The Global Platform Reader on COVID-19 and older people in low and middle-income countries

Contents

Introduction to Volume 1 of the Global Platform Reader on Coronavirus and Older People in Low and Middle-Income Countries.

5 NOVEMBER 2021

By Peter Lloyd-Sherlock.

https://corona-older.com/

This e-reader presents an edited selection of some of the many blogs and short pieces posted on the Global Platform since it was established in April 2020. All of these are still available on the main Global Platform site here: **https://corona-older.com/** Their inclusion in this new format will hopefully facilitate their use by academics, students and other experts. We have organised the blogs thematically for convenience.

Please pay attention to the date each piece was posted on the site. These pieces were written at different moments over an 18-month period, during which the global context of the pandemic radically shifted and sometimes confounded expectations. Some of the predications made by these pieces may have been prescient: others less so. Much of the data and evidence they rely on may have been superseded by more recent material. Rather than a reflection of our current knowledge base in late 2021, these papers provide a historical record into how academics and other experts grappled with a fast-moving, unprecedented global calamity.

Also, please note that these pieces were produced very quickly and have not been subject to the peer-review processes of academic journals. A key ethos of the Global Platform has been to post potentially useful information as quickly as possible, to support fast policy responses. Authors of these short pieces should not be held responsible for any errors or inaccuracies for material produced and posted in a context of crisis. That said, it is my belief that the quality of these papers (many of which later led to peer-reviewed papers) is extremely strong.

GLOBAL PLATFORM

Another key ethos of the Global Platform is to share all available information and analysis as freely and widely as possible. As such, there are no copyright or intellectual property issues associated with this material. However, we would appreciate it if you can cite any materials you draw on for new publications. Our preferred citation format is:

Aravinda Guntupali "India's COVID-19 vaccination campaign update: older people remain a low priority", 2 November 2021. Available at: **https://corona-older.com/2021/11/02/indias-covid-19-vaccination-campaign-update-older-people-remain-a-low-priority/**

The future of the Global Platform is uncertain, as we are almost entirely unfunded. Sadly, the numbers of older people dying of COVID-19 or being harmed by the pandemic in other ways remain very high. In the early days of the Global Platform, members expressed a hope that the pandemic would spur a major global initiative addressing the needs of older people in the global south. This has not materialised and, if anything, global interest in these issues is waning. Since the need for a network that focusses on these issues is greater than ever, we will strive to maintain the Global Platform's profile with regular events and fresh content.

Hopefully, we will continue to post new blogs and short papers, and we will be able to produce a second volume of this reader next year. This depends on the capacity of our network members to produce these materials. Many of you -the people reading this- may well be in positions to contribute valuable insights, new evidence or simply a local perspective. Please do! More than funding, the Global Platform needs your active engagement.

Thanks and stay safe,
Peter Lloyd-Sherlock
5 November 2021

Part One
Vaccinations

South Africa: Booster vaccines must be offered to older people immediately.

9 DECEMBER 2021

By Leon Geffen and Gabrielle Kelly.

This is an edited version of an article posted on groundup.org.za

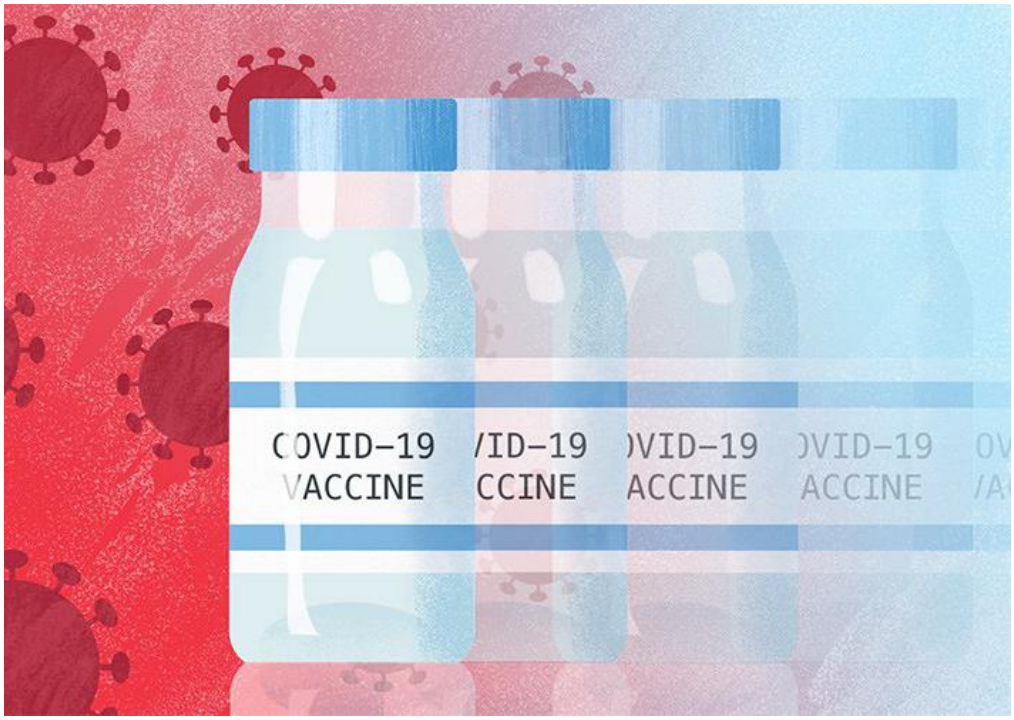
https://corona-older.com/2021/12/09/booster-vaccines-must-be-offered-to-older-people-immediately/

The six month gap is too long. It should be reduced to four.

Older people have borne the brunt of Covid. They are at greater risk of dying from Covid because of weaker immunity and because they are more likely to have comorbidities than younger people.

Evidence shows that booster vaccines will give them more protection. There is no time to waste: the government must make booster doses available to all people over 60 immediately. Failing to do so would be a human rights violation.

On Wednesday the medicines regulator approved Pfizer booster shots. This is a welcome step, but the boosters are only available six months after a person has had their second vaccine shot. By our calculation, the very first Pfizer vaccine recipients will only be due to get a booster from the end of December. Most won't be eligible until February and March 2022. (Also as we write this, the health department still has to give the go-ahead for booster shots, which may mean more delays).



Booster vaccines will help protect older people, who have borne the brunt of Covid.

Illustration: Lisa Nelson

With the spectre of Omicron and a fourth wave and the fact that booster shots would still be effective if used with a shorter gap than six months, this frankly isn't good enough. We are concerned that not only are older people prejudiced through the lack of access to booster vaccines, but the health department and the National Institute for Communicable Diseases (NICD) do not sufficiently recognise the unique ways in which Covid is affecting older people.

For example, the health department publishes the number of official Covid deaths daily. But the last time it stratified these numbers by age was 18 months ago, on 13 June 2020.

While official data on mortality in older people is limited, the Medical Research Council's excess death reports show that since 3 May 2020 about 200,000 of the over 270,000 excess deaths were of people over 60.

The risk of Covid infection and death is especially high for those living in care homes where people tend to be in poorer health and many older people share rooms and ablution facilities.

Data from a select number of care homes shows us that people over 60 have an almost eight times greater chance of dying than those younger than 60. The Covid fatality rate in people over 80 in care homes, according to data published daily by the NICD, is in the region of 20%.

Many older people's lives have been restricted since March 2020 out of fear of death and illness. They have been unable to go out and participate in society because of fear of infection. Care homes were closed to visitors for many months in 2020 and social activities and interaction between residents and with the outside world continue to be limited, with significant negative effects on the mental health of residents. Many older people are less confident with technology and have not been able to connect digitally with friends and family. Almost two years after the onset of the pandemic, many continue to live restricted lives despite simple measures that can be implemented to improve their situation. The simplest measure is to provide booster vaccines.

The evidence in favour of booster vaccines is compelling. Vaccine efficacy wanes over time, possibly over a four to six month period, and maybe faster in older people whose ability to mount an immune response to the vaccine is reduced compared to younger people.

Older people living in care homes and community settings started getting vaccinated in May. Many had their second doses more than four months ago. There has been very little reported vaccine hesitancy in both the residents of care homes and the employees who provide care to them. We're seeing rates of 80% to 90% uptake in preliminary studies. Outside care homes, vaccine uptake has also been significantly higher among older people than in younger populations.

An Israeli study published in the leading medical journal, the New England Journal of Medicine, showed a ten-fold reduction in serious infections (hospitalisations, need for supplemental oxygen) and a five-fold reduction in breakthrough infections, with booster shots.

There are millions of Pfizer doses available. Government recently stopped taking shipments of new doses. We clearly can't use our vaccine stock fast enough.

The health department has acknowledged the benefit of booster vaccines for groups of people who are immunosuppressed. Since 1 December, the government has allowed a Pfizer booster for this group in a shorter time than the six month period that the regulator has now approved for booster shots. This is good, and in fact all people with comorbidities should be allowed a booster.

We understand that there are legal complexities involved in making the booster

period shorter than six months for all people over 60, because to some extent the regulator's hands are tied by what Pfizer is willing to apply for. But we are in a state of disaster and the government must act urgently to overcome bureaucratic and legal obstacles. Our Constitution guarantees the right to life and dignity above all else. The health department must therefore allow access to Pfizer boosters for any person over 60 who was vaccinated four or more months ago.

Failing to do so immediately will lead to unnecessary suffering and death. It will deprive older people of opportunities to live meaningful lives, and to participate in the society around them and the world at large.

The authors are with the Samson Institute for Ageing Research.

Disclosure: Leon Geffen is the brother of the GroundUp editor.

Views expressed are not necessarily GroundUp's.

World Health Organisation data show Bolivia has provided more doses of COVID-19 vaccine to people aged under 30 than to people aged 60 or more.

16 NOVEMBER 2021

By Peter Lloyd-Sherlock.

https://corona-older.com/2021/11/16/world-health-organisation-data-show-bolivia-has-provided-more-doses-of-covid-19-vaccine-to-people-aged-under-30-than-to-people-aged-60-or-more/

Recently, WHO started to publish data on COVID-19 vaccination for older people and total population. You can find the site here: **https://app.powerbi.com/**

For some of the countries which are included on the WHO site, the data are alarming. Table 1 presents data for Bolivia on the percentages of people at different ages who had received either one, two or no doses of vaccine by the end of August 2021. It shows that 40 per cent of those aged 60 or more were completely unvaccinated. Strikingly, it shows that more doses had been provided to people aged 18 to 29 than people aged 60 or more.

Reliable data on COVID-19 deaths by age group are not available for Bolivia (which itself is a concern), but the available information indicates that around 60 per cent of deaths have been aged 60 or more **[https://eldeber.com.bo/santa-cruz/en-santa-cruz-el-58-de-fallecidos-por-covid-19-son-mayores-de-60-anos_240686]**.

Four days ago, it was reported that COVID-19 vaccines would now start to be provided to children aged 12 or over **[https://www.eldiario.es/sociedad/ultima-hora-coronavirus-actualidad-politica-11-noviembre_6_8479020_1080993.html]**. It is unclear how many older people in Bolivia remain unvaccinated and so I call on the Ministry of Health to provide an urgent update.

TABLE 1 – Covid-19 vaccination by age group, Bolivia, August 2021.

	% no dose	% 1 dose	% 2 doses	Number of doses provided (1000)
18-29	69	3	28	1,558
30-39	62	3	35	1,220
40-49	53	12	35	1,015
50-59	46	9	45	873
60+	40	6	54	1,354

Older people in India, Indonesia, Sri Lanka and Thailand have a lower COVID-19 vaccine priority than younger people and this is causing thousands of needless deaths.

16 NOVEMBER 2021

By Peter Lloyd-Sherlock.

https://corona-older.com/2021/11/16/older-people-in-india-indonesia-sri-lanka-and-thailand-have-a-lower-covid-19-vaccine-priority-than-younger-people-and-this-is-causing-thousands-of-needless-deaths/

Recently, WHO started to publish data on COVID-19 vaccination for older people and total population. [https://app.powerbi.com/]

Although the site includes information for a large number of countries, several are not included. Examples include Mexico, South Africa and Peru. Presumably this is either because their health ministries are not prepared to publish these data or because WHO does not consider them sufficiently reliable. Even so, the data that are available tell an interesting story, especially with a little additional analysis.

Table 1 compares the performance of four countries in Asia by the end of August 2021. In three, people aged 60 or more accounted for a lower share of doses provided than they do of the total population. This means people aged 60 or more were actually less likely to have received at least one dose than people aged from birth to 59.

The case of Sri Lanka is especially concerning. Only 3% of vaccines have been given to people aged 60 or more: an age group accounting for 16% of its total population. India appears to perform slightly better, although if we just consider the adult population (excluding people aged under 18 who make up about a third of the total population), the share aged 60 or more rises to 15%, compared to only 11% of all doses administered.

These huge discrepancies cannot be explained by the prioritisation of frontline health workers. Their numbers only equate to a small share of doses give to under 60s.

Available data indicate that for unvaccinated people aged 60 or more who are infected by COVID-19, average risk of dying is at least 1.5%. For people aged under 60, this risk falls to around 0.02%. Yet rather than prioritise older people, these countries are doing the very opposite. This is leading to many thousands of needless deaths.

TABLE 1 – COVID-19 vaccination coverage for older people and total population, August 2021.

	Doses administered (million)	Doses administered to people 60+ (million)	% of all doses administered that go to people aged 60+	People aged 60+ at % of total population	% people aged 60+ with no dose
India	816	87	11%	10%	36%
Indonesia	142	10	7%	10%	74%
Sri Lanka	30	1	3%	16%	64%
Thailand	39	6	15%	19%	56%

WHO publishes COVID-19 vaccination coverage data by age group.

4 NOVEMBER 2021

By Peter Lloyd-Sherlock.

Kudos to the World Health Organisation for publishing age-disaggregated data on its vaccination coverage portal. You can access it here: **https://app.powerbi.com/**

Not all countries currently provide the data. Notable exceptions include India, Mexico and China. And the data for some countries are not especially up to date. Nevertheless, this is an important first step towards holding some countries for their failure to protect their older citizens. The Global Platform will publish more analysis in the next weeks, but we have quickly put together some tables for a number of countries.

Table 1 shows enormous variations in full vaccination coverage of people aged 60 or more. Thailand, Bulgaria and Indonesia stand out as poor performers, while Argentina, Chile and Iran have achieved much higher rates of coverage.

https://corona-older.com/2021/11/05/who-publishes-covid-19-vaccination-coverage-data-by-age-group/

TABLE 1 – % of people aged 60 or more by vaccination status, selected countries

	2 doses	1 dose	0 dose	
Argentina	78	14	8	Aug 21
Brazil	58	42	0	May 21
Bulgaria	25	5	70	Sept 21
Chile	88	3	9	May 21
Indonesia	18	7	75	Aug 21
Iran	73	19	8	Sept 21
Jamaica	18	15	77	Aug 21
Poland	74	26	0	Sept 21
Thailand	8	36	56	Aug 21

Vaccine ageism and crimes against humanity.

4 NOVEMBER 2021

By Peter Lloyd-Sherlock.

https://corona-older.com/2021/11/02/vaccine-ageism-and-crimes-against-humanity/

A few days ago, the British Medical Journal published an opinion piece: "Crimes against humanity in Brazil's covid-19 response—a lesson to us all" **[https://www.bmj.com/content/375/bmj.n2625]**. It reports on a national senate inquiry that finds parts of Brazil's national government, including President Bolsonaro guilty of crimes against humanity as a result of their wilful obstruction of polices that might have limited the pandemic's death toll. The piece concludes that:

"the international community has a duty to acknowledge that this is a crime which, although inflicted on the people of Brazil, has targeted and threatened the whole of humanity."

There can be no argument against this powerful denunciation of those responsible for Brazil's public health catastrophe. However, some other countries' performances have been even worse, especially since vaccinations became available. This prompted me to write the following piece that the BMJ has just posted here **https://www.bmj.com/content/375/bmj.n2625/rapid-responses**

Dear Editor,

I commend the Brazilian senate inquiry and the authors of this piece for publicising the many failures of Brazil's federal government in its response to the COVID-19 pandemic. I share their view that the national president's behaviour constitutes crimes against humanity, which could not go unpunished.

Nevertheless, I feel it is essential to draw attention to one aspect of Brazil's pandemic response that is not specifically dealt with in the article. Whilst it is true that the federal government's initial procurement of COVID-19 vaccines was unjustifiably delayed, the country's subsequent vaccination campaign has been a considerable success.

This can be seen both in terms of overall levels of coverage achieved and more specific rates for the most vulnerable groups. Currently, around 65 per cent of Brazilians have received two doses of vaccine **[https://graphics.reuters.com/world-coronavirus-tracker-and-maps/countries-and-territories/brazil/]** Roll-out was particularly fast for people at older ages and for indigenous groups: by early July over 85 per cent of indigenous people and of people aged 70 or more were fully vaccinated **[https://veja.abril.com.br/saude/mais-de-86-dos-idosos-acima-de-70-anos-estao-totalmente-vacinados/ ; https://www.correiobraziliense.com.br/brasil/2021/06/4931494-populacao-indigena-lidera-indice-de-vacinacao-no-brasil.html]**. In comparison, most other middle-income countries, including India, Mexico, Thailand and South Africa, have achieved lower rates of overall coverage and have done less to prioritise the most vulnerable. For example, In Bulgaria, as of 26 October 2021, only 21.0 per cent of people aged 80 or more had been fully vaccinated, compared to 31 per cent of people aged between 60 and 69 and 19.7 per cent of those aged 25 to 49 **[https://ourworldindata.org/grapher/covid-fully-vaccinated-by-age?tab=table&country=~FRA]**.

Of course, none of the credit for Brazil's relative success in vaccinating its population should go to President Bolsonaro. Instead, it is a testament to the dedication and hard work of the county's public health agencies, both at the national and local government levels.

Had Brazil's vaccination campaign taken the same approach as these other countries, the numbers of confirmed COVID-19 deaths is likely to have been closer to a million than to the actual level of around 600,000.

Yes, Bolsonaro deserves to be put on trial for his criminal actions. But what about those responsible for the calamitous vaccination campaigns of other countries, which are responsible for millions of avoidable deaths? The international community has had almost nothing to say about that.

India's COVID-19 vaccination campaign update: older people remain a low priority.

2 NOVEMBER 2021

By Aravinda Guntupali.

- Fewer than half of people aged 60 or over have been fully vaccinated.
- Over 250 million people aged under 60 are now fully vaccinated, compared to only 65 million people aged 60 or more.
- This reflects a failure to prioritise people most in need of the vaccinaton and will have contributed to many thousands of avoidable deaths.

https://corona-older.com/2021/11/02/indias-covid-19-vaccination-campaign-update-older-people-remain-a-low-priority/

India's COVID-19 vaccination coverage has crossed 1040 million doses as of 27th October 2021 **[https://pib.gov.in/PressReleseDetail.aspx?PRID=1726112]**. Only 30% of these are second doses. The vaccination was carried out by 94,323 health facilities that mainly were public-funded (97%). While India's absolute number of vaccines is impressive, they are yet to reach out to 34% of the adult population eligible to receive the vaccines.

The Government of India has designed an ambitious target of producing more than 2 billion doses of vaccine by the end of 2021, as India needs more than 1800 million doses to administer the vaccine to all the eligible population **[https://www.pib.gov.in/PressReleasePage.aspx?PRID=1718869%20]**. India also approved importing of vaccines made outside India following the second wave. Given the vaccine shortages during the first wave and second wave of the pandemic, it becomes crucial for countries to prioritise vaccination to vulnerable people, including the older population. India, however, did not prioritise older people the way high-income countries have prioritised. The timeline below illustrates the vaccine rollout strategy of India. On 16th January 2021, India prioritised Health Care Workers and Frontline workers to get either Covisheild (Indian version of AstraZeneca produced by the Serum Institute of India locally) or Covaxin (designed and manufactured by Indian company Bharat Biotech). Vaccination for the public started on 1st March, and the government announced that only older adults aged 60 and above and middle-aged adults 45 and above with non-communicale diseases (NCDs) were eligible to take the vaccine. While this strategy didn't completely prioritise older adults, it allowed older adults to visit the public health facilities without competing with the adult population aged 18 and above. During this period, we need to note that there was vaccine hesitancy among the public worldwide due to the fear of clots that could arise from taking

the AstraZeneca vaccine. In addition, some members of the public feared taking India's homegrown vaccine that was still undertaking the third phase of a clinical trial [https://www.bbc.co.uk/news/world-asia-india-55534902].

After partially prioritising older people, India opened its vaccination intake for all adults aged 45 and above. Soon after a month, the vaccines were open to all adults aged 18 and above.

FIGURE 1 – Timeline and the strategy of Indian vaccination rollout

India's vaccination coverage

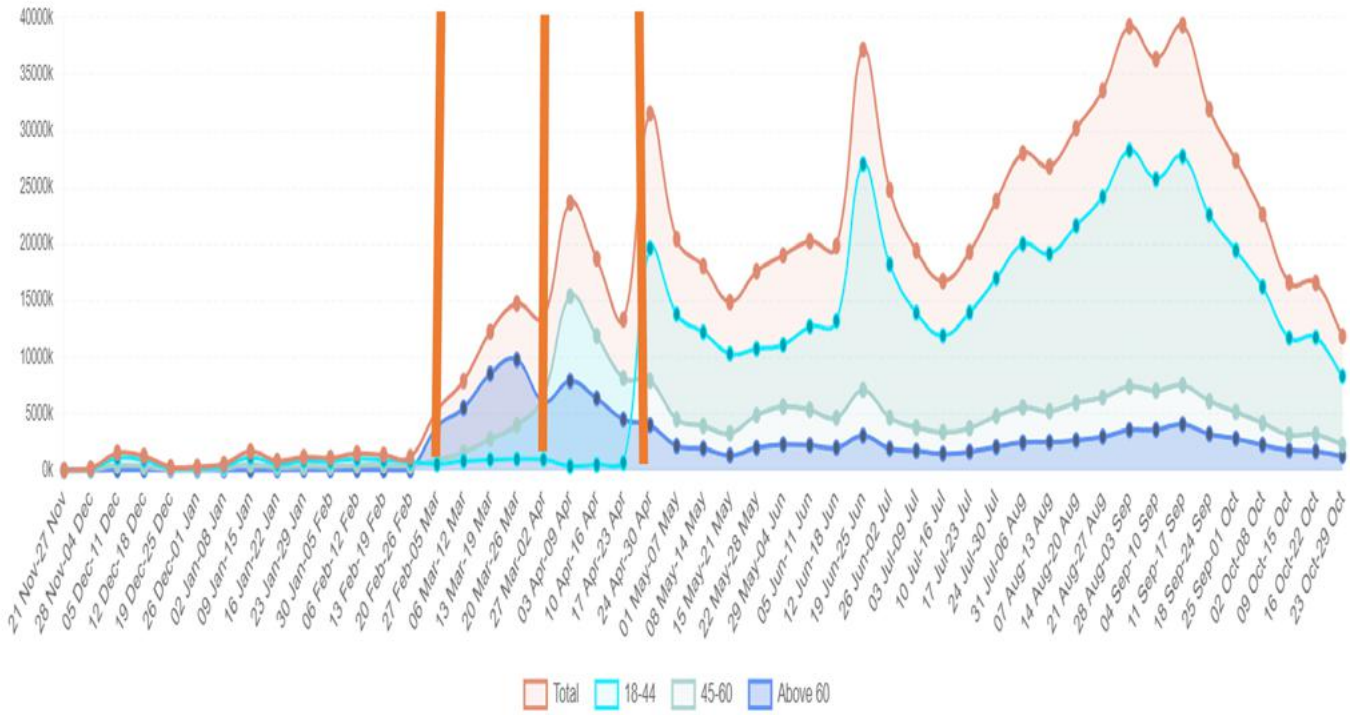
Table 1 provides vaccination coverage in India since the inception of the COVID vaccination programme in January 2021. Out of 139 million projected number of older people aged 60 and above, 78% received their first dose. However, only 47% of them received a second dose. As one in 2 older adults aged 60 and above are not fully vaccinated, their risk for disease, morbidity and mortality continues to be higher given the higher vulnerabilities in later life. As seen in Figure 2, vaccination uptake of older people was higher when they were prioritised along with adults 45 and above with NCDs. Soon after the vaccines were open to everyone aged 45 and above with or without NCDs, there was a dip in the vaccination update among older adults. A further significant drop was observed from May 2021 onwards when older people no longer had any prioritisation. Almost all Indian states except Kerala (Figure 3) has experienced this decline in vaccine uptake among older people once the short span of prioritisation was removed. After experiencing a few dips, Kerala ensured the momentum of vaccination of older people by introducing several supporting mechanisms while following the central government's strategy of not-prioritising older people. For instance, the state of Kerala released guidelines to prioritise older people and people with disabilities when they visit a health facility for vaccination. Health workers visited older people with health conditions and mobility disabilities to provide vaccines at their homes. Also, rapid antigen test was replaced with RT-PCR test and asked care homes to carry out once in 3 months RT-PCR tests to all the residents. All these initiatives ensured that the Kerala vaccine update was better among older people than the national uptake.

TABLE 1 – Vaccination coverage in India between 16th January and by 27th October 2021

Source: Press Release of Ministry of Health and Family Welfare, 27th October 2021 https://pib.gov.in/PressReleseDetail.aspx?PRID=1726112

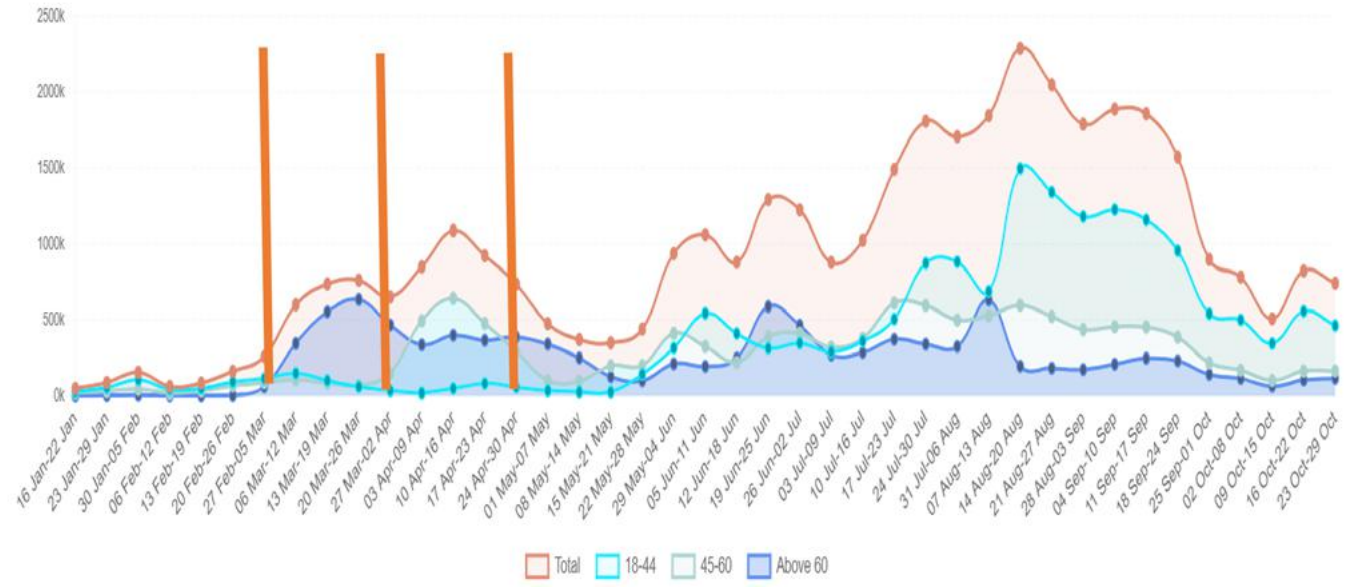
Age group or Profession	Dose	Absolute number in million
Health Care Workers	1st Dose	10.4
	2nd Dose	9.2
Frontline workers	1st Dose	18.4
	2nd Dose	15.8
18-44 years	1st Dose	412.4
	2nd Dose	133.2
45-59 years	1st Dose	173.3
	2nd Dose	93.4
Over 60 years	1st Dose	108.8
	2nd Dose	65.0
1st Dose	1st Dose	723.2
2nd Dose	2nd Dose	316.7

FIGURE 2 – COVID vaccination by age groups in India



Source: CoWIN Dashboard

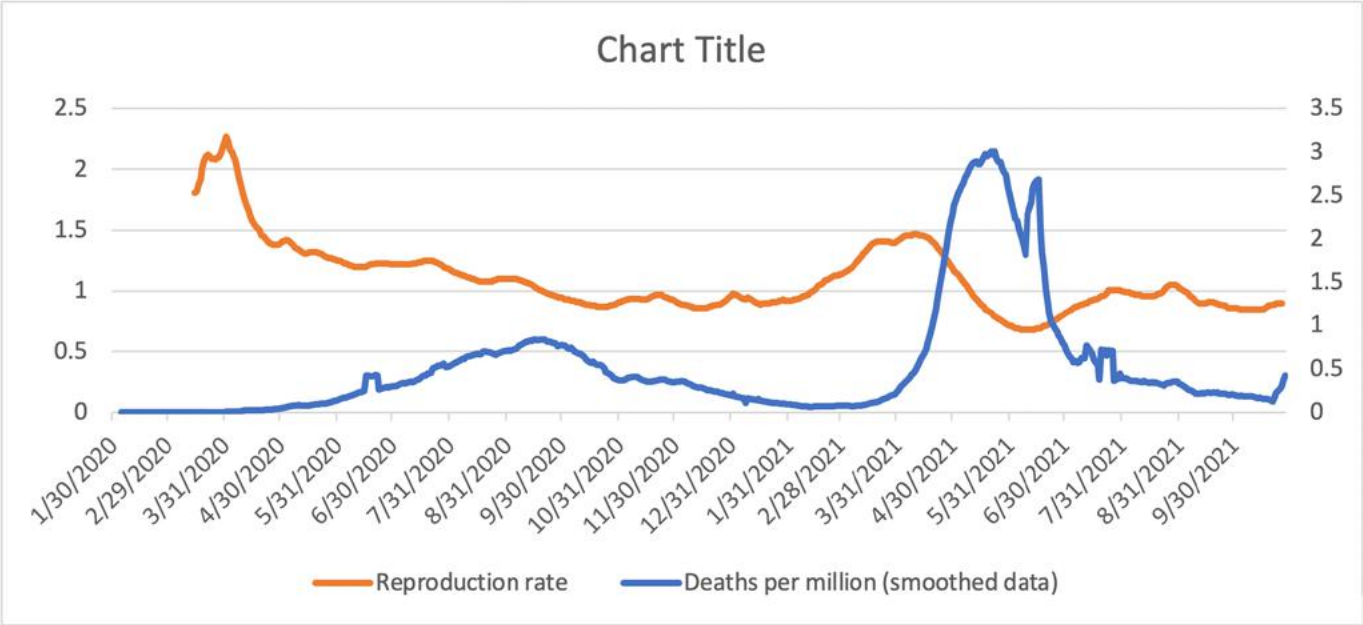
FIGURE 3 – COVID vaccination by age groups in Kerala



Source: CoWIN Dashboard

India's reported COVID deaths during the two waves of the pandemic are nearing half a million in November 2021. Figure 4 illustrates the daily deaths and Reproduction rate (R0) that signifies the contagiousness of COVID virus (OWID, 2021 **[https://ourworldindata.org/covid-deaths]**) until 28th October. Several Indian and global scholars have argued that the Indian mortality data is underreported. There are multiple estimates on the level of underreporting. The lack of coherence between the contagiousness and mortality in the Figure 4 also raises concerns on the data quality.

FIGURE 4 – Deaths per million and reproduction rate in India from the start of the pandemic to end of October 2021



COVID-19 vaccination ageism reaches a new level in Thailand.

21 SEPTEMBER 2021

By Peter Lloyd-Sherlock.

https://corona-older.com/2021/09/21/covid-19-vaccination-ageism-reaches-a-new-level-in-thailand/

Thailand has a strong tradition of family respect and support for older people, but there are signs that the COVID-19 pandemic has put these norms under pressure, both in terms of family behaviour and in state policy.

According to media reports a few weeks ago [UCA News. Elderly left to die as Thailand's Covid crisis worsens. July 30, 2021.]:

> *"An 80-year-old Thai man was driven by his daughter and her husband to a village temple in the northeastern province of Nakhon Ratchasima and left to his fate, lying helplessly on a dirt trail leading to the Buddhist monastery of Wat Pa Suan Thamma Sawaddee.*
>
> *"The octogenarian, who was infected with Covid-19, was likely dumped by his daughter so that she would not have to take care of him during a raging months-long outbreak of the contagion that has seen human misery reach endemic proportions….*
>
> *"The day before, another octogenarian was found lying alone at Victory Monument in the heart of Bangkok. Vendors plying their trade nearby discovered the 80-year-old man and alerted health officials, who arrived too late as he had already died, with Covid-19 suspected as the cause."*

COVID-19 case Fatality Rates by age group

Characteristics of Deaths (276 deaths)	Wave: 1 Jan - 14 Dec 2020 (60 deaths)	Wave: 15 Dec 2020 - 31 Mar 2021 (34 deaths)	Wave: 1 April 2021 - now (305 deaths)
Case Fatality Rate (CFR) in each age group			
• 20-39 years old	0.20%	0.02%	0.11%
• 40-59 years old	2.10%	0.02%	0.76%
• 60+ years old	6.50%	2.60%	4.19%

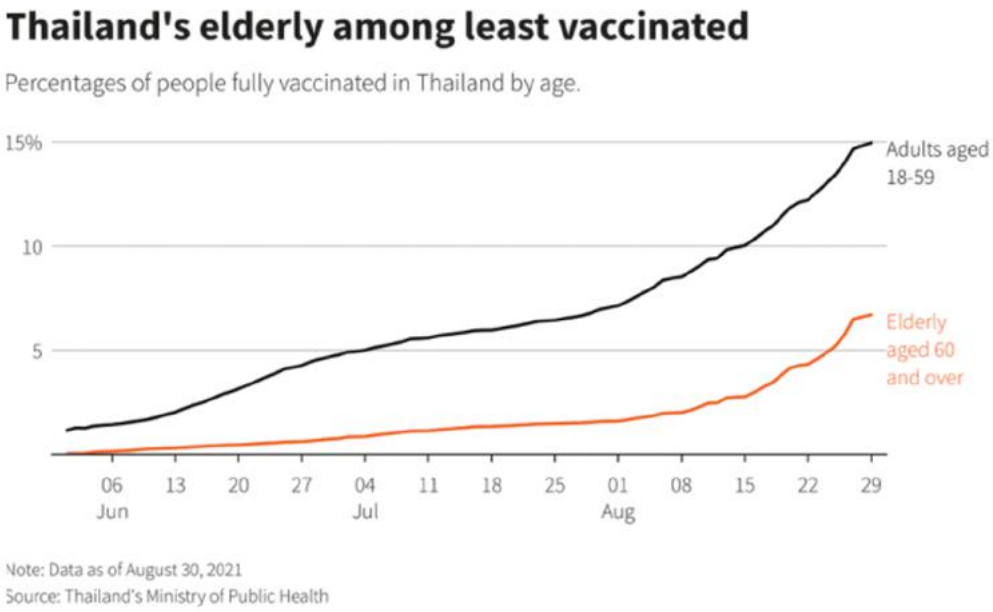
Source: Thailand Ministry of Public Health, 9 May 2021.
https://ddc.moph.go.th/viralpneumonia/eng/file/situation/situation-no486-090564n.pdf

These are only isolated reports, but they indicate that family support for older people with COVID-19 is not guaranteed.

More significantly, it is clear that government vaccination has prioritised younger age groups ahead of older Thais, despite their significantly higher risk of dying of COVID-19. Previous posts on the Global Platform and other related publications have described the vaccination policies of countries such as Bulgaria, the Philippines and India and fundamentally ageist. Yet none of those countries has equalled Thailand's "achievement" of doubling the rate of vaccination among people aged 18 to 59, compared to those aged 60 or more. It is claimed that this was the result of the Thai government prioritising the tourist industry and people living in the capital city.

The consequence of this ageist vaccination policy will have been thousands of avoidable deaths. Through August 2021, while doses were being provided to millions of low risk younger adults, Thailand experienced a sudden and unprecedented wave of COVID-19 deaths. The large majority of those deaths were unvaccinated older people.

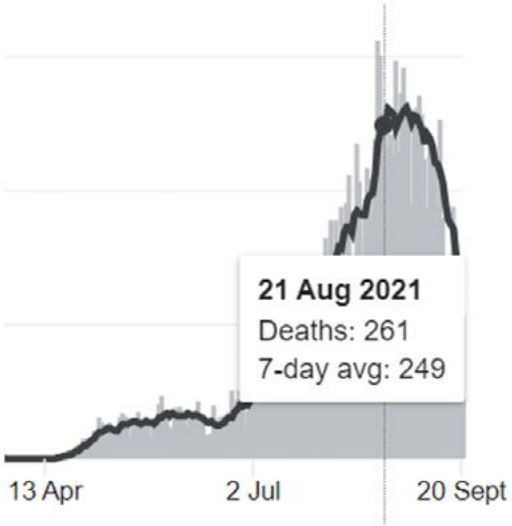
This chart speaks for itself:



Source: https://www.reuters.com/world/asia-pacific/exclusive-thailands-elderly-lag-behind-covid-vaccination-drive-data-show-2021-08-31/

Reported COVID-19 deaths in Thailand

Source: https://github.com/CSSEGISandData/COVID-19



Vaccine cakeism and moral dilemmas.

14 SEPTEMBER 2021

By Peter Lloyd-Sherlock.

Cakeism def. The wish to have or do two good things at the same time when this is impossible. From the phrase "to have your cake and eat it too".

[https://dictionary.cambridge.org/]

https://corona-older.com/2021/09/14/vaccine-cakeism-and-moral-dilemmas/

Over the past months, a lot has been said about vaccine nationalism. Much less has been said about vaccine ageism (the decision of some countries to prioritise lower risk groups over those at the oldest ages). And almost nothing has been said about vaccine cakeism.

In a world of finite resources, policymaking is about managing trade-offs between different needs, interests and entitlements. This has never been truer than during the pandemic. There is a tendency in global policy and agenda-setting for different voices to promote the specific interests of their own groups without considering what that may mean for the rest.

For example, globally there is only a finite amount of COVID-19 vaccine doses. This resource is not being distributed equitably, due to both vaccine nationalism and, in some cases, vaccine ageism. But in more recent months, the main driver of global vaccination inequality has arguably been vaccine cakeism. Almost all vaccinations being provided in high-income countries have been for younger people with relatively limited risk. At the same time, many high-risk groups in low and middle-income countries, including frontline health and care workers, the oldest old and people with specific health conditions are yet to receive a single dose.

There is a brutal equation here. Each dose given to a younger person in a rich country means one less dose for a vulnerable person in a poor one. Back in May, the Director General of WHO made this point very directly:

> "In January, I spoke about the potential unfolding of a moral catastrophe. Unfortunately, we're now witnessing this play out. In a handful of rich countries, which bought up the majority of the supply, lower-risk groups are now being vaccinated…I understand why some countries want to vaccinate their children and adolescents, but right now I urge them to reconsider and to instead

> donate vaccines to Covax." **[https://www.theguardian.com/world/2021/may/14/vaccinate-vulnerable-global-poor-before-rich-children-who-says]**

By way of example: in the USA over the past 14 days, around 4.5 million people aged under 40 received either a first or second dose of COVID-19 vaccination. **[https://covid.cdc.gov/covid-data-tracker/#vaccination-demographic]** That's roughly equivalent to the total number of people aged 70 or more living in Vietnam.

How can this be reconciled with the calls from high-income country public health experts to prioritise the COVID-19 of younger people? **[https://www.theguardian.com/world/2021/sep/13/vaccinating-teenagers-against-covid-is-priority-says-uk-epidemiologist?CMP=Share_iOSApp_Other]**

This is a very uncomfortable issue for people like me with adolescent children trying to navigate the risks and uncertainties of our own family "pandemic worlds".

It also poses a dilemma for organisations with a mandate for representing the interests of younger people. According to UNICEF:

> "A recent analysis showed it is possible for well-supplied countries to donate vaccine doses without having a significant impact on their commitments to vaccinate their own adult population". **[https://www.unicef.org/coronavirus/covax]**

UNICEF quite rightly does not refer to vaccinating children against COVID-19, either in rich or in poor countries. By referring to "adult populations", it implies that COVID-19 vaccine should not go into the arms of children anywhere until governments have met their commitments to COVAX. But, understandably, UNICEF doesn't go so far as to state this explicitly.

We can see other example of cakeism in COVID-19 policies. In this week's Lancet, we discuss vaccine ageism, but (with reference to acute COVID-19 care) we also recognise that in a context of resource scarcity and a need for brutal pragmatism

> "All things being equal, people at older ages are less likely to respond positively to treatment and therefore some age rationing might have maximised years of life saved." **[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01689-5/fulltext]**

As someone who works on older people's rights, it sticks in the craw to say that denying older people acute COVID-19 care may have sometimes been justifiable. But, of course, every older person on a ventilator meant somebody else wasn't.

The easy, perhaps glib answer is we need more of everything: more vaccine doses, more ventilators, more compassion. But, until that time comes, advocacy networks should be mindful that trade-offs exist and should try to find ways to resolve them. This is much more easily said than done and it goes against the grain for people and organisations focussed on specific interest groups, be they older people, children or others.

And on a personal level, the dilemmas of vaccine cakeism are real and acute. What happens when my own child is offered a jab? I really don't know.

Barriers to vaccinating older people in Nepal. The limitations of public health infrastructure and the vicissitudes of vaccine nationalism.

05 JULY 2021

By Peter Lloyd-Sherlock and Jagadish K Chhetri (Nepalese Society of Gerontology and Geriatrics).

https://corona-older.com/2021/07/05/barriers-to-vaccinating-older-people-in-nepal-the-limitations-of-public-health-infrastructure-and-the-vicissitudes-of-vaccine-nationalism/

Several Global Platform blogs and papers have criticised the failure of some governments to give people at the oldest ages sufficient priority in their COVID-19 vaccination strategies.

In the cases of some other countries, older people have received priority status, but the capacity of the public health system to reach many of them has been limited. As a result, many of the most vulnerable older people, such as those with limited mobility, without access to digital technology or living in rural areas remain unprotected.

This would appear to be the case in Nepal and HelpAge International have kindly agreed to share a new blog on these vaccination barriers **https://www.helpage.org/newsroom/latest-news/older-people-are-prioritised-on-paper-but-not-in-reality/**

As in many countries, Nepal has to contend with specific challenges, including disruption caused by the monsoon season and the fickle geopolitics of vaccine supply from other countries. Also, there have been frequent changes of leadership in government departments responsible for procuring and managing vaccines.

Nepal's vaccination strategy may not be ageist, but this will be of little comfort to the many older Nepalese who remain at extreme risk of COVID-19.

Dear Prime Minister Modi, making COVID-19 vaccination free for people aged 45 and under will cause thousands of additional deaths.

10 JUNE 2021

By Peter Lloyd-Sherlock, Aravinda Guntupali and Sridhar Venkatapuram.

https://corona-older.com/2021/06/10/dear-prime-minister-modi-making-covid-19-vaccination-free-for-people-aged-45-and-under-will-cause-thousands-of-additional-deaths/

On 7 June 2021 India's Prime Minister Narendra Modi announced that from 21 June COVID-19 vaccination would be made free for people aged 45 and under **[https://www.reuters.com/business/healthcare-pharmaceuticals/indias-modi-pm-announces-free-covid-19-vaccines-all-adults-2021-06-07/]**.

People in this age range had become eligible for vaccines in back in May, but (unlike people at older ages), were required to pay. At first sight, the new policy looks like the end of unfair discrimination against younger Indians. In his national address, Prime Minister Modi stated:

"Several voices were raised. Like why age groups were created for vaccination? On the other hand, someone said that why should the central government decide the age limit? There were some voices also that why are the elderly being vaccinated earlier?" **[https://pib.gov.in/PressReleseDetail.aspx?PRID=1726112]**.

Also, there has been widespread criticism that many people in India have struggled to pay for COVID-19 vaccination and that this has led to a high degree of inequality **[https://www.independent.co.uk/news/vaccine-inequality-in-india-sends-many-falling-through-gaps-india-english-new-delhi-indians-uttar-pradesh-b1853958.html]**.

In fact, offering younger adults in India a free vaccine will do a lot more harm than good.

A high proportion of India's population aged 60 or more have still to receive even one dose of any vaccine, despite having had theoretically free access since March. This is mainly because there has not been enough free vaccine to go round. People aged over 60 are at least 50 times more likely to die of a COVID-19 infection than those aged 45 or under. Put another way, you need to vaccinate 50 times as many people aged 18 to 45 to save one life, than if you vaccinate people aged 60 or more. Yet over recent weeks, the

number of people aged under 45 getting a first vaccine dose has been substantially higher than the number aged 60 or more **[https://pubmed.ncbi.nlm.nih.gov/34108191/]**. Despite requiring them to pay, vaccine roll-out for younger adults in India is proceeding faster than among older people.

It is not possible to give reliable estimate of how many lives in India will be unnecessarily lost due to this misguided approach to age prioritisation. According to official reports, over 18,000 people died due to COVID-19 last week. No data are available on the distribution of these deaths across age categories and international experts indicate the true numbers of COVID-19 deaths are in fact much higher **[http://www.healthdata.org/print/8660]**. As such, the weekly number of deaths resulting from denying vaccination to those at greatest risk will be in the thousands rather than the hundreds.

The majority of Indians of all ages will struggle to access free vaccines, regardless of Prime Ministerial Promises. And the majority of poor Indians of all ages will struggle to pay for their own. And this new policy means the majority of vaccinations will continue to be provided to those least in need.

Bulgaria and COVID-19 vaccine ageism.

20 MAY 2021

By Peter Lloyd-Sherlock.

https://corona-older.com/2021/05/20/bulgaria-and-covid-19-vaccine-ageism/

Today, the UK's Guardian newspaper published this report on the Bulgarian government's decision to exclude the vast majority of older people from COVID-19 vaccination **[https://www.theguardian.com/global-development/2021/may/20/putting-economics-over-ethics-is-a-dismal-vaccination-strategy-bulgaria-shows-why?CMP=Share_iOSApp_Other]**. As a result, only around ten per cent of the country's over-80s have been vaccinated to date.

Bulgarian academic Dimitrina Petrova is quoted in The Guardian:

"In Bulgaria, those over 65 were in the fourth group on vaccination priority lists, giving way to pretty much everyone else in society – the health workforce, teaching staff, anyone involved in basic public life activities".

A separate media report on 26 April 2021 claimed that Bulgaria has the highest rate of Covid-19 related hospitalisation in Europe, and that most people aged over 80 were being denied hospital admission, in order to prioritise younger people **[https://euobserver.com/coronavirus/151639]**.

Current data [Hannah Ritchie, Esteban Ortiz-Ospina, Diana Beltekian, Edouard Mathieu, Joe Hasell, Bobbie Macdonald, Charlie Giattino, Cameron Appel, Lucas Rodés-Guirao and Max Roser (2020) – "Coronavirus Pandemic (COVID-19)". Published online at OurWorldInData.org. Retrieved from: **https://ourworldindata.org/coronavirus** [Online Resource] show that reported COVID-19 mortality in Bulgaria is 17,000, although this is thought to be a substantial under-estimate of the actual levels. During the pandemic, Bulgaria has seen the highest rate of overall excess mortality among older people of any country in Europe, including the UK **[https://www.bmj.com/content/bmj/372/bmj.n799.full.pdf]**.

Bulgaria is not the only country that is focussing COVID-19 vaccination on people at younger ages. The Global Platform has

published blogs on this with reference to India, The Philippines, Peru and Indonesia. This explicitly ageist and unethical policy has been publicly criticised by the Director General of the World Health Organisation, who said:

"There is a disturbing narrative in some countries that it's OK if older people die. It's not OK… It is important that everywhere older people are prioritised for vaccination. Those most at risk of severe disease and death from COVID-19, including health workers and older people, must come first. And they must come first everywhere." **[https://twitter.com/DrTedros/status/1358084910569975810]**

We urge the governments of these and other countries to ensure that access to COVID-19 vaccines is determined on the basis of need, rather than discriminatory criteria.

To what extent does COVID-19 vaccination protect older people in care homes? Some new evidence from Brazil and Argentina.

15 MAY 2021

By Peter Lloyd-Sherlock, Lucas Sempe and Karla Giacomin.

https://corona-older.com/2021/05/15/to-what-extent-does-covid-19-vaccination-protect-older-people-in-care-homes-some-new-evidence-from-brazil-and-argentina/

On 11 May the Brazilian media reported that there had been a large outbreak of new COVID-19 cases among older people in a residential care facility in the state of Minas Gerais **[https://g1.globo.com/mg/sul-de-minas/noticia/2021/05/11/asilo-confirma-infeccao-de-33-idosos-pela-covid-19-em-lavras-todos-haviam-sido-vacinados.ghtml]**. It was reported that 33 of the care home's 46 residents and one member of staff had so far been tested positive for the virus. All of these individuals had already been vaccinated. The point of entry into the care home remains unknown and the care home insists it had followed all the required infection control protocols.

The same day similar reports appeared relating to a care home in Argentina, where 20 older residents and three members of staff had been tested positive for the virus **[https://el-periodico.com.ar/contenido/124558/a-una-semana-del-brote-en-el-geriatrico-los-abuelos-siguen-bien-remarco-vicente]**.

At first sight, this seems worrying news, calling into question the efficacy of these vaccines. However, the most telling point is that all the infected residents and staff in both care homes appeared to be well and none had, as yet, presented COVID-19 symptoms. In other words, the vaccine had not prevented infection, but had (so far) prevented serious illness among this high-risk population group.

