DRAFT

OPERATIONAL GUIDELINES

ELDERLY CARE AT HEALTH AND WELLNESS CENTRES

OPERATIONAL GUIDELINES – ELDERLY CARE

Background and Rationale

(i) Population ageing is inevitable and with socio-economic development, declining fertility and increase in survival at older ages, the proportion of older people (60 years and above) in general population has increased substantially within a relatively short period of time. India recorded a significant improvement in life expectancy at birth, which was 47 years in 1969, growing to 60 years in 1994 and 69 years in 2019[1].The share of population of elderly was 8% in 2015 i.e. 106 million (10 crores plus) across the nation making India the second largest global population of elderly citizens. Further, it has been projected that by 2050 the elderly population will increase to 19%[2].

(ii) As the elderly population continues to grow, elderly dependency ratio will rise dramatically from 0.12 to 0.31. Gender disparity has also been reported with 50% of women aged 75 years and older report difficulty with at least one Activity of Daily Life (ADL) compared to only 24% of men, adding the focus towards female elderly care[3].

(iii) Elderly populations have varying and complex social and health- care needs. For example, while dementia may be addressed with health inputs, the social and financial insecurities that may co-exist require inputs from the social welfare and finance sectors. A multidisciplinary and multisectoral approach, comprising professionals and general staff from several relevant sectors, should be considered as the key mode of care delivery for the elderly populations.

(iv) World report on ageing and health (2015) defines goal of healthy ageing as maintaining the functional ability in elderly to enable wellbeing. The concept of healthy ageing focuses on both intrinsic capacity as well as functional ability of elderly population. WHO's guidelines on Integrated Care for Older People (ICOPE) also embodies focus on optimizing the intrinsic capacity and functional ability as the key to healthy ageing. Inclusion of this approach in delivery of primary health care services for elderly would not only strengthen the existing service delivery at HWCs for elderly but would also support the society to minimize the care-dependency of elderly.

(v) Ministry of Health & Family Welfare launched "National Programme for the Health Care of Elderly" (NPCHE)[7] in 2010 with an objective to provide dedicated health care facilities to the senior citizens (>60 year of age).

The programme aims to provide accessible, affordable, and high-quality long-term, comprehensive and dedicated care services to an Ageing population; create a new "architecture" for Ageing; and build a framework to create an enabling environment

for "a Society for all Ages". It also promotes the concept of Active and Healthy Ageing. One of the objective of the programme is also to strengthen the convergence between various departments i.e. National health Mission, AYUSH and Ministry of Social Justice and Empowerment.

(vi) The guidelines on Elderly care at Health and Wellness Centres envisages strengthening of healthcare delivery for elderly patients in both rural and urban areas and to be included in the set of services being offered as part of Comprehensive primary health care. This intervention would be an adjunct to NPHCE and utilize the existing resources under this programme.

(vii) In view of the opportunities and challenges pertaining to the ageing population, HWCs with support of community based platforms, would also focus on promoting and protecting rights of elderly people and elimination of discriminations including neglect, abuse and violence against elderly and enhancing their dignity in the community.

(viii) The range of facilities and outreach mechanisms vary widely between and within States, and local context specific mechanisms would need to evolve through a process of piloting and study like need based assessment for delivering service, HR rationalization etc. before being scaled up.

(ix) These Operational Guidelines are intended for State and District Program Managers and service providers to strengthen health care services for the elderly. Other companion documents include training manuals and standard treatment guidelines that would be updated and disseminated on a periodic basis.

Service Delivery Framework

The Operational Guidelines of Elderly care at Health and wellness centers envisages mobility-based classification of elderly with three main categories - Mobile Elderly, Restricted elderly and Bedbound / Home bound elderly for any reason. Such categories would be used in the assessment of high-risk elderly and prioritize accordingly for service delivery.

With age friendly primary health care services, the consequences of chronic disease conditions can be minimized through promotive and preventive care including screening, early detection and follow up of those who undergoing treatment or with advanced disease conditions. Services for the health care of the elderly will be delivered at the community and facility levels.

