Nutrition interventions for older people in emergencies: *a summary*

The background

The right to adequate food is recognised in a number of international instruments and includes the right to be free from hunger. When asked about their needs in emergencies older people prioritise health and food alongside shelter. Adequate food and nutritional intake is critical for maintaining good health, and is hence a key determinant of people's ability to survive and recover from disasters. Older people have specific needs in relation to their general food intake, micronutrient requirements and palatability of food, which makes them particularly vulnerable to disruptions in food security.

Perhaps the single most important factor in determining the nutritional vulnerability of older people affected by emergencies is the attitude of humanitarian personnel who feel that older people "have had their day" or are "a waste of resources". These attitudes mean that very few programmes are developed to meet the specific needs of older people and that the design of most humanitarian interventions unwittingly discriminates against them.

Source: Borrel A, Addressing the nutritional needs of older people in emergency situations in Africa: ideas for action. HelpAge International Africa Regional Development Centre, 2001, Foreword

In emergency situations, older people may find it hard to access food. For example, when they are displaced, older people may face difficulties in registering for the general food rations, meet challenges in accessing food distributions (waiting in queues for long periods, competing with younger more aggressive beneficiaries), and difficulties transporting the food. These obstacles potentially undermine equal access. Additionally, older people may face difficulties eating the food provided, which might be different from their usual diet. They may be unable to chew the food, or unable to cook due to a lack of fuel.

In droughts and food crisis situations, where the price of food is generally high, older people, who are often amongst the poorest, are frequently unable to afford enough food for themselves or their families. Furthermore, in cases of food insecurity, older people may choose to give their ration to younger members of their family.

Despite the growing body of evidence related to older people's challenges in meeting their nutritional needs in emergencies, there are very few specific nutrition interventions targeting older people in humanitarian situations, in

contrast to pregnant and lactating women and children under five for whom targeted assistance is a well established practice.

The World Food Programme (WFP) 2012 nutrition policy states that:

> "*In countries, provinces or districts where GAM prevalence is at least 10 per cent among children aged 6–59 months – or where it is 5–9 per cent, but aggravating factors exist – WFP will work with governments to strengthen and expand programmes for treating children aged 6–59 months with MAM and reducing undernutrition among pregnant and lactating women*"[1]

WFP's position is representative of the approach taken by most major actors in nutritional response across the UN and NGO sector in which older people are generally not considered a priority.

This document provides general guidance for the implementation of emergency nutrition activities ensuring the inclusion of older people and addressing their specific needs. Its primary target is humanitarian actors working in the field - no specific knowledge of nutrition is assumed.

While the guidance recognises the connection between nutritional wellbeing, food security and health care it does not provide guidance on programming in these areas. These can be found in other HelpAge documentation.[2]

At both global and field level, this guidance can also be used to highlight and advocate for the nutrition needs of older people in humanitarian crisis.

[1]. *WFP Nutrition Policy*, 17 January 2012, Policy Issues, Executive Board First Regular Session Rome, 13–15 February 2012, Agenda item 5, document for approval.

[2]. *Health interventions for older people in emergencies* (available in French and English) http://www.helpage.org/what-we-do/emergencies/health-interventions-for-older-people-in-emergencies-/ and *Food security and livelihoods interventions for older people in emergencies* (available in French in early 2013) http://www.helpage.org/what-we-do/emergencies/food-security-and-livelihoods-interventions-for-older-people-in-emergencies/

The commitments

The United Nations defines older people as those 60 years of age and above. However, the definition should be adapted to local contexts. For example, in many developing countries, people aged 50 years are considered to be old due to cultural and social factors which contribute to this perception.