These experiences show the importance of vaccinating all care home residents and staff, and of continuing regular testing afterwards. This is not always a simple task, since many care homes in Latin America operate informally and are not registered with local government agencies **[https://corona-older.com/2020/11/24/an-emergency-strategy-for-managing-covid-19-in-long-term-care-facilities-in-low-and-middle-income-countries-the-ciat-framework-version-2/]**. In other words, these facilities are effectively invisible to public health authorities. The COVID-19 pandemic has demonstrated the urgent need to improve regulation of care homes in the region.

India sidelines older people from COVID-19 vaccination.

13 MAY 2021

By Nidheesh M K, Tata Institute of Social Sciences, Mumbai and P.Lloyd-Sherlock, University of East Anglia.

https://corona-older.com/2021/05/13/india-sidelines-older-people-from-covid-19-vaccination/

By mid-May 2021, around 40 per cent of people aged 60 or more in India had received at least one dose of a COVID-19 vaccine. Vaccination coverage of the older population could have been much higher if the country had adopted a more age-focussed approach. Since the start of April, anyone aged 45 or more has had the same vaccination entitlement as older people and on 1 May this entitlement was extended to anyone aged 18 or more. Since this last change, the proportion of first doses of vaccine being administered to older people has fallen from around 30 to under 20 per cent. Due to elevated COVID-19 case fatality among the oldest, this policy will result in tens of thousands of deaths that could have been averted through age-targetted vaccination.

Global evidence shows that the case fatality for Covid-19 is much higher among older people than for younger age groups and is significantly higher for people with conditions such as heart disease, kidney

disease, lung disease, cancer and dementia. In India, the available state-level data indicate most deaths due to Covid-19 occur among older adults and people with comorbidities. As of March 2021, 88 percent of India's Covid-19 deaths were among people over the age of 45.[1] Due to reporting and diagnosis issues, the real number of COVID-19 deaths is much higher than officially reported levels and older people are likely to make up a significantly larger share of it. [2]

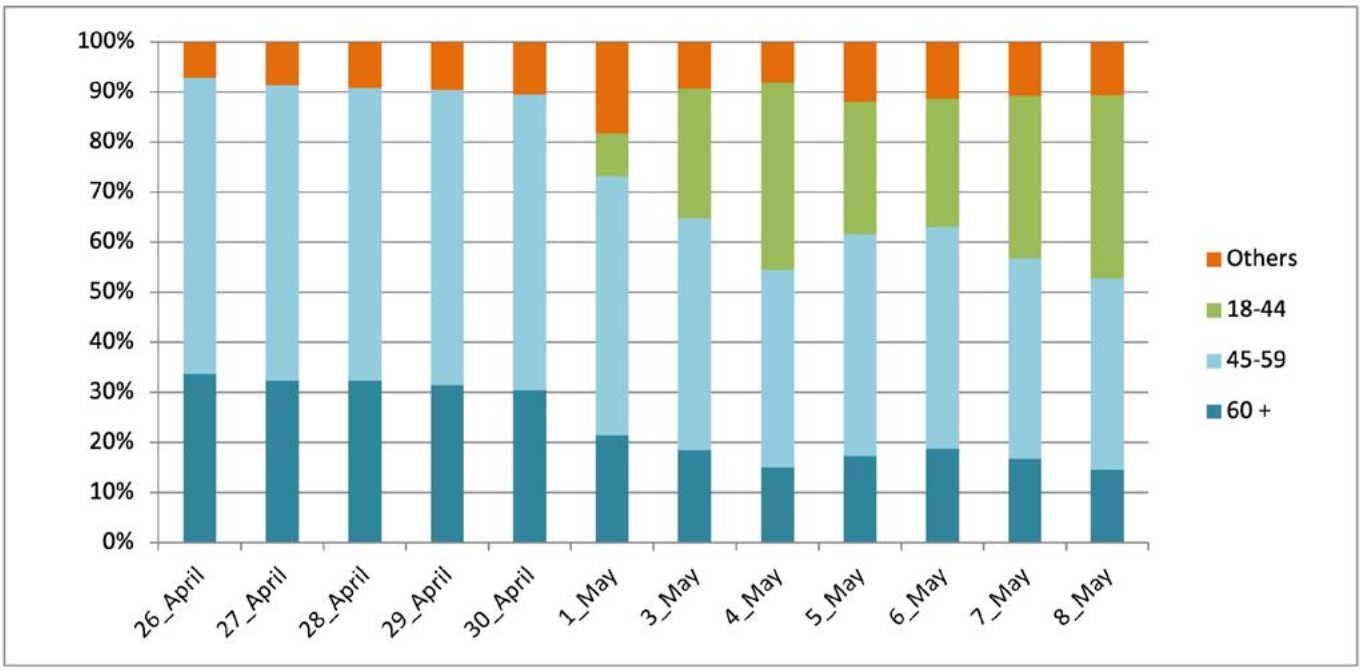
On January 16th 2021, India began the first phase of its vaccination programme with health care workers, followed later by other "frontline workers". From March 1st, the vaccine was made available to people aged 60 and above, and to people over the age of 45 with comorbidities. In a third phase, from April 1st, it was made available to the entire population over the age of 45 and on 1 May to all adults. Four months after the program's inception, about 10 percent of India's total population have received ar least one dose, including about 40 percent of people aged 60 and above and 30 percent of people aged between 45 to 59. [3]

Why has progress not been faster? The media and experts point out that the main reasons for vaccine shortage in India is the delay in placing vaccine orders, reluctance in allowing foreign companies to administer the vaccine and the insufficient vaccine production capacity of Indian manufacturers. In addition, reports show that the union government lacks transparency in the distribution of vaccines to states, i.e. it is neither based on the number of Covid-19 cases nor the target population. [4,5]

In April 2021, with the second wave of Covid-19, health systems in many Indian cities collapsed. The mortality rate has risen in major cities due to insufficient healthcare services and shortages of oxygen supply. The union government responded to this situation in several ways. First, it allowed foreign companies to administer vaccines in India in order to accelerate the roll-out. Second, it permitted two Indian vaccine manufacturers (Serum Institute and Bharath Biotech) to set the prices for 50 percent of their vaccine production. Third, it granted all people aged 18 or over vaccination entitlement, although people aged 18 to 44 would be required to pay for it.

FIGURE 1 – Daily Vaccination Rate among Older People and Other Ages and Other Age Groups

Percent distribution of daily first vaccine doses by age, from 26th April to May 8th



Source: Author's creation using data from https://pib.gov.in/allRel.aspx
(Others –Healthcare workers and frontline workers)

Figure 1 refers to people receiving a first dose of COVID-19 vaccine. In the last week of April, about 30 percent of these first doses were administered to older people. However, since the vaccine became available to people aged 18 to 44 years old, the share provided to older people dropped to less than 20 percent. In absolute terms this was a fall from 400,000 to 150,000 older people vaccinations a day. By contrast, people aged between 18 to 44 are receiving more doses of vaccine than older people.

India is currently facing a challenge in providing adequate healthcare services and vaccines; at this point vaccinating everyone over the age of 18 can be seen as politically and economically motivated. In addition, existing online vaccine registration systems may hinder the timely delivery of the vaccine to people without digital literacy. At present, reports indicate that the rate of vaccination is very low in rural areas. **[6]** As per the 2011 census, about 70 percent of India's older population live in rural areas. The literacy rate among older people is 44 percent, and a large section of the older people are digitally illiterate. In this situation, the information related to the necessity of vaccination may not reach everyone equally.

Not surprisingly, the decision to end age targeting and to partially privatize the vaccination system has generated a great deal of criticism and concern about ensuring the vaccines will be available to those who need them most. **[7,8,9]**

In India, about 80 million older people are yet to be vaccinated. Until they have received at least one dose, the priority for vaccination should still be older people and other people with relevant comorbidities. Vaccinating larger numbers of younger people than of older people will have led to many avertable deaths. Although the government claims it will provide the vaccine free of charge to anyone over the age of 45, doses may not be immediately available in the face of the current vaccine shortage. This may force older people to pay for vaccination through the private sector. Social security and pension coverage in India are minimal and therefore older people from less advantaged sectors will struggle to meet this cost. And those, of course, are the people who are least able to protect themselves from infection or access treatment if they become ill. In sum, India's approach to COVID-19 vaccination prioritization is deeply inequitable, both between age groups and within them.

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COVID-19 vaccination and ageism in the Philippines.

12 APRIL 2021

By Peter Lloyd-Sherlock and Lucas Sempe. Additional information provided by Pamela Joy Mariano Capistrano, Ateneo de Manila University.

https://corona-older.com/2021/04/12/covid-19-vaccination-and-ageism-in-the-philippines/

The Global Platform has drawn attention to previous proposals to exclude or de-prioritise older people in COVID-19 vaccination programmes in countries such as Indonesia and Peru. For examples, see our blog on 12 February [1] and this comment published in the British Medical Journal [2].

Concerns about these cases led to the following statement from the Director General of the World Health Organisation, which we very much welcome:

"There is a disturbing narrative in some countries that it's OK if older people die. It's not OK… It is important that everywhere older people are prioritised for vaccination. Those most at risk of severe disease and death from COVID-19, including health workers and older people, must come first. And they must come first everywhere." [3]

Official data report that over 15,000 people in the Philippines have died due to COVID-19 and the majority of those deaths have been people aged 60 or more [4]. This is likely to be a substantial underestimate of the true number of deaths resulting from the pandemic. It calls for a robust vaccination campaign, prioritising those people at highest risk of dying or becoming seriously ill. It has been reported that the majority of Filipinos of all ages claim they do not want to be vaccinated. [5]

On 12 April 2021, with reference to the Philippines' faltering COVID-19 vaccination programme, President Duterte, stated:

"Let's prioritise those who, once they get a vaccine, there's a chance that he would live and live productively. Most of the senior citizens are no longer that productive." [6]

This was not a lapse, nor was it an unguarded off-the-cuff comment. This was a carefully premeditated statement made in high profile pre-recorded speech. In line with the macho posturing of some other national leaders, Duterte boasted that he would deny

himself (aged 76) the vaccination. By making this perverse grand gesture, he appeared to be seeking to shame those "selfish older people" who have the temerity to seek vaccination.

As it happens, the large majority of the ten million adults aged 60 or more in the Philippines do not have a pension. Consequently, many have no alternative to remaining productive for as long as they possibly can. This point seems to have eluded the President.

In our other blogs, we set out the reasons why discouraging older people from being vaccinated against COVID-19 is wrong, both on moral grounds and in terms of public health effectiveness. Sadly, Duterte is unlikely to be the last global leader to take this reprehensible stance.

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Providing Covid-19 vaccination to older people in Goias, Brazil: Experiences and further challenges.

8 APRIL 2021

By Fabiana da Cunha Saddi (Federal University of Goias, Brazil), with the collaboration of Peter Lloyd-Sherlock (University of East Anglia).

https://corona-older.com/2021/04/08/providing-covid-19-vaccination-to-older-people-in-goias-brazil-experiences-and-further-challenges/

Goias was the second Brazilian state to start a vaccination campaign against COVID-19, and the governor (who happens to be a doctor) personally gave the first vaccine to an older person [1]. The focus has been on older people and front-line health workers. Vaccinations have been offered in a number of different settings, including drive through service points, health units, long-term care facilities (LTCFs) and sometimes at home. By 5 April 2021, 550,918 people in Goias had received at least one dose and 135,400 had received both [2]. Vaccines have been provided to all older people living in the state's 209 registered (LTCFs) [3], and people aged over 76 are now receiving their second dose [4]. However, the general situation is still critical, with 12,118 confirmed COVID-19 deaths by 5 April and 489.522 cases confirmed in the last 4 weeks [5].

Goias' relatively rapid vaccination roll-out has led to a recent decline in COVID-19 deaths (in contrast to the increasing numbers of deaths in Brazil as a whole) [6, 7] and has permitted a partial relaxation of a strict lockdown implemented in February and March.

Despite its general success, the Goias vaccination campaign has not been without problems. Health workers report that some older people have refused to be vaccinated.

PHOTO 1 – The Governor of Goias, who is a medical doctor, applying the vaccine to a 73-year-old woman.

Available at: https://www.correiobraziliense.com.br/brasil/2021/01/4901117-goias-incia-vacinacao-contra-a-covid-19-idosa-e-vacinada-em-anapolis.html

Credit: TV Anhanguera.

This problem has been especially common among poor older people living in remote parts of the capital [8] and the state, as happened in other parts of the globe [9]. There have been some exceptional cases of malpractice, including a nurse who administered an empty syringe – with no vaccine – to an older person. The case was widely reported in the local media and the nurse was subsequently fired [10; 11]. A municipal health secretary and her coordinator organized a list of names, including people from the private sector and their relatives and friends, given them fictitious positions in the public health systems, so that they could be vaccinated against COVID-19 without having to wait for their turn. After a denouncement, a prosecutor judicially requested the resignation of the two civil servants involved [12].

There is a lack of information on effective responses to vaccines against COVID-19 in Goias. It is known, for instance, that older people who live in LTCFs in Brazil can suffer adverse effects, as happened in Bauru, where six older people died after being fully immunized [13]. Considering the emergency and temporary status of the approval of COVID-19 vaccines [14], as well as the fact that older people are the first to be vaccinate, notifications on vaccine's side effects and safety conditions should be encouraged. Information should be verified, monitored, and made available to the public in a reliable way [15].

Efforts continue to be made to address these concerns, with front line health and social workers frequently engaging with social and mainstream media. Messaging seeks to emphasise the safety of the vaccines and refers to Brazilian research demonstrating their high levels of efficacy, including preliminary results showing its efficacy against the new variants [16, 17]. Experts also emphasise the importance of receiving both doses, referring to cases such as an 85 year-old man who recently died of COVID-19 shortly before he was due to receive the second dose [18].

The state government plans to accelerate the vaccination campaign in April, reaching the entire population aged 60 or more and then reaching out to people at younger ages with chronic diseases [19]. Vaccine supply is not a major problem. On April 2, Goias received a further 241,800 units of CoronaVac, and 25,000 of AstraZeneca [20]. Additionally, municipalities are making their own arrangements to jointly purchase vaccines [21].

As in all countries, vaccination will be a key part in the public health response to COVID-19. Despite the wider national crisis in Brazil, Goias state appears to have made good progress. However, this should not deflect attention from the other public health measures and behavioural changes that will be essential for managing the pandemic. For example, there is no available information about testing, surveillance and other protective measures in LTCFs across Goias. Sustainable responses to the COVID-19 pandemic will require institutional strengthening in public health, as well as closer integration with social assistance agencies supporting dependent older people.

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Appropriate strategies for COVID-19 vaccine prioritisation in low and middle-income countries.

12 FEBRUARY 2021

By Peter Lloyd-Sherlock, Adelina Comas-Herrera and Martin McKee.

https://corona-older.com/2021/02/12/appropriate-strategies-for-covid-19-vaccine-prioritisation-in-low-and-middle-income-countries/

As COVID-19 vaccines become available, many low and middle-income countries (LMICs) are publishing prioritisation plans. Beyond giving some or all health workers the highest priority, these plans differ markedly. Some follow a similar approach to most high-income countries. Mexico, for example, starts with people aged 80 or more, moving progressively through those aged 70-79 and 60-69 [1]. Peru, in contrast, places everyone aged 60 or more into a single category below several other groups, including the military, private security guards and election workers [2]. Brazil is prioritising its indigenous population of all ages above non-indigenous older people, other than those living in care homes [3]. Unusually, Indonesia initially prioritised younger people over those aged 60 or more in the first phase of roll-out [4].

Governments have sought to justify their priorities in different ways. Peru has concerns about forthcoming national elections. Indonesian officials argue there are insufficient data on safety of China's Sinovac vaccine in older people [1]. Nevertheless, there is an evident need for systematic guidance for prioritisation. WHO has published ethical guidance, but we argue that it lacks specificity and should focus on three key considerations [5, 6].

Openness and clarity about goals.

WHO guidance states: "The overarching goals of protecting individuals and public health, while recognizing the need to minimize impact on societies and economies, should drive the allocation process of health products across different countries" [6]. Minimising deaths, easing pressure on hospitals, limiting spread of infection, or accelerating a return to normal life are all desirable outcomes, but not always mutually compatible [7]. For example, groups most at risk of dying of COVID-19 may not be those most likely to spread infection or most important for rebooting economies. [1] Rather than strike a messy compromise, governments must establish a primary objective.

On 6 February 2021, the Director General of WHO set out a more focussed, less ambiguous goal, stating: "There is a disturbing narrative in some countries that it's OK if older people die. It's not OK… It is important that everywhere older people are prioritised for vaccination. Those most at risk of severe disease and death from COVID-19, including health workers and older people, must come first. And they must come first everywhere." [9].

Realism about local context.

Prioritisation must reflect the speed of procurement of particular vaccines and national capacity to roll them out to different groups. India's purported aim of treating all its 250 million people aged 50 and over as a single group avoids difficult choices, but the country would be better served by a more differentiated strategy [10]. LMICs with prevalent HIV and TB should consider evidence of high COVID-19 case fatality among people with these infections [11]. Also, prioritisation will only be meaningful if it is linked to feasible delivery plans addressing access barriers and vaccine acceptance. Even in some high-income countries rollout has already diverged from stated priorities, due to difficulties reaching high priority groups [12].

Equity and social justice.

The prioritisation of different groups for vaccination will have large effects on the overall burden of harms generated by the pandemic in each country. It will also affect how these harms are distributed across different groups within these societies. Any strategy should be consistent with the primary objective of a vaccination programme. And those objectives must themselves be guided by principles of equity and social justice. These are:

Prioritisation should be a consensual process, based on informed societal debate, with the participations of all social sectors.

Vaccination should conform to wider principles of universal rights to health. This means vaccines should be free or affordable for all and that access will not be influenced by ability to pay or political leverage. There is already evidence of lobbying by corporations to prioritise the vaccination of their own staff and of senior political figures jumping the queue [13, 14].

Policy should take into account that some groups have limited logistical capacity to mobilise notionally universal entitlements to access vaccinations. For example, poor, frail older people or disabled people face particular challenges in reaching a vaccination point.

Concluding thoughts.

This short paper establishes some general parameters to support policymaking and national debate. Within each of these, it identifies preliminary sets of considerations. While these can be applied to all countries and settings, it does not follow that the resultant policies will be the same. A one-size-fits-all global template will be neither feasible nor desirable. Inevitably, decisions will be shaped by a complex interplay of political considerations, expediency and heuristic framing. Nevertheless, it is to be hoped that to some degree they will reflect the available scientific evidence.

[1] Some commentators have claimed that older people are most at risk of death, but are less at risk of spreading infection, since they have less social or economic interaction with others [8]. There is no evidence to support this claim, which reflects a misguided and stereotyped assumption of old age and marginality.

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Equitable global access to coronavirus disease 2019 vaccine.

30 DECEMBER 2020

By Peter Lloyd-Sherlock (University of East Anglia), Paramita Muljono (University of East Anglia) and Shah Ebrahim (London School of Hygiene and Tropical Medicine).

https://corona-older.com/2020/12/30/3575/

Concern about vaccine nationalism is important and well-founded, but it has overshadowed another key form of injustice: vaccine ageism.

In Indonesia, as in many low and middle-income countries (LMICs), the main form of COVID19 vaccination that will be available over the coming months will be Sinovac, produced in China.

The initial SINOVAC trials in China that led to licensing for use were only conducted on adults aged under 60 [1]. Subsequent trials in Indonesia also exclude over 59 year-olds. The clinical trial research team leader, Kusnandi Rusmil, commented to BBC Indonesia: ""Why do we target people of a productive age? These people can work hard, so the country will not have a deficit" [2]. As a result, there is no information about either its safety or efficacy for people at older ages. Further trials of SINOVAC for people at older ages have since begun in countries such as Brazil [3]. Media reports suggest that SINOVAC may be effective for older people, but at a lower level than for other ages [4]. However, related findings are yet to be published.

Due to the lack of published evidence, the government of Indonesia has decided to exclude people aged 60 and over from their vaccine roll-out [5]. In the (ageist) words of Minister of Health Terawan Agus Putranto, the target is to vaccinate 107,206,544 people aged between 18 and 59, as they are of "productive age". An article in the national media concludes: "Isn't it strange that if we want to vaccinate them, we will have to fly our children or grandma and grandpa to England?" [5]. This age-targeted vaccination policy will lead to reservoirs of Covid-19 among children and older people, resulting in continuing viral transmission, more hospital admissions and avoidable deaths. The aim of vaccination programmes is not simply to protect individuals, but to achieve herd immunity in order to protect whole populations, including vaccine non-responders and non-compliers [6].

Not all candidate COVID-19 vaccine trials have excluded older people, and it is welcome that ongoing trials of SINOVAC will include them [7]. Whether this will lead to vaccine policy change in countries like Indonesia remains to be seen. There is a long and problematic history of excluding older people from trials of vaccines or treatments for conditions that affect them greatly [8]. There is a long, problematic tradition of infantilising "grandpa and grandma" and of justifying discrimination on the basis of false claims that people aged 60 or more are by definition unproductive and younger adults universally productive. Nationalist self-interest will mean that most LMICs will be at the back of the global vaccine queue; and vaccine ageism will mean that older people will be at the back of the queue in many LMICs.

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COVID-19 vaccination and older people: an interview with Anderson Brito.

9 DECEMBER 2020

By Thais de Carvalho Rodrigues Lopes.

As the world starts to vaccinate, a lot of questions have started to appear in the media about the characteristics and reliability of different jabs. To better understand the challenges of mass immunisation in the context of low and middle-income countries (LMICs), we have contacted Dr Anderson Brito, a virologist with experience in the Brazilian context. Anderson has been at the forefront of science outreach about COVID-19 in Brazil. He holds MSc in Microbiology from the University of São Paulo and a PhD in Computational Biology from Imperial College London. He is currently a Postdoctoral Associate at the Yale School of Public Health, investigating the emergence, transmission and evolution of viruses. In this brief interview, he discusses the main differences among different vaccines, the types of jab that are more likely to ease the pandemic given the infrastructure in LMICs and the importance of shaping strong vaccination campaigns.

Could you summarise the main differences among the vaccines that are on the run at the moment?

Anderson Brito: The goal of a vaccine for a virus is to expose our body to proteins that viruses would produce during a real infection. It's like a training for our immune system, which will learn how to react when a real infection happens. The first-generation vaccines, since decades ago, were made out of the actual virus (or other microorganism), which were inactivated or attenuated (weakened) in laboratory, to deliver several proteins that the active virus would produce during an infection, but with little or no ability to replicate in our body.

The second-generation vaccines, made of protein subunits, came to simplify the process. Vaccines began to be produced mainly based on proteins or fragments of viral proteins, which are sufficient to ensure immunity.

The third-generation vaccines do not aim to directly provide viral proteins to our body, but rather a "recipe" for protein production:

ANDERSON BRITO – **For more information about Dr Brito's work and media coverage, see his GitHub.**

https://corona-older.com/2020/12/09/covid-19-vaccination-and-older-people-an-interview-with-anderson-brito/

messenger RNAs. In Molecular Biology, it is known that "DNA serves as a template for RNA synthesis, and RNA serves as a template for protein synthesis": DNA › RNA › Protein. Coronaviruses have genetic material made of RNA (which serves as a template for protein synthesis). Pfizer and Moderna vaccines contain a fragment of the viral RNA, which corresponds to the viral gene used to generate the spike protein. RNA molecules are coated by layer of lipids (fat), which form the nanoparticle used to deliver RNAs to our cells, when the vaccine is injected into our body. There, RNAs serve as a template for the synthesis of spike proteins. In this way, our immune system will have access to viral proteins, and will be trained to fight against the coronavirus, in a very safe, effective and sophisticated way.

Considering the stage of testing and the costs of mass vaccination, what is the most likely vaccine to ease the COVID-19 crisis in Brazil and in other low- and middle-income countries? Could you tell us why?

Countries like Brazil have industrial capacity to produce vaccines of first and second generation. The vaccine developed by SinoVac, for example, is a vaccine of first generation, made with inactive viruses, in collaboration with Instituto Butantan, in São Paulo, which is known to produce vaccines against Flu virus, Hepatitis A/B, HPV, Rabies, etc. Given that such vaccine formulations are more stable at regular refrigerator temperatures, slightly above zero degree Celsius, this type of vaccines are more likely to ease the COVID-19 crisis in low- and middle-income countries.

Few older people were included in the COVID-19 vaccines tests. Could this pose a future problem?

Vaccines in phase III are expected to be tested in thousands of individuals, from multiple groups, with a large variety of ages, sex, and genetic backgrounds. A deficit in the number of individuals from certain groups in such trials pose problems, as vaccine developers would not be able to ensure the vaccine is safe and effective for all. However, the vaccines being approved so far, or about to be approved, were tested in older adults (65+) and have shown to be safe and effective.

Are there any challenges to the mass vaccination of the risk group?

The management of a vaccination campaign itself is a major challenge. But once a vaccine is approved by public health agencies, individuals in risk groups will be in the priority list to get vaccinated. In this sense, the challenges are more related to logistics, especially when it comes to the usage of vaccines of RNA, which require special refrigerators to keep them at -70 degree Celsius, up to five days prior to their administration to the public.

Are there any previsions of how long immunisation will last?

As for other coronaviruses, the duration of the immunity to the novel coronavirus SARS-CoV-2 may last for at least 12 months, as recent studies revealed for immunity to coronaviruses that cause common cold. Since this pandemic started less than a year ago, it is not possible to ascertain whether or not the immunity will last longer than that, but several studies are under way to find out.

Is the vaccine still effective if the virus mutates?

The virus SARS-CoV-2 accumulates around 2 or 3 mutations per month. This is a quite fast evolutionary rate, but coronaviruses rarely use other mechanisms of evolution, such as recombination and reassortment, which allow certain viruses to evolve much faster, posing challenges to vaccine development. HIV, for example, are known to recombine, that is, it exchanges parts of its genome with other related, but distinct HIV lineages, allowing the virus to accumulate changes much faster. A similar mechanism is adopted by the Flu virus (Influenza), which exchange segments of genetic material with other Influenza viruses

(including those infecting birds and pigs), which allow them to diversify very quickly. This in part explains, for example, why developing a vaccine for HIV is difficult, and why we need to get a new Flu shot every year. The periodicity of the vaccination against SARS-CoV-2 is still to be determined, but I would expect immunity to last more than a year, as the evolutionary rate of SARS-CoV-2 is not as fast as others mentioned above.

What are the advantages and disadvantages of an RNA vaccine?

Advantages: If they prove to be effective, RNA-based third-generation vaccines can revolutionize the way the pharmaceutical industry will produce vaccines. The synthesis of RNA fragments in a laboratory is relatively simple, and in the face of a new epidemic, the mastery of this new technique will allow faster vaccine production, as it does not depend on the production of viral structures such as proteins or complete viral particles on a large scale.

Disadvantages: RNA molecules are especially sensitive, and can be degraded, especially if maintained in inadequate temperature conditions. Therefore, it is necessary that such vaccines are kept in specific refrigerators, commonly found in research laboratories, which keep the vaccines at temperatures as low as -80 degrees Celsius.

Part Two

Data issues on older people and COVID-19 mortality

Estimating excess mortality in the first wave of Peru's COVID-19 pandemic: More than just an academic exercise?

21 AUGUST 2021

By Lucas Sempé, Peter Lloyd-Sherlock, Shah Ebrahim, Ramón Martínez, Martin McKee and Enrique Acosta.

https://corona-older.com/2021/08/21/estimating-excess-mortality-in-the-first-wave-of-perus-covid-19-pandemic-more-than-just-an-academic-exercise/

Lancet Americas has just published a paper in which we develop a new method for estimating excess numbers of deaths during the COVID-19 pandemic and applies this method to Peru **https://www.sciencedirect.com/science/article/pii/S2667193X21000314**

What does the paper show?

- During Peru's 1st wave of the pandemic (March to December 2020), we estimate there were 173,099 "excess deaths". Considering the size of Peru's population (33 million), this is the highest per capita rate of excess mortality reported for any country during the pandemic in 2020.
- Our excess mortality estimate is almost double official reports of COVID-19 deaths over the same period. This is a much larger difference than those reported in studies of high-income countries. In other words, the impact of the pandemic in countries like Peru (probably most low and middle-income countries) has been grossly under-estimated, due to under-reporting or misdiagnosis.
- 12.5% of Peru's population is aged 60 or more, but this age group accounted for 74 per cent of our estimated excess deaths.

What does this actually mean?

Estimates of excess all-cause mortality are the most effective way to assess the impact of COVID-19 on people of all ages, including older adults. Robust estimates take into account that not all deaths caused by COVID-19 will be registered or attributed to that cause. They also include indirect mortality effects of the pandemic, such as deaths caused by reduced treatment for other health conditions. All of this is especially important for low and middle-income countries where death registration tends to be less complete and cause of death data less reliable than in high-income countries.

It is not possible to be sure about how representative these findings are for other countries in Latin America or other regions. And it should not be forgotten that our study does not include Peru's second and more severe pandemic wave which occurred in 2021.

Although we did not aim to be obscure, our paper is not a simple read. Making reliable estimates about excess deaths over a period of time may sound simple, but in practice it is a messy and complicated process; especially for those countries where the data are less complete or reliable.

Some might question the purpose of perfecting methods to count deaths in Peru or anywhere else for that matter. In our view, it is vital that we document the real impact of this global catastrophe, especially in poorer countries where it continues to be under-stated.

Staring into a black hole. Data on COVID-19 mortality in India.

7 AUGUST 2021

By Peter Lloyd-Sherlock, Aravinda Guntupali, Arokiasamy Perianayagam and Martin McKee.

https://corona-older.com/2021/08/07/staring-into-a-black-hole-data-on-covid-19-mortality-in-india/

The Covid-19 pandemic has brought into sharp focus the lack of a comprehensive system of statistics on mortality and cause of death in India. By 25 May 2021, only 299,296 Covid-19 of an estimated 654,395 deaths were recorded officially [1]. Volunteers in the state of Kerala found records of 4,559 deaths in local media between March and December 2020, but only 2,646 deaths reported by official sources [2]. Similarly, 8,286 cremations were reported for seven Gujarati cities between 15th April and 3rd May 2021, compared to only 1,061 officially recorded deaths [3]. Just 50 Covid-19 deaths were reported for the city of Bhopal during the first three weeks of April 2021, but other sources estimated there had been over a thousand [4]. If anything, these ad hoc studies may understate the true level of under-reporting, since not all deaths are recorded in the media.

These large disparities should come as no surprise, given the failure to establish an effective civil registration system. As recently as 2015, less than a third of deaths in some Indian states were reported [5]. Of those recorded, only around 22 per cent receive a medically certified cause of death [6]. India's limited mortality data contrasts with the good availability of data in many other countries [7]. Importantly, a study of completeness of death registration in 2015 found very low, and declining, rates in some Indian states, such as Nagaland (29%) and Manipur (34%), while others, from Kerala and Tamil Nadu in the South to Punjab and Haryana in the North, had achieved 100% coverage [5].

Indian data on all-cause mortality are too incomplete to permit comparisons over time. These are needed to capture the overall mortality impact of the pandemic, including likely increases in deaths from other conditions due to reduced access to treatment and other effects. There is also a problem of transparency. In 2020, Indian and global researchers asked the Government of India to release the civil registration data for deaths during the pandemic, along with mortality data for the two preceding years,

in order to calculate excess deaths **[8]**. This request was not granted, perhaps reflecting the government's own lack of confidence in these data.

As India's data on all-cause mortality are so poor, more disaggregated analysis of infections, comorbidities, hospitalizations and fatalities by age, sex and socio-economic status are not possible. This is of great concern, since these data are necessary to inform policies such as vaccination priorities.

We make three urgent recommendations.

First, we urge organisations that compile comparative international datasets on COVID-19 mortality, including John Hopkins and WHO, to be more careful in their presentation of data for countries like India, where their quality are so poor that they do more to obscure than reflect the true impact of the pandemic. This could include clearly signalling cases where the available data appear to be highly unreliable.

Second, we urge India's national government to commit the required investment and support for a more complete system of death registration. This should be done in conjunction with the strengthening of primary health care facilities in rural areas, which can serve as registration and surveillance points for deaths that occur at home, and should ensure learning from those states that have achieved high registration rates. To enhance cause of death attribution, the use of verbal autopsy by primary health care staff should be scaled up markedly **[9]**.

Third, as a short-term expedient, we recommend the rapid extension and adaptation of existing demographic and health surveys to capture mortality at all ages, as well as other direct and indirect effects of the pandemic. This will provide useful insights about high-risk populations in deprived settings.

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Data update: Older people in South Africa and excess mortality during the COVID-19 pandemic.

18 JUNE 2021

By Peter Lloyd-Sherlock, Leon Geffen, Gabrielle Kelly and Lucas Sempe.

KEY POINTS:

From 3 May 2020 to 12 June 2021

- The official COVID-19 death-count was 57,706.
- But excess mortality was 169,978.
- It is estimated that 85-95% of these excess deaths were COVID-19 related.
- People aged 60+ accounted for 77% of all excess deaths (130,500 deaths).

This is an update for a short paper posted by the Global Platform on 1 March 2021 **[https://corona-older.com/2021/03/01/older-people-in-south-africa-and-excess-mortality-during-the-covid-19-pandemic/]**.

Estimates of excess all-cause mortality are the most effective way to assess the impact of COVID-19 mortality on people of all ages, including older adults. Robust estimates can take into account that not all deaths caused by COVID-19 will be registered or attributed to that cause. They also include indirect mortality effects of the pandemic, such as deaths caused by reduced treatment for other health conditions. All of this is especially important for low and middle-income countries (LMICs) where death registration tends to be less complete and cause of death data less reliable than in high-income countries.

Other Global Platform blogs and papers refer to the poor coverage and quality of COVID-19 mortality data for older people in many LMICs **[1,2]**. In some cases, depending on data availability, there is potential to generate robust estimates of excess deaths caused by the pandemic. To date, few countries have done this on a regular or systematic basis and few have included specific analysis of people at older ages.

South Africa has not published age-breakdowns for reported COVID-19 deaths

https://corona-older.com/2021/06/18/data-update-older-people-in-south-africa-and-excess-mortality-during-the-covid-19-pandemic/

since 13 June 2020, perhaps due to concerns about the reliability of cause of death data. Instead, the South African Medical Research Council in partnership with the University of Cape Town Centre for Actuarial Research has been providing weekly updates on excess mortality. These include comparisons between people aged under 60 and those aged 60 and over [3]. Their analysis is based on a robust methodology and takes incomplete death registration into account (which not all excess mortality estimates do).

The main purpose of this blog is to draw attention to these weekly reports. Here are some highlights from the report that covers the period from 3 May 2020 to 12 June 2021, along with some additional comments.

Over this period, the total number of excess deaths from natural causes totalled 169,978. This compares to a total of 57,706 reported COVID-19 deaths over the same period. In simple terms, the number of all-age excess deaths was three times the number of reported COVID-19 deaths. This is a much larger difference than those reported for high-income countries. For example, separate studies of the USA show differentials of between 28 and 33%. [4,5]. The most likely explanation for the large differential in South Africa is that many COVID-19 deaths are either unregistered or are wrongly attributed to other causes. This is borne out in a separate South African Medical Research Council Report that estimates 85 to 95 per cent of excess deaths between May 2020 and February 2021 were COVID-19 related [6].

Of these excess deaths in South Africa, 130,500 (76.8%) occurred among people aged 60 or more. For the reasons given above, these are likely to be mainly caused by COVID-19 (either single-handedly or in combination with other risk factors, such as diabetes, HIV or TB) [7,8].

Like many countries, South African has experienced several waves of COVID-19 mortality. The second wave, which occurred in early 2021, saw higher rates than the initial 2020 wave. During the first five weeks of 2021, excess natural cause deaths of all ages totalled 54,774, 40% of the cumulative death total since 3 May 2020. A third wave is now underway and it is still unclear what at what rate mortality will peak.

Some more general points can be taken from these data.

First, more caution should be exercised when trumpeting the apparent successes of some sub-Saharan African countries in keeping COVID-19 deaths at low levels [9]. There may be some truth in this, but the South African experience suggests that the majority of COVID-19 deaths have gone undetected and unreported. Sadly, health and population registration systems in most of the region are much less developed than South Africa and this also prevents robust estimates of excess mortality. Relatedly, even LMICs with high numbers of reported COVID-19 deaths, such as Brazil, India or Mexico, may be capturing a much smaller share of the true death toll than high-income countries are able to.

Second, the South African data indicate the degree to which the risk of excess mortality is linked to older age. People aged 60 or over make up 9.4% of the national population, but account for 78% of excess deaths. Other studies have noted that people at younger ages account for up a larger share of reported COVID-19 deaths in LMICs than in high-income countries [10]. This is a dangerous and potentially misleading conclusion to draw for countries where most COVID-19 deaths appear to go unreported. Diagnosing cause of death is especially challenging for older people with multiple health conditions, so under-reporting is likely to more frequent at older ages [11].

In sum, the two main take-home messages from these South Africa data are (i) under-reporting of COVID-19 deaths is much more common than in high-income countries and (ii) older people account for the great majority of these unreported deaths.

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Who knows how many people are really dying of Covid-19 in India? The limitations of publicly available data on mortality.

6 JUNE 2021

By Arokiasamy Perianayagam, Aravinda Guntupali and Peter Lloyd-Sherlock.

https://corona-older.com/2021/06/06/who-knows-how-many-people-are-really-dying-of-covid-19-in-india-the-limitations-of-publicly-available-data-on-mortality/

In India as in many other low and middle-income countries (LMICs), the Covid-19 pandemic has brought into sharp focus the lack of a comprehensive publicly available civil registration data system. There is an absence of epidemiological data, including the demographics of Covid-19 infections and fatalities. Published data are limited to regional reports, snapshot figures in official briefs, screenshots from webinars, and media accounts (Mukherji 2021). India's limited data supply contrasts with the availability of Covid-19 information in high-income countries and also some LMICs. For example, the Centre for Disease Control shares a weekly Covid-19 data tracker in addition to providing unit-level epidemiological data (CDC, 2021). In Central America, Costa Rica has a well-established system of death registration and epidemiological surveillance, which has enabled relatively complete data on the pandemic as it unfolded (WHO, 2010; Chaves et al, 2020).

Researchers argue that the true number of Covid-19 infections and the overall burden of Covid-19 related mortality in most LMICs are much higher than official reports state (Lloyd-Sherlock et al, 2020). By May 2021, WHO had documented approximately 3.5 million officially reported COVID-19 deaths (WHO, 2021). However, it has been estimated that the true numbers of global COVID-19 deaths, both reported and unreported, may in fact be 6.9 million (IHME, 2021). In the case of India, 299,296 Covid-19 deaths had been reported on 25 May 2021, but experts estimate that the actual toll has been more than double with 654,395 deaths (IHME, 2021).

High levels of excess mortality have been reported for many countries (Freitas et al, 2020; Dahal et al, 2021). As well as deaths directly attributable to the pandemic, this measure takes into account less direct mortality effects, including reduced access to treatment for other health conditions, as well as the economic and social disruptions caused by lockdowns. There are good reasons to predict very high rates of excess mortality

in India. Many people in urgent need of critical health care for pre-existing chronic conditions, new acute conditions, or for maternal and childcare, have had extremely limited access to these services (WHO, 2020).

Historically, the Indian government's annual mortality reports have never included the detailed data needed to calculate excess mortality. Consequently, none of the Indian government's reports, press releases, or presentations produced during the pandemic to date have referred to excess deaths.
In August 2020, several Indian and global researchers asked the Government of India to release the civil registration data for deaths during the pandemic, along with mortality data for the two years preceding the pandemic, in order to calculate excess deaths (Appeal for the excess death data, 2020). However, this request was not granted.

Some individual states, including Kerala and Maharastra, have strengthened their mortality databases during the pandemic. Kerala is the only state to publish excess death data based on district-level mortality data for the years 2019 and 2020. This showed, while the first wave of the pandemic resulted in 2,646 reported COVID-19 deaths, other causes of death declined by a larger amount. This led to an 11% overall reduction in the total number of deaths (Government of Kerala, 2020).
There are a number of possible explanations for this unexpected result. Historically, Kerala has established much more extensive public health and social welfare systems than other Indian states and this may have facilitated efforts to control infection. Less positively (and more plausibly), the share of deaths that are registered may have fallen in Kerala during the pandemic, as larger numbers of people have been dying at home rather than in hospital.

There are a number of reasons for the poor quality of mortality data in India. Detection of COVID-19 cases is hindered by weak surveillance systems, particularly in rural and semi-urban areas. There has been widespread misclassification of Covid-19 deaths, due to a shortage of skilled health care professionals. Several reports have highlighted significant underreporting of mortality by comparing official data to media reports and funerals. In the state of Kerala, a group of volunteers led by a physician tracked mortality data reported by seven local newspapers and five TV channels between March and December 2020. They estimated that 4,559 deaths occurred in Kerala during the first wave of the pandemic rather than the 2,646 deaths reported by official sources (COVID Kerala, 2021). Kerala is one of the most educated states in India and is assumed to have the best data in India. If Kerala shows this level of underestimation of deaths, it is likely to be worse in many other states.

Similar comparisons have been made across the country during the second wave which, to date, has generated much larger numbers of deaths than the first wave. For instance, a Gujarati newspaper reported 8,286 cremations in 7 major cities in Gujarat between 15th April and 3rd May 2021: significantly higher than the 1,061 deaths reported by official sources (The Quint, 11th May 2021). In the city of Bhopal in the government reported just 50 Covid-19 deaths in the first three weeks of April 2021, but other sources estimated that there had been at least a thousand (**The Importance of Knowing How Many Have Died of COVID-19 in India – The Wire Science**, 2021).

Since official Indian data on overall levels of Covid-19 mortality (as well as on indirect deaths) significantly understate the actual number deaths, it follows that any data providing a higher degree of granularity are even less reliable. Disaggregated data on infections, comorbidities, hospitalizations and fatalities by age and sex and or socio-economic status are essential for understanding the course of the pandemic, for identifying groups at most risk and evaluating the effects of policies such as targeted vaccination (Scully et al 2020).

The Covid-19 pandemic in India has brought

two important lessons. First, the need to strengthen the regular civil registration surveillance system. This system remains very incomplete in rural areas and there are also gaps for semi-urban ones. Second, rapid population-based epidemiological surveillance surveys are crucial for collecting the data needed to assess excess mortality for high-risk populations during and after the pandemic (Balbo et al 2020). Existing nation-wide longitudinal surveys – such as the Demographic Health Survey (DHS), Health and Retirement Study (HRS), Living Standards Measurement Surveys (LSMS) – may provide a useful platform for these rapid Covid-19 surveys (Adjiwanou et al 2020, World Bank 2020, Subramanian and James 2020). However, none of these include high-risk groups such as older people living in long-term care facilities.

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The changing age profile of COVID-19 mortality in Brazil: A new global trend?

29 APRIL 2021

By Luis Eugenio de Souza, Karla Giacomin and Peter Lloyd-Sherlock.

https://corona-older.com/2021/04/29/the-changing-age-profile-of-covid-19-mortality-in-brazil-a-new-global-trend/

Younger adults are now accounting for a higher share of reported COVID-19 mortality in Brazil [1]. Between November 2020 and March 2021, the proportion of reported COVID-19 deaths among people aged between 30 and 59 rose from 20.3 to 26.9 per cent. This occurred at the same time as a sharp rise in overall reported COVID-19 mortality, from around 500 to around 2,500 deaths a day [1].

Does Brazil's changing COVID-19 mortality age profile prefigure a more global trend? The Brazilian experience partly reflects the impact of vaccination programmes focussing on people at older ages [2]. Additionally, large numbers of deaths among older Brazilians over the past year may mean those who survive are relatively healthy and therefore more resilient; an effect also seen in other countries [3]. Behavioural factors may have also contributed to Brazil's surge in deaths at younger ages. As in other countries, there are reports of reduced social distancing by younger adults due to economic necessity and "isolation fatigue" [4]. This was highlighted by the death of a high-profile social media influencer, aged 22, after posting a film celebrating her crowded parties [5]. Concerns have also been raised that older Brazilians are prematurely abandoning social distancing after just one dose of the vaccine [6].

All these effects are not unique to Brazil. More specifically, there is preliminary evidence that case fatality among younger adults for the new Manaus variant is higher than for earlier variants [7]. The rapid spread of the Manaus variant beyond Brazil's borders is cause for global concern [8].

Though significant, the shifting age profile of COVID-19 mortality in Brazil should not obscure the fact that nearly three-quarters of these deaths still occur among people aged 60 or more. Despite their reduced share of reported COVID-19 mortality, the absolute number of daily COVID-19 deaths for people aged 60 or more has risen from around 400 to over 2,000 over the past four months. The media's focus on younger people is

understandable, but can contribute to an ageist bias in perceptions of the pandemic. This has included some unhelpfully ageist commentaries:

There are fewer wrinkles and less gray hair among patients in Brazil's intensive care units as the country reels from a surge in Covid-19 that is increasingly hitting people under 60 **[9]**.

Moreover, there is emerging evidence that the risk of COVID-19 mortality for people of all ages, old and young, is significantly higher for disadvantaged groups **[10]**. COVID-19 is a disease of socio-economic disadvantage, just as much as it is one of later life.

One key lesson emerges from Brazil for the rest of the world. Though important, mass COVID-19 vaccination cannot turn the tide of the pandemic single-handedly, especially when dangerous new variants become prevalent. When this happens, there is no alternative to strict, coordinated measures including lockdowns. Tragically, President Bolsonaro continues to place politics over the lives of his citizens.

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COVID-19 and older people in Mexico: The perils of premature data analysis.

4 APRIL 2021

By Peter Lloyd-Sherlock, University of East Anglia.

https://corona-older.com/2021/04/04/covid-19-and-older-people-in-mexico-the-perils-of-premature-data-analysis/

Several Global Platform blogs and related publications draw attention to the limited quality and availability of age-disaggregated data on COVID-19 mortality in low and middle-income countries (LMICs) **[link]**. Sometimes researchers have to do the best they can with questionable data, perhaps adding a caveat or two as an insurance policy. But sometimes the data are so flawed that researchers should disengage.

Mexico is a case in point. At the end of March the Ministry of Health "revised" its estimate of all-age COVID-19 mortality from 201,832 to 294,287 **[link]**. Yet, unlike most other LMICs, Mexico had appeared to be an exceptional example of good practice in publishing detailed data on COVID-19. For most the pandemic, an official government website **[link]** appeared to offer up-to-date information on many issues, including age–disaggregated data on mortality, cases and hospitalisation. Interesting, this user-friendly site does not appear to have caught up with the official revision, claiming all age mortality to be only 204,011 as of 3 April 2021.

The same official website shows that people aged 60 or more accounted for 63 per cent of reported COVID-19 deaths. This is a lower share than reported for other Latin American countries, such as Brazil (77 per cent) or Argentina (84 per cent). The apparently lower concentration of deaths at older ages has promoted some analysis and discussion **[link]**. One of the more plausible explanations is that very high rates of diabetes and obesity among people at younger ages increased their case fatality rates **[link]**. There may be some validity in this explanation and it may indeed be the case that older people really do account for a lower share of COVID-19 deaths in Mexico than in other countries. But, given the lack of reliable data, we really can't say: the revised estimates do not include an age-breakdown.

My guess is that older people have accounted for much more than 63 per cent of Mexico's COVID-19 deaths to date. This is based on two things: (i) comparisons with similar

countries and (ii) separate studies that reveal COVID-19 deaths among older people are less likely to be correctly diagnosed than they are for people at younger ages, and therefore go uncounted **[1]**.

The consequences of this policy failure are serious for Mexicans of all ages. Older people, in particular, have been misled into under-estimating the risk of the pandemic. There is also a lesson for researchers. For months, Mexican health workers have been questioning the accuracy of official statistics **[link]**, but their concerns were largely ignored. Mexico's COVID-19 data website may looks professional and is easy to use, but the data it presents are highly misleading. Best left alone.

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Older people in South Africa and excess mortality during the COVID-19 pandemic.

1 MARCH 2021

By Peter Lloyd-Sherlock, Leon Geffen, Gabrielle Kelly and Lucas Sempe.

https://corona-older.com/2021/03/01/older-people-in-south-africa-and-excess-mortality-during-the-covid-19-pandemic/

Estimates of excess all-cause mortality are the most effective way to assess the impact of COVID-19 mortality on people of all ages, including older adults. Robust estimates can take into account that not all deaths caused by COVID-19 will be registered or attributed to that cause. They also include indirect mortality effects of the pandemic, such as deaths caused by reduced treatment for other health conditions. All of this is especially important for low and middle-income countries (LMICs) where death registration tends to be less complete and cause of death data less reliable than in high-income countries.

Other Global Platform blogs and papers refer to the poor coverage and quality of COVID-19 mortality data for older people in many LMICs [1, 2]. In some cases, depending on data availability, there is potential to generate robust estimates of excess deaths caused by the pandemic. To date, few countries have done this on a regular or systematic basis and few have included specific analysis of people at older ages.

South Africa has not published age-breakdowns for reported COVID-19 deaths since 13 June 2020, perhaps due to concerns about the reliability of cause of death data. Instead, the South African Medical Research Council in partnership with the University of Cape Town Centre for Actuarial Research has been providing weekly updates on excess mortality. These include comparisons between people aged under 60 and those aged 60 and over [3]. Their analysis is based on a robust methodology and takes incomplete death registration into account (which not all excess mortality estimates do).

The main purpose of this blog is to draw attention to these weekly reports. Here are some highlights from the report that covers the period from 3 May 2020 to 6 February 2021, along with some additional comments. Over this period, the total number of excess deaths from natural causes totalled 137,731. This compares to a total of 45,902 reported COVID-19 deaths over the same period. In

simple terms, the number of all-age excess deaths was three times the number of reported COVID-19 deaths. This is a much larger difference than those reported for high-income countries. For example, separate studies of the USA show differentials of between 28 and 33%. **[4, 5]**. The most likely explanation for the large differential in South Africa is that many COVID-19 deaths are either unregistered or are wrongly attributed to other causes.