Individual/ Family/ Community level:

The Front-line workers – ASHA/ASHA Facilitators, Multi-Purpose Workers (MPW -F/M, Community Health Workers (CHW), where available, would provide care via community platforms. Services delivered at this level would include:

- Household visits to be undertaken by ASHA/AF supported and supplemented by MPWs (F/M) for community mobilization for improved care seeking, risk assessments, counselling and increasing supportive environment in families and community.
- Awareness generation in the community about healthy lifestyle for the elderly to promote active and healthy ageing, recognizing signs and symptoms for common health problems affecting the elderly, and various social security schemes for the elderly.
- Providing information to the community members especially families having elderly people regarding promotive and preventive care viz. environmental modification, nutritional intervention, lifestyle and behavioral changes for healthy ageing and physical activities including yoga.
- Identification of elderly individuals in need of care in the community. Mapping of population under HWC for elderly in the family to identify bedbound, restricted and mobile elderly. In addition, ASHA would identify destitute elderly in her area and list them to establish a communication between the primary health care team and the identified elderly.
- ASHA Facilitators with support from Multi-Purpose Worker (F/M) would undertake initial person centered assessment (*Annexure I*) for any individual with suspected decline in intrinsic capacity. Individuals identified with priority conditions associated with declined intrinsic capacity are to be referred to the linked HWC for in-depth assessment and obtaining a personalized care plan.
- Identification of caregivers within or outside the family with support from HWC and linking them to nearest health care facility. During the household and follow up visits, frontline workers would also provide support to caregivers ensuring their physical and mental wellbeing.
- Facilitating formation of Elderly Support Groups and Elderly Care-giver Support Groups to ensure engagement of elderly and caregivers as well as family members. Monthly meetings of these support groups would be held in the community and facilitated by CHO/MPW(F/M).
- Forming linkages with community fora such as Gram Sabha, ULBs, SHGs, VHSNCs/MAS, and involvement of local NGOs and self-help groups. Engagement of community fora in ensuring healthy and facilitative environments for elderly in the community, which would help in decreasing the burden on caregivers.
- Identification and reporting of medical conditions suspected to be elderly abuse cases to the HWC and provide support in family counselling and redressal of medical issues.

Health and Wellness Centre – Sub Centre:

Community Health Officers (CHO) would provide the primary level care at the Health and Wellness Centres-Sub Health Centres, including screening and primary management, and would enable adherence to treatment protocols. Services delivered at this level will include:

- Screening of elderly individuals for Cognitive decline, Limited mobility, Malnutrition, Visual impairment, hearing loss, depressive symptoms in addition to existing services at HWCs including NCD screening. This would enable early identification of chronic conditions in the elderly and facilitate prompt referral for treatment and follow up to ensure treatment compliance.*(Annexure II)*
- For elderly identified at the community level, with priority conditions associated with declined intrinsic capacity, an in-depth assessment (*Annexure I*) would be done at HWC to develop a personalized care plan.
- Facilitation in identifying the care giver and providing guidance regarding care to be given especially for the bed bound elderly. Primary Health Care team lead by CHO to also ensure that a continuous psychological intervention, training and support is being offered to family members and other informal caregivers of care-dependent elderly people.
- CHO would maintain a list of medicines required by the elderly which have been prescribed to them by Medical Officer or Specialist and dispense them at the HWC. For bedbound elderly, ASHA/AF would be engaged to provide medicines at their doorstep.
- CHOs would be facilitating the identification of elderly in the community needing assistive devices such as canes, crutches, and walkers etc. which would increase base of support, improve balance, and increase activity and independence. The required assistive devices could be procured from the PHC, depending on the need based assessment undertaken by Primary Health Care team at the HWC/community level.
- For common and emergency geriatric ailments, CHO would be providing immediate / primary management and referral to the Medical Officer at the linked PHC, if and when required.
- Oral supplemental nutrition with dietary advice should be recommended for elderly affected by undernutrition.
- Maintain a record of all the general OPD for elderly, camps related or referral records in a standardized recording format.
- Establish linkages with – a) NGOs for support group meetings and health promotional activities; b) government departments, such as Department of Social Justice and Empowerment, District Legal Aid Authority, Panchayati Raj Institutions (PRIs), Urban Local Bodies (ULB) etc. to facilitate access to entitlements/schemes/programs for the benefit of the elderly; c) referral and integrated/coordinated care linkages with other programs (elderly and palliative care, communicable diseases and NCDs program etc.)