The right to food and to be free from hunger is a fundamental part of our human rights and of our understanding of living with dignity. The 1948 Universal Declaration of Human Rights enshrines the right to food in relation to an adequate standard of living. Article 25 states that "Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family, including food, clothing, housing..." It is also enshrined in the 1966 International Covenant on Economic, Social and Cultural Rights, and is protected by regional treaties and national constitutions

The right to food is part of a wide range of factors that help us lead a healthy life. The Committee on Economic, Social and Cultural Rights, the body responsible for monitoring the International Covenant on Economic, Social and Cultural Rights, calls these the “underlying determinants of health”. They include:

- safe drinking water and adequate sanitation
- **safe food**
- **adequate nutrition** and housing
- healthy working and environmental conditions
- health-related education and information
- gender equality.

Humanitarian principles affirm that everyone has the right to humanitarian assistance, following the principles of impartiality and non-discrimination: “…no one should be discriminated against on any grounds of status, including age, gender…” (The Sphere project 2011[3]).

You should therefore be committed to including older people in your nutrition response in emergency situations, by assessing their needs and their nutrition status and ensuring that they are targeted in nutrition interventions.

[3]. *The Sphere Project, Humanitarian charter and minimum standards in humanitarian response*, The Sphere Project, UK, 2011

Nutritional vulnerability of older people in emergencies

The underlying causes to malnutrition are usually grouped in three categories:

- household food insecurity
- inadequate care (health care, social care, etc.)
- unhealthy household environment and lack of health services (poor public health)[4].

These causes are often present in emergency situations, and increase the vulnerability of older people to malnutrition. Reciprocally they are likely to be magnified by older people's common vulnerabilities in emergencies: lack of family support, difficulty accessing services, lack of understanding of their needs, levels of disability etc. making older people often the most vulnerable group.

Nutrition needs of older people

In older age both the quality and the quantity of the diet are important to ensure that requirements for macronutrient and micronutrient intakes are met. The nutrient density of the food (ie the amount of nutrient per 1,000kcal) should increase to compensate for lower energy intake. This also applies to proteins.

As with the general population, older people need energy and a balanced diet.

Risk factors for older people nutrition in emergencies

As it ages, the human body's composition of fat and muscle changes, influenced by modified hormonal activity. There is a progressive loss of muscle and an increase in fat stores. With muscle loss, people's ability to move and maintain balance is affected, making falls more likely, and limiting their ability to flee or fight in case of danger.

Adults with reduced appetite due to illness, psychosocial stress, age or disability often face a range of nutritional risks that can be further exacerbated in an emergency. This may lead to an inadequate energy and micronutrient intake at a time when the body needs it most:

- Tooth loss, gum disease and difficulties chewing and swallowing have serious nutritional consequences as less, or more limited selections of food are taken.
- Sensory loss and other physical problems affect older people's ability to access adequate food and sunlight (important for healthy levels of vitamin D).
- Individuals with reduced mobility or eyesight are at particular risk of being separated from immediate family (or care givers) in a disaster. Consequently finding foods they can easily eat, carrying bags or baskets or cooking and cleaning may become unmanageable tasks.

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[4]. UNICEF Framework for malnutrition, http://conflict.lshtm.ac.uk/page_138.htm

- Loss of vision and hearing may contribute to social isolation, and eating alone may lead to poor appetite. Not surprisingly, the prevalence of undernutrition is high among those who are homebound or bedridden, and those who have high levels of sensory impairment.
- Older people are more vulnerable to dehydration, whether it is caused by hot weather or a health condition (eg diarrhoea, cholera), and it is important to make sure that they have access to safe drinking water.
- The immune system is declining with age. It is compromised by nutrient deficiencies. A combination of age and malnutrition makes older people more vulnerable to infectious diseases.

Social factors have an impact on older people's welfare and nutritional status. Poverty, psychological and emotional conditions (such as depression or bereavement) have an influence on the diet, but one of the most important risk factors for an older person is isolation, whether it is due to the loss of their family or to the indifference of the surrounding community. Some studies have shown that older people who are left on their own are likely to suffer from psychiatric morbidity, and also more likely to die.

The action points

These guidelines recommend some key action points for addressing the nutrition needs of older people in emergencies. Some follow the minimum standards defined by the Sphere Project (The Sphere Project 2001, Minimum Standards in Food Security and Nutrition) and are adapted specifically for older people.

