# ASSESSING THE IMPACT OF COVID-19 ON OLDER PEOPLE IN THE AFRICAN REGION

A study conducted by the World Health Organisation Regional Office for Africa

World Health Organization
REGIONAL OFFICE FOR Africa

**Assessing the impact of Covid-19 on older people in the African Region: a study conducted by the World Health Organisation Regional Office for Africa**

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**Designed in the WHO Regional Office for Africa, Brazzaville, the Republic of Congo**

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# Table of Contents

# List of Figures and Tables

# Acknowledgements

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# Acronyms

| | |
|---|---|
| AFRO | African Regional Office |
| AU | African Union |
| CAR | Central African Republic |
| CBO | Community-based organisation |
| CDC | Centre for Disease Control |
| CHW | Community Health Worker |
| COVID-19 | Coronavirus disease 2019 |
| COVAX | COVID-19 Vaccine Global Access |
| DoH | Department of Health |
| DRC | Democratic Republic of the Congo |
| FA | Functional ability |
| GDP | Gross Domestic Product |
| GNI | Gross National Income |
| HALE | Healthy Life Expectancy |
| HDI | Human Development Index |
| IC | Intrinsic capacity |
| IDP | internally displaced persons |
| ICOPE | Integrated Care of Older Persons |
| ILO | International Labour Organisation |
| IMF | International Monetary Fund |
| IHR | International Health Regulations |
| IPC | Infection and Prevention Control |
| LEAP | Livelihood Empowerment Against Poverty |
| LTC | Long-term care |
| NCD | Non-communicable disease |
| NGO | Non-government organisation |
| NPO | Non-profit organisation |
| PHC | Primary healthcare |
| POC | Person of concern |
| PPE | Personal protective equipment |
| SCT | Social cash transfer |
| SOPs | Standard operation procedures |
| SSA | Sub-Saharan Africa |
| UN | United Nations |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNHCR | United Nations High Commission for Refugees |
| UNICEF | United Nations Children's Fund |
| VITT | Vaccine-induced thrombosis and thrombocytopenia |
| VSO | Volunteer Service Overseas |
| VUP | Vision 2020 Umurenge Programme (VUP) |
| WASH | Water sanitation and hygiene |
| WHO | World Health Organisation |

# Executive Summary

## Introduction

The COVID-19 pandemic has had a significant impact on older persons both globally and in the African region. Although overall the region's population is younger relative to many other world regions, the WHO AFRO region has a population just over 62 million older people and is ageing rapidly, with the number of older people expected to triple in the next three decades (Aboderin et al., 2020).

As has been the case in other countries, risk of severe illness and mortality among people infected with COVID-19 has mainly been concentrated among people with co-morbidities, particularly non-communicable diseases (NCDs). Older adults are also at significantly greater risk of complications from COVID-19 and case fatality rates increase significantly with age due to reduced immunity (Bandaranayake and Shaw, 2016) and the increased likelihood of pre-existing chronic disease (Clark et al., 2020; Kuylen et al., 2021) as well as reliance on other people due to frailty and disability (Wilkinson, 2020). Persons over 60 represent a significant proportion of lives lost in the global pandemic(Comas-Herrera et al., 2020) and over 50% of the deaths in the region (WHO Regional Office for Africa, 2020) In resource-constrained African countries, older persons are at enhanced risk of COVID-19 mortality due to poor access to critical care (Biccard et al., 2021). Case fatality rates and excess mortality figures have been significantly higher among older people across the region

The UN Secretary-General's Policy Brief on the Impact of COVID-19 on Older Persons (United Nations Sustainable Development Group, 2020) highlighted the vulnerabilities of older people and impacts – mortality, economic well-being, mental health, vulnerability, abuse and neglect, as well as the work that older people do as essential workers and care providers. He called on older people to be integrated into the overall socio-economic and humanitarian responses to covid and for health, social and long-term care services to older people to be strengthened. One year on, it is important to assess the impact of the pandemic on older people in the region and understand to what extent the call to include older people was heeded.

This report aims to achieve the following objectives:

- Gather and analyse health, social and economic data available on COVID-19 in older people in countries including those most affected by COVID-19.
- Conduct critical analysis of COVID-19 mitigation measures that have been implemented by countries including essential health services for older people, gaps and needs to be further addressed by African countries.
- Document experiences, good practices and lessons learned that can be shared among countries.
- Propose concrete actions in mitigating COVID-19 impact in older people
- Propose priority actions in the recovery period in context of the UN Decade of Healthy Ageing 2021-2030 for WHO AFRO and for African countries.

## Methodology

The study primarily a desktop review, complemented with regional and national stakeholder interviews for six country case studies.

***The review of the grey and published literature and existing data sets included:*** distillation, review and comparative synthesis of existing data and evidence from official global databases and available WHO data, repositories, scientific and grey literature and continental reporting mechanisms. We captured evidence for the continental-level and country-level data for the 47 countries in the WHO AFRO region to produce a) an analysis of the impact of COVID on older persons at the national, sub-regional and regional level; b) critically analyse COVID-19 impact mitigation measures at the national, sub-regional and regional level.

### *WHO Regional Partner Interviews*

To complement the desktop review and address gaps in implementing reporting available in the literature, Zoom interviews were conducted with WHO partners selected based on their collaboration with the WHO and capacity/willingness to participate. Nine individuals were interviewed in total.

### *Country Case studies*

To deepen the broader regional analysis, six case studies on the following countries have been developed based on the following categories and in consultation with the WHO project team:

a. COVID-19 epidemiological data
b. Proportion of population age > 60 / size of the older population
c. Language / geography
d. Vaccination plan (as an indication of health system resilience)
e. Extent of COVID-19 testing carried out

The following six countries selected for the case studies:
1) South Africa; 2) Ghana; 3) Rwanda; 4) Mozambique; 5) Senegal; 6) Mauritius

These case studies draw on a combination of a) a more detailed country-level documentary analysis based on the data/documents discussed above; and b) semi-structured qualitative interviews with key informants to understand the existence and efficacy of systems in place to promote healthy ageing and the response of governments, business and civil society to mitigate the risk of COVID-19 infection among older persons and respond to their health, social and financial needs in the context of the COVID-19 pandemic.

For each case study, the following key respondents were interviewed for each case study:

1) Representatives from ministry of health and social development
2) Frontline health workers
3) Community health workers
4) Representatives for older persons' organizations

## *Limitations of study*

Limited availability of quality age-disaggregated health, economic and social data limits detailed reporting on some focus areas of the report. The literature on ageing in Africa is patchy and not evenly spread across countries, with significantly more papers focused countries such as Nigeria, South Africa, Ghana and Senegal than others. Case studies only included limited numbers of interview participants and, although key informants were specifically selected based on their knowledge of COVID-19 response to older people, the case studies may not be fully representative of the country's experience.

## Overview of findings

- Country populations in the African region are ageing rapidly and the burdens of NCDs are growing, but little provision has been made in planning for this demographic and epidemiological transition from a health and development perspective and the region is lagging behind others globally in terms of putting systems and structures in place to support healthy ageing. This left many countries ill-prepared for responding directly to older people's particular needs during the pandemic. The massive economic impact of the COVID-19 pandemic on the region is likely to slow progress in policy development and implementation around healthy ageing and has already resulted in disinvestment in older persons' care in some contexts with negative long-term consequences on the health, wellbeing and long-term care of older people.
- Older people are vulnerable to poverty and informal labour market participation remains high among older people due to weak social and contributory provision coverage in most of the region (22%). The inability of working older adults to earn an income during COVID-19 lockdowns and the need to continue physical distancing due to high-COVID risk increases poverty rates and food insecurity among those without access to social protection and increases dependence on younger people for their financial security (a particular challenge given disruptions in remittances and income of younger household earners during the pandemic).
- Levels of education and competence with digital technology leaves older people behind in terms of access to information about COVID-19, as well as services and forms of social interaction that have increasingly gone online during the COVID-19 pandemic, leaving older people increasingly isolated and challenged in terms of accessing resources and services.
- Health systems in most countries were poorly prepared for COVID-19 and the lack of critical care resources has impacted older people who are more likely to require such care. Case fatality rates and excess mortality rates have been high among older people in the region and, given low testing rates and poor-quality data, the impact on older people has likely been underestimated in many countries.
- Widespread interruptions to health service access, particularly in primary care, that have happened as a result of lockdowns and older person's fears of infection in health facilities, have implications for the management of chronic conditions and longer-term consequences for efforts to maintain intrinsic capacity and functional ability of people as they age.
- COVID-19 has highlighted the need for early planning and communication for alternative management of comorbidities in older patients in any future pandemic, thereby avoiding related exacerbation of chronic illness or loss in IC or FA that may result from treatment failure.
- Long-term care services for older people have been heavily impacted by COVID-19, both at the community level and in residential care facilities, with implications for the health of older people well-being of both older people and their caregivers (both formal and informal).
- Societal ageism and abuse -of older people has increased in the region over the period of the COVID-19 pandemic, with longer term implications for how older people are perceived and included in economic and social life and efforts to "build back better" after COVID-19.
- There has been poor inclusion of older people in national-level COVID-19 response planning and implementation, both in terms of stakeholder consultation and efforts focused on including older people in health system and socio-economic response. Vaccination roll-out efforts being a significant exception in terms of specific efforts to target older people but vaccination programmes in the region have lagged behind other regions due budgetary and logistical challenges and vaccine hesitancy, and a large proportion of the older people remain unvaccinated.
- Older people who continued to receive pensions over the course of the pandemic were likely less impacted by the economic impact of COVID-19, and countries with

existing social protection for older people were better equipped to respond to older people, while those without these systems struggled to reach older people with cash transfers, food parcels or other in-kind support

- Countries where existing networks of older persons organisations or other community-based networks were strong, were better-able to reach older people in terms of targeted and appropriate messaging and provision of socio-economic support but community provision of long-term care services to older people are threatened by budget cuts and the additional costs of operating during the COVID-19 pandemic.
- The COVID pandemic has revealed real gaps in data on older people and this has made it hard to include older people in the response. African countries with more up-to-date statistics have found it easier to address challenges posed by COVID-19.

# Priority Actions

The below priority actions should be implemented by all member states in the region with the support of regional and international development partners.

**1. Expedite policy implementation in the context of the Decade of Healthy Ageing 2021-2030.** Governments in the region are signatories to international frameworks on ageing, and policies and plans on ageing but adoption of the policies into law has been slow. Governments are urged to ratify such policies as it has been demonstrated that where there were existing programmes for older people, coordination of managing the COVID-19 pandemic was more efficient and such mechanisms will have relevance to services for older people and to future pandemics.

***2. Strengthen the health care systems and service delivery***

- ***Strengthen infrastructure and services provided at all levels of care including at the primary and community care.*** Well-developed community and primary care services enhance the mobilisation and information dissemination to communities including older persons and are linked to primary and tertiary care.
    - Prevention - ensure that older people are systematically reached and supported in applying IPC measures
    - Triage - protecting people from being infected in health facilities, home-based care services etc.
    - Case management - strengthening access to equipment, rapid response, prioritised in case management
    - Data management - surveillance system that generates age-disaggregated data to allow us to focus on appropriate action according to age
    - Governance - fragmentation and lack of coordination results in a lack of person-centredness. Involve other actors such as community-based organisations as part of the response.
- ***Strengthen Universal Health Coverage Coverage*** to support the health and hence productivity of the population by enabling access to services for health promotion, disease prevention, diagnosis, treatment, rehabilitation and palliation.
- ***Training and education of care professionals.*** To improve quality of services for older people, curricula in education and training institutions need to include training in caring for older persons. Management of conditions of older persons including optimizing IC and FA requires specific knowledge and skill.
- ***Training and education of care professionals.*** To improve quality of services for older people, curricula in education and training institutions need to include training in caring for older persons. Management of conditions of older persons including optimizing IC and FA requires specific knowledge and skill.
- ***Promote and support research on ageing and data collection*** across the lifespan with age and gender disaggregation of data. There is scant research focused on ageing in the region and the limited research conducted does not frequently provide age disaggregated data. Quality data is essential for planning and service development for older people, within both the health system and the social sector and is key to developing innovative approaches to ageing that are grounded in the realities of the region.
- ***Develop long-term care system and services,*** training and support to families providing care to older people to promote human right and reduce abuse of older persons. The number of older persons is increasing rapidly in the region. Internal and external migration and mortality due to epidemics and pandemics is changing family structure and available support.
- ***Implement the WHO Integrated Care of Older People model*** (see Annex 2) to deliver integrated -primary care to older people.

**3. Strengthen and support community-based associations and networks of older people** that can advocate for older people's right and needs, support the provision of long-term care and social services, and provide a link between government and older people. Governments should engage in formalised collaborations with CBOs as part of risk communication and community engagement strategies to reach older people in the context of COVID-19 and beyond.

**4. Provide age friendly environments** that promote access to health care and community participation for older people. Older people face several barriers to participating,

including the physical environment, ageist attitudes and legislative arrangements. Member states need to create physically safe and inclusive environments for older people to engage in integenerational relationships and participate in social and community life in the context of COIVD-19, thereby mitigating the negative affects of social isolation and physical incapacity and improving mental health.

5. **Develop social protection mechanisms** to support older people and vulnerable populations. The COVID-19 outbreak response should include social protection for older people via social pensions, cash transfers and in-kind assistance. Adequate social protection provisioning also supports UHC by supporting financial access to health services.

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# 1. Introduction

The COVID-19 pandemic has had a significant impact on older persons both globally and in the African region. Although overall the region's population is younger relative to many other world regions, the WHO AFRO region has a population just over 62 million older people and is ageing rapidly, with the number of older people expected to triple in the next three decades (Aboderin et al., 2020).

As has been the case in other countries, risk of severe illness and mortality among people infected with COVID-19 has mainly been concentrated among people with co-morbidities, particularly non-communicable diseases (NCDs). Older adults are also at significantly greater risk of complications from COVID-19 and case fatality rates increase significantly with age due to reduced immunity (Bandaranayake and Shaw, 2016) and the increased likelihood of pre-existing chronic disease (Clark et al., 2020; Kuylen et al., 2021) as well as reliance on other people due to frailty and disability (Wilkinson, 2020). Persons over 60 represent a significant proportion of lives lost in the global pandemic (Comas-Herrera et al., 2020) and over 50% of the deaths in the region (WHO Regional Office for Africa, 2020) In resource-constrained African countries, older persons are at enhanced risk of COVID-19 mortality due to poor access to critical care (Biccard et al., 2021). Although age-disaggregated mortality data is not available for all countries in the region, WHO data shows case fatality rates (CFR) and excess mortality figures have been significantly higher among older people across the region (see Section 4.1 for a table showing CFRs for select countries).

Apart from the biomedical risk factors, socio-economic, long-term care and health system factors play an important role in health outcomes for older persons(Goutte et al., 2020; Mukherji, 2020; Yancy, 2020). The economic and social costs of measures to contain the spread of the disease have had negative impacts on all populations across a region already faced with high levels of poverty, food insecurity and weak health and long-term care systems. Older people, who are more likely to live in poverty and have more complex health needs, have borne the brunt of the pandemic (Lloyd-Sherlock et al., 2020). The pandemic has had a major effect on health systems and the delivery of essential services, which impacts older people who have chronic conditions. Older people are also more likely to face discrimination in medical decision-making and triage, particularly in resource constrained environments (Erasmus, 2020).

The COVID-19 pandemic is likely to bring about long-lasting changes to healthcare and social welfare systems internationally and the post-lockdown era presents an opportunity to "build back better" and improve systems and service delivery for older persons, whose needs are often overlooked both by governments and in the development agenda. This requires managing epidemiological vulnerability by managing chronic disease more effectively, reducing transmission, limiting health system limitations, and reducing the impact of control measures such as shielding and self-isolation, which may negatively impact on the health and well-being of older persons9. It also requires the building or extension of social protection systems that support people's livelihoods as they age.

The UN Secretary-General's *Policy Brief on the Impact of COVID-19 on Older Persons* (United Nations Sustainable Development Group, 2020) highlighted the vulnerabilities of older people and impacts – mortality, economic well-being, mental health, vulnerability, abuse and neglect, as well as the work that older people do as essential workers and care providers. He called on older people to be integrated into the overall socio-economic and humanitarian responses to covid and for health, social and long-term care services to older people to be strengthened. One year on, it is important to assess the impact of the pandemic on older people in the region and understand to what extent the call to include older people was heeded.

This report aims to 1) review the impact of COVID-19 on older people, 2) understand efforts to mitigate these effects, and 3) propose actions for mitigating COVID-10 impact on older people in the context of the UN Decade of Healthy Ageing 2021-2030 and, more broadly, the Sustainable Development Goals.

There is significant diversity in the 47 countries included in this report in terms of developmental levels, public health issues and health systems capacity and this report provides priority actions for countries based on this context.

## *Objectives*

- To gather and analyse health, social and economic data available on COVID-19 in older people in countries including those most affected by COVID-19.
- To conduct critical analysis of COVID-19 mitigation measures that have been implemented by countries including essential health services for older people, gaps and needs to be further addressed by African countries.
- To document experiences, good practices and lessons learned that can be shared among countries.
- To propose concrete actions in mitigating COVID-19 impact in older people
- To propose priority actions in the recovery period in context of the UN Decade of Healthy Ageing 2021-2030 for WHO AFRO and for African countries.

## Research questions

- How have older persons in the African region been impacted by the COVID-19 pandemic, both from a health and socio-economic perspective?

- To what extent have countries implemented measures to mitigate the negative effects of the pandemic on older persons?
- What good practices and lessons can be identified from the experiences of countries in the region in handling the pandemic and its impact on older persons specifically?
- What actions should be prioritised in terms of meeting the needs of older persons in the recovery period considering the context of the Decade of Healthy Ageing 2021-2030?

# 2. Methodology

We addressed the six broad objectives of the assignment through a combination of: 1) direct stakeholder consultation and engagement via interviews and 2) the distillation, review and comparative synthesis of existing data and evidence from official global databases and available WHO data, repositories, scientific and grey literature and continental reporting mechanisms.

Although it is impossible to capture the work of all actors contributing to the COVID-19 response, interviews with UN agencies and international development partners and review of the literature provide some examples of interventions carried out. Further detailed examples are provided in the six country case studies (Ghana, Mauritius, Mozambique, Rwanda, Senegal and South Africa), which are based on interviews conducted at national level with government officials, frontline workers and older persons' organisations.

## *Review of the grey and published literature and existing data sets*

We captured evidence for the continental-level and country-level data for the 47 countries in the WHO AFRO region to produce a) an analysis of the impact of COVID on older persons at the national, sub-regional and regional level; b) critically analyse COVID-19 impact mitigation measures at the national, sub-regional and regional level.

Data for the desktop review were obtained via targeted key word searches for specific indicators related to the impact of COVID-19 on older people in UN databases, Our World in Data, EBSCOHost (MEDLINE), Google Scholar and online media platforms. Country-level searches for all 47 countries were conducted to capture examples of COVID-19 interventions.

Tables containing 1) demographics and life expectancy data, 2) economic indicators, 3) health systems indicators and 4) COVID-19 data for all 47 countries are provided in Tables A-E in Annex 1.

## *WHO Regional Partner Interviews*

Although it is impossible to capture the work of all actors contributing to the COVID-19 response, interviews with UN agencies and international development partners and review of the literature provide some examples of interventions carried out.

To complement the desktop review and address gaps in implementing reporting available in the literature, Zoom interviews were conducted with WHO partners selected based on their collaboration with the WHO and capacity/willingness to participate. Nine individuals were interviewed in total (see list of interview participants in Annex 3).

## *Country Case studies*

To deepen the broader regional analysis, six case studies on the following countries have been developed based on the following categories and in consultation with the WHO project team:

a. COVID-19 epidemiological data
b. Proportion of population > 60 / size of the older population
c. Language / geography
d. Vaccination plan (as an indication of health system resilience)
e. Extent of testing carried out

The following six countries selected for the case studies:

1) South Africa; 2) Ghana; 3) Rwanda; 4) Mozambique; 5) Senegal; 6) Mauritius

These case studies draw on a combination of a) a more detailed country-level documentary analysis based on the data/documents discussed above; and b) semi-structured qualitative interviews with key informants to understand the existence and efficacy of systems in place to promote healthy ageing and the response of governments, business and civil society to mitigate the risk of COVID-19 infection among older persons and respond to their health, social and financial needs in the context of the COVID-19 pandemic.

For each case study, the following key respondents were interviewed for each case study:

1) Representatives from ministry of health and social development
2) Frontline health workers
3) Community health workers
4) Representatives for older persons' organizations

Key informants were included in the study based on consultation with WHO regional, sub-regional and country focal point persons and were selected based on their policy/ programmatic involvement in the areas of older people and the COVID-19 health, economic and social responses. All participants were interviewed in their professional capacity and the confidentiality and anonymity of participants will be preserved throughout, unless they preferred to be quoted in their professional capacity. In these cases, participants were asked to choose how they would like any quotes/data from their interviews presented in the assessment report (e.g. WHO

official; WHO official East African region; Health worker; Dr. Gabrielle Kelly [researcher] etc.)

These interviews and focus groups took place through a combination of in-person and online/telephonic interviews based on wi-fi connectivity and risk of COVID-19 exposure via in-person interviews in a given setting. Any in-person interviews adhered strictly to COVID-19 prevention protocol.

### *Limitations of study*

Limited availability of quality age-disaggregated health, economic and social data limits detailed reporting on some areas of the report. The literature on ageing in Africa is patchy and not evenly spread across countries, with significantly more papers focused countries such as Nigeria, South Africa, Ghana and Senegal than in other countries. Case studies only included limited numbers of interview participants and, although key informants were specifically selected based on their knowledge of COVID-19 respond to older people, the case studies may not be fully representative of the country's experience.

# 3. The context: demographics, economic, ageing policies and structures and health systems capacity

The 47 countries in the AFRO region are diverse in terms of their demographics, level of economic and human development, health systems capacity and development and implementation of policies and programmes to promote healthy ageing.

## 3.1 Demographic data

With the lowest proportion of people over 60 in the world, Africa is often described as world's youngest region, but this perception is harmful in that it overlooks the large number of older people in the region, resulting in the neglect of their needs in favour of other development issues (Aboderin et al., 2020). In terms of absolute population numbers, Africa in fact has the largest population of older people in the world (in 2020 74.4 million individuals aged 60 and older were estimated to live on the continent, 54.3 million of which reside in sub-Saharan Africa). While the proportion of older people remains well below the global average of 12% in all countries in the African region (except Mauritius (17%) and Seychelles (13%), improvements in health and human development across the region are resulting in longer life expectancies and rapid population ageing. Despite only comprising around 5% of the population in Nigeria, Tanzania and Kenya, these highly populated countries have the 19th, 50th and 54th largest populations of older people globally and are expected to move up considerably in the world rankings over the next 30 years. The number of older people in the region expected to triple in the next three decades, while the proportion of older people is expected to increase to over 9% .

***Table 1 Comparison ageing indicators in African region to globally (2019 )***

| Metric | Regional | Global |
|---|---|---|
| Total life expectancy (years) | 65.2 | 72.6 |
| Proportion of population aged 60+ (%) | 5.3 | 12 |
| Healthy life expectancy at birth (years) | 56 | 63.7 |
| Healthy life expectancy at age 60 (year) | 12.8 | 15.8 |
| Median Human Development Report Adjust Life Expectancy Index (%) | 0.667 | 0.823 |
| Old age dependency ratio [1] (%) | 5.9 | 13.3 |
| Median age | 20 | 31 |

While people in Africa are living longer than previously, they are not necessarily in better health. The African region lags behind other regions globally in terms of the health and well-being of older people. HelpAge International's Global Age Watch 2015 Index rank's 96 countries' provision for older people globally based on four domains:

1) Income security (pension income coverage, poverty rate in old age, relative welfare of older people, GNI per capita)

1 The demographic old-age dependency ratio is defined as the number of individuals aged 65 and over per 100 people of working age (age 15-64).

2) Health status (life expectancy at age 60, healthy life expectancy at age 60, psychological well-being);
3) Capability (employment of older people, educational status of older people) and;
4) Enabling environment (social connections, physical safety, civic freedom and access to public transport).

Except for Mauritius, the 10 African countries included all rank near the bottom of the ratings. See table 2 below.