Primary Health Centre/Urban Primary Health Centre (Health and Wellness Centre) level:

Medical Officers at PHC/UPHC will provide assured elderly care services which includes:

- Conducting comprehensive health assessment of the elderly persons including for Cognitive decline, Limited mobility, Malnutrition, Visual impairment, hearing loss, depressive symptoms along with existing services like NCD screening.
- Treatment including pain management for common geriatric ailments, and provision of medicines and counselling. Oral supplemental nutrition with dietary advice should be recommended for elderly affected by undernutrition.
- A weekly geriatric clinic could be organized at the PHC/UPHC where a trained Medical Officer would provide services. This would improve access to care in a hassle-free manner for the elderly. Rehabilitation services including through physiotherapy and counselling, to be provided on fixed day approach.
- Organizing screening camps including counselling on life style modifications, as an outreach activity for elderly in the community.
- Indenting and purchase of required assistive devices for the elderly and coordinating with primary health care team for distribution to the disabled elderly persons to make them ambulatory.
- Maintaining a record of all the general OPD for elderly, camps related or referral records in a standardized recording format.
- Public awareness on promotional, preventive and rehabilitative aspects of geriatrics during health and village/urban sanitation day/camps.
- Medical Officer would also liaise with the other National Health programme for the provision of diagnostics, equipment, consumables, medicines and services for Elderly clinic.

Secondary and Tertiary Centre level

- Availability of specialist services (General Medicine; Orthopedics, Ophthalmology; ENT, Dental, Psychiatry services etc.) will ensure multi-disciplinary care upon referral of elderly people to the secondary level. Rehabilitation services like physiotherapy and counseling services will be available by specialists at the secondary level facility. Geriatric clinic will be arranged twice a week at the CHC level and regularly at DH/SDH levels.
- Rehabilitation worker, where present, at the CHC level would also be involved in making domiciliary visits for bed bound elderly and supporting the care givers and family members.
- Specialists would also provide the ongoing clinical support and supervision for the continued management of persons with teleconsultation from the HWC - PHC/UPHC in an integrated and coordinated manner.

- Facilities for laboratory investigations for diagnosis and provision of medicines for geriatric medical and health problem.
- Referrals will be made to tertiary care facility like DH/Regional Geriatric Centre for complications.
- The secondary level facilities will hold awareness generation activities at the facility level, and may provide assistance in the outreach activities being conducted at the HWC or community level.

Health Promotion including IEC for Behavior Change Communication

- Promoting healthy behaviors to adopt healthy lifestyles behavior change is critical for prevention and control of Chronic conditions including Non-Communicable diseases in the elderly. IEC activities pertaining to the associated risk factors such as tobacco and alcohol consumption, poor dietary habits, physical inactivity and various morbidities, and awareness material on the same must be displayed at the HWCs. Awareness generation in the community regarding modifications within the physical home environment would help reduce hazards that cause falls and fractures in the elderly. Individual and family counseling would be needed for households with bed-bound elderly individuals, and for psychosocial needs of the elderly including counseling for the caregivers.
- Community awareness activities to be undertaken on promotional, preventive and rehabilitative care during Village/ward level meetings.
- Organization of health education camps to address basic issues like personal hygiene maintenance, nutritional counseling and explaining the associated risks to the caregiver would be done. Local NGOs involvement and other Self-Help Groups can be utilized for imparting health education, providing support to open accounts and informing the authorities on any pending issues relating to fund transfer under existing National schemes.
- Other awareness generation activities will include:
    - Sensitizing caregivers in identifying common elderly problems and providing them with home-based solutions.
    - Prevention of risks of fall, malnutrition and neglect of care which is very common in elderly through identifying and providing advice for geriatric friendly home settings.
    - Awareness on various social security schemes such as Pradhan Mantri Suraksha Bima Yojana, National Pension System etc. for elderly and also providing various aids under NPCHE programme
- Linkages to be established with existing National Health Programmes like mental health, eye health, oral health and tobacco cessation programme. This will facilitate easy access to consultation at counseling Centres, deaddiction Centres, etc.