Of these excess deaths in South Africa, 103,748 (75.3%) occurred among people aged 60 or more. For the reasons given above, these are likely to be mainly caused by COVID-19 (either single-handedly or in combination with other risk factors, such as diabetes, HIV or TB) **[6, 7]**.

Like many countries, South African is currently experiencing a second wave of COVID-19 mortality, with rates that are higher than during the earlier one. During the first five weeks of 2021, excess natural cause deaths of all ages totalled 54,774, 40% of the cumulative death total since 3 May 2020.

Some more general points can be taken from these data.

First, more caution should be exercised when trumpeting the apparent successes of some sub-Saharan African countries in keeping COVID-19 deaths at low levels **[8]**. There may be some truth in this, but the South African experience suggests that the majority of COVID-19 deaths have gone undetected and unreported. Sadly, health and population registration systems in most of the region are much less developed than South Africa and this also prevents robust estimates of excess mortality. Relatedly, even LMICs with high numbers of reported COVID-19 deaths, such as Brazil, India or Mexico, may be capturing a much smaller share of the true death toll than high-income countries are able to.

Second, the South African data indicate the degree to which the risk of excess mortality is linked to older age. People aged 60 or over make up 8.4% of the national population, but account for 75% of excess deaths. Other studies have noted that people at younger ages account for up a larger share of reported COVID-19 deaths in LMICs than in high-income countries **[9]**. This is a dangerous and potentially misleading conclusion to draw for countries where most COVID-19 deaths appear to go unreported. Diagnosing cause of death is especially challenging for older people with multiple health conditions, so under-reporting is likely to more frequent at older ages **[10]**.

In sum, the two main take-home messages from these South Africa data are (i) under-reporting of COVID-19 deaths is much more common than in high-income countries and (ii) older people account for the great majority of these unreported deaths.

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COVID deaths among older persons in South Africa have been significantly underestimated.

28 JANUARY 2021

By Gabrielle Kelly, The Samson Institute for Ageing Research, South Africa.

https://corona-older.com/2021/01/28/covid-deaths-among-older-persons-in-south-africa-have-been-significantly-underestimated/

South Africa has experienced the highest burden of COVID-19 mortality in Africa, with 41 797 deaths officially reported as of 27 January 2021. However, the 112,280 excess deaths reported since May 2020 in the South African Medical Research Council (SA MRC) Report on Weekly Deaths demonstrate that the impact of the pandemic has been far greater than official COVID-19 statistics indicate.

National COVID-19 mortality data disaggregated by age is not publicly available past June 2020. However, the SA MRC report indicates that between 2 May 2020 and 16 January 2021, there were almost 84,906 excess natural deaths among persons older than 60. A significant proportion of these deaths are likely to be directly attributable to COVID-19 or the combined effects of decreased access to health care and decline in physical function, cognitive decline and mental health due to social isolation and inactivity brought about by lockdown and social distancing requirements.

Infection and mortality rates are likely to be highest among persons residing in long-term care facilities and, according to Cowper et al (2020), NICD sentinel surveillance and long-term care facilities showed infection rates of around 10% among residents and 12% among staff in the first wave of the pandemic (rates which are likely higher in the more aggressive second wave).

Given these devastating direct and indirect impacts of COVID on older persons, there is an urgent need to pay attention to policies and practices for managing COVID-19 among this population group, and in LTC facilities in particular.

Postscript: The United Nations World Data Forum recognises the deplorable state of data on older people and COVID-19.

2 DECEMBER 2020

By Peter Lloyd-Sherlock,
University of East Anglia.

https://corona-older.com/2020/12/02/the-united-nations-world-data-forum-recognises-the-deplorable-state-of-data-on-older-people-and-covid-19/

The Global Platform has been one of very few voices of protest against the failure of many countries to provide age-disaggregated data on COVID-19 an older people, as well as the very poor quality of the limited data that are published (**https://corona-older.com/data-and-tools/**).

As part of this campaign, in October we posted a blog about the lack of reference to this issue by the United Nations World Data Forum, "Left even further behind": The United Nations World Data Forum and COVID-19 data ageism (**https://corona-older.com/2020/10/18/left-even-further-behind-the-united-nations-world-data-forum-and-covid-19-data-ageism/**). We shared the blog with UNWDF and, to their great credit, they responded by inviting us to contribute to their own series. You can now access this new paper here: **https://unstats.un.org/unsd/undataforum/blog/Older-people-and-age-disaggregated-COVID-19-mortality/**

Reliable, public age-disaggregated COVID-19 data are essential both for our general understanding of the pandemic, and for monitoring its direct and indirect impacts on people of different ages. They remain woefully inadequate, especially in low and middle-income countries. Kudos to UNWDF for supporting our campaign for urgent action.

"Left even further behind": The United Nations World Data Forum and COVID-19 data ageism.

18 OCTOBER 2020

By Peter Lloyd-Sherlock, University of East Anglia.

https://corona-older.com/2020/10/18/left-even-further-behind-the-united-nations-world-data-forum-and-covid-19-data-ageism/

The United Nations World Data Forum has a great **blog series**, including 54 informative postings since the start of 2018. All of these blogs are excellent as far as they go, but none deals with older people. By contrast, five exclusively focus on gender and data issues. This is surprising when blog topics include how to "**Integrate intersecting inequalities to leave no one behind**".

On October 8, 2020, the Forum posted a blog on "**Who is being left behind in COVID-19 data?**" It is genuinely an excellent piece, in terms of what it does say. But once again, it demonstrates an utter neglect of the current crisis of COVID-19 data ageism. Zero reference is made to either age or older people, yet just about every other form of diversity imaginable gets at least a name-check. For example:

"..the lack of disaggregated data and diversity-sensitive analysis needed to measure COVID-19's impact on different gender, racial, and ethnic groups, as well as on people with disabilities makes it difficult to facilitate targeted policies".

My spirits were momentarily raised when I saw a reference to "the institutionalized groups". Were care homes for older people now on the UN World Data Forum's radar? This still excludes about 97% of older people who live elsewhere, but would at least be a start. My hopes were rapidly quashed as my eyes moved across the page and I read: "the institutionalized groups, for example, those living in places of detention". Although that may be an apt description of some care homes, I don't think it was intentional.

The blog quite rights discusses the plight of many groups left behind in COVID-19 data, but somehow neglects older adults who account for over 75% of global COVID-19 deaths. It would seem older people have been left even further behind those groups who are recognised as left behind.

By the way, none of the UN World Data Forum's 13 excellent webinars held since April 2019

make specific reference to older people either.

The United Nations World Data Forum's 2020 **Virtual Conference** will take place between 19 and 21 October 2020. It aims to "satisfy demand for the latest data solutions and thinking to support the 2030 Agenda for Sustainable Development and now more urgently for the monitoring and recovery from COVID-19".

How this the Forum addressed the evident crisis of data on COVID-19 and older people? The Forum's six thematic foci are set out in detail, but none refers to older people. However (fanfare, please!), one of the many sessions listed in the programme is "Ageing 2.0: livehacks for better data and living". The Ageing 2.0 Network is an excellent initiative, with a focus on applying innovation, IT and enterprise to improve the lives of older people. It's great they are included in the 2020 Virtual Conference and I hope their session goes well. But Ageing 2.0 does not have a remit to address the current scandal of COVID-19 data ageism.

Here's hoping that the United Nations World Data Forum quickly shifts from being an unwitting facilitator of COVID-19 data ageism to challenging it.

In the meantime, please check out the online data resources provided by the Global Platform for the Rapid Generation and Transfer of Knowledge on COVID-19 and older adults in low and middle-income countries: **https://corona-older.com/**

Garbage in, garbage out: An update on problems of data availability and quality for COVID-19 and older people in low and middle-income countries.

5 OCTOBER 2020

By Peter Lloyd-Sherlock, Barbara Corso, Shah Ebrahim, Ramon Martinez, Nadia Minicuci, Ilaria Rocco, Lucas Sempe, Patricia Solis.

https://corona-older.com/2020/10/05/garbage-in-garbage-out-an-update-on-problems-of-data-availability-and-quality-for-covid-19-and-older-people-in-low-and-middle-income-countries/

Back on 25 June, the Global Platform posted its first **paper** about the availability and quality of data on Covid-19 and older people in low and middle-income countries (LMICs). We also ran a webinar on the same theme We plan to make age-disaggregated data on COVID-19 and excess mortality in LMIC one of our main focuses of activity over the next few months, and our new site now has a particular section relating to this issue. As far as we know, nobody else seems to be presenting or engaging critically with this sort of data: neither of the major global COVID-19 databases (**WHO's COVID-19 dashboard** and **Johns Hopkins Coronavirus Resource Centre**) currently provide age-specific data. Over the next few months, we will provide updated lists of data sources, along with guidance about how to interpret, as well as many, many warnings about drawing easy and fast conclusions.

We need good data about how COVID-19 is affecting older adults in LMICs. Although the pattern of the pandemic has not always followed experts' predictions, one early prediction still holds firm: the majority of deaths resulting from the pandemic are occurring among older adults in LMICs. It would be useful to be more precise about how large a majority this is, but (as we show in this paper), current data do not allow for that. Since older people are the main at-risk group, any general response to the pandemic has to pay special attention to people in this age group, even if only to manage overall pressure on health services. Beyond that, without data on older people, we cannot assess whether they are being fairly treated and whether preventive actions are reducing or even increasing their risk of dying. Amidst widespread concerns about explicit and implicit ageism in COVID-19 policy, there is a need to keep a close eye on what is really going on.

Our previous paper on this issue looked at data on reported cases and deaths of older people attributed to COVID-19. It also touched on the need to develop more comprehensive

TABLE 1 – Age disaggregated data for reported cases and mortality due to Covid-19, selected countries (data available as of 12 August 2020).

1	2		3		4				5	
	COVID-19 experience				Incidence/ 100,000		Death rates per 100,000		Current case fatality %	
	Total cases	Total deaths	Cases 60+	Deaths 60+	Total	60+	Total	60+	Total	60+
Mexico, 9 August	518,231	54,266	94,577	26,699	406.22	661.91	42.54	186.86	10.47	28.23
Algeria, 22 June	11,332	852	3484	637	26.32	81.74	1.98	14.95	7.52	18.28
Argentina, 11 July	95,607	1807	12403	1467	212.75	178.06	4.02	21.06	1.89	11.83
Costa Rica, 27 July	15,605	112	888	79	309.16	117.28	2.22	10.43	0.72	8.90
India, 15 July	79,519	1,842	8510	942	5.82	6.17	0.13	0.68	2.32	11.07
Pakistan, 31 May*	72,460				33.46					
Philippines, 15 July	58,152	1,733	8215	1076	53.79	88.35	1.60	11.57	2.98	13.10
South Africa, 27 June	137,387	2,398	15431	1329	234.62	310.02	4.10	26.70	1.75	8.61
Turkey, 19 July	220,657	5,491	24275	3870	264.48	222.11	6.58	35.41	2.49	15.94

Source: https://databank.worldbank.org/reports.aspx?source=2&series=SP.POP.TOTL&country= (Year: 2019*)

* Website not fully functional since that date.

and reliable indicators, such as excess overall mortality. Lucas Sempe has since published a **paper** setting out a method for making this calculation and applying it to the case of Peru. Among other things, it shows that official figures up to 12 July captured only around a fifth of total excess mortality and registered deaths, and that under-reporting was higher for people at older ages.

Rates of COVID-19 infection and mortality are key indicators, but do not cover many other important issues about how the pandemic is affecting older people in LMICs. This requires many other forms of data. Liat Ayalon's webinar talk set out this wider agenda, including a need for robust evidence about social isolation, subjective wellbeing and experiences of discrimination. At the same time, she calls for data that permit analysis of patterns within older populations and asks which national and global bodies should be responsible for marshalling and monitoring these data. Given the many issues of importance and the limited capacity to gather and process data in LMICs, a starting point may be to identify the most urgent priorities, critically evaluate the data coverage of these issues and then advocate for improvement.

That will be an issue for a future paper we hope to write. This one takes the same narrow focus on cases and deaths as the previous paper on data. In large part, this is because these are the data that are most widely reported at this point in time. Two months after our previous paper, we ask what can be safely deduced from the available data, drawing attention to pitfalls in analyses that take the numbers at face value. And we show that with the current data, we can deduce very little.

Table 1 provides data for a limited set of LMICs. We have **a more comprehensive excel table for all countries on our site** and hope to update it every few weeks. You can find a list of websites where we source these data **here**. Table 1, compiled in early August 2020, includes countries which provide at least some age-specific data and where there have been at least 100 reported COVID-19 deaths. There are some prominent examples missing from the list: most notably Brazil, whose data reporting on the pandemic has been particularly problematic.

What can we conclude from these data?

Let's go column by column…

Column 1 shows that few countries are providing recent updates, and some data are weeks or even months old (31 May for Pakistan). This is a concern, given the fast-developing nature of the pandemic in these countries. It also makes it harder to compare between countries which may be at different points in the pandemic curve.

Columns 2 shows the total numbers of reported cases and deaths where age data are included. **[1]** Column 3 shows the number of reported cases and deaths that occurred among older people. Column 4 presents these data (and those for the total population) in terms of cases per 100,000 ("incidence") and death rates per 100,000 people (both cases and people who are not). Column 5 then shows case fatality rates: the percentage of people who were reported to have tested positive and who had died at the time of reporting.

This is an impressive and complex set of data (even if many countries are not included and much was out of date). But what can we take from it? A useful way to make sense of the data is to compare countries. We will do this with Mexico and Argentina.

By 9 August 2020, 26,699 people aged 60+ in Mexico were reported to have died as a result of COVID-19. In Argentina, by 11 July the equivalent number was 1,467. It is striking that older people accounted for 81.2% of all deaths in Argentina, but only 49.2% in Mexico. This is even more surprising since the current case fatality rate for older people in Mexico (28.23%) was much higher than in Argentina

(11.83%). Put simply, older people in Mexico who were tested positive for COVID-19 were more than twice as likely to have succumbed from this condition (at the time of reporting), than those in Argentina. For the total populations of these countries, current case fatality varied by more than five times (10.47 in Mexico versus 1.89 for Argentina).

These strange patterns can be explained in two different ways.

First, is Argentina under-counting COVID-19 deaths to a much greater degree than Mexico? There have been newspaper reports drawing attention to COVID-19 mortality data in both countries. It would not appear likely that the situation in Argentina is substantially worse than for Mexico, where, back in July, the Financial Times reported that: **"tens of thousands of deaths may have been missed in the official statistics"**. A **study of Mexico** found 122,765 more people had died than expected between mid-March and 1 August. Of these only around half (67,326) had been attributed to COVID-19. No similar research has been done for Argentina yet, but it is unlikely to have performed even worse than Mexico.

Second, is Mexico's testing system identifying a substantially lower share of people with the virus than in Argentina? There is much more to support this explanation. **Official data** show that by September 2020, Mexico was providing 9 tests per 100,000 people each day, compared to 56 in Argentina. In the UK, where the limited availability of testing in relation to need is widely acknowledged, daily testing was 345 per 100,000. In other words, data on cases in both countries say more about the availability of tests than of the real incidence of COVID-19.

Putting all of this together, can we draw any conclusions from the data in Table 1?

The short answer is "precious few". We can get a general sense of the scale of the pandemic in different countries. We can see which countries are publishing data and when they are updated –which is an interesting piece of data in itself. But if I were asked to referee a paper submitted to an academic journal that sought to draw any further conclusions from this sort of data, I would feel compelled to reject it. The Mexican government has what seems to be a state-of-art data portal on the pandemic, with large amounts of apparently important information neatly presented in charts and graphics. But if the quality of these data is as poor as claimed by the Financial Times, then they may do more to obscure than clarify the reality of the pandemic.

It is easy to criticise the governments of countries like Mexico about the woeful state of these data. At the same time, we must not ignore how challenging the collection and compilation of good data must be. Diagnosing cause of death is not easy at the best of times and, as Aravinda Guntupali mentioned in her webinar presentation that in countries like India cause of death data were extremely incomplete even before the pandemic hit, and **concerns of missing COVID-19 deaths persist**. Inevitably, these problems are especially pronounced for people at very old ages, both due to higher frequency of multiple health conditions and a tendency to view these events as simply dying of old age. The picture is further complicated by changes in definition of a COVID-19 death. In the UK this definition was restricted to deaths within 28 days of a positive test on 12 August 2020 which **reduced the death count by 5,300**. Definitions applied in LMICs are not easily found and may not be comparable. And anyway, shouldn't we be taking a wider approach than just counting deaths directly attributed to COVID-19, and consider fatalities caused by other conditions which would not have occurred in non-pandemic circumstances?

In the face of these many problems, what hope is there that we can eventually get

a clearer view of the pandemic? This will require new methods of data collection and analysis. They are likely to be more labour-intensive and challenging than simply clicking on a government portal. Poring over hospital and health district records, as well as other "downstream" sources may provide a clearer albeit imperfect picture. As **Sempe's paper** shows, constructing robust estimates of excess mortality is not for the statistically faint-hearted. The Global Platform will keep a particular eye out for similar studies.

In the meantime, we feel that our simple **calculator** that estimates potential COVID-19 deaths by age group (the PICHM) offers the best approach for most LMICs until things improve.

Please do share with us any new data sources we haven't already listed on our site. And please, please bear in mind the many dangers of trying to make any sense of the numbers. Here's hoping that we will be able to publish future papers that focus more on what the data really do say and less on what they don't.

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[1] Not all reported cases include age data. For example, in Algeria a further 1,973 COVID-19 deaths had been recorded without an age.

Problems of data availability and quality for COVID-19 and older people in LMICs.

25 JUNE 2020

By Peter Lloyd-Sherlock and Aravinda Guntupali, with contributions from Liat Ayalon, Joseph Batac, Leon Geffen, Syed Moeez, Lucas Sempe, Martin McKee, Susan Nungo, Yelda Özen, Walaa Talaat.

https://corona-older.com/2020/06/25/problems-of-data-availability-and-quality-for-covid-19-and-older-people-in-lmics/

In all countries, the risk of dying from a COVID-19 infection increases markedly with advancing age. As a result, people at older ages make up the majority of reported COVID-19 deaths, even in countries where population ageing is still at a relatively early stage. It might be expected, then, that policymakers and researchers would pay particular attention to the effects of the pandemic on this age group. Yet this is clearly not the case. Global public health responses have done little to move beyond the existing situation, characterised by the exclusion of and discrimination against older people. This can be seen in many areas of policy and debate, some of which are discussed in other **contributions to the Global Platform**. This blog focusses specifically on data issues.

Excluding older people from routine data reporting and indicators is a time-honoured (or arguably "dishonoured") tradition, reflecting normalised ageism. For much of the HIV pandemic, data on infections were not collected for people aged 50 or more, based on the misguided view that older people were not at risk of infection (Albone, 2011). More recently, older people have been excluded from mortality reporting and targets for non-communicable diseases (NCDs), such as heart disease and diabetes, even though they are disproportionately at risk of dying from these conditions. The main justification put forward for this was an ageist argument that policy-makers should focus on so-called "premature" deaths among younger adults (Lloyd-Sherlock et al, 2016). More generally, most surveys of health and population, even in high-income countries, exclude older people in residential care facilities, but still claim that they are nationally representative.

Tragically, numbers of COVID-19 cases and deaths are increasing rapidly in many low and middle-income countries (LMICs). To what extent are the data that are reported capturing the experiences of people at older ages? The short answer is that the provision

of specific data about people at older ages has been very limited, and much of what has been published is of questionable quality.

Several LMICs provide no age-disaggregated data at all either for reported cases or for deaths from Covid-19. Examples at the time of writing this blog include Indonesia, Turkey, Egypt and Kenya. A number of other countries, including Peru and Brazil, only provide age-breakdowns for deaths, but not for cases.

Table 1 summarises data for LMICs for which we have been able to obtain data. Not all of these data are derived from official sources. In India, for example, where the National Ministry of Health does not provide age breakdowns, a **crowdsourced project** has compiled these data from local government bulletins and other official sources.

Table 1 shows that older people made up more than half reported COVID-19 deaths in all these countries. Yet the range is quite wide: from 52% in Mexico to 62% in the Philippines. The final column in Table 1 provides a ratio of reported cases to reported deaths for people aged 60 and over. This indicates that in Mexico for each COVID-19 death there were 3.65 cases; whereas in Pakistan there were 10.36. Taken at face value, this suggests that older people in Mexico who become infected with COVID-19 are more than twice as likely to die than their counterparts in Pakistan. If this were really true, the potential implications for global health would be huge and we should be looking closely at the "Pakistan Miracle". It is, however, far more likely that these variations are mainly the result of problematic data reporting. Perhaps Mexico is under-counting cases among older people; perhaps Pakistan is under-counting deaths; perhaps both counties are under-counting everything. These data come with a very large health warning and do not provide a basis for meaningful analysis.

TABLE 1 – Age disaggregated data for reported cases and mortality attributed to Covid-19, selected countries.

Country	Date	Total reported cases	Total reported deaths	% of total pop aged 60+	% cases 60+	% deaths 60+	Ratio of cases to deaths for people 60+
Pakistan	31 May	72,460	8,565	6.7	11.82	53.61	10.36
Mexico	1 June	93,435	10,167	11.2	20.49	51.96	3.62
South Africa	22 June	101590	1991	8.5	10.70*	55.05	14.61#
Philippines	6 June	20,626	987	8.6	16.80	61.50	5.71
India	20 May	112,027	3,433	10.1	9.70	51.6	5.32

Source: Pakistan; Mexico; South Africa; Philippines; India: Joe et al (2020).

* as at 13 June 2020 # denominator of cases as at 13 June, the numerator of deaths as at 22 June.

The issue of data quality is relevant for people of all ages and is especially pertinent in LMICs where the vast majority of deaths occur outside of hospital settings and for whom the cause is rarely certified by a trained physician. And this issue of data quality is particularly important for older people, both because they are the group most affected by the pandemic and because the cause of death is more prone to misreporting for people at older ages. Older people are more likely to have other health conditions, such as heart disease, and, even

where COVID-19 symptoms are present, death may be attributed to other comorbid conditions. The experience of high-income countries shows that COVID-19 mortality has been widely under-reported in care home settings (Comas-Herrera et al, 2020). This is likely to occur in LMICs, which contain large numbers of such facilities, many of which are unregistered and not subject to oversight by public health agencies (Lloyd-Sherlock et al, 2020a).

Ultimately, the best way to measure the impact of the pandemic on older people, and people of all ages, will be through careful comparison of overall mortality rates during the pandemic and for corresponding months in preceding years. This will permit estimation of excess deaths which are potentially attributed to the pandemic: both directly as a result of COVID-19 or due to more indirect effects of the pandemic, such as reduced access to treatment for other health conditions. This will provide a more complete measure of the mortality effects of the pandemic. Another advantage of this approach is that it does not depend on accurate reporting of specific causes of death. In the UK between 7 March and 5 June, there were **51,804 recorded deaths** directly attributed to COVID-19, plus a further 12,729 excess deaths for other causes. For those LMICs where estimates of excess mortality are available, the proportion of excess deaths attributed to COVID-19 is much lower than in high-income countries. For example, in Ecuador, there were 3,358 reported Covid-19 deaths during March, April and May, but excess mortality is **estimated to have been 16,107**.

Excess mortality data disaggregated by age group are only publicly available for some high-income countries. Data for England and Wales show excess deaths for causes not attributed to COVID-19 occurred predominantly among people at older ages (Office for National Statistics, 2020). If this pattern were to be replicated across LMICs (and there is no reason to expect that it would not be), it would mean that, even in countries where age data of reported Covid-19 cases and deaths are available, the true impact of COVID-19 on older people is being vastly understated. Failing to provide such data masks the degree to which older people in all countries are "bearing the brunt" of this global pandemic (Lloyd-Sherlock et al, 2020).

Collation of high-quality mortality data will benefit both health care providers and policymakers. Hopefully, the availability and quality of age-disaggregated data on Covid-19 and excess deaths in LMICs will quickly improve. These data will be essential, both to help our general understanding of the pandemic and to ensure that older people are being fairly treated.

The Global Platform is looking to develop a number of new activities to support this process. First, we are setting up an open online resource to contain all known sources of age-disaggregated data on Covid-19 in LMICs.

Please send us information so we can extend and update our coverage of different countries.

Please use the site as a resource for your own analysis and advocacy (and please acknowledge us when you do).

In the near future, the Global Platform plans to produce a shared statement about these issues. Please let us know if you would like to be part of that.

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Part Three
Social Protection

No pensions for five months: How Jharkhand's poor were left poorer during the pandemic.

3 MARCH 2021

By Dr Walaa Talaat, Lecturer of Economics, Ain Shams University.

https://corona-older.com/2021/03/03/no-pensions-for-five-months-how-jharkhands-poor-were-left-poorer-during-the-pandemic/

In one district, pension funds were diverted to make payments under the Centre's Covid-19 relief package.

In 2020, the state government of Jharkhand, India stopped distributing pensions to nearly a million older and disabled people.

According to Florian Juergens, Global Social Protection Advisor, HelpAge International:

> *For any government to suspend the payment of pensions during COVID-19 would be heart-breaking and outrageous. Evidence from India and elsewhere clearly shows that older people are not only the hardest hit by the virus itself, but also suffer from devastating blows to their livelihoods, resulting in widespread poverty and hardship.*
>
> *Social protection systems – and especially pensions – should be there for people in such times of need. To cut the lifelines of poor older people at the moment they need it the most is to disregard their human right to social security. It will greatly contribute to increased misery amongst affected older people and their families.*
>
> *That a government could simply stop the payment of pensions in the middle of a crisis like COVID-19 reinforces the importance of enshrining social protection as a legal right that cannot be take away at will. States should take the pandemic as an opportunity and reminder to finally realize older people's human right to social security.*

florian.juergens@helpage.org

Social protection and older people in Egypt during the COVID-19 pandemic.

2 JUNE 2020

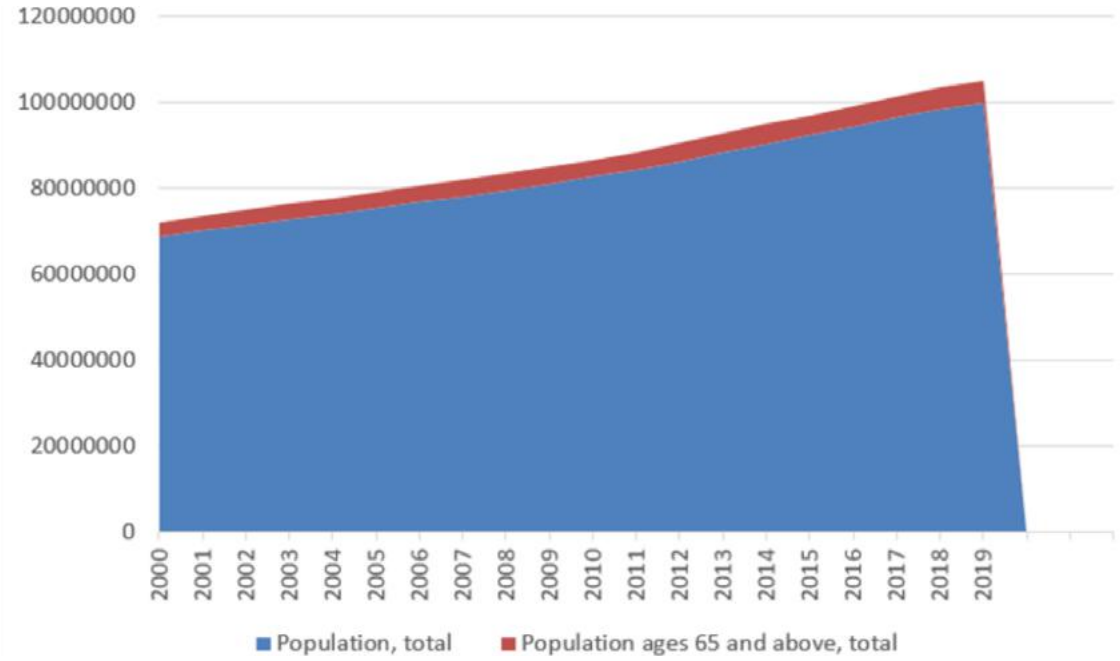
By Dr Walaa Talaat, Lecturer of Economics, Ain Shams University.

https://corona-older.com/2020/06/02/social-protection-and-older-people-in-egypt-during-the-covid-19-pandemic/

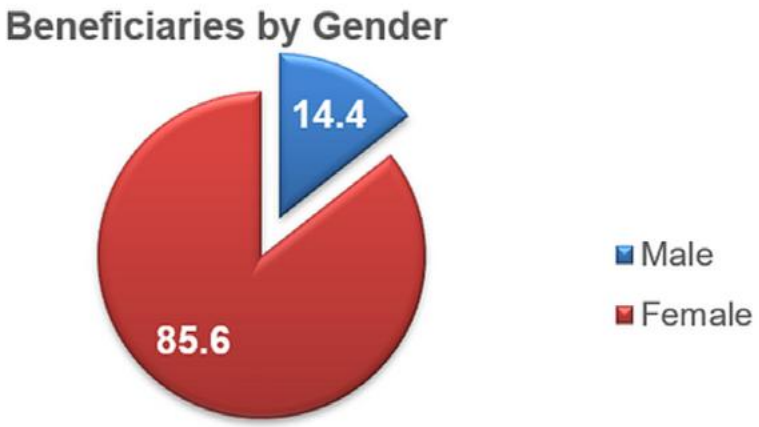
In Egypt, as elsewhere, it is to be expected that the main burden of Covid-19 mortality will fall on older people. The number of the population aged above 65 in Egypt is 5,297,000, which accounts for 4.6 per cent of the total population in 2019. CAPMAS 2019 reports that life expectancy in Egypt is around 73.9 years (72.7 years for males, and 75.1 years for females). As of May 31, there were 24,985 confirmed cases of Covid-19 and 959 deaths in Egypt.

Data about the number of cases and deaths among older people are not available on the Ministry of Health and Population's website. Cairo governorate occupies the first rank in the rates of confirmed cases in Egypt with about 7,000 cases, followed by Giza governorates with nearly 3000 recorded cases. Egypt is implementing 14-day quarantine periods and other preventative measures. There were claims that when patients called the emergency services number there is either a delay or no response. A new mobile application Sehet Misr (Egypt's health) was launched in April to advise whether cases require hospital care or self-isolated at home depending on symptoms, to offer medical advice to raise people's awareness to prevent infection.

To what extent may social safety nets mitigate the potential effects of Covid-19? Egypt has been providing two separate schemes called "Takaful" and "Karama" (solidarity and dignity) since 2015 through the Ministry of Social Solidarity (MOSS) with the support of LE 6.32 billion (US$ 400 million) from the World Bank. Eligibility for Takaful is targeted on poor households with children under 18, while Karama targets poor older people, orphans and households living with disabilities. These schemes operate in 345 districts that contain 5630 villages in the 27 governorates. 85.6 per cent of the beneficiaries are women as shown in the pie chart, out of which 13.6 per cent are divorcees and widows, 6.7 per cent are people with disabilities, and 2.1 per cent are older people. This program serves 2.5 million household families in 2019 of a total of around 9 million individual households; men, women and children.



Source: Author's calculations based on World Bank Indicators



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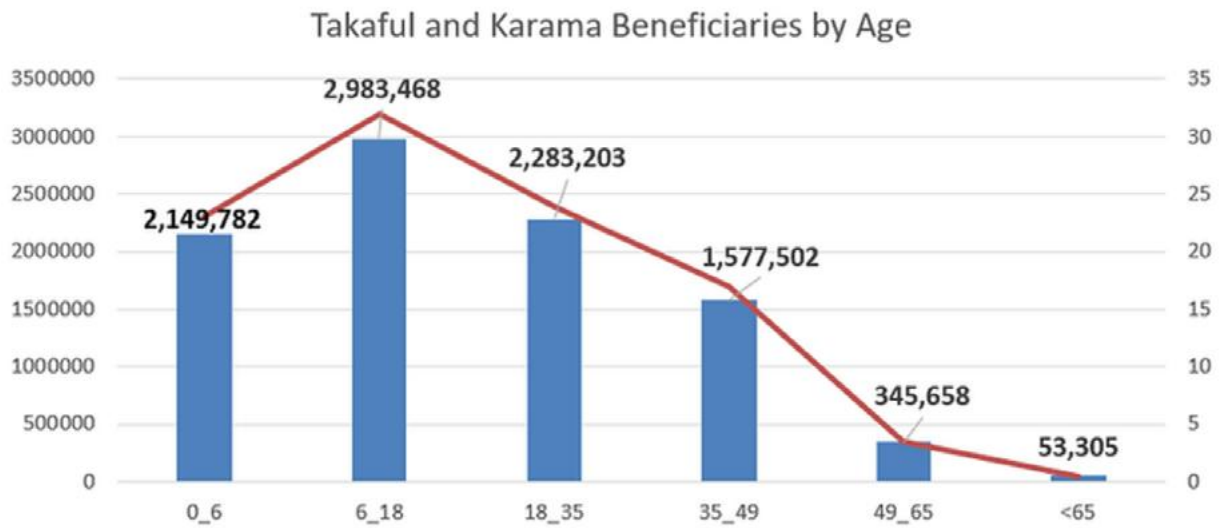
The desegregation of Takful and Karama beneficiaries by age in 2019 is shown in the figure below. This shows that only 0.5 per cent of the beneficiaries of this program are aged 65 or over. The low numbers of older people are covered by these schemes is mainly because the large majority of this age group already receive pensions from the MOSS. The 53,305 older people receiving benefits from these safety net programmes are likely to be the poorest of the poor, either lacking pensions or living in large households where their pension income is shared across large numbers of people.



Source: Author's calculations based on Data from MOSS (2019)

To offset the repercussions of Covid-19 on poor, older and working classes households, the Minister of MOSS, announced in March that 100,000 new households would be added to Takaful and Karam, and that the value of benefits would be raised 3 times from EGP 350 (US$ 22) a month to EGP 950 (US$ 66). However, the MOSS did not specify the number of the newly enrolled for Karama households that contain older people. A needs assessment should be rolled out during the pandemic for older people, especially the poor ones.

Additionally, in April 2020, the MOSS announced several proposals and scenarios for pensioners in order to reduce crowding in national social insurance offices, as well as 4,350 outlets, post offices and 10,000 automated teller machines. One category (pensioners who earn LE 1000 or less) were paid on specific days of the month (Wednesday, 1st; Thursday, 2nd; and Saturday, 4th of April). This category accounts for 2.4 million pensioners. A second category, those with monthly pensions worth between LE 1000 and LE 2000, were be paid on Sunday, 5th; Monday, 6th; and Tuesday, 7th of April. They are accounted for 2.5 million pensioners. And a third category, with pensions worth more than LE 2000 were paid days Wednesday, 8th; and Thursday, 9th of April. This group accounts for 1.8 million people.

As of Sunday, 12th of April, pensioners of any category who had not been able to collect pensions until that date could collect them whenever they wished from the designated outlets.

The Ministry decided, exceptionally, to allow the use of all pension cards that had previously been suspended due to not following a required update and reactivation carried out every 6 months. The Central Bank of Egypt agreed to cancel all the fees and commissions applied to pension withdrawal

from ATMs for a period of 6 months in order to reduce overcrowding in designated pension offices. The Ministry has provided chairs and benches in front of designated offices for pensioners to wait their turn in shaded areas. In some pension collection offices, young adults have volunteered to provide preventive measures such as hand sterilization for pensioners.

Civil society has joined government efforts to fight the pandemic by distributing face masks, sterile materials, and sterilising streets. Also, one of biggest charities in Egypt, the Resala Charity Organization, has supported the government's efforts by launching a charity challenge, which raised more than LE 3 million (US$ 189, 873) to assist households impacted during the pandemic, including the poor older people. Several Egyptian celebrities have participated in this challenge and contributed by around LE 1 million (US$ 63,291). Moreover, religious institutions have also joined the government's effort to confront this outbreak. Ahmad Al-Tayyeb, Grand Imam of Al-Azhar El-Sharief, has donated LE 5 million (US$ 316,455), in support of Egypt's Covid-19 efforts. In Alexandria, the Coptic Orthodox Church has also donated LE 3 million (US$ 189,873), as a contribution for the purchase of ventilators.

The same ministry is responsible for regulating residential care facilities for older people in Egypt. Available data about these facilities are very limited. In 2016 a national newspaper reported that there were at least 174 such facilities in Egypt, containing around 3,500 older people. It will be important to monitor the situation in these facilities as the pandemic progresses.

Unintended consequences of changes to pension delivery amidst COVID19: The case of South Africa.

19 MAY 2021

By Gabrielle Kelly, Samson Institute for Ageing Research, South Africa.

https://corona-older.com/2020/05/19/unintended-consequences-of-changes-to-pension-delivery-amidst-covid19-the-case-of-south-africa/

In the context of the COVID-19 pandemic, it is critical that social assistance reaches older persons in need of financial support to address their particular risks and vulnerabilities. Given the high risk older persons face in terms of COVID-19 morbidity and mortality, governments in low and middle-income countries that provide cash transfers to older persons as part of their social protection strategies have had to rapidly implement measures to mitigate infection risk at pay points. With colleagues, I helped to develop guidance for safe pension delivery and collection which was published by HelpAge International here.

These measures have ranged from home delivery of pensions to the appointment of proxies and the implementation of hygiene protocols. Implementing rapid and widescale changes such as these in a context of such uncertainty is challenging and, as with other aspects of the pandemic, learning from the experiences of other countries is vital.

South Africa provides a good example of the importance of considering the unintended consequences of new policies when developing strategies to protect vulnerable populations such as older persons. While good in theory, efforts to stagger pension payments may, in fact, have increased risk of infection in some areas.

South Africa has one of the largest and most generous social pension systems among low and middle-income countries. The South African Social Assistance Agency (SASSA) pays non-contributory, means-tested Old Age Grants to around 3.6 million people monthly – approximately 70% of the population of older persons. These are valued at R1860 (US$100) per month (R1880 if over 80) and have been increased by R250 (US$14) from May to October as part of the government's response to the devastating economic effects of a very strict COVID-19 social and economic lockdown.

Every month over 18.6 million grants are collected by 11.3 million people from heavily congested pay points, putting older persons collecting their pensions at risk of COVID-19 exposure. The government has put hygiene and social distancing measures in place at South African Post Office and the SASSA mobile cash points that still operate in rural areas, but 95% of payments are typically collected either at ATMs or merchant retailers where the government has to rely on third-parties to implement appropriate measures.

To protect vulnerable groups, a decision was made to allow older persons and people with disabilities (PWDs) to collect their social grants earlier than other categories of social grant recipients. However, this has failed for the past two payment cycles for the following reasons:

- For April payments, payments to older people and people with disabilities were made a day earlier (30 March). However, money was still transferred into the accounts of Child Support Grant beneficiaries on the same day, making it very difficult to keep these beneficiaries away from collection points. This resulted in older persons being pushed and shoved out of the way by younger people desperate to receive their grants in a context where many households were starting to feel the effects of the lockdown.

- In May, SASSA attempted to solve the problems experienced the previous month by separating out the payment files so that older persons and PWDs could be paid on separate days. A decision was also made to delay payments to the 3rd and 4thday of each month or the first working day after this date, presumably to keep grant beneficiaries away from the other end of month shoppers. Payments to Child Support Grant beneficiaries started two days later and payments at SASSA cash pay points started two days after that (including to older persons). The delayed payment dates meant that between April and May older persons were forced to wait five days longer than usual to receive desperately needed income that is generally spent within the first few days of the month. Tight deadlines and a shortage of SASSA administrative staff to separate out the payment files also resulted in errors in some provinces, with some people receiving their grants twice while others received nothing. This resulted in mass confusion and long queues.

Another challenge was the delay of payments at SASSA pay points which operate exclusively in rural areas where the South Africa Post Office, retail merchants and ATM services are not available. In April and May payments at these sites only began on the 3rd and the 7th days of those respective months. Unwilling to wait to receive their cash, older people from rural areas flooded into towns and cities, forcing them to spend their scarce resources on transport into areas where rates of transmission were likely higher and creating congestion at already busy payment locations. Compounded by payment glitches, this resulted in long snaking lines of several kilometres in many areas. Numerous media reports from across the country showed older people sleeping in lines overnight, with several deaths due to long waits without food or water also reported. Although efforts to ensure social distancing and hand sanitising were made at many sites, crowd control becomes increasingly difficult when people are congregating in very large numbers over long periods of time.

De-congesting pay points via electronic means provide the most promising solution

for containing the spread of the virus. For several years, SASSA has been encouraging people not to draw their money all at once and rather use their SASSA cards as a debit card throughout the month. Although heavily promoted over the past few months, take-up of this suggestion appears to have been low, possibly because of a lack of trust. Mobile money transfers present another possible option and are being used for paying the COVID-19 Social Relief of Distress Grant. However, mobile transfers may not be very accessible or easy to use for many older persons. Another new initiative that may help to de-congest payment points is the South African Post Office's recent roll-out of 10,000 cashless ATMs to serve as additional social grant pay points. To use these machines beneficiaries will select an amount to be debited from their SASSA card and the cashless ATM will print out two slips, one to hand over to the over a spaza shop (an informal convenience shop operated usually from a home), and in exchange, the merchant will give the customer cash or goods to the value of the withdrawal. Beneficiaries will also be able to use cashless ATMs to purchase pre-paid electricity and airtime, and pay bills.

COVID-19 in Mauritius: Pensions reaching older people's accounts with a flexible time to shop.

24 APRIL 2020

By Vijay Nairadoo.

https://corona-older.com/2020/04/24/covid-19-in-mauritius-pensions-reaching-older-peoples-accounts-with-a-flexible-time-to-shop/

A first-person account: We are under lockdown and curfew during the night, starting yesterday. Many people, a minority though, are unruly going to the beach, to the market in large numbers, or to buy beers.

The situation is critical. The government has instituted a special communication cell, holding a press conference every day. The Prime Minister is in the forefront, together with the Minister of Health. Apart from imported infected cases, two medical practitioners have been contaminated locally, a dentist and a Consultant doctor. Both have been placed in quarantine, like all other cases.

More hospitals will be requisitioned for quarantine purposes. There are 36 confirmed cases, but more are in quarantine. As of now, there have been two deaths; one a Mauritian who came from England after a visit to his relatives and one, a Mauritian who had travelled from Belgium.

The Government offered to organise the return of hundreds of Mauritian students and other citizens from Europe, India and Dubai. The Dubai students were desperate without resources and appealed to the state for help to be repatriated home. I have yet to confirm when they will be returning but the government has agreed to offer them support. Everybody returning is sent directly to quarantine, their parents are not allowed even to meet with them at the airport.

The Government has a blanket message for the population: they warn everybody to stay home. There is a specific time from 09.00 a.m to 10.00 a.m for older people and the disabled to go out for shopping or stretching.

The Government is the only one providing official messages via press conferences which are directly disseminated through all radios, on social media and shown on TV bulletins every day. Social distancing,

wearing masks and even gloves (though gloves much less) is in practice and this is what I do when I go to the shop or the bakery.

To minimise traffic, the public buses are only allowed to plough in one-hour intervals and there are very few passengers. There are police barricades to stop drivers and pedestrians. There is also an effective teaching programme, conducted by more than one doctor on TV and radio stations. Older people are receiving their pension as usual, directly to their bank accounts. Those who go to collect them at the local post office go on specific days.

The Government has voted a stimulus package of 2.5D billion rupees for Small and Medium Enterprises. Whatever loans and bills we have to settle during the lockdown, we can do so afterwards without having to pay fines. Housing loans will be exempt from accumulated interests during this period. Schools are closed and students are following on-line courses.

As a network member, I have dedicated my Monday press article to older persons on the challenges posed by the COVID19. I have also posted a video on the same subject appealing to civil society, the local Red Cross and the Blue Crescent to develop with the village, district and municipal councils a strategy to pay daily visits to older people living alone and those who can't go out easily because of health problems.

This blog was originally published on HelpAge International and can be found here.

Vijay Nairadoo is the President of the Commission for the Rights of Older People of DIS-MOI, (DROITS HUMAINS OCEAN INDIEN), an association set up to help to promote a strong human rights culture amongst the populations of the South-West Indian Ocean region. They are mainly focused on Mauritius but are also expanding into the other small island nations of Comoros, Madagascar, Reunion and Seychelles.

Letter from Argentina: Older people, pensioners, and care homes on the frontlines against COVID-19.

14 APRIL 2020
UPDATED 15 APRIL 2020

By Nelida Redondo, Fundacion SIDOM, Buenos. Aires, Argentina [redondo.nelida@gmail.com].

https://corona-older.com/2020/04/14/letter-from-argentina-older-people-pensioners-and-care-home-on-the-frontlines-against-covid-19/

The initial cases:

The first recorded case of COVID-19 in Argentina was on 3 March 2020. A 43-year-old man who had recently been in Italy, Spain and Germany walked into a health insurance clinic in Buenos Aires when he developed symptoms. The patient is reported to have made a full recovery. The first death attributed to COVID-19 was recorded on 7 March 2020 when a 64-year-old man who had just visited France and had pre-existing health conditions succumbed to the virus.

Between 3rd March and 13th April, 2208 cases of COVID-19 have been reported. Of this 97 people died and 515 people who reportedly recovered. The average age of people known to have been infected is 45. The average age of people known to have died from COVID19 is 68.

A national lock-down was put in place on 20 March. Initially, this was due to end on 31 March, but it has since been extended to 13 April and, most recently, 26 April. As in many countries in Latin America, a significant share of the population live in shantytowns or other precarious settings, where high population density impedes physical distancing. The policy response has been to isolate these communities in their entireties–nobody is allowed to either enter or leave. At the same time, religious organisations have provided special dormitory shelters for older people living in these over-crowded shantytowns.

The quality of health services for older people in Argentina has been a subject of criticism for many years. In recent days, the website Change.org has started to transcribe and publish public complaints about the reduction of health treatment availability for frail, older people and those with other health conditions, as a result of the pandemic. Some local governments have developed emergency volunteer programmes to provide basic support for older people, such as help with buying essential food and medication.

Pension chaos:

All older people in Argentina receive a pension from either a contributory or an assistance scheme. In theory, this should help to shield them against some of the indirect impacts of the pandemic. Instead, a poorly thought-out intervention has exposed large numbers of pensioners to infection.

From late evening on 3rd April until the next morning, around one and a half million older people waited on pavements in long queues for banks to open, so they could collect their pension benefits. It was one of the coldest nights of the year. These banks had been closed since 20 March, to reduce infections and to protect the staff working there.

Almost all pensioners in Argentina habitually collect their pensions from banks, rather than using ATMs or other means. As such, many had been unable to access their pensions and were experiencing financial distress. It was announced on 3rd April that the banks would reopen for a few hours on the following day, specifically to process pension payments.

Understandably, many older people were concerned that not all pensions would be processed in this short window and so they were anxious not to be at the back of the queue. To date, the effects of this unfortunate incident on these older people, both in terms of COVID-19 infection and other forms of harm are not known.

Nursing home and care homes on the frontline:

Argentina contains a large number of nursing and care homes. The actual number is unknown, as many are unregistered and operate on the fringes of legality. An informed estimate would be at least 10,000 such establishments. In many cases, the quality of care is very poor and residents usually share rooms with several other people.

The first reported instance of the death of a nursing home resident was on 24th March in Buenos Aires city. The older woman in question had been visited by a relative who had recently been abroad. The city authorities transferred all 35 residents of this nursing home, as well as staff, to a hospital isolation unit. On 2nd April another nursing home was evacuated after having received a visit from a person who was infected and three residents had been tested positive. To date, there are no known additional cases of infection in nursing homes or care homes in Buenos Aires city.

On 12th April it was reported that 32 people, including 25 older people and 7 staff, had been infected with COVID-19 in a nursing home located in another part of Argentina in the rural district of Córdoba Province. The infection was traced to a family doctor who had treated residents and who went on to develop symptoms. A further 49 older people remain in the same nursing home, having been tested as negative.

On 13 April a care home in Moreno, an outlying neighbourhood of Buenos Aires city, was closed down by the local authorities following the deaths of two older residents. The number of residents of this care home who are now infected is not yet known. Following the first resident's death on 5th April, it was announced that the care home had been inspected and found not to be meeting local government care standards. Of the remaining residents, 15 were transferred to hospitals and 2 to their own families (who declared that they would remain in isolation). The local government later reported that this nursing home had admitted new residents after a national freeze on new admissions (and visits) had been announced. The infection was brought into the home by one of these newly admitted residents.

Part Four
Long-term care

COVID-19 and long-term care in the Western Cape, South Africa. A tale of two facilities.

16 NOVEMBER 2021

By Gabrielle Kelly, Alice Ashwell, Leon Geffen, and Peter Lloyd-Sherlock.

https://corona-older.com/2021/11/16/covid-19-and-long-term-care-in-the-western-cape-south-africa-a-tale-of-two-facilities/

Little information is currently available about how COVID-19 has affected long-term care facilities (LTCFs) in countries like South Africa. Based on the experiences of LTCFs in high-income countries, we were deeply concerned about the situation in these countries and were able to obtain funding for a study in South Africa, Brazil and Mexico [1]. Research is ongoing, but we have been stunned by the initial data we have been able to collect.

In the spirit of immediate knowledge-sharing, this blog shares some of this information with reference to two different LTCFs in the Western Cape of South Africa. There are 418 registered residential frail care facilities across the nine provinces of South Africa, almost a third of which (120) are in the Western Cape Province [2]. There is significant variation in the resources available to these facilities, driving economic inequalities in the care of older people and, presumably, the capacity of facilities to respond to the COVID-19 pandemic.

This blog draws on information provided by managers of two residential frail care facilities (or LTCFs) that cater to relatively wealthy and relatively poor older South Africans and reflects on differences in how management, staff and residents of these facilities experienced the COVID-19 pandemic. [3] This is not a carefully worked academic paper and we make no claims about the extent to which these experiences are more widely representative. Nevertheless, they demonstrate the need for a more systematic set of public policy responses to these different forms of vulnerability, along the lines of this framework [link].