***Table 2 Global Age Watch 2015 Rankings (96 Countries)***

| Country | Overall index [range 1 – 96] | Income security [range 1-96] | Health status [range 1-96] | Capability [range 1-96] | Enabling environment [range 1-96] |
|---|---|---|---|---|---|
| Mauritius | 42 | 9 | 63 | 75 | 38 |
| South Africa | 78 | 19 | 89 | 69 | 83 |
| Ghana | 81 | 88 | 77 | 23 | 56 |
| Nigeria | 86 | 90 | 88 | 49 | 75 |
| Uganda | 88 | 92 | 92 | 45 | 70 |
| Rwanda | 89 | 93 | 81 | 80 | 13 |
| Zambia | 90 | 89 | 91 | 67 | 84 |
| Tanzania | 91 | 94 | 69 | 89 | 88 |
| Mozambique | 94 | 84 | 94 | 94 | 96 |
| Malawi | 95 | 96 | 95 | 84 | 94 |

**High prevalence of chronic disease, disability and ageing.** There is a link between the high prevalence of chronic disease, disability and ageing, and an association between increase in chronic disease and care burden (Chatterji et al., 2015; Tollman et al., 2008; World Health Organisation, 2015) . While there has been compression of morbidity (i.e. the postponement of disability until later in life) in more developed countries, this is not occurring to the same extent in developing countries (Aboderin and Ferreira, 2008; Age International, 2015; Chatterji et al., 2015) There is a growing burden of non-communicable disease in Africa (Bigna and Noubiap, 2019; Mudie et al., 2019) and weak investment and capacity for NCD prevention and control. Gouda et al found a 67% increase in disability-adjusted life-years (DALYs) due to NCDs in sub-Saharan Africa, increasing from 90.6 million DALYs in 1990 to 151.3 million in 2017 (Gouda et al., 2019). The age standardised mortality rate for NCDs per 100 000 (see Table A in Annex 1) is high in many countries of the region, particularly in countries such as Lesotho, Eswatini and the Central African Republic and the burden of NCDs in the WHO African region is predicted to overtake the burden of mortality and morbidity from communicable diseases by 2030 (World Health Organization Regional Office for Africa, 2016) .Age is an established risk factor for the development of chronic disease and multiple chronic disease, and co-morbidities increase risk of severe COVID-19 infections and mortality.

**Poor health leads to lower quality of life and levels of well-being and higher levels of disability amongst older people** (Pillay and Maharaj, 2013; World Health Organisation, 2015). Further, older people commonly experience multimorbidity, particularly those who are socioeconomically disadvantaged (Barnett et al., 2012; Marengoni et al., 2011). As Table 2 above shows, Healthy Life Expectancy (HALE) in Africa is only 56 years – the lowest globally, where total life expectancy is 65.2. By comparison, global life expectancy is longer at 72.6 and healthy life expectancy is 63.7. It is notable that there a much smaller difference in HALE at age 60 in the region (12.8) and the global figure (15.8) than is the case for HALE at birth. There is significant variation in HALE across the region – for example, there is a more than 20 year difference between Lesotho's HALE at birth of 44.24 or the Central African Repbulic's HALE of 46.37 and the HALE in Algeria, Cabo Verde, Seychelles and Mauritius (see Table A in Annex 2), with similar patterns observed for HALE at age 60. The countries with higher HALE have significantly higher coverage of essential health services than Lesotho (78% Algeria, 71% Seychelles, 69% Cabo Verde and 63% Mauritius vs. 48% for Lesotho)

Furthermore, the now widespread availability of anti-retroviral drugs for HIV means that many people with HIV are now living into old age, which has considerable implications in terms of their health needs, particularly if they also acquire chronic diseases of lifestyle as they age (Negin et al., 2014). Negin et al. found that weaker grip strength, lower body-mass index and higher disability scores in older people living with HIV than in the HIV-negative poopulation of the same age cohort (50+) (Negin et al., 2012).

**Data on disability prevalence and needs across all age groups is sparse and inaccurate** in the African region, due to complexities and varying approaches in measuring disability in censuses and surveys. However,

existing global data shows that mobility, sensory and cognitive impairments are significantly more prevalent in developing countries, particularly among older populations, people living in poverty and women. For instance, data from the World Health Survey (2002-2004) showed that disability prevalence among people aged 60 years and over was 43.4% in lower-income countries compared to 29.5% in higher income countries (World Health Organization and World Bank, 2011) Prevalence among women of all ages in lower-income countries was 22.1% (vs. 13.8% for men) and 14.4% for women vs 9.1% for men in higher-income countries. Rates of disability are 22.4% among the poorest quintile in developing countries. National studies on living conditions of people with disabilities in Namibia, Zambia, Malawi and Zimbabwe have shown large gaps in service provision for people with disabilities (World Health Organization and World Bank, 2011). The high rates of disability among older groups in low-income settings, combined with poor service provision has considerable implications for older persons' ability to participate effectively in social and economic life and to access services and information in the region. The breakdown of older populations by gender is not available for many countries in the region, however existing studies/reports indicate that, **life expectancy is generally higher for older women,** making it likely that a larger proportion of the older population are women than men.It is therefore important to pay attention to the intersection between old age and gender issues and the particular vulnerabilities that women face through the life course (United Nations: Office of the High Commissioner, 2019). For example, older women are more likely to live in poverty than older men, with one of the main reasons being that they are less likely to have contributed to contributory pension programmes than older men. Persisting inequalities also exist between rural and urban populations. Given their increased likelihood of living into advanced old age, older women are also more likely to become incapacitated and therefore care dependent than men, making them more vulnerable to isolation, exclusion and abuse (United Nations: Office of the High Commissioner, 2019).

Given the structure of populations in most African countries, older people do not comprise a significant burden to society in terms of economic dependency (defined as number of people 60+ per 100 working people aged 15-59). This can be observed in the dependency ratios recorded in Table A in Annex 1, which are significantly lower than elsewhere in the world. As Table 1 above shows, the global average is 13.3, while the regional average is 5.9. As is shown in the annex, 47 of the 48 countries in the African region have dependency ratios well under 13 (Mauritius is the exception with a ratio of 17).

In fact, youth dependency ratios are the highest globally and in some countries with social pension systems, such as South Africa, older people are supporting multiple youth dependents. Older people, particularly women, also make significant contributions to households in terms of care provision (particularly in terms of child care) and many people continue to work in the informal or formal economy past age 60 (see Section 2.2)

## 3.2 Economic and social development

There is significant variation in terms of level of economic and human development in the African region, but for the most part countries in the region are economically constrained, with 51% of the 47 countries being classified as low-income and 34% lower-middle income and only 7 countries being classified as upper middle income or high income (see Table B in Annex 2).

In low-income countries and countries with very high rates of extreme poverty, older people faced difficult living conditions prior to the COVID-19 pandemic and a larger share of older people live in the bottom two wealth quintiles than younger adults in the region (Aboderin et al., 2020). Older women are particularly vulnerable to poverty due to lower levels of labour market participation, levels of education and land ownership. However, women may also have closer ties to younger-kin than older men and may receive more resources and care from family, implying that gender differences in economic status may not be as clear-cut as is often assumed (Aboderin et al., 2020; Knodel and Ofstedal, 2003; Sabates-Wheeler et al., 2020). Resource constrained settings also place limitations on governments' capacity to respond to the pandemic and low-income countries have relied heavily on the UN system and international development agencies and funders to support their response.

> *Older people are particularly vulnerable in conflict settings and other humanitarian emergencies such as drought and internally displaced persons (IDPs), refugees and stateless older people require additional support and protection (UNHCR and HelpAge International, 2021).*
> *Older persons have the same basic needs as others, but face increased risks as a result of ageing, including neglect, discrimination and abuse. While they may face challenges during displacement, they should not be seen as passive, dependent recipients of assistance. They may be community leaders and involved in transfer of knowledge, culture, skills and crafts. They are also health workers, carers and among many essential service providers. Older women often provide care for older relatives increasing their risk to COVID-19 infection. (Interview with Gislaine Ngaska, UNHCR West Africa)*

Persons over 60 make up 4% of the population of displaced persons worldwide (UNCHR, 2021). The negative impact of the displacement and the COVID-19 pandemic on older people was expressed in an interview with Dr Gislaine Ada Ngasaka, UNHCR, May 2021:
'In addition to their vulnerability to COVID-19, which is deepened in confined IDP or refugee camp settings, older

people face challenges in accessing information, humanitarian assistance and abuse, particularly among women. In forced displacement situations, sensory, cognitive and mobility impairments that would normally not impact daily functioning, can overwhelm older persons' capacity to cope.'
Countries in the Sahel region, Burundi, Central African Republic, DRC, Nigeria, South Sudan and Ethiopia's Tigray region have faced the challenge of COVID-19 in the context of ongoing emergencies.

**Older people are important contributors to economic and social life in the region.** As contributory and non-contributory pension coverage is low across the region (see Section 2.3), 70% of adults in Sub-Saharan Africa aged 60 to 64 remain in the labour market and almost half of those 65+ remain in the labour market and in some countries such as Burundi, Cameroon, Liberia, Madagascar, Mozambique, Niger, Rwanda and Tanzania, this proportion exceeds 80% among the 60-64 group and above 60% among those aged 65+. There is, however, significant variation across countries and countries with greater pension coverage are more likely to have lower labour participation rates. Labour force participation is also highly gendered, with significantly higher participation rates among men (except in Rwanda, where labour force participation among women aged 60 to 64 and 65+ is very high at 91.7% and 75.7% respectively and exceeds the figures of 88.5% and 74.2% for men in these same age categories). The need to continue to earn an income in the absence of an old age pension puts older people at significant risk of COVID-19 exposure and other communicable diseases.

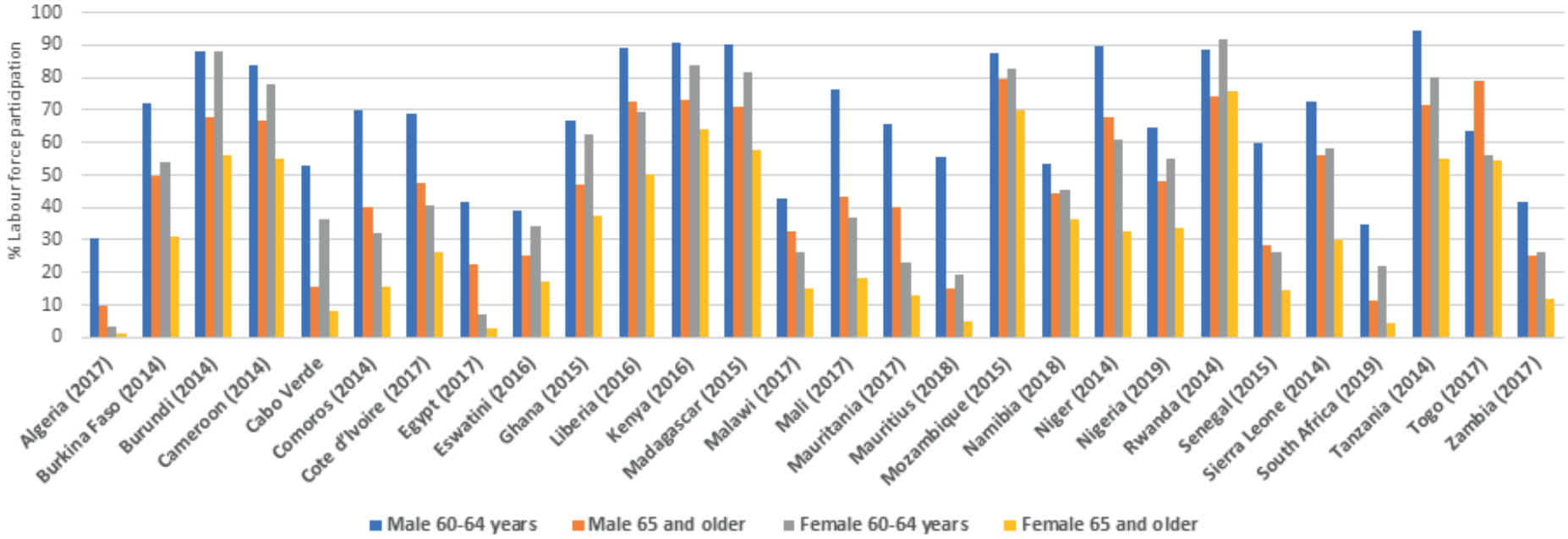


***Figure 1 Labour force participation rates of older adults by sex and age of***

*Source: International Labour Organisation: ILOSTAT, 2020 Global Estimates*

**High levels of agricultural activity.** In addition to formal and informal labour, many older people continue to participate in agricultural activities and land ownership tends to be higher amongst older people in the region (Aboderin et al., 2020). In the context of older people's ongoing involvement in the labour market, as well as farming, it can be expected that the direct negative economic impacts of COVID-19 lockdowns were felt strongly among older people in the region, where labour force participation is significantly higher among older people, particularly those aged 65+ (43%) than the estimated global average of 20.5% (International Labour Organization, 2020)

**Low levels of education.** While national surveys over the past few decades show that older people in the region have become more educated over time (Aboderin et al., 2020), in some countries such as Burkina Faso, Mali and Ethiopia, between 85% and 95% of older people have no education (Aboderin et al., 2020). Levels of educational attainment are significantly lower among women across the region, including in countries such as South Africa, Namibia, Ghana and Zambia where overall levels of educational attainment are higher (Aboderin et al., 2020). The relatively low levels of education among older people in the region has important implications for older people's ability to access accurate information about the COVID-19 pandemic and understand how to protect themselves from the disease or seek the health or social assistance they may need or access services online. The "digital divide" between older and younger populations, which is reinforced by low levels of education and poverty, also has negative implications for older people's participation in society, particularly during the COVID-19 pandemic where much of social and economic life has gone online (Martins Van Jaarsveld, 2020). Older age groups in countries across the world have significantly lower rates of internet use and technological engagement than other age groups due to lack of motivation and skills deficits (AARP International, 2017; Martins Van Jaarsveld, 2020). While internet usage, particularly via mobile phones is growing rapidly in the African region, the age-related digital divide is compounded by lack of access to technology. For example, in South Africa, where 48.7% of households had internet access in 2016, only 5.4% of internet users (not including mobile device connections) were over the age of 60 (AARP International, 2017). The digital divide also prevents older people from using telehealth services to access care and one recent study showed 40% of older people were unable to use telehealth resources because of being unable to use the necessary technology (Lam et al., 2020)

## 3.3 Policies, Plans and Structures for Healthy Ageing

Healthy Ageing is defined by the WHO as "developing and maintaining the functional ability (FA) that enables well-being in older age. Functional ability is determined by the intrinsic capacity (IC) of an individual (i.e., the combination of all the individual's physical and mental capacities), the environment in which he or she lives (broadly includes physical, social and policy environments) and the interactions among them."

Four key international policy instruments have guided action on ageing since 2002: *The Political declaration and Madrid international plan of action on ageing , the World Health Organization's Active Ageing Policy Framework* (World Health Organisation, 2002) *and the WHO Global Strategy and Action Plan on Ageing and Health 2016-2020* (World Health Organisation, 2017a). The UN Decade of Healthy Ageing 2021-2030 and related Action Plan is now the main strategy in place to achieve and support actions to build a society for all ages.

***The Madrid Plan of Action on Ageing and the Political Declaration*** adopted at the Second World Assembly on Ageing in April 2002 put ageing issues on the international agenda. Signatories of the political declaration, committed to taking action to develop a society that meets the needs of older persons and to act in three priority areas: advancing health and well-being into old age, older persons and development, and ensuring enabling and supportive environments. This includes incorporating ageing into social and economic strategies, policies, and action. The plan takes a life course approach to reducing the cumulative effects of factors that increase the risk of disease, functional ability and potential dependence in older age. It promotes universal and equal access to healthcare services, including physical and mental health services, the development and strengthening of PHC systems to meet the needs of older persons, and the provision of coordinated and integrated services that promote continuity of care. The plan also highlights the need for training health professionals and community worker on the needs of older persons.

***World Health Organization's (WHO) Active Ageing Policy Framewor***k was drafted in 2002 as a contribution to the Second World Assembly on Ageing. Since then, the Active Ageing framework has informed the development of policy on ageing in numerous countries worldwide. The framework and what it provides for was a break away from a narrow focus on disease prevention and health care, instead it argues for healthy and active living and lifestyles, across the lifespan, to benefit individuals in old age.

***WHO Global Strategy and Action Plan on Ageing and Health (2016–2020).*** This strategy advances the 2030 Agenda for Sustainable Development and Sustainable Development Goals , which makes it clear that a healthy life and the right to health do not start or end at a specific age.

The plan extends the Madrid International Plan of Action on Ageing and the WHO's policy framework on active ageing. It was adopted by the sixty-ninth World Health Assembly in May 2016 and provides a political mandate for the action that is required to ensure that everyone can experience both a long and healthy life. The plan recognises the multidimensional, chronic and complex health needs of older persons and the poor suitability of existing health systems, which are often fragmented and ageist, lacking in geriatric expertise and which create barriers to older persons' engagement with and access to health care.

***UN Decade of Healthy Ageing 2021-2030***. The member states of the UN adopted the UN Decade of Healthy Ageing in May 2020. The programme proposal defines Healthy Ageing as developing and maintaining IC and FA that enables well-being in older age, reducing care dependency and associated costs to healthcare systems. The programme is based on the Global Strategy and Action Plan on Ageing and Health (2016–2020) and reflects the vision of the Sustainable Development Goals of leaving no one behind. The programme takes a multidimensional approach, recognising the contribution of physical, social and economic environments to experiences of ageing. The delivery of person-centred, integrated care and primary health services responsive to older people and the strengthening of PHC are some of the key objectives.

***2030 Agenda for Sustainable Development***. Inclusion is at the heart of the 2030 Sustainable Development Goals. These 17 universal and cross-cutting goals provide the action plan to achieve sustainable development and human rights for all people, particularly vulnerable groups such as older people.

A spurt of policy activity followed the adoption of the United Nations' Madrid International Plan of Action on Ageing in 2002, but until recently progress to develop and implement policies around ageing have been slow. The African Union, as well as many governments in Sub-Saharan Africa, signed the two international frameworks on ageing, the 2002 United Nations Madrid International Plan of Action on Ageing (MIPAA) and the 2003 African Union Policy Framework and Plan of Action on Ageing (AU-Plan). As a result of these commitments, on 31 January 2016, the African Union adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons. As of July 2020, only three countries have ratified the protocol, Lesotho, Benin and Ethiopia (HelpAge International, 2020a).

However, there seems to be renewed focus on the area and the Progress Report on the Implementation of the Global Strategy and Plan of Action on Ageing and Health (World Health Organisation, 2020a) shows that in 2019, twenty-three [2] Nevertheless, over half of the countries in the region have no national ageing programme and weak capacity to implement integrated age-related programming. A review on National Policies and Older People's Healthcare in Sub-Saharan Africa by Saka et al., revealed that action to adopt policies into law has been slow (Saka et al., 2019). Only a few countries, including Ghana, Mozambique, South Africa, Uganda and Tanzania, have legal frameworks on the ageing population, while a few like Nigeria, Cameroon and Rwanda have drafted policies which are awaiting passage into law by their legislatures.

Countries achievements in terms of the 10 indicators of the WHO Global Strategy and Action Plan on Ageing and Health (GSAP) (World Health Organisation, 2017a) and in terms of implementing social protection for older people remains weak.

2 Algeria, Benin, Burkina Faso, Botswana, Cabo Verde, Cameroon, Congo, Ivory Coast, Ethiopia, Eritrea, Gabon, Gambia, Ghana, Madagascar, Mauritius, Niger, Nigeria, Mozambique, United Republic of Tanzania, Rwanda, Senegal, Zambia and Zimbabwe

*Table 3 Achievement of GSAP indicators in the African region*

| GSAP Indicator | % of countries in the WHO African region | % of countries globally |
|---|---|---|
| Countries with a focal point on ageing and health in the Ministry of Health | 40% | 58% |
| Countries with national plans, policies or strategies on ageing and health | 34% | 45% |
| Countries with a national multi-stakeholder forum or committee on ageing and health | 30% | 45% |
| Countries with national legislation & enforcement mechanisms against age-based discrimination | 23% | 45% |
| Countries with national regulations / legislation to support access to assistive devices | 13% | 19% |
| Countries that have a national programme to foster age-friendly environments | 11% | 14% |
| Countries that have a national policy to support comprehensive assessments of health & social care needs | 8% | 14% |
| Countries that have a long-term care policy / plan / strategy / framework (stand-alone or integrated within an ageing and health plan) | 23% | 41% |
| Countries with nationally representative, cross-sectional data on Healthy Ageing (health status & needs of older adults) | 11% | 28% |
| Countries with longitudinal, nationally representative data on Healthy Ageing (health status & needs of older adults) | 6% | 18% |

*Source: Decade of Healthy Ageing Baseline Report* (World Health Organization, 2020)

**Older people are often excluded from data collection efforts due to upper age caps on surveys.** For example 34 of the 40 countries in Africa completing the WHO STEPS survey on NCDs did not include anyone over the age of 64, despite higher prevalence of NCDs in older people and many Demographic and Health Surveys exclude women over 50 and men over 55/60 (Organization, 2020). The lack of disaggregated population data makes it difficult to understand older people's needs or to plan for their inclusion in programmes (Interview with Roseline Kihumba, HelpAge International).

**Income security and poor pension coverage.** The right to income security in old age, as grounded in human rights instruments and international labour standards, includes the right to an adequate pension. Improving old age pension coverage is a critical component of Sustainable Development Goal 1 (No poverty). Pension coverage globally is poor (less than 50%) and for many of those who do receive a pension, pension levels are not adequate. As a result, the majority of the world's older women and men have no income security, have no right to retire and have to continue working as long as they can – often badly paid and in precarious conditions.

In Sub-Saharan Africa, with the exception of countries in Southern Africa (where only 40.2% of employment is in the informal sector), the vast majority (89.2% ) of employment in Sub-Saharan Africa is in the informal sector (International Labour Organisation, 2018), putting contributory pension programmes out of reach for a select few (usually public sector employees). More women participate in the informal than the formal labour market than men in the region (92.1% vs. 86.4%) and are therefore less likely to contribute to contributory pension programmes than men (International Labour Organisation, 2018).

Social protection programming in the form of noncontributory pensions or other cash transfers for older people is also very limited. Although in recent years, many middle-and low-income countries have made great efforts to expand the coverage of contributory pension schemes and to establish non-contributory (social) pensions to guarantee basic income security in old age to all (International Labour Office and Social Protection Department, 2014; Sabates-Wheeler et al., 2020), Sub-Saharan Africa still lags behind, largely because of government scepticism about financing such programmes (United Nations Development Programme, 2019). Implementation of basic universal old age pensions need not be particularly complicated or expensive and are affordable for emerging economies if political will is present, existing pension schemes are re-evaluated (for example regressive civil servant pension schemes serving a small minority) and eligibility criteria carefully managed (Stewart and Yermo, 2009). Lesotho, a LMIC country has had a universal pension for people over 70 since 2004,. Less than 25% of adults in the region above the statutory retirement age are covered by either a contributory or non-contributory pension (Aboderin et al., 2020). As is shown in Table 3 below, only 15 countries offer social protection targeted at older people in the form of social pensions, including: Algeria, Botswana, Cabo Verde, Eswatini, Lesotho, Kenya, Mauritius, Mozambique, Namibia, Nigeria (pilot and only in Ekiti and Osun states), Seychelles, South Africa, Uganda (pilot), Zambia (household grant) and the self-governing state of Zanzibar in Tanzania. Of these programmes, only programmes in Botswana, Mauritius, Namibia, Seychelles and Zanzibar are universal pension programmes.

*Table 3 Pension coverage in the African region (various years)*

| Country | Old age total pension coverage ILO1 | *Contributory*[1] | *Non-contributory*[1] | % of population 60 + covered by a social pension (HelpAge)[2] |
|---|---|---|---|---|
| ALGERIA | 63.6 | 51.1 | 12.5 | 8 |
| BOTSWANA | 100 | 0 | 100 | 65 |
| CABO VERDE | 92.1 | 24.1 | 68 | 68 |
| MAURITIUS | 100 | | 100 | 100 |
| NAMIBIA | 98.4 | | 98.4 | 100 |
| SEYCHELLES | 100 | 11.4 | 88.6 | 88 |
| SOUTH AFRICA | 92.6 | | | 74 |
| ESWATINI | 86 | | 86 | 77 |
| KENYA | 24.8 | | | 15 |
| LESOTHO | 94 | | 94 | 61 |
| MOZAMBIQUE | 17.3 | 1.7 | 15.6 | 24 |
| UNITED REPUBLIC OF TANZANIA | 3.2 | 3.2 | 100 (Zanzibar) | 100 (Zanzibar) |
| ZAMBIA | 8.8 | 8.8 | - | 1 |
| NIGERIA | 7.8 | 7.8 | | <1 |
| UGANDA | 6.6 | 4.5 | 2.1 | 4 |

*Source: ILO 1World Social Protection Report 2020; 2 HelpAge Pension Watch Database 2020*

The absence of adequate social protection provisioning for older people in the region made older people highly vulnerable to the economic impacts of COVID-19 (See Section 4.2).