- AYUSH services available at the primary and secondary health facilities would also provide elderly care services. The elderly subgroup will have an option if they wish to consult AYUSH practitioners. Linkages with AYUSH / local NGOs for providing yoga, meditation and physical exercise including multimodal exercise (balance, strength, flexibility and functional training) for elderly at risk of falls will be made.
- Support groups for elderly should be organized to improve motivation and share the challenges and success of the elder abuse, lifestyle changes, reduction in the substance abuse and adherence to treatment.
- Following a specialist's assessment, home modifications to remove environmental hazards that could cause falls could be recommended for older people at risk of falls.

Referral and treatment: Ensuring Continuum of Care:

- Well-defined referral linkages are to be established across all levels of health care facilities. Well established networks of health and social care providers would enable timely referral of identified elderly individuals. [1]
- Strong referral pathways for elderly care would also improve access to care in case of an unforeseen emergencies like falls and thus ensuring timely management to avoid complications.
- Regular and sustained follow up with integration among different range of services delivered across the levels of health care facilities is an essential component for implementing elderly care services at the HWCs. This helps in early detection of complications and thus avoiding unnecessary emergencies.
- Elderly with complications of acute or chronic diseases and severe conditions are to be referred from the SC-HWC to the PHC Medical Officer. Referral to specialists at the secondary or tertiary level to be accompanied by specific instructions to the elderly patient regarding details of the specific facility, day and time of visit for fixed day specialty OPDs, etc. ASHA/MPHW should continue to follow up patients coming from the higher centers back to the community. Written treatment plan from the referral Centres will be followed up for adherence at the HWC.
- In order to expand access to services, and reach remote populations, Mobile Medical Units would enable an expansion of service delivery and serve the role of enabling the provision of care and serving to establish Continuum of care.
- Medical colleges with existing Elderly care set up would act as tertiary referral Centre.

Drugs and diagnostics:

[1] Integrated care for older people (ICOPE) implementation framework : guidance for systems and services.

- Medicines supply would be as per the state Essential Drug List (EDL), facility wise and buffer stocks would be maintained at all levels.
- The Drugs and Vaccines Distribution System (DVDMS) linked with Comprehensive Primary Health Care - IT application should support regular supply and availability of required medicines and diagnostics.
- Prescribing of medicines will be done by the Medical Officer at the level of PHC/UPHC. Medication will be prescribed for use as per the Standard treatment guidelines.
- Subsequent dispensing of medicines for patient who are being followed up in the community can be done at the level of the SHC-HWCs by the Community Health Officer on the recommendation of and in consultation with the MOs.
- Special attention will be given to the home bound / bedridden elderly persons regarding drug prescription and dispensing as well as assistive devices.
- The Medical Officer will liaise with the other National programme for the provision of diagnostics, equipment, consumables, medicines and services for Geriatric Clinic.