GENERAL FEATURES OF EACH FACILITY

Facility 1

This LTCF, located in a low-income neighbourhood, was built over 50 years ago and was described as resembling a boarding

school. There are no private rooms and many of its 136 residents live in single-sex dormitories, each containing up to 20 people. Toilets and bathrooms are located outside the dormitories. The manager commented: "It's a challenge to keep them all together in peace."

The facility falls under an umbrella non-profit organisation that runs other frail care centres and retirement villages in the region and is registered with and funded by the DSD, indicating that it should meet most required norms and standards. However, like many facilities providing services to low-income residents, the facility was in a precarious financial position prior to COVID-19. Financial operations are almost entirely funded from two sources: grants from the Department of Social Development (DSD) and residents' personal old age grants (non-contributory means-tested government pensions), which they are required to hand over to the NGO which runs the facility. Together, these two sources amount to about US$420 a month per resident, which only permits very basic levels of care and the ratio of employees to residents is one to ten. According to government regulations, the ratio of caregivers to frail older persons should be 1:5, but this is challenging in most state funded facilities given the low subsidies provided by the DSD relative to the cost of care and the facility often relies on local donations of food and other essential products. Many residents complain about losing their pensions, which is typically their only source of income. According to the manager:

They don't understand there is no money. They say, "Give me my old age grant, then I'll live on the street. They don't even have money for cigarettes. They sell our chairs over the fence to the school for cigarettes!

The manager claimed that her budget was not sufficient to provide adequate care before the pandemic and that meeting residents' daily food needs was a continual challenge. Occasionally, they receive small food donations from local businesses.

Facility 2

This LTCF is part of a larger 'retirement village' and located in an affluent leafy, suburb. As well as the LTCF, this includes 680 privately-owned individual properties, with limited provision of assisted living services. The LTCF provides a combination of levels of support, including assisted living, frail care and specialist dementia care. At the time of interview there were 121 residents, with around 104 staff. Some residents have private rooms, others share, up to a maximum of four per dormitory. All rooms and dorms have en suite bathrooms. The facility caters almost exclusively for affluent older people and does not receive funding or admissions from the DSD.

COVID CASES AND DEATHS

By 12 October 2021, **Facility 1** reported 78 cases among residents (around half of their total), not including cases that went undetected. Of those, eight had died from COVID-19, along with 12 residents who died of other causes during the pandemic. Data on staff cases were not available, although the manager commented: "I'm one of the few lucky ones who hasn't had covid". Impressively, the manager claimed that there had been no cases of COVID-19 among residents in 2021.

Facility 2 had a COVID-19 outbreak in August 2020, with 10 registered cases among residents and 18 among the 104 staff. During this outbreak, two residents' deaths were attributed to COVID-19, with a further resident dying because they were unable to access essential hospital treatment for a different health condition. There have been no further reported cases or COVID-19 deaths since the August outbreak.

SUPPORT FROM GOVERNMENT AGENCIES

The LTC sector in the province is primarily overseen and supported by the Department of Social Development and Department of Health. DSD has the mandate for monitoring norms and standards and supporting long-term facilities in South Africa, while the Department of Health plays a more limited role, providing medication and incontinence products and registering and monitoring dementia care facilities. This dual responsibility can cause conflicts and confusion, including during the pandemic, and there were significant disagreements over which department was mandated to provide PPE. This resulted in significant delays in providing PPE and limited provision of PPE/PPE funding thereafter, which had disproportionate impact on low-resourced facilities such as Facility 1.

Facility 1

Even before the pandemic, Facility 1 struggled to obtain basic materials from the Department of Health (DOH). The manager observed:

Three quarters of the time they don't have stock. Nappies have been out of stock for 3 years. We must fight for gauze to treat pressure sores.

In the early months of the pandemic, Facility 1 received no PPE from governments agencies, and supplies continue to be limited. The manager resorted to making appeals for donations or purchasing equipment from the NGO's limited funds. While they did receive ongoing telephonic support from DSD, no meaningful support was provided to the facility by the Department of Health.

Facility manager expressed frustration on numerous occasions that there was a large disconnect between the norms and standards that government agencies required them to meet and the provision if funding and support to make this feasible, especially during the COVID-19 pandemic. She noted:

They send the guidelines via email for you to implement according to the norms and standards, but not the resources…. If they come to do inspections, they want to know why there isn't a basin in this room, why are there no hand towels? If I put them out now, the residents will take them within 10 minutes and blow their noses on them, throw them in the bin, flush them down the toilet – then the drains are blocked… I can't change the structure of this place to comply with the norms and standards. They say there has to be a basin in all the rooms – now they mark me down… We have to replace vinyl concertina doors –they've been here for 55 yrs. Because they are bigger than a normal door for wheelchairs it will cost R12,700 per door and I need to replace 40… It feels like we are being set up to fail.

During the pandemic, Facility 1 was reluctant to send residents to state hospital, the manager claiming that:

They can sit for two days in a wheelchair. They don't sleep. I don't even know if they give them food.

Facility 2

Eacility 2 was much more positive about their relationship with government agencies and the support they were provided:

The DoH was very helpful during covid with regulations, protocols, training… They gave us just the same as the state entities. Very effective and helpful. DSD also helped a lot if we were worried or struggling… They will give you numbers and help you with everything. Don't wait for them to contact you. You'll wait forever. Contact them and they respond.

The only criticism was:

They trained a bit late, but I won't fault them on that because none of us knew anything. They had to get their ducks in a row first. It took them a while to do the Zoom training. It was also noted that all annual inspections

had been suspended since the pandemic started.

INFECTION CONTROL AND LOCKDOWN

Given concerns about the rapid spread of COVID-19 and lack of health system preparedness, South Africa instituted a stringent lockdown on 26 March 2016, well ahead of community transmission of the virus. Concerns about spread through LTCFs resulted in the lock-down of these facilities in early March and lockdown regulations allowed no visitors or volunteers and only very strict exits and entries from facilities for most of 2020, with lockdowns being put back in place in the context of the second and third waves in December 2020 and May 2021.

Facility 1

As was the case with most facilities, Facility 1 put in place strict lockdown protocols well before significant numbers of COVID-19 cases were reported in the province. Many residents are immune compromised due to HIV or other conditions, so the management tried to implement a strict lockdown protocol. Family visits were completely suspended for much of 2020. During 2021 measures were relaxed to some extent, although children are still banned from visiting. Residents are now permitted to go outside the facility in some circumstances, the manager noting:

When they go on family visits, they must go out for seven days and come back with a negative test. If they go out for two to three days, or if they go to a wedding or funeral, I isolate them.

During the period of full lockdown many of the residents struggled to adjust to the new protocols. Few had cell-phones and the NGO lacked the resources to facilitate virtual meetings with relatives. The manager observed:

Some of them thought I tried to keep them in jail… They got cabin fever… They kicked out the windows, hit each other. Their backgrounds are that they fight for everything. To get that out of them is a challenge… They have no respect because nobody respected them.

More generally, it was difficult for Facility 1 to impose infection control protocols by either staff or residents, due to a lack of protective equipment and other materials, as well as a reluctance to comply among some residents. The Facility's small pre-pandemic budget was further stretched, due to the need to purchase PPE and additional cleaning materials.

Facility 2

From the start of the lockdown strict infection control measures were enacted. According to the manager:

We washed uniforms onsite overnight. We organised and paid for our own staff transport for a long time. We did training all the time…. We had to remind and re-train: washing hands, sanitising, masks. Everyone had their own sanitiser and masks. We were very extreme. We had a machine that 'oxinates' everything that came in.. We F10'd the wards every 48 hrs (sanitising agent, backpack sprayers). We cleaned like crazy. We sprayed feet and went crazy. We've relaxed a bit – we still do it now and again.

She added:

In the beginning you couldn't find PPE. We had masks made which was expensive – gloves were expensive. The company had a lot of money invested in PPE – it was unbudgeted.

A further challenge was that:

Dementia patients can't understand, and they wander around.

Despite having more resources available to facilitate virtual communication, the manager indicated that residents and families struggled

tremendously with the ban on family visits:

The families were difficult because they couldn't see the residents. We could blame the DSD.

We saw what the lockdown did to residents. We saw it every day … mentally. We tried our best to be the family – we video called, Skyped and bought an i-pad so they could see. We tried to do activities with the residents. We took them outside. The company invested money in visiting rooms with screens and pipes so they can hear. We tried everything to get the people to see their families… Someone was appointed in frail care to entertain residents because they were not allowed out. They were entertained in the dining areas with sand art, music days, table tennis.

The manager added that the lockdown led to a high degree of depression in the wider retirement village complex, including "two attempted suicides, which you don't see a lot in a retirement estate."

During 2021, these restrictions were considerably relaxed and the manager was able to make some more positive observations:

It's better now – the morale is better now… The pandemic: Brought us closer to the residents because we were their families.

STAFFING ISSUES

Facility 1

Although Facility 1 was unable to provide data on cases of COVID-19 among staff, it was evident that infection had been widespread, especially in the early months of the pandemic. This led to a very high level of absenteeism:

Having 20 staff off all at once with a staff of about 46 – half ended up with covid having to isolate.

The manager suggested that high rates of infection among staff were in part due to their own difficult living conditions in low-income communities where capacity to practice physical distancing and apply appropriate hygiene protocols is unrealistic.

You can understand it because living in an RDP house[4] with 6-8 in a house with two rooms.

In the beginning about 20 staff were infected. In 2020 the biggest challenge was having staff available. Absenteeism greatly increased workloads for remaining staff, which in turn was a cause of additional absenteeism:

They're working hard, going through burnout, experiencing emotional and physical changes due to covid. We gave them a very small raise (about 1-1.5%) but we haven't received an increase from the DSD.

Facility 1

Many of the impacts of the pandemic on staff were similar to those reported for Facility 1. For example:

During COVID it was a challenge as if one staff member tested positive, the whole shift was sent home. We were just learning about Covid. We used a home-based care nursing agency temporarily – but it was better to use own staff on extra shifts because they know the patients. Also, it was more expensive to use an agency.

The staff got depressed and overworked because they were the families to the residents for this time. All the new things happening. Everyone outside felt depressed – keeping the morale up was difficult – to keep residents and staff feeling positive. It was difficult because you were not allowed to do team buildings. I tried meeting one shift at a time at 6 am and speak about everything.

On a more personal note, the manager added:

I had PTSD – I was in a state because you feel so responsible and there's nothing you can do to change it… And what it did to us as staff – it took away a lot of our family life – we were so tired. They were all at home and didn't experience the same anxiety we did battling the 'thing' that we didn't understand.

VACCINATION

Facility 1

By October 2021 most residents of Facility 1 had received at least one dose of COVID-19 vaccine. However, the process of administering the vaccinations had been far from perfect. According to the manager:

At first, I had to beg them to come out to our facility – they wanted us to take the residents there… When they came, our manager was still preparing a list of employees and residents who wanted the jab. I had to hand it over to them. If they had sent an email beforehand explaining what was necessary, we would have had it all ready. We started running around, so we looked disorganised. The residents don't have cell-phones, so I had to use my phone to register them / apply for the vax passport…. It was difficult to get hold of family members who needed to give consent because some elders are unable to decide for themselves. In some cases, their number no longer existed, or the phone had been passed on to someone else, or they couldn't afford to phone back….

What was problematic was that they brought members of the public into our facility where we have restricted visitors. They told the public that there was a clinic at our facility. But we are not a covid clinic. The vaccine team were to come out especially for our residents the elders, not for the wider community…

Twenty of our 136 residents did not want the vax initially. It was their choice. Now they want it, but the vaccine people won't come out again. And some of these people are bedridden, so I can't take them to the clinic. Now they are saying they don't have jabs available. I've been asking for weeks to vax 20 people – they don't even answer me.

By the time of interview only around half of staff had received one or more doses of vaccine. The manager said that this reflected the personal choices of staff members. Many were not vaccinated when the team visited the facility. For some of these, remaining unvaccinated was a personal choice. For many, however, it was because obtaining a vaccine outside the facility was often difficult, especially in the first part of 2021 when only the Johnson and Johnson vaccine was available via clinicals trial to health and care workers at select sites and public vaccination sites were not widely available. Speaking of her own experience, the manager noted:

I went to Hospital X and waited from 8 to 4 pm without being attended to. That's why people don't go.

Facility 2

This facility's experience of vaccination was considerably more positive. Staff included a number of registered nurses, two of whom were trained and given temporary licences to administer the vaccine. A nearby government hospital sent a vaccination team and 400 residents of the LTCF and wider retirement village were vaccinated in a single day. A further 200 were required to travel to the hospital to be vaccinated. According to the manager:

They are super-effective – I recommended the residents in the houses to go there. They set up a vax clinic – a beautiful place – so well organised. The staff are super. You never waited.

By the time of interview, only three residents had not been vaccinated. Six staff had not

been vaccinated, out of choice and they were not permitted to work in the frail care section of the facility. According to the manager: "We are not pushing them to have it. Still a choice".

FINAL COMMENTS

Despite the large differences between these two LTCFs, they have faced similar sets of challenges during the pandemic. Both have been affected by COVID-19 mortality and infection, as well as by staffing issues and the challenges of infection control. Both have struggled to meet these challenges, notwithstanding the heroic efforts of some staff. At the same time, it is evident that Facility 1 has been especially exposed to the effects of the pandemic and has had fewer resources with which to face it. This facility manager's accounts demonstrate the impossibility of providing adequate care to residents with the limited available resources and a lack of external support.

This is not an academic paper. We have not conducted systematic analysis across these two facilities and the other ones included in our study. We plan to complete our analysis and submit papers for peer-reviewed publication in the next few months. But for now, we simply want to share some of the accounts we have heard.

REFERENCES

[1] UKRI GCRF/Newton Fund Agile Response Fund, EP/V043110/1.

[2] Currently only facilities offering "residential frail care services" need to be registered with the Department of Social Development (DSD) and are included in these statistics. According to the Older Persons Act of 2006 a frail older person is an older person in need of 24-hour care due to a physical or mental condition which renders him or her incapable of caring for himself or herself. All frail care centres must be registered with the DSD regardless of whether they receive DSD funding or not. Approximately 117 facilities are funded (around 9000 residents) and there are also around 183 private facilities in the province, many of which are retirement villages or assisted living centres and are therefore not registered (although most have been reporting COVID-19 data to the government).

[3] For some wider context about the country's long-term care system, see **https://www.cambridge.org/core/journals/journal-of-social-policy/article/abs/longterm-care-for-older-people-in-south-africa-the-enduring-legacies-of-apartheid-and-hivaids/8DFDAA029A7B1EA3AAE708E31B6CC0F7**

[4] Government Housing Subsidy (RDP) houses are allocated to qualifying low-income families.

COVID-19 and community health services for dependent older people in Fortaleza, Brazil.

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By Adriano Maluf and Peter Lloyd-Sherlock.

https://corona-older.com/2021/11/09/covid-19-and-community-health-services-for-dependent-older-people-in-fortaleza-brazil/

It can be taken for granted that the COVID-19 pandemic has reduced older people's access to essential health and social care services. However, collecting specific data on these effects has been challenging. Health workers have been overwhelmed with crisis management and researchers have been unable to go into the field due to the risks of infection. Over the past four years, we have been part of a larger team in a project assessing interventions to address the health and social care needs of poor older people in Brazil.[1] This has involved fieldwork and data collection in two different cities: Belo Horizonte and Fortaleza. Our plans were made before the COVID-19 pandemic and so we have had to adjust to the new challenges this has posed.

One part of the project required us to interview vulnerable, care dependent older people about their needs and use of health services. This work was due to begin in early 2020 when the pandemic hit Brazil and we were forced to put it on hold for more than a year. Three months ago, we were able to resume. This had required us to adapt our data collection strategy to the new situation, ensuring that it was safe, ethical and that the questions we were asking were still relevant.

One key challenge we faced was that neither of us could travel to Brazil. This meant we had to develop a close working partnership with local Community Health Agents (known in Brazil as Agentes Comunitários de Saúde or ACSs). These ACSs are based in local health posts and provide a range of community services, such as vaccinations, home visits, collecting patients' histories and assessing their general wellbeing. A small number of ACSs in Fortaleza agreed to help us identify and recruit older people for our study and to facilitate the interviews, which we conducted remotely using Zoom.

This has not been a perfect process. On one hand, having the ACSs present in the interview was often useful as they could clarify any question which the older person or his/her

carer could not answer. On the other, the presence of the ACS may have discouraged informants from making any criticisms about the quality of care they were receiving, as well as raising other conflicts of interest. For example, after one interview it emerged that the ACS and older person were in fact neighbours and had known each other for a long time.

The interviews are ongoing, due to the limited free time of ACSs and other health professionals who are still dealing with the overwhelming challenges of the pandemic. But the testimonies we have collected to date are starting to reveal the degree to which these vulnerable older people have been cut adrift.

Even before the pandemic, many health and social care needs of our informants were not being properly met. But in from early 2020 almost all other health services previously provided to older patients were suspended, as the system focused exclusively on COVID-19. Despite the personal risks they faced, ACSs have continued to make home visits during most of the pandemic. However, they have usually avoided meeting older people in person, due to their elevated risk of death, if infected. Instead, ACSs have usually relied on doorstep discussions with family members, although some families refused to have any face-to-face contact with the ACS due to fears of infection. There were significant challenges for the ACSs to support frail and dependent older people in the community during the pandemic. In one of the 'postos de saúde' (health centres), the main medical doctor interrupted his work as he himself was in the high-risk group for contracting COVID-19. The health service in this particular posto de saude was reduced to a nurse with the support of ACSs in monitoring patients who presented signs of COVID infection, including older people, and when necessary, instructing patients or their families to seek the hospital services if their health deteriorated. Apart from emergencies, any other health conditions were deferred to until the health service could resume normal activities.

Having the ACS rely on family members' accounts and communicating with the older patient added an extra barrier for the ACS to support this population. Additionally, many families tried to avoid as much as possible seeking hospital care, resulting in many older people dying in their homes or arriving at the hospital when it was too late.

The case of one 89 year-old informant gives a powerful illustration of how the pandemic has affected the oldest old. Dona Olicia (not her real name) already had a number of health problems dating back several years and had limited mobility after breaking her hip in a fall in 2016. In early February 2020, she broke her leg in another fall and spent some time in hospital. In terms of the timing of this event, she might be considered fortunate -by March and April the city's hospitals had been overwhelmed with acute COVID-19 cases. A few days after her discharge, Dona Olicia made an outpatient visit for preliminary rehabilitation, but following that all health support was suspended. Her follow-up treatment was interrupted for 7 months – a period which could have been used for her to regain mobility in her leg. Her carers tried to speak with the doctor for further instructions but had no reply. No other support or instruction was given to Dona Olicia from March to July. During this time, she kept her leg immobile, preventing her rehabilitation at short and long term. Over time, Doña Olicia has become less mobile and now experiences chronic pain. She has been prescribed stronger pain medication and told that she needs to visit the local health post in order to resume treatment. However, she says she is in too much pain to walk there.

The lack of health services dedicated to looking after older people in their own homes can play a major role in unnecessary hospitalisations. Dona Lucia is bedbound and a wheelchair user. She requires round the clock care which is provided by her daughter. Dona Lucia's mental capacity

fluctuates through the day and she has a speech impairment. She sleeps in a special bed which is elevated to facilitate lifting her in and out. In April 2020 she had a fall from this bed and sustained a cut to the head that bled profusely. She was taken to hospital where the cut was treated. In hospital, she had several tests including a CT scan to check if the fall had caused any internal damage. Dona Lucia spent 2 days at the hospital waiting for the necessary tests which all came back clear. The doctor who looked after Dona Lucia recommended fitting a bed guard in Dona Lucia's home to prevent any further accidents. However, the family did not fit the guard because they could find any in the local shops. Instead, Dona Lucia's daughter placed the wheelchair next to bed hoping this would prevent her mother having a second fall. In July 2020 Dona Lucia had another fall and broke her nose as she hit her face against the wheel of the wheelchair. Dona Lucia was taken to hospital for 3 days for the necessary treatment and tests. After this incident, a friend of the family found a website which sells bed guards. The cost of the bed guard was around 120 Brazilian Reais (25 American Dollars). Dona Lucia did not experience further falls since using the guard bed.

Despite the challenges of remotely collecting data in the field, the testimonies of these older people and their carers are able to reveal the extent to which they have suffered the effects of health service disruption. Once we have the full set of interviews and have been able to analyse them systematically, we hope to develop them into an academic paper.

REFERENCES

[1] This project is funded by a partnership between the UK's Medical Research Council/Newton Fund (Grant Number: MR/R024219/1) and the Confederation of Foundations for Brazilian Research Support, with the participation of FAPEMIG (Grant Number: APQ-01141-18) and FUNCAP/CE (Grant Number: 0133-00003.01.00/18).

An emergency strategy for managing COVID-19 in long-term care facilities in low and middle-income countries: The CIAT Framework (Version 3*).

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*Note: this is the third iteration of a "live document", to be developed and updated over time. This iteration has been revised throughout and includes a **new section on COVID-19 vaccination.**

Introduction.

There is a broad misperception that there are very few long-term care facilities (LTCFs) in low and middle-income countries (LMICs). In fact, there are large and rapidly growing networks of residential care services for older people in Latin America, many parts of Asia, South Africa and other middle-income settings (Camarano et al, 2010; Cheung Wong and Leung, 2012; Lloyd-Sherlock, 2019). In high-income countries, there is a substantial body of evidence that LTCF populations have been the most high-risk group for COVID-19 mortality and this is generating (belatedly) a strong policy focus on this issue (Comas-Herrera et al, 2020; Cousins, 2020).

This paper draws on available evidence to assess the COVID-19 vulnerability of LTCFs in different LMICs, taking note of specific features of provision before and during the pandemic. Based on this assessment, it sets out a broad framework for guiding emergency interventions to address these vulnerabilities. [1] Drawing on stakeholder engagement in different LMICs, the paper reviews ongoing interventions by different government agencies and situates them within our policy framework.

General features of LTCFs in middle-income countries and vulnerability to COVID-19.

LTCFs in LMICs are highly diverse, as are the wider cultural and institutional contexts within which they operate. Indeed, official and popular terminologies for long-term care facilities are varied, unsystematic and inconsistent, both across and within countries.

Despite this confusion, research and stakeholder insights from a range of countries and local settings (Argentina, Brazil, Mexico, South Africa, Thailand and China) reveal some broadly generalizable features of interest (Lloyd-Sherlock, Sasat, Sanee, Miyoshi & Lee, 2020; Lloyd-Sherlock, Penhale and Redondo, 2019; Rosenthal, E., Jehn, E. and Galván, 2010; Feng et al, 2020). This section briefly summarises these, focussing on elements that differ from those commonly seen in high-income countries and that relate to COVID-19 vulnerability.

1. *LTCFs are predominantly operated by the private sector.*

Many LMIC governments run small numbers of facilities, but often these deny admission to older people with complex care needs such as dementia. In Bangkok, for example, there are just two government-operated care homes, with a combined capacity of around 350 residents. Older people seeking admission to these two homes must not suffer from communicable diseases, any psychiatric problem, or serious functional impairments (Lloyd-Sherlock, Sasat, Sanee, Miyoshi & Lee, 2020).

In some LMICs many LTCFS have traditionally been operated by religious organisations and NGOs. However, provision is increasingly dominated by private for-profit organisations (INAPAM, 2020). An emergency survey of LTCFs in Peru conducted in April 2020 was able to locate 146 facilities, of which just one was run by a state agency: 14 were run by religious organisations and the remaining 131 were privately operated (Defensoría del Pueblo, 2020). This is a fast-growing and (at least before the pandemic) often lucrative industry. It is highly diverse sector, with market segmentation ranging from luxury facilities for the very rich to much more basic, informal facilities. For example, a study in the Argentine city of La Plata identified over 60 private LTCFs, including informal "boarding houses" with untrained staff, as well as luxury nursing homes claiming to have a full range of therapeutic services (Lloyd-Sherlock, Penhale and Redondo, 2019). According to a local official in Thailand:

"There are thousands of them. You can find them at every corner of Bangkok… There are places set up by non-experts who lack professional knowledge… It's unclear who is responsible for registration or control" (Lloyd-Sherlock, Sasat, Sanee, Miyoshi & Lee, 2020).

2. *Many LTCFs are not registered with official agencies and hence "invisible" to the responsible authorities.*

Among the more informal facilities, many are not listed or registered with the responsible government agencies. In some LMICs, it is estimated that there are at least as many unregistered, "invisible" facilities as there are official ones. The main form of evidence that these invisible care homes exist is from media reports. For example, in February 2018, it was reported that of 30 care homes operating in the Argentine city of Tres Arroyos (population 57,000), 27 were completely unregulated. **[2]** And there are also many establishments we might call "de facto care homes", such as casual hostels with permanent populations that have aged over time. These facilities may not define themselves as LTCFs, but they are for the purposes of this pandemic. A study on South Africa notes that, whilst over 400 LTCFs were registered with official agencies, it is thought that there are also growing numbers of informal, unregistered care homes. According to a representative of the South African Human Rights Commission:

"We don't know precisely how many (unregulated LTCFs) there are out there, but we know that people have a tendency of opening their houses and converting them into residential homes for older persons…In Pretoria there are about six places operating within a very small radius from one another and they are functioning without control … We are saying that these places need to be

registered so they comply with standards" (SAHRC, 2010).

Similarly, it is thought that at least 200 mainly private-run old age homes operate in Jamaica, but only 14 were registered with the authorities before the pandemic (Amour, Robinson & Govia, 2020).

Informal interviews with LTCF managers in Mexico and Argentina reveal that there are many disincentives for facilities to register with official agencies and few advantages. The process of registration can be time-consuming and registered facilities are then required to pay related taxes and are subject to greater scrutiny. From their point of view, this makes them less competitive than the many LTCFs who opt not to register.

3. *Regulation and quality assurance are almost entirely lacking.*

Any state regulation of unregistered care homes is by definition impossible and there is no evidence of this role being played by non-state actors or self-regulation. There are no examples in LMICs of government agencies providing public information (such as websites) listing facilities and providing information about their service quality. Even registered LTCFs are weakly regulated, if at all, even when funded by the state. A primary health care professional in Bangkok mentioned that they were not permitted to visit providers, even if they had concerns about particular residents. A care home director in the same city observed:

"Yes, a public health official comes, but not more than once a year. Usually, we just need to submit some documents to show that we comply with their standards. The documents are mainly about the services we offer and the design of the building. They don't go into any detail" (Lloyd-Sherlock, Sasat, Sanee, Miyoshi & Lee, 2020).

Informants from a local government regulatory agency in Argentina reported that, due to concerns about staff absenteeism, they were prohibited from working outside the city centre office (Lloyd-Sherlock, Penhale and Redondo, 2019). This prevented them from visiting LTCFs in person. They added that several local LTCFs were owned by former directors of this same regulatory agency.

In 2012 South Africa's Department of Social Development reported that only 13 of 412 registered LTCFs had been assessed for compliance with norms and standards and that only a quarter of LTCF staff knew about official norms and standards (Department of Social Development, 2012). In 2019 Mexico's National Institute for Older People (INAPAM) conducted a survey of 415 registered LTCFs. It found that none of these facilities fully complied with official standards and called for urgent action from the federal government (INAPAM, 2020). INAPAM was unable to assess compliance for a further 44 facilities, as their inspectors were not permitted access: no measures were taken against these LTCFs.

4. *Responsibility for regulation is fragmented and uncoordinated.*

In most LMICs the main responsibility for regulating LTCFs is devolved to local government agencies, but coordination between health and social departments is even weaker than in high-income countries. Chile's national Ministry for Social Assistance funds LTCFs run by private organisations. However, responsibility for visiting and regulating the quality of care provided lies with the Ministry of Health and there is little coordination between the two agencies (Villalobos Dintrans, 2017). A similar division occurs between the Departments of Health and Social Development in South Africa. A study of local LTCF regulation in Argentina asked different agencies if they ever met with their counterparts in other agencies in the same city (Lloyd-Sherlock, Penhale and Redondo, 2019). All responded that this had not even been considered, despite the

proximity of their offices, and strong informal networks (for example, several informants had been trained in the same department of the local university). At the same time, coordination between local agencies and national ones with wider responsibilities for LTCFs is often weak.

5. *There is evidence of uneven quality and infringements of human rights.*

Poor service quality and resident abuse are serious issues in high-income countries (WHO, 2015), but there is evidence that they are especially common and severe across LTCFs in LMICs. In part, this is a result of the limited capacity of responsible agencies to oversee and regulate the sector. It also reflects resource scarcities of different types. Residents usually share rooms, facilities are very limited and skilled staff in short supply. This limited capacity explains why many LTCFs prefer not to admit older people with high levels of dependency and that life expectancy for residents who become care dependent after admission is often short. As a result, a high proportion of residents have few or only limited care needs. For example, a survey of 1,840 LTCFs in Argentina found fewer than 60% of residents had any level of care dependency (Roqué et al, 2016). Similarly, a survey of LTCFs in Belo Horizonte, Brazil found 29% of residents had no care needs (Teixeira Barral de Lacerda et al, 2017). INAPAM's survey of registered LTCFs in Mexico reported that 42 per cent of older residents had no care needs (INAPAM), 2020). **[3]** There is evidence from some countries that these abuses have continued during the pandemic. **[4]**

There is evidence that many LTCFs, even those with mainly independent residents, operate along the principles of rigid and highly controlling "total institutions", which were sometimes applied in high-income countries in the past (Mali, 2008). For example, a survey in Argentina found that in 43% residents were prohibited from personalising their bedrooms in any way (Roqué et al, 2016). Some directors and staff have little awareness or understanding about the human rights of residents. The same survey in Argentina found only 17% of LTCFs required the consent of older people to be admitted. There is evidence that LTCFs which practise rigid models of control and minimising resident agency have intensified these practices in the context of COVID-19 infection control to a degree described by The Lancet as "dehumanising" (Lancet, 2020).

6. *LTCFs face similar issues with staffing as those in high-income countries, but more severely.*

Often LTCF staff are unqualified, low-paid and work on a part-time basis across multiple care homes. The wider lack of regulation of LTCFs permits these practices. A South African survey of 405 regulated homes in 2010 found that over a fifth of care homes never had access to a trained nurse. There were indications of poor conditions for care home staff, including low pay and a lack of managerial support (Department of Social Development, 2010). A qualitative study of LTCF staff in South Africa found low pay, irregular work patterns, inadequate training and high ratios of residents to staff (Mapira, Kelly and Geffen, 2019). The survey of LTCFs in La Plata, Argentina found that many care homes were at times left under the supervision of a single unqualified worker (Lloyd-Sherlock, Penhale and Redondo, 2019). The low status and exploitation of LTCF staff is a key contributory factor to the poor quality of care provided to residents.

The CIAT Framework.

The CIAT Framework combines and summarises broad elements for an emergency strategy to address the potential effects of COVID-19 in LMICs. It has been

developed by an informal network of experts and draws on actual experiences in different countries and cities.

The different steps and components for the Framework are summarised in Figure 1. Ideally, these steps should occur in sequence, starting with Coordinate and moving through the others to Targeted Support. In practice, however, it may be necessary to take a less sequential approach, applying different elements of CIAT as and when the opportunities arise. Likewise, the fast-changing situation will require for assessment to be a continuous process and for policies to adapt rapidly.

Step 1: COORDINATE

- Any strategy must be led by an inter-agency and inter-disciplinary Task Force, with seamless coordination between health and social agencies.
- The Task Force must have backing from the highest levels of government (such as the president's or mayor's office).
- The Task Force must urgently develop a basic and feasible set of guidance, suited to the realities of local LTCFs.

Creating a seamless inter-agency task force like this is essential for many reasons, not least to avoid the following experience reported in the UK:

"On March 17, Sir Simon Stevens, the NHS chief executive, said hospitals had to get 90,000 beds cleared, so they needed to get 30,000 people out. So they sent patients with no tests into care homes. They said: "We don't need tests — you've just got to take them."

"We discharged known, suspected, and unknown cases into care homes which were unprepared, with no formal warning that the patients were infected, no testing available, and no PPE to prevent transmission. We actively seeded this into the very population that was most vulnerable." **[5]**

Coordination between local government social and health agencies responsible for LTCFs has historically been even more limited than in many high-income countries. Past experience shows that inter-agency cooperation happens most quickly when it is given full backing from **highest levels of government** (such as the president's or mayor's office). LTCFs must be seen as a national priority: just as important as "mainstream" health services. High-income countries have learned this to their cost and LMICs seem to be repeating this mistake. Similar issues were reported form some LMICs during the pandemic, including Chile where in the early stages of the pandemic older hospital patients were also discharged into LTCFs without testing or suitable precautions (Browne, Fasce , Pineda & Villalobos, 2020). LTCF managers in Mexico report that residents' access to in- and out-patient health services was extremely limited during parts of the pandemic, leaving their own unqualified staff to deal with a wide range of health problems. It is not unusual for several incomplete lists of LTCFs to be held by different local agencies, with a lack of coordination hindering information sharing.

Inter-sectoral collaboration is never easy, but there are some positive examples from LMICs. In the Brazilian state of Bahia, a new official entity (the Inter-sectoral Commission for Monitoring LTCFs) was established in April 2020, with membership including the departments of health and social development, among others **[http://www.saude.ba.gov.br/2020/07/06/creasi-integra-comissao-que-realiza-acompanhamento-das-instituicoes-de-longa-permanencia-do-estado-da-bahia/]**. In the Brazilian city of Fortaleza, the local health department has worked in partnership with the local social assistance department since the pandemic began. This has included developing joint surveys of care homes and a coordinated strategy **[https://www.corona-older.com/post/letter-from-brazil-covid-19-and-older-people-in-fortaleza-brazil-s-worst-hit-city]**.

In some municipalities, such as Fortaleza

and Belo Horizonte, this has prompted unprecedented inter-sectoral cooperation. In the state of Bahia and Botucatu (São Paulo state), cooperation has extended to the inclusion of local universities and other agencies in new commissions. This facilitated rapid information sharing and inter-agency emergency surveys of LTCFs during the early stages of the pandemic (Lloyd-Sherlock et al, 2021). Inter-agency cooperation also facilitated LTCF priority access to testing and vaccines, as they became available.

In South Africa inter-agency coordination has been quite limited at the level of local government. Nationally, the National Institute of Communicable Diseases collaborated with the Department of Health and Department of Social Development to establish an epidemiological surveillance programme of 19 facilities. However, this was limited to collecting information on reported COVID-19 cases and deaths in these facilities. No efforts were made to cover the other 2000 or so LTCFs registered with the Department of Social Development or to collect data on other issues (Cowper et al, 2020).

The Task Force must urgently develop a basic and feasible set of guidance and or protocols, suited to the realities of local LTCFs. Some LMIC governments have been slow to provide information and emergency guidance for care homes.**[6]** Organisations such as WHO have published detailed guidance and increasing numbers of LMIC governments are doing the same. These are very good in technical terms, but limited funds, resources and infrastructure mean that many of their recommendations will be unfeasible for the large majority of LTCFs in LMICs. Also, they are strongly focussed on infection control and pay less attention to the many other ways in which the pandemic can affect LTCFs, residents, families and staff.

Although the WHO guidance is a useful reference point, the Task Force should quickly identify the simplest and most affordable measures that can realistically be implemented in all LTCFs, including the most precarious and poorly resourced. This should be specific to local context and updated as new knowledge emerges.

South Africa's Western Cape Province have drawn on WHO, CDC and Department of Health guidelines to produce their own practical guidelines for prevention and management in LTCFs **[https://coronavirus.westerncape.gov.za/resources]**. They provide clear and simple information on basic infection control, including posters in different languages. They reflect some specific aspects of local context, such as the widespread sharing of rooms, but do not address other specific challenges related to the limited local availability of PPE, thermometers and other equipment.

Step 2. IDENTIFY

- The Task Force must develop specific strategies to locate and develop constructive engagement with all LTCFs in their area: registered, unregistered and de facto ones.
- The Task Force should be empowered to offer all facilities some form of "amnesty" for past and ongoing infractions of official LTCF standards, on condition that they cooperate with the CIAT Strategy.

It will not be possible to support LTCFs or their residents if public agencies are unaware of their existence, have poor information about them or are unable to persuade them to engage. Large numbers of facilities are unregistered and, even for those that are, official information is often minimal and unreliable. As such, the Task Force will need to rapidly find ways to locate and engage with all facilities. For example, unregistered homes may be located by local NGOs, civil society organisations, key informants and appeals to the general public. As well as gathering essential information about LTCFs, the Task Force should seek to develop a frank two-way dialogue with LTCF managers.

In Bahia state, Brazil, the Inter-sectoral Commission for Monitoring LTCFs developed an effective strategy to identify all LTCFs. It reviewed, verified and combined existing lists of LTCFs held separately by different local agencies. Additionally, information about LTCFs was obtained from health and social assistance managers. All LTCFs were contacted either by phone or email. When this was not possible, the Commission requested to local agencies to verify their records **[http://www.saude.ba.gov.br/2020/07/06/creasi-integra-comissao-que-realiza-acompanhamento-das-instituicoes-de-longa-permanencia-do-estado-da-bahia/]**. By September 2020, they had identified 200 facilities, including informal shared living arrangements that did not self-identify as LTCFs.

In Mexico a second special INED program was launched: "Daily monitoring and support of shelters and LTCFs" (Vivaldo-Martínez, Ocejo-Rojo, García Cruz & Montes-de-Oca Zavala, 2021). INED identified 159 active LTCFs which are monitored on a daily basis in order to strengthen their capacity to face the health contingency. This covers the bulk of the city's 203 registered LTCFs, although there are many more unregistered ones. This program is especially relevant as it involves the coordination between the Ministry of Health, the Ministry of Inclusion and Social Welfare, and the Private Assistance Board that regulates Private Assistance Institutions. This coordination facilitated rapid transfers of residents with symptoms to hospitals.

A key element of LTCF engagement will be reconsidering the realism and legal status of different sets of guidance, protocols, advice and standards, including those that pre-date the pandemic and those which have since been produced. If these entail legally mandated requirements, some LTCFs may perceive them as a threat and be reluctant to engage with them. The recent case of an Argentine LTCF demonstrates the need to change from a business as usual approach to a more pragmatic and flexible one. Following the deaths of five residents from Covid-19, the Director (who had notified the authorities of the first case several weeks previously, but had received almost no external assistance) was put under investigation for failing to comply with highly demanding and detailed official care standards that pre-dated the epidemic. This approach will have discouraged other LTCFs from cooperating with official agencies and for unregulated homes to come out of the shadows. It may well also lead to under-reporting of Covid-19 deaths by LTCFs.**[7]**

Interviews with care home directors in Mexico drew attention to the economic impact that the pandemic has had on their facilities. Expenses have increased, due to the needs to comply with new Covid-19 protocols, at the same time as income has fallen due to the deaths of existing residents. For care homes were operating with low profitability before the pandemic, this will reduce their capacity to follow previous and newly-established protocols. This calls for an approach from government agencies that is supportive and pragmatic, rather than inflexible and purely punitive.

It may be appropriate to offer LTCFs some form of "amnesty" for past and ongoing infractions of official standards, so long as they agree to cooperate in the CIAT Strategy. If LTCF directors are concerned about possible prosecution, they are unlikely to engage and are unlikely to report truthfully about the situation in their homes. This amnesty should be framed as a pragmatic, temporary emergency measure. It will be politically controversial, hence the need for high-level political support for the Task Force. It should not extend to very serious cases of abuse of residents (falling short of the required number of smoke alarms is one thing; serious abuse is quite another).

Despite the controversial nature of care home amnesties, some local governments have already introduced emergency legislation to permit this, including the Province of Buenos Aires on 9 May 2020.**[8]** In this case, the

term "amnesty" was avoided and replaced by the concept of "progressively regularising" LTCFs. This permits facilities that were not previously registered and/or were not compliant with required standards to continue operating without prosecution until a phase of formalisation has been completed (this time period remains undefined) **[http://www.saij.gob.ar/15171-local-buenos-aires-declaran-estado-emergencia-sanitaria-establecimientos-geriatricos-gestion-publica-privada-toda-provincia-buenos-aires-]**.

Step 3. Assess

- The Task Force should conduct an emergency survey of local LTCF preparations and vulnerability to COVID-19.
- This survey information can be used to:

Identify LTCFs at greatest risk, based on simple criteria.

Identify specific issues of concern for all LTCFs (equipment, information, space limits, hospitals dumping infected patients, etc.), to prioritise local actions.

This emergency survey should entail a short, focussed and simple online or email questionnaire collecting the most immediately relevant information. Some local governments in LMICs have already run limited surveys along these lines, building on local government coordination and effective mapping of facilities. In Fortaleza it was found that all LTCFs were facing serious challenges to prepare for the pandemic. However, a small number were especially vulnerable, lacking any capacity to screen for potential symptoms and struggling to access daily food and medicines. These high-risk LTCFs were targeted for priority support and the city's health and social assistance departments continue to work closely with them.**[9]** Similarly in Bahia, it was possible to collect information from all LTCFs every three days. For those LTCFs in Bahia reporting symptoms or positive cases of COVID-19 more intensive daily monitoring was instigated.

Similarly, in Peru the National Human Rights Ombudsman (Defensoría del Pueblo), ran an emergency survey of COVID-19 responses in 59 registered and 87 non-registered LTCFs (Defensoría del Pueblo, 2020). Among other things, it found 42% had not developed a specific COVID-19 plan or protocol, only 4 had implemented protocols to manage risk infection from family visits, and 71 per cent reported they had not received specific instructions from the local health authorities. The survey found 22% of LTCFs admitted that they did not provide influenza vaccination for residents. Additionally, LTCFs expressed concerns about the suspension of payments by residents' families, as the wider economic impacts of the pandemic hit.

In cities with large numbers of LTCFs, where many are unregistered and where local government capacity is more limited than in Fortaleza or Bahia, assessing facilities will be more challenging. In these cases, NGOs and other organisations may play a key role in identifying and engaging with local LTCFs. This has been done in the Argentine city of La Plata, where Red Mayor, a local NGO, co-developed a website for monitoring and sharing information about both registered and informal LTCF: **http://www.redmayorlaplata.com/**. In May they collaborated with local LTCFs to run an online survey of Covid-19 preparations. The survey revealed that some LTCFs in the city lacked any protective equipment or capacity to meet new official pandemic care home legislation. They shared their findings with local government agencies who promised to prioritise this issue. Following this, the local government established a new norm that testing should be provided for all LTCF employees.

Step 4. Targeted support

- LTCFs identified as high-risk should be given priority status for targeted support.

- Focus on cooperative support rather than punitive measures.
- It may be necessary for high-risk LTCFs to be put under direct control of the Task Force if their management is very weak.

There is growing evidence from high-income countries that the effective protection of LTCF residents requires repeated testing of all residents, including those who do not present symptoms [**https://www.corona-older.com/post/letter-from-south-korea-covid-19-response-and-questions-on-quality-long-term-care-for-older-adults**; Blain et al, 2020]. Sadly, this ideal response is far from feasible for most care homes in most LMICs (as well as some high-income countries). Nevertheless, other quite simple and cheap actions can potentially mitigate care home vulnerability, including providing adequate protective equipment and improving general hygiene practice.

A good example of this is the targeted support approach being applied in the Brazilian city of Belo Horizonte **[https://www.corona-older.com/webinars]**. In late April the city government conducted an emergency survey which reached 179 facilities. It applied a number of criteria, including number of residents per room, access to protective equipment and capacity to isolate cases to identify those establishments most in need of support. These LTCFs have received priority support from multi-disciplinary teams, including monitoring of residents for potential Covid-19 symptoms and developing realistic emergency protocols.

Less orthodox strategies include relocating residents with no/low dependency to other locations away from the LTCF, such as hotels, even before any cases are detected there. Where necessary, these relocated residents could be offered an element of care support in the new setting. This would reduce the risk of infection for relocated residents and would increase space and resources available for remaining LTCF residents. A version of this strategy has already been implemented on a limited basis in Chile, with assistance from religious organisations **[http://www.desarrollosocialyfamilia.gob.cl/noticias/gobierno-anuncia-medias-para-prevenir-contagio-de-covid-19-en-establecimientos-de-larga-estadia-elea]**.

Having conducted an online survey of local LTCFs, the Task Force should sustain this communication, both in terms of monitoring the unfolding situation and in terms of listening to their specific concerns. This can then support specific capacity-building strategies, such as offering emergency online education and training to staff. This strategy has been effectively applied in the Brazilian state of Bahia **[http://www.saude.ba.gov.br/2020/07/06/creasi-integra-comissao-que-realiza-acompanhamento-das-instituicoes-de-longa-permanencia-do-estado-da-bahia/]**, linked to a wider National Movement for Supporting LTCFs **[https://www.frentenacionalilpi.com.br/].**

New digital technologies and capabilities are rapidly emerging in response to the crisis and their potential should be harnessed to support LTCF staff. For example, residents' restricted physical access to health centres and hospital care may require greater use of digital consultation between LTCFs and health care professionals. Many residents will require assistance from staff to book and conduct digital consultations for treatment, booking vaccination or for engagement with family members. This will require focussed staff training which might be provided in simple leaflets or online.

Interventions to support LTCF staff should be mindful of their own concerns, and, in many cases, their limited prior training, low status and insecure work status. Checks should be made of LTCF staff who work across multiple facilities, and this practice should be discouraged. This has been an important mechanism of viral entry into LTCFs in some countries (Fortiér, 2020). In Brazil, there are reported cases of LTCF staff working in both health and LTCF facilities, including COVID-19 Reference Centres (Wachholz et al, 2020).

This is another reason for strong coordination between local health and social assistance agencies. Interventions to support LTCF staff should be mindful of their concerns and, in many cases, their limited prior training, low status, and insecure work contracts. There is a need to guarantee salary during quarantine periods for staff who are tested positive. In Brazil, new legislation passed in April 2020 stipulates all employees be paid in full for the first 15 days of sick leave or social isolation due to COVID-19, and employers can deduct this from social security payments (Government of Brazil, 2020). However, most LTCF workers in Brazil are employed on an informal basis, so this does not apply to their situation. There may be opportunities to develop simple, tailored digital contact tracing systems for LTC staff, which would reduce the risk of viral entry into LTCFs (Wilmink et al, 2020). To encourage participation and compliance, this information should be only be used for public health purposes and not to penalise staff who contravene labour law or other employment regulations.

The CIAT Framework and COVID-19 vaccination.

Implementing the CIAT framework is an essential pre-condition for achieving full vaccination of LTCFs.

Ensuring that LTCF residents and staff are prioritised in vaccination roll-out requires that official agencies are aware of their existence and have established some dialogue with them. It also requires seamless cooperation between health and social care agencies, and good communication with LTCF managers. Interviews with some LTCF managers reveal problems with accessing vaccination for residents and staff. In some cases, vaccination was not provided on site at the LTCFs, and so managers resorted to arranging transport to vaccination centres for their frailer residents. Many LTCFs complain that staff have not received priority status for vaccination, since they are not formally categorised as front-line health workers. This problem is especially acute where large numbers of staff are employed on a casual basis.

There is a need to keep vaccine registration processes simple for LTCFs, given the pressures on staff time. For example, in South Africa, facilities have been asked several times to complete different forms capturing information on individual residents and staff, significantly burdening overstretched administrative systems. Other implementation challenges in the rollout to LTCFs in South Africa include 1) a lack of wi-fi in some facilities, which is needed for vaccination teams to access and populate the online vaccination database; 2) vaccine hesitancy among residents and staff and family members who may refuse to give consent for persons with cognitive impairment.

In Bahia, Brazil residents and staff in all identified facilities have been provided COVID-19 vaccinations (Duarte, 2020). In other parts of Brazil as well as many other LMICs registers of LTCFs are very incomplete and so full inclusion in vaccination will be much harder to achieve. There are anecdotal reports that previously unregistered LTCFs have made their presence known to the authorities, so they can be included in vaccination roll-out. This may represent an opportunity to develop more complete registers.

There have been reports of new COVID-19 cases in LTCFs once residents had received both vaccine doses (Lloyd-Sherlock, Sempe and Giacomin, 2021). This is a reminder that current COVID-19 vaccines do not provide complete protection against current variants of the virus. In some of these LTCFs all the infected residents and staff homes appeared to be well and none had presented COVID-19 symptoms at the time of reporting. As such, vaccination had not prevented infection, but had prevented serious illness among this high-risk population group. Separate reports indicate that there have been some COVID-19 deaths in other fully vaccinated LTCFs. **[10]**

Sustaining the CIAT Framework and building a legacy of improved provision.

The main focus of this document is emergency strategies to respond to the immediate effects of COVID-19 on LTCFs in low and middle-income countries. Despite its concern with the "here and now", it is essential to situate these responses within a wider and longer-term strategy. At the very least, the Task Force should maintain monitoring and evaluation of both LTCFs and the effects of its responses for the duration of the pandemic. As the nature of the pandemic shifts, there will need to revise strategies. Ideally, the Task Force should look to share and receive useful knowledge with similar Task Forces in other local governments.

As shown above, even after all LTCF residents and staff are fully vaccinated against current strains of COVID-19, it is still essential to continuing regular testing and surveillance. This should also include any changes to protocols about family visitation and to ensure that LTCF residents' appropriate access to health services.

More ambitiously, efforts should be made to ensure that once the immediate crisis has passed, LTCF policy does not revert to its pre-pandemic status. There may be particular opportunities to enhance these policies and to significantly reshape the LTCF sector. First, the engagement and information acquired through emergency responses must be retained and kept up to date. This includes the detection of previously unidentified LTCFs as part of vaccination roll-out. Second, inter-sectoral collaboration must evolve from an ad hoc strategy to a fully institutionalised system. A starting point would be for different agencies to combine intelligence about local LTCFs into a unified, shared database. Third, full use must be made of what may well be a narrow window of policy opportunity. The pandemic has brought out into the open the many problems of the LTCF sector and has raised its political and public profile. This interest creates new scope to carry through much-needed reforms. But this interest may not last for long.