Conversely, in countries with good pension coverage, but limited social protection for the working-age population, low-income households depend on older people's pensions for survival, a situation which has likely increased during the economic fallout of pandemic. For example, in South Africa pensions shape household formation as young people group around older people (Button and Ncapai, 2019; Kimuna and Makiwane, 2007). Skip-generation households are increasingly common; these households are typically headed by an older woman who become responsible for caring for grandchildren and often supporting several other family members financially (Button and Ncapai, 2019; Kimuna and Makiwane, 2007). Dependence on older people's income can drive financial abuse or exploitation of older persons within households or criminal targeting of older people within communities (Jacobs, 2020; Lloyd-Sherlock et al., 2018)

## 3.3.1 Long-term care provision

Long-term care for older people can take on many forms and is defined by the WHO as "all activities undertaken by others to ensure that people with, or at risk of, a significant ongoing loss of capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity" (World Health Organization, 2015)

**Lack of comprehensive long-term care systems** in much of the region. Only 3 countries - South Africa, Mauritius and Seychelles have made efforts to develop national long-term care systems (World Health Organisation, 2017b). Most of the nursing homes on the continent are concentrated in South Africa, which has a large number of government funded and private long-term care facilities. In Mauritius and Seychelles, care homes exist, but the focus is on encouraging home-based care with support and funding provided to beneficiaries to cover care costs, thereby allowing older people to remain in their homes and communities while receiving quality care. In South Africa a small cash transfer (the Grant-in-Aid) is available to state Old Age Pension beneficiaries who have care needs, but this amount is not sufficient to support home-based care.

**Lack of regulation of existing long term care facilities (LTCFs).** Some governments, such as Kenya, provide funding for care facilities, although without a formal regulatory framework (National Gender and Equality Commission Headquarters, 2016). Private institutions and faith-based institutions do exist in some countries such as Lesotho, Kenya, Zimbabwe, Ghana and Nigeria, but in very limited numbers and with little regulation. Residential and nursing homes; and palliative services provided in public health care settings are for the most part either unaffordable or distantly located (which increases the cost of out-of-pocket expenses for older

persons). The lack of regulation of existing LTCFs, as well as other long-standing problems such as lack of accountability, fragmentation between health and long-term care and an undervalued work force (Mapira et al., 2019), are concerning in the context of the COVID-19 pandemic. The vulnerability of older people in LTCFs to COVID-19 in terms of rapid spread and high mortality rates is well established globally (Barnett and Grabowski, 2020; Connolly, 2020; Salcher-Konrad et al., 2020). In the African region, LTCFs lack the necessary staffing, systems and equipment to protect residents and staff from COVID-19 pandemic and residents often share rooms, putting older people in this facilities at significant risk (Lloyd-Sherlock et al., 2020; Makoni, 2020).

**Cultural preference for family provision of care.** For the most part long-term care is provided by family, without organised training or support and there is a strong cultural preference for family provision of care. However, factors such as social change, migration and poverty make it difficult for families to provide quality care and there is little support provided by governments to support household and community care for older people (Aboderin, n.d.). Older persons' organisations may provide support for care provision in the form of training and education, respite care, monitoring or psychosocial, but these organisations are often struggle with funding and have limited capacity and reach. Poorly supported family care provision places a particularly heavy burden on such women and girls, often resulting in their exclusion from schooling or labour market participation.

**Innovative approaches to providing organised care.** The WHO report *Towards Long-term Care System in Sub-Saharan Africa* highlights some innovative approaches to providing organised care that have been introduced by civil society or private companies. In Ghana, care plans are implemented by volunteer and paid caregivers (World Health Organisation, 2017b). In Kenya, private nursing agencies offer multi-disciplinary integrated and personal care for paying clients specialized home health care, nutritional advice, psychosocial support and disease management services. In Tanzania, HelpAge International's Better Health for Older People programme supports older people via trained volunteers who make home visits and implement individualised care plans and screening, health services and medications are provided free of charge to people participating in the programme and other services are offered in partnership with community-based and faith based organisations and networks (World Health Organisation, 2017b).

## 3.4 Health Systems Capacity and Preparedness

Health systems have a responsibility to offer safe, accessible, affordable and quality health care, including assistive and palliative care, for all people, without discrimination. Given the increased risk of multiple chronic conditions, along with increased disability and frailty, an ageing population is likely to bring about increasing number people who need health and long-term care, and this is generally associated with rising demands on the health and long-term care systems and corresponding costs (Solanki et al., 2019).

Despite a growing burden of chronic disease, health systems and development assistance to support these systems in Africa remain primarily focused on communicable disease . The vast majority of health budgets in Africa are dedicated to controlling infectious diseases, especially in the wake of the HIV epidemic, and a very small proportion of health budgets are spent on chronic disease or services for older people (de-Graft Aikins et al., 2010; Tollman et al., 2006).

**Access to and quality of health care remains poor in most countries in Africa**. Globally, public health care spending in Africa is among the lowest (Kaneda and Ashford, 2020) and as Table E in Annex B demonstrates, the proportion of GDP spent on health in 2018 (which on average was 5.1% in Sub-Saharan Africa) is well below the 15% of national budgets that AU member states pledged to commit to improving health systems by signing the 2001 Abuja Declaration (World Health Organization, 2016), and below the global average of 9.8% for all countries. Prioritisation of health spending is not necessarily related to country wealth on the continent and two notable exceptions are Sierra Leone (16.1%) has invested heavily in health systems and Universal Health Coverage over the past few years and Central African Republic, which increased its expenditure dramatically in 2018 to 11% of GDP.

The vast majority of health budgets in Africa are dedicated to high-end care accessed by relatively few individuals and small proportion of health budgets are spent on primary care services (World Health Organization, 2016), where older people's health issues are best identified and managed to preserve intrinsic capacity and functional ability. Despite a growing burden of non-communicable diseases on the continent, particularly among older people, health services for NCD prevention and management are limited, poorly integrated and funding levels for NCDs by both government and international donors are weak and implementation of the "Best Buys" and other recommendations from the WHO *Global Action Plan for the Prevention and Control of NCDs* (2013-2020) have been low (Allen et al., 2020; Devermont and Harris, 2020; World Health Organisation, 2017c). The WHO Study on Ageing and Health in Ghana showed that 96% of older people with hypertension did not have adequate treatment to control their condition (Lloyd-Sherlock et al., 2014). Given the disproportionate risk of COVID-19 to older people and people with NCDs, the neglect of these populations is particularly notable in the context of COVID-19 (Devermont and Harris, 2020). For example, people living with uncontrolled diabetes were found to be 12 times more likely to die from COVID-19 [Adjusted hazard ratio 12.07, 95% CI, 9.6-

15.02] across all public-sector patients in the Western Cape province of South Africa (Western Cape Department of Health in collaboration with the National Institute for Communicable Diseases, 2020)

**Poor access to health services.** Older people, particularly those with mobility or sensory impairments may struggle to access health services for various reasons including long distances to facilities, lack of or cost of transportation and difficulties in recruiting someone to accompany them to the facility (Western Cape Department of Health in collaboration with the National Institute for Communicable Diseases, 2020). A recent geolocation study showed that across SSA, the proportion of adults aged 60 years and older with an estimated travel time of **greater than six hours** to the nearest hospital was 9.6% (95% CI: 5.2 – 16.9) and for healthcare facilities of any type, using a travel time cut-off of two hours, the corresponding proportions were 15.9% (95% CI: 10.1 – 24.4) (Geldsetzer et al., 2020). Although there is national and sub-national variation in access, most countries in the region contain areas where adults over 60 would have travel times to the nearest hospital of 12+ hours or 6+ hours to the nearest health facility. These findings clearly demonstrate that health care is not easily accessible for most older persons in the region. Low physical access to healthcare in the region has significant implications in terms of receiving care for COVID-19 (or even a COVID-19 diagnosis) for older people in the region.

**Poor implementation of policies to promote access to health care for older people in SSA.**
Most countries in Sub-Saharan Africa do not have health care access policies targeted at older persons and this category of the population largely do not have health insurance and policies to Universal Health Coverage (UHC) are limited (Saka et al., 2019).

**Universal health coverage** is defined as ensuring that "all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship." UHC is measured by

- Service Coverage (SDG indicator 3.8.1): The proportion of a population that can access essential quality health services (World Health Organisation, 2021a)
- Out of pocket payments (SDG indicator 3.8.2).: The proportion of the population that spends a large amount of household income on health

A 2017 UHC categorisation of African countries (see Figure 2 below) revealed that only eight countries[3] had high service coverage ≥ 50% and low out-of-pocket payment (≤40%). Mauritius, although having a high level of health coverage, had a high level out-of-pocket payment.

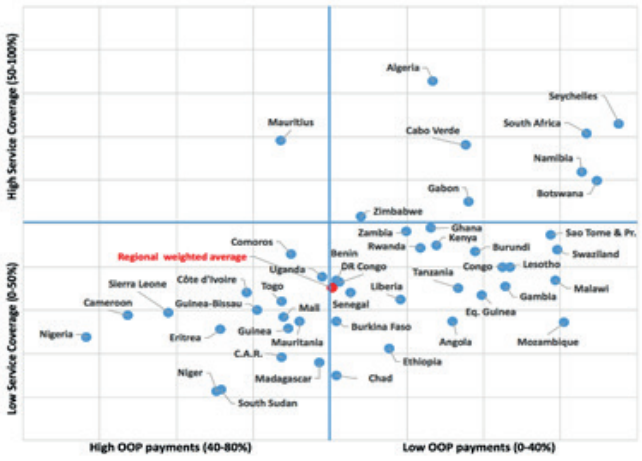


*Figure 2 Mapping of countries in the African region by UHC coverage indicators add year*

With the exception of countries such as Senegal, Ghana and South Africa, that have either implemented free healthcare or exempted the older people from paying health insurance premiums, older people in many other SSA countries are not covered by health insurance (Parmar et al., 2014; Saka et al., 2019) Ghana's National Health Insurance Scheme and Senegal's Plan Sesame provide two notable exceptions but both programmes are mired with implementation challenges (Ba et al., 2014; Sackey, 2019; Smith-Cavros et al., 2017) Nigeria, the country with the largest population of older people in SSA, has no health care access policies targeted at older persons and the health insurance is intrinsically designed to exclude this category of the population (Mohammed et al., 2013). Only a few countries in SSA, including South Africa, Ghana, Nigeria and Cameroon, have evidence of integration of NCDs treatments into primary healthcare. Mental health, an essential component of well-being over the life course, has been neglected as a health priority in the region .

**Age-friendliness of facilities and care provided.** The first contact with health care systems for a majority of the population in sub-Saharan Africa and other regions is the primary health centre. The role that Primary health centres (PHC) play in the health of older persons in all countries and the need for these centres to be accessible and adapted to the needs of older populations is critical. The achievement of this requires health care systems to be age friendly and for health and care workers to be capacitated to identify and address older people's needs. With generally poor infrastructure, the physical environment of health care facilities, for example **the lack of ramps for people with mobility restrictions** and **limited seating** and weak healthcare management systems, resulting in issues such as long queues or weak referral systems can be significant barriers to access for older people (Kelly et al., 2019; Naidoo and Van Wyk, 2019). Older people have to access healthcare services in general clinics with everyone else and health services are not necessarily well integrated or focused on NCDs, which disproportionately effect older persons. Only a few countries have health care services targeted at older people, even then, such services are

3 Algeria, Botswana, Carbo Verde, Gabon, Namibia, Seychelles, South Africa and Zimbabwe

available only in urban centres. Quality and responsive care is also limited by the lack of health worker training in caring for older persons, low awareness of age-related conditions, dealing with multi-morbidity and communicating effectively with older people (Dotchin et al., 2013; Frost et al., 2015; Peltzer and Phaswana-Mafuya, 2012).

## Country-level preparedness for COVID-19

Sub-Saharan Africa (SSA) experience of disease outbreaks such as Ebola, has given some countries in the region, particularly in Central and West Africa, a head start in terms of preparedness and health infrastructure to control the spread of coronavirus. However, the majority of countries have limited

health care infrastructure including a shortage of health care personnel, equipment, essential medicines, and insufficient intensive care units to manage the critically ill. The 2019 Global Health Security Index showed that countries in the region have the most insecure health systems globally (Global Health Security Index, 2019) and this lack of resilience posed a significant threat to fragile health systems in the face of COVID-19, and therefore ability of older people to access COVID-19 and other forms of healthcare during the pandemic. The implementation of the 2005 International Health Regulations (IHR) (World Health Organisation, 2016) by governments in Africa with their development partners is weak. The IHR are a set of legal instruments designed to ensure and improve the capacity of all signatories or state parties to prevent, detect, assess, notify and respond to public health risks and acute events such as COVID-19 (World Health Organisation, 2019). This is confirmed by the 2018 and 2019 State Party Self-Assessment Annual Reporting (SPAR) (World Health Organisation, 2019) of the World Health Organisation's Monitoring and Evaluation Framework, in which the global including African countries participated. In sub-Saharan Africa (SSA), for the capacity 'Health Service Provision', of its 47 countries, only seven had a score above 60%. And thirteen had a score less than 30%. This indicates that country-level strategic preparedness for COVID-19 was generally low in the African region, which had implications for older people who among the most at risk.

According to the WHO COVID-19 Strategic Preparedness and Response Status for COVID-19 documents (summarised for the African region in Table 4 below), as measured in February, March and June 2020, The Central African Republic and Comoros were least prepared (at Level 1), with the majority of countries falling into Level 2 or Level 3 and only Algeria and Mauritius falling under Level 4. There were no changes in levels of preparedness in the region between February and June 2020.

***Table 4 Country-level strategic preparedness and response.***

| Level 5 | Level 4 | Level 3 | Level 2 | Level 1 |
|---|---|---|---|---|
| No AFRO region countries | Algeria<br>Mauritius | Angola<br>Cameroon<br>Congo<br>Côte d'Ivoire<br>DRC<br>Eswatini<br>Ethiopia<br>Ghana<br>Guinea<br>Kenya<br>Liberia<br>Malawi<br>Mozambique<br>Niger<br>Nigeria<br>Rwanda<br>Senegal<br>Seychelles<br>Sierra Leone<br>South Africa<br>Uganda<br>United Republic of Tanzania<br>Zimbabwe | Benin<br>Botswana<br>Burkina Faso<br>Burundi<br>Cabo Verde<br>Chad<br>Djibouti<br>Equatorial Guinea<br>Eritrea<br>Gabon<br>Gambia<br>Guinea-Bissau<br>Lesotho<br>Madagascar<br>Mauritania<br>Namibia<br>Sao Tome and Principe<br>South Sudan<br>Togo<br>Zambia | Central African Republic<br>Comoros<br><br>*No other countries classified as Level 1 globally* |

*Source: WHO COVID-19 Strategic Response Documents February, March, June 2020*

Sub-Saharan Africa has the fewest hospital beds per 1000 people in the world, with most countries having fewer than 1 hospital bed per 1000 people, with a global average of 2.9 per 1000 people (The World Bank, 2021a). According to WHO's readiness survey for COVID-19 at the start of the pandemic, countries such as Angola, Burkina Faso, Burundi, Central African Republic, Cote d'Ivoire, Congo Brazzaville, Guinea Bissau, Lesotho, Malawi, Mali, Mozambique, Niger, Sao Tome and Principe, Seychelles, South Sudan, and Zimbabwe had no ICU beds available to treat COVID-19 at the time and there was a shortage of the necessary specialised health staff across the region (Finnan, 2020). Other surveys have reported similar findings, as well as discrepancies between official reports and actual capacity in terms of functional equipment and available trained staff (Atumanya et al., 2020; Houreld et al., 2021). Furthermore, existing resources to treat critically ill patients are often only located in referral hospitals in urban areas that are difficult for people in rural areas to access (Murthy et al., 2015).

By December 2020, only 9 countries (19%) in the African region had more than 2 ICU beds per 100,000 in the population, while 49% of countries in the region had less than 0.5 per 100,000 in the population. Given the need for ICU services during the pandemic, this created considerable concern from the outset of the pandemic around management of serious COVID cases.

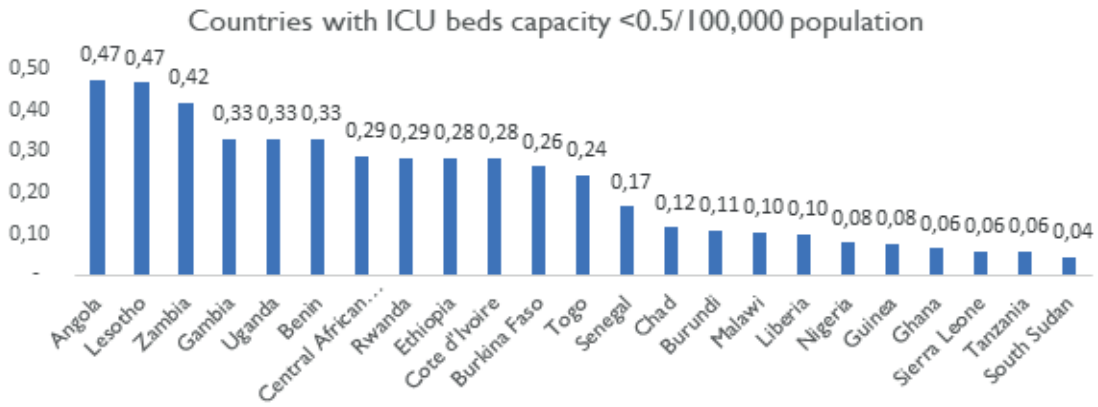


***Figure 3 Source: Presentation on WHO Case Management Support to Countries May 2021***

Availability of oxygen plants in the region is low, with 16 countries having only one Oxygen Pressure Swing Absorption generator.

A capacity assessment of intensive care units conducted by Africa CDC in July 2020 showed that most AU Member States had very limited intensive care unit capacity and one-third of AU Member States had four or less mechanical ventilators per million population. According to WHO data from September 2020, two countries – Comoros and Central African Republic - had no ventilators available whatsoever.

## A Situation analysis of care services and older people in SSA: Summary of Key Findings

Demographics:

- While the proportion of older people in most countries in the continent is below the global average, Africa is ageing fast and has the largest population of older people in the world
- The region lags behind others in terms of the health and well-being of older people, leading to lower quality of life and higher levels of disability
- The burden of NCDs is growing in Africa, for which old age is a significant risk factor. This presents a growing healthcare cost and also increases risk of severe COVID-19 infection and mortality
- Levels of economic dependency by older people are lower than elsewhere in the world and older people make significant contributions to households in terms of continued employment and care provision.

Economic and social development:

- There is significant variation in levels of development in the region, but most are economically constrained (only 7 are classified as upper middle-income or high income countries)
- Living conditions are difficult for older people in low-income countries and are particularly vulnerable in conflict and humanitarian emergency settings in the region
- Older people and older women in particular are highly likely to live in poverty across the region
- Labour force participation (mainly in the informal economy) and agricultural activity remains high among people 60+ due to lack of adequate contributory and social pension programming
- Older people in conflict or humanitarian emergency setting are particularly vulnerable.

- While more educated than previously, levels of educational attainment among older people are relatively low, particularly among older women.
- The digital divide has negative implications for older people's participation in society and the economy in the COVID-19 era.

Policies, Plans and Structures for Healthy Ageing

- While policy development and implementation of policies and programmes to support healthy ageing are growing, the region is lagging behind others.
- As a result, older people have poor access to appropriate health care and long-term care and poor income security

Health systems and long-term care capacity and country-level preparedness for COVID-19

- Older people struggle to access appropriate healthcare in the region prior to the COVID-19 pandemic and barriers to access are likely to impact on accessibility of care for COVID-19.
- Weak investment in health systems and in NCD management in particular, left most countries in the region poorly prepared for COVID-19
- Long-term care capacity is weak, with little support for older people ageing in community or in institutional settings.

# 4. Impact of COVID-19 on older persons

## 4.1 Impact on older people's health and wellbeing

### COVID-19 infections, mortality and older persons

Across the globe, older people are the population most vulnerable to severe COVID-19 illness and mortality, and the case fatality rate for persons over 60 years, for all countries globally is generally signficantly higher than that of people under 60 (Bonanad et al., 2020; Levin et al., 2020).

A rapid review of international systematic reviews, primary studies and South African patient data conducted by Young et al.(Young et al., 2020) shows the influence of NCD co-morbidity and age on hospitalisation and mortality of patients with COVID-19.

**Data collection on COVID-19 and its impact on vulnerable groups across the region has been patchy due to low capacity and disruptions** in statistical data collection by ministries of health and national statistical offices, as well as COVID-19 testing capacity (Riddell, n.d.). Data on older people in the region is particularly scant and the disaggregated demographic and health data on older persons is not available for most countries and existing household survey and health survey data is likely not accurate (HelpAge International, 2020b).

Furthermore, it is expected that COVID-19 statistics are inaccurate and likely underestimated due to limitations in testing across many countries in the region. The majority of AU Member States report fewer tests per confirmed case than WHO's recommended benchmark of 10-30 tests per confirmed case (Hanghøj and Boisen, 2014; Kretchy et al., 2020, 2014; Nakata, 2012).

**The mortality impact of COVID-19 on older people.** Data in Table D of Annexes shows general COVID-19 infection data and mortality rates from across the region. However, case fatality rate data is only available to 17 countries who reported these rates to the WHO at various times since the start of the pandemic.

Table 5 below indicates that, as has been the pattern globally, case fatality rates are significantly higher among older persons (age 60+) than those under 60. Therefore, regardless of the quality of reporting, it is clear that older persons have been most impacted by the pandemic and we can expect that this is also likely the case in countries in the region that have not been collecting age-disaggregated data. Older persons should, therefore, be a focus in terms of policy and programmatic interventions to mitigate the impact of COVID-19 in the region.

*Table 5 Disaggregated infection and mortality data provided by 17 African countries to WHO*

| Country | % cases aged 60+ | CFR Cases > Age 60 | CFR Cases < 60 |
|---|---|---|---|
| Burkina Faso | 11.9 | 5.4 | 0.5 |
| Chad | 11.8 | 14.9 | 1.8 |
| Cote d'Ivoire | 7.3 | 3.6 | 0.2 |
| DRC | 14.7 | 8.7 | 1.4 |
| Eswatini | 11.4 | 3.4 | 0.3 |
| Guinea | 11 | 3.2 | 0.2 |
| Kenya | 7.3 | 10.6 | 1.1 |
| Liberia | 11 | 8.5 | 1.7 |
| Mauritius | 12.8 | 8.3 | 1.2 |
| Namibia | 6.2 | 5.8 | 0.5 |
| Niger | 14.7 | 16.2 | 2.1 |
| Rwanda | 3.8 | 8.2 | 0.3 |
| Sao Tome & Principe | 15 | 3.3 | 1 |
| Senegal | 24.3 | 2 | 0.2 |
| Seychelles | 7.5 | 4.6 | 0.1 |
| Uganda | 8.2 | 4.9 | 0.4 |
| Zimbabwe | 6.5 | 10.1 | 1.3 |
| Total | 10.6 | 5.8 | 0.7 |

*Source: WHO AFRO Epidemiological team add the period of the report*

**The mortality impact of COVID-19 on older people is most obvious in South Africa,** which has been hardest hit by the pandemic in the region with almost 1.6 million cases and 54,825 COVID-19 deaths recorded by 10 May 2021. South Africa stopped providing publicly available age-disaggregated mortality data fairly early in the pandemic (June 2020), but well over half of the officially recorded deaths at the time were among people over the age of 60. Excess mortality data gives the most telling picture of the impact on older people. Despite having one of the highest testing rates in the region, it is expected that the number of deaths directly attributed to COVID-19 have been vastly undercounted, particularly in more rural areas where testing rates have been lower and excess mortality rates are markedly higher, based on excess mortality data, which compares the predicted numbers of weekly deaths based on previous years to the actual number of recorded weekly deaths over the COVID-19 pandemic period. Over the past year (3 May 2020 to 1 May 2021) there have been an estimated 157,542 excess deaths in South Africa (Bradshaw et al., 2021), 85-95% of which are expected to be directly to COVID-19 and the remainder the impact of lockdown, particularly reduced access to health services (Moultrie et al., 2021). 76% of the deaths (11,896) have been among people over the age of 60

## Effect of COVID-19 on older people's access to essential health services

The growing burden of NCDs has proven to be a global challenge, with health systems struggling to meet the needs of persons living with NCD, particularly in LMICS (World Health Organisation, 2018). The COVID-19 pandemic has forcibly illustrated existing weaknesses within global health systems and has disrupted services for prevention and treatment, making people living with NCDs, who are already vulnerable to COVID-19, more at risk of becoming severely ill or dying of COVID-19. Chronic disease management relies heavily on treatment adherence for adequate therapeutic outcomes (Viswanathan et al., 2012) and health service interruptions during COVID-19 have serious implications for people with NCDs, many of which are older people.