Capacity Building Plan

- ASHAs/AFs would be trained in undertaking initial person-centred assessment in the community, identifying risk factors for common conditions in the elderly, awareness generation regarding lifestyle modification in the elderly, providing support to caregivers, and services available for elderly at HWCs and referral centres. AFs would be trained to provide better support to ASHAs.
- Primary Health Care team - ASHAs /AF /MPW/CHO would also be trained to build skills and competencies to train caregivers and support them in developing a range of practical skills like transferring a bed bound elderly within house, support in daily routine activities like eating, bathing etc.
- MPWs would be trained on preventive and promotive care for elderly problems, related to early detection of cases, primary management, referral and follow up mechanism.
- Existing pool of State and District ASHA trainers would be trained to undertake training of ASHAs in a cascade manner.
- CHOs/MOs would be trained on conducting in-depth person-centred assessment of elderly, providing preventive and promotive care for the elderly, primary management of common geriatric ailments, referral and follow up mechanism. Training would also be given to the Primary Health Care Team at the HWCs on assessment of intrinsic capacity and functional ability of the elderly. They would also be trained on the various assistive devices for the elderly and their usage.
- Regional Geriatric Centres (*Annexure III)* established under NPHCE would support in building skills and competencies of Medical Officers in Elderly care. In addition, they would also be used for training of trainers for state and national level trainers for different cadre of health workers across the level of care.

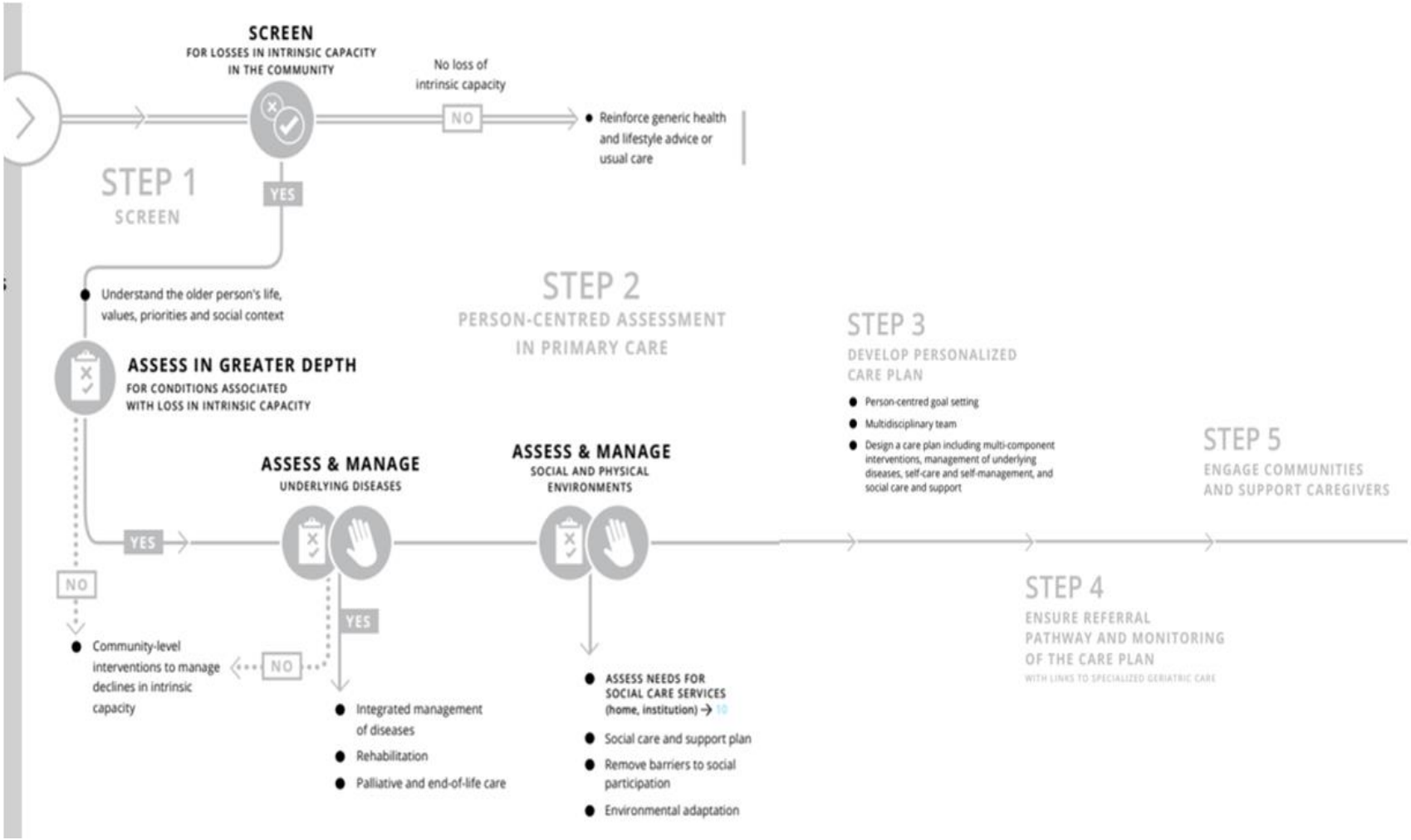
- A one-day Orientation of Programme officers and BPM/DPM would be required so that they are in synergy with the programme features and understand the roles and responsibilities related to support (including availability of medicines and consumables), monitoring (reports, records) and supervision.