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[1] An earlier version of the CIAT Framework is available at https://corona-older.com/2020/06/09/an-emergency-strategy-for-managing-covid-19-in-care-homes-in-lmics-the-ciat-framework-version-1/

[2] http://lavozdelpueblo.com.ar/noticia/70298-Tres%20geri%C3%A1tricos%20habilitados%20y%20m%C3%A1s%20de%20veinte%20%22clandestinos%22%20. For other examples of media reports on this in Latin America, see http://www.eltiempo.com/bogota/hogares-geriatricos-un-negociofuera-de-control/16341055 (Colombia), http://elvocero.com/investigan-muertes-en-hogares-de-ancianosfatulos/ (Mexico); http://g1.globo.com/sp/campinas-regiao/noticia/2015/12/policia-militar-de-americanaencontra-duas-casas-de-repouso-clandestinas.html (Brazil); http://www.taringa.net/posts/info/6916249/Cuatro-de-cada-diez-geriatricos-de-Buenos-Aires-sontruchos.html (Argentina).

[3] In South Africa, by contrast, to be eligible for admission to a government-funded LTCF, older people should be assessed and classified as highly care dependent.

[4] https://www.infobae.com/sociedad/policiales/2021/05/05/video-que-encontraron-en-el-allanamiento-al-geriatrico-del-horror-de-quilmes-donde-ataban-y-drogaban-a-jubilados/?outputType=amp-type

[5] https://www.telegraph.co.uk/news/2020/03/17/coronavirus-arguably-greatest-challenge-have-faced-nhs-says/

[6] For an example from Pakistan, see https://www.geo.tv/latest/285629-dotage-vs-covid-19-how-pakistans-old-age-homes-are-coping-with-coronavirus

[7] https://www.clarin.com/sociedad/coronavirus-contagio-masivo-san-martin-enciende-alarma-geriatricos-gba_0_5_cniChQt.html

[8] http://www.ciudadyderechos.org.ar/derechosbasicos_l.php?id=21&id2=101&id3=66.

[9] https://www.corona-older.com/post/letter-from-brazil-covid-19-and-older-people-in-fortaleza-brazil-s-worst-hit-city

[10] https://g1.globo.com/pr/norte-noroeste/noticia/2021/06/12/cinco-idosos-morrem-vitimas-da-covid-19-apos-surto-da-doenca-em-asilo-de-arapongas.ghtml

FIGURE 1 – The CIAT Matrix.

Coordinate	**T**ype of care home	**I**dentify	**A**ssess and risk-rate	**T**argeted support
CREATE NEW CROSS-AGENCY TASK FORCE WITH HIGH-LEVEL SUPPORT	Registered with good information	Verify existing lists	Short survey tool (enhance ones already being applied)	Do not enforce pre-covid protocols, just ensure they are doing the key things to manage covid risk Relocate less care dependent residents?
	Registered in theory, but little reliable information.	Use registration lists to conduct brief telephone interview to check home still operates and get some basic information (eg updated contact details of director). Explain context of assessment survey and reassure that no prosecutions for infractions of protocols.	ditto	Ditto
	Unregistered	Multiple means: local stakeholders, public engagement, reassure that will only prosecute in most extreme forms of abuse	Same survey tool, but perhaps administered by a less official agency (seen as less of a threat)	Ditto
	De facto	Ditto	ditto	Ditto

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The CIAT emergency strategy framework for managing covid-19 in long-term care facilities: The case of Brazil.

14 APRIL 2021

Over the past year, members of the Global Platform have worked together to produce a set of emergency guidance for managing the COVID-19 pandemic in long-term care facilities. This guidance pays particular attention to the contexts of low and middle-income countries. You can find the general guidance here: **https://corona-older.com/2020/11/24/an-emergency-strategy-for-managing-covid-19-in-long-term-care-facilities-in-low-and-middle-income-countries-the-ciat-framework-version-2/**

Of course, there is great diversity between different low and middle-income countries and so it is important to tailor this general strategy to support specific contexts. With that in mind, we have now produced a version of the CIAT Framework with specific reference to Brazil.

You can access the paper here:

https://cdn.publisher.gn1.link/ggaging.com/pdf/gga020621a03.pdf

We will soon share a version in Portuguese.

If you are aware of any relevant experiences in Brazil or another low or middle-income country, please email them to **p.lloyd-sherlock@uea.ac.uk**. We will include them in new papers and your contribution will be acknowledged.

https://corona-older.com/2021/04/14/the-ciat-emergency-strategy-framework-for-managing-covid-19-in-long-term-care-facilities-the-case-of-brazil/

Academic support for long-term care facilities in Minas Gerais, Brazil. The “PUC No Lar” project (English translation).

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https://corona-older.com/2021/03/10/apoio-para-ilpis-em-minas-gerais-brasil-durante-a-pandemia-projeto-de-extensao-puc-no-lar-english/

The COVID-19 pandemic highlights the vulnerability of older people to high mortality, but due to their age and due to prevalent comorbidities such as chronic respiratory disease, cardiovascular diseases, cancer and diabetes (NUNES et al., 2020). A close look should be given to older people in Long Term Care Facilities (LTCFs), since they contains highly aged populations who often have high levels of care dependency. Regarding COVID-19 infection control, the LTCF have aggravating factors such as a community environment, with incoming and outgoing professionals from other settings (such as hospitals, other LTCFs, health services and public transport). This increases the contamination risk for residents (MORAES et al., 2020).

In this context, the PUC no Lar extension project arose to support LTCFs in the state of Minas Gerais, with a focus on the Metropolitan Region of Belo Horizonte. The project aims to share knowledge about preventive actions and precautionary measures against the coronavirus pandemic and, thus, to promote health education in LTCFs. The project relied on the use of information technology to reach potential beneficiaries in different ways: a website, videoconferences, the production of electronic booklets, telephone contacts and video production. In addition, socialization strategies were implemented among older LTCF residents, as well as with their social and family networks. The project has also advised on strategies to improve the ambience of these institutions.

The “PUC no Lar” the project team includes 20 students from biomedicine, nursing, energy engineering, physiotherapy, medicine and information system courses. Initially, extension workers were divided into two lines of action: those who stayed behind the scenes in the production of education materials and videos and on the front line, running videoconferences and live interactions. Training videos were produced to respond to general population’s questions and doubts about COVID-19. These questions were

communicated through social networks and in alliance with a separate network, the Brazilian National Front for Strengthening LTCFs **[https://www.frentenacionalilpi.com.br/]**. These questions were put into themes, such as prevention (subdivided into guidelines, PPE, sanitizers, cleaning/gowning), food, health services, mental health; testing; transmission/infection; treatment; immunization and symptoms/lethality. From 238 questions received, the project produced 142 videos that were posted on Youtube **[https://www.youtube.com/channel/UCPAypBHrYMmkUeq-ZBWzw8w]**, Facebook, Instagram and also a dedicated website **[https://pucnolar.site/]**.

On the front line, to promote more direct contact with professionals, residents and their families, weekly videoconferences were run through Google Meet. These addressed topics related to the pandemic and selected by the project team and the beneficiaries. Topics included: management of suspected and confirmed cases of COVID-19; the role of multi-professional teams in the management of COVID-19; impacts of social isolation on the mental health of residents and measures to minimize isolation; care in the hygiene and disinfection of food and kitchen utensils; tests available for COVID-19; expectations and progress for vaccination against COVID-19; older person-centred care; palliative care; and "taking care of those who take care" (concerned with the mental health of social care and health professionals).

Meetings took place every week, 26 in total, and were attended by representatives of LTCFs in the cities of Betim, Belo Horizonte, Contagem, Mateus Leme, Santa Luzia, and Ouro Preto. About 42 institutions were part of the project during 2020.

On 1 October 2020, the project implemented the "Live Solidária de Afetos", which roughly translated as "Affection Solidary Event" to mark the international day of older people. In this event, songs were chosen and sung by the residents of 8 LTCFs in a presentation broadcasted by YouTube, along with musicians from the region who joined in the virtual party. All sanitary measures were followed during the event by all participating institutions. The entire project team and the social and family networks of residents were invited to attend this live event.

Due to the suspension of visits to LTCFs during the pandemic and the reports from LTCFs regarding difficulties in sustaining the mental health of residents, "PUC no Lar" started to develop and provide booklets with interactive and educational activities to be performed by residents and with professional support. These booklets aimed to improve the atmosphere in the institutions during the pandemic period, to promote independence and self-esteem of residents and to strengthen bonds between residents and carers. The documents' content was based on LTCF suggestions and ideas developed by the project itself. They were presented to the institutions during the weekly meetings and delivered via whatsapp and email. Each booklet has a detailed description of its objectives, proposals for execution, recommended bibliography and sanitary measures to be respected to perform the activity.

The first booklet was called "Fact or Rumor", and aimed to provide residents with quality information about COVID-19. By deconstructing examples of fake news, residents had the opportunity to answer questions and receive information in an entertaining and engaging way. Other booklets deal with self-care, well-being and stress management, including "Relaxation therapies", "Poems and Poetry" and "Self-Hug". There are booklets with interactive activities promoting the participation and social interaction of residents, including such as "Bingo game", "Photo Mural" and "Miss you, session". These aimed to entertain residents and reduce their feelings of abandonment by strengthening links between those involved. In total, nine booklets were developed and shared with LTCFs.

Another element of the project was "Alô PUC no Lar", which aimed to support socialization strategies to link residents with the project team and reduce social isolation. Weekly meetings or calls on specific topics were mediated by staff from the LTCFs, using Whatsapp, Google Meet and voice calls. By now, on average, there have been at least two meetings for each project team member. In 2020, "PUC NO LAR" ran two live events, 26 videoconferences, nine booklets and 142 educational videos. The project directly reached an average of 1260 people in the video conferences, from 42 LTCFs. The evaluations of all participants were extremely positive, which has encouraged us to maintain the project during 2021.

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COVID-19 and older people in Mexico City: The response of the city's Department of Welfare and Social Inclusion [1] (English version).

12 FEBRUARY 2021

By Marissa Vivaldo-Martínez [2], Almudena Ocejo-Rojo [3], Beatriz García Cruz [4] y Verónica Montes-de-Oca Zavala [5].

https://corona-older.com/2021/02/16/las-personas-mayores-frente-al-covid-19-en-la-ciudad-de-mexico-el-papel-de-la-secretaria-de-inclusion-y-bienestar-social-copy/

Mexico City (CDMX) contained just over 9 million inhabitants in 2015 (INEGI, 2019), with a population aged 60 and over of 1.2 million INEGI, 2015). Older people in the city face great challenges in terms of gender equality, education, health, mobility, access to employment, decent work, care, spaces for participation, violence, among many other issues. These have worsened during the pandemic. The current city government of has a Department of Welfare and Social Inclusion (SIBISO) which includes the Institute for Dignified Aging (INED). Mexico City government's programs and actions for older people have become a benchmark for other cities and for the design and implementation of policies at the federal level.

INED has looked to develop innovative perspectives in terms of care, not only for older people, but as its name indicates, with reference to aging. It places a strong focus on community action.

To carry out these tasks, it has an administration of approximately 80 people and a team of 1,200 people, almost entirely women (only two men), known as Professionals in Services to Older People (PSAM) **[6]**. The PSAM began operation 15 years ago as health promoters, originally attached to the Ministry of Health. Their profile has been professionalized with training and constant updating to apply a social as well as clinical approach. PSAMs are the heart of the Institute and their main activity is the care older people. This entails neighbourhood monitoring, house by house, developing personalized and direct contact not only with beneficiaries but their families and environments. PSAMs operate as a direct link between older citizens and the government, passing information about older people's situations and needs back to government agencies.

This community work has been severely disrupted since the COVID-19 pandemic. The work of registering and monitoring beneficiaries has continued, but given the recommendation of social distancing, these

have been carried out through a telephone service strategy, trying to maintain closeness and daily monitoring to know if people have any specific needs.

Support for older people living alone or in a situation of abandonment.

During the pandemic, a special program was launched to carry out specific support actions aimed at older people who live alone and who, from the records of the PSAM, are known to lack a social support network and family. In Mexico City, between 10% and 12% of people over the age of 68 live in single-family homes. Although we know that living in a single-family home does not always mean older people lack a support network, it is estimated that this is the case for between 8% and 10% of them.

A dedicated team of 200 PSAM was formed, who are in charge of following up through telephone calls, twice a week, to 5,844 older people addressing aspects of basic needs (food and medical), health care, emotional support and support in carrying out procedures or services. In case people do not respond, a specific follow-up of daily calls is carried out until the person is contacted. Between March and December 2020, 1,793 people were supported who requested help with medicine, food, and errands.

Not all older people who live alone without a support network have financial resources to purchase a telephone or to hire airtime in order to have access to these services. Faced with this reality, the city government worked with foundations and telephone companies to donate devices and airtime to avoid the isolation of this group of older people.

Also, SIBISO has separate focus on "Attention to Priority Populations" which is in charge of offering temporary shelter [7] to people in a situation of social abandonment. It is estimated that 50% of this population is over 60 years of age.

Support for long-term care facilities (LTCFS).

In the face of the health emergency caused by COVID-19 and given the devastating experiences in different countries, a second special INED program was launched: "Daily monitoring and support of shelters and LTCFs". INED identified 159 active LTCFs which are monitored on a daily basis in order to strengthen their capacity to face the health contingency. This covers the bulk of the city's 203 registered LTCFs, although there are many more unregistered ones.

This program is especially relevant as it involves the coordination between the Ministry of Health, the Ministry of Inclusion and Social Welfare, and the Private Assistance Board that regulates Private Assistance Institutions (IAP). The biggest challenge of this collaboration is defining the scope of action of each agency but, thanks to a disposition to cooperate and to work creatively it has been possible to implement the following actions:

- Training in online mode to the staff on care and prevention measures on the COVID-19, its characteristics and measures of prevention, control and care of suspected and confirmed cases.
- Design and delivery of the Action Protocol against COVID-19 [8] and other informational materials.
- Support for the disinfection of spaces through the delivery of cleaning materials (brooms, bleach, antibacterial gel, liquid soap).
- Monitoring and targeting of preventive measures according to the specific needs of institutional care to long term.
- Guidance and telephone support in case of suspected and / or confirmed cases of COVID-19.
- Support for stays in hospital transfers.
- Remote emotional support of caregivers through the Gerontology Coordination Unit, in which a psychology professional conducts an initial interview to assess any problem and, where appropriate, makes a follow-up plan based subsequent

telephone calls.
- Medical advice from the Geriatrics Coordination Unit.

In addition to the above, SIBISO through INED, reinforced these actions as of May 2020 through an Inter-Institutional Protocol that consists of:

- Daily telephone follow-up to the 159 LTCFs, regarding their needs for support and action in scenarios of suspected outbreak or contagion.
- Immediate support in cases of suspected infection. The calls are made in the morning and in case of reporting a suspicious case or contagion, the dispatch of the health team is immediately managed to make an on-site review of the situation of both the residents and the staff of the LTCF through the application of tests and medical care.
- On-site identification of the need to transfer to hospitals. This focuses on ensuring that older people with symptoms receive timely care in the shortest possible time. This is due to the fact that cases were observed among people aged 80 and over, which progressed from mild to severe symptoms in a very short period of time.
- Delivery of support / services requested. It was identified that a significant number of LTCF lack the resources for the acquisition of basic supplies, for which reason they are provided food products, basic protective equipment for personnel, and cleaning and disinfection equipment.

Despite these efforts, the progress of the pandemic brought suspected and confirmed cases of COVID-19 inside LTCFs. By December 2020, 38 LTCFs had reported suspected or confirmed cases, with a total of 475 confirmed cases.

By way of conclusion.

Without a doubt, care for older people in one of the largest cities in the world is a challenge. The efforts of LTCFs in the face of the health emergency stand out. There were initial difficulties in establishing communication with the authorities as LTCFs feared being sanctioned, judged, or penalized for their deficiencies. However, following the advice of the 2nd edition of the Technical Guide for the Prevention and Control of COVID-19 Infection in the WHO LTCFs (WHO, 2021), efforts were made to develop a constructive engagement with LTCFs, to enable contact and appropriate responses.

The pandemic has shown the need to update official data on LTCFs and to overcome the technological exclusion of older persons. On the other hand, this crisis has made it clear that the community approach that has characterized INED is its main strength. It has allowed it to carry out work in the territory with knowledge of the economic, emotional, social and family conditions of the beneficiaries of its programs. This has helped the monitoring and implementation of these programs and also informed the design of emergency measures.

Prompted by the crisis the creation of a Public Care System for Mexico City involving various government agencies such as the Secretary of Inclusion and Welfare, the Secretary of Health and others is now being discussed. Perhaps there is no more propitious moment than this health crisis, to value the human right to care and public health among the most disadvantaged populations.

[1] The authors acknowledge the participation of Diego Ruiz Adoney and Karen Madrigal for the compilation of statistical information and information transcripts for this document.

[2] Interdisciplinary University Seminar on Aging and Old Age (SUIEV), U NAM.

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[4] Institute of Worthy Aging, Secretariat of Inclusion and Social Welfare, GCDMX.

[5] Social Research Institute and Coordinator SUIEV, UNAM.

[6] This program began in 2000 with the current president of Mexico as Head of Government and recruited health advocates, women and men alike, but were on the the they got the job and over 20 years they have been maintained, now with a base position in the Government.

[7] This temporary home is Espacio TECHO (Transition between the Street and the Home), it is a temporary shelter that offers case-by-case support to people in the process of integration and social inclusion. In this temporary home, people have previously been valued at the Valuation and Channeling Center (CVC), they can continue advancing in their process of social inclusion, if required. It offers quality social services such as: social care, medical care and specialized care on a case-by-case basis, where a social worker provides accompaniment to 20 cases of people who have decided to start their process of social inclusion.

[8] **https://www.jap.cdmx.gob.mx/portal/index.php?option=com_docman&view=download&alias=3969-sintesis-de-las-medidas-de-prevencio-ny-control-frente-al-covid-19-in-asylum-or-residence & category_slug = 2020-misc & Itemid = 262 & lang = en**

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LINKS OF INTEREST

https://www.sibiso.cdmx.gob.mx/
https://web.facebook.com/SIBISOCDMX

Twitter: **@CDMX_SIBISO**
Instagram: **sibiso_cdmx**
YouTube: **SIBISO CDMX**

Belo Horizonte's pioneering community care programme for older people.

10 MARCH 2021

By Peter Lloyd-Sherlock and Karla Giacomin.

With contributions from the IHOB Belo Horizonte research team (Janaina Aredes, Poliana Carvalho, Quesia Ferreira, Joselia Firmo, Lucas Sempe).

https://corona-older.com/2020/11/24/belo-horizontes-pioneering-community-care-programme-for-older-people/

PMC: a different kind of intervention for older people.

Since 2011, the Brazilian city of Belo Horizonte has been running an innovative scheme to support care-dependent older people in disadvantaged communities: Programa Maior Cuidado (PMC – Older Person's Care Programme). The city government had been concerned about the limited capacity and sometimes very low quality of care provided by local long-term care facilities and by evidence of rapidly growing numbers of care-dependent older people living in poor neighbourhoods. Consequently, it was keen to develop a new model of community-based health and social care for these older people (Sartini and Correia, 2011).

From the outset, PMC has had a number of key features that set it apart from other community-based health and social care programmes for older people. It was developed jointly by the municipal departments of health and of social assistance, and they continue to run it in partnership. This inter-sectoral approach has been almost unheard of in Latin America, leading to service fragmentation and an abrupt disconnect between health and social care.

Local health and social assistance centres have joint teams, which meet monthly to screen new potential participants and to review existing cases. A key PMC philosophy is to consider the wider circumstances of older people and their families; not just the older person's health and functional status. This is especially relevant in the communities where PMC operates, where many families are facing multiple problems and deprivations. Their difficult circumstances affect the chances that older people will get good quality care at home and require support from social assistants as well as health workers.

A second unique element of PMC is that participating families receive support from trained PMC carers, who are recruited from

similar communities and are paid a basic wage. PMC carers work 40 hours a week, caring for between one and three families. Each family receives between 10 and 40 hours of care support a week, depending on the level of need of the older person and the family's wider situation. PMC carers have a uniform and are jointly supervised by staff from the local health and social assistance centres.

PMC carers are not expected to completely replace family care responsibility for dependent relatives. Instead, the focus is on providing primary carers some respite from what is often an exhausting 24/7 activity. At the same time, PMC carers are expected to work with family members to build their own care skills and competence. Together with the older person, the PMC carer and family agree a care plan and try to get all household members involved. As well as providing daily support, PMC carers monitor the situation of the older person and report back to the inter-sectoral case reviews.

PMC before the COVID-19 pandemic.

PMC was initially rolled out in a selection of Belo Horizonte's poorer neighbourhoods, covering 53 health centres, employing 130 PMC carers (mostly women) and reaching 550 families. Between 2011 and 2018 the number of PMC families increased, reaching 735. Each year, around 200 families would leave PMC, most frequently because the older person had died or for reasons such as their families retake care or more exceptionally their entry into a long-term care facility. They would be replaced by new families from a waiting list of applicants.

During PMC's early years, there were anecdotal reports that the scheme was operating effectively and was very popular with older people and their family carers. This encouraged us to look more closely at PMC in 2018 as part of an MRC/Brazil-funded project [1]. We were under no illusions that working with disadvantaged families in poor and sometimes violent neighbourhoods could not be easy. We also knew, from past experience, that developing effective partnerships across different government agencies was by no means simple.

We ran a series of workshops with health and social care workers involved in PMC, as well as with lay carers. Their views about PMC were overwhelmingly positive. Comments included:

"There was a woman who used to keep all sorts of rubbish in her hair –cigarette ends, bits of paper, little packets of food. Once a PMC carer started to visit her, she started to bathe herself more often and take more interest in her appearance… She had a violent life and the nephew she lived with was a drug user".

"A typical case is an older woman who needs a lot of support and lives with her husband who is also quite frail. They weren't in a position to look after themselves properly. Before they joined PMC she was admitted into hospital several times, mainly due to dehydration. PMC can prevent these unnecessary hospital admissions because the PMC carer can intervene sooner. They get in touch with the health centre which can then deal with the problem without anyone needing to be hospitalised. I think that woman would be dead by now if she weren't in PMC".

"Older people often develop a close bond with their PMC carer. This means that they sometimes share information with this person that they would avoid mentioning to a doctor. This really helps the people in the health centre to ensure they are OK".

"PMC isn't just about care for the older person: it really helps their families. And in some of these families, it's a case of one older person caring for another one".

"The daughter of one older woman told me that now they are in PMC she has time to wash her own clothes and do some things for

herself. Before that, she didn't have time for anything".

We also conducted a number of interviews with older people and families participating in PMC. Again, these were overwhelmingly positive. For example, a 92 year-old man who had multiple chronic health conditions and had been hospitalised on several occasions for failing to manage them commented that:

"She comes every day in the week and stays with me for two hours… She's with me the whole time, keeps an eye on me and chats with me. She helps me to have a bath and keeps me entertained when I need it."

His daughter and main family carer added that

"The PMC carer sets up his oxygen supply and stays with him chatting about this and that… She's always on the look-out in case there is anything different about him. She notices little things and then she'll tell me: "Look, there must be something going on with him. I'll have word with the people at the health centre."

Our evaluation of PMC is ongoing, but we have also been able to carry out quantitative analysis about how the scheme affects patterns of health service use. This analysis is based on comparisons of data for PMC families and data for other older people from the city government's Department of Health. Applying propensity score matching analysis to control for age, sex and socio-economic status, older people in PMC families are less likely to make emergency visits to health centres and more likely to make planned visits. A significantly higher proportion of health centre visits by older people in PMC were for rehabilitation and a significantly lower proportion for conditions such as uncontrolled hypertension [2]. Our work on other effects of PMC is ongoing, but the findings we have so far indicate that PMC is effective at preventing acute health episodes and in supporting older people's recovery when these episodes still occur.

Challenges and limitations of PMC before the COVID-19 pandemic.

Although our findings indicated many positive effects of PMC on older people as well as their families, our research found that the scheme was not without problems. As is the case in almost all interventions that include different government agencies, communication and coordination was not always perfect. For example, there were sometimes disagreements about the suitability of PMC carers to provide more complex care support, such as assisting with intubated feeding. Although the jointly monthly case review meetings usually worked well, there were sometimes challenges in linking into other parts of the health system. We also found some weaknesses in record keeping, a lack of documentation establishing clear roles and responsibilities for the various agencies, and inconsistent data sharing.

Sometimes the difficult social contexts in which PMC operated limited its potential effectiveness. Family members were often dealing with a wide range of challenges and were not always predisposed to care for older relatives, even with the support and encouragement of PMC carers. One informant commented:

"There's a woman with a history of frequent falls. She's blind and has Parkinson's. She lives with her children, but they are out all day. And, anyway, the children see having falls as just normal, 'an old age thing'. They have no idea about what it means to care for an older person".

Sometimes families had a confused understanding of the scheme and the role of PMC carers, such as assuming they were health professionals or, conversely, were intended to perform general housework. Also, some vulnerable older people lived alone or with people who were not present during much of the day. Since a key element of PMC is working with family carers, this begged the question whether these cases were eligible for

inclusion or whether a different scheme was needed for their specific situation.

A related issue was the policy of PMC to periodically rotate carers, so that they did not become too close to a particular family. This was often very unpopular with older people. Our 92 year-old informant commented:

"My first PMC carer stayed with me for a year and four months. I adored her. There will never be another carer like her [cries]".

His daughter added that not all carers were as good as others, a point also made by other informants, but noted that there were mechanisms to deal with this issue:

"One carer spent more time on her phone than paying attention to my father. She didn't stay with him for long, because they quickly kicked her out of the programme. I think they must have received complaints from other families".

A more general concern expressed by PMC carers, as well as health and social workers was that the capacity of the scheme to include families remained small relative to the local need. This led to long waiting lists and some older people on these lists would die before being enrolled. It also placed considerable pressure on PMC staff to identify the most urgent cases.

Despite these many challenges, our evaluation showed that PMC was generating many benefits and that there was scope to build on this experience. In early 2019 we learned of a separate international study of older people in deprived urban neighbourhoods. **[3]** This covered a network of cities, including Belo Horizonte, but not neighbourhoods where PMC was then operating. The study collected older people's views about what they thought would most improve their lives. Without prompting, the most frequent response was that they wished they lived in one of the neighbourhoods where PMC was operating.

In mid-2019, we shared our findings with representatives from the city departments of health and social assistance, as well as other stakeholders. On the basis of these findings, it was decided to substantially extend PMC into new poor neighbourhoods and to carry out some reforms of its operational and information systems. By February 2020 the number of older people included in the programme increased from 524 to 633.

Then COVID-19 hit.

PMC during the pandemic.

The first cases of COVID-19 in Belo Horizonte were reported on 8 March 2020. Like other cities in Brazil, rates of infection were thought to be especially high in more deprived neighbourhoods and older people were at particular risk of COVID-19 mortality. As such, the pandemic posed major challenges for PMC's continued operation, just at a time as its participants needed it most.

In June and July 2020 we ran a series of informal online discussion panels with PMC carers, as well as health and social assistance staff. Not surprisingly, there was a strong consensus that the previous months had been extremely challenging. Due to risks of infection, most home visits were initially suspended and efforts were made to substitute them with telephone calls and other forms of remote communication. This was far from ideal and some older people struggled to adapt to this new way of doing things, although PMC carers were still able to touch base and share information with family carers. This included keeping families updated about the status of the pandemic, official guidance and general advice, which to some extent reduced their anxiety and uncertainty. Not all home visits were suspended and PMC carers told us they had been given good access to PPE and specific COVID-19 training. This gradually enabled them to increase the number of home visits and several referred to the evident delight of older people when they were finally able to meet again. For those

cases where in-person visits were not yet possible, PMC carers mentioned that some older people had grown more comfortable with telephone support and that the conversations were lasting longer and becoming more relaxed. They had heard that some older people would spend the day next to the telephone waiting for the call from PMC.

We have not yet been able to obtain data to allow us to study specific effects of PMC on health service use, as well as COVID-19 infection and mortality during the pandemic. However, the comments from these discussion panels indicate that that the programme was able to adapt to these new challenges and, at the very least, was able to reduce the distress and enhance the mental health of these vulnerable families during a time of crisis. We have been able to observe that record keeping has improved since our evaluation in 2018, although the growth of the scheme has been put on hold. Between February and September 2020 the number of older people assisted, either in person or remotely, each month declined from 633 to 541. In other words, PMC managed to continue supporting 85 per cent of families during the pandemic. Several of the 15 per cent no longer included were older people who had died, either due to COVID-19 or other causes.

Is PMC a model for other cities?

Irrespective of the COVID-19 pandemic, many local and national governments in Brazil as well as other middle-income countries have been looking at how to address a fast-emerging policy challenge. There are growing numbers of older people with care needs, and this includes people living in deprived neighbourhoods. The wishful idea that these needs can usually be met by unsupported carers, as part of a wider context of altruistic, functional family life, is increasingly out of step with reality. Primary health care services have struggled to move away from a long-standing focus on issues like mother and child health or infectious disease control and rarely work in partnership with social work agencies. As a result, growing numbers of dependent older people experience neglect and receive inadequate care. This also leads to pressures on health services due to hospital admissions that might have been avoided.

Popular solutions being assessed or debated include facilitating the establishment of private home care agencies, repurposing primary health care staff and providing dependent older people with cash transfers exclusively used to purchase care from the private sector. [4] We feel that PMC has many advantages over these approaches, due to a number of features that are unusual, if not unique.

First, PMC pays carers a basic wage, rather than relying on community volunteers. Experiences of volunteer carer schemes in countries such as Costa Rica and Thailand show that, though they provide some support, the contributions made by carers are limited and inconsistent (Lloyd-Sherlock et al, 2017). With payment, comes an element of professionalism for PMC carers, with clear roles and responsibilities, including fixed hours and specified roles. And if they under-perform PMC carers will be removed from the programme. There are other examples of schemes in Latin America that train and pay home carers, but these are not usually integrated into wider health and social work teams.

A second point of originality is the intersectorality, which runs through all PMC operations, including joint case review meetings, combined inputs into personal care plans and communication with PMC carers. Rather than focus exclusively on the health and functional status of older people, PMC considers their wider family situations. In many PMC families this situation is far from ideal and requires more holistic forms of support. PMC has been able to sustain an effective partnership between departments of health and social assistance for nearly a decade, spanning three different local government administrations.

Inevitably, a key policy consideration is the value for money offered by schemes such as PMC. Obtaining reliable cost data for the programme is not possible, since many resources are subsumed within wider activities undertaken by health and social work staff. It is clear, however, that the lion's share of costs comes from the monthly payments to the PMC carers. Many of these carers are the only income-providers for their own families, and so this is far from a wasted investment of public funds.

PMC is not a panacea. Our research to date has not been blind to its imperfections and limitations. Nevertheless, PMC offers a valuable example to other cities in Brazil and beyond. There is a growing body of evidence showing its many beneficial effects on older people, their families, and for the PMC carers. We are continuing to study PMC, both with a view to build on its potential in Belo Horizonte and to provide evidence for other cities.

[1] MR/R024219/1: Improving the effectiveness and efficiency of Health and social care services for vulnerable Older Brazilians (IHOB).

[2] See Appendix 1 (summary of analysis).

[3] **https://wp.ufpel.edu.br/placeageproject/en/index-2/**

[4] For a recent discussion of these options in a Latin American context, see Cafagna, et al (2019).

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LINK TO APPENDIX 1

Appendix 1: Complex analysis on the effects of PMC on specific outcomes of interest, by Lucas Sempé and Peter Lloyd-Sherlock

Developing and implementing a strategy for COVID-19 and long-term care facilities for older people in the Brazilian state of Bahia (English translation).

5 NOVEMBER 2020

By Meirelayne Duarte [a,b], Monica Frank [a,b], Janine Soub [b,c], Helena Patáro [b,c], Júlia Costa [b,c], Diana Oliveira [b,c].

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https://corona-older.com/2020/11/05/developing-and-implementing-a-strategy-for-covid-19-and-long-term-care-facilities-for-older-people-in-the-brazilian-state-of-bahia/

Brazil has 27 states, grouped in five regions: the North, Northeast, Southeast, South and Midwest. Bahia is the largest state in the Northeast, with 417 municipalities and an estimated population of 15 million. The state capital, Salvador, has approximately three million inhabitants. The Brazilian Institute of Geography and Statistics estimates that people aged 60 or more make up 14% of the population of Bahia and 17% of the population of Salvador.

In recent decades, some public policies for older people have been implemented in Brazil. However there are still many gaps, especially with regard to Long-Term Care Facilities (LTCFs). The Covid-19 pandemic, with a high lethality rate in LTCFs across of the world, signalled the need for new emergency strategies to protect this vulnerable population.

In this context, the INTERSECTORIAL COMMITTEE ON MONITORING LTCFs IN THE STATE OF BAHIA was established by the Health Department of the State of Bahia (SESAB) Ordinance 133 on April 3, 2020. It consists of representatives of SESAB, the Secretariat of Justice, Human Rights and Social Development and the Federal University of Bahia. The Commission aims to monitor health actions at LTCFs, in order to intervene and advise on the care for the people who live there, in the face of the Covid-19 pandemic.

The Commission is managed by the State Reference Centre for Older People's Health Care. It has six work-teams, linked to SESAB's Care Management Directorate. Four teams systematically monitor every LTCFs every 72 hours. One team provides daily monitoring of LTCFs with symptomatic/positive cases. A technical-operational team supports coordination between municipal and state agencies in areas such as testing and hospital referrals.

Mapping of local LTCFs was based on information provided by the State Health Surveillance agency, as well as local health

and social assistance managers and a national Social Assistance register of facilities. Although several agencies had lists of LTCFs, these all had discrepancies and sometimes duplicated data. Therefore, a priority action was to analyse these lists, checking for duplicates and errors. This work was essential for the compilation of a single list of LTCFs. This is now a shared reference list for all agencies involved. In the case of LTCFs where attempts to make contact (by phone or e-mail) were unsuccessful, the support team contacts the Directorate of Primary Care to request updated information from managers working at the municipal level.

The Commission monitors any institutional setting that contains at least one older person. These include care facilities that do not exclusively contain older residents, as well as emergency shelters. These institutions are not legally defined as LTCFs by the National Health Surveillance Agency ((RDC 286/2005 of).

By 6 October 2020, 200 LTCFs had been mapped across 83 (20%) of the 417 municipalities in the state of Bahia. All were being monitored by the Commission's teams, representing 5,154 older residents. Four of these LTCFs have so far closed in the course of the pandemic. Of the remaining 196, 75 are in the municipality of Salvador, housing 1,923 older people.

By 6 October 2020, 152 LTCFs (76%) had been included in daily follow-ups, due to suspected/ confirmed cases of Covid-19 among residents/employees, with a total of 1,033 confirmed cases in the residents (20% of all residents). By this date, 2.3% of the population of LTCFs in the state of Bahia had died from Covid-19, and the case fatality rate for this population was 11.2%.

These levels of morbidity and mortality in LTCFs in Bahia are well below those described in other regions of the world. They can be explained by, among other factors, the monitoring and interventions promoted by the Commission. This included:

- Mapping all LTCFs in Bahia State;
- Emailing all LTCFs documents with guidance for managers and staff (Annex A);
- Developing an electronic monitoring form for each LTCF, managed by telephone contact every 72 hours and every 24 hours for LTCFs with suspected/ confirmed cases of Covid-19;
- Production of video classes with educational guidelines;
- Holding a meeting with the State Civil Defence Agency to estimate the need for basic food parcels and hygiene kits to be delivered to the LTCFs;
- Conducting web conferences with municipal health managers and LTCFs in partnership with Telessaúde [Tele-Health] Bahia (Annex B) and with the support of the Brazilian Society of Geriatrics and Gerontology (Bahia Branch);
- Developing strategies for epidemiological and health surveillance with municipal health departments;
- Developing with municipal agencies new health actions in collaboration with social assistance;
- Coordination across municipal social assistance secretariats, the Ministry of Public Affairs, the Public Defender's Office and the Council for the Rights of Older People;
- Working with the SESAB Central Public Health Laboratory to provide testing for older people in LTCFs and with the supply of testing kits to local municipalities;
- Preparing flowcharts for LTCFs with: a) guidance for managing Covid-19 risk for older residents; b) risk classification for older residents, based on notions of therapeutic proportionality; c) testing of residents' contact persons; d) hospital transfer of residents tested positive;
- Meetings with representatives of the State Operational Health Committee to support technical and scientific alignment of the different forms of LTCF support proposed by the Commission;

- Holding web conferences with the president of the National Front for the Strengthening of LTCFs [this is a national network of academics and other stakeholders interested in supporting LTCFs during the pandemic, see **https://www.frentenacionalilpi.com.br/**], to align our emergency plans, to update our clinical-care protocols and to develop a tele-education intervention with 150 Bahian LTCFs;
- Participation in web conferences to monitor LTCFs in four local municipalities as part of a specific project funded by Banco Itaú;
- Participation in a public hearing on LTCFs held by the Municipality of Salvador on ILPIs.

ANNEX A – GUIDANCE DOCUMENTS SENT TO LTCFS

1. Nota Técnica 27/2020 COE/SESAB. Available at **http://www.saude.ba.gov.br/wp-content/uploads/2020/04/NT-n%C2%BA-53-de-06.04.2020-Orientacoes-Gerais-Trabalhadores-no-enfrentamento-a-pandemia-ATUALIZADA-EM-27-DE-ABRIL-DE-2020.pdf**
2. Nota Técnica 09/2020 -COSAPI/CGCIVI/DAPES/SAPS/MS; Available at **https://idoso.mppr.mp.br/arquivos/File/ILPI_NT_N_9_2020_COSAPI_CGCIVI_DAPES_SAPS_MS.pdf**
3. Nota Técnica 23/2020-SAPS/GAB/SAPS/MS; Available at **http://189.28.128.100/dab/docs/portaldab/documentos/nt_23_2020_SAPS_GAB_SAPS_MS.pdf**
4. Portaria 65, de 06 demaio de 2020, do Ministério da Cidadania; Available at **https://www.in.gov.br/web/dou/-/portaria-n-65-de-6-de-maio-de-2020-255614645**
5. Relatório da Frente Nacional de Fortalecimento das ILPIs; Available at **http://www.ampid.org.br/v1/wp-content/uploads/2020/04/Relato%CC%81rio-final-1.pdf**

ANNEX B – WEB CONFERENCE

Plantão Coronavírus: orientações gerais para o cuidado da pessoa idosa. Available at **https://www.youtube.com/watch?v=brWaZIhi5aM**

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Care homes and coronavirus in Thailand: How long will they remain unscathed?

13 MAY 2020

By Siriphan Sasat, Aree Sanee and Peter Lloyd-Sherlock.

https://corona-older.com/2020/05/13/care-homes-and-coronavirus-in-thailand-how-long-will-they-remain-unscathed/

The evolution of the pandemic in Thailand up to early May 2020

The first reported case of Covid-19 in Thailand was in mid-January 2020: a 61-year-old woman returning from China. Later that month, the first confirmed case of community transmission was reported: a taxi driver who had frequent contact with foreign visitors. Initial restrictions on social contacts were quite limited and large gatherings were sometimes still permitted (including a Thai boxing stadium event on 6 March). This led to a rapid increase in the number of daily reported cases, which peaked at 188 on 22 March.

Since early March, a series of government measures have been rolled out, including bans on large gatherings for sporting events or other purposes and the closure of bars and restaurants. These measures coincided with a rapid fall in the numbers of reported daily infections. By 7 May the total number of reported cases stood at 3,004 and deaths attributed to Covid-19 at 56. In the light of this apparent success in keeping the pandemic in check, some lockdown measures are now being gradually relaxed.

Residential long-term care in Thailand before the pandemic

A detailed study on care homes in Bangkok, based on fieldwork conducted in 2019 is available here.

The study notes that there is no unified government register or list of care homes, which means that information about the sector is very limited and unsystematic. The city of Bangkok contains two government-run care homes, with a combined capacity of 350 people. These government homes operate to some extent as shelters for indigent older people and do not admit people with pre-existing functional impairments. A small number of care homes are also operated by NGOs and religious organisations. However,

the care home sector is dominated by private for-profit providers. Some of these run expensive facilities comparable to those in high-income countries. But there is also evidence of rapidly growing numbers of more informal, small-scale facilities. According to local key informants:

> "There are thousands of them. You can find them at every corner of Bangkok." And "There are places set up by non-experts who lack professional knowledge… It's unclear who is responsible for registration or control."

Responsibility for care home regulation is divided across different government departments and there are no official standards or service guidelines for the sector. Private providers for-profit organisations are, theoretically, under the regulatory authority of the Ministry of Commerce for tax purposes. Draft guidelines have been developed by the Ministry of Public Health, but are yet to be made into law.

Pandemic preparations in care homes

The fieldwork, analysis and drafting of this paper were completed before the onset of the Covid-19 pandemic. Nevertheless, many of the findings have direct implications for responses to this new challenge in Thailand's complex residential long-term care sector.

The limitations of state regulation and the absence of effective information and quality assurance systems have hampered the development of effective policy responses. Independently of the fieldwork conducted for this paper, in late April 2020 informal discussions were held with a small number of staff and directors in public and private residential facilities. In all private facilities, interviewees commented that no government guidance or advice for care homes had been made available to them. In the absence of guidance in Thai, several had resorted to translating guidance provided in English from the World Health Organisation and other sources. At the time of these interviews, private care home respondents reported there had been no specific contact with government agencies about the pandemic. In early May, the first set of official guidance was provided to government-run providers, but, to our knowledge, this has not been shared with NGOs or privately-run care homes.

In the absence of official guidance or support, the care homes we spoke to were taking matters into their own hands by adopting a number of emergency measures. Directors were acutely aware of how much the pandemic has affected care homes in high-income countries, where regulations, facilities and standards are generally much better.

Immediate responses have included, in some cases: improvements to hygiene, temperature screening, asking staff to move into the facility and to refrain from leaving, and postponing resident visits to hospitals and health centres. Respondents informed us that they had very little access to PPE or other protective equipment and that the situation was becoming increasingly tense and stressful for both the staff and for the residents.

To date, despite these concerns, there has not been a single reported case of Covid-19 infection in a care home anywhere in Thailand. There are, however, no grounds for complacency and it may well be just a matter of time until this situation quickly changes. As is true in many developing countries, past and ongoing policy neglect of residential LTC providers have left their residents and staff in an acutely vulnerable position

Note: The first Thai guidance for COVID -19 for care homes was released yesterday (12 May 2020). It is a collaboration between the Department of Health Service Support, Ministry of Public Health, and Department of Older Person, Ministry of Social Development and Human Security.

COVID-19: How Pakistan's old age homes are coping with the outbreak.

6 MAY 2020

In the fight against the mysterious contagion known as COVID-19, not everyone faces the same peril — a few stand to lose more than others.

It has now been widely accepted that factors such as immunity, age and general exposure have a definite role in who is more susceptible to contracting the disease.

Among places where extra vigilance is required to ensure the well-being of people, are old age homes where most residents, given their advanced age and failing health, are strong candidates for the pathogen.

The owner of one such old-age home, Salim Gill, said his team is going the whole nine yards in order to ensure that all precautionary measures are strictly followed within the shelter's premises.

He has been running Gills Shelter since 2008.

"We have stopped taking any new admissions at the moment since we don't want the place to be overcrowded," said Gill, stressing that hygiene and sterility always remain their top priority.

Other steps, such as reducing the number of residents per room, provision of masks and other safety kits — especially to those who suffer certain respiratory disorders — are also ensured by the management, he added.

When asked about the set meeting hours for family members, Gill said that given the present circumstances, the management has requested family members to contact their loved ones housed at the shelter home through phone or to maintain virtual contact through video calls or voice notes.

"We have also prohibited entry to any outsider during these days of the crisis," said Gill, adding that "an ounce of prevention is better than a pound of cure".

https://corona-older.com/2020/05/06/covid-19-how-pakistans-old-age-homes-are-coping-with-the-outbreak/

The snowball effect

Gill, while sharing his concerns on how the elderly are predisposed to catching the disease owing to their age, said that residents at the shelter are "already grappling with a number of health issues".

"Exposure to the contagious disease would exhaust their immune systems which with the passage of time are already deteriorating," he said.

Meanwhile, over at Darul Sakoon, which is a shelter for the homeless open to all ages, a social media campaign has been rolled out.

"In order to stem the spread of coronavirus among senior citizens, we have initiated social media campaigns edifying on the 'do's and don'ts' of dealing with the disease," said Enna

Daniel, who is currently serving as a branch manager at the non-profit.

"With laxity and misinformation, we can only worsen things for those who already have a lot relying on their immune systems," she added.

In this regard, Darul Sukoon has halted all its recreational activities and has issued directives for physiotherapists to conduct their sessions only for crucial patients — that too with extreme prudence and care.

"Since most of our residents are ones who were abandoned by their families, or have no one left in the world, we don't have any visitors as such. However, we used to host a number of students, volunteers and other delegations, which has now been put on hold as per our safety measures," said Daniel.

'No facilitation from the government yet'

The manager regretted that the government has not issued any particular Standard Operating Procedures (SOPs) for old age homes. "In fact, we have not been contacted for masks and safety kits either, given that we need them now more than ever," she said.

"Left with no other choice, we were compelled to buy overpriced masks," she rued.

Putting similar concerns forward, Gill said: "I have been in touch with the management of other shelter homes and none of us has received word from the officials as yet."

"However, earlier this month, the government issued a health advisory for the safety of citizens living in shelter homes across the country," he said. Gill said noted, adding that most shelter home residents are capable of looking after themselves, unlike old age homes where residents need looking after and without care, risks are doubled.

"The government somehow missed the most vulnerable fraction [of the population]," he remarked.

On the other hand, a representative from the Anmol old age home in Karachi said that a team of Rangers had visited the facility a few days back and had handed out masks and sanitisers to the residents.

"They [Rangers' team] also sprayed antiseptics to ensure sterility and cleanliness inside the premises," he added.

'Remember, we leave no one behind'

According to a statement by the World Health Organisation: "… All communities must be supported to deliver interventions to ensure older people have what they need. This support includes safe access to nutritious food, basic supplies, money and medicine to support physical health and access to social and mental health support and information to maintaining emotional well-being. All older people should be treated with respect and dignity during these times. Remember, we leave no one behind."

Health experts around the globe have highlighted the need to take timely measures

to mitigate the losses incurred due to the disease. A strict lockdown and government support is vital to shield the vulnerable in nursing homes, shelter homes and old age homes alike.

According to an estimate by the UN Population Fund (UNFPA), Pakistan will have 43.3 million elderly by 2025. Experts reckon the actual figure could rise even more due to better life expectancy.

Even though a study published in the Pakistan Journal of Public Health concluded that a majority of the elderly "didn't feel secure in leaving their home and living in a home with strangers", the same study found that old age homes are preferred by people with chronic diseases or living alone.

With an expected rise in Pakistan's ageing population and no signs of the pandemic letting up any time soon, old age and shelter homes are in for a rough ride without government support.

"We are doing our best to protect our residents from the disease. However, we might not be able to continue [to keep our residents protected] if the authorities don't step up to facilitate us," admitted Daniel.

This story was first published on GeoTV and can be accessed here

Letter from South Korea: COVID-19 response and questions on quality long-term care for older adults.

28 APRIL 2020

By Sanghwa Lee, International Initiative for Impact Evaluation (3ie).

https://corona-older.com/2020/04/28/letter-from-south-korea-covid-19-response-and-questions-on-quality-long-term-care-for-older-adults/

South Korea had its first case of COVID-19 on January 20, 2020, from a Chinese citizen returning from Wuhan, China [1]. Upon her arrival at the airport, she showed suspicious symptoms and was moved to Incheon Medical Centre, one of several nationally designated hospitals for the COVID-19 response. A month later, there was a sudden mass infection of over 6,000 people in Daegu, in part because of gatherings at the Shincheonji Church of Jesus. Despite this mass event, within three months infection rates have stabilised at 10 or fewer cases a day of whom over 80% had recovered by the end of April 2020 [2]. How South Korea has responded to the pandemic may provide some insights for other countries.

Special measures to support older people and other vulnerable groups

During the 2009 A/H1N1influenza pandemic, there were evident shortages of primary facilities and hospitals which could deal with the condition and this became a high-profile political issue. Subsequently, the national government developed a new network of 'nationally-designated hospitals', including outpatient and inpatient facilities with dedicated infectious disease prevention and care units. These hospitals provide care for patients with respiratory problems during normal times and serve as national quarantine hospitals for patients with pandemic-related infectious diseases during crises [3]. As well as additional financial support and incentives for medical facilities and staff, the government targeted groups seen as more vulnerable to the virus, including older people.

This support includes reductions in debts, a monthly allowance and emergency vouchers [4]. Seoul's city government has developed new older people-focused care services, including real-time personalized care, a rapid reporting system, and changes to how some services are delivered to older people. To date, there have been no recorded infections among older people and carers covered by these new initiatives [5].

In health facilities, in-patient beds have been prioritized for people more vulnerable to the virus and who have moderate to severe symptoms [6]. The government covers in-patient and treatment costs for confirmed patients, as well as the costs of diagnostic tests for suspected cases [6]. Mild or asymptomatic confirmed cases who have been discharged from hospitals but who find it difficult to get treatment at home can stay at Living and Treatment Centers, Community Treatment Centers which offer 24/7 monitoring and medical support [6].

Mass, indiscriminate testing to identify people infected with COVID-19

Mass testing did not lead to a health system breakdown. Instead, it helped greatly to identify people infected with COVID-19, including asymptomatic carriers. This permitted speedy management of the crisis before community transmission became widespread [7]. Time and cost-efficient testing systems were implemented, including Drive-thru and Walk-thru testing sites, which other countries such as the US and Japan have since started to adopt.

FIGURE 1 – Drive-Thru and Walk Thru COVID-19 testing sites in South Korea.