Even high income countries have experienced shortages of hospital and ICU beds, ventilators, medical workers and protective equipment, necessitating rationing of ICU care and ventilators (Baker and Fink, 2020; Rosenbaum, 2020). In LMICs, rationing is even more likely. Death rates following COVID-19 critical care admission are higher in Africa than in other regions, with one study showing that almost half of critically patients admitted died with the most likely explanation being a lack of oxygen, ICU equipment and specialised staff, which compromised patient care (Biccard et al., 2021). Older people are highly likely to bear the brunt of health care shortages, both in terms of their higher likelihood of needing critical care services and because of ageist attitudes that may result in denial of care in favour of younger people (HelpAge International, 2021; Lloyd-Sherlock et al., 2020).

As stated by Dr. Tedros Adhanom Ghebreyesus, Director General of the World Health Organisation, 5 February 2021: *"There is a disturbing narrative in some countries that it's OK if older people die. It's not OK… 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."*

Despite plans to strengthen capacity, health services in many African countries were interrupted or inaccessible and hospitals were unable to cater and handle patient loads, with implications for acute, chronic and emergency care (PERC, n.d.). - also see references for further examples of inaccessibility and disruptions (Bhalla, 2021; Devermont and Harris, 2020; Gyasi, 2020a; Hulland, 2020; Zhang et al., 2020). The intense focus on COVID-19 rather than other health issues may have also led to setbacks in managing malaria, HIV/AIDS, tuberculosis and other infectious diseases on the continent. For instance, a large meningitis outbreak in Ghana led to 40 deaths due to late reporting and lack of care (Adjorlolo and Egbenya, 2020). NCD services, on which older people rely, were also heavily disrupted (see Table 6).

Examples of this situation was confirmed in the case studies on Mozambique and South Africa:

> " Although no health centre in the areas surveyed had been closed completely as a result of COVID-19, normal consultations were halted, and only emergency services were available. Consultations once re-opened only saw 10 patients per day."

Furthermore, older persons' organisations that usually offer services to link older people to healthcare services via free transport services or home visits were not able to offer these services, further reducing healthcare access. An example of this is provided from the South African case study:

> " Muthande Society for the Aged have been running a very big transport operation, taking older people to clinics for their tablets and to see the doctor - we have been running that for the past 20 years – they were all dependent on that facility to access healthcare, but they could not because our drivers were not permitted to interact with them because of the risks involved."

The WHO has conducted two national pulse surveys of ministry of health officials in five WHO regions on the continuity of health services during the pandemic. The first survey was conducted between May and July 2020 and a second survey between October 2020 and February 2021(World Health Organisation, 2021b, 2020c). The surveys conducted to assess the impact of the COVID-19 pandemic on up to 25 essential health services in countries revealed that in general, disruptions of essential health services were reported by nearly all countries, and more so in lower-income than higher-income countries. As Table 6, below shows, there was less disruption reported in the second survey, which covered the "second wave" of the COVID-19 pandemic than in the first

survey and "first wave", indicating progress in implementing measures to maintain essential services over the course of the pandemic.

Primary care and rehabilitative, palliative and long-term care services were heavily affected in the region. Interruptions to primary care were most damaging because, as stated in the report,

> " primary care plays a key role in the health system, providing first-contact, accessible, continuous, comprehensive and coordinated patient-focused care. Primary care sits at the foundation of achieving universal health coverage (UHC), and any disruptions in this setting causes severe impact across the health system for service delivery and the overall health and well-being of patients."

***Table 6 Disruptions to healthcare services in the WHO African region. infection and mortality data provided by 17 African countries to WHO***

| Health Service | Round 1 (May - July 2020) | CFR Cases > Age 60 |
|---|---|---|
| NCD services (overall) | - | 43% |
| Cancer diagnosis and treatment | 48% | 46% |
| Diabetes management | 58% | 54% |
| Hypertension management | 64% | 59% |
| PHC routine scheduled visits | No disaggregated data for African region available | 53% |
| PHC prescription renewals for chronic medications | No disaggregated data for African region available | 47% |
| Long-term care services | No disaggregated data for African region available | 35% |
| Palliative care services | No disaggregated data for African region available | 39% |
| Rehabilitation services | No disaggregated data for African region available | 50% |
| Services for older adults with mental health conditions, disabilities or dementia | 68% | 46% |
| Suspension or limited provision of mobile clinics (policy) | 70% | 43% |
| Suspension or limited provision of community-based care (policy) | 45% | 39% |

*Source: WHO Global Dashboard: Tracking continuity of essential health services during the COVID-19 pandemic (August 2020 and March 2021)*

The main causes cited for reduced access were decrease in inpatient volume, closure of population-level screening programmes, public transport lockdowns, clinical staff deployed to COVID-19, closure of outpatient diseases and specific clinics and insufficient staff (World Health Organisation, 2021b). COVID has significantly affected availability of already limited healthcare staff (particularly physicians) in the region due infection or refusal to work because of high risks of exposure (Paquette, 2020). In terms of demand-side factors, fear of infection has been a big driver of non-attendance at healthcare facilities (Gates Foundation, 2020).

Data from the Partnership for Evidence-Based Response to COVID-19 survey in 18 AU states[4] in August 2020 also supports findings of widespread disruptions with 44% of households with an ongoing need for health care indicating disruptions in health visits and 47% experiencing difficulties in accessing medications. Given limited access to health facilities, older people were forced to purchase their medication privately, presenting unexpected and possibly unaffordable healthcare costs.

Rapid needs assessments focused on the needs of older people during the COVID-19 pandemic in Mozambique, Rwanda, Uganda, Ethiopia, Kenya, Tanzania, South Sudan, Zimbabwe show that older people's access to healthcare and medication was impacted during the pandemic (HelpAge International, 2020c, 2020d, 2020e, 2020f, 2020g, 2020h; HelpAge International and Center for Community Development Solutions, 2020; HelpAge International and Humanitarian and Development Consortium, 2020; HelpAge International and Nsindagiza Organization, 2020).

4 Countries surveyed include: Cameroon, Cote d'Ivoire, DRC, Egypt, Ethiopia, Ghana, Guinea, Kenya, Liberia, Mozambique, Nigeria, South Africa, Sudan, Tunisia, Uganda, Zambia and Zimbabwe. Egypt, Tunisia and Sudan are AU member states but are not classified as part of the WHO African Region.

In terms of access to COVID-19 services, the burden of severe COVID-19 cases on health systems across the region has varied tremendously based on the scale of the pandemic, the demographic and epidemiological services, as well as health systems capacity. While mortality rates have been lower in the region than elsewhere, it has the highest mortality rate among critically ill patients (48.2% vs. 31.5% globally), with delayed access to ICU care being a primary driver of mortality.

## Mental health among older adults during Covid 19 pandemic

COVID-19 has had a major impact on the mental health and wellbeing of older people. Fear, anxiety, information overload, economic stress, grief and loss and social isolation due to COVID-19 can result in the development of mental illness in individuals who have no know previous psychiatric conditions, or it can exacerbate an existing current condition (Ho et al., 2020).

Mental health services on the region are particularly under-resourced (Gyasi, n.d.) and were disrupted by the pandemic (see section on **health systems disruptions** above). Strict emergency lockdowns in the region, resulting in prolonged separation from caregivers and family, caused major changes among older adults regarding day-to-day functioning and routines and caused an escalation of poverty and hunger and the closing down of many important services, social activities and support networks (Gyasi, n.d.).

Older people were less able to adapt to online forms of communication and social contact and this "digital divide" leaves older people increasingly isolated and vulnerable to loneliness and depression (Martins Van Jaarsveld, 2020). This concern was also expressed by older persons organisations interviewed for the country case studies - they found it difficult to reach older people via digital modes and were concerned by the lack of social opportunities for older people in the absence of in-person social visits or planned activities.

> *" They cannot talk to themselves as they used to because some of them may be ill and they are not able to interact. Most of them do not like the technological twist to their social lives. They are not able to go to church service, another relief for them… they have church service on the radio and television...radio and television has become their partners". (Interview with representative from an older persons' organisation, Ghana)*

The impact of lockdown or quarantine on older adults with cognitive impairment or dementia, especially if hospitalized or in a long-term care facility, may result in the development of feelings of greater fear, anxiety, anger and stress with it being difficult to fully understand the reasons for actions taken relating to COVID-19 restrictions (Iodice et al., 2021; Mo and Shi, 2020). HelpAge International found that mental health support is an important need of older people during the pandemic, both in African countries where it has conducted needs assessments and globally (HelpAge International, 2021).

## Impact of COVID-19 on persons with long-term care needs

Many people with long-term care needs were impacted on by the lock down with the implementation of physical distancing, movement restrictions and curfews. They experienced food insecurity, a shortage of medication, poverty, and isolation. In many cases this was exacerbated by lack of reliable and/or the absence internet connectivity. Home care by external caregivers was complicated by infection concerns and NGOs providing services or care support to older people were not able to operate, reducing support to older people and family care providers. Interviews with older persons' organisations for the six country case studies (see (Ashwell et al., 2020)) show that adult day care facilities, respite care and community care services for older people were heavily disrupted by the pandemic in these countries and most likely, elsewhere in the region. People in the care of their families, particularly people with dementia or frailty, were vulnerable to abuse in the stress and confinement of lockdown, which was heightened by the lack of support services (Jacobs, 2020).

In terms of long-term care facilities providing care for people who cannot live independently within community settings, not much evidence is available on the impact of COVID-19 outside of South Africa, which has the greatest number of LTC facilities in the region (World Health Organisation, 2017d). COVID-19 outbreaks occurred in many LTC facilities South Africa (Ashwell et al., 2020). A study of sentinel surveillance data in South Africa as of late August 2020 revealed that 10% of residents and 12% of staff acquired the disease in facilities included in ongoing monitoring efforts and that case fatality rates were 10% among residents infected (Cowper et al., 2020). Case fatality rates in these facilities, especially those relying heavily on state, were severely challenged by the pandemic in terms of their preparedness and capacity to contain outbreaks, staff shortages as infection rates increased, lack of PPE and the costs of implementing IPC measures (Ashwell et al., 2020; Lee-Francke, 2021). The no visitor policies imposed also had negative effects on health and well-being of older people in facilities and pressures on staff. Furthermore, funding cuts to long-term care facilities, as well as the removal of older people from facilities by family members and higher costs in terms of staffing and quarantine and sanitation requirements, has resulted in severe financial constraints which threaten the quality of care (Ashwell et al., 2020; Lee-Francke, 2021) See the South African case study in Section 7 for more detail. Data on COVID-19 in LTC facilities elsewhere in the region does not appear to be available.

## 4.2 Socio-economic impacts on older persons

Although hard lockdowns helped to delay the spread of COVID-19 in the region, restrictions on movement and social and economic activities had significant negative effects on all 47 countries in terms of domestic consumption, business solvency, active labour and household income, as well as international flow effects such as remittances, foreign aid, foreign direct investment and trade (Ozili, 2020; UNDP Africa, 2021). The immediate effects can be seen in terms of annual GDP contractions in 75% of countries in the region in 2020 and reduced growth in the other 25% of countries (see Table E in Annex B). This increased poverty at the household level and threatened the gains many countries had made in terms of economic and development progress, particularly in countries vulnerable to economic shocks (Morsy et al., 2020; OECD, 2020; The World Bank, 2020). Countries dependent on oil and mineral resource such as the DRC and Angola that were affected by commodity price drops, as well as tourism dependent countries which have struggled with challenges of longer-term reduced international travel were particularly hard-hit - Seychelles experienced a drop in GDP of 15.9%, while Mauritius and Cabo Verde experienced GDP contractions of 12.9.% and 11% respectively. These economic shocks, combined with the costs of implementing COVID-19 national mitigation strategies have forced many countries to take on even more unsustainable debt, with long-term consequences for economic prosperity and possibly security in the region. In November, Zambia became the first country to default on its debt since the pandemic (Golubski and Holtz, 2021).

Fiscal pressure brought about by the combination of economic decline and COVID-19 government spending is likely to reduce investment in policies and programmes to support healthy ageing, both in the short and longer-term. For instance, government funding for long-term care programming for older people in South Africa has been significantly cut due to budget reallocations, threatening both community and residential care provision at a time when older people are particularly at-risk (Stent, 2020).

Older people are particularly vulnerable to poverty and given the lack of social protection for older people in much of Africa (see Section 2.3), older people who were informal traders or depend on other household members or remittances would have been particularly affected. In the absence of pensions, many older people in the region are dependent on remittances from family members. Economic shutdowns both regionally and across the globe resulted in reductions in remittance flows to the region (UNDP Africa, 2021) and, thus, disruptions in a reliable source of income to older people. Many older people in Africa remain economically active in the formal or informal economy (Aboderin et al., 2020) and given that the majority (96%) of older people working in the region do so in the generally informal sector (International Labour Organisation, 2018), they are likely to be low-income earners with little savings, making them particularly vulnerable to shocks such as COVID-19 lockdowns and more likely to be excluded by formal labour market interventions put in place by governments in the COVID-19 context.

Poor nutrition is a risk factor to the declines in intrinsic capacity in older people. Malnutrition is a modifiable risk factor of sarcopenia (age-related low muscle strength and muscle mass), and both malnutrition and sarcopenia are associated with functional decline in older adults (Ligthart-Melis et al., 2020; Verlaan et al., 2017). Increased food prices in many countries also increased food insecurity and impoverishment among all groups, including older people (The World Bank, 2021b). Countries in the Sahel and West Africa were already experiencing high levels of food insecurity, malnutrition, instability and displacement, which was only made worse by COVID-19 (SWAC/OECD, 2020). The Food and Agriculture Organisation of the UN and World Food Programme's early warning system warns that the economic downturn as result of COVID-19 has contributed to significant food insecurity - Burkina Faso, Nigeria and South Sudan are on the brink of famine and food crises are ongoing in Zimbabwe, Mozambique, DRC, Sierra Leone, Mali and Niger, Central African Republic, Ethiopia (World Food Programme, 2020).

Case study findings closure of services for older persons, which often include food support, also had a serious impact on older people's food security.

> *"We feed about 2,000 a day through luncheon clubs and all the people depending on all those two meals a day…their lives were just shut-down. We could not go to their houses because we could make them more vulnerable by visiting them." (Interview, Muthande Society for the Aged, South Africa).*

Rapid needs assessments of older people conducted by HelpAge International and their partners in Mozambique, Rwanda, Uganda, Tanzania, Ethiopia, South Sudan and Zimbabwe showed significantly increased income and food insecurity in settings where assessments took place, forcing older people to reduce the quality or quantity of food consumed. Older age groups where prevalence of disability was higher, were particularly impacted. (HelpAge International, 2020a, 2020b, 2020c, 2020d).

## 4.3 Older people's rights and issues of ageism and abuse

The mistreatment of older adults, a serious violation of human rights, has been receiving significant attention globally and is a public health problem of great proportion amid the growing ageing population which is increasing susceptibility to abuse as well as placing strain on related health systems. A recent systematic review conducted to determine the global and regional prevalence of abuse revealed that one in six older adults globally have been affected. The impact of elder abuse alongside ageism has further increased during COVID-19 especially in LMIC regions such as Africa where millions of older adults are being exposed to human rights violations (Ajiboye et al., n.d.). These violations are occurring in individual's homes, in institutions and care facilities as well as through reduced access and discriminatory decision-making regarding access to COVID-related lifesaving resources. Furthermore, older adults are being discriminated against regarding access to health services, including home-based visits and community care (Hada, 2021).

Various examples of abuse and ageism are highlighted below. An analysis was conducted on tweets made to identify ageist content, on a social media platform Twitter, relating to COVID- 19 and older adults. The results highlighted that approximately one- quarter of the analyzed tweets (n=351 tweets) had ageist and/or offensive content toward older adults (Jimenez- Sotomayor et al., 2020).

While there were almost no reports of ageism in the allocation of COVID-19 care resources in interviews conducted for this report, there were examples from the media of older people being unable to access acute or chronic healthcare or being denied access to health resources such as ventilators in favour of younger patients. In general, health care facilities do not have or have limited access to some of the vital equipment required for acute care. This is evidenced in these examples:

- Most of the community and primary care centres in Kenya lack medication and do not have access to some of the vital equipment used to treat respiratory conditions that are necessary to treat COVID-19 (Battle, 2020). These limitations in access to care affect all populations, but disproportionately effect older people who are more likely to require in-hospital treatment.
- Resource allocation policies were put in place in some settings, either informally or formally, that de-prioritised care for older people in South Africa, where critical care triage guidelines disproportionately discriminate against older adults (Erasmus, 2020) In the Western Cape province, the official COVID-19 critical care triage decision tool explicitly indicated that patients older than 70 years may not be ventilated and that patients older than 65 years with comorbidity may not be considered for ventilation (Brydon, 2020).
- In DRC, HelpAge DRC reported that at least one older person (a 68-year-old man) had died after being taken off a ventilator very shortly after being ventilated to make way for another patient as only three were available in the facility and it was hospital policy to prioritise younger patients (HelpAge International, 2020i)

The ongoing need for physical distancing or the "shielding" of older people makes it difficult for them to continue participating in economic and social life, increasing their isolation and possibly ageist perceptions that they are a vulnerable and dependent group. Research was conducted in five global regions, including Africa, to establish whether aging narratives had become more negative from before to during the pandemic. Ageing narratives based on scores, showed that South Africa scored the highest in societal ageism of all countries included in the study during the peak pandemic period, while Ghana showed the weakest trend towards negativity in ageing narratives of all countries (Ng et al., 2021).

In Cote d'Ivoire, it was made compulsory for only older adults to be confined to their homes during the pandemic and in Tanzania it was advised to remain socially distant from older people, with older people commenting that relatives denied them food or reduced their food portions and would not allow them to leave the house (Helpage International, 2021). In Kenya older members of the National Assembly were mocked by the House minority and in Rwanda older adults were subjected to not receiving any service from service providers who couldn't serve them due to fear of infection. In Ghana older adults were not allowed access to social intervention programmes (Helpage International, 2021). Since the outbreak of Covid-19, HelpAge in DRC received 33 calls in the first three months of the COVID-19 pandemic related to abuse of older adults (neglect 55%, physical 20% and financial 25%), which is significantly higher than the 41 calls received for the whole of 2019. This compares to 41 calls for the whole of 2019. In Mauritius it was reported that two women aged 85 and 87 were assaulted for their pensions. In Kenya an older man was kidnapped by a group of young men who demanded a ransom for his release and left him for dead after assaulting him when the ransom was not given (HelpAge International, 2020i). In South Africa, domestic and family violence (which is very often targeted at care dependent older persons) have increased significantly in during the COVID-19 pandemic (Jacobs, 2020). Caregiver stress and increased care burden, due to confinement, limited external support and long working hours (in the case of formal care) and fear and anxiety, put older people at risk of abuse in both informal and formal long-term care settings (Jacobs, 2020).

## Impact of COVID-19 on older persons: A summary of key findings

Impact on older people's health and well-being

- Available data indicates that COVID-19 case fatality and excess mortality among older people over the pandemic period is significantly higher than among the younger population on the continent.
- Mortality rates for people admitted to critical care (most likely to be older people with co-morbidities) have been higher than in other regions globally due to shortage of necessary equipment and staff.
- Older people's access to essential health services, particularly primary care, has been heavily impacted by the pandemic.
- Access to long-term care services and caregiver support at community level has been disrupted by COVID-19 movement restrictions, challenges in working safely with older people and funding challenges.
- Information on the impact of long-term care facility residents is limited outside of South Africa, but data from SA shows difficulties in managing outbreaks in these facilities due to lack of PPE, training, funding and staff shortages.
- COVID-19 physical distancing restrictions and the total lockdown of residential LTC facilities had negative impacts on the mental health and general wellbeing of older people.

Socio-economic impacts

- Economies in Africa were heavily impacted by COVID-19, with long-term consequences for overall economic and social development in the region, including government investment in frameworks to promote healthy ageing.
- Older people's livelihoods were impacted by lockdown restrictions, with negative implications for consumption and food security, which was particularly noticeable given the lack of social protection for older people in the region

Impact on older people's rights and issues of ageism and abuse

- Older people have been discriminated against regarding access to health services and, in some cases, in terms of freedom of movement.
- Perceptions of older people as vulnerable and dependent have been reinforced by the pandemic, increasing societal ageism

# 5. COVID-19 response and older people in Africa

Given the unprecedented health, economic and social impact of the COVID-19 pandemic, there has been a significant response by national governments, as well as international, regional and national non-government actors to limit the spread of COVID-19, strengthen health systems and support individuals faced with COVID-19 and its consequences. This section of the report focuses on the following set of responses: 1) general response; 2) health and long-term care systems response, 3) socio-economic response, including social protection response, food-aid and in-kind response, engagement of community stakeholders and advocacy and communication.

Further detailed examples are provided in the six country case studies (Ghana, Mauritius, Mozambique, Rwanda, Senegal and South Africa) in Section 7, which are based on interviews conducted at national level with government officials, frontline workers and older persons' organisations.

## General response

The UN response has been organised around 5 pillars, as well as cross-cutting issues. These include Health First, Protection People, Economy Recovery, Macroeconomic response and Social Cohesion and Communication. Responses have been guided by the socio-economic impact assessments conducted by the UNDP. The WHO and partners in the African region have produced technical documents tailored specifically to the region.

Given older people's significant vulnerability to COVID-19, global, regional and national-level response plans to slow the spread and mitigate the effects of COVID-19 benefit older persons by protecting them from infection. However, given the particular needs and vulnerabilities of older people and frequent marginalisation of older people, it is also necessary to implement strategies and interventions targeted particularly at older people or put in place plans to ensure their inclusion in more general programmes. The UN Global Humanitarian Response Plan focuses on particularly vulnerable countries and includes *Humanitarian Response Plans* (which applied to 11 AFRO region countries[4] ) and *Regional Refugee Response Plans*[5] which apply to 14 AFRO region countries. These broad plans repeatedly mention older persons as a category of

5 Burkina Faso, Burundi, Cameroon, CAR, Chad, DRC, Ethiopia, Mali, Niger, Nigeria, South Sudan

6 Angola, Burundi, Cameroon, Chad, DRC, Kenya, Niger, Nigeria, Republic of the Congo, Rwanda, South Sudan, Uganda, Tanzania, Zambia

vulnerability and advise that needs assessments and targeted outreach efforts and programmes be put in place to support older people living in already precarious situations.

Older people are frequently mentioned as a vulnerable group in briefs and documents reviewed as part of this assessment. The UN Policy Brief *The Impact of COVID-19 on Older Persons* (United Nations, 2020a) urges for the inclusion of older people in the response to COVID because blanket approaches prevent older people from accessing generally available services. The *UN Policy Brief on a Disability-inclusive Response to COVID-19* highlights the potential for discrimination in the allocation of scarce medical resources to people with disabilities and their particular vulnerability to COVID-19, as well as the socio-economic impacts of the disease and in humanitarian disaster contexts, which include many older persons (an estimated 46% of older people aged 60 and over are people with disabilities) (United Nations, 2020b). However, in response documents reviewed, older people are generally described and grouped with other vulnerable categories (children, women, people with co-morbidities, refugees etc.) Based on interviews conducted for this report, national government engagement with older persons organisations in terms of developing the response that was inclusive of and capable of reaching older people appears to have been fairly limited. However, Roseline Kihumba from HelpAge International did note that in Uganda, Tanzania, Nigeria, Ethiopia, Kenya and Rwanda, their partner organisations were able to insert themselves into the conversation between the ministries of health and civil society organisations within these respective countries.