They are not exhaustive but they provide guidance for basic nutrition interventions.

Key action points to address nutrition interventions for older people in emergencies

Action point 1: Assess the food situation of older people

- Get to know the national policy on nutrition.
- Collect information on recent food security and anthropometric surveys.
- Collect information on food availability, access, consumption and utilisation.
- Gather information on the food interventions currently in place.
- Get information on the functioning of the health system, as food responses are often delivered through existing health structures.
- Include gender analysis in the assessment.
- Involve older people in the needs assessment through focus group discussions and individual meetings.

Action point 2: Assess the nutritional status of older people

- Middle upper arm circumference (MUAC) is the best tool to assess the nutritional status of older people. Also look for malnutrition oedemas.
- HelpAge is recommending to use the following case definition for acute malnutrition: moderate acute malnutrition (MAM) when MUAC <210mm, severe acute malnutrition (SAM) when MUAC <185mm or when presence of oedema.
- Use MUAC in nutrition surveys, set up screening points at reception areas in refugees or displaced camps, train community workers to use it while visiting older people at home.
- Organise nutrition surveys and assess the presence of potential risk factors, using sound sampling and analysing methods.

Action point 3: Plan nutrition interventions for older people

- Adapt the general food ration to the needs of older people: evaluate its energy composition and micronutrient content, assess the acceptability of the food products (palatability, chewability, digestibility).
- Set up blanket supplementary feeding programmes to prevent acute malnutrition in older people, by complementing the general food ration.
- Organise supplementary feeding programmes to treat moderate acute malnutrition in older people and prevent them to get severely malnourished: eg organise fortnightly distributions of specific dry rations, providing 1,000 to 1,500kcal/person/day.
- Put in place community-based management of severely acutely malnourished older people for therapeutic feeding programmes: this includes community mobilisation for active case-finding, outpatient care for older people with uncomplicated SAM, inpatient care for older with SAM and acute medical complications, and management of MAM though supplementary feeding. Specific food products are needed.

Action point 4: Prevent and treat micronutrient deficiencies

- Micronutrient deficiencies have severe consequences for older people's mental and physical health, their immune system and their functional abilities.
- Strategies for preventing micronutrient deficiency include the promotion of diet diversity and balance such as provision of fresh food items, of fortified foods, or distribution of micronutrient supplements.

Action point 5: Monitor and evaluate your projects

- Use "The Minimum Reporting Package (MRP) for Emergency Supplementary and Therapeutic Feeding Programme User guidelines" to monitor your programmes: it consists of guidelines on what data to collect, and software for standard analysis and reports.
- Evaluate the coverage of your programmes with SQUEAC (Semi-Quantitative Evaluation of Access and Coverage) and SLEAC (Simplified LQAS Evaluation and Coverage).

Action point 6: Build partnerships

- Be an active member of the country nutrition cluster, or the equivalent national coordinating authority.
- Develop strategies to work with NGOs already involved in selective feeding programmes, to include a component on the management of geriatric acute malnutrition.

Action point 7: Advocate for older people's right to nutrition

- Gather and share reliable sex and age disaggregated data and making evidence-based recommendations to the cluster partners and with the various relevant levels of the relevant Ministry to raise awareness of the numbers and vulnerabilities of older people.
- Coordinate with international and local partners who share a similar goal.
- Advocacy messages include: Older people are a vulnerable group for malnutrition, they should be included in national nutrition strategies, community-management of acute malnutrition is a valid strategy for the management of older people acute severe malnutrition.

Recommendations for a balanced diet for older people

Energy intake: an older person requires between 2,000kcal (around 8,800kJ) and 2,500kcal (around 10,500kJ) per day to maintain their energetic balance. This varies with age, sex and physical activity.

Fat, sugar, salt and meal size: intake of fat, sugar and salt in older people's diets needs to be limited for health reasons. Enough should be included to enhance flavours and provide valuable nutrients but not so much as to raise the risks of cancer, atherosclerosis and other chronic diseases. In addition the slowing of the digestive process with age means older people need smaller, more frequent meals than younger people. Five or six small, reduced fat meals a day are better than one or two big meals.