Monitoring and Supervision:

The programme and monitoring data for Elderly services needs to be integrated and adopted in the existing monitoring system, operational under MoHFW. The following indicators would be used to monitor the programme:

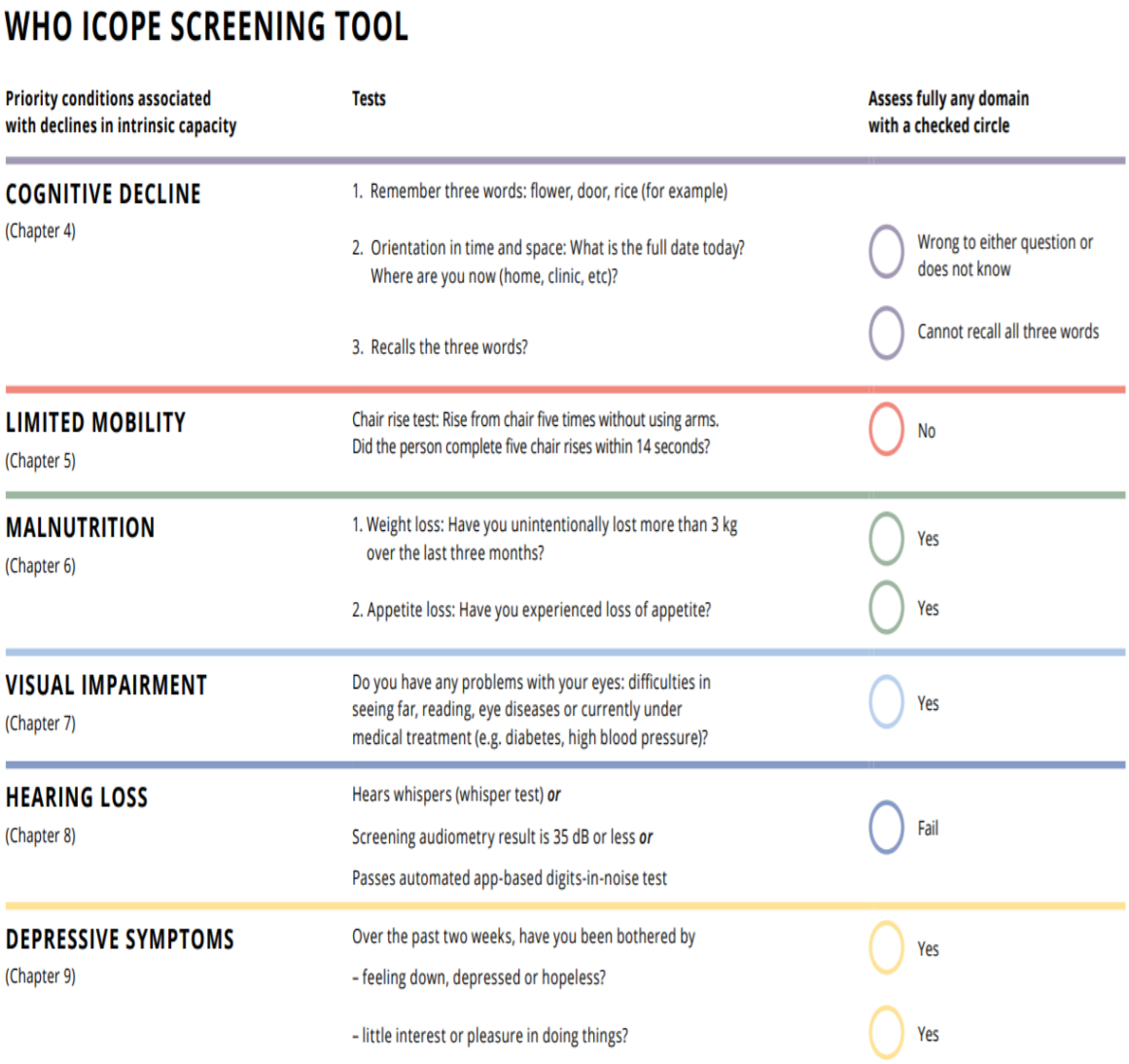
- Proportion of bed bound elderly in the HWC catchment area (Bed bound elderly/Total number of elderly X100)
- Proportion of elderly population screened as part of comprehensive geriatric assessment by CHO
- Proportion of elderly individuals provided with supportive/assistive devices
- Proportion of elderly reported with cognitive decline
- Proportion of elderly reported with malnutrition
- Proportion of elderly reported with Visual impairment
- Proportion of elderly reported with Hearing loss
- Proportion of elderly reported with depressive symptoms