How the response to older people has been operationalised implemented and the extent to which older people's needs have been a specific focus are unclear from documents, but it is expected that older people may have been overlooked. On the UN website there are specific resource pages dedicated to women, youth and disability inclusion, but the policy brief published on older persons appears to be the main resource available (United Nations Sustainable Development Group, 2020). However, older people and people with NCDs are notably included in the following documents which provide guidance on helping older people and people with NCDs to avoid healthcare activities and include guidance on modifying service delivery during periods of high transmission:

- East and Southern Africa Region Joint Interim Guidance on Continuity of Essential Health and Nutrition Services during the COVID-19 Pandemic developed by Africa CDC, WHO, UNICEF, UNFPA and Volunteer Service Overseas (VSO).
- World Health Organisation. COVID-19 Operational guidance for maintaining essential health services during an outbreak (World Health Organisation, 2020d).
- World Health Organisation. Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic (World Health Organisation, 2020e)
- World Health Organisation. Infection prevention and control guidance for long-term care facilities in the context of COVID-19 (Wold Health Organisation, 2021).
- World Health Organisation. Preventing and managing COVID-19 across long-term care services: policy brief (World Health Organisation, 2020f).
- World Health Organisation. COVID-19 Clinical management Living guidance: 25 January 2021 (World Health Organisation, 2021c)
- World Health Organisation. Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines: 1 June 2021. (World Health Organisation, 2020g).
- World Health Organisation. COVID-19 Global Risk Communication and Community Engagement Strategy – interim guidance. December 2020-May 2021.
- The UNHCR Community Mobilization and Community Engagement document and UNHCR vaccine guidance document for its country operations, which encourages prioritising vaccines for older people (Interview Gislaine Ngasaka, UNCHR).
- The Regional Risk Communication and Community Engagement Group. COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement, which includes a section on older people

*The If not now, when?* By HelpAge International shows that although humanitarian agencies pay lip service to the need to consider older persons specific risks needs or mainstream their needs in interventions, there has been very little actual support to older people in the face of humanitarian crises. The lack of age-disaggregated data and failure to consult with older people around planning and implementation of policies and programmes impedes the development of meaningful humanitarian responses that are inclusive of their needs. A lack of input from older people also makes it more likely that assumptions will be made about older persons that increase rather than facilitate their independence. Factors such as barriers to accessing aid distribution and health services, which are increased by disability, limit older people's ability to benefit from interventions and, most likely, those provided during the COVID-19 crisis. Research carried out for the HelpAge report showed that older men and women, but particularly women are vulnerable to neglect and isolation, denial of resources, services and opportunities; financial abuse; emotional abuse; physical abuse and have no safe place in their community.  Women were more likely to have limited access to healthcare, food and have no income with 30% saying they could not cope at all. Older people are also highly likely to be providers of care, particularly for children and the burden this places on older people is often overlooked.

Given the number of actors involved, diversity and often local nature of these responses, it is difficult to comprehensively

map this response across the region. Furthermore, as noted in the introduction to this section, many interventions are focused fairly broadly on "vulnerable groups" – a category which generally includes older people but which does not necessarily focus on including older people or meeting their specific needs. For example, in Liberia, the advocacy group *Coalition of Caregivers and Advocates for the Elderly in Liberia* has highlighted the vulnerability and their frustration at exclusion of older persons during the pandemic as the response of development partners has focused largely on younger populations such as child-bearing women. They found that large numbers of older people in Monrovia have become homeless and are forced to beg for food. Another example is provided by a series of national dialogues run by The Gambia office of Westminster Foundation for Democracy on the Gambian response to COVID-19 (Westminster Foundation for Democracy (WFD), 2020), which demonstrated how distribution of relief does not always take into account the needs of older people with sensory or mobility disabilities, or who are more likely to struggle with access to information about support and less likely able to reach support due to transport difficulties. The dialogues revealed how vulnerable groups such as people with disabilities and women were not sufficiently included in planning or carrying out the response and as a result were discriminated against in terms of the distribution of relief and communication campaigns. While the specific concerns of older people were not the focus of these dialogues (which is telling in itself), many of the challenges faced by people with disabilities can be applied to older people.

## 5.1 Health and Long-term Care Systems Response

Countries worldwide are facing many challenges as they strive to ensure that health systems maintain essential health services as they respond to the COVID-19 pandemic. Disruptions to essential health services – including services for health promotion, disease prevention, diagnosis, treatment, rehabilitation and palliation are a cause for serious concern and have the potential for severe adverse health effects, especially in vulnerable populations.

> *Lockdowns, and concentration of health resources on COVID-19 may marginalize older persons and create barriers to obtaining health services for their existing underlying conditions, some of which may increase their vulnerability to COVID-19, with an impact on their well-being and mental health.* Gislaine Ngasaka, UNHCR

The United Nations and its associated agencies and development partners launched a comprehensive response to mitigate the COVID-19 pandemic on countries around the world. The WHO assisted governments to develop Strategic Preparedness and Response Plans, providing operational planning support and guidelines, Standard Operating Procedures (SOPs) and messaging campaigns.

Safely managed water, sanitation, and hygiene (WASH) services are an essential part of preventing and protecting human health during infectious disease outbreaks, including the current COVID-19 pandemic. High levels of transmission were also of concern, particularly in areas with poor access to WASH facilities and conflict zones and areas with high numbers of internally displaced persons, refugees, asylum seekers etc. that already have poor access to healthcare such as Burkina Faso. However, some subregions were better prepared than others – countries in West and Central Africa had strengthened health capacity and expertise in case identification and contact tracing as a result of the 2014 Ebola outbreak and had more experience in maintaining other essential health services over this time. The WHO has acknowledged how the fight against the Ebola virus has contributed to significant developments in countries' capacity to respond to health emergencies, such as infrastructure and skills for laboratory testing, exchanges of capacities across countries, partnerships among technical agencies, international organisations and the private sector, and public health awareness among the population. The case study reports on Ghana and Senegal reflect on the benefits of this preparedness (see Sections 7.1 and 7.5 of this report). Senegal, in particular has been praised for its response and was ranked second on Foreign Policy's COVID-19 global response index (97.2) after New Zealand, even with a low resource base (Shesgreen, 2020).

Given the lack of preparedness, together with the high levels of risk of spread and, potentially, mortality in the region, the WHO assisted countries in preparing response plans to increase health systems capacity, which were implemented in partnership with UN Partners and financial partners such as the World Bank, IMF and African Development Bank. One example of capacity being built is testing. In January 2020, along with South Africa, Senegal was the only country with the capacity to conduct lab tests for SARS-CoV-2 (Seyedi, 2020), but by April 54 countries were able to diagnose COVID-19 effectively. In terms of strengthening case management, with support from the Africa CDC, funding from the Global Fund and the WHO, the number of ventilators available in the region increased from 2,935 to 10,553 in April 2021 and the number of oxygen concentrators increased from 2,600 to 6,780 and case management Emergency Medical Teams (EMTs) have been deployed to countries in need (WHO Regional Office for Africa, 2021). Given their vulnerability to critical COVID-19 illness, these additional resources benefitted older people in the region in terms of access to care.

Countries' preparedness and response plans for the COVID-19 pandemic are based on some of the ten pillars of the WHO. However, despite progress being made in terms of the ten WHO response pillars, which, in combination, benefit older people who are most at risk, examples of responses that specifically focus on older people are scarce.

### 10 WHO COVID-19 Response Pillars

**Pillar 1:** Coordination, planning, financing, and monitoring

**Pillar 2:** Risk communication, community engagement and infodemic management

**Pillar 3:** Surveillance, epidemiological investigation, contact tracing,

and adjustment of public health and social measures

**Pillar 4:** Points of entry, international travel and transport, and mass gatherings

**Pillar 5:** Laboratories and diagnostics

**Pillar 6:** Infection prevention and control, and protection of the health workforce

**Pillar 7:** Case management, clinical operations, and therapeutics

**Pillar 8:** Operational support and logistics, and supply chains

**Pillar 9:** Maintaining essential health services and systems

**Pillar 10:** Vaccination

Some national level examples of responses that specifically addressed the needs of older people include:

- In Botswana, primary care services were re-structured to reduce over-crowding in health facilities which included the continuation of NCD clinics. The Ministry of Health and Wellness (MoHW) recommended extension of review periods for stable chronic care patients and allowed for the chronic medication refills at the pharmacy without need for prior doctor's consultation. Family physician-led facilities have developed implementation plans dichotomising chronic care patients into those who would be reviewed and those who would get extended medication refills. The review of acute care patients continues as before (Motlhatlhedi et al., 2020).
- In Uganda, motorbike taxis were used to distribute medicine to people with NCDs. (Interview with Ida Ameda, UNICEF).
- In the Western Cape province of South Africa, chronic medication delivery to older patients with chronic conditions was arranged by the Metropolitan Health Services to reduce the risk of COVID-19 exposure in health facilities (eNCA, 2020).
- Some centres developed their own programmes (albeit of limited value). For example, the University College Hospital in Ibadan encourages older patients to remain at home while family can call dedicated telephone lines to ask for support as regards medication use as well as for other health-related matters. According to one study, this approach was carried out for 95% of patients on their database (Baiyewu et al., 2020).
- Community health workers, older persons' organisations and community leaders have been critical in reaching older people. In Mozambique, HelpAge International has assisted by providing logistical and financial support and assisting with transporting older people to health centres to receive vaccinations (Interview with Roseline Kihumba, HelpAge International).
- The Rwandan Biomedical Centre provided free COVID-19 tests in Kigali to 20,000 older people and people with NCDs during the second wave in January 2021 to encourage testing and establish levels of transmission in these groups (Zinhua, 2021).
- Home visits and telephonic follow-ups of COVID-19 positive older people, including screening, examination, monitoring, provision of medication and education by a mobile health team (see Senegal case study).
- Older people were able to collect a 3 to 6-month supply of their chronic medications in several countries, including Ghana, South Africa and Mozambique (see case studies).

## *Limitations in the response to older people*

Health systems in many countries have poor reach at the community level and communities rely on community-based organisations to fill these gaps, often with little government support. COVID-19 exposed the lack of reach that government had to older people through primary healthcare. Lack of PPE prevented outreach to older people, particularly in the earlier phases of the pandemic.

In Nigeria, primary healthcare infrastructure is limited and mostly focused on maternal and child health and other services such as NCD screening and management and those orientated to older people, are limited in the rural areas where 9 million of the 15 million people live. One positive development emerging from this is the development of a policy directive to mainstream NCD and health promotion and prevention for older people into the primary healthcare system.

**Interventions specifically for older adults for mental health support in Africa is lacking.** Mental Health Innovation Network has devised a project combining research, capacity building and engagement activities in order to better understand and support the mental health response to the current COVID-19 pandemic in 25 African countries (Mental Health Innovation Network, 2021). A WHO survey of 28 African countries in August 2020 found that about 70% reported that their COVID-19 mental health response plans were only partially funded, with some reporting no funding at all (PERC, n.d.).

## *COVID-19 National Vaccination Deployment*

Most high and many upper-middle income countries are in the advanced stages of COVID-19 vaccination rollouts. But many low-income countries, including most across Africa, are still at the early stages of vaccinating their populations, mainly due to a shortage of vaccines.

In Africa as of 29 May 2021, 2.3 per 100 persons has been vaccinated, this is in comparison to Asia, 21; Europe, 46; North America, 60 and the global average of 24. Countries with a proportion of at least 2 per 100 persons vaccinated in SSA include only 17 countries, with countries with smaller populations achieving these figures more easily than high population countries such as Nigeria which has only vaccinated 1 per 100 people despite having administered just over 1.98 million vaccines.

Dr Matshidiso Moeti, the World Health Organization (WHO) Regional Director for Africa said *"Although progress is being made, many African countries have barely moved beyond the starting line. Limited stocks and supply bottlenecks are putting COVID-19 vaccines out of reach of many people in this region. Fair access to vaccines must be a reality if we are to collectively make a dent on this pandemic."*

Most countries in the region have a vaccine doses policy that prioritises key workers, clinically vulnerable groups, and older persons groups as is the global trend that follows the WHO's Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines.

In all 47 countries reviewed, older people were either listed as first or second priority, along with people with co-morbidities. Estimation of the proportion of persons with underlying health conditions will be a complex process, countries with health surveys may inform these estimates (World Health Organisation, 2020g). 'Pre-listing' populations includes mapping populations, screening people and scheduling appointments for vaccination in advance. Good pre-listing has been key element in the most rapid and well-targeted COVID-19 vaccine rollouts. Strong logistical preparations and coordination have also been key to reaching people in remote areas. In Ghana, Angola and Nigeria, mobile vaccination teams backed by community mobilizers reached older people for pre-registration and vaccinations living in hard-to-reach communities (World Health Organisation, 2021d). Angola's electronic pre-registration system helped ensure the right people were vaccinated and that they know where and when to get the vaccine. Early evidence from across Africa shows that many are eager to get the vaccine, despite very limited supplies. Yet battling hesitancy among some older people, as well as managing demand and eagerness among the young has been a challenge in some countries. Reported side-effects globally, although extremely rare, have created confusion and concern among populations already hesitant about the rapid development of the vaccines. Despite being a priority group communication has not been adequately geared towards older people, resulting in confusion and hesitation about the vaccination process (Interview Ida Ameda, UNICEF).

Although age-disaggregated data is not available for all countries, Table 7 reflects the number of vaccinations administered to older people in countries where data is available. This data is drawn from the WHO Africa COVID-19 Vaccination Data Update on 31 May, but is drawn from multiple sources and therefore may not be from the same time frame or very recent and should be viewed with caution, but does provide a rough indication of the extent to which older people are being prioritised in relation to other groups such as health workers, government officials and other frontline workers such as tourism sector workers who received first priority in the case of Mauritius.

7 No age definition of older people is provided in the WHO dashboard but presumably this is based on each country's definition of older people for the purpose of vaccination eligibility.

*Table 7 Vaccination of older people in African region as of 31 May 2021*

| Country | Total number of older people vaccinated | Total number of people vaccinated | Older people as % of total number vaccinated [7] |
|---|---|---|---|
| Central African Republic | 12669 | 14593 | 86.82 |
| Cabo Verde | 15878 | 24382 | 65.12 |
| Angola | 571144 | 909215 | 62.82 |
| Togo | 194054 | 311938 | 62.21 |
| Eswatini | 17168 | 34897 | 49.20 |
| Botswana | 25124 | 54620 | 46.00 |
| Ethiopia | 797086 | 1805006 | 44.16 |
| Senegal | 218870 | 522575 | 41.88 |
| Mali | 52953 | 127042 | 41.68 |
| Madagascar | 12958 | 32101 | 40.37 |
| Cote d'Ivoire | 181003 | 542100 | 33.39 |
| Kenya | 293305 | 969561 | 30.25 |
| Nigeria | 470155 | 1637078 | 28.72 |
| Cameroon | 18479 | 68160 | 27.11 |
| Niger | 39558 | 159525 | 24.80 |
| Zambia | 27963 | 140843 | 19.85 |
| Ghana | 163106 | 852047 | 19.14 |
| Gambia | 4344 | 26893 | 16.15 |
| Uganda | 70472 | 585267 | 12.04 |
| Liberia | 6067 | 55892 | 10.85 |
| Malawi | 37909 | 354777 | 10.69 |
| Sierra Leone | 8167 | 78403 | 10.42 |
| Namibia | 6553 | 76578 | 8.56 |
| Guinea | 21196 | 339177 | 6.25 |
| Mozambique | 20925 | 394777 | 5.30 |
| Mauritius | 18034 | 400801 | 4.50 |
| Republic of Congo | 4222 | 99159 | 4.26 |

*Source: WHO Africa COVID-19 Vaccination Daily Update Dashboard, 31 May 2021*

In other countries, vaccine rollouts have also been delayed by operational and financial hurdles or logistical difficulties such as reaching remote locations. South Africa, despite its relative wealth and health systems capacity, was slow to acquire and roll-out vaccines and has been delayed by challenges with the AstraZeneca vaccine which was reported to be less effective in preventing transmission of the B.1.351 (Beta) variant discovered in South Africa and concerns about risks of vaccine-induced thrombosis and thrombocytopenia (VITT) from the Johnson & Johnson vaccine. As a result of these delays, the roll-out of vaccines to older people in South Africa only began on 17 May 2021 as part of the phase 2 roll-out and after two months, only 52% of the 5.36 million people over 60 have booked been registered on the national Electronic Vaccination Data System. The government has now recognised challenges in the online registration process for populations such as older people and is allowing walk-ins. There is also significant inequality between those with health insurance and those without in terms of vaccination coverage (48% vs. 26%)(National Department of Health, 2021).

The WHO is supporting countries to tackle the challenges by reinforcing planning and coordination, advocating more financial resources as well as setting up effective communications strategies to address vaccine hesitancy and misinformation (World Health Organisation, 2021e). WHO partners such as Action Against Hunger and the UNHCR have been critical in ensuring last mile delivery of vaccines, particularly in hard to reach places.

## 5.1.1 Long-term care services for older persons

Long-term care for older people, both in home settings and care facilities has been heavily affected by the COVID-19 pandemic.

For the most part, long-term care of older people in the region takes place within the household. In the context of COVID-19, stay at home orders and reduced access to health and social services increased pressure on family caregivers. In Kenya, the Red Cross Society promoted home-based care (Interview with Lillian Matemu, Kenya Red Cross Society), but no examples were found of support provided to households caring for older people over this time in terms of guidance or provision of support to caregivers of older people.

Long-term care service provision for older people by NPOs in community settings has also been disrupted by the pandemic, both in terms of funding and ability to provide regular services. In South Africa, senior's clubs programmes, which could no longer operate during lockdown were adapted to provide fortnightly food parcels and hygiene packages to these members from these programmes. The Department of Social Development, in collaboration with corporate partners, also distributed food parcels and hygiene packs to older people unable to access community services. They also provided education and advice on coping with social distancing. However, many other seniors clubs lost funding as funds were re-directed to the COVID response (Cowan, 2020; News24, 2021, p. 24; Voigt, 2020).

Older persons organisations in other countries in the region have been similarly affected in terms of their general services and social activities (see case studies in Section 7 for examples), but after the end of the hard lockdown and since PPE has become available, have played a critical role in reaching older people by visiting door-to-door for the purpose of vaccination outreach or provision of support where possible.

South Africa and Mauritius, with the largest number of long-term care facilities has had the most comprehensive response in terms of formal care:

South Africa

- Restrictions on access to long-term care facilities via lockdowns, even prior to the national lockdown
- Some long-term care residential facilities housed care workers on site to avoid transmission to older people via the community (this response relied on public donations of food, mattresses etc.)
- Inclusion of some LTC facilities in the National Institute of Communicable Disease's online hospital surveillance platform (DATCOV19) as well as weekly collection of infection recovery and mortality data from facilities.
- The dissemination of memos providing guidance to facilities as well as the development of a bulk SMS system to communicate with key contact people within facilities.
- Standard operating procedures were produced by the Department of Social Development and Department of Health one province (the Western Cape) and by the Samson Institute for Ageing Research.
- The national Department of Social Development produced a summary table of directives for residential LTC facilities appropriate to the national regulations for each of the five levels of national lockdown.
- Training for health staff and care workers and technical support for low-resourced facilities in some provinces.
- Deep cleaning of LTC facilities with outbreaks by volunteers.
- Limited procurement of PPE and hand sanitiser for facilities.
- Private donations of PPE (Nazareth Care, 2020).
- The response by the Department of Social Development in South Africa, has, however, been criticised for being slow and inefficient and LTC facilities were forced to develop their own responses while waiting for government guidance and support and there have been numerous large outbreaks in facilities across the country (see Section 3.2).

Mauritius

- Welfare and Elderly Persons' Protection Unit officers continued to provide services to long-term care facilities and residents
- Rapid COVID-19 testing conducted in 72 LTC facilities.
- Provided ongoing domiciliary visits to bedridden older adults and all persons over 90 to deliver medication and provide necessary care.
- Telephonic counselling was made available to older people.

## 5.1.2 Risk communication and community engagement

Governments and development partners have carried out widespread communication campaigns around COVID-19 and the vulnerability of older people and people with NCDs seems to have been highlighted.

**However, reaching older people, who were more likely to be isolated at home, are less likely to have access to mobile phones or electricity than their younger counterparts, have lower levels of education and digital literacy than the general population, are more likely to speak local languages and may have sensory impairments are more challenging to reach and tailored communications are necessary to ensure the inclusion of older people** (Aboderin et al., 2020; Martins Van Jaarsveld, 2020).

In addition to fairly generic government information and stakeholder engagement campaigns, civil society organisations and communities have taken on an important role in raising awareness of COVID-19 and the need for older persons to protect themselves and younger people to understand their risks and in communicating the details of vaccine rollouts, mainly through community-level activities and door-to-door campaigns.

- The Regional Working Group for Risk Communication and Community Engagement in West and Central Africa (Regional Working Group for RCCE in West and Central Africa, 2021), comprised of UN agencies and development partners working in the region, developed a library of resources in local languages for download and dissemination, including resources focused on protecting older people, as well as a free online course on risk communications and community engagement and adapting communications to be accessible to audiences such as people with disabilities or with low literacy.
- In Cameroon ACAMAGE, a HelpAge network partner has played an advocacy important role in sensitising governments and civil society organisations and provided communication materials for partners to use at a national level, as well as engaging in their own campaigns. Community Development Volunteers for Technical Assistance has been establishing an educational framework in hard-to-reach rural communities by training and supporting community volunteers to sensitize and educate vulnerable populations on prevention measures.
- In Mozambique, solar-powered radios were distributed by HelpAge International to older people in rural communities to enable them to receive COVID-19 communication and community news, as well as provide them with some form of entertainment and connection to the outside world as they remained at home to avoid COVID-19 infection.
- Humanity and Inclusion have worked in the Central African Republic to ensure that vulnerable groups such as people with disabilities and older people are not excluded in the COVID-19 response, working both with the government national crisis unit and civil society actors to share targeted messages and carry training at community level to facilitate local sensitisation campaigns (Relief Web, 2020).
- In Senegal the #AarSunuMaakYi #Shield3age campaign run by Action Solidaire International aimed at raising awareness around the vulnerability of older people and the importance of practising social distancing to protect them (see images below)
- The Centre for Human rights in Pretoria created the Age With Rights ran a 10-day campaign focused on older people's human rights and highlighting the impact of COVID-19 on older persons (see images below) (Booyzen, 2020).
- ARIACOV, an action research project in support of the African response to COVID-19 found that older people themselves have been important advocates for adhering to public health protocols (Laborde-balen et al., 2020).
- In Rwanda, drones were used for community awareness in hard-to-reach rural areas (World Health Organisation, 2020h) .
- Campaign in Madagascar run by CARE International and funded by the EU, local relief teams are focusing on older people and people with disabilities in terms of raising awareness of COVID-19 and its prevention.
- WhatsApp groups were used extensively in health communication in Botswana and this has been expanded to other social media platforms during the pandemic and has also come to include patient care (Motlhatlhedi et al., 2020) - inclusiveness of older people seems doubtful?






## COVID-19 response and older people in Africa: A summary of key findings

### General response

- Given low levels of health system preparedness, almost all governments imposed very stringent lockdown restrictions early in the pandemic
- There has been a significant response from governments and development partners to mitigate the spread and impact of COVID-19 but although older people benefit from these activities and are typically included as a vulnerable group, there has been very limited consultation with older people in planning the response at national level and specific targeting of older people in terms of the 5 UN response pillars seems fairly limited given their particular vulnerability.

#### Health and long-term care systems response

- Although progress has been made in terms of strengthening health systems, national-level examples of interventions specifically designed to be inclusive or target older people in terms of COVID-19 are scarce outside of national vaccination communication and deployment campaigns.
- Although COVID-19 vaccination efforts in the region have lagged behind other regions, older people are listed as first or second priority for vaccination and present a fairly high proportion of people vaccinated in most countries where data is available.
- Outside of the work done by HelpAge International and their partners, little work has been done to support community-based long-term care services for older people.
- Availability of support for the limited number of long-term care facilities in the region is unclear but has been relatively well supported in Mauritius and South Africa although the speed and depth of the response by government has been critiqued in the South African case.