Source: Central Disaster Management Headquarters & Central Disease Control Headquarters. (2020). Patient treatment and management. http://ncov.mohw.go.kr/baroView2.do?brdId=4&brdGubun=42

A principal of openness, freedom of movement, and transparency

"To contain the virus, you have to contain people's movement. … Our default approach has from the very beginning been to respect people's right to freedom of movement and then to implement measures that are necessary and proportionate to the need to manage risk. Our measures have adapted to the evolving nature of this challenge, but this principle of openness has been preserved to the very best of our abilities." – Kang Kyung-Wha, South Korea's Foreign Minister **[8]**

While letting people move freely, the government has focussed on identifying and quickly treating people infected with COVID-19. If there is a newly infected COVID-19 patient, the central and local governments track his/her source of infection and isolate their contacts through rapid epidemiological investigations. Private data are carefully managed, as the media and civil society are accustomed to holding the government to account, due to decades of mobilising for democratization.

Remaining tasks: improving the quality of LTC facilities for older people

While South Korea appears to have managed the crisis in a speedy and appropriate manner, there are still some issues of concern for older people. These include quality control of long-term care facilities. Around 60% of deaths due to COVID-19 in South Korea have been caused by mass infections **[9]**, which occurred mostly at care facilities. For example, Daesil care facility in Dalseong-gun has had 100 confirmed cases **[10]**. These cases to some extent reveal pre-existing problems of quality and management in LTC facilities in South Korea. The government has now taken measures to strengthen quarantine and care management at these facilities **[11]**. The mass infection of older people at LTC facilities could have been prevented, however, if the existing quality issues **[12]** had been properly addressed before the pandemic.

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COVID19 in Kerala: Grassroots responses, state initiatives and an inspirational care home initiative.

23 APRIL 2020

By Nadeem Ahmed Moonakal, Dr Dhanasree Jayaram and Dr Peter Lloyd-Sherlock.

https://corona-older.com/2020/04/23/covid19-in-kerala-grassroots-responses-state-initiatives-and-an-inspirational-care-home-initiative/

The state of Kerala, in southern India, has long been recognised as exceptional, in terms of its successful approach to human and social development. Experts in international development refer to the "Kerala Model", which has achieved higher levels of gender equality, and access to health and education than more affluent regions.

It is not entirely surprising that Kerala has, to date at least, appeared to have been relatively successful in meeting the new challenges of the COVID-19 pandemic. In March, Kerala had the highest number of COVID-19 positive cases in India: it is now ranked tenth (as of April 22). Of course, it is too early to say that Kerala has **flattened the curve**, as the numbers of recoveries and freshly infected cases are varying every day.

Experts attribute Kerala's relative success to a decentralised healthcare system, as well as a strong tradition of primary health care in rural areas and high rates of female literacy. Additionally, Kerala has a very strong tradition of public action by grassroots organisations, which have been actively engaged in past crises -most recently the 2018/19 floods.

Population ageing in Kerala

Kerala is **ageing faster** than any other Indian state. In 2011, 13 per cent of the population were aged 60 or over. A higher proportion of older people live alone in Kerala than in other parts of India, since rates of labour migration of younger family members are especially high. Kerala was one of the first Indian states to introduce an 'Old Age Policy' in 2006, and this was upgraded in 2013's **'State Old Age Policy'**.

Before the COVID-19 pandemic, initiatives included the **Age-Friendly Panchayat** scheme which aimed to transform all panchayats (village councils) into age-friendly ones and the ***Vayomithram*** scheme which extended the state's well-developed primary health services to meet the needs of older people. These

programmes supplement central government schemes, such as the **National Old Age Pension Scheme** (for people aged over 59 below the poverty line).

The arrival of COVID-19 in Kerala

The first wave of cases in Kerala entailed the successful recovery of three **infected students** who had returned from Wuhan, China. There is no evidence that this led to secondary infections or related deaths.

A second wave began with the return of three members of a family from Italy to Kerala's Pathanamthitta district. It was clear that secondary infections were unavoidable since the **family had visited many places** before being tested. Among the recorded secondary infections are a **93-year-old man husband and his 88-year-old wife**. Despite having illnesses such as diabetes and hypertension, the couple survived. This boosted the confidence of Kerala's healthcare authorities and workers, particularly since more infections quickly began to appear across the state.

More than the pandemic itself, measures adopted by the central and state governments such as lockdowns have affected older people immensely. The provision of essential supplies, non-COVID-19 related medical support, and social/psychological support systems have all been disrupted. When the lockdown was announced, the state government took a few prompt measures and some were joint with civil society groups and non-governmental organisations. Working with Anganwadi (centres providing care for mothers and young children in rural areas) state workers and village officials have rapidly collected information about older people's general circumstances and health status. Specific measures have included advancing the distribution of **social pensions**, food aid and medicines to vulnerable older people through a new **Senior Citizen Cell** scheme.

Lockdowns and care homes

In a state where the **number of old age homes** has skyrocketed in the past decades, these institutions play a huge role in safeguarding the lives of its older population. Government-run homes have conducted disinfection programmes with the help of local fire brigades and have installed additional washbasins. To enhance the immunity of residents, dietary changes have been made, including providing more fruits and vegetables.

Residents of old age homes across the state are being encouraged to engage in recreational activities, including new yoga classes and the acquisition of books and newspapers. In the Kannur district government care home, a resident provides weekly briefings about the situation to fellow residents, through an in-house public address system. Advice and comments from medical practitioners and healthcare experts are also shared through this mechanism.

> Kannur district is one of the biggest COVID-19 hotspots in Kerala, with over **100 positive cases** as of April 22. Hence, lockdown-related measures have been extremely stringent there, with special measures in care homes. Despite these restrictions, the Kannur district government care home has succeeded in establishing an unusual and inspiring new activity: the development of an in-house hand-wash production facility. As well as being used in the home, this hand-wash is now provided to other organisations across the state. According to Mohanan Bharghavan, Superintendent of the home, "The in-house hand wash manufacturing programme motivates the residents to engage with society, and this helps in mainstreaming the rehabilitation process."

This is only one of several positive stories that have emerged out of Kerala in these distressing times. All the stakeholders in the

state at different levels of governance are proposing and implementing new measures for older people.

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COVID19: ensuring care homes in low and middle-income countries are prepared for the pandemic.

15 APRIL 2020

This blog was written by Dr Peter Lloyd-Sherlock, Professor of Social Policy and International Development at UEA, as a response to an Editorial posted on *The BMJ* – COVID-19: why we need a national health and social care service

https://corona-older.com/2020/04/15/covid19-ensuring-care-homes-in-low-and-middle-income-countries-are-prepared-for-the-pandemic/

Dear Editor

In high-income countries, concerns about large numbers of COVID-19 deaths in residential long-term facilities (LTFs) have been widely documented in the media and emerging academic literature [1]. It is likely that low and middle-income countries (LMICs) will eventually account for the majority of associated mortality, and, just as in high-income countries, deaths will be strongly concentrated among the oldest age groups [2].

The international literature and media have made virtually no reference to the specific risks posed to residents and staff based in similar facilities in LMICs. This reflects a general misconception that almost no older people in LMICs live in LTFS, reflecting strong social norms of intergenerational support and the wide availability of unpaid, largely female, family care [3].

Yet this is not the reality in many LMICs, especially in large urban centres. In Argentina, for example, the National Association of Long-Term Care Providers estimated that there were around 6,000 LTFs operating in the country in 2010 [4]. Many of these care homes operate informally, outside or on the fringes of legality, and subject to little if any regulation or quality assurance. Similar findings have been reported in other LMICs [5 and 6]. Responsibility is often divided between different local government departments (typically health and social development). There is growing evidence that conditions are often very poor and single bedrooms are a rare exception. These LTFs represent a very high-risk environment for COVID-19 infection.

Some national and regional agencies are seeking to develop guidance for COVID-19 management in LTFs [7]. The World Health Organisation has provided some useful technical guidance for LTFs [8], but this is not always appropriate to the needs of many facilities, even in high-income countries, due to resources and space constraints

[9]. Regardless of guideline suitability, the limited capacity of official regulators will reduce scope to implement or enforce them. There is emerging evidence from the field of widespread misinformation and inappropriate responses in these settings. We have received reports of LTFs which are yet to develop infection control protocols and other facilities which are denying family members all contact with or updates about residents (few of whom have access to telephones or computers).

There is an urgent need to rapidly upgrade the capacity of government agencies responsible for regulating LTFs in LMICs and to strengthen coordination when responsibilities are split. Where many LTFs are run on an informal, illegal basis, there may be a strong case to offer these facilities guaranteed amnesties from prosecution in exchange for cooperation in responding to the pandemic. There are precedents with previous collaborations between public health entities and illegal brothels to improve control of HIV and other sexually transmitted infections [10]. Also, regulators should hold urgent meetings with local LTF managers and civil society organisations representing the interests of older people, to ensure that key stakeholders participate in the development of local strategies. Where feasible, civil society organisations should seek to rapidly map LTFs and monitor in their locales, since many may not be on official registers. There is some evidence that this can be effective when deployed in combination with social media and online platforms [11].

More generally, across LMICS there is a need to overcome widespread denial about growing numbers of LTFs and the low quality of care they sometimes provide. The current crisis may represent an opportunity to increase the profile of this issue among policy-makers and to develop effective regulation.

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Part Five
Miscellaneous

‘Count Me In’. The role and contributions of older people during Covid-19; Reflections from Pakistan.

5 JUNE 2021

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https://corona-older.com/2021/06/05/count-me-in-the-role-and-contributions-of-older-people-during-covid-19-reflections-from-pakistan/

Pakistan is the sixth most populous country in the world and is projected to be the third most populous by 2050. Its population aged 60 and over was 14.9 million in 2020 and is projected to reach 40.6 million by 2050 (UN Population Division, 2021). Official sources report that there had been 20,000 deaths attributable to COVID-19 by 21 May 2021 (Worldometers, 2021), but this is likely to be a substantial underestimate of the real levels of COVID-19 mortality (Ahmed, 2021). As in India, the country is now experiencing a pronounced second wave. According to the Ministry of Health, people aged 60 or more account for around 40% of the total number of COVID-19 inpatients (Bureau of Statistics, 2020). Although older people are a priority group for vaccination, progress to date has been very slow, with only 1.7 per cent of the population receiving at least one dose by 20 May 2021 (https://covid.gov.pk/stats/pakistan). It is important to speed up the vaccination roll-out in Pakistan to safeguard older people and to ease pressure on the health system.

COVID-19 has given rise to economic insecurity especially for those older people who were previously working informally and in small businesses, and depended on these for their livelihoods. These small businesses have been strongly hit by COVID-19 (Ayesha, 2021). Only around 20 per cent of people aged 60 or more in Pakistan receive any form of old age pension (Qureshi, 2021).

Consequently, the most important institution that supports and provides services to older people in Pakistan remains the “Joint Family System” (Khan, 2014). It is claimed that older people in Pakistan who are embedded within this joint family system focus on religious activities and spending time with grandchildren. As part of this, their contributions towards infant care, family patronage and helping with household chores are significant. Other social activities like providing volunteer services for public welfare by retired health care professionals, both male and female, have been widely observed

during the COVID-19 pandemic (Geo TV, 2021). Field observations demonstrate that in family structures where partners are working as front line medical staff, grandparents have stepped up to provide additional childcare (Ayesha, 2021). Similarly, many retired medical professionals including doctors, nurses, midwives, community health workers and social workers have returned to work on a voluntary basis.

Some countries have given older people a lower priority for COVID-19 vaccination due to claims that they make few, if any, social or economic contributions. Of course, vaccination should be a human right and those at most risk of dying must come first. Nevertheless, the available evidence from Pakistan demonstrates the many important contributions made by a substantial proportion of its older population.

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The direct and indirect effects of the COVID-19 pandemic on older people in low and middle-income countries: One year on.

4 MAY 2021

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https://corona-older.com/2021/05/04/the-direct-and-indirect-effects-of-the-covid-19-pandemic-on-older-people-in-low-and-middle-income-countries-one-year-on/

In March 2020, the BMJ published a comment on the potential effects that the COVID-19 pandemic might have on older adults in low and middle-income countries (LMICs) [1]. This predicted that older people in LMICs would account for a large share of COVID-19 mortality, since these countries contain around 70 per cent of the global population aged 60 or more and there is less access to effective health interventions than in high-income countries. It also predicted that older people in LMICs would be particularly affected by the indirect effects of the pandemic on their health, economic and social status.

One year later, it is instructive to evaluate these predictions. We review available data on both the direct and less direct effects of the pandemic on older people in LMICs. Given the diversity of national experience, we focus on three specific countries, selected because they have had the highest number of reported COVID-19 deaths in their respective regions: Brazil (Latin America), India (Asia) and South Africa (Africa).

Mortality of older people in LMICs during the COVID-19 pandemic.

Figure 1 shows that Asia, Africa, and South America accounted for 38.2 per cent of total reported global COVID-19 deaths by 3 March 2021. If Mexico (which is not part of South America) is added to these regions, the global share increases to 45.6 per cent. These data are likely to under-state the share of global COVID-19 deaths in LMICs, due to problems in diagnosis, attributing cause of death, inconsistent definitions of COVID deaths, as well as incomplete mortality registration [2], an interpretation is supported by studies of overall excess mortality, which find a larger differential with reported COVID-19 deaths than in high-income countries [3]. It is therefore reasonable to assume that LMICs account

for the majority of global COVID-19 deaths. This share is likely to grow as unequal access to vaccination means mortality becomes increasingly concentrated in these LMICs.

FIGURE 1 – Global shares of reported COVID-19 mortality as of 9 March 2021.

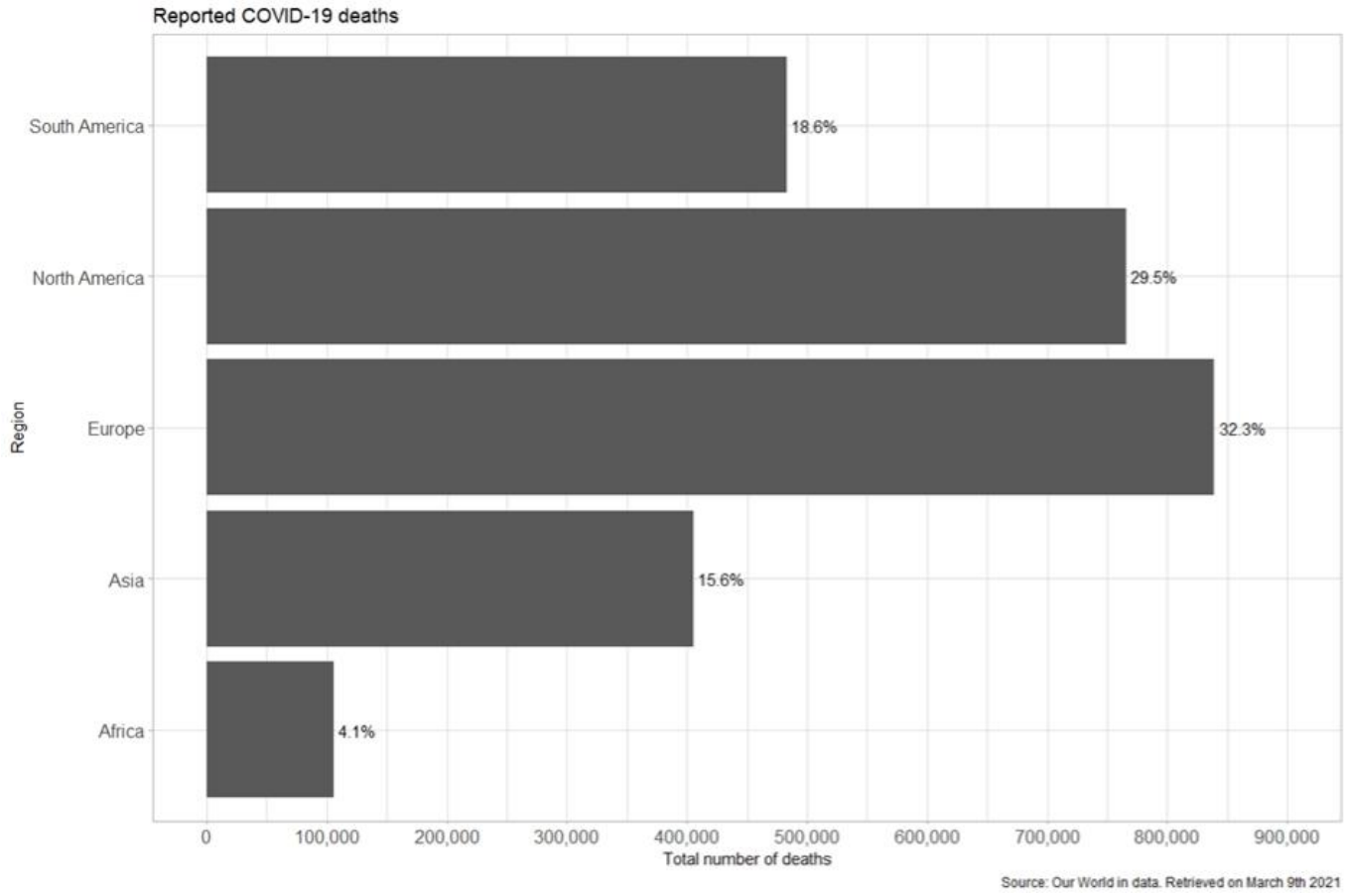

Table 1 presents available national data on reported COVID-19 mortality for all ages and people aged 60 or more among LMICs reporting at least 20,000 COVID-19 deaths by 3 March 2021. Iran does not publish age-disaggregated data and three other countries are yet to do so in 2021. Moreover the robustness of this information has been questioned in some countries that do regularly publish age-specific data, such as Mexico [4]. Consequently, the reliability of these data is limited. Table 1 shows the share of reported COVID-19 deaths occurring among people aged 60 or more ranged from 40.1 per cent in Indonesia to 84.5 per cent in Chile. In six of the 11 countries for which data are available, people aged 60 or more accounted for over three-quarters of deaths.

Table 2 presents estimates of excess mortality for Brazil and South Africa. There are no published national estimates of excess mortality during the COVID-19 pandemic for India. In Brazil, the number of all-age excess deaths was around double the number of reported COVID-19 deaths over the same period; in South Africa it was around treble. Separate data show gaps between excess and reported COVID-19 deaths are larger in South African provinces with lower rates of COVID-19 testing [5]. Together, these findings suggests that many COVID-19 deaths have gone unreported and that a large share of these deaths occurred at older ages.

TABLE 1 – Reported COVID-19 mortality, all-ages and people aged 60 or more, selected LMICs. Most recent data available by 3 March 2021.

Country	All-age	Population aged 60 or more	Population aged 60 or more as % of all-age	Date of most recent data for population aged 60 or more
Argentina	52546	44146	84.0	2/26/2021
Brazil	371208	275400	74.2	4/19/2021
Chile	20346	17202	84.5	2/20/2021
Colombia	78263	61654	78.8	4/20/2021
India	100875	55869	55.4	10/2/2020
Iran *	69574	N.D.		4/25/2021
Indonesia	20102	8070	40.1	12/21/2020
Mexico	190604	120698	63.3	3/7/2021
Peru	57537	39749	69.1	4/18/2021
South Africa	2413	1337	55.4	6/27/2020
Turkey	9799	8089	82.6	10/26/2020
Ukraine	41931	33422	79.7	4/19/2021
United States	545750	478420	87.7	2021-04-10
United Kingdom	148221	138345	93.3	2021-03-19

Source: COVerAGE-DB (all countries other than *); For Iran: Max Roser, Hannah Ritchie, Esteban Ortiz-Ospina and Joe Hasell (2020) – "Coronavirus Pandemic (COVID-19)".

TABLE 2 – Estimates of excess mortality for Brazil and South Africa.

	Estimated excess mortality			
	Period of estimate (start and end date)	All ages	Population aged 60 or more	Population aged 60 or more as % of all-age
Brazil	15 March 2020 to 6 June 2020	62,490	44,546	71.3
South Africa	3 May 2020 to 6 February 2021	137,731	103,748	75.3

Source: https://www.vitalstrategies.org/resources/excess-mortality-in-brazil-a-detailed-description-of-trends-in-mortality-during-the-covid-19-pan-

Indirect effects of the COVID-19 pandemic on older people in LMICs.

Economic and social effects.

As for people of all ages, lockdowns and other restrictions on normal activities affect the social and economic status of older adults in many ways. The timing and rigour of lockdowns has varied across LMICs. In some, lockdowns have not distinguished between older adults and other people, while in others they have. In South Africa, a comprehensive lockdown for people of all ages was strictly enforced between late March and early May 2020. As the lockdown was relaxed, specific restrictions on people aged 60 or more were introduced, including a requirement to work from home whenever this was feasible. In India a strict national lockdown was implemented over a similar period, followed by more localised measures. In Brazil, lockdown measures were briefly adopted by local governments during April and May 2020 and re-established in January 2021 in response to a second pandemic wave. In parts of Brazil, this included specific restrictions on older people, such as only leaving home for urgent, unavoidable reasons. One supposed justification for age-specific lockdowns is that they do not affect people of "working age". However, a high proportion of poor older people in LMICs remain economically active, and there is evidence that heavy-handed lockdowns can disrupt their livelihoods, as well as limit access to services and deepen social isolation [6].

In 2018 only around 20 per cent of people aged 60 or more in LMICs received regular monthly pensions [7]. Limited social protection will have increased the economic impacts of the pandemic. A survey of older people in India found 65 per cent reported that their economic situation had deteriorated substantially during the lockdown [6]. Unusually, both South Africa and Brazil have pension systems providing monthly cash benefits of at least US$124 (South Africa) and US$190 (Brazil) to the majority of older citizens. During the pandemic, both countries have offered pensioners additional emergency payments. However, there is evidence of older people being coerced to share pensions with other relatives, as family livelihoods come under growing strain [8].

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A lower proportion of older people live alone in LMICs than is usually the case in high-income countries. This may limit social isolation during lockdown, but (in contexts of crowded, substandard housing and family stress) it may also increase exposure to abuse and infection. A survey of 5,000 older people across India found 56 per cent claimed they suffered at least one form of abuse and most reported this had worsened since the start of lockdown [9]. In South Africa, older grandparents have maintained caregiving roles in multigenerational households, despite health risks [10].

Access to health services.

Scarce hospital resources in LMICs have limited the access of all age groups to effective treatment for acute COVID-19; specific discrimination against older people has not attracted particular attention even though guidelines and protocols in South Africa present older age as a legitimate criterion for withholding acute and intensive care admission [11]. In August 2020, India's Supreme Court ruled that older people should not be discriminated against in decisions to admit to hospital but it has been reported that this ruling has been ignored [12].

Hospital data from LMICs show that older people accounted for substantially lower shares of COVID-19 admissions than of reported COVID-19 mortality. In Brazil people aged over 60 accounted for around half of COVID-19 hospital admissions and, in South Africa, less than a third [13-14]. A study in India found the median age of people admitted to a tertiary level hospital for COVID-19 was just 33.5 [15]. These findings

strongly suggest that old age has often been a criterion for not being admitted to hospital.

There are almost no data for LMICs on older people's access to either inpatient or outpatient health services for conditions not directly related to COVID-19. Studies from Brazil report reduced all-age hospitalisations for non-communicable disease and disruptions to home visits for older people [16, 17]. In South Africa, interventions to maintain older people's access to medication and ease crowding in health centres included giving prescriptions to cover longer periods and home delivery of medications [18].

Long-term care facilities (LTCFs).

Since fewer older adults in LMICs live in LTCFs than in high-income countries, these settings are unlikely to have accounted for comparable shares of COVID-19 mortality. Mortality data for LTCFs are not easily disaggregated from other settings, as deaths of residents may occur in hospitals. Likewise, data on infections in LTCFs are of limited validity, due to low levels of testing. Nevertheless, studies of LTCFs in Brazil and India indicate higher infection prevalence than for community-dwelling older people [19, 20].

Before the pandemic, oversight and regulation of LTCFs in LMICs was often limited and, where it existed at all, delegated to local government. The pandemic has reduced capacity to monitor or support facilities over the past year. India and South Africa have seen little specific state support for LTCFs. In Brazil, a national stakeholder network lobbied for more government action, prompting an emergency allocation of US$25 million to LTCFs, although the use of these funds remains unclear [21].

Conclusion.

The available evidence to assess how the COVID-19 pandemic has affected older people in LMICs is limited, fragmentary and sometimes of dubious validity. The lack of age-disaggregated mortality data for many LMICs constitutes a major failure of surveillance and public accountability that has largely gone unchallenged by global health agencies. The available data indicate LMICs have accounted for the majority of global COVID-19 deaths and that older people have accounted for the majority of COVID-19 deaths in these countries.

The three country cases are not necessarily representative of their respective regions, but provide insights about different national experiences. The fragmentary evidence indicates older people are just as vulnerable to the wider economic and social effects of the pandemic as other age groups. Co-residence with other relatives means the social and economic harms resulting from the pandemic will have spread across increasingly distressed households. Although some older people in LMICs have continued access to pensions, most depend on paid work and family support. Evidence about how the pandemic has affected older people's access to health services remains scant and indirect: this calls for urgent, focussed research.

Will these effects on older people continue through 2021? Beyond vaccine nationalism, capacity to deliver vaccines will depend on the state of health service infrastructure predating the pandemic. The inability of many LMICs to vaccinate the majority of their older people against influenza indicates the scale of this challenge [22].

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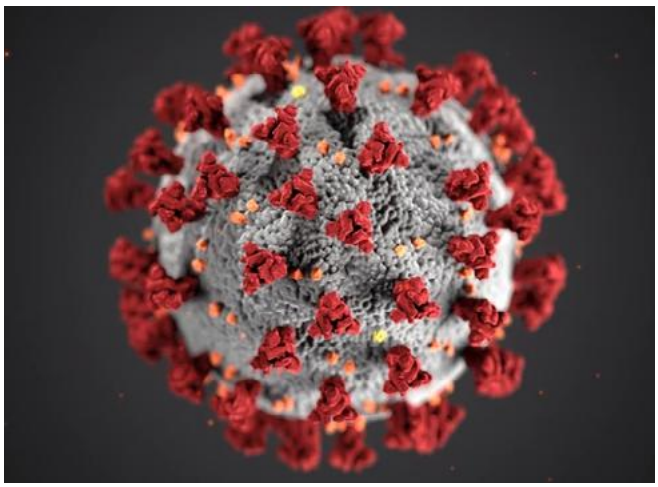
“We have to call it pneumonia”. Tanzania leads the way in COVID-19 denialism.

11 MARCH 2021

By Peter Lloyd-Sherlock.



https://corona-older.com/2021/03/11/we-have-to-call-it-pneumonia-tanzania-leads-the-way-in-covid-19-denialism/

Over the past months, the world of global health has been so busy that some important stories have slipped under my radar. This morning, I came across a new report in the Guardian referring to COVID-19 in Tanzania **[https://www.theguardian.com/world/2021/mar/10/tanzania-missing-president-kenya-covid-says-opposition-leader?CMP=Share_iOSApp_Other]**. The focus of this report is the apparent admission of the national president (aged 61) to a hospital in neighbouring Kenya, due to symptoms of acute COVID-19.

My first reaction was to add one more name to the grisly roll-call of national leaders who have experienced the virus at first hand. The Guardian noted with irony that Tanzania’s president could also be added to the grisly roll-call of national leaders who continue to deny the seriousness of the pandemic. Apparently, President Magufuli has followed the dismal and much more high-profile example of Brazil’s Bolsonaro. For example, the BBC has published allegations that President Magafuli refuses to wear a mask and attends mass public gatherings without taking any precautions **[https://www.bbc.co.uk/news/world-africa-56347756]**.

Digging around on the internet, revealed the depth of COVID-19 policy failure in Tanzania.

When the first case of COVID-19 was recorded in March 2020, the reaction was instant and dramatic. Within a day it was ruled that all schools and universities were to shut with immediate effect and all public gatherings were banned. This policy was not sustained and Tanzania went on to proclaim itself the “lockdown-free ‘Sweden of Africa’ **[https://www.telegraph.co.uk/travel/destinations/africa/tanzania/articles/how-to-visit-no-coronavirus-lockdown/]**.

It is not possible to assess the effectiveness of these measures as in May 2020 the government decided to stop publishing any data on COVID-19 and, shockingly, banned health facilities from conducting COVID-19 tests. This remains the case until today.

Applying an Orwellian "double-think", the President and senior officials frequently claimed that the lack of data demonstrated that COVID-19 was not a significant issue for Tanzania **[https://www.bbc.co.uk/news/topics/cjnwl8q4qdrt/tanzania?ns_mchannel=social&ns_source=twitter&ns_campaign=bbc_live&ns_]**

In February 2021, the national Health Minister announced that Tanzania would not accept COVID-19 vaccines from other countries. According to the Lancet:

"In the glare of cameras, Gwajima and the health officials drank a herbal concoction including ginger, garlic, and lemons, and inhaled steam from herbs, promoting them as natural means of killing the virus. Gwajima went on to warn journalists about reporting unofficial figures on COVID-19 or any disease." **[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00362-7/fulltext]**

Despite efforts to repress reporting on the real state of the pandemic, some information has leaked out over recent months. And this information strongly challenges the government's version of events.

Health workers have referred to large numbers of older people seeking hospital care but not being allowed to test them or to diagnose them as COVID-19 cases **[https://www.theguardian.com/world/2021/mar/10/tanzania-missing-president-kenya-covid-says-opposition-leader?CMP=Share_iOSApp_Other]**. Hospital staff refer to being overwhelmed and facing critical shortages of beds and oxygen **[https://www.theguardian.com/world/2021/feb/28/tanzania-leader-says-prayer-will-cure-covid-as-hospitals-overflow]**. Yet when a senior health official visited a major hospital he claimed there were no COVID-19 cases, referring to "rumours which may cause unnecessary panic" **[https://www.theguardian.com/world/2021/feb/28/tanzania-leader-says-prayer-will-cure-covid-as-hospitals-overflow]**.

In early March, a representative of the Catholic Church in Tanzania claimed 60 nuns and 25 priests had died in just the previous two months after showing symptoms of coronavirus, including respiratory distress. They added that none of the 500 health centres they operate in Tanzania are allowed to test for COVID-19. **[https://www.bbc.co.uk/news/topics/cjnwl8q4qdrt/tanzania?ns_mchannel=social&ns_source=twitter&ns_campaign=bbc_live&ns_]**

There are reports that numbers of funerals (one of the most reliable indicators of excess mortality in poor countries) have increased dramatically in recent months, reaching levels that are higher than those in "living memory". **[https://www.theguardian.com/world/2021/feb/28/tanzania-leader-says-prayer-will-cure-covid-as-hospitals-overflow]**. For older Tanzanians this "living memory" will include the 1990s, when Tanzania had one of the highest levels of HIV/AIDS mortality in the world.

The World Health Organisation has repeatedly made public calls for Tanzania to take a more responsible approach to the COVID-19 pandemic, and has expressed concern that it is also placing neighbouring countries at risk **[https://www.theguardian.com/world/2021/feb/28/tanzania-leader-says-prayer-will-cure-covid-as-hospitals-overflow]**.

As in all countries, older people in Tanzania will be disproportionately affected by the COVID-19 pandemic. Without reliable information, it is difficult to assess what that will mean in reality. According to HelpAge only four per cent of older people in Tanzania receive a pension and their access to basic health services was already minimal before the pandemic. **[https://www.helpage.org/where-we-work/africa/tanzania/]**. Research of outpatient health facilities conducted shortly before the pandemic reported that compliance with basic hygiene and infection control was generally inadequate **[https://pubmed.ncbi.nlm.nih.gov/32389195/]**.

The Guardian provides a compelling story about one older man who experienced acute symptoms of COVID-19 and was admitted to hospital, but was not able to access the acute care he needed. His daughter commented:

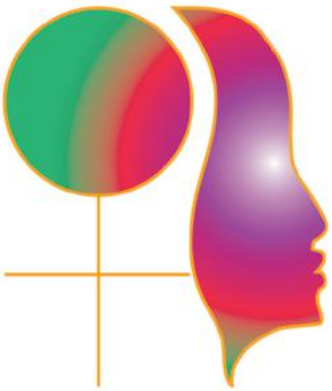
"They said we could only keep him where he was and hope for the best. They called it pneumonia but said 'Your father has the same condition that everybody is facing everywhere'… Since January we have lost six family members…. I wouldn't want anyone to watch their father die the way I did. It's so wrong." **https://www.theguardian.com/world/2021/feb/28/tanzania-leader-says-prayer-will-cure-covid-as-hospitals-overflow**

Tragically, most older people in Tanzania who experience acute COVID-19 will not even get as far as a hospital.

UK Civil Society Women's Alliance: The impact of the Covid-19 pandemic on older women.

15 FEBRUARY 2021

Briefing note, 5 July 2020
(extended in December 2020)



https://corona-older.com/2021/02/15/uk-civil-society-womens-alliance-the-impact-of-the-covid-19-pandemic-on-older-women/

Preface

This note highlights issues faced by older women across the four nations of the United Kingdom during the Covid-19 pandemic, and sets out recommendations on how these should be addressed. It was developed over the last six weeks, a period of rapidly changing circumstances, by the UK Civil Society Women's Alliance (UKCSWA) expert group on older women. The group comprises academics, UK and development NGOs, as well as representatives of civil society. I am grateful to all who contributed to and supported the development of this note.

At the request of Professor Peter Lloyd Sherlock, the note was extended in December 2020 with additional material relating to low- and middle-income countries by Kate Horstead (Age International) – see pages 16 onwards.

Elizabeth Sclater
Convenor, expert group on older women, UKCSWA

Download and view the full note here (pdf):
The impact of the Covid-19 pandemic on older women

COVID-19 and intergenerational justice: Trying to get the bigger picture.

11 DECEMBER 2020

By Peter Lloyd-Sherlock.

https://corona-older.com/2020/12/11/covid-19-and-intergenerational-justice-trying-to-get-the-bigger-picture/

A few weeks ago I participated in a fascinating discussion with fellow members of a new Task Force on Humanitarian Relief, Social Protection and Vulnerable Groups, as part of a Lancet Commission on COVID-19 **[https://covid19commission.org/humanitarian-relief]**. I was the only member with a particular focus on older people, while several others had interests in children and young people. This age bias is of course problematic, but it was also a good opportunity to hear the thinking of people I don't usually interact with professionally. Among other things, this forced me to think harder about how older people fit into the "bigger COVID-19 picture". How does age fit and intersect with other issues and identities? How can we encourage more inclusive, joined-up thinking?

Task Force members were asked to put together short notes setting out their thoughts. The rest of this blog sets out my own effort. Part of this fed into a very short piece just published in The Lancet here **[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32547-2/fulltext]**. Other parts fed into a presentation given as part of a Global Platform webinar on COVID-19, intergenerational justice and people of different ages, along with excellent contributions from Sridhar Venkatapuram, Paul Ladd and Ola Abualghaib **[https://www.youtube.com/watch?v=XT11g-hHeFs&feature=youtu.be]**.

Long-term care facilities (LTCFs) for older people have been major foci of COVID-19 mortality, not just in high-income countries, but across Latin America. There are many reasons for this, including:-

One of the main points of viral entry into LTCFs has been through care workers, who work part-time across a number of facilities. When one LTCF becomes infected, these workers spread the virus to the others. Often, these women have no choice other than to work across multiple facilities, since they are part of

a low-status, casual workforce. Often, LTCFs prefer not to employ them on a full-time, formal basis. Many are immigrants and from deprived communities. Almost none own cars and so travel from facility to facility on public transport, adding a further risk of infection. They are afraid of being tested, since they may well lose their jobs if found to be positive (and they lack access to adequate social protection). Most have large families who depend on this income and many live in over-crowded environments, which are high-risk infection environments.

This story applies a gendered lens to understand multiple, intersecting vulnerabilities and deprivations. It shows that we cannot look at vulnerabilities of people at different ages (frail older people in LTCFs, low status care workers) independently of each other. Instead, it shows that (always through a gendered lens), we need to view age, life course and generation as fundamentally connected shapers of life chances and vulnerabilities.

COVID-19 affects all age groups greatly and in multiple ways. These effects are different for different age groups and for people in different situations, be they frail older people, children/youth in education or "workers" of all ages. And these differential effects and experiences are playing out within a broader crisis of inter-generational justice. Even before the pandemic hit, it was evident that the established (partly mythic) inter-generational contract based around education (re)production and retirement was in crisis on many fronts including.

- Mounting pressures of population ageing on public services and care.
- Less access to secure employment during "working years".
- A growing generation gap in opportunities to participate in housing markets.
- Changing norms and practices of gender roles though the life course.
- Concerns about how current consumption, environmental degradation, etc. will affect future generations.

The COVID-19 pandemic has exacerbated many of these tensions and these have often been framed in terms of impossible policy dilemmas: should we prioritise keeping schools open, saving jobs or keeping at-risk older people safe? And they have heightened existing discourses of ageism and "youthism" (such as blaming feckless young people for irresponsible behaviour). Increasingly, there seems to be a zero-sum tug of war between the generations.

This view of fundamentally conflicting group interests is profoundly unhelpful and damaging. It could feed into a bitter post-pandemic legacy of social division. How can we respond to this threat?

A starting point is to critically rethink the generational social contract, applying new ideas of intergenerational justice and consumption through the life-course. Potentially, this could explore new ethical frameworks to guide policy responses to those "impossible dilemmas". It will require new ways of thinking among academics, policy-makers and societally, with contributions from across the disciplines: moral philosophy, fiscal economics, social science and more. It will also need high-level political support, perhaps in the form of a new United Nations Commission on generational justice.

Another response to the crisis will be to build on existing experiences that demonstrate how to construct communities of interest across the ages. Examples include high rates of volunteering by retired older people, often for causes addressing the needs of children or other groups. Here is a specific example from my own "research world" of what that new type of thinking might look like. It offers a contrast to the "story" at the top of the page.

The Programa Maior Cuidado (PMC) in Minas

Gerais, Brazil employs women from deprived communities as part of a new system of integrated health and social care for frail older people in these same communities. These women are paid a basic wage and provided training to support family carers and liaise with local health and social assistance providers. The aim is to build the capacity of family carers at the same time as reducing their daily care burden. PMC has continued to operate during the pandemic. There is evidence that PMC has provided sustainable and socially useful paid employment for hundreds of women. It has enhanced the quality of life of older people, as well as family carers. There is also evidence that it has reduced risk factors for unnecessary hospitalisation and emergency health service use. Other cities in Brazil are now looking to develop similar interventions. More detail about PMC is available here: ***Belo Horizonte's pioneering community care programme for older people.***

Promoting policies like PMC to build interests across age groups will be just as great a challenge as developing new ways of thinking about intersectional intergenerational justice. It's high time to make a start.

“As if at war, (but) the enemy is nowhere to be seen!”

28 OCTOBER 2020

By Tengku Syawila Fithry (Independent Researcher) and Elisabeth Schröder-Butterfill (University of Southampton).

https://corona-older.com/2020/10/28/as-if-at-war-but-the-enemy-is-nowhere-to-be-seen/

Appeals to use masks and minimise activities outside the home as part of the COVID-19 transmission prevention protocol are not new to the people of Jambi city. The city, split by the Batanghari river, is the capital of Jambi province on the island of Sumatra, Indonesia. It has a history of being shrouded in smog due to nearby forest and field fires, which have been occurring with increasing frequency since 1997. 2019 was one of the worst years, with disastrous forest fires affecting Jambi twice. Dangerous levels of air pollution due to exposure to smoke from the forest fires cause Jambi’s inhabitants to experience breathing problems and stinging eyes. Usually when the smog thickens, the local government issues an appeal for residents to reduce their activities outside the home and to use masks if they have to venture out. This is to minimise respiratory tract disease, especially in children and elderly people.

Does this familiarity with appeals to wear a mask make it easier to comply, now that the COVID-19 pandemic has hit Jambi? After the first positive case of COVID-19 was announced by the Indonesian government, the city of Jambi experienced a hike in the price of masks, especially medical masks. Activities outside the house reduced drastically. Just like when the smog from fire thickens, people

The banners read: Fight COVID (or the ‘enemy COVID’)

chose to stay indoors, and many people used a mask if they had to pursue activities outside. But since the Eid al-Fitr celebrations – approximately three months into the pandemic – for various reasons most people have returned to their normal activities outside the home. Masks are still seen a lot, although it cannot be denied that the number who do not wear a mask is also not small, including among the older population.

Not many elderly people are seen in public spaces since the pandemic hit Jambi city. Those who are in evidence are for the most part pursuing economic needs – they are working. One of them, let's call him Mr Agus, is an older man originally from Java. He works as a parking assistant for a bakery, and he strictly obeys the rules about wearing a mask. His job of giving cues to customers exiting the car park onto a busy road relies entirely on his hand and voice signals. Even though he admits that the mask sometimes makes his voice inaudible, this is not a reason for him to take it off. The bakery where this nearly 70-year-old man works applies the health protocols as determined by the city government. But Mr Agus explains that he used them even before Jambi implemented regulations and sanctions related to wearing masks outside the home. "I trust the government and follow their recommendations", he says. The combination of personal awareness and diligence of the bakery lead the old man to follow the precautionary rules with greater discipline.

It's the same with another older man, let's call him Mr Saleh. He's a 60-year old who works daily as a scavenger. He, too, obediently keeps wearing a mask while pedalling and occasionally pushing his bicycle which is loaded with the results of his scavenging. Juggling with rubbish has made him quite accustomed to wearing a mask. The pandemic merely makes him more reliable in its use. He says that when the smog engulfed the city, he also always wore a mask. He cites a proverb – which plays on the similarity of the Indonesian words 'can' [bisa] and 'normal' [biasa] – to capture the sense that by doing something regularly, repeatedly, it becomes something that is easily done. Mr Saleh does not find it difficult to wear a mask in his daily activities because he has been used to it since before the pandemic.

The habit of wearing a mask is also strictly enforced by Mrs Siti, an elderly woman who works as a massage therapist in Jambi. Even though her work is not done outside the home, Mrs Siti never takes off her mask when working. Previously, for almost 3 months, Mrs Siti did not accept customers at all. Eventually the pressure of economic needs made her return to working. According to Mrs Siti, the COVID-19 pandemic has a bigger impact on her life than the regular haze and smog season. Even though she also experienced a decrease in the number of customers during the haze, there were still some who came, and she also had no worries about accepting customers. Returning to work, Mrs Siti has made her own rules to protect her

health. Apart from the strict use of masks, she immediately washes her hands after finishing a massage. She is unwilling to accept customers who have just returned to Jambi from out of town or customers who complain of cough and shortness of breath. She is worried about the transmission of Covid-19, especially due to her advanced age. "I am old, according to the TV, I'll more easily get infected."

Of course, there are still older people who are not used to wearing a mask properly or are even reluctant to use one at all. One such older man, aged about 65, sells children's balloons every day. He can be seen opening one of his mask straps so that it no longer covers his nose and mouth properly. It is not easy for this elder, let's call him Mr Hamid, to keep his mouth and nose tightly covered while pedalling his bike. Maintaining balance of his bike and the load of balloons already makes his breathing difficult. All the more so, when his nose and mouth have to be covered by a mask. "But when I arrive at the place where I sell the balloons, I wear the mask again," the old man confesses. Mr Hamid explains that just like when the smog hit, he still has to work outside the house. Wearing a mask is one way to minimize the effect of smoke inhalation, even though he can't always use it properly. He feels he has no choice but leave the house, even though he knows that people of his age have a higher level of vulnerability: vulnerable to haze, now vulnerable to COVID-19. "It's like being in a battle, the enemy invisible. When it was smoke, it was still visible to the eye; but this corona, we can't even see it!"

Similar arguments are used by another elderly man who works selling snacks around the clock. Every day he has to push his sales cart up to a dozen kilometres. He seems not to care about the pandemic that was happening. The mask he is carrying he has stuffed into his trouser pocket. He admits that he only brings one in case there is a mask raid by the city government at any time. Since the haze era, he has never been able to stand wearing

a mask. The hot air and his advanced age, he says, made him feel short of breath when wearing a mask. The invisibility of Covid19 makes it seem unreal and contributes to his indifference: "Later it won't be corona that kills you, but shortness of breath", according to this old man.

Both haze and the COVID-19 virus are having a clear impact on the elderly of Jambi. The limitations to doing activities outside the home and the threat of health problems make the lives of elderly Indonesians in both situations become increasingly constrained. And of course it also has an impact on social and economic life. Imagine if somehow both came together?! For the time being, this dual threat seems averted. Rain has started to fall again in the city of Jambi, and the dry season is thought to be over. There are good reasons to hope that at least the pandemic will not be exacerbated by the haze.

Note: The photos were taken by Tengku Syawila Fithry, with permission by the people photographed.

Challenging assumptions on the International Day of Older Persons.

5 OCTOBER 2020

By Jemma Stovell, HelpAge International.

Original post from: **HelpAge International**, reproduced with due authorisation.

https://corona-older.com/2020/10/05/challenging-assumptions-on-the-international-day-of-older-persons/

We all age differently. Yet, we often hear older people being talked about as if they are all the same: sick, unable to learn new things, and resistant to change. Stereotypes are powerful and can influence our attitudes, limiting our beliefs about what we think people are capable of.

During COVID-19 I have noticed dominant stereotypes in the media of older people as vulnerable and frail and have seen how this has influenced policy decisions. For example, in Bosnia-Herzegovina, people over 65 were not allowed to go outside, with no exceptions for grocery shopping, pharmacy visits, or even taking out the garbage. **[1]** Over 200 older people were fined for leaving their homes. **[2]**

On this year's International Day of Older Persons, we want to challenge ageist assumptions and expose ageism. Here are four common assumptions about older people and why we must tackle them.

Physical activity as we get older

When I started working on ageism, I first became aware of my own unconscious bias during a yoga class. A woman in her 70s was next to me and I thought to myself "this class will be too hard for her". I made an instant judgement based on her age, which was a mistake because she was at ease in the class, whereas I was the one who struggled.

Stereotypes like this can impact an older person's health. Evidence has shown that such negative beliefs can adversely affect an older person's health. Older adults with negative

attitudes about ageing could live 7.5 years less than those with a positive attitude. [3] While older people with a positive view of ageing, tend to participate in physical activity more frequently. [4]

Of course, our bodies change as we get older and we might not be as good at certain activities as when we were younger, but we shouldn't assume that because we are older, we are unable to be active.

Technology and older people

Another common stereotype about older people is that they don't know how to use technology. Assuming that young people are computer geniuses and older people are technologically inept is not helpful. There are some older people who are tech-savvy, just as there are younger people who are not.

Assuming older people can't use technology, has a bigger impact than we might think. Technological developments are influencing the nature of work and if people are considered insufficiently skilled or motivated to engage with digital technology because of their age, they may have fewer job opportunities, be overlooked for training or discriminated against because of this underlying assumption. [5]

Assuming older people can't use technology also means that they are often not considered in the design of new technology. This could ultimately affect their ability to participate on an equal basis with other members of society as we move to participate in new ways online. [6] As services continue to move online, we must make sure older people aren't left behind.

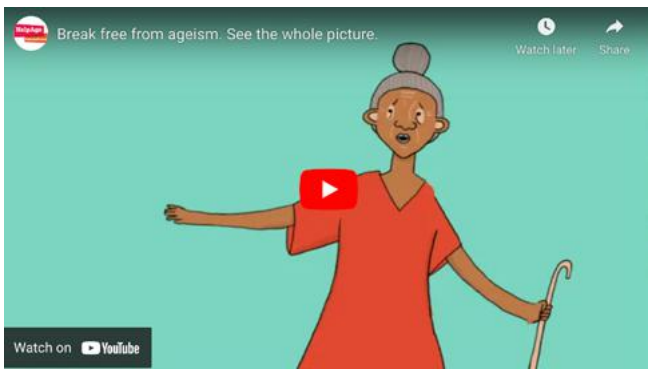
Stereotypes that limit our autonomy

Benevolent ageism is another form of patronising treatment that older people experience. It is often unintentional and can seem innocent, but can be extremely harmful. Older people are often assumed to be fragile and need to be protected. This might mean that family members think they know what is best and that they are doing the right thing. But failing to let older people make decisions for themselves is paternalistic and threatens older people's autonomy and independence.

The choices we make, and the actions we take constitute a significant part of who we are. We must have the freedom to make decisions for ourselves, within family contexts and going about our lives, no matter what age we are.

One older woman in Argentina told us how she used to get out of the house a lot, doing her own chores, but then her children started to take over. She said "I felt as if my hands and feet had been tied. And at night I started having a lot of nightmares."

Older age doesn't equal vulnerability



We are often described as frail and vulnerable when we are older. Throughout COVID-19 we have seen policymakers, the public and the media stereotyping those over the age of 70 as helpless, frail, unable to make decisions for themselves, and unable to contribute to society. But old age should not, in and of itself, be used as a marker of frailty and vulnerability. Ageing is a process that we all experience in different ways. Some of us might need extra support to walk or have different health issues, but some of us won't. Stereotyping all older people as vulnerable fails to acknowledge our differences.

Let's get rid of the labels

It is normal to make assumptions, we do it to simplify and make sense of the world around us. But assumptions about ageing and older people can have negative consequences, even if we don't mean them to. This has come to a head in the response to COVID-19 and has exposed the ageism that exists in society and highlighted the need to tackle it. On this International Day of Older Persons, I'm going to take time to consider my own assumptions and pledge to get rid of the labels we give older people. I hope you will too.

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Living with a person with dementia during COVID19: Creating cognitive ramps, daily routines and meaningful activities.

26 SEPTEMBER 2020

By Dr. Eva S. van der Ploeg [1] and Dr. Cameron J. Camp [2].

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https://corona-older.com/2020/09/26/living-with-a-person-with-dementia-during-covid19-creating-cognitive-ramps-daily-routines-and-meaningful-activities/

The COVID-19 outbreak is impacting everyone, not only physically when becoming ill and socially because of the new distancing regulations, but the **WHO also has concerns about people's mental health**. A large proportion of people with dementia lives at home, even more so in LMIC's, where frequently care homes are rare and restricted to urban areas. Family carers such as partners or adult children take care of older people, more often than not without support from professional services. Being forced to stay at home, wearing masks and social distancing may lead to increased confusion in people with dementia. In memory care, an additional challenge is that residents may no longer be allowed to be visited by their families. The main challenge for everyone who cares for people with dementia face is to explain over and over again why these new rules are in place and what they imply. From our work with people with dementia and those caring for them, we have two suggestions how to respond to the repeated queries and possibly emotional responses that follow from the situation. These are, creating: 1) an extended memory source that the person can use to remind them of the current situation, and; 2) daily routines and meaningful activity.