Protein is important in later stages of life for sustaining a healthy immune system, preventing muscle wasting and optimising bone density. Older people should eat high quality protein such as egg white, lean meat, poultry and fish. Milk and milk products, soy products (such as tofu), beans, lentils and nuts are key protein sources for vegetarians. Two portions of protein foods a day are recommended.

Fibre and water help to prevent constipation. Fibre is found in whole grains such as brown bread, whole cereals and brown rice, as well as legumes, fruits and vegetables. As people age they often feel less thirsty and can become dehydrated, especially in warm climates. They should be encouraged to drink 1-1.5 litres of water or other fluids (such as soups or fruit juices) every day.

Micronutrients (minerals and vitamins) are important to protect the immune system and reduce the risk of chronic disease. Micronutrient deficiencies are significantly associated with frailty in older people. Key micronutrients are:

- **Calcium** (from milk, yogurt, cheese and green leafy vegetables) is essential to maintain good bone health. It is recommended that older people eat at least three portions of dairy foods every day (four to five portions after the age of 75).
- **Vitamin D** helps to absorb calcium. The main natural source is sunlight, but it is also found in eggs, milk and oily fish (such as sardines, salmon, herring and mackerel).
- **Vitamin C** helps to repair the body and absorb iron. It is found in fruits and vegetables, especially citrus fruit and green vegetables.
- **Iron** is important for general health, as it is used by the body to produce red blood cells. Sources include red meat, liver, beans and lentils.
- **Vitamin B12 and folic acid** (folate or vitamin B9) are essential for maintaining the body functions. Their deficiency can cause anaemia, and is associated with an increased risk of depression in older people. Sources of vitamin B12 are found in foods coming from animals, including fish and shellfish, meat (especially liver), poultry, eggs, milk, and milk products. Folates are also found in liver as well as leafy vegetables and legumes.
- **Other** vitamins and minerals, such as vitamin A for vision, other B-complex vitamins, vitamin K, magnesium, zinc and iodine are also important.

Vitamins and Mineral requirements for older people - Safe levels of intake (summary)

Source: UNHCR, UNICEF, WFP, WHO, Food and Nutrition Needs in Emergencies, WHO, Geneva, 2002, http://www.unscn.org/layout/modules/resources/files/Food_and_Nutrition_needs_in_Emergencies_-_handbook_2002__UNH.pdf

	Male and Female ≥60	Male ≥60	Female ≥60
Vitamin A (mg retinol equivalent RE[a])	540	600	540
Vitamin D (µg calciferol)	3.2	3.2	3.2
Thiamine (vitamin B1) (mg)[b]	0.8	0.9	0.75
Riboflavin (vitamin B2) (mg)[b]	1.3	1.4	1.2
Niacin equivalents (vitamin B3) (mg)[b]	10.9	11.9	10.3
Folic acid (µg)	185	200	170
Vitamin B12 (µg)	1.0	1.0	1.0
Vitamin C (mg)	30	30	30
Iron (mg)[c] Low (5-9%)	15	15	15
Iodine (µg)	150	150	150

a: Vitamin A requirements may be met by absorption of vitamin A itself (retinol) or provitamin A carotenoids, which have varying equivalence in terms of vitamin A activity. The requirement is expressed in terms of the retinol equivalent (RE), which is defined by the following relationships: 1µg retinol =1.0mg RE; 1mg beta-carotene =0.167g RE; 1µg other provitamin A carotenoid =0.084mg RE

b: β-vitamin requirements are proportional to energy intake and are calculated: Thiamine: 0.4mg per 1,000kcal ingested; riboflavin: 0.6mg per 1,000kcal ingested; niacin equivalent: 6.6mg per 1,000kcal.

c: Basis of calculation of iron requirements =7.5 per cent (diet as in developing countries)