#### Advocacy and communication

- Governments and development partners communication campaigns around COVID-19 have been more generic. However, the vulnerability of older people and people with NCDs seems to have been highlighted
- Civil society organisations and communities have taken on an important role in raising awareness of COVID-19 and the need for older persons to protect themselves and younger people to understand their risks and in communicating the details of vaccine rollouts, mainly through community-level activities and door-to-door campaigns.

# 6. Response to the socio-economic impact of COVID-19 on older people

Given the massive economic effects of lockdown measures designed to limit the spread of COVID-19 across the world, governments, civil society, businesses and development partners contributed to efforts to provide relief. Unfortunately, many countries lack sufficient resources to respond adequately to the scale of the economic and social impact of the pandemic. This section provides an overview of the social protection response by governments, as well as non-government actors in Africa and the inclusion or direct targeting of older persons, who are generally already highly vulnerable to poverty, in this response. Guided by the UNDP's Social Economic Impact Assessments, UN country teams developed response plans to support national recovery efforts (United Nations Development Programme, 2020)

## 6.1 Social protection response

According to the ILO tracker of *Social Protection Responses to the COVID-19 Crisis around the World* (International Labour Organisation, 2021), 94% of African countries in the WHO AFRO region initiated some sort of social protection response to the COVID-19 pandemic with only Eritrea, CAR and Tanzania (excluding Zanzibar) not responding at all, and Burundi responding only by subsidising the price of soap. These social protection responses are fairly wide-ranging and include: access to healthcare; sickness benefits; unemployment protection; old age pensions, survivor and disability pensions; social assistance through cash transfers and in-kind benefits; family leave and care policies; breaks in tax and social security payments; and changes in distribution modalities to increase safety. The most commonly used interventions were cash transfer and food and nutrition programmes: a total of 24 countries in the WHO AFRO region introduced social assistance or adjusted existing food and nutrition programmes, 22 countries in the region introduced special allowances or grants and 18 countries introduced health-focused social protection programmes such as WASH or PPE distribution, free testing or treatment for COVID-19, or increasing health systems funding and capacity (health systems interventions discussed in more detail in Section 4.2).

### 6.1.1 Cash transfer programmes

Like in much of the Global South, social protection systems in countries in sub-Saharan Africa have been expanding rapidly over the past two decades, mainly driven through the introduction of cash transfer programmes (United Nations Development Programme, 2019). Government policy-makers and international donors have recognised that narrow safety nets approaches are not sufficient to reduce risk and vulnerability amongst those that fall outside of the formal economy (Kabeer and Fellow, 2009) and as a result there has been a paradigmatic shift towards promoting human welfare through social policy rather than purely economic growth and cash transfers in particular have become a significant part of the development discourse and response. Cash transfer programmes were first introduced by international organisations, often as a more efficient and effective alternative to food-aid in the region or in the case of emergency responses (Barrientos, 2011; Slater, 2011), but increasingly to target extremely poor or vulnerable households and to achieve the Sustainable Development Goals, including increased access to healthcare (Lloyd-Sherlock and Agrawal, 2014). More recently, cash transfer programmes in Africa have expanded beyond donor-funded or pilot programmes are being institutionalised within African States (United Nations Development Programme, 2019).

However, the distribution of such programmes is unevenly spread - social assistance in Central and Western Africa have shorter histories and are smaller in coverage, less institutionalised and are more dependent on funding from international donors. In the case of programmes targeted at older people, social assistance to older people in the form of non-contributory or social pensions have been in place for decades in Southern Africa and to a lesser extent in East Africa, in the case of South Africa, over 100 years (United Nations Development Programme, 2019). In East Africa, Zanzibar has introduced a universal social pension and Kenya and Uganda are rapidly expanding coverage of social pension programmes. On the other hand, social assistance programmes for older people in West and Central Africa are almost non-existent, with Cabo Verde being the only country in either region with a non-contributory or social pension (although Ghana does target older persons through its Livelihood Empowerment Against Poverty Programme (The Transfer Project, 2021), combining health insurance with cash transfers to vulnerable households).

### 6.1.2 Inclusion of older people in new or expanded cash transfer programmes in response to COVID-19

The COVID-19 pandemic has highlighted the vulnerability of many populations to shocks and social assistance in the form

of cash transfers has been used extensively as a vehicle of support in the COVID-19 pandemic. Countries have expanded coverage or the value of transfers on existing programmes (for example in the case of the Zambian Social Cash Transfer programme, which has done both), or introducing new emergency COVID-19 grants, for example in Namibia, which

introduced the COVID-19 Social Relief of Distress grant at the beginning of April and within three weeks had paid out nearly 580,000 people (Seekings and Gronbach, 2020). In general, countries with well institutionalised, domestically funded social assistance programmes such as Kenya, Namibia and South Africa quickly provided emergency relief measures, while countries with weaker social assistance systems were generally slower to respond and did not have the same capacity or data to target or implement interventions (Dafuleya, 2020). However, even countries without extensive programming did develop new programmes, for instance in the case of Angola the Social Monetary Transfer Programme which aimed to include 1.6 million people, the South Sudan Safety Net Project.

In some of these newly introduced or expanded COVID-19 programmes, older people have been targeted as a category of vulnerability, but the extent to which older people have actually been included as beneficiaries is unclear. Furthermore, some programmes which are targeted at households rather than individuals may not benefit older people or people with disabilities within the household due to power dynamics (Kelly and Mwanza, 2017).

### 6.1.3 Contributory pensions

While most countries in Africa offer some sort of contributory state pension (most often for civil servants), contributory pension coverage is well below 20% in most countries in the region, except Algeria (51%), Sao Tome and Principe (53%), Gabon (30%), Ghana (33%), Cabo Verde (24%), Congo (23.5%), Togo (22%). In Sub-Saharan Africa only 22 per cent of people above the retirement age receive any sort of pension, including non-contributory pension systems in place in some countries (International Labour Organization, 2018)

While no new contributory programmes were introduced as a result of COVID-19, a few countries made adjustments to existing contributory pension programmes to protect retirees. These measures included increased value of contributory or civil service pensions in Zimbabwe, Zambia, Sao Tome and Principe and Cameroon and measures such as making pension collection safer, as was the case in Algeria where proxies were able to collect on behalf of pensioners and in Cabo Verde where pensioners could use a phone app to collect their pensions[8].

### 6.1.4 Social (Non-contributory) Pensions

Only 13 countries in Africa make some sort of social pension provision for older persons, including: Algeria, Botswana, Cabo Verde, Eswatini, Lesotho, Kenya, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Uganda, Zambia and the self-governing state of Zanzibar in Tanzania. In cases where pensions were available, these programmes continued to provide important support to older persons during the pandemic.

While new social pension programmes were introduced in the context of COVID-19, South Sudan did introduce a new cash transfer for vulnerable populations (including older people). Some countries with existing social pension programmes increased the value of payments (in the case of South Africa, Zambia, Zanzibar and Kenya) or extended existing programmes to include new beneficiaries (Kenya). Other measures taken by governments included efforts to make pension collection safer via the appointment of proxies to collect payments on behalf of older people, electronic payments or staggering pension pay-outs. These efforts were met with mixed success as communication of logistics and access to or understanding of electronic transfer systems among older people created challenges, even delaying payment and unintentionally increasing the risk of exposure to COVID-19, as was the case in South Africa where older people queued for hours to access pensions (Kelly, 2020).

The table below summarises all types of COVID-19 related social protection interventions targeting older people in the region.

8 The efficacy of these interventions is not known and the age friendliness of the technology used in the Cabo Verde intervention may be questionable.

***Table 8 Summary of social protection interventions for older people in the African region in the context of COVID-19***

| | |
|---|---|
| Algeria | Proxies able to collect contributory and non-contributory pensions on behalf of pensioners, reducing risk of exposure |
| Cabo Verde | Pensioners could access pension through a phone app instead of going to agencies where they are at risk of COVID-19 exposure<br>Provision of home care for the older people with food assistance and other financial support. |
| Cameroon | The government increased pension benefits by 20% for contributory pensions that had not been re-evaluated in the 2016 reform programme.<br>Introduced homecare for the older people living in isolation |
| Congo | Food aid was provided to vulnerable population, including older people |
| Eswatini | Old Age Grants (universal pension) were paid electronically to protect older people congregating at pay points (Government of Eswatini, 2020) |
| Kenya | Increase in benefit level of the Older Persons Cash Transfer and extended programme to include more beneficiaries (Oyunge and Chebii, 2021) |
| Ghana | No direct targeting of older people but household targeting of older people through the Livelihood Empowerment Against Poverty (LEAP) programme – LEAP beneficiaries received one additional payment in May<br>Food packages provided to older persons groups by government |
| Lesotho | From December 2020, The COVID-19 Relief Fund for Older Persons was paid to older people not receiving social or other pensions or food aid, this included people between the age of 60 and 69 who usually do not qualify (Government of Lesotho, 2020).<br>Seeds were also donated by the government for older people to plant and grow food. |
| Malawi | In Malawi, the Social Cash Transfer programme beneficiaries, many of whom are older persons, received top-up payments (50% of household heads are 65+ and 15% living in recipient households are 65+) (Zinhua, 2020) |
| Mauritania | Introduced financial aid to older people for three months via cash transfers |
| Mozambique | In Mozambique, households headed by older persons benefit from the Basic Social Subsidy Programme and existing beneficiaries received a single cash transfer equivalent to 3 months of regular subsidies. |
| Rwanda | The Government of Rwanda is making following adaptations in the existing cash transfers un-der the Vision 2020 Umurenge Programme (VUP), which will include the expansion of coverage to additional 56,000 families (in addition to the current 310,000 families) through the expan-sion of Direct Support unconditional cash transfers to additional families with old age, disabil-ity, and critical illness (HelpAge International, 2020j). |
| São Tomé And Príncipe | Increased value of old age pensions and reduced bank charges for pension transactions |
| South Africa | Increased value of old age grant (non-contributory pension) by R250 from May to October 2020.<br>Staggered payment days to accommodate social distancing (not initially effective), prioritising older persons and people with disabilities |
| South Sudan | Targeted in new cash transfer for vulnerable households (including those with older people) through the South Sudan Safety Net (HelpAge International, 2020j). |
| United Republic of Tanzania (Zanzibar) | The Zanzibar government decided to increase the monthly transfer of their universal social pension by 20 per cent. |
| Zambia | Zambia increased allocation to public service pensions<br>Zambia vertically expanded its existing Social Cash Transfer (SCT) programme, which targets households headed by older persons, by increasing the value of payments by including them in the Emergency Cash Transfer (ECT) Programme where they received 400 Kwacha for 6 months in addition to usual bi-monthly payments of K800 (UNICEF, n.d.).<br>SCT and ECT beneficiaries were provided with information on health and COVID-19, personal hygiene, nutrition and linked to support in terms of violence and abuse and disability-specific needs |
| Zimbabwe | Pensioners received a cash benefit in April equivalent to one month's pay-out and the public service pension fund received additional budget allocation (Chiduku, 2020). |

*Source: (HelpAge International, 2020j; International Labour Organization, 2021) and other sources cited in table*

There are also reports that obvious gaps in social protection provisioning which have been highlighted by COVID-19 will lead to positive progress in terms of extension of social protection to older people. For instance, in Nigeria, older people were not included in the social register that was used to target cash transfers and food aid. Difficulties in reaching older people and people with disabilities and their obvious exclusion from social protection policies has resulted in **a review of social protection policy and the expansion of the social register** to include older people in conditional cash transfers, labour market programmes and possibly even a universal old age pension, which stakeholders in the older persons sector are advocating it (Interview Emem Omakara, Stakeholder Group on Ageing Africa).

Older people in Uganda struggled to access the universal old age pension pilot programme – the Senior Citizens Grant (SCG) - and another pilot programme, the Expanding Social Protection Programme (ESPP – targeting people over the age of 80), which provide cash payments to older people.

Currently, older people cannot access these funds due to the social distancing restrictions. This leaves older persons with no alternative source of income for their livelihoods (HelpAge International, n.d.). The Uganda Reach the Aged Association and National Council of Older Persons engaged with the Ugandan government to try and overcome these challenges, which threatened older people's livelihoods [9]. In Kenya, development partners reported in interviews that concerns about collection of cash led to significant interruptions in the Older Persons Cash Transfer programme that increased the vulnerability of older persons.

On the other hand, concerns about affordability brought about by pressure on the fiscus as a result of COVID-19 has led to regressive actions by governments. For example, in Kenya the government proposed in the 2020-2021 budget that contributory retirement benefits be taxed.

## 6.2 Food-aid and other in-kind responses

Given limitations in determining inclusion of older people in general programmes or programmes focusing on vulnerable populations, we have attempted to gather as many examples as possible of the type of interventions that have been focused particularly on older people.

- Businesses put in place measures to protect older customers in South Africa and various supermarkets opened up their stores an hour earlier to allow older adults to shop and also had an online purchase option with food being delivered.
- Faith-based organisations have played an important role in the distribution of food aid to older people, who tend to be more active in religious activities than the general population. For example, the Lutheran Church in Ghana and Islamic Relief in Niger, which has distributed food aid and hygiene kits, as well as awareness raising campaigns to vulnerable populations, including older people(Islamic Relief Worldwide, 2020; Mumia, 2020).
- There have also been more spontaneous and informal community-driven responses and fund-raising efforts, such as volunteers doing grocery deliveries for older people in South Africa (le Roux, 2020).
- Cash transfers have also been used by non-government actors – HelpAge DRC and Age International has been working with trained community partners and 3,000 older people, by providing handwashing facilities and raising awareness of the risk of COVID, as well as providing provide cash payments to the most vulnerable (Age International, n.d.).
- The Salesian Institute in the Congo has worked to visit older people, distribute food and basic necessities, as well as provide information on the correct use of anti-Covid-19 protection devices (Agenzia iNfo Salesiana, n.d.).
- In Rwanda the NGO, Taking Care of Retired People, carried out home visits and distributed food and pigs for farming to older people and encouraged families to mobilise in helping to prevent the spread of Covid-19 (GAROP, 2020).
- In Uganda, the Grandmother Consortium, a non-governmental organisation, with the aim of having a unified voice for advocacy for grandmothers led by grandmothers themselves and create an environment where their rights and needs in areas such as social protection, health and care and violence and abuse are integrated in all national programs in Uganda (Nyaka AIDS Orphans Project, n.d.). Their COVID response included emergency supplies to the most vulnerable, gardening projects, public health messaging and proiding other support.
- In Kampala, Uganda, Young African Refugees for Integral Development (YARID) distributed food directly to vulnerable refugees, including older persons, persons with disability, persons with chronic illness—and provided food and non-food packages to 200 households.

However, challenges in provision of sustenance during the pandemic were expressed in the case study interviews:

*"Already they (older people) have to pay a lot for sustenance, drugs, food, staff and because of the pandemic, the restriction, most of them their children came from abroad and could not return and so they couldn't pay. But there is no guarantee. The older person has always felt neglected by the government or relatives and it is not different with the arrival of the COVID and had rather intensified because some of them who were helping them are now financially handicap and do not have much*

9 The outcome of this intervention could not be established but it demonstrates active engagement by the older persons' sector.

*money. They think nobody is thinking about then. That is the general feeling. I'm also old. Am 72 years old." (Focal person, Ghana Health Services, 2021)*

## 6.3 Engagement of Community Stakeholders

Engaging with older people in designing and implementing responses is critical in reaching older people and ensuring interventions are appropriate. **Numerous development partners interviewed indicated that COVID-19 showed limitations in government reach to older people and linking government interventions to existing community or traditional systems or networks of older persons' organisations proved to be a very fruitful approach** in places such as Kenya, Nigeria and Rwanda. In Rwanda, the Ministry of Local Government formally engaged community-level leaders (Mutwarasibos) that have community registers which includes information on households with older persons and these were used for the purposes of disseminating cash transfers, as well as vaccination and communication campaigns.

Organisations focused specifically on older people such as HelpAge International and Age International, worked both together and with local partners, using existing networks of community-based organisations in Gambia, Liberia, Nigeria, Cameroon, South Sudan, Ethiopia, Kenya, Uganda, Rwanda, DRC, Tanzania, Malawi, Zambia Zimbabwe, Mozambique, Lesotho, South Africa to carry out advocacy work, food distribution, distribution of hygiene, PPE and medical kits, information and awareness raising, provided phone and psychosocial support and worked to support the well-being of older people and community cohesion. **However, these targeted responses are limited to these organisation's country networks which are more extensive in Eastern and Southern Africa than Central or Western Africa.** HelpAge International also conducted Rapid Needs Assessments in 8 countries (Mozambique, Rwanda, two regions of Ethiopia, Kenya, Tanzania, South Sudan, Zimbabwe and Uganda). At national level HelpAge Age International raised funds for older persons in Africa as part of the consortium for the Coronavirus appeal of the Disaster Emergency Committee for use in DRC and South Sudan. HelpAge reported an increase in funding related to the pandemic response, indicating that there has been a recognition of older people's needs over this time.

HelpAge International have also produced a useful set of documents to support network members in engaging in the national planning process around COVID-19 and how to engage with stakeholders as well as guidelines covering topics such as: safe pension payments, developing rights-based public health responses, long-term care, palliative care and guidance for older persons and carers.

The Kenya Red Cross provides a good example of a multi-faced and cross-cutting response to COVID-19 that includes and protects older people and people with disabilities and works through and strengthens community structures to reach older people. Key efforts to promote inclusion of older people in the response include:

- **Enhancing participation and empowerment of older people** by engaging them as stakeholders and resources through community dialogue and community action platforms sessions and using older people as advocates and older persons' organisations as resources at the community level to understand older people's needs, reach and communicate with older people
- **Making communication around age friendly:** Inclusion of people with sensory or physical disabilities or limited social engagement or levels of education in communication campaigns, using sign language interpreters, door-to-door visits to households identified as having older residents, simplification of messaging and translation into all languages with organisations of older people and people with disabilities
- **Supporting health service continuity for older people**
    - **NCD screening and management** - trained community health workers to carry out NCD screening and ensure continuity of care via ongoing management and medicine delivery to older people
    - **Provision of home-based care to older adults** using community health volunteers
    - **Provision of mental services and gender-based violence support**
- **Supporting the livelihoods of older people** by carrying out vulnerability mapping for the provision of livelihood support in the form of cash transfers or food packages used old age as a criterion for disbursement and linking people to government social protection interventions such as the universal old age pension and national health insurance
- **Focus on mainstreaming** in organisational policies and all response planning and response mechanisms to ensure inclusion happens both in policy and in practice **PPE provision and WASH facilities** – ensuring older people had masks and access to handwashing facilities

## Response to the socio-economic impact of COVID-19 on older people: A Summary of key findings

Response to the socio-economic impact of COVID-19 on older people

- Countries with existing social protection systems for older people were better equipped to respond to older people while those without these systems struggled to reach older people with cash transfers, food parcels or other in-kind support
- No new social pension systems were introduced in the region in the COVID-19 context but some existing programmes were extended, benefits temporarily increased for contributory and social pensions in some settings and provision was made in some cases for safer pension collection in some countries.
- Faith-based organisations, local and international NGOs carried out interventions including cash transfers, food distribution and providing WASH facilities and IPC materials.
- Countries where existing networks of older persons organisations or other community-based networks were strong were better-able to reach older people in terms of targeted messaging and provision of socio-economic support.

COVID-19 and the need for older persons to protect themselves and younger people to understand their risks and in communicating the details of vaccine rollouts, mainly through community-level activities and door-to-door campaigns.

# 7. Case studies

## 7.1 Ghana case study

Ghana is a lower-middle income country, which is ranked 138 out of 189 countries on the Human Development Index. Approximately 6.4% of the population in Ghana is older than 60, which is just above the median value for the region (5.3%). Despite having introduced National Health Insurance in 2003, in terms of Universal Health Care provision Ghana offers low levels of service coverage (47%) and out-of-pocket payments are common for consultations and medicine (Akweongo et al., 2021). See Tables in Annex 1 for more detailed demographic, health systems and economic data on Ghana and all 47 countries in the region.

## Healthy ageing situation

Ghana has a National Ageing Policy and action plan developed in 2010 in-line with the Madrid International Plan of Action, however this has not yet been passed into law.

People over the age of 70 benefit from free access to the National Health Insurance scheme and the needs of the elderly have been taken into account in the national essential drugs list (World Health Organisation, 2020b).

A Geriatric Department was recently set up in the Family Health Division of the Ghana Health Service to ensure facilities are implementing the national ageing policy and that staff are more age conscious and facilities and services are more age friendly at all levels of the health system. However, stakeholders interviewed described the programme as being very much in its infancy. Nevertheless, the following are initiatives planned by the department:

- Modification and implementation of the WHO ICOPE model in the Ghanaian context.
- There is a particular focus on community health care delivery with community nurses targeting the elderly with home visits.
- Develop district-level programmes to provide social, psychological and psychiatric support to older people.
- In hospitals, ramps are available for access, but no other provisions in place to make facilities age friendly. However, there is growing awareness around this issue and it has been included in the supportive supervision system put in place to improve infrastructure and services in the various categories in the health care delivery system.
- Geriatric clinics to be established in district hospitals, including newly-built ones

High levels of ageism exist in Ghana, with the targeting of witchcraft accusations at older women and the continued existence of witch camps (segregated communities for those accused of witchcraft) in Northern Ghana being discussed by almost all interview participants. This renewed attention on this long-neglected issue is in light of the highly publicised lynching of a 90-year old woman in July 2020.

Formal long-term care options are limited. There are very few care homes, but long-term care in the form of home care by professional nurses is available to those who can afford it.

Ghana does not provide non-contributory or social pensions to older people and with low wages in the formal sector and high levels of informal sector work (86.7%), most people retire without any form of pension or struggle with low and difficult to access pension fund pay-outs, leading to high rates of poverty within this group (Kpessa-Whyte and Tsekpo, 2020). However, older people are targeted as a group of the extreme poor as part of the Ghana's Livelihood Empowerment Against Poverty (LEAP) programme, which provides cash transfers to very poor people, particularly in households with orphans or vulnerable children, the elderly and people with extreme disabilities. Beneficiaries also receive free national health insurance.

The Ministry of Gender, Children and Social protection also attempted to introduce another welfare programme to ensure supportive and enabling environments via priority treatment in hospitals, banks and subsidised public transport for older people via the EBAN card which was piloted in 2015. However, unfortunately implementation stalled and did not progress beyond the pilot phase.

## COVID-19 pandemic in Ghana

Ghana responded quickly and forcefully to the COVID-19 pandemic with a stringent government restriction after the first reported cases on 12 March 2020 with a stringency index score of 86.11 the Oxford Coronavirus Government Response Tracker. Ghana was ranked fifth on Foreign Policy's COVID-19 global response index (83.2) after New Zealand based on pre-COVID conditions, public health directives, COVID-19 financial response, public communications and COVID-19 status in terms of death rates and case rates per million, scoring 100 for public health directives and fact-based communication despite having limited health capacity.

The 2014 Ebola outbreak accelerated Ghana's preparedness efforts. Although the country did not experience any Ebola cases over this time, it took decisive actions to plan and prepare for this possibility, which assisted with its capacity and preparedness to deal with any future infectious disease outbreak. Ghana has had one of the highest COVID-19 testing rates in Africa, using pooled testing to increase capacity and did extensive contact tracing. The government also employed a number of novel technologies to fight the virus, including veronica buckets for handwashing

Ghana was first country in Africa to receive vaccines and began a rapid rollout on 1 March 2021 and 1.23 million vaccine doses have been given, with 1.2% of the population fully vaccinated.

## Impact of COVID-19 on older people in Ghana

Interviews conducted supported other reports that older people in Ghana have experienced significant disruptions to their lives and livelihoods.

*"Already they have to pay a lot for sustenance, drugs, food, staff and because of the pandemic, the restriction, most of them their children came from abroad and could not return and so they couldn't pay. But there is no guarantee. The older person has always felt neglected by the government or relatives and it is not different with the arrival of the COVID and had rather intensified because some of them who were helping them are now financially handicapped and do not have much money. They think nobody is thinking about then. That is the general feeling. I'm also old. Am 72 years old." (Director, Older Persons Organisation, 2021)*

*"Children can adapt but for the aged its difficult, they are adamant in their ways and they are used to their settings. It takes a lot of coercing for them to understand that better ways are ahead of us.. but it's been challenging and the death toll unfortunately has been high, we pray for every new day that comes and they are thankful for a new day." (Director, Older Persons Organisation 2021)*

In one study on the psychological impacts of COVID-19 on older people, older Ghanaians described feeling significant fears and anxieties about their vulnerability and feeling overwhelmed by information about COVID, finding much of it conflicting and confusing. With the government providing little to no support, older people relied heavily on family for financial support and food (Oti-Boadi and Andoh-Arthur, Unpublished). At the same time, older people have encountered ageism and there have been reports of neglect and domestic abuse in their homes and they also suffer age discriminations in healthcare settings (Gyasi, 2020b).