Annexure I : Generic Care Pathway : Person centered assessment



Source: World Health Organization. (2019). Integrated care for older people (ICOPE): guidance for person-centered assessment and pathways in primary care. World Health Organization.

Annexure II – WHO ICOPE SCREENING TOOL



WHO ICOPE SCREENING TOOL

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

Source: World Health Organization. (2019). Integrated care for older people (ICOPE). World Health Organization

Annexure III – Regional Geriatric Centres

	Regional Institutes	States Linked
1	All India Institute of Medical Sciences, New Delhi	Delhi, Haryana, Uttarakhand, Punjab Himachal Pradesh, Madhya Pradesh
2	Institute of Medical Sciences, Banaras Hindu University, Uttar Pradesh	Uttar Pradesh, Bihar, Jharkhand, West Bengal
3	Sher-e-Kashmir Institute of Medical Sciences, Srinagar, Jammu & Kashmir	Jammu & Kashmir
4	Govt. Medical College, Tiruvananthapuram, Kerala	Kerala, Southern Districts of Karnataka & Tamil Nadu
5	Guwahati Medical College, Guwahati, Assam	Assam & NE States
6	Madras Medical College, Chennai, Tamil Nadu	Tamil Nadu, Andhra Pradesh, Orissa
7	SN Medical College, Jodhpur, Rajasthan	Rajasthan & Gujarat
8	Grants Medical College & JJ Hospital, Mumbai, Maharashtra	Maharashtra, Goa, Northern Districts of Karnataka, Chattisgarh

Source: Operational Guidelines - NPHCE, National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India.

Annexure -IV

Questionnaires for Assessment for Elderly:

Risk Assessment of Falls :

S.No	Item	Yes	No
1	Have you ever had a fall in last one year?		
2	Are you taking more than 4 types of medicines? (sedatives, antidepressants, anti-Parkinson's, antihypertensives, diuretics, etc)		
3	Are you suffering from any of the following? (anxiety, depression, loss of judgement / cooperation / insight)		
4	Did you have dizziness or lightheadedness on getting up from the bed in last one year?		

