children, F75, F100 or HEM,⁶ porridge, family meal and fruits/vegetables), with added minerals and vitamins. However, the amount of milk given per kilogram of body weight is much less for adults than children as dairy-related energy needs decrease with age. The nutritional treatment is divided into four phases:

Phase 1: during the acute phase of the treatment, older people and other adults receive only a diet of F75 milk, which contains low levels of protein, fat and sodium. The initial goal of this phase is to prevent further tissue loss. The average duration of Phase 1 is four days. When appetite is regained and, as in the case of kwashiorkor, as the oedema is reduced, individuals are promoted to the Transition Phase.

Transition Phase: it allows gradual increase in the amount of protein and fat, in order to restore the physiological imbalances and avoid any abrupt changes in diet (from F75 milk to F100 milk). After 2 days in the Transition Phase, older adults enter Phase 2.

Phase 2 (Rehabilitation phase): beneficiaries begin to regain lost weight and appetite increases. During rehabilitation, older persons and other adults become very hungry and often refuse the formula feed (i.e. milk), demanding solid foods. At this stage, meals are given, based on the recipient's traditional foods with added oil, minerals and vitamins. The diet comprises a variety of foods and allows the older people to eat as much as they desire. The variety of food includes vegetables (tomatoes and green leaves), beans, meat, fish and fruits. Older adults continue to receive the formula feed (F100 milk), which is supplemented with porridge made from corn soya bean (CSB), oil and sugar, and enriched with vitamins and minerals. At this stage, eight meals (seven servings of milk and one of porridge) are provided to the beneficiaries each day, as they still require intensive care. The beneficiaries move onto the Consolidation Phase (Phase 3) once they reach a BMI equal to or above 15 (for older persons) or a BMI equal or above 17 for other adults.

Phase 3 (Consolidation Phase): this is the final stage of the treatment where the beneficiary is prepared for discharge. The beneficiary continues to receive a formula feed (F100 milk) but the number of meals is reduced to five. They continue to receive porridge made from CSB, oil and sugar and enriched with a mineral and vitamin complex. The family plate (pulses, vegetables, meat and fish) and fruits continue to be provided for adults and older persons in this phase.

All adults⁷ and older persons received systematic treatment, which included Vitamin A, folic acid, amoxicillin, mebendazole, ferrous sulphate and chloroquine. They were attended to by a medical assistant every day in Phase 1 to assess and follow up on their underlying medical problems. In Phases 2 and 3, older adults were attended to once every two days. For those whose condition was deteriorating, reviews were increased to once a day until their condition improved. Specific treatment was given according to diagnosis.

During the treatment, health education relating to the prevention and management of malnutrition was imparted to the beneficiaries on a daily basis. Health educators also tackled the problem of defaulters from the centre. During the reporting period, the number of defaulters among adults and older persons was 5.4%, which was considered to be satisfactory (the ACF target is <15%). ACF health educators and home visitors continued to spread messages in the community about malnutrition. The main reason for defaulting was the preference for special solid food instead of the formula diet (i.e. milk).

Adults, mainly pregnant and lactating women, were discharged from the feeding centre when they were considered to be eating well, had gained weight, had maintained a BMI of equal or above 17.5 for eight days, no longer had oedema for 15 days and were able to walk. For older people, the same criteria applied, with the exception that BMI should remain equal to or greater than 16.5 for at least eight days.

⁶ F75 and F100 are therapeutic milks used in Phases I and II in the treatment of severe malnutrition. F75 has an energy value of 75kcal per 100ml, while F100 provides 100kcal/100ml. Both milks are fortified with vitamins and minerals.
HEM = High Energy Milk formula is Dry Skimmed Milk+Oil+Sugar+Complex of minerals and vitamins.

⁷ Postmenopausal women.

The outcomes of the individuals followed up during the study period study were as follows:

- Of the 103 admitted, 68% (17 adults and 53 older persons) were successfully treated during the period. By the end of Feb 2001, 19 adults and older persons were still being treated in the TFC.
- Two adults and eight older persons were transferred to hospital. Among the eight transferred older people, two died (one due to TB and the other due to severe pneumonia), while the remaining six were later discharged from hospital and went home.
- Four older persons defaulted during the reporting period (Default rate = 5.4%).
- No death of adults or older persons occurred in the TFC between October 2000 and February 2001.
- The average weight gain for both adults and older persons was 6.6g/kg/day and the average length of stay for both adults and older persons was 42.1 days.
- The average weight gain was lower than ACF's general recommendations⁸ and the length of stay longer than recommended. Thus, treatment of severe malnutrition in these two groups takes longer than in children.