Older people living with disabilities in Ghana during the COVID-19 pandemic are among the most vulnerable. The government does provide a social grant for disabled people in Ghana however it has been reported that it is not enough to cover basic daily expenditures resulting in older persons with disabilities during the pandemic to feel socially and economically excluded and emotionally isolated. During the pandemic older persons living with disabilities have received reduced care from caregivers due to enforced lockdown measures. This resulted in suffering and profound loneliness and hunger and even thoughts of suicide. Additionally, those who lived with their family members were also kept indoors for several weeks also resulting in mood disturbances and psychosocial issues. It was reported that family members had lost confidence in the Ghanaian health-care system in protecting their older disabled relatives (Lebrasseur et al., 2021)

## Responses to Covid-19 supporting older persons

The following examples of responses targeted at or specifically focused on older people by government and other stakeholders that were identified via interviews, media or literature are tabulated below – these examples are of national-level interventions unless a specific region is identified.

# Coordination of response

The process of executing of the Emergency National Preparedness and Response Plan has been hinged on intersectoral, inter-ministerial and other forms of collaboration. Ghana's Inter-ministerial Coordinating Committee was the highest level of command for coordinating the COVID-19 response and the government acknowledged the contribution of the WHO and Africa CDC in terms of knowledge sharing and capacity building and WHO guidelines, including guidelines for care of older persons, were implemented in developing case management and other guidelines.

Although external consultation was limited, civil society organisations, including those representing older people were included in stakeholder meetings with the Ministry of Health to support planning of the response and outreach to vulnerable groups was made the responsibility of civil society organisations. The response plan identifies older people as a vulnerable group.

*"The inter-ministerial committee acted as the response command and it was through the efforts of these ministries, ministry of health, ministry of Interior, Ministry of Defense, Ministry of Gender, Children and Social Protection, churches and all sectors came in to develop the plan and saw to its implementation". (Programmes coordinator, Ghana Health service)*

# Response to primary impacts of COVID-19

Older people were not targeted specifically in the COVID-19 health response, but general measures were supposed to include older people. As a programmes coordinator from the Ghana Health Service noted in an interview: "There were no specific programs for the elderly, but through appropriate consultations, the general measures seem to tackle well those that were identified within this pandemic situation."

| Case management of COVID-19 patients | | | |
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| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Health Service | Community-based surveillance, home visits and contact tracing<br><br>Needs were assessed in the anticipation of the care and all comorbidities were considered in care provision.<br><br>At the district level, a COVID-19 team provided clinical care and a social worker, dietician and clinical psychologists were on standby to intervene as and when it was necessary. In the care process, if issues were identified that could impact their survival even post-discharge, patients were referred these services. | Some hospitals were overwhelmed and full to capacity but no age-related criteria were applied in terms of offering access to care.<br>In fact, older people were often prioritised for beds in hospitals designated for COVID-19 treatment. | Only limited numbers of facilities had access to equipment and human resources needed for those who were seriously ill and patients needed to be transferred. Other hospitals acted as holding centres that provided oxygen until a patient could be transferred but these holding centres were always full as they had to wait on tests before admitting or transferring patients, which created delays in receipt of critical care. |
| **Maintaining Essential Health Services** | | | |
| **Health services** | Some strategies were put in place to mitigate the disruption of essential health services which included community communications, triaging to identify priorities, the redirection of patients to alternative healthcare facilities, the provision of home-based care where appropriate, telemedicine to replace in-person consults, task shift/role delegation, integration of several services into single visits and self-care interventions (World Health Organisation, 2021f).<br><br>**Call centres were set up to allow for telemedical consults**<br><br>The World Health Organization and Centre for Disease organised training programs for health workers on home care to manage access for all groups of people | In the case of chronic patients, the care team would give medication for 3 months to reduce need to visit facilities and this was approved by the NHI.<br><br>Allowed family members to fetch medication for older or other at-risk family members<br><br>Assigned patients contacts in the chronic care units to call or whatsApp with challenges or questions about treatment.<br><br>Gave older people appointment days to reduce the need for them to wait | Limitations in PPE and associated price increase limited provision of care, but this issue has been resolved through local production of PPE<br><br>Protocols put in place to protect health workers limited access to non-COVID patients during periods of peak transmission<br><br>Reduced outpatient clinics and number of patients that could attend<br><br>Access to health services limited as caregivers could not accompany older people during COVID and transportation issues were also a challenge<br><br>Disruptions to PHC services included routine scheduled visits and referrals to speciality care and prescription renewals for chronic medications. Emergency, operative and critical care services had disruptions with elective surgeries and inpatient critical care services and rehabilitation services were disrupted (World Health Organisation, 2021f). Medications not on the NHI list have to be paid for out of pocket, creating barriers to care. |

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| Community health nurses - | People with NCDs were visited - checked blood pressure, sugar levels and conducted health talks | Conducted home visits to older people who were not visiting facilities | Older people reported that home visits have been infrequent<br><br>**PPE shortages** |
| **Vaccine roll-out** | | | |
| Community health workers<br><br>Care organisations | Mobile clinics as well as mass campaigns were used to reach older people, starting in Accra and Kumasi<br><br>First phase considered a success – people were accessed through the national ID cards and the general public was also encouraged to bring their elderly relatives for the vaccines.<br><br>Organizations used their own networks to get their clients vaccinated. They registered them and also educated them about the vaccine and its side effects. | Older people reached for vaccination via community channels<br>The community health nurses who are aware of where the older people were (especially those with mobility challenges) were reached in their homes for vaccination registration.<br>Vaccinations took place at community level | Vaccine hesitancy, concern about side effects and efficacy<br><br>500-600 people would come out to a community site, health workers but only had one tablet for capturing information and there were also internet challenges<br><br>There was no engagement with older person's organisations by government to assist with the rollout. Organisations didn't receive any education from government on how to educate their older clients. Staff did their own research on the vaccine and the after effects and that is what was used to educate the clients.<br><br>Proximity was an issue and created barriers to access for some older people |
| **Risk communication and community engagement** | | | |
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Ministry of Communications<br><br>Community health workers<br><br>Older people and older person's organisations | Mainstream media communication campaigns<br><br>Risk communication took place through network of community health officers and volunteers, as outreach through community centres and well as durbars (platforms for community engagement held by community leaders)<br><br>All information regarding the pandemic was from the ministry and given to the ministry of information and National Commission for Civic Education (NCCE) to disseminate. Some NGOS also went to some communities to educate them and share masks and sanitizers for them. Religious groups and other Civil Society organizations donated items to the Ministry as part of the response. (MoH)<br>No outside consultation but international stakeholders helped to support the planning. | Older people were highlighted as a vulnerable group in all campaigns<br><br>In some organisations education was provided for the clients whenever messages from the Ministry was released which were then forwarded to clients through WhatsApp. | Older people were mentioned in general communication campaigns as a vulnerable group but communication not necessarily targeted at older adult and therefore not necessarily appropriate, except perhaps in the case of home visits<br><br>There was reduced healthcare utilization among non-COVID-19 patients.<br><br>There was a lack of mHealth services available to non-COVID-19 patients.<br><br>Misinformation in the media created anxiety and confusion among older people |

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| **Infection prevention and control** | | | |
| Community Health Workers<br>Older person's organisations<br><br>Government and The Ministry of Trade and Industry | The government introduced local innovations and production of PPE development of test kits, and equipping existing state laboratories. Manufacturing companies were selected to produce sufficient PPE for the frontline health workers locally | Provision of PPE to older people by government<br>Specific focus on older people in contact tracing activities – home visits ensuring their safety | Shortage of PPE |
| **Long-term care provision for older people** | | | |
| Long-term care facilities<br><br>Households | The few existing old age homes were targeted for vaccination rollouts.<br><br>"Witch camps", where many of the elderly women accused of witchcraft are living with dementia or other forms of mental illness or physical disabilities were targeted with PPE, money, mattresses, clothes in Ghana.<br><br>Care workers from home care agencies and day centres went to the homes of clients and stayed with them and charged them half the price from what they were paying before (an hourly rate when being cared for at the centre). It was better to go take care of them in their homes and receive some of their salary than to do nothing. The Ministry of Health provided face masks for staff in care organisations (8 per staff member) and the clients were supposed to have disinfectants and other items and hand washing facilities, however there was not enough and the Ministry indicated that they had inadequate resources and could not provide more PPE | | The care workers were unable to take on more clients as they were losing a lot of money and decided to rather concentrate on the old clients who were already registered with the organisation. This caused a loss in incoming finances.<br><br>Because of the COVID-19 restrictions and infection concerns, there were no volunteers to assist with older people, particularly given limitations in PPE early in the pandemic.<br><br>Day care facilities run by older persons organisations could not operate, reducing access to services |

## Responses to the secondary impacts of COVID

Rather, the National Disaster Management Organisation (NADMO) was tasked to reach out to the vulnerable through a food distribution program. Unsurprisingly, NADMO lacked the needed data and specifications of their target. In what could be described as a survival of the fittest approach to sharing relief items, NADMO failed to incorporate the needs of the elderly in their interventions. The difficulty in reaching frail aged people while maintaining the needed social and physical distancing protocols becomes a challenge.

| Social services and social assistance | | | |
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| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Ministry of Gender and Social Protection (MoGSP)<br><br>Metros and Sub-metros<br><br>National Disaster Management Organisation (NDAMO) | Psychological interventions were organized for the elderly who had mental and social problems.<br><br>The MoGSP established the HelpLine of Hope to report domestic abuse, abandonment etc. for all vulnerable groups, including older people<br><br>Provision of food rations – cooked and raw for vulnerable and housebound people<br><br>The Ministry collaborated with Civil Society Organization-Narrow Aged Care Foundation who supported older persons in their homes and provided them with palliative care in their homes<br><br>Various district and municipalcities have a mandate of identifying the vulnerable groups within their community and offer them nutritional relief and financial support through using already existing platforms such as The Livelihood Empowerment Against Poverty (LEAP) which was already targeting older adults and offering them financial assistance. LEAP beneficiaries were offered an additional one-off cash transfer in May 2020 during the lockdown period and top-ups of 10 cedis for urban and 20 cedis for rural beneficiaries were paid to defray transport *costs to banks as community distribution points were closed until July.*<br><br>The Single Window Engagement Service for citizen engagement with the social protection system increased call centre capacity and also referred calls related to requests for assistance to extend emergency relief benefits (Dadzie and Raju, 2021). | The government provided 1470 food packages to 16 older persons groups via the Centre for Ageing studies at the University of Ghana (University of Ghana, n.d.). | It was reported that from a government level, there was support for the older people during the lockdown but since then nothing has come from government. In terms of direct support to older people.<br><br>Lack of resources in the ministry for implementation<br><br>There were reports that during lockdown there was discrimination against the elderly in terms of sharing of relief packages.<br><br>COVID should be a wake-up call to the government because nobody expected it to happen and the aged have more affected because of the underlying problems they have which come with ageing. Getting the much needed attention from the government was reported as not being well received towards the aged.<br><br>NADMO's targeting of vulnerable groups with food aid was poorly planned due to inadequate targeting data with NADMO failing to incorporate the needs of older people in this project (Deku et al., 2021)the novel coronavirus (COVID 19.<br>Reaching older people while observing appropriate safety protocol could be challenging.<br><br>Access to LEAP cash transfers were limited during lockdown to contactless forms of payment and, in general, pay stations are not disability friendly, making access difficult for older people with disabilities. However, provisions were made to enable caregivers to assist older people in accessing their money. |

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| Older persons organisations and other civil society organisations<br><br>UNICEF | Some NGOS also went to some communities to educate them and share masks and sanitizers for them. Religious groups and other Civil Society organizations donated items to the Ministry as part of the response.<br><br>Market Women's Association provided food for vulnerable groups, including the aged<br><br>Education about social distancing and vaccination<br><br>Carers took older people to centres to be vaccinated (not government support)<br><br>UNICEF implemented a COVID-19 response programme in Ghana with a focus on access to care and protection services and improve access to water and sanitation, hygiene and behavioural change among people in vulnerable communities. | Government provided food items which was distributed by older person's organisations, but this support was limited | Difficult to reach out to older people during lockdown, as well as afterwards due to COVID protocols<br><br>Day centres, such as those run by HelpAge Ghana provide day care centres with funding from the Ministry, but these could not operate during lockdown – home outreach used instead. Have tried to use zoom and other video calling but technology is a challenge<br><br>COVID-19 testing required before visiting a facility for older people – this is expensive and acts as a barrier to access to those providing support.<br><br>Older people not necessarily cooperative about social distancing<br><br>Struggles with funding of older person's organisations due to decreased member participation and re-direction of funds towards COVID<br><br>Difficult providing home-care because of the risk of infection – had to provide 24-hour care at half price – also limited the number of clients they could take on<br><br>No PPE provided to care providers by government – sewed their own |
| Churches | Provided material support to vulnerable parishioners, particularly older people (Mumia, 2020). | | Outside of the church, support was mainly provided within family structures<br><br>Hesitancy in volunteering because of fear of infection |

# Examples of good practice

- Use of telephone consultation and other forms of telemedicine introduced by some hospitals to ensure continuity of care.
- Including older people in outreach campaigns:
    - Older people were part of some outreach campaigns. "My grandmum was educating people in the market…she told people to mask-up and that it was real" (Interview, Community Nurse, 2021).
- Using data and beneficiary engagement systems from existing social protection platforms to reach vulnerable populations such as older people (Dadzie and Raju, 2020).
- Political leadership and accurate and understandable vaccination messaging is key to fighting vaccine hesitancy by building trust and confidence, reducing perceptions of risk and building social norms around vaccination (World Health Organization and UNICEF, 2021). In this has been carried out with clear messages and well-planned work with radio, TV, social media and through trained spokespeople, influencers, partner organizations and among communities (World Health Organisation, 2021e).

## Challenges and limitations of the response

- Weaknesses in data systems were revealed by the pandemic and limited the effective targeting of social and economic interventions.
- Intense focus on COVID-19 led to neglect of other health issues, most notably in the case of the large-scale meningitis outbreak which had a high fatality rate due to a slower than normal response (Adjorlolo and Egbenya, 2020)a low-resource country, that is confronted with the coronavirus disease 2019 (COVID-19.
- Initial PPE shortages not only interrupted health service delivery but made it difficult to provide support to older people in community settings without putting them at risk.

# 7.2 South Africa case study

South Africa has a total population of 56,978,635 million with 56,978,635 persons (9.4%) aged 60 years and over. South Africa an upper-middle income country, with a ranking on the Human Development Index of 114 with a score of 0.7. Absolute poverty is high, with an extreme poverty rate (those living under $1.90 per day) of 18.9, and there are significant levels of inequality with a GINI coefficient of 63. The country's health expenditure is 8.1 percent of Gross Domestic Product (GDP) (South African Government News Agency, 2021). South Africa has greater health systems capacity than most countries in the region and there is 69% coverage of essential health services according to the Universal Healthcare service coverage index. However, South Africa has had very high levels of community transmission, hospitalisation and mortality, due to COVID-19, which health system struggled to deal with despite an early lockdown designed to prepare. There is a significant difference between the public and private healthcare system which has greatly impacted the response to COVID-19. See Tables in Annex 1 for more detailed demographic, health systems and economic data on Ghana and all 47 countries in the region.

## Healthy ageing situation

- The South African Older Persons Act 13 of 2006 is a framework focused on the empowerment and protection of older adults and aims to enhance the promotion of their status, rights, well-being, safety and security. The legislation also promotes a shift from institutional care to community-based care and regulates the registration and management of residential care facilities and community-based care and support services.
- South Africa also has a Policy for Older Persons, which was developed in 2005 after South Africa signed the political declaration adopting the Madrid International Plan of Action on Ageing in 2002. The policy outlines a multisectoral response to the challenges of ageing and includes free health services for older persons, increased training on ageing issues and improved geriatric services.
- A means-tested old age pension in the form of the Older Person's Grant is provided to people over the age of 60 and has high population coverage (around 73% of the population).
- However, outside of the provision of free healthcare, social grants and the limited parameters of the Older Persons Act of 2006, no further policy or legislation has been developed, and there has been little implementation of programmes targeting older persons across government sectors.
- There are various frameworks that have been put in place for the management of non-communicable diseases (NCDs) and although not explicitly focused upon older people, the effective implementation thereof would improve health services for older people with the impact that COVID-19 has on individuals living with NCDs. These frameworks include the following:
    - Strategic Plan for the Prevention and control of Non-Communicable Diseases 2021-2026 (Draft) which takes a life-course approach to the management of NCDs.
    - The following models: Integrated Chronic Disease Management, Integrated Clinical Services Management and the Ideal Clinic Realisation and Maintenance Programme aim to improve the efficiency and decrease the strain on the healthcare system by ensuring the coordination of care, transitioning to self-management at a community level and developing an individual's sense of responsibility for their own health.

## COVID-19 pandemic in South Africa

The first case of COVID-19 infection in South Africa was reported on March 5, 2020. A nationwide lockdown was put in place from midnight March 26, 2020 with South Africa having had one of the stricter lockdowns on the continent with a government stringency index of 87.96 according to the Oxford Coronavirus Government Response Tracker (OxCGRT) project. South Africa was reported to have the largest outbreak on the African continent with over 1.67 million cases and with the highest mortality figures of 89.01 cumulative deaths per million (Statista South Africa, 2021). As discussed in Section 3.2, excess mortality, particularly among older people is expected to far exceed the 56 506 reported deaths (as of 31 May, 2021) (Statista South Africa, 2021).

The case fatality rate according to Our World in Data, is 3.41. South Africa has had a high testing capacity, however this became an issue during the first wave when the public health sector was unable to cope with the demands of all the testing with delays in receiving results experienced of up to two weeks during the peak of the pandemic. A targeted testing strategy was introduced in July 2020 to accommodate constrained testing capacity during the first wave of the pandemic with priority given to hospitalised patients, health workers, older people and people with chronic diseases to reduce testing backlogs and criteria were relaxed in October 2020 as testing resources as a result of expanded testing resources (National Department of Health, 2020).

Additionally, PPE was limited and inadequate initially when the virus broke out in South Africa during the first lockdown. This impacted the public sector and millions had to be spent to acquire enough PPE (Christianson, 2020). South Africa has a relatively high capacity of intensive care units available nationwide, however over the last decade these figures have shown disparities especially between the public and private sectors with private sectors not generally being very accessible to the majority of the population. This resulted in a lack of emergency COVID-related recourses within the public sector resulting in rationing and triage decisions having to be made which often impacted older adults (Schröder et al., 2021).

# Impact of COVID-19 on older persons

COVID-19 impacted older people differently based on whether they were living in community settings or long-term care facilities.

# Community settings

The suspension of community-based activities for older people run by non-profit organisations has had significant impacts on the health and wellbeing of older people. Older persons' organisations that offer luncheon clubs, income-generating activities, transportation services and social activities have not been operational or have had to operate in a more limited capacity, reducing older people's linkages to food, income, healthcare and social connection. For example, one organisation interviewed for this report was running a big transport operation for free to all older persons in their programme to take them to the clinics and hospitals to see doctors and get their medication. This was also shut down during lockdown with devastating effects on health and chronic conditions.

> *"We feed about 2,000 a day through luncheon clubs and all the people depending on all those two meals a day… their lives were just shut-down. We could not go to their houses because we could make them more vulnerable by visiting them." (Interview, Muthande Society for the Aged, South Africa).*

> *"Muthande Society for the Aged have been running a very big transport operation, taking older people to clinics for their tablets and to see the doctor - we have been running that for the past 20 years – they were all dependent on that facility to access healthcare, but they could not because our drivers were not permitted to interact with them because of the risks involved."*

Life has been very difficult for older persons and many older people have gone into survival mode (Interview, Muthande Society for the Aged, May 2021). There were reported stories of older adults feeling helpless at not being able to support their families, participate in traditional death rites or attend funeral being part of a rite of passage when a spouse dies. Due to this loss of rich cultural practices, there has been a lot of unresolved grief (Vukani News, 2020).

Older people in communities also struggled with physical distancing requirements and the absence of their usual social activities.

While there has likely been an increase in abuse of older people within long-term care homes and community settings (Jacobs, 2020), older persons organisations reported that reporting of incidences of abuse has been low, most likely due to a lack of resources. Organisations were able to pick up in changes in behaviour at places where the older adults congregate (clinics) and so forth, but those living in isolation could not be monitored in some areas. Issues of support became an issue where older people didn't want to accept support as much as they needed it and there were increased cases of attacks reported on older people who lived alone with them being vulnerable targets. Some organisations engaged with community groups like neighbourhood watch and policing forums and asked them to be aware of older adults in their community living alone and to set up some kind of a support structure for them[10].

Older persons organisations also reported issues surrounding the financial abuse of older persons' pensions where their children would take control of their pension and use the money for themselves. There were many reports of adult children losing their jobs and having to come home from the city to live with their parents and using their pension. Additionally, all the early childhood development centres that provide day care to young children were closed for several months, which meant that the older persons very often had to look their grandchildren. Many of these children have still returned to day care facilities due to financial constraints brought about by COVID-19 and older people remain responsible for their care (Interview, Muthande Society for the Aged, May 2021)

10 (NOAH, May 2021)

## Long-term care facilities

The introduction of COVID protocols within LTCFs created confusion and unhappiness among residents, especially among people with cognitive impairment. Isolation and loneliness became apparent within older people in residential LTC facilities and many experienced depression and anxiety about the health and wellbeing of their children, many of whom were affected financially by the pandemic (Interview, TAFTA, May 2021).

A significant increase in interpersonal conflict was seen in some care homes where residents' ability to leave the facility, see their families and participate in physical and social activities was restricted (Interview, NOAH, May 2021)..

## Responses to COVID-19 supporting older persons

The following examples of responses targeted at or specifically focused on older people by government and other stakeholders that were identified via interviews, media or literature are tabulated below – these examples are of national-level interventions unless a specific region is identified.

### *Coordination of response*

As part of the response to the pandemic, the government established a National Coronavirus Command Council, chaired by the President and comprised 19 cabinet ministers. This included members of the Inter-Ministerial Committee on COVID-19, their respective directors-general, the head of the National Defence Force, the National Police Commissioner, and a secretariat (Singh, 2020). Older people have not been involved in consultations around planning the response.