For positive response to >2 questions, refer to CHO. (adapted from Falls Risk Assessment Tool)

Activity of Daily Living (CHO):

Activities Points (0 or 1)	Independence (1 point) NO supervision, direction or personal assistance	Dependence (0 point) WITH supervision, direction, personal assistance or total care

Bathing	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	(0 POINTS) Needs help with bathing more than one part of the body, getting in or out
Dressing	(1 POINT) Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
Toileting	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode
Transferring	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.
Continence	(1 POINT) Exercises complete self-control over urination and defecation	(0 POINTS) Is partially or totally incontinent of bowel or bladder.
Feeding	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding

TOTAL POINTS = _____ 6 = High (patient independent) 0 = Low (patient very dependent)

Geriatric Depression Scale (CHO):

Item	**Answer**	**Score**
Are you basically satisfied with your life?	Yes/ **No**	

Have you dropped many of your activities and interests?	**Yes**/ No	
Do you feel that your life is empty?	**Yes**/ No	
Do you often get bored?	**Yes**/ No	
Are you in good spirits most of the time?	Yes/ **No**	
Are you afraid that something bad is going to happen to you?	**Yes**/ No	
Do you feel happy most of the time?	Yes/ **No**	
Do you often feel helpless?	**Yes**/ No	
Do you prefer to stay at home, rather than going out and doing new things?	**Yes**/ No	
Do you feel you have more problems with memory than most?	**Yes**/ No	
Do you think it is wonderful to be alive now?	Yes/ **No**	
Do you feel pretty worthless the way you are now?	**Yes**/ No	
Do you feel full of energy?	Yes/ **No**	
Do you feel that your situation is hopeless?	**Yes**/ No	
Do you think that most people are better off than you are?	**Yes**/ No	

Answers in bold indicate depression. Score 1 point for each bolded answer. A score > 5 points is suggestive of depression. A score ≥ 10 points is almost always indicative of depression.

A score > 5 points should warrant a referral to the PHC

Annexure V : MMSE (Mini Mental Status Examination):

Mini-Mental State Examination (MMSE)

Patient's Name: _____ Date: _____

***Instructions:* Ask the questions in the order listed. Score one point for each correct response within each question or activity.**

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day of the week? Month?"
5		"Where are we now: State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials: _____
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, …) Stop after five answers. Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.) 
30		TOTAL

(Adapted from Rovner & Folstein, 1987)

Source:www.medicine.uiowa.edu/igec/tools/cognitive/MMSE.pdf

If value < 24 refer the individual to PHC, if the individual has studied above 8th class

If value < 21 refer the individual to PHC, if the individual has studied below 8th class

Annexure VI : Suggestive List of Equipment at the HWC – SHC/PHC/UPHC

Logistics:

SC- HWC	Walking Sticks
	Calipers
	Infrared Lamp
	Shoulder Wheel
	Pulley
	Walker (ordinary)
PHC/UPHC	Exercise Bicycle
	Nebulizer
	Shoulder Wheel
	Walker (ordinary)
	Cervical traction (manual)
	Lumber Traction
	Gait Training Apparatus
	Infrared Lamp

Source: Operational Guidelines - NPHCE, National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India.

Table of References:

1. SRS based abridged life tables 2013-17 : http://censusindia.gov.in/Vital_Statistics/SRS_Life_Table/SRS%20based%20Abridged%20Life%20Tables%202013-17.pdf
2. Elderly in India 2016 : http://mospi.nic.in/sites/default/files/publication_reports/ElderlyinIndia_2016.pdf
3. Arokiasamy P, Bloom D, Lee J, et al. Longitudinal Aging Study in India: Vision, Design, Implementation, and Preliminary Findings. In: National Research Council (US) Panel on Policy Research and Data Needs to Meet the Challenge of Aging in Asia; Smith JP, Majmundar M, editors. Aging in Asia: Findings From New and Emerging Data Initiatives. Washington (DC): National Academies Press (US); 2012. 3. Available from: https://www.ncbi.nlm.nih.gov/books/NBK109220/
4. WHO Guidelines on Integrated Care for Older People (ICOPE), World Health Organization.
5. WHO Regional strategy for healthy ageing (2013–2018), World Health Organization.
6. World report on ageing and health, World Health Organization.
7. NPHCE Operational guidelines. DGHS, MOHFW. https://main.mohfw.gov.in/sites/default/files/8324324521Operational_Guidelines_NPHCE_final.pdf
8. National Sample Survey Organization (NSSO) Ministry of Statistics and Programme Implementation Government of India