Creating an extended memory is what we call a cognitive ramp in the Original Montessori for Dementia method (dr. Camp). Instead of repeatedly trying to provide the information in the hope that it will be processed, stored and remembered, use an external 'brain' to make the information accessible. This could be an alternative version of a Memory Book, a so-called Event Book. It is essential to create this book together with the person with dementia. Firstly, this requires a conversation, where you try to find out what the person thinks is going on; are there associations with war times; are they upset that someone seems to keep them indoors and isolated against their will? The second step would be to explain the situation. Examples of external aids for this have been created by the French organization AG&D. English translations of these are found at the **website of the second author**. After ensuring

the situation is understood, the pair creates their own storybook in words or images that the person with dementia choses. If the person with dementia can write it themselves this is preferred. If not, they should be invited to sign their name on the bottom of each page. If the older person is illiterate, the book should consists of images or drawings, that are again chosen in close collaboration with the person themselves. If they are able to draw themselves they should be part of the creation of the book. As an alternative, they may 'sign' the pages with a figure that has meaning to them and which they will recognise as their own later. They may not remember making this book, but seeing their own handwriting or signature gives reassurance that they had part in this documentation. The book should be placed in the same, easy accessible place. If everyone consistently refers the person to the book when questions arise, it may automatically become the place to go to after some practice. The book also may be used as a diary to document daily activities, news, and developments.

Complementary to having an Event Book, is to create a routine and activities that will be the focus of attention for the person with dementia in this new situation. When truly engaged in meaningful activity, it is not possible to also be engaged in behaviours such as repeated questions or emotional responses. For example, it would be helpful for the carer if the person with dementia assists with duties around the house. Again, the person with dementia's input is essential to ensure what they like to be involved with. Some examples are assisting with cooking, baking, setting the table, cleaning, drying dishes. It is essential to break tasks down in smaller steps, to demonstrate the task and practice together – there are principles of Original Montessori for Dementia (Joltin et al., 2012). If stories are printed in large font, the person with dementia might read to others during domestic activities. In a dementia care residence in Oregon, U.S.A., residents began planting individual plants. Every resident chooses what they want to plant. They plant tomato plants, herbs and lettuce in large pails (socially distanced). On a regular basis, staff will put the pails on carts and visit residents in their room so they can monitor the growth of their plants.

Like for everyone, it is important to stay in contact with other people. As keeping physical distance may be difficult, this may involve the use of video conferencing. If keeping a conversation going is difficult, these are options for other things to do: make music or sing together, providing written lyrics when needed; asking the person with dementia to read stories to young children; practice religious rituals, and; play online games together. Offline, the person with dementia can stay connected to the community by calling other older adults who are isolated to check up on them; writing postcards, or; making gifts or cloth masks to send out. We know of a memory care centre where residents are given components of masks and sew them together, then put them outside their rooms for collection. The masks are sanitized and distributed to health care workers. Finally, staying active is important. Again digital means can be supportive, for example to use recorded sessions of (chair) exercise, yoga and meditation (please see supplementary powerpoint with a number of mindfulness practices made especially for people with dementia and family carers). Remember, everybody can help: a head of the kitchen of a facility that we work with took the time to explain the facetime app to a resident so that he could connect with his family through his phone.

Disclosure statements

Dr. Camp is the developer of Original Montessori for Dementia.

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A Letter from Yogyakarta – Finding ways to support older adults under the 'new normal' in Yogyakarta.

24 AUGUST 2020

By Hezti Insriani and Nathan Porath.

In Indonesia a new acronym is on people's lips, AKB (pronounced AA Ka Be!). The acronym standing for Adaptasi Kebiasaan Baru, translates into English as 'adaption to the new 'as usual' / adaptation to the new routine'. The acronym expresses that a new form of normal behaviour is necessary during this pandemic period. It was introduced after it was felt that the expression 'New Normal' was too vague, and what was needed was a more specific term in the Indonesian language that people could relate to properly. Adaptation is never a simple process of following rules. People always find enterprising ways to maintain 'business as usual' and pursue what is important for them under the new and limiting conditions.

Indonesia is a nation which has become very conscious of its 'older citizenry', and many of its leaders and commentators have become concerned with the future of the over sixty-year olds. During the Covid-19 pandemic, the Indonesian government set up several regulations of how to stem the spread of the disease. People are now globally familiar with these regulations, such as practicing social distancing, washing hands, wearing masks, staying at home and limiting one's travels.

https://corona-older.com/2020/08/24/a-letter-from-yogyakarta-finding-ways-to-support-older-adults-under-the-new-normal-in-yogyakarta/

An older woman selling spices in a Yogyakarta market

Photo: courtesy of Hezti Insriani

A bottle of soap on a bucket with a tap filled with water (Yogyakarta 2020)

Photo: courtesy of Hezti Insriani

Whereas older adults have been advised that they are a high-risk group and should be particularly cautious, younger people are also cautioned to be considerate towards older people's health risks during the pandemic.

Many older adults have become accustomed to the AKB period by confining themselves to their homes out of fear of contracting the disease. People now have access to information disseminated by government and non-government organisations through various media outlets. Many videos about Covid-19 and older adults have been made and broadcast on television and uploaded on internet, many in the form of short and easy to follow animated films. So there has been accessible communication about the pandemic to large parts of Indonesia. For many older adults, losing a friend or hearing that an old school mate died after contracting the virus has been a push to access such material to fully understand the pandemic and AKB and take precautions and curb one's movements and contacts.

There are others, though, who still need to work in the markets for a living, even after at least one market in Yogyakarta was identified as a cluster-source for the spread of the disease in the city. Older market vendors now cover their faces with masks as do most customers. Yet the masks affect verbal communication and some older vendors say that they cannot hear their customers talking to them with their mouths covered. This sometimes leads to misunderstanding, or a breach of social distancing or even the customer walking away without making a purchase. Many privately-owned grocery stores can't afford the hand sanitizers which are on display in government institutions, hospitals, banks and department stores. These owners make their own sanitizing corner by placing a bottle of hand soap on or near a bucket with water just at the entrance of their shop with a sign asking customers to wash their hands before entering. Even with these precautions many older adults still feel anxious about walking around in public places and so stay at home. Social distancing has also led to general anxiety about the mental effects that fear of the pandemic and social distancing can have on people, and particularly on the mental health of older adults. Those people most vulnerable are those who live alone and might not have access to the internet or mobile phones.

Visiting health clinics is another place that raises anxiety in older adults who are undergoing treatment. For health problems older adults in Yogyakarta can still visit the primary health care services (puskesmas) in their neighbourhood. But there is still fear of contagion, as in early August it was revealed that 10 health care workers in one village were diagnosed positive for Covid-19 and this clinic was closed. Patients were referred to other clinics further away which has led to some stress among patients.

Various NGOs which provide formal care

to older adults have had to reorganise or reschedule their activities. Yet the pandemic has not stopped these organisations from extending care to their clients, even if through more limited means. NGOs working with older adults have been searching for new ways of keeping contact with their clients. The NGO 'Indonesia Ramah Lansia' (Age-friendly Indonesia,IRL), which is active in Yogyakarta, organised a meeting which brought together thirty people who were updated about events and were giving masks to take back with them to their hamlets. This very active NGO has established a school for older adults in one village where there is a low infection rate. The school teaches people about health issues relating to older adults. Since the beginning of August this year it has been holding classes as a trial run. The NGO intends to hold classes twice a month under strict social distancing rules. People must wear masks and have their temperatures checked before entering the open-spaced hall and sit at a distance from each other. Such courses allow older people to leave the house and safely meet other people. The NGO has also come together with other organisations to produce an online course which is now attended by 60 people. The course teaches about health and therapy matters. Participants in the course can engage their teachers and give feedback after listening to the lecturer.

Another NGO which provides public services to older adults also found its own way in continuing its support to older adults within its village jurisdiction. This NGO has developed a food delivery service for older adults. Its personnel, who adhere to social distancing rules, also make weekly visits to older people's homes and provide them with psychological support.

Since the start of the pandemic in Indonesia, mosques and churches had to overcome initial confusion and commotion, then reorganise their services to comply with the health protocol. Worshipers in mosques keep apart from each other and must sanitize their hands before entering. Churches, by contrast, took their services online. Recently, though, several churches have started to re-conduct their Sunday services in the church. They require from attendees to wear masks and follow social distancing rules. But other social activities, particularly those held for older adults, such as exercise and gymnastics, have been put on hold. Instead members of the congregation socialise by communicating through online forums.

Such organisations seem to have overcome their initial trepidations and are now more confident in finding ways to reach out to their clients and providing them with a modified version of their usual services. All these organisations have tried to find ways to maintain their activities during this unfortunate AKB period in Indonesia.

A class for older adults in Yogyakarta, organised by IRL

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Alternatives to the dystopian COVID-19 pandemic future for older adults in the Phillipines.

21 AUGUST 2020

Blog Contribution of Joseph H. Batac (with Peter Lloyd-Sherlock). 139 Nagbalon, Marilao, Bulacan, Philippines as of 04 August 2020.

https://corona-older.com/2020/08/21/alternatives-to-the-dystopian-covid-19-pandemic-future-for-older-adults-in-the-phillipines/

Tuesday 4th August 2020: Today marks the resumption of a near-total lockdown in Bulacan province, after two months of relative relaxation. In fact, it is nearly five months (147 days) since an official protocol required all people aged 60 and over to remain confined to their own homes and to stay away from public places. This aspect of the lockdown wasn't temporarily relaxed and it is enforced by village disaster management volunteer and neighborhood watch groups. Older people in these villages have little choice but to comply and remain at home.

The effects of this age-specific lockdown on older people can only be imagined. As well as social isolation and mental health impacts, many of these people will have lost access to paid work. The Philippines does have a social pension system, but the numbers of older people who receive payments are very small, and they are worth only US$10 a month. Understandably, many older people need to work to survive. There have been some efforts to address their economic vulnerability. In late April the government provided a small number of older adults a one-off cash transfer worth about US$100. In theory, these payments went to the "poorest of the poor" and those few people who already received the US$10 monthly social pension were ineligible for this extra support. As this was an emergency ad hoc initiative, there was no time to apply a formal targeting mechanism based on systematic data. Instead, government representatives drew up lists of potentially eligible older people and these were then (in theory) vetted by local social welfare offices. In Joseph's village, fewer than one in ten older residents received this one-off payment.

At the same time, the government has provided a US$200 million fiscal stimulus for micro, small and medium enterprises. This sounds like a large amount, but in a country the size of the Philippines, and where many people are employed in small-scale, informal activities, it is unlikely to reach the large majority of these enterprises. Certainly, there has been no evidence of this happening in

Joseph's village. And the scheme makes no special provision for enterprises run by or employing older adults.

Even less is being done to mitigate the brutal social and psychological impacts of five months of lockdown. In other countries, many stay-at-homers have been able to make increasing use of digital communication to attenuate these effects. The villages of Bulacan, as in many parts of the Philippines, opportunities to do this are very limited. Most older adults have few years of schooling and made little or no use of smart phones or computers before COVID-19 arrived. As Filipino society has become increasingly reliant on digital technology in the context of the pandemic, this digital exclusion has become a growing driver of older adults' isolation.

And anyway, five months into the pandemic, there is still no public of information of specific relevance to older people, be it online or in a non-digital format. The only information from government health agencies is unspecific to older people, simply urging the population to stay at home, wash hands, wear a mask and take the usual preventive strategies. This neglect of older people has gone unchallenged. Banning older people from public places and forcing them to remain at home has left them socially invisible, and has undermined advocacy and lobbying by older people's organisations.

Despite being singled out for a draconian lockdown, older people still make up the large majority of COVID-19 deaths in the Philippines. Official mortality data (which are unlikely to capture the full picture) show people aged 60 or more accounted for over 60% of deaths attributed to the disease by mid-July. People aged 60+ represent 8.6% of the national population, which means that their risk of COVID-19 mortality has been about 7 times higher than for the national average. Yet despite these figures, older adults are not a priority for testing or treatment. Capacity for testing, tracing and supportive isolation has significantly increased, but older adults are only tested when they can show they have been in close contact with another person infected with COVID-19.

In the context of this old-age lockdown, it is not easy to know how older people are living their lives within the four walls on their own homes. Past experience suggests they may be doing much to help their families cope with the crisis, be it with housework or childcare. Hopefully, older people's past experiences of hardship (including several major conflicts), as well as their generally strong religious faith, will boost their resilience and be a source of strength and inspiration to younger relatives. In parts of the country with larger numbers of reported cases, state-run schools remain closed. It is likely that grandparents will be doing much to help with their families' additional needs for child care, as well as with home-schooling.

And so, as the sixth month of pandemic life begins, older people may continue to be socially invisible, but may also continue to hold together families struggling with the strains of this unfolding crisis.

Letter from Bali: Resilience and solidarity amidst the pandemic.

30 MAY 2020

By Eva van der Ploeg, independent researcher based in Bali.

https://corona-older.com/2020/05/30/letter-from-bali-resilience-and-solidarity-amidst-the-pandemic/

PHOTO 1 – The man selling doughnuts in Denpasar

Photo: courtesy of Hezti Insriani

While Indonesia as a whole has over 22,000 confirmed cases of Covid19 and over 1,300 deaths, the island of Bali suffers from secondary consequences that will be representative of many other regions around the globe that rely on tourism as the main source of income.

As is to be expected of the number 1 tourist destination in the world, the local Balinese government responded quickly and scrupulously. Soon after the first cases in China emerged, everyone entering Bali through the airport and other entry points was screened. Where necessary, incomers were quarantined.

The result has been impressive: Bali has seen fewer than 400 cases until this day and never more than 100 active cases at the same time. Only four people have died. Apparently, Covid19 presents with similar symptoms as dengue fever, of which there is an increased number of cases. But even when adding the fatalities attributed to dengue, the number of deaths would be less than 20 in a population of four million.

Unfortunately, the “Island of Gods”, as it is known in Indonesia, suffers badly from secondary consequences of the pandemic. Tourism is currently down 100% compared to one year ago. This is devastating, as around 55% of the population depends on tourism as their main source of income. 2,400 employees have been laid off and another 70,000 are furloughed. Many others have been put on reduced hours (and thus income) for the past two months. Some workers responded fast and returned to their home villages either around Bali or on Java, Timur and Flores. However, many remained and then became stuck when domestic travel was banned by the national government for the past month out of fear that the pandemic would be spread at an increased rate during ‘mudik’ – the outflux of people during Ramadhan to their places of origin.

Balinese families traditionally live together in a

large family context. Usually, at least one son remains living with his parents and is joined by his wife and children. Older people are cared for by all family members, usually also those living elsewhere. On the one hand, this means that elderly people are looked after well and are not alone. On the other hand, it means that this vulnerable group is hit as hard as anyone else when their adult children lose their jobs. And the few older people who are alone are in immediate danger of losing work, income and housing, too. We hear heartbreaking stories of people being removed from their 'kos' (shared rental living) when they cannot afford the monthly rent. Take the older man who sells doughnuts on one of the main roads of Denpasar. These days he only brings out a small number of doughnuts to sell and is frequently seen sleeping on the pavement.

Reports from the 'kampungs' (villages) are less depressing. While observing new regulations like wearing face masks and frequent hand washing, older people are reported still to go out. The markets are open, and elderly people go there to sell and buy produce. They are looked after by their families, stimulated to maintain their usual activities and at the same time 'more protected' by younger family members as well.

There are clearly huge underlying issues of inequality and being underpaid that need to be addressed by national and local governments in the future. However, the rapid changes over the past two months also have some beautiful 'side effects'. Not only do families look after each other, but the 'banjar' (local community) also keeps track of people who may need help.

PHOTO 1 – This man and his family in Singaraja, North Bali, have just received sembako

Credit: Eva van der Ploeg

There are numerous pop-up 'restaurants' where people can pick up free meals. This sense of solidarity has extended beyond the Balinese looking after their own. Immigrants from Europe, America and Australia have started projects to support families, both Balinese and those who have not been able to return to where they'd like to be. 'Sembako' is distributed to families in need: these are food packages with 9 basic ingredients, including rice, cooking oil, sugar and instant noodles. Some expats have set up random sembako outlets along the main roads to share with those on the road. This sometimes leads to a rush by those interested.

PHOTO 2 – Alternative sembako, including not only basic staples, but also painkillers, soap, toothbrushes and toothpaste and fresh fruit

Credit: Kembar Tembau

People are inventive; social media are full of people advertising their rice, fruits, vegetables, chickens for sale etc. Many people have started buying directly from the source, instead of going to expensive, usually foreign-owned supermarkets. And amongst these new initiatives and reconnections, amid the sharing and caring, Bali still has the same serene feeling to it. Everyone hopes to welcome back tourists soon to share the beauty and spirituality of the Island of Gods, but in a new way, where locals do not entirely depend on tourism for their income and wellbeing. A seed has been planted.

Using humour to deliver important messages in central Java: Comedy as a mechanism against COVID19.

30 MAY 2020

By Nathan Porath, University of Southampton, and Hezti Insriani, independent researcher.

https://corona-older.com/2020/05/30/using-humour-to-deliver-important-messages-in-central-java-comedy-as-a-mechanism-against-covid19/

There is an adage that laughter is the best medicine. Comedy does not only help to alleviate stressful situations, but it can also serve to make a point about human conduct through an unthreatening play of words, incongruous representations and witty punch lines.

In Java (Indonesia), a new local celebrity has emerged, who has been championing the cause of keeping older people safe during the COVID-19 pandemic. Mbah Minto ('old Mrs Minto') is a seventy-year-old woman who has been involved in the creation of several comedic sketches filmed with a thirty-year-old man from Central Java, who goes by the stage name of Ucup. Mbah Minto lives in a one-room brick house and in poverty. Ucup was already making short videos for his Instagram. He decided to work with Mbah Minto because when he first met her, she was alone, and he wanted to help her out.

To the average Indonesian, Mbah Minto's appearance conforms to a stereotype of an older person: grey-haired, with few remaining front teeth, walking with a careful gait, holding on to staff and seemingly oblivious to the fast changes of modern consumer culture occurring around her. She speaks in low Javanese, utilising all the vocal earthy expressions that typically signify this more egalitarian speech register (in what is otherwise a very hierarchical language and culture).

In the sketches, Mbah Minto plays an elderly mother living alone in her one-room house. Her bed is hard, and she cooks her food in a wok resting on a clay stove outside in her yard. She has a mobile phone which seems out of place in her simple home setting.

In an "Instagram Live" interview, she confirmed that she really does not know how to use it. Her inability to use a mobile phone in real life only strengthens the comedic image of her exaggerated skilful use of it in the sketches.

Her performance commends the importance of modern communication for older people during

this time of crisis. The sketches usually start with her thinking out loud (talking to the viewer) or doing something at home. She then gets on the phone to her son (played by Ucup). She develops a dialogue with him. She speaks with a soft but firm tone of voice signalling authority and wisdom about the subject matter she is developing with 'her son'. The dialogue is accompanied by musical cues and background audience laughter which accompany Mbah Minto's punch lines. The last scenes always show Mbah Minto laughing joyously at the camera, thus persuading the viewer to laugh with her.

Although this unlikely duo was already making several sketches for Instagram, they came to public attention after producing a sketch which endorsed the government's warning that children could put their elders at risk if they travelled back home for Idul Fitri.

The video opens with a scene showing her cooking on her clay stove as the phone rings. Her son tells her he wants to come back home to see her. She tells him not to, as there is a virus this season. He persists, saying he misses her. She rebuffs him by saying she will send him a photo of herself. She then places the mobile phone in front of her face and, like a teenager, takes a selfie. She then carefully presses the button on the phone and sends it to him. He receives a stern image of her. She then asks him, 'how is it, am I beautiful?' He affirms that she still is, but still not easily dissuaded, he tells her that he is a healthy man and can still come back to see her. She reminds him that he is young and might not be easily affected by the virus, but she is old. She adds that if he returns, he could bring the virus with him, he should, therefore, empathise with her and stay put. Then she audaciously slips into the conversation that he doesn't need to return home this time, but some money could travel back home in his stead. Cheekily, she asks him if he still has kept her bank number at which point Mbah Minto can't restrain herself and begins to giggle. After the call, Ucup thinks out aloud and says, 'for sure I will not go home now but maybe some money can be sent to mother'. As an afterthought, he muses: 'there is one problem'. Taking out some banknotes from his pocket, he adds: 'this is my money!' (all I have).

Here are some snapshots from the videos that have been going viral:

Mbah Minto cheekily asking her 'son' if he still has her account number (as an indirect way of asking him to deposit money into it! YouTube

And on reflection giggling at her own 'naughtiness' for asking it.

Since this video was made a few businesses have approached the couple asking them to make similar videos while advertising a health product. In another video which was made to promote a hand sanitizer cream, Mbah Minto is filmed rubbing her hands. She is clearly showing how to do so. Then, thinking out a loud she says that she is always cleaning them now to avoid the virus.

Mbah Minto disinfecting her hands YouTube

Mbah Minto showing how to clean the hands with hand sanitizer cream YouTube

Then as though wishing a spell she mutters, 'virus keep away from me', while the recording of a laughing audience can be heard in the background. Her private magical world is interrupted by the phone ringing. She mumbles, 'the phone is ringing again' and looks at it to see that it is her son calling her. She surmises that as he could not come back home, he must be missing her a lot as he has been phoning her 50 times a day. She then answers the phone and Ucup asks her what is she doing? She says that she has just cleaned her hands following the government's advice to do so. She then adds that when he sends her money, he should not forget to spray his hands first. She then throws her little bottle up in the air and magically it transforms into a larger spray bottle. Mbah Minto tells him in a strong Javanese accent, the bottle's name, Hani Shanitaker, Sekreet Sreen, (Hand Sanitizer, Secret Clean), accentuating the trilled 'R', a typical Javanese phoneme. In the background is the sound of a recorded audience laughing, Ucup laughs and Mbah Minto holding the bottle laughs at her deliberate faux pas of English words. Ucup then says: 'wow you have become diligent in washing your hands now'. She retorts 'of course and when done (with clean) hands, I will be ready to receive your THR (holiday allowance for Idul Fitri)!'

The comedy conveys its messages through a play on ageist stereotypes and expectations and counter-expectations, and on the symbolic juxtaposition of recognisably traditional and modern signifiers. In the comedy sketches, Mbah Minto represents the older generation and every Javanese person's mother or grandmother. From this exalted position, she speaks to both young and old. The messages in the comedic sketches are clear, don't return home this year, keep in touch by phone calls, but you can still show your love to your parents by giving them some financial support to help them through and keep your hands clean. To lighten the weight of a difficult order borne during a threatening time, the duo has conveyed these messages through homegrown familiar humour.

Letter from Eastern Indonesia: COVID-19 and the older people.

27 MAY 2020
UPDATED 28 MAY 2020

By Lenny L. Ekawati, DPhil student at Linacre College, Oxford, and Project Coordinator at the Eijkman-Oxford Clinical Research Unit in Jakarta; and Benidiktus Delpada, Independent Researcher.

https://corona-older.com/2020/05/27/letter-from-eastern-indonesia-covid-19-and-the-older-people/

"Don't return home (for the annual celebrations at the end of the fasting month of Ramadhan)!" was a **recent recommendation** by Indonesia's President to prevent the spread of COVID-19 to areas outside of Jakarta and major cities, the epicentres of the pandemic in Indonesia.

Why are visits home forbidden this year? The main reasons are because (1) the Virus SARS-Cov-2 can attack anyone, and the number of positive cases in Indonesia is still rising daily; (2) the use of public transport, such as bus, planes, boats and trains make it impossible for travellers to maintain physical distancing so that the risk of spread during travel is very high; (3) travellers from an area classified as a 'red zone' (i.e. with many cases of COVID-19), such as Jakarta, can become carriers and infect elderly family members in their villages of origin.

Having learnt from China and Italy, the Indonesian government was eager to remind people of the fact that older people and people with chronic illnesses are at heightened risk of experiencing severe or even fatal manifestations of the virus. Reminders by the government about how to protect older

Members of the police force in NTT (Eastern Indonesia) distribute essential food items during the pandemic

people from infection are being echoed daily. If you think about it, the recommendations are not complicated: We are encouraged to stay at home, and if we must leave the house, we should use a form of transport which is not crowded; we should wash hands regularly with water and soap and always wear a mask. After returning home, masks should be taken off, hands and feet washed, and clothing changed. Not difficult, or is it?

The concept of social distancing which underlies much of this advice is based on an epidemiological understanding of how disease spreads from person to person. However, as in many other parts of Indonesia, social distancing becomes a challenge in Nusa Tenggara Timur (NTT), a collection of islands in Eastern Indonesia. Why? Because the culture of NTT is well-known for being friendly and warm, tolerant and communal. Social distance is anathema. In this context, how public messages are conveyed and the choice of words become important. The desired social distancing is not coterminous with not socialising but keeping a physical distance between people and avoiding crowds.

Feeling sad, depressed, worried, confused, afraid or angry during a pandemic is normal. In an effort to implement the advice to stay at home, while still interacting and socialising with elderly relatives or friends, younger family members are being encouraged to telephone, use video calls or social media like WhatApp groups or Facebook. Older people who are not familiar with mobile phones or internet technology are expected to feel the impact of the pandemic more deeply, starting with the emergence of loneliness, anxiety right up to depression. In Nusa Tenggara Timur, information about such issues is still rare, and there is a clear need for research about the experience of older people in connection with emotions, worries, fears or even trauma of death in this part of the world.

The provincial government in NTT has two routine social assistance programmes, the so-called 'Family Hope Programme' (PKH) and the essential food items (sembako) support for members of society who are less fortunate, including older people and those with disabilities. To date, only around 2,000 of the 36,000 elderly people in NTT have received assistance from the government. The cash or essential items are distributed via post offices, old people's homes or local authorities.

In connection with the coronavirus epidemic, the regional government of Alor island has newly made use of the so-called village fund for two purposes. (The village fund, or dana desa, is money from the central government given to local communities for community development and empowerment programmes.) First, to buy essential food items which are then sold cheaply in locations which can easily be reached by local inhabitants. This is being done in order to prevent people from gathering in traditional markets which often become a source for the spreading of the disease. Second, to distribute cash support for families in need in 76 villages. Meanwhile, in 102 other villages, families in need receive cash assistance of Rp. 600,000 [approx. £35] per month from the Family Hope Program (PKH) and Ministry of Social Affairs assistance.

Despite these programmes, there are older people in Alor who refuse to accept government support in the form of staples and essential items, because they are still capable of working the land and growing local food like cassava, bananas, corn and beans. As one older woman put it: "I have to make the effort myself. God gave me 10 fingers so that I can work."

An elderly resident of Alor refusing government help during the COVID-19 pandemic

Another interesting encounter involved a small foundation giving support in the form of staples. This foundation was confronted with complaints by elderly transgender people (waria) who had lost their jobs during the pandemic. They deserve attention because, on the one hand, the regional government does not allocate support for them because many don't hold an identity card (KTP). On the other hand, as transgender persons, they face difficulties arranging health insurance and accessing health facilities. Moreover, if infected by COVID-19, they are highly vulnerable to experiencing stigma and discrimination by the society around them.

In the face of the pandemic, the government requires resources which are flexible in order to carry out tests on the vulnerable population, such as older people. In guidelines published by the government, it says that if an older person has symptoms of the virus, they should quarantine. Their health status has to be evaluated by medical staff, and if their situation worsens, the older person must immediately be moved to the hospital for further care. Furthermore, the procedure for disinfecting the older person's house has to be done by a health authority or other competent body. The problem is that these helpful and specific guidelines collide with local realities in Eastern Indonesia, which is an area that is poor and under-resourced. Health facilities in NTT are very limited, hence the likelihood is high that not all cases of COVID-19 among the older population can be handled properly.

Similar problems arise with routine medication normally consumed by older people who have a chronic illness such as asthma, cancer, diabetes, stroke and hypertension. In normal times, older people can routinely obtain their necessary medication. But during this pandemic, any visits on their part to hospitals or primary health clinics (puskesmas) for check-ups or to pick up medication increase the risk of their exposure to the virus. Help from health workers, health volunteers and staff at elderly primary health services is very much needed by older people during this difficult time.

Older people who live with the younger generation during this pandemic have many advantages. Why? Because younger people can help older people with chronic illness to visit primary health centres or can collect their routine medication for them. Aside from this, the younger generation can leave the house to shop for daily needs so that older people can remain at home. Indeed, local reports confirm the important role that younger people have in supporting the older generation and reinforcing the advice for them to keep safe. Less encouraging is the fact that young and middle-aged people seem to be more affected by the pandemic, not least indirectly via the loss of work.

Lastly, the recommendation by the government to work from home, learn from home and conduct religious worship at home brings positive effects. During the fasting month of Ramadhan, families spent more time together at home and praying together strengthened the bonds between family members. Many religious leaders supported this by saying that personal and family health is the primary responsibility, more important than worshipping together as in other years. However, some people still chose to loosen their commitment to 'staying at home' with the argument that communal worship brings greater rewards. In the lead-up to the end of Ramadhan, the situation became much laxer in many places, as people started going out more and shopping in preparation for the Idul Fitri celebrations. Roads and markets became crowded with traders and shoppers, without continuing to pay heed to the physical distancing rules.

There is cause for worry that the violations of the recommendations for preventing the spread of disease during the end of Ramadhan and the ensuing festivities will result in an increase in COVID cases within the next few weeks. As the saying goes, what we do today will define our tomorrow. Who

knows until when? Some Indonesians have greeted with dismay the President's recent statement that "we need to make peace" with the virus and adapt to a **new normal**. Given that Indonesia is still facing a rise in cases and fatalities, this adjustment of the message from 'stay at home' to 'live side by side with the virus and remain productive' seems premature.

Disclaimer: The views expressed in this article are personal and do not represent the views of Eijkman-Oxford Clinical Research Unit or Eijkman Institute for Molecular Biology.

Isolating older people 'A lot of benign neglect': How Ghana's social changes are isolating older people.

26 MAY 2020

By Kwasi Gyamfi Asiedu.

https://corona-older.com/2020/05/26/isolating-older-people-a-lot-of-benign-neglect-how-ghanas-social-changes-are-isolating-older-people/

The modernising economy is changing family structures – but can 'western' residential homes be accepted culturally?

After breakfast on a Friday morning, a small group of elderly people are engaging in gentle exercises – walking to one end of a walled compound and back. Some of them need the assistance of nurses or walkers, or both, to complete the journey.

"Usually, we do this a couple of times but it is a little bit cold today so we are going just once," says Henry Ofori Mensah, administrator at **Comfort For The Aged**, a residential care home in Kasoa, a dormitory town west of Accra, Ghana's capital. At the turn of the century, a facility like this would have been hard to imagine in Ghana.

About **58% of Ghana's population is under the age of 25**. But improvements in public health and advances in medicine have meant that life expectancy has increased from 54 years in 1984 to **63 years in 2016**.

According to the World Health Organization, 12% of Ghana's population could be over the age of 60 by 2050 – up from 7% in 2010. These demographic changes coupled with rapid urbanisation (more than half of Ghana's population **now live in cities**) and global migration is changing the way families care for older people.

Traditionally, elderly relatives stayed at home to help raise grandchildren and, as they aged, they were, in turn, cared for by those younger family members.

But Ghana, **now a middle-income country**, has an expanding middle class. An **increase in** women's education **means family sizes** have shrunk substantially. The **total fertility rate in Ghana has almost halved** from 6.4 children per woman in 1988 to 3.9 children per woman (3.3 children for an urban woman) in 2017.

The pace of urban life, the demands of education and work means that many families

are struggling to care for their elderly relatives.

"Grandma will wake up to an empty house, has, maybe, the TV for company … and **because of traffic**, [the rest of the family] come home late at night. That is when she is trying to talk to them but they are tired," says Dr Esi Ansah, founder of the Association of Ghana's Elders (Age).

> "So there is a lot of benign neglect; a lot of seniors are around people but they are alone and lonely. The state assumes the family will take care of people but families have changed, family structures have changed," says Ansah.

Chronic loneliness can precipitate depression and, "once depression sets in, so many other things follow," says Dr Akye Essuman, director of **Ghana's first geriatric medicine fellowship**. "People with hypertension can get out of control; if they have diabetes that can also get out of control." Private care homes are slowly but steadily being introduced in the hope of revolutionising how this conservative society on the cusp of tradition and modernity cares for its senior citizens. Already, there are three care homes in operation and two more are under construction around Accra.

> "I want to stay here a little because if I go home there is nobody there. I am always lonely."

Founded by Judith Comfort Asomani in 2016, Comfort For The Aged is one of these. During her time working as a nurse, Asomani found that many elderly patients did not want to go home after being discharged from the hospital. She recalls people telling her, "I want to stay here a little because if I go home there is nobody there. I am always lonely."

"For the first year, because it wasn't known in Ghana, nobody was coming," says Asomani. It was only after the care home switched their adverts from a local language radio station to an English language station popular with educated professionals that the business started to look up. Today, there are seven residents aged between 70 and 89. The home can accommodate up to 10 people, says Mensah. Fees are on average around $250 (£202) a month depending on the type of care residents need. Apart from hypertension, some of the residents have Alzheimer's or Parkinson's disease or are recovering from strokes.

The home has a structured daily routine, with nurses on hand to help with medication, hospital visits and other assisted living services such as grooming. Family visits usually happen at the weekend and there are occasional excursions.

> "We had one client who had been alone in the house for a long time and in the end, the woman couldn't talk. But when she came here, she started talking because we were always engaging [with] her," says Asomani. "We give them total nursing care. When you come here, you stay as if you are in your house."

During the three-week coronavirus **lockdown of Ghana's two largest metropolitan areas**, staff stayed at the residential home and visitors were banned to prevent the virus from spreading into the home, a restriction that remains in place.

Benjamin Ocansey, an electronics technician in Accra, moved his 89-year-old mother from a village in Ghana's central region to the care home six months ago because of her mobility issues. "In the rural area, the management of such conditions is next to nothing [but in the care home], she is going to get all those services and the management will be better than when she is on her own in the family home," he said. However, the main challenge is confronting societal perceptions about care homes. "[They are] culturally perceived as a foreign or western concept, which is alien to the Ghanaian culture," says Dr Delali Adjoa Dovie of the Centre for Ageing Studies at the University of Ghana.

One thing nearly all of the residents have in common is that they have previously lived, or their children currently live, in the west. Initially, Ocansey's five younger siblings were not happy about their mother's move to the home. "They had no knowledge of how the care system worked so they thought that I was going to dump her somewhere and forget about her," he says.

But after visiting the home, there was a change of mind and some siblings have begun contributing to the monthly costs.

There are no government-run care homes for older people and the cost of private care homes puts them out of reach for many Ghanaians struggling to look after ageing parents. A **national ageing policy** drafted in 2010 is "still sitting on ice", says Ansah. Essuman believes it is also important to develop alternative care structures, such as daycare centres and home care services so that older adults can stay in their own homes to receive care for as long as possible.

> "We need to look at what is culturally acceptable and what is also medically prudent and see where we can marry the two."

This story was originally published on *The Guardian* and can be accessed **here**.

Letter from Brazil: COVID-19 and older people in Fortaleza, Brazil's worst-hit city.

23 MAY 2020

This blog is written by Peter Lloyd-Sherlock. It draws on and develops content from the presentation made by João Bastos for the Global Platform's 7th weekly webinar, available in Portuguese here.

https://corona-older.com/2020/05/23/letter-from-brazil-covid-19-and-older-people-in-fortaleza-brazils-worst-hit-city/

Fortaleza lies on Brazil's beautiful northeast coast. This is one of the poorer parts of the country but the local government has made recent strides to promote international tourism. Over the last couple of years, the local airport was upgraded and now receives direct flights from Europe and North America. But what had seemed like a success story of local development also paved the way for Coronavirus' early arrival. It is no coincidence that the three worst-affected cities in Brazil all have airports with international connections.

Over the past few years, I've been involved in a research project in Fortaleza, looking to develop integrated health and social care services for older people. One of the reasons why we chose to work in Fortaleza was the city's deserved international status as a pioneer of public health interventions, including community health agents. Also, several leading experts on older people's health are based there.

João Bastos is one of these experts. As well as former President of the Brazilian Society for Geriatrics and Gerontology, he is the city government's lead on health services for older people. João himself was one of the first Covid-19 cases in Fortaleza, falling ill in March, but fortunately making a good recovery after a few miserable and worrying days.

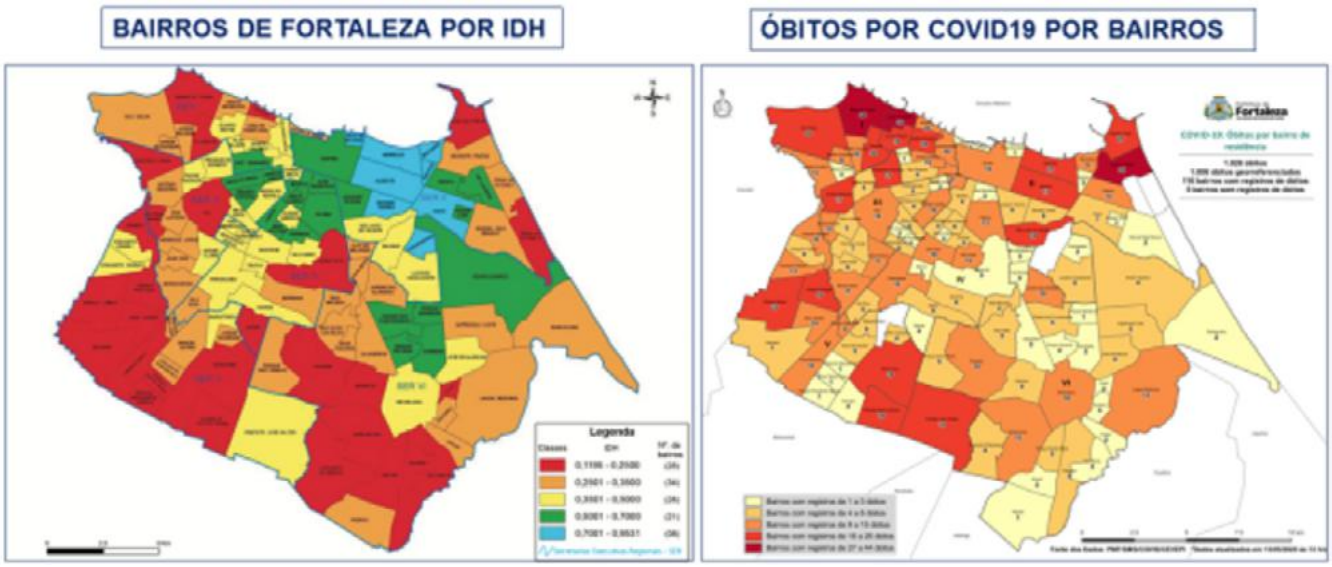
Fortaleza airport: the price of global connectivity?

As soon as he was back on this feet, João and his colleagues started to prepare for the pandemic. Unlike countries such as the UK, the city health department paid particular attention to the situation in local care homes. Liaising closely with the city's department for social assistance (which has overall responsibility for care homes), they visited all the city's old age homes and conducted a quick survey in order to identify those at most risk. The survey (conducted back in mid-April) found that all care homes were facing serious challenges. But a small number were especially vulnerable, lacking any capacity to screen for potential symptoms and struggling to access daily food and medicines. These high-risk care homes were targeted for priority support and the city's health and social assistance departments continue to work closely with them.

At the same time, the city government rolled out a raft of other sensible public health measures including efforts by the city mayor and state governor to establish a lockdown (directly at odds with the damaging approach taken by national president Bolsonaro).

It would be nice to report that this enlightened approach to preparing for the pandemic, meant that Fortaleza has been spared its worst effects. Sadly, the numbers say otherwise. By 20 May, Fortaleza had a Covid-19 death rate (505/million population) approaching to that of Italy (534), and the rate continues to spiral.

As in all cities, this burden has not been shared equally across the population. To date, 77 per cent of recorded deaths have been among people aged 60 or more. Covid-19 deaths have been heavily concentrated in the poorest parts of the city. This chart from João's presentation compares neighbourhoods with higher rates of socio-economic deprivation (on the left) with numbers of Covid-19 deaths to date. It tells its own story…



Socioeconomic inequality and Covid-19 deaths in Fortaleza, by mid-May 2020.

Socio-economic disparities in Covid-19 deaths are hardly surprising in a country with such high levels of inequality. As many have observed, Covid-19 mortality is not just associated with age, male sex and other health conditions: it is a socially-determined outcome. There are many ways in which poorer Brazilians are especially exposed to the pandemic. Perhaps the most obvious is the limited scope for social distancing in densely populated neighbourhoods with precarious infrastructure.

Social distancing here???

Inpatient health resources in Fortaleza, especially intensive care, are extremely limited and will not be available to the vast majority of people suffering from severe symptoms. A few days ago, the local press ran a story about a young man who **camped for 6 days outside an emergency clinic** to pressure staff into providing a bed for his seriously ill father. He eventually succeeded, but this does not change the fundamental shortage of services.

João and his colleagues in Fortaleza are painfully aware of the need to reach out to older people in the city's poorest neighbourhoods. Immediately after presenting to our webinar, he met local health and social assistance agencies to launch a new initiative to identify and support care-dependent older people in the city's many favelas.

Fortaleza may be the hardest-hit city in Brazil to date, but it is unlikely to remain so for much longer. Other cities in Brazil and beyond have much to learn from the impressive efforts of its public health and social assistance workers to cope with this catastrophe.

Older man given hospital bed after son camps outside the hospital for six days.

DRC has seen epidemics before, but COVID-19's toll on older people leaves me sleepless.

18 MAY 2020

By Anatole Bandu.

https://corona-older.com/2020/05/18/drc-has-seen-epidemics-before-but-covid-19s-toll-on-older-people-leaves-me-sleepless/

Many of the people I support in Kinshasa have no money, no soap, no water – and when they are struggling to breathe, no ventilators

We're used to emergencies and people dying in the Democratic Republic of the Congo, whether it's a result of the long-running **conflict or Ebola**, cholera and malaria. But coronavirus has knocked us for a six because it has affected people we are very close to.

I've been working in development for decades, but I have to admit I have shed tears these past few weeks.

So far in the DRC, there have been more than 50 Covid-19 deaths, all of them in our capital, Kinshasa, where I am based. There are 1,298 confirmed cases, most in the city.

I know many people who died, but I was very close in particular to Dorcas, 66, and Michel, 78. They were very much loved and respected members of an older people's association. Michel and I joked that we were father and son as he shares the same name as my late father.

They both knew where all the older people lived and whenever any had problems, they were the first to respond. Dorcas leaves behind a frail, elderly husband who has high blood pressure, and we are very worried for him.

Unsurprisingly, in the past month, our work has been dealing with people suffering from Covid-19 or the consequences of the **government-imposed lockdown**.

We started getting calls as soon as the lockdown began. Many of the older people we support have chronic diseases, such as hypertension and diabetes, and without public transport were unable to get their medicines. They have no money for taxis. So we have been delivering medicines to people's doors.

One couple in Kinshasa's Gombe commune both suffered from hypertension. They had been trying to access their medicine for a while before they called us. When we delivered it, the

husband was very short of breath. We called an emergency response team, who tested him for Covid-19.

It took a week for the results to come back and he was taken to hospital, where he died two days later. The hospital had no ventilators and very few health workers. Many had left, too scared to work without PPE.

His wife also became very ill. Unsurprisingly, when I last delivered her medicine she was very depressed, frightened and confused. She was struggling to speak and just looked up at the sky, muttering she was offering her life up to God as she had no idea what tomorrow would bring. She died last week in the hospital, unable to breathe. There was no ventilator.

Another woman in Nsele, a poor area of the city, had lost her husband to Covid and she tested positive for the virus. She talked about her fears for her two grandchildren, for whom she was the sole carer, as her eldest child died of Aids in 2018.

When we had discussed coronavirus, she said the disease is caused by not washing your hands with soap and water. She wasn't surprised that she and her husband contracted it, as they have no clean water in the house and used charcoal ash instead of soap, which she could not afford.

She was also admitted to hospital and died. Again, there were no ventilators.

Older people here really have nothing. We have no state pensions in the DRC.

On the one hand, our economy is weak, with limited funds to support older people or sustain a robust health system. On the other, many aid agencies prioritise other groups such as women and children.

We need a stronger health system to be able to cope with disease outbreaks and we need humanitarian aid that targets older people, who are vulnerable.

When there are disease outbreaks such as Covid-19 and Ebola, people fear for their lives and flee, leaving behind elderly relatives. This happened to my own mother during the Ebola outbreak in Goma in 2018. She was 78 and had hypertension and diabetes. Sadly, family members left her alone when they fled. When I discovered what had happened I organised for her to be taken to hospital but it was too late. She had passed away.

As soon as we heard about the **Ebola outbreak in Beni last month**, we mobilised a team to visit older people, distribute soap and hand sanitiser, carry out education and awareness-raising and generally check they were OK. So far, no older people have died of the disease there.

When she was with us, my mother was a champion of older people and I'm doing what I can to keep her legacy alive.

But at the moment, I struggle to sleep at night, knowing that many older people will die in the coming days here in Kinshasa. That is very hard to bear.

Anatole Bandu is country representative for **HelpAge** DRC. This blog was published in *The Guardian* and can be accessed **here**.

Letter from Indonesia: Older adults in Yogyakarta coping with the changes since 2nd March.

15 MAY 2020

By Hezti Insriani, Ciptaningrat Larastiti, Dyah Rahayuningtyas, Nathan Porath.

https://corona-older.com/2020/05/15/letter-from-indonesia-older-adults-in-yogyakarta-coping-with-the-changes-since-2nd-march/

On the 2nd of March Indonesia announced its first two cases of COVID-19 patients. Until this date, Indonesian nationals could look out in wonder from their vast nation-state across the seas at neighbouring countries fighting to contain the virus. Could and would this disease reach the shores of any of Indonesia's 11,000 inhabited islands? The thought that it possibly had already done so undetected must have crossed many people's minds. From this date, however, Indonesian complacency was dislodged and normal life destined to change.

Initially, the cases appeared confined to Jakarta and a few major cities. With the gradual increase of people in the provinces testing positive during March, government authorities and health personnel became concerned that the disease could spread like a forest fire through village communities and areas with poorer health services, making it difficult if not impossible to trace and manage. In Yogyakarta (on Java) the first reports of coronavirus infections surfaced during the third week of March. As of 13th May, there have been over 180 reported cases in Yogyakarta. Of these, at least 33 people are over 59 years and at least four **have died**.

Since then the Indonesian government has taken measures to reduce people's risk of contracting the virus. Health media have been instructing people to use and safely discard masks, promoting handwashing and social distancing and persuading people to stay home and avoid large gatherings. The health authorities have also taken to checking people's temperatures and sanitising public spaces. Directives for some of these measures are presented in unthreatening and easy to follow animated films on television and the internet. Indonesian officials have also expressed their concern with the heightened vulnerability of older people, recognising that special measures should be taken to protect them.

One major worry in stemming the virus has been the potential for its spread through

mass inter-regional mobility. With rapidly diminishing economic possibilities in larger cities and the homeschooling policy, there was concern that many people would want to return to their natal village, thereby putting elders at risk. Some returnees were unwilling to self-isolate upon arrival. This caused antagonism towards those who flaunted quarantine procedures. In Yogyakarta, there have been reports of unpleasant situations between villagers and returnees. People were asked to self-quarantine, and basic food items have been organised for those infected with the virus. Some sub-districts in Yogyakarta have turned to more extreme measures. In response to the influx of returnees, residents have independently placed their residential area under lock-down. They have set up barriers in roads leading to their hamlets and placed guards to bar people from entry without permission. Most of the signs on these barriers warn people not to underestimate the severity of COVID-19's

Closure of the main road to a subdistrict in Yogyakarta. The banner reads, 'Emergency Response Centre, main gate for exiting and entering the village'

Photo by Rahayuningtyas

Although village lockdown has not been encouraged by the central government, provincial governments have been allowed to make their own decisions as to what strategies they want to take. Posters with the image of an elderly person requesting younger relatives not to visit them this year have been appearing on street corners.

A sterilising unit in a mosque as one strategy to prevent the spread of the virus by those attending congregational prayers. The sign reads '(It is) required to enter the unit before entering mosque'

Photo by Rahayuningtyas

A further worry was how to manage the movement of people during the days leading up to Ramadan. Normally, prior to the start of the fasting month, many people return to their natal villages for annual visits. Congregational prayers are carried out in mosques and prayer houses, and people break the fast together in larger gatherings. This year has seen encouragement for people to stay put, pray from home and avoid making social visits. For those who cling to the conviction that communal prayer in the mosque is more powerful, sterilising units have been placed at the entrance and the floor is marked to encourage social distancing. With the mosques much quieter this year, the 'takjil' food traditionally prepared for worshippers who break the fast together is being distributed among local families experiencing economic hardship.

Practising social distancing while praying in a mosque in Yogyakarta Photo obtained by Rahayuningtyas

A member of Indonesia Ramah Lansia (IRL)/Indonesian Elderly Friendly Organisation hands over a donation of masks to a hamlet head. The label on the box reads 'donation of non-medical masks for the elderly people's school' Photo courtesy IRL

In Yogyakarta, there is still relatively easy access to medicine and medical facilities. Hospitals and primary healthcare services remain open although older adults are advised to avoid them. Older Indonesians must be initially shocked to see health personnel dressed in PPE. One older adult returning from a hospital visit in Yogyakarta confided to his daughter that he had "a sense of loneliness and fear, the medics and doctors were dressed like astronauts!" He was not the only person to react with anxiety on seeing the new medical dress. The way medicine is represented can influence a patient's decision whether they want to access it. With constant warnings to keep safe from the virus and the sight of hospital personnel attired in a way usually seen only in sci-fi movies, many older adults might feel more than a little anxious to visit hospitals for their monthly check-up or other health needs.