ACF planned to follow-up the nutritional status of the older persons and other adults for six months after discharge. However, in January 2001, the period of follow up was reduced to three months due to lack of food supplies from WFP. During the first month of follow up, adults and elders were visited weekly and their nutritional status assessed.

They received a ration of CSB, oil and sugar which provided a total of 1,019kcal per day. For the second month, beneficiaries were seen every two weeks and then once during the third month. They continued to receive a ration that provided 509kcal per day in the second month and 255kcal per day in the third month.

Challenges faced and solutions

The main constraints that the TFC staff faced were:

- The absence of adequate numbers of carers to accommodate the additional needs (i.e. assistance with toileting, bathing, and laundry) of adults or older persons who were very weak or disabled.
- Some of the adults and older persons preferred to eat solid food and were unwilling to consume the formula diet (milk).

To address this problem, HelpAge appointed a social worker to care for those adults and older persons who were disabled or too weak. A family meal (lentils, vegetables, meat and fish) was provided from Phase 2 onwards. It is usually recommended to introduce the family meal only during Phase 3 as the most efficient treatment regimen is based on the specific nutritional products (F75, F100 or HEM). The introduction of the porridge and family meal is only to prepare the person for the food that she/he will receive at home.

Activity:

The group is to establish the key four facts relating to this situation and be prepared to highlight these to an in-coming CEO.

You have 3 minutes with the CEO before they leave for a field visit, including this project site.

What do you want them to be aware of and what do you wish to share to enable this project to be further supported by the CEO?

⁸ Adult Malnutrition in Emergencies, Field Guidelines, Action contre la Faim, Carlos Navarro-Colorado; 2006.
http://www.actioncontrelafaim.org/sites/default/files/publications/fichiers/adult_malnutrition_guidelines_gb0108-sept2006_0.pdf

Case study 6: Haiti: HelpAge International tackles psychosocial components

Learning objective: Generate awareness of psychosocial components within planning and design of interventions.

In Haiti, HelpAge International established Older People Associations (OPAs) in displaced camps and communes immediately after the earthquake. These OPAs aim at involving older people in community activities such as home visiting, disaster risk reduction, livelihood and income generating activities, and re-socialisation of older people. They also aim at representing older people in the community and defend their rights.

HelpAge provided each OPA with a small functioning budget (to be maintained through income generating activities) and with media equipment (TV, DVD and CD players). Each OPA has an equipped community centre.

Anecdotal evidence points to a number of self-started initiatives and actions taking place as a result of these OPAs:

- In Croix des Bouquets, the OPA has successfully advocated for the integration of older people in a 'cash for work' activity and obtained the dismissal of a camp committee that was not working for the well-being of camp residents.
- In Jacmel, one OPA has created a cash box where members can contribute. With the contributions, they are able to support a members facing problems. For example they were able to cover funeral fees for one member.
- In Petion-Ville, OPA members have started a literacy programme for those of the association who cannot read and members have replicated the training they receive on hygiene promotion to prevent cholera.
- In Petit-Goâve, the communal association has taken the initiative of setting up OPA at the communal section level.
- In two camps (Marassa 14 and Theatre National) OPA members were allowed to join the camp committee.
- In Petion-Ville, OP are more aware of their rights and are more demanding. For example one OP requested better service at one health centre.
- Two health centres: Eliazar Germain in Petion-Ville and Memphis Medical Mission in Croix des Bouquets have opened up special lines for older people, as a new good practice.
- A video clip produced by HelpAge has allowed an older person placed in a nursing home to reunite with relatives who thought she was dead.
- Older people are socialising more now, while attending games sessions or the 'media club'.

Questions:

Q: Outline three key reasons from this article as to the importance of establishing OPAs?

Q: List some of the opportunities and challenges of supporting OPAs in an emergency setting.

Q: From your experience, what recommendations would you give to the group to enable these associations to be effectively established?