A member of IRL teaching older adults how to wear masks Photo courtesy IRL

Visiting older adults by formal and volunteer carers from primary health care services have been stopped due to the pandemic. Some local volunteers are older adults themselves. Social programmes and activities organised

by concerned local NGOs for the social well-being of the older population have also been temporarily put on hold, as have religious institutions offering face-to-face social services for older people.

Javanese poster on Yogyakarta street corner: 'Son and daughter, if you miss me, just make a phone call. It's the corona season. Don't return (home). Your return will endanger your mother and father'

Photo by Larastiti

During the pandemic there still is family to socialise with. Older adults in Yogyakarta usually live with other family members or have family members living close-by. The younger relatives can purchase medicine and food. Whether this is a safe solution depends on the younger people's own measures to protect themselves in public. For poorer older adults living in small overcrowded houses, it would be difficult if not impossible to keep a distance from an infected family member. We can also surmise that it is most difficult for elderly people to keep a distance from their children and particularly grandchildren who are not living with them. For many older adults who are not technologically literate or lack the appropriate technology, using social media for virtual visits might not be an option. Thus, family members living locally may still try to sneak in a visit. After all, it must be very difficult for a grandparent to reject a visit from an angelically exuberant grandchild!

Letter from Uganda: “People will die of corona even before they get corona”

14 MAY 2020

By Stella Aguti, an independent researcher based in Mbale Uganda; and Ben Jones, Senior Lecturer in International Development at the University of East Anglia.

https://corona-older.com/2020/05/14/letter-from-uganda-people-will-die-of-corona-even-before-they-get-corona/

Sulaiman Odongo Sulaiman in his hometown, Mbale.

What is it like living with hypertension during the COVID19 pandemic? We spoke to Sulaiman Odongo Sulaiman a 68-year-old retired soldier living in the eastern Ugandan town of Mbale. Sulaiman has eight children and like many people of his generation has invested heavily in his children’s education. One of his sons is a medical laboratory technician. He lives with his second wife and a number of relatives, and his wife buys and sells charcoal, and Sulaiman sells water from a tap in his home. Sulaiman has no pension, as he had served in the army of Idi Amin’s government. Like many older people in Uganda is responsible for helping out younger people, while also trying to manage his own poor health.

Sulaiman’s high blood pressure has been with him for some time. In 2004 he collapsed with a stroke and spent three months in St. Martin’s Hospital in Mbale. Sulaiman manages his health carefully. The stroke has left him partially paralysed on one side, and he looks after his condition through taking medicine daily, manging his diet as best he can, as well as going along to a nearby clinic when he feels that his blood pressure is a problem. While Sulaiman sometimes suffers from malaria, he describes this as a ‘minor disease’. It is high blood pressure that has become the ‘major disease’ in his life.

We asked him about COVID19. Sulaiman told us the following:

> It started from China and after that, it moved slowly up to Uganda also. So when it reached in Uganda the President addressed the country and took strict measures such as the quarantine and the lockdown. So now we are staying at home.

In fact, Uganda’s lockdown is one of the severest in Africa. Up until a recent relaxing of the rules on Monday 4 May, Uganda experienced a lockdown where all internal travel was banned, all schools, businesses and most government offices closed. There

is a curfew after 7 pm, and only medical, military and police vehicles are allowed on the road. If travelling by private transport special permission must be sought. If you are found moving after 7 pm or travelling during the daytime without a permission slip, you are taken into the police station and fined.

At the time of our interview, Sulaiman told us there had been eighty-seven positive cases in Uganda fifty-two of which had been discharged. Sulaiman, like many other Ugandans, is concerned about the virus coming into the country and tells us about 'a Kenyan driver who was brought to Mbale Referral Hospital for treatment'. There have, so far, been no coronavirus deaths in Uganda.

More troubling to Sulaiman is the lockdown:

> I tell you the lockdown is not good. It will make you panic. Things are so uncertain. We don't know how long it will be for. It is not easy to survive at this time. Most of us are poor and in town, we struggle for food. People will die.

The safety net available to most people is that of family and friends. Support from the government is very limited. Sulaiman told us that short-term borrowing from friends was one option, but this is becoming harder. Most people have little in the way of savings. As the lockdown continues the situation is becoming harder. For Sulaiman and his wife, the charcoal business has stopped, and they are left supporting relatives who are not able to go out to work. He told us: 'people will die of corona even before they get corona'. Sulaiman wants the lockdown ended and people given the chance to find some food: 'what I know if the government does not release people, they will die of hunger before corona comes'. Sulaiman said that he was down from three meals a day to two meals, sometimes one.

> People will die of corona even before they get corona

Sulaiman is still able to go to the clinic to get medicine and a check-up. Many others in the neighbourhood who need hospital attention or a qualified doctor are in a more difficult position. The government requires permission from the office of the Resident District Commissioner if a patient needs private transport to visit a medical facility. This means many women are not going to the hospital to give birth. Added to this is the collapse of the public transport system. Those who live a long way from the hospital are unable to seek out care. Many of those on anti-retroviral treatment for HIV, for example, cannot afford to go to the hospital to get the medicines they need.

We asked Sulaiman about social distancing. He said that it was very difficult in the sort of neighbourhood he lives in. He has tried to install some hand 'preservative' measures for those coming to get water from his tap and puts out a basin of OMO laundry detergent for handwashing purposes. Sulaiman also spoke of how hard it was to stay inside in the cramped conditions of his two-room dwelling; how talking to his customers, sharing news and debating the virus is one of the few joys in his life at present. The water supply is on and off, and when people know the tap is working they crowd around.

As Sulaiman told us earlier that week: 'the lockdown is working; the lockdown is not working'.

As reported to Stella Aguti and Ben Jones.

Letter from Guinea: “Chez nous, C’est la peur”, COVID19 in one of the poorest countries in the world.

13 MAY 2020

Reflections on the impacts of COVID-19 in Guinea, by Cindy Wilhelm, School of International Development, University of East Anglia, UK.

https://corona-older.com/2020/05/13/letter-from-guinea-chez-nous-cest-la-peur-covid19-in-one-of-the-poorest-countries-in-the-world/

Exactly one year ago I arrived in the capital of Guinea, Conakry. Researching mining sector reforms in the former French colony located in West Africa, I made unforgettable experiences while getting to know the country and its people. And I learned very quickly that life in Guinea is not easy. The lack of water and electricity in the capital, the poor hygiene and overcrowding in spaces like transport or markets, and horror stories from hospitals (including my own experience in hospital) have left a deep impression on me. A common Guinean saying states that public hospitals in Guinea are “butcheries” that are places you go to die.

One of my first thoughts that struck me when the pandemic began to reach Europe was ‘please not Africa. Please not Guinea.’ One by one, the disease reached countries on the African continent, and Guinea was one of them. As of 12 May, **2,146 people have tested positive in Guinea**, with a death toll of 11 and a fatality rate of 0.5% according to the John Hopkins University.

If we believe these numbers, Guinea is seemingly doing well. The fatality rate and death toll are relatively low compared to other countries. Even compared to its neighbours like Sierra Leone or Senegal, things seem to look

The NGO Mining without poverty (AMSP) distributes water containers, soap and disinfectant in the mining region of Mandiana.

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brighter in Guinea.

Ebola has left its experiences in Guinea. The national health agency Agence Nationale de Sécurité Sanitaire (ANSS) that is a legacy of Ebola oversees the provision of information, testing, and is a central point that everyone with symptoms needs to contact.

The epicentre of the disease is in the capital, and three treatment centres have been installed. The central government in Guinea has been quick in its response. The airport has been shut down and commercial flights suspended, a nocturnal lockdown imposed, the use of masks was declared mandatory in public, and the whole city of Conakry is put under quarantine making it seemingly impossible to leave or enter.

Yet, one of my Guinean friends tells me "chez nous, c'est la peur", here there is fear. The fear that the deadly virus will continue to spread and leave the capital and reach the poorest communities in the interior of the country.

There are a few things that speak in favour of Guinea having an advantage facing the disease compared to the experiences in Europe. The Guinean population is extremely young, and life expectancy low. COVID experiences so far and research suggests that individuals older than 65 are significantly more at risk to die from the disease. The 2018 census in Guinea shows that only 3.64% of the Guinean population is 65 years or older. In contrast, 23.3% of the Italian population **is over 65**.

However, Guineans live in proximity in small spaces together. It is common that numerous families share only a few rooms, and to my knowledge, the concept of care homes for the elderly does not exist. Guinea is also heavily impacted by HIV and diseases like Malaria, Dengue, Tuberculosis, Typhoid are omnipresent. Many Guineans might have an immune system that is already under constraints and that might leave them more exposed to the disease.

Yesterday I joined a webinar on the coordination of communication and information campaigns to reach communities in Guinea where NGOs shared their strategies. I asked the panellists, among which two were Guinean doctors, if there was any special attention paid on informing Guineans about who is more vulnerable and who might need special protection. The response was that unfortunately, there was no such strategy yet.

COVID exposes the structural weaknesses encountered in Guinea on a daily basis. Der SPIEGEL **reported from a hospital in Conakry** and a nurse told the newspaper that even without COVID the hospital does not have enough material. She is very pessimistic and feels left alone. During Ebola West Africa had

AMSP Staff providing information about how to protect yourself from the disease in communities in the Mandiana area.

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AMSP Staff providing information about how to protect yourself from the disease in communities in the Mandiana area.

the support of the international community, but now they fear that there will not be any assistance. Le Monde **asks** "How can it be justified to the population that there is only one single ventilator in the public hospitals in Conakry, the capital of Guinea, where the first case has been diagnosed in mid-March?"

Not only medical materials are a problem. The government announced on 06 April that it would cover the costs of water and electricity for three months due to the pandemic. This is quite ironic, considering that there is simply no water access, even in ministry buildings in Conakry. And the tap water that might be available is certainly not safe. And at this time of the year right before the rainy season the hours per day without electricity significantly outweigh those with electricity access. Even the Donka hospital that is one of the COVID treatment centres did not even have running water access until only recently. The Guinean news site Guinéenews regularly reports about the catastrophic situation and lack of capacities in hospitals to treat COVID patients.

NGOs and the private sector have been quick in taking matters into their own hands. International mining companies provide the communities in their areas and government institutions with equipment like masks, hand sanitizer, soap, but even ventilators. The NGOs that I know well that usually work in the field of civil society responses to mining activities were also quick in reaching out to their communities to provide information, but also vital resources.

One of the issues discussed in the webinar, but also that my friends and informants are concerned about, is the lack of information. The centrally provided information is in French, which particularly older people and those without literacy skills in the villages cannot understand. Information in local languages has been slowly spread, and again NGOs have been key. What also concerns me is the spread of fake news that I observe myself, but that also the NGOs are worried about. Dubious remedies against the disease, or the rumour that corona is a virus of white people or travellers only circulate widely.

I fear that despite the Ebola experiences and the possible demographic advantage, COVID may expose this catastrophic infrastructure in Guinea further and lead to a tragedy. If the disease spreads further in Conakry and reaches the most vulnerable communities in the rest of the country, the worst might be yet to come.

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Youth and elderly to leave homes at different times as Turkey eases lockdown.

6 MAY 2020

https://corona-older.com/2020/05/06/youth-and-elderly-to-leave-homes-at-different-times-as-turkey-eases-lockdown/

Turkey has announced it will ease lockdown measures next week that were imposed across much of the country amid signs of success in its efforts to contain the coronavirus.

The move comes despite worries from doctors that the pandemic is still killing too many people and that easing restrictions could backfire.

Starting next week, the youth and elderly will be allowed to leave their homes for short walks in different four-hour slots, and shopping malls, clothing stores and hairdressers will be allowed to reopen, Turkey's President Recep Tayyip Erdogan announced in a televised speech on Monday.

In addition, Turkey is lifting domestic travel restrictions on seven provinces that are tourism destinations, including the seaside cities of Antalya and Bodrum. Mr Erdogan also announced that authorities would allow the sale of facial masks, banned to prevent profiteering.

The lockdown on other major cities, including Istanbul, Ankara, and Izmir will continue, and Mr Erdogan warned that if social distancing and hygiene rules were not maintained, including the wearing of masks in businesses and offices, the government could reverse course and reimpose stringent rules.

"We are at an important point in the fight against the epidemic," Mr Erdogan said. "Our number of patients is constantly decreasing, and the number of patients that are recovering increases exponentially. We will return to normal, but this will be a new normal. Nothing will return to the order we knew before in our country as well as the whole world."

Turkey has imposed draconian restrictions on public life, shutting most businesses and barring anyone under 20 or over 65 from the streets. Weekends have been even more severe, with all but essential medical and security workers confined to their homes in 31 provinces.

The removal of the restrictions comes as the country has seen the daily death toll from Covid-19 plummet from a peak of 127 on 19 April to less than 65 over the last two days. But the Istanbul Chamber of Medicine, a doctors' association, has warned against easing measures too soon. Turkey has the eighth-most coronavirus cases and 12th highest number of fatalities in the world despite possibly undercounting infections.

At least 3,461 people have died of coronavirus in Turkey and more than 127,000 have tested positive. The chamber said that the number of deaths in Istanbul province, the region of the country hardest hit by a coronavirus, was between 3 and 35 per cent higher this year than previous years, suggesting a possible undercounting of cases.

"Despite the decrease in the number of patients applied to hospitals and the inpatients in the eighth week of the pandemic compared to previous weeks, the danger remains serious in Istanbul," said a statement by the chamber. "The discussion about the relaxation of measures should be evaluated in the light of this fact and that the cost of an early and wrong decision will be heavy."

The staggered approach to removing restrictions resembles the strategy employed by other nations, including France and neighbouring Iran, which are lifting lockdowns in various regions according to colour codes corresponding to the severity of the pandemic.

Turkey's economy was already in dire straits before the pandemic struck, with inflation rising, the currency losing value, and a $437bn mountain of foreign debt bearing down on the country.

Mr Erdogan has been eager to get the wheels of the economy spinning, and the government has permitted some construction, manufacturing and mining to continue even as much of the country was shut down to prevent the spread of the virus.

This story was originally published on *The Independent* and can be accessed **here**.

Older people and COVID-19: Making the most of the lockdown in Jordan.

6 MAY 2020

By Sameer Sharbaji.

https://corona-older.com/2020/05/06/older-people-and-covid-19-making-the-most-of-the-lockdown-in-jordan/

When I first heard about COVID-19, I did not take it seriously. I thought it would never come near Jordan since China is very far away from us. But after reading and hearing more information about it, and when cases in Jordan started growing, I started to fear for me and my family's wellbeing.

After becoming a pensioner, the only way to fill my free time was to go to the mosque, meet my friends and pray together. One day when I went to pray and found the mosque's door was closed with a paper that said 'The mosque is closed for your safety, please pray at your homes', I cried.

COVID-19 has affected my life greatly, I have stopped going out, I have stopped going to the mosque and I have a lot of free time. But at the same time, now my family and I pray together, including my grandchildren. We eat all of our meals together which brings us closer. It has given us time to communicate and become closer to each other, especially with my grandchildren – I teach them and help them with their homework.

We follow all the precautions, I am strict about this with my family. it is a must to wear masks and gloves when going out and to sanitise and clean everything. Luckily my daughter and son understand that my wife and I are over 60, and the virus poses greater risks to us because of our age. And of course, we are forbidden by the government to go out, so they always go and get the groceries for us.

The number of cases in Jordan really worries me, but what worries me, even more, is how many people are risking their lives and the lives of others by breaking the law and going out, even though the government has banned going out. It seems they don't understand that this disease spreads easily and fast, and it can be fatal to those whose immune system is weak. It worries me that some people might have COVID-19 and sit with their families, without getting checked, even though it's free to do so. Putting their family's

lives at risk is not worth whatever reason they hide.

Thankfully, I have all my medicine. I am also very pleased with all the precautionary measures that the Jordanian government is taking. It was very quick to take actions and control the situation. I feel the government is closer to us the people. If you call 911, they will immediately come and test you for COVID-19. If the test comes positive, they will take you away and monitor your wellbeing and the wellbeing of those who came in contact with the patient. The number of recoveries is growing every day.

This blog was originally posted on HelpAge International and can be accessed **here**.

A world turned upside down: COVID19, poverty, and older people in Chennai, an Indian metropolis.

5 MAY 2020

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https://corona-older.com/2020/05/05/a-world-turned-upside-down-covid19-poverty-and-older-people-in-chennai-an-indian-metropolis/

While the general expectation is that COVID19 will run wild through the high-density, low-income settlements inhabited by Chennai's economically marginalised, what is also being seen is a great deal of suffering due to the impact of the virus. This suffering is observed in the deepening impoverishment and changing intergenerational relations that is forcing some older people into greater dependency while marginalising others into depleting economic engagements.

Currently, the greatest threat for people living in low-income settlements is the COVID19-related impacts. First, India is a highly segregated society. Segregated by class, caste and labour conditions, in which 90% of workers have no rights, and are mostly employed on daily wages. There are few points of contact that would provide person-to-person spread between slum dwellers and the 'flying classes' who brought the disease to India on flights from Wuhan, UAE, Italy and so on. Further, the longstanding stigmatization of slum dwellers and low caste people as sources of contagion, which underpins widespread human rights abuses in India, meaning that the people most likely to be carrying the disease, the middle classes, shut off all contact with those least likely to have it—slum dwellers.

Second, India implemented a lockdown on the 25 March, when it only had 519 cases, quarantining tourists, banning international commercial flights and suspending train services. Third, it established Containment Zones for any buildings or areas with one or more confirmed cases. Containment is backed up with targeted testing and tracing. As of 29 April, there are 170 containment zones across India and 1075 deaths. In these zones no one can leave their homes and groceries are delivered through government channels.

The lockdown and containment are stringently policed, often heavy-handily. For most of the urban poor Covid-19 has brought their economic lives to a standstill. Research undertaken in five Chennai slums between

2007-10, including the 2008 international banking crisis, that translated into a significant economic slowdown in Chennai, is instructive. Chennai's labour market is segregated by age, gender and education, and has until now provided considerable economic space for older people, who occupied the areas of the economy that younger people had vacated for higher status, easier conditions and better pay. Young people from low-income households tend to work in locations seen as modern, in shopping malls, driving taxis, on large building sites and in factories as well as domestic work. Middle-aged and older women tend to be self-employed, hawking goods, trading as pavement vendors in street markets. Middle-aged men drive auto-rickshaws, older men work as security, security guards and cycle-rickshaw pullers. The building sites, shopping malls and factories have shut. People servicing the 'balcony class', many of whom now work from home, have been told to stay away. What remains open as sources of work for slum dwellers?

Subsidised, Amma canteens, mostly staffed by middle-aged women, hospital work for young women, street markets which provided the main arena of work for older women selling greens, vegetables and flowers and some associated transport work for older men as market porters, rickshaw pullers and auto-drivers. People on low, insecure, daily incomes do not earn enough to save. There is no question that after five weeks without work everyone in Chennai's low-income settlements, whose nutritional status would not have been good, anaemia and malnutrition being endemic, will have cut food expenditures to the bone – commonly to one small carbohydrate meal a day and fermented rice water, which people resort to when they have nothing else. Protein and vegetables will be rare, especially if people are trading pulses for rice to put more food on the plate.

Beyond this, the wider context impinges on people's health and capacity to seek healthcare. Water shortages and temperatures ranging from 34 degree Celsius to 40 degree Celsius contribute to dehydration and heatstroke. Free health services are centrally located, hence inaccessible for most people, while private doctors and medication need to be paid for. All this in a context where male slum dwellers already have a life expectancy of 5 years less than non-slum, reflecting globally established social gradients in morbidity and mortality. Slum residents will have lost assets, being unable to redeem pawned items, and will be working their way through what assets that remain, a steel cooking vessel, a sari. Many will have nothing to pawn and unless they have a regular pension to back a loan, will not be able to get credit for food or even minor pharmacy expenses. They will not be able to pay or collect rents, creating a range of problems for renters but also for people, particularly older single women, who sub-divide their dwelling for an income. Most importantly, the family, neighbour and kin networks on which older and younger depend to reduce poverty risks will be unable to help them.

For the urban poor starvation, uncared for sickness and deepening vulnerability are currently the greatest dangers they face; these will drive them back into finding work, often servicing those classes and sectors who comprise the current pool in which COVID-19 swims. This will bring the virus to the slums. It will happen for two reasons. First, the competition for work will necessitate a rapid re-establishment of prior economic relations. Second is the paucity of government provision. The government provided basic rations of no-cost rice, pulses, oil and sugar and Rs1000 to the poorest ration cardholders. The Government also paid Rs1,000 payments to members of the unorganised sector Welfare Boards, whose coverage of the targeted population is poor and random and to registered pavement vendors, yet most older vendors are not registered. The Old Age Pension is Rs1,000 per month for the proportion of qualifying people who receive this provision, capped well below the numbers who need it. What does Rs1000 amount to? Thirteen years ago rents in Chennai's slum

settlements were commonly between Rs600-Rs1250 per month. In 2007, for Rs600 it was just possible to rent a run-down, thatched hut big enough to roll out two single person mats on to a bare mud floor, no light, no water, no toilet. In 2020, a one-off payment of Rs1000 for a lockdown that would last six or more weeks is gestural politics. Street markets and associated activities represent a key self-organising arena of essential economic activity, largely abandoned by young people and overlooked by the State, has until now provided opportunities for older people to work in a context in which state welfare provision is derisory and coverage random, being primarily aimed at vote banking rather than welfare. The question is whether current government organizing of vegetable distribution in Containment Zones and relocation of wholesale markets will generate long-term attempts to relocate and license trading.

Experience has demonstrated that in those contexts, ageist norms are used to lock older people, particularly older women, out of their livelihood. There is a danger that older people will be displaced in markets by younger people, either their younger family members or via market organisers, thereby forcing them into greater poverty and dependency – assuming that they have people on whom they can become dependent. In this world turned upside down, the poor are, currently, much more at risk from excess, COVID-related deaths than COVID-19 itself. Loss of health, assets, jobs, housing and the disruption of social and economic networks beyond their settlements are the immediate impacts of lockdown. There will be mid and long term impacts. At best mid-term impacts will be relatively short-lived, requiring greater labour force participation for everyone in low-income settlements – but not the 'pull your socks up' participation that neo-liberal economists like to think will raise household incomes. People of all ages and abilities will be forced onto the labour market, lowering pay rates. Older women and men, a higher percentage of whom are already in paid work more than people aged 15-19, will be forced into more body depleting hours and conditions on less pay, in a context in which ageism in employment and wages is well established. Family and kin networks will develop holes due to the underlying health conditions, deepening nutritional deficits and untreated morbidity under COVID conditions and directly from COVID-19 if it gets into the slums. Tamil Nadu is a state with a comparatively low fertility rate. COVID direct and indirect consequences will sharpen the long term risks of reducing the size of family networks in the context of weak state support. Older people with small, depleted or no family, with no or inadequate pensions or who have lost work will find their capacity to cater for themselves or to rely on others significantly constrained. They could well become even more tied into impoverished family networks that increasingly depend on older people's inputs. There is no getting away from the need for a realistic income for all people over age 60 and a pension programme that guarantees such. Irrespective of whether COVID-19 finds its way into Chennai's low-income settlements or not, excess COVID-related deaths are a certainty. Whether they will ever be recognized as such will come down to politics.

Letter from Jakarta: Tales of resilience and vulnerability amidst COVID-19.

5 MAY 2020

By Florencia Yuniferti Sare & Elisabeth Schröder-Butterfill.

https://corona-older.com/2020/05/05/letter-from-jakarta-tales-of-resilience-and-vulnerability-amidst-covid-19/

Indonesia has so far seen approximately 12,000 confirmed COVID-19 cases and more than 400 deaths. The epicentre of the Indonesian pandemic is Jakarta, home to nearly 10 million people. Many of these maintain close ties to their communities of origin spread across the archipelago. Here we report on the situation in a densely populated, relatively impoverished urban neighbourhood (kampung) of Jakarta. Nearly 30,000 people live in an area of less than 0.3 square km, with dwellings, small shops, home industries and garment factories crammed close together.

Since early April, a poster published by the Jakarta government has been widely distributed. It highlights the special dangers of COVID-19 for older people and provides guidance for keeping older people safe. This poster has caused confusion among local health volunteers (kader): How can 1-metre distance (let alone 2, as advised in the UK!) be maintained when interacting with elderly people? How can good ventilation and sunlight be ensured? On average, dwellings are just 30 square meters in size, often shared by 8 or more people. The alleyways are so narrow that hardly any sunlight penetrates. Many of the houses are dark, narrow, and stuffy, and the recent floods in Jakarta mean that if it rains, water still seeps through floors and into the alleys. Given the degree of crowding, residents are long used to treating the

Photo credit: Haryo, BBC News Indonesia, 28.04.2020

alleyways and passages as natural extensions to their homes. Much of daily life happens here: washing clothes, cooking food, selling vegetables, catching sunrays and chatting. "We have to be clever here", says one health volunteer. "It's impossible to keep a distance according to the government's instructions. So, we have to find other ways to avoid infection." The instruction to 'stay at home' has been reinterpreted to mean 'stay in the immediate neighbourhood'! Entrance points to the kampung, such as a bridge over a river forming a natural boundary, have been sealed off.

A key local response has been the purchase of water pumps and handwashing facilities throughout the neighbourhood. A resident, recently qualified as a doctor, provides training on correct handwashing to health volunteers, who in turn pass on this knowledge to others. Elderly people are also instructed in this way. Besides, great efforts are made to keep the environment clean, for example by spraying houses and alleyways with disinfectant every few days. The area is home to several garment factories which produce textiles, especially for export to Africa. As export has been temporarily suspended, many of the factories have closed. However, some have been repurposed to make protective gear. Thanks to the generosity of these factories, thousands of re-usable masks have been distributed among residents. It is hoped that this measure will help to prevent the spread of the disease.

So far there have been two confirmed COVID-19 casualties in the neighbourhood, and several people have tested positive. Their identity is being protected, but this causes concern to the village officials who feel they need to know which areas to isolate in order to keep others safe. Thus far any identification of cases has been as a result of people approaching the health centre or hospital, not thanks to any symptom tracking or testing in the community. For this, there aren't the testing resources, nor the protective equipment to undertake such work safely.

The collective response to help mitigate the effects of the lockdown have been tremendous. Every day a changing team of volunteers prepares parcels of cooked food for approximately 100 households in the kampung. The primary targets for the food distribution are elderly people, to reduce the burden on their families, many of whom have experienced job losses in recent weeks. Intergenerational co-residence is the norm in this crowded location, and most elderly people depend on their children and grandchildren for their daily needs. Relatively few older people still work. In addition to the cooked food, there are handouts comprising rice, oil and other essentials from the President and the Governor of Jakarta. This targets more than 3,000 households in the kampung. As there is considerable overlap in the recipients of presidential and gubernatorial largesse, there have been understandable grumbles from

Photo credit: Neneng, RW09

residents who have not received any support. A local leader thus exhorts those who have benefited to remember their neighbours and "share the fortune, especially in these difficult times".

Since the end of March, all regular health programmes conducted by local health volunteers (kader) have been stopped. This includes drop-in health services for elderly people and home visits by health volunteers. News that one volunteer in a different part of Jakarta died of coronavirus following a home visit on a dengue fever prevention programme has acted as a strong disincentive. However, health monitoring efforts continue, albeit in a different mode. Kader women have organised themselves into WhatsApp groups to report on local circumstances in real-time. Health volunteers keep tabs on elderly people who are unwell or have not been seen for a while. Visits still happen, but any enquiry is done from the threshold of the house and while wearing gloves and a mask. What causes the most concern is that all routine health checks and hospital visits have been put on hold. Elderly people with diagnoses of cancer, high blood pressure, cholesterol, stroke or heart disease are no longer being sent to the hospital for check-ups, as the primary health centres who make referrals consider this too dangerous. One woman explained that she phones the doctor when her mother needs a repeat prescription. But without her mother being properly examined, how can she be sure the medication and dose are still correct? Of course, some elderly people have never seen a doctor when ill, they merely drink jamu (herbal remedy). For them, the lockdown has not affected their healthcare.

Ramadhan this year is a quiet affair, with all communal prayer abolished and visits home by migrant labourers forbidden. The fast is still broken at sunset in the alleyways in front of people's houses but in small groups of families who live close together. Yet for many elderly people in the neighbourhood, the lockdown seems to bring unexpected rewards. As one resident put it: "I see my parents laughing more, joking, looking happy because we are all together. Maybe it's different in other families. But the impression I get is that elderly people are happier because now many people are engaging them in a chat. Now everyone has time for elderly people."

Letter from Philippines: Older people in Bulacan, Philippines subject to unofficial village curfews.

28 APRIL 2020

By Joseph H. Batac.

https://corona-older.com/2020/04/28/letter-from-philippines-older-people-in-bulacan-philippines-subject-to-unofficial-village-curfews/

The Philippines had only one case when the World Health Organisation (WHO) declared COVID-19 a Public Health Emergency of International Concern (PHEIC). When the WHO declared COVID-19 a pandemic, the Philippines had forty-five cases of infection and two deaths. Most of these cases were in Metro Manila and the adjoining provinces of Luzon Island.

On 15 March 2020, the highest public health alert level was issued by the Philippine Department of Health, with social distancing as the main measure, and lockdown for Metro Manila and Luzon Island. Only public and private health services were allowed to continue operating while the rest of the economy was shut down.

Bulacan Province is located to the north of Metro Manila. In December 2019, the provincial government launched a program on ageing headed by Bulacan State University. This program focused on a number of strategies to enhance the wellbeing of older people: food, fitness, faculty (mental stimulation), friends, family, feelings, faith, financials, future and fear. For simplicity, F10 was the title of the program. F10 was conceptualized with the active involvement of the heads of the senior citizen organizations in each of the 24 towns and cities of Bulacan province.

In the F10 monthly meeting of March 2020, COVID-19 was discussed with reference to reports from the WHO and China. It was emphasized that older people are at high risk of contracting the virus and of dying. There was consensus about a need to take extra precaution, given the lack of immunity or a vaccine. The preferred action was for people to stay at home more often.

Like most local governments in low and middle-income countries, Bulacan Province had no pandemic preparedness plan in place. The initial information on managing the spread of COVID-19 focussed on personal hygiene. When the Luzon island lockdown was

put in place by the national government, the idea of social and physical distancing became more prominent. In fact, some villages have imposed a 24/7 curfew on older people, even though there were no written, formal directives from any national or provincial government agencies. These 24/7 curfews for older people have been enforced by volunteer village security forces and community watch groups who, just like local public health personnel, the police and the military of the national government, do not have any education or training on COVID-19.

There have been no protocols or guidance about the care and support of older people during the pandemic from either the national nor provincial governments. This complete lack of timely and accurate information on the management of COVID-19 for older people has influenced the approach taken by village security forces and local public health personnel. Even basic information on nutritional support to strengthen the immune system and physiology was not available. This has resulted in older people being simply confined to their homes, relying on family and neighbours for access to their daily food needs, medical services and social outreach. The quality of life of these older people has deteriorated markedly in physiological, psychological and sociological dimensions during six weeks of lockdown to date.

> *This has resulted in older people being simply confined to their homes, relying on family and neighbours for access to their daily food needs, medical services and social outreach.*

While the lockdown was able to reduce the infection rate of COVID-19, nearly 70% of deaths are among older people. The national government has just extended the lockdown period for another two weeks, until 15 May 2020. Even so, there is no local government discussion or plan about how to provide older people in the community with support for testing, tracing or coping with the problems caused by social isolation and village curfews.

Once the lockdown is lifted, there will be a need for Bulacan Province's Organization of Older People to organize and plan for life over the next two to three years by which time a vaccine will hopefully be administered and/or herd immunity has taken hold. The F10 program will have to be revised and updated to consider changes in the community-based public health system caused by the pandemic.

COVID-19 will hit the elderly even harder in developing countries.

25 APRIL 2020

By Peter Lloyd-Sherlock and Karl Pillemer.

https://corona-older.com/2020/04/25/covid-19-will-hit-the-elderly-even-harder-in-developing-countries/

Even as the devastating effects of the coronavirus epidemic on human health, economic well-being and social institutions become known in countries like ours (England and the United States), there is an even greater tragedy in the making: the unimaginable suffering in developing countries for older people.

Developing countries will be the hardest hit by the coronavirus (even if the leaders of some of those countries, such as Brazil's President Jair Bolsonaro, beg to differ), yet the global call to arms to fight the virus focuses almost exclusively on the young. At first glance, this may not seem surprising, given the relatively youthful populations in many African, Asian and Latin American countries. However, the demographics say otherwise.

Many of these developing nations have been rapidly catching up with the richest countries when it comes to ageing. Indeed, these nations now account for almost 70 per cent of the planet's population aged 60 or more (that's about 723 million older adults). Brazil alone contains 30 million people 60 and over, and India 140 million, compared to 76 million in the U.S. These elders are the virus's most vulnerable targets.

In many of these places, therefore, the proportion of people infected with coronavirus who then go on to die will be higher than what we have seen in China or in developed countries. The capacity of health systems in many developing countries to screen, let alone treat, COVID-19, is very limited.

Each coronavirus test costs around $50, which exceeds yearly government per capita health spending in places like Bangladesh, Benin and Haiti. Limited access to masks and other forms of personal protective equipment (PPE) will lead to massive losses among already depleted health workforces. The availability of ventilators and critical care is negligible.

Mortality for older people will be driven up by high rates of diabetes and cardiovascular

disease in developing countries; these are no longer diseases unique to the developed world. Imagine the case of South Africa, which has the highest reported rate of adult hypertension for any country on the planet, rich or poor. And that is before we consider the potential effect of HIV, which remains a widespread condition in many of these populations.

There are also reasons to expect high overall rates of infection in many developing countries. Other than for the lucky elites, social and physical distancing is largely unfeasible in the cramped and overcrowded neighbourhoods of cities like Jakarta, Nairobi or Port-au-Prince. The demands of daily life and livelihoods will make draconian lockdowns untenable, no matter how brutally they are enforced. Significant numbers of people, young and old, still lack access to water, soap and opportunities to support basic hygiene.

Where do older people come in? Some experts have run the numbers to see how many people at different ages could die of COVID-19 if Chinese fatality rates were to apply. The results are chilling. Even if only 10 per cent of the population of developing regions were to be infected, they indicate that over nine million deaths would result—of which 6.8 million would be among people aged 60 or over. Applying these assumptions just to Brazil would mean 258,000 deaths—something Bolsonaro might keep in mind when he makes statements such as "Some will die. I'm sorry. That's life."

Unfortunately, international responses have been inadequate in recognizing the special vulnerability of the aged. For example, the World Health Organization's single set of guidance for older people refers only to those living in long-term care facilities, which are a rarity in developing countries. Moreover, the guidance is lost in WHO's Web pages, hidden inside a section on "schools, workplaces and other institutions."

Although our knowledge about the virus and of what works is still in its infancy, however, there are relatively simple things poor countries can do to lessen this impending old-age calamity. For example, some are encouraging older people to send younger family members to collect medication or pensions on their behalf. Even if these measures were to have only marginal effects, the sheer numbers of potential deaths mean that they could translate into many thousands of lives saved.

Some national governments are hurriedly putting together guidance and emergency plans. To some degree, they recognize a need to consider the special vulnerabilities of older people. But this is a challenging task. What quick advice might you offer a community nurse who has mainly worked in maternal and child health about how to assist a frail, confused older person with multiple health conditions?

It is clear that ageism is not just the preserve of richer countries, and that mitigation strategies, while important, will not be enough to protect the most vulnerable. Tragically, it may take the wave of elder deaths that is about to hit the world's poorer countries to shift these skewed priorities.

Originally published in the *Scientific American* and can be found here.

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Coronavirus and other health conditions: So many more questions than answers.

19 APRIL 2020

By Peter Lloyd-Sherlock and Max Bachmann, University of East Anglia.

https://corona-older.com/2020/04/19/coronavirus-and-other-health-conditions-so-many-more-questions-than-answers/

In the midst of our current anxiety about Coronavirus, there are so many different issues, so much complexity we are all struggling to understand and make sense of. One of these challenging issues is how a single health condition may interact with the multitude of other ailments, illnesses and aches and pains we all endure on a frequent basis.

None of us is perfect when it comes to health [1]: we all have something going on most of the time. So, when does this backdrop of imperfections amount to what the new canon on COVID-19 darkly refers to as "underlying health conditions"? Or to what clinicians and scientists call "comorbidities". [2]

In the emerging tradition of our webinar blog series (last week's one on ageism is here), our aim is limited to asking a few simple questions and establishing a framework for future thinking.

The most high-profile question is **how do different comorbid conditions affect people's risk of developing severe symptoms and of dying**, once they are infected with COVID-19. There is already robust evidence that these effects can be significant for a range of conditions, including heart disease, diabetes, high blood pressure and lung disease.

Twenty years ago, you might have been forgiven for thinking that these health conditions were rather uncommon among older people living in low and middle-income countries (LMICs). Today we have a wealth of evidence that they are widespread. For example, a WHO survey found that nearly 80 per cent of older people in South Africa have dangerously high blood pressure. At the same time, low coverage of older people in LMICs for vaccinations against influenza and pneumonia puts them at particular risk if they develop acute respiratory symptoms as a result of COVID-19.

A related question is **how different health conditions affect people's risk of becoming**

infected with COVID-19 in the first place. Public debate has quite rightly focussed on the importance of things like hygiene and physical distancing. But we shouldn't forget that natural immunity to viruses is not a fixed entity –it can vary greatly between people and for the same person at different times.

Old age itself is associated with declining immune function (what geriatricians awkwardly term "immunosenescence"). But so are many, many other things ranging from Vitamin D deficiency to general stress. And some conditions (or treatments such as chemotherapy) can lead to a virtual shutdown of the immune system.

A third big and complex set of questions refers to **non-clinical interactions between comorbid conditions and COVID-19**. This can include behavioural effects. For example, the evidence is rapidly emerging that older people in all countries are now at significantly higher risk of dying of conditions unrelated to COVID-19, because they are reluctant to access health services (due to fear of infection or not wishing to take precedence over "more urgent" cases) or as services are becoming less available to them.

A Canadian oncologist recently tweeted: "As a high volume cancer surgeon, I've noticed a significant decrease in referrals during COVID. Will we see a wave of advanced cancers presenting post-COVID?" In LMICs where access to life-saving treatment was very limited even before the new pandemic, these effects will be even more acute. This is just one example of many other interactions.

How do we help older people get medication and treatment for chronic health conditions without exposing them to infection in health facilities swamped with COVID-19 cases? What are the specific challenges of managing the condition for people with dementia? How can we avoid a vicious cycle of isolation, loneliness, stress and depression among older people?

So many questions….

For the sake of completeness, we will add just one more set of issues to the list. **Over the longer-run (months and years), how will COVID-19 interact with other health conditions?** This may be a less immediate concern for now but may come to prominence sooner rather than later. Evidence is emerging from China and other countries that some COVID-survivors will face permanent damage to the lungs, heart, liver, kidneys and other organs, as well as chronic fatigue.

Our webinar on 24 April will try to start to address some of these issues. We don't expect to do more than scratch the surface of this colossal and multifaceted public health crisis.

Before then, you may find these resources helpful:

Alzheimer's Disease International. Advice and support during COVID-19

The NCD Alliance. Coronavirus (COVID-19)

REFERENCES

[1] The World Health Organisation defines health as: "a state of complete physical, mental and social well-being and not merely the absence of disease or

[2] "Comorbidity" basically refers to one or more diseases or conditions that occur along with another condition in the same person at the same time. In theory, this could include just about any condition under the sun, but most scientists prefer to focus on more serious ones.

The COVID-19 pandemic: India faces the biggest challenge of the 21st Century in the form of the COVID-19 pandemic.

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By Dr Dhanasree Jayaram.

https://corona-older.com/2020/04/17/the-covid-19-pandemic-india-faces-the-biggest-challenge-of-the-21st-century-in-the-form-of-the-covid-19-pandemic/

The COVID-19 pandemic has left the whole world scrambling for options to tackle the worst crisis that it has witnessed since the **"Second World War"**, as put by the United Nations Secretary-General, António Guterres. The unprecedented situation has brought disarray in many countries, and in reality, it has shown gaping loopholes in the existing governance mechanisms in most countries, irrespective of the stage of development they are in.

India, a **lower middle-income country** (according to World Bank classification) is grappling with several challenges as the government imposed a 21-day nation-wide complete lockdown on March 25 and it has now been extended up to May 3. The country is expected to continue to be at risk even if the health (and mortality-related) challenges are sufficiently addressed in light of crippling of its economy and its developmental gains possibly being eroded.

The Indian Government was swift to declare the lockdown – a more stringent version in comparison to many other countries – to drive a population of more than 1.3 billion into practising 'social distancing'. When the lockdown was announced by the Indian Prime Minister Narendra Modi, the numbers of infected cases and fatalities were still slow, but everybody was aware that this was only the beginning of the **growing number of COVID-19 infection clusters** across the country, particularly in cities such as Mumbai, Delhi and Bengaluru. **Testing** has been ramped up in the past few days, but testing and healthcare facilities (including ventilators) remain limited. It is clear that the country has a long way to go in terms of aggressively adopting the 'trace, test and treat' strategy that some countries like South Korea have implemented.

What does the lockdown mean for the disadvantaged sections?

The central and state governments in India have chosen to prioritise lives over livelihoods

as of now, under these circumstances. The plight of the migrant labourers, in particular, is yet to be effectively addressed by the authorities. There is a brewing humanitarian crisis in the Indian cities as the unemployed migrant labourers are trying to return to their homes in other states. Daily wagers, construction workers, house helps and millions of other Indians working in informal sectors are hit adversely by the lockdown. The concerned authorities have done little to provide these migrant workers **"safety, shelter and food"** in these difficult times.

Slowly, states are waking up to the problem though, as in the case of **Maharashtra**, which has released a five-point action plan that consists of steps to provide various types of assistance to migrant workers. At the end of the 21-day lockdown, a law and order situation cropped up as migrant workers crowded at one of Mumbai's (Maharastra's capital city) railway stations to return to their hometowns in huge numbers. The state also has reported the highest number of COVID-19 cases in the country (over 3,000, as of April 17). As much as, or at times, more than the state agencies, **non-governmental organisations** (NGOs) have been active in delivering much-needed humanitarian assistance to the disadvantaged sections, especially by offering free meals.

The **Finance Ministry** has been struggling to tackle the economic slowdown since last year, but with the COVID-19 crisis, the situation has worsened. It plans to release financial relief package in a staggered manner, according to reports, specifically to aid industrial and service sectors, and the socio-economically underprivileged sections. However, the fear is that even though the government has announced **direct cash transfers to women**, disabled, and farmers; increase in the provision of food grains; and provision of free cooking cylinders among other measures, these may negligible in comparison to the scale of the problem that the country faces.

Impacts on the Older People in India

If there is one section of the population that is at a much higher risk of infection as well as fallouts of the lockdown, it is the older people. Not only are they anxious about the higher mortality rates among the older adults, but also they are struggling to carry out their **daily household chores, as well as obtain essential supplies** and healthcare services (that are, to a large extent, dedicated to combatting the pandemic). They are battling loneliness too, as the lockdown has cut off most of their social contacts.

According to data produced by HelpAge India, around six percent of India's older people live alone and a significant proportion of them live in villages (as their children migrate to cities in search of employment opportunities), where the support systems usually exist in the form of **self-help groups and community setups**. If these systems are not adequately functional, the older population is left even more vulnerable.

In many states, including Punjab, Uttar Pradesh, Haryana, and Kerala, state governments and local administrations are taking steps to ensure the supply of essential and medical supplies. In India's Information Technology (IT) hub, **Bengaluru**, NGOs and other private actors are also stepping in to provide any form of assistance to older people by delivering essentials, providing mental health support in these distressing times and so on.

The road ahead is daunting

The implementation of many well-intentioned proposals and measures need to take place at various levels of governance (central, state and local bodies) as per a timeline. However, most often, the urgency of the issues is not recognised and they are trapped in bureaucratic red tape, whether it concerns the shortage of masks and sanitisers or the disbursement of financial packages. Some

states are doing better than the others are. Among the better-performing ones, Kerala (that was at one point leading with the most number of cases) is now flattening the curve, with cases of recovery outnumbering that of active ones and fresh infections – thanks partly to its **decentralised** systems.

India has been able to reduce its poverty rate and enhance people's living standards in recent decades (as evident in the rise of the middle class). However, an extended lockdown could erode these achievements due to the unparalleled effects of the pandemic, lockdown and other measures on health, jobs, incomes, supply/demand, education, and food security among others. In fact, the persisting income inequality and the digital divide could worsen. **Food riots** could happen if the people's requirements are not met through social provisioning, especially those whose incomes have been disrupted completely.

There is a discernible spike in the number of cases in many parts (clusters) of the country and the level of uncertainty about the peaking of COVID-19 infection is high. The **mathematical models** seem to be giving different predictions about the peaking of infection and the kind of measures that can help curb the spread of the virus. In such a scenario, the extension of the lockdown was obvious. Yet, the Indian Government needs to do everything it could to keep the economy afloat and social security schemes functioning amidst the COVID-19 pandemic.

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Trying (and probably failing) to make sense of ageism in the midst of COVID-19.

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By Peter Lloyd-Sherlock.

https://corona-older.com/2020/04/11/trying-and-probably-failing-to-make-sense-of-ageism-in-the-midst-of-covid-19/

Writing about ageism and COVID-19 is not for the faint-hearted. Whatever gets said is likely to offend at least one constituency and get shot down in flames by others. And, frankly, I don't feel sure of my ground about what the right questions should be, let alone the answers.

But, as this is such an important issue of the day, it's worth having a stab at saying something with the aim of provoking debate. One "safe" question is probably: **"What has changed (if anything) in terms of ageism and health as a result of the COVID-19 pandemic?"**

This needs breaking down into questions about specific changes, like:

- A change in the overall importance of the issue of ageism and health (or at least in a growing profile and awareness of its most egregious forms).

- Specific ways in which ageism plays out in the COVID-19 pandemic. Of course, denying older people life-saving treatment is nothing new in high-income countries. And, arguably, it is more the rule than the exception in many developing countries due to the combined effects of resource scarcity and age-discrimination. Ventilators are just the tip of a tragic and unacknowledged iceberg. (As an aside: There is a worrying circularity about using higher fatality rates among older people to justify denying them access to ventilators, which then increases fatality rates among older people).

- Changes in the discourse of ageism, ranging from the increasingly desperate efforts of campaigners to promote a rights-based approach that says age should never be a consideration in decision-making to the quasi-eugenic (and to my mind, criminal) advocates of letting a few old people die for the "greater good". Elsewhere, a new narrative of brutal pragmatism calls for age-based triage on

the principals of "women and children first to the life-boats".

So even as I draft this blog, what seemed a more straightforward question is starting to come apart at the seams…

To figure out what may have changed in my own personal thinking, I re-read a blog on ageism and health I did for a human rights organisation a couple of years ago. You can find it here: **https://ageing-equal.org/trying-to-make-sense-of-ageism-in-health/**

Here are some bits I picked out with my virtual highlighting pen, interspersed with new thoughts.

"Often, decisions about access to health care take into account the age of the individual. When can this be considered reasonable prioritisation of scarce resources and when does this become unjustifiably ageist?"

An easy question to ask. A fiendishly difficult one to answer.

"there is entrenched ageism in health policy and practice, at both the global and the national levels".

This has been one of my hobby-horses for many a year, mainly with reference to the marginalisation of older people from non-communicable disease policy and targets. In the light of COVID-19's disproportionate impacts on older people, it seems fair to ask whether global and national agencies have started to address their own ageism, or whether it is still business as usual.

Sadly, the evidence suggests little change to date. WHO has shown little inclination to place older people at the centre of its responses to the pandemic (despite the best effort of some individuals in that organisation), prompting an **open letter in the British Medical Journal**. This morning I came across a new **UN Policy Brief on COVID-19 and Women**. Based on a quick scan (all any of us have time for these days), it appears to be an excellent document. And, yes, it does refer to older people. Just the once, mind you, and on page 14. By contrast, the brief goes to great lengths to discuss the vulnerabilities of girls and younger women, gender-based violence (but not elder abuse). To my mind, this brief is a perfect reflection of the priority-landscapes of global health and development networks. Older people occasionally get a look-in, but almost never more than a glancing mention. Even when they are one of the key stakeholders for that particular issue.

In the past, I was not sure where I stood in terms of the need for a global UN-type agency with an exclusive mandate to represent the interests and vulnerabilities of older people. The COVID-19 pandemic (and WHO's tragic decision in 2018 to shut down its only department with an exclusive remit for older people) has convinced me of the urgent need for this. Time for another petition or open letter (watch this space…..).

"It isn't easy to identify a point at which the sad necessity of priority-setting and rationing access to health services crosses a line and becomes unjustifiable discrimination."

Of course, it isn't. But there has never been a greater need to develop some broad guidance. This is in everyone's interest, including health workers who need to be confident about where the line can be drawn between (i) acceptable emergency triage decisions at times of great stress and (ii) discretionary discrimination potentially subject to future prosecution. This isn't helped by the ageist discourse and neglect of older people in global agencies, which can unwittingly legitimise or encourage discriminatory decision-making.

"We need to go beyond vague platitudes of "good health for all" and identify clear parameters of what is unacceptable."

I have no idea what those parameters are. It's

beyond my university pay grade (and cowardly disposition) to stick my neck out. Whatever they are, they will have to be workable in the context of this crisis, rather than just another set of idealised protocols of no relevance in most health care settings (especially in developing countries). They require ethical and legal rigour. And, in the final analysis, they will be a political decision, hopefully, based on a modicum of consensus and (dare I say it?) compromise.

OK –that's my 1000 word take on this thorny issue.

It's easy to be critical. And I haven't shrunk from criticising WHO and other organisations over the last few weeks. So please don't hold back from criticising this blog and helping me get my head around this.

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