# *Response to the primary impacts of COVID-19 on older people*

| Case management | | | |
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| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Western Cape Department of Health - Virtual Emergency Care Tactical Operation | High risk diabetes patients, including older diabetics, with positive COVID-19 tests were identified using provincial public health data and private and public testing data. A team of six doctors conducted telemedicine consults with high risk groups and were offered admission to an intermediate care facility, even if they were not clinically ill and were followed up with daily if they chose not to be admitted. This allowed for provision of tight glycaemic control (which improves outcomes for diabetic patients with COVID), continuous oxygen and opportunities for rapid escalation of care in case of deterioration. Mortality among those successfully contacted was 4.5% as opposed to the 28% fatality rate among this high risk group (David, 2020). | Older people were identified as a specific sub-group within the VECTOR programmes focus population.<br><br>*No other notable interventions specifically targeting older people were identified* | Across the country, there was a lack of staff, resources and hospital beds. Hospitals were overwhelmed. Additionally, staff who became sick or who were striking because of a lack of PPE and other IPC measures resulted in changed roles such as doctors having to wash linen and nurses having to sweep and clean (Harding, 2020).<br><br>Insufficient ICU beds and ventilation equipment led to the implementation of resource allocation policies that discriminated against older adults (Brydon, 2020). |
| **Maintaining Essential Health Services** | | | |
| Department of Health | Some strategies were put in place to mitigate the disruption of essential health services which included community communications, the redirection of patients to alternative healthcare facilities, the provision of home-based care where appropriate and self-care interventions (World Health Organisation, 2021f)<br><br>People with chronic illness were allowed to take 3 months of medication from pharmacy clinics to avoid having to visit monthly.<br><br>Electronic pharmacy dispensing units implemented in the Free State and Gauteng provided access to medication outside of health facilities (see Examples of Good Practice section below). | Chronic medication delivery to older patients homes was implemented by the Metropolitan Health Services in the Western Cape (eNCA, 2020).<br>CHWs went and visited the homes of those living out in rural areas to check on those with chronic conditions and do screening.<br><br>Access to medication was provided to via the Central Chronic Medicine Dispensing and Distribution programme, which allows qualifying people (including older people) to register to collect 6 months of pre-packaged medication which could be collected by up to two nominated persons, allowing older people to avoid crowded clinics.<br><br>In the rural areas around Hoedspruit, a positive was that the CHWs were able to have regular contact with the older people in the villages as they were all given mobile phones by the government. They would get all the contact details of the family in and out of the homes and were able to stay in touch. | Disruptions to PHC services included routine scheduled visits and referrals to speciality care. Emergency, operative and critical care services were all disrupted and palliative services were disrupted.<br><br>During lockdown, essential health service delivery was interrupted, particularly in under-resourced settings and there was wide-scale avoidance of health facilities for follow-up, check-ups and prescription refills, as well as supply chain interruptions which affected medicine delivery (Dahab et al., 2020; South African Institute of Race Relations, 2020). A significant portion of the natural excess deaths is believed by researchers to be the result of interrupted services and re-orientation of health services towards COVID-19 (Moultrie et al., 2021).<br><br>NCD services were all disrupted including care for asthma, diabetes, cancer, cardiovascular and hypertension. Services for older adults with mental health conditions, disabilities or cognitive difficulties were only minimally disrupted.<br><br>Changes to service delivery platform access was limited in community-based care and in in-patient care.<br><br>Issues of safety were raised among staff travelling to and from clinics and organisations with there being reduced transport |

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| | | | Continuation of health services was disrupted during COVID lockdown. Outpatient clinics were scaled down and became more difficult to access and primary level facilities in some places provided only limited services and surgeries were cancelled (Medical Brief, 2020; Siedner et al., 2020).<br><br>CHWs had to deal with a lot of fear among the older people. In many cases the older people were locking themselves in their rooms/homes and it was difficult to get in to check up on them.<br><br>It was noted by CHWs that often it was challenging entering the homes of older persons as the family members would disrespect the CHWs by indicating that only educated people like social workers could take care of their parents and that they didn't think that the CHWs were educated This left them feeling demotivated and unappreciated.<br><br>The people out in the communities were the hardest hit as they couldn't access services and for those who did go to the hospitals, who too afraid to go, were very often marginalised. The older people were hugely frustrated with the response where the chronic needs of patients were not met with the focus mainly being on COVID response. |
| **Risk communication and community engagement** | | | |
| National Institute for Communicable Disease<br><br>National, Provincial and District Departments of Health<br><br>Presidency<br><br>Older person's organisations | Widespread government and media campaigns on COVID19 highlighted the risk of COVID-19 to older people.<br><br>The National Coronavirus hotline, WhatsApp applications and government websites provided information on the pandemic and the vulnerability of certain groups.<br><br>In some areas around Hoedspruit CHWs helped the DoH to do the screening for COVID by going from house to house to do the screenings, health education and COVID awareness raising. | There were several awareness campaigns rural areas targeting older people by handing out PPE and explaining the importance of social distancing and hand washing | |

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| Civil society organisations<br><br>Community health workers | The Centre for Human Rights in Pretoria created the Age With Rights - a campaign which reaffirmed that older persons should be able to exercise their human rights and highlighted the impact of COVID-19 on older persons and what can be done to make life better (Booyzen, 2020)<br><br>In collaboration with community partners, Medicine Sans Frontier implemented a Shielding and Protection Programme for vulnerable groups, including older people. This included community pickup points for chronic medications in some areas and telephonic counselling.<br><br>Some older persons organisations made use of WhatsApp and SMS platforms to keep people connected and for them to stay in touch with the communities and in-house residents by sending out messages of COVID updates and support. They also got local media personalities to offer messages of support to help keep the motivation up. There were also caring services created where volunteers would phone older people out in the communities to check up on them to see how they are doing.<br><br>CHWs were involved in the education of COVID protocols and assisted with the vaccine registration process. | | From a cost perspective, the infrastructure setup and providing data was challenging and also the issue of safety and security regarding staff travelling being a concern with the usual modes of transport not been used. |

**Infection prevention and control**

| Entities | Activities inclusive of older people | Activities specifically focused on older people | Challenges |
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| Department of Health<br><br>National Institute Community Development and Management and First National Bank | The DOH deployed teams to conduct manual contact tracing in every district. Subsequently, the WhatsApp-based COVIDConnect service was launched which allows index cases to anonymously notify their contacts as prompted by the system.<br><br>COVID Alert SA mobile application was developed to strengthen digital contact tracing efforts. | | Centralised data made it attractive to hackers if there was no end-to-end encryption.<br><br>Not everyone has WhatsApp and internet access (8)<br><br>The App was initially affected by “fake news”.<br><br>Issues around where the data should be stored and privacy concerns |

| Vaccine Roll out | | | |
|---|---|---|---|
| Department of Health and Government Communication and Information System (GCIS) | Older people can register on the electronic vaccination data system online, via whatsApp, SMS, telephone or QR code on their phone. 50 000 People in nursing homes do not need to register as vaccinations will be carried out within these facilities (South African Government News Agency, 2021). Older people living in long-term care facilities were registered by their facilities and were vaccinated on-site.<br><br>Registration drives have targeted older people | Phase 2 of the vaccine rollout prioritises older people and 5 million vaccinations have been made available for this group (Discovery, 2021). | Challenges with the electronic vaccination system and appointments has made access difficult for older people. As a result, walk-in vaccinations are allowed.<br><br>Some of the older people were very confused about the vaccination process due to their being a lack of available information and education on the process. This left many older people not wanting to get the vaccine.<br><br>The vaccine roll-out created a whole new set of fears especially with the new Indian strain and the impact of the comments made by media. The media story with the vaccine being the work of the devil created a major panic among some older organisation's residents.<br><br>There were problems noted among some organisations regarding the registration process of the vaccine with some highlighting that the platform wasn't working properly, and the registration process took up to four times in some cases.<br><br>It was reported in some cases that older people feared that the CHWs were coming in to try get rid of them and poison them by making them go get the vaccine injections but the CHWs pushed to try educating them and explained that they were safe. |

| Long-term care provision for older people | | |
|---|---|---|
| **Entities** | **Activities** | **Challenges** |
| Departments of Health and Social Development<br><br>Business<br><br>Older person's organisations and long-term care facilities | Detailed standard operating procedures were developed to prevent and manage COVID-19 in residential facilities in the Western Cape, but no national guidelines were disseminated.<br><br>Referral protocols were put in place where any old age home reporting an infection would have been assisted and supported.<br><br>Some long-term care residential facilities housed care workers on site to avoid transmission to older people via the community (this response relied on public donations of food, mattresses etc.)<br><br>Inclusion of some LTC facilities in the National Institute of Communicable Disease's online hospital surveillance platform (DATCOV19) as well as weekly collection of infection recovery and mortality data from facilities.<br><br>The dissemination of memos providing guidance to facilities as well as the development of a bulk SMS system to communicate with key contact people within facilities.<br><br>The national Department of Social Development produced a summary table of directives for residential LTC facilities appropriate to the national regulations for each of the five levels of national lockdown.<br><br>Training for health staff and care workers and technical support for low-resourced facilities in some provinces.<br><br>Deep cleaning of LTC facilities with outbreaks by volunteers.<br><br>Limited procurement of PPE and hand sanitiser for facilities via the DSD.<br>Private donations of PPE (Nazareth Care, 2020).<br>Guidance documents for providing health care or palliative care in care homes were shared with all facilities to disseminate to facilities but use may have been limited. Initially, care homes were dissuaded from sending all but emergency cases for medical attention (Jacobs et al., 2020).<br><br>The DoH has collaborated with National Institute of Community Development and Management and First National Bank to train and capacitate 89 resource-constrained residential facilities on infection control, health and safety guidelines and palliative care, amongst other things.<br><br>In the Western Cape 15 000 masks and 50 litres of sanitizers were distributed to old age homes across the Western province. Additional relief staff were provided where and when needed and specialised training for carers was implemented. The WC DoH facilitated the deployment of volunteers to deep-clean old age homes – with a focus on homes in vulnerable communities and hotspot areas. An additional R 1.755 million was made available for old age homes for the management of COVID-19, over and above existing allocations. Sanitizers and face shields were distributed to 117 old age homes (Department of Social Development, 2020).<br><br>At the Association for the Aged in Durban, the care teams at all the facilities had been trained on hygiene protocols and were educating the residents about how to reduce the risk of infection. Educational posters had been put up in rooms and hand sanitisers placed at entrances and other high-risk areas, including the frail-care facilities. This was reported in various other organisations. | LTCFs experienced significant financial strain due to unpaid subsidies, an inability to fill vacant room and large costs spent on PPE and adapting facilities.<br><br>Limited support for community-based long-term care, particularly given difficulties that older persons' organisations had in operating.<br><br>Families often don't want CHWs providing care to care dependent older people as they are not part of the family.<br><br>There was inadequate government support and guidance on the compliance towards prescribed regulations. The government did not prioritise this sector for support in terms of emergency funding or the provision of PPE. This led to a financial crisis with residents and their families not being able to pay their rental and vacant rooms not bringing in revenue. |

# Responses to the secondary impacts of COVID

| Social services and social assistance | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| SASSA<br><br>Civil society<br><br>Community volunteers<br><br><br><br><br>Grocery stores<br><br><br>The Solidarity Fund alongside<br><br>Department of Social Development<br><br>Corporate donors<br><br>Older person's organisations | <br><br><br><br><br><br><br>In some places, at the end of each day, grocery stores made the almost expired foods available to those who were in need<br><br>The Solidarity Fund alongside the DSD delivered food parcels to those in need, including older people (South African Government News Agency, 2020a). | SASSA created particular payment days for older people on the last two days of the month whereas the rest of the population receive it on the first.<br>The recipients of old age grant received a top-up of R250 as part of the government's socio-economic measures to mitigate the impact of COVID-19 on the poor and most vulnerable (South African Government News Agency, 2020b).<br><br>Volunteer organisations arranged to drop off shopping for free at older persons homes (le Roux, 2020)<br><br>Various supermarkets opened up their stores an early earlier to allow older adults to shop and also had an online purchase option with food being delivered.<br><br>There was also the development of food and gardening programmes to assist older persons in having daily access to food with households receiving gardening food seed starter packs [11].<br><br>Older persons organisations adapted their offering to provide fortnightly food parcels and hygiene packages to people unable to access services.<br><br>DSD in collaboration with partners also distributed food parcels and hygiene packs to older people.<br><br>In some rural areas, farmers provided communities with fruit and there were organisations and individual volunteer groups that handed out food parcels and blankets. In some areas, older people were considered to be protected and were well looked out for [12].<br><br>Community forums became involved and looked out for older adults who lived alone and were vulnerable targets for crime.<br>Older person's organisations teamed up with groups such as the Depression and Anxiety group of South Africa who provided off-site support to older adults virtually[13]. | The collection of social grants was initially a disaster due to poor planning with there being excessively long queues that didn't favour older adults who were more likely to collect grants in person than to use ATMs, particularly in rural areas (Cruywagen and Ellis, 2020). |

11 Interview NOAH, May 2021

12 Interview Hlokomela, May 2021).

13 (Interview TAFTA, May 2021)

## Examples of good practice

Although there are definitely gaps in the South African response to older people, there has been a much more targeted response to the needs of older people than in many other countries in the region. There is a strong presence of persons organisations throughout South Africa that put the needs of older people first and made their wellbeing a priority, even in the face of significant and growing resource constraints. South Africa generally has a strong civil society and, together with business and government, there was a concerted effort to raise funds to meet the needs of older people both in LTC facilities and communities. Other examples of good practice include:

- Widespread uptake of the old age grant and the temporary increase in value of the grant in 2020 protected older people from the impacts felt in other regions, demonstrating the value of social protection provisioning for older people.
- There was a national DoH directive on allocating chronic medication for extended timeframes.
- The VECTOR programme of early tracking of high-risk older persons with COVID-19 via telephone is a low-cost and efficacious intervention where health data is available and particularly useful in rural settings where access to health resources is more challenging.
- Local initiatives rolled out by the Western Cape, Free State and Gauteng health departments delivered medications to patients outside of health facilities which could be rolled out and maintained after the lockdown period to de-congest PHC facilities and shield older persons.
    - In the Western Cape, an innovative model for home delivery of medications in Western Cape could enable up to 200 000 parcels per month to be delivered to people's homes via 2500 CHWs. The model leverages existing systems of community-oriented primary care and networks of non-profit organisations (NPOs) and CHWs. During lockdown drivers from NPOs, Ubers and courier companies, government motor transport and volunteer drivers delivered pre-packaged medications of stable patients to NPOs for CHWs to collect for door-to-door distributions (Brey et al., 2020).
    - Right ePharmacy Dispensing Units (PDU) were implemented which is an ATM-like innovation that uses electronic and robotic technology to dispense medication, decentralising dispensary services and providing chronic patients with fast access to their medication, while allowing them to stay away from public hospitals and clinics and reducing chances of COVID-19 infection (Right ePharmacy, n.d.). This had been rolled out at several sites in the Free State and Gauteng provinces. In addition, a central dispensing unit (CDU) had dedicated pharmacists who packaged and labelled medication daily and sent it out for the various Collect & Go smart lockers. Right ePharmacy has site agents stationed at hospitals and clinics, who support patients and facilitate referrals to the Department of Health's (DoH) CDUs. The CDU also sent patients reminders to collect medication and notifies the clinic when the medicine is returned to the CDU. Once patients start using Right ePharmacy's services, they can collect repeat medication at the ATM pharmacy or smart locker. The CDU also packages and dispenses medication for local old age homes, limiting the time the elderly spends in clinics and hospitals.

## Challenges and limitations of the response

- A major challenge was the dwindling of subsidies from the State towards long-term care residential facilities and community-based organisations, which was exacerbated during the pandemic. Sourcing outside funding from private organisations became a main source of funding with this also being challenging in some cases.
- The impact of providing PPE was a major cost to many organisations and the implementation of harsh COVID-19 protocols.
- The issues surrounding a lack of transport caused many problems among older people and staff. Healthcare systems were severely overwhelmed which impacted the healthcare of older people who had reduced access to primary healthcare services.
- Fear of infection resulted in LTCFs having to undertake additional costs where staff having to live in for extended periods and residents had to be moved from their rooms to make space for isolation facilities. This led to a financial crisis with residents and their families not being able to pay their rentals and vacant rooms not bringing in revenue (Ashwell et al., 2020).
- Older people were often too afraid to go to hospitals as they feared contracting the virus and were often marginalised and treated poorly.
- Older persons' organisations could not offer essential services to members at a time where they most needed social support, health education and linkages to services.

# 7.3 Mauritius case study

Mauritius has a total population of 1,386,129 with 240 012 persons (17.3%) aged 60 years and over – the highest in the region. The country's health expenditure was 5.7 percent of Gross Domestic Product in 2018 ("Global Health Expenditure Database," n.d.).

Mauritius is an upper middle income country and it has the highest ranking on the Human Development Index of 66

with a score of 0.804 in the region of Africa. The country was previously classified as a high income country but has recently been reclassified by the World Bank as an upper middle income country as a result of the devastating impact of COVID-19 on the Mauritian economy (which is highly reliant on tourism). Absolute poverty is low with an extreme poverty rate (those living under $1.90 per day) of 0.2%, and it is less unequal than many other African countries with a Gini coefficient of 36.8. The health systems capacity in Mauritius is high with a 63% coverage of essential health services. See Tables in Annex 1 for more detailed demographic, health systems and economic data on Ghana and all 47 countries in the region.

## Level of support for healthy ageing at the country level

- Mauritius has a well-established health and social protection system in place. Despite being a small and wealthy country and therefore contextually different from many countries in the region, it nevertheless provides many examples of good practices in supporting older people in the African region.
- Mauritius was the first country to put a national policy in place for older adults in 2001. The Protection of Elderly Persons Act 2005 aims at protecting older people from all forms of neglect and abuse. Older people are afforded further rights and protections in the more general National Human Rights Action Plan (2012–2020) (World Health Organisation, 2017b)
- The Ministry of Social Integration, Social Security and National Solidarity developed the National Strategy Paper and Action Plan on Ageing 2016-2020 (Mauritius News-Wire, 2016) which is currently being implemented.
- The Residential Care Homes Act 2003 was enacted in order to establish standards and codes of practice and to monitor the quality of care delivered in private homes. Regular inspections of both public and private homes help to ensure that residents receive adequate care (Organisation, 2017). In the future, Mauritius expects to face even greater demands for long-term care. Its Observatory on Ageing (established in 2013) provides data to help inform policy and service development. The Government of Mauritius foresees rising rates of dementia and disability and increased overall demand for long-term care and is planning for a 52% increase in publicly funded residential bed capacity by 2030 (Organisation, 2017).
- Mauritius has a national programme to foster age-friendly environments, which falls under the purview of the Ministry of Social Security, which has an inter-sectoral committee to plan and implement it (Ministry of Social Security and National Solidarity, n.d.).
- Most of the social assistance programmes in Mauritius predate independence. These include the Basic Invalidity Pension and Carer's Allowances and Guardian's Allowance that were introduced in 1950, both with the objectives of enhancing the welfare, empowerment and integration of the population of persons with disabilities, elderly and other vulnerable groups. In 1951, the Basic Retirement Pension was introduced to provide high coverage cash transfers to the elderly, which reached 186,118 participants in 2015. The range of the monthly cash transfer amount is US$181.43 to US$1209.55 (UNDP, 2019, p. 2019) and additionally, older people have access to free public transport and free health care (Organisation, 2017).
- Ministry of Social Security and National Solidarity Domiciliary Care provide domiciliary care by doctors on a monthly basis to people aged 90 and above, as well as people with disabilities aged 60 and above. The services also includes health talks and physiotherapy and vaccination for elderly and home based 24 hr nursing care for those in need.
- The Ministry of Health and Wellness has Area and Community Health Centres which offer health care services to old age patients in their respective catchment areas. Regular screening for NCD risk factors and health education is carried out by the Health Promotion Unit of the Ministry of Health and Wellness. Medical social workers cater to social and family problems among older people. Community based rehabilitation workers cater to the disability needs of the elderly population ensuring cross referrals.
- Medical Unit of ministry of social security provide domiciliary care to elderly 90 year and above and bed ridden elderly 60 year and above on a monthly basis.
- Some mediclinics and area health centres are age-friendly, with ramp access for wheelchair patients and for those who cannot use stairs and support bars in toilets to facilitate use by elderly patients. However, community health centres do not have these provisions. All public healthcare facilities have a fast track system for the vulnerable, including elderly, people with disabilities and children.
- The Ministry of Health and Wellness has Area and Community Health Centres which offer healthcare services to old age patients in their respective catchment areas. Regular screening for NCD risk factors and health education is carried out by the Health Promotion Unit of the Ministry of Health and Wellness. Medical social workers cater to social and family problems in the elderly.

## COVID-19 pandemic in Mauritius

On March 18, 2021 the first three cases of COVID-19 were registered and consequently, on March 19, the borders were closed and eventually a complete lockdown was implemented on March 24, 2021 (Kowlessur et al., 2020). Mauritius had a strict lockdown with a stringency index of 82.41 (Kowlessur et al., 2020).

Along with Algeria, Mauritius is the only country rated as Level 4 for the WHO COVID-19 Strategic Preparedness and

Response Status for COVID-19, indicating a high level of preparedness relative to other countries in the region (see Table 4 in Section 2.4 of the main report).

The case fatality rate according to Our World in Data, has been 1.04. The current distribution of deaths as of July 11th , 2021 among 2260 confirmed adults cases was only 18 (World Health Organisation, 2021g).

## Impact of COVID-19 on older people

- Life for an older person in Mauritius during COVID-19 pandemic resulted in reports of them being bored, feeling uneasy and experiencing a sort of helplessness - particularly those living alone. Additionally, anxiety, fear and a lack of emotional support were commonly reported among older people.
- There were restrictions in movement and old people were deprived of usual leisure activities during the period of confinement. Moreover, some of the older people could not have their children visit them. Some of the older persons with renal dysfunction and other serious illnesses succumbed (COVID-19 was not the primary cause of death) though they could have lived longer.
- There has been an increase in the price of consumables, food and medicine, which has increased the cost of living for older people. However, in July 2021 the government decided to put in place price controls and subsidise basic items to offset recent increases brought about by COVID-19.
- Older people living alone have experienced burglaries and some cases of elder abuse were reported.
- Funding for older person's organisations has been reallocated to COVID-19 and community-level activities and advocacy campaigns have been limited by COVID-19 restrictions.

## Responses to COVID-19 supporting older persons

The following examples of responses targeted at or specifically focused on older people by government and other stakeholders that were identified via interviews, media or literature are tabulated below – these examples are of national-level interventions unless a specific region is identified.

## *Coordination of response*

There was a rapid response from the Mauritian government with all the major departments being involved in tackling COVID-19. These included: Ministry of Social Integration, Social Security and National Solidarity and the Ministry of Health and Wellness (Kowlessur et al., 2020).

## *Response to primary impacts of COVID-19*

| **Case management** | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Ministry of Health and Wellness | Older persons had access to COVID 19 related health services same as other patients with COVID-19. There was no discrimination due to age.<br><br>Hospitals were not overwhelmed in either waves of COVID-19 in 2020 and 2021. All patients were admitted in a dedicated COVID hospital or in treatment centres. However, admissions in all hospitals were restricted to semi-urgent and urgent cases. Patients with appointments in the OPDs were rescheduled and were requested to renew their prescriptions.<br><br>Cold cases for surgery were postponed to create more bed space.<br><br>Oxygen and ventilation were offered depending on the clinical status of the patient.<br>In cases where all ICU beds were occupied, patients requiring ventilation were transferred to other health institutions.<br><br>Palliative care services were available during periods of high community transmission of COVID on an out-patient basis in the Oncology Unit of the hospital.<br><br>Staffing was rescheduled to compensate a lack of staff who were shifted to hospitals caring for COVID patients. All staff for essential services were advised to attend duty and all leave was cancelled. | | |

| Maintaining Essential Health Services | | | |
|---|---|---|---|
| Ministry of Health and Wellness | No challenges were experienced in accessing appropriate acute health care services in the context of the COVID-19 pandemic by older persons. The ambulance and SAMU services[14], and Hotline services were operational throughout the lockdown and confinement periods in 2020 and 2021 respectively.<br><br>Health services for chronic conditions were fully operational in the primary health care centres. All patients, including older persons, had access to these services, free of any costs.<br><br>At hospitals, the appointments in the OPDs for non-urgent conditions were postponed, but medications were renewed until the next appointment. To avoid the spread of the virus, these patients were advised to collect their medications at the nearest health care facility in their locality. In certain cases, telemedicine was utilised. | Older people were fast-tracked at pharmacy counters for receipt of their medication<br><br>The annual National Influenza Vaccine Programme was continued during the pandemic and during the lockdown in 2020, door-to-door vaccination took place in collaboration with the Mauritius Police Force who provided security to staff. The flu vaccine was administered free of charge to older persons. In 2021 the vaccination took place in dedicated community centres, managed according to the alphabetical order system to avoid overcrowding. | The lockdown was with immediate effect resulting in there being a rupture in the services provided as staff did not have transport or could not move around to get to their workplace. However gradually the government provided work access permits for the continuity in the services. |
| **Community health services** | | | |
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Ministry of Health and Wellness<br><br>Ministry of Social Integration Social Security and National Solidarity | | The Ministry of Health and Wellness has Area and Community Health Centres which offer health services to old age patients in their respective catchment areas. Regular screening for NCD risk factors and health education is carried out by the Health Promotion Unit of the Ministry of Health and Wellness. Medical social workers cater to social and family problems in the elderly.<br><br>Medical Unit of ministry of social security provide domiciliary care to elderly 90 year and above and bedridden elderly 60 year and above on a monthly basis | |

14 SAMU are the Emergency Medical Services available for transport of urgent cases to hospital and for emergency care.

| Risk communication and community engagement | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| All government departments<br><br>National media<br><br>Civil society | All age groups, including older persons, were included in COVID-related education and outreach campaigns. These included production and distribution of flyers on how to use a mask correctly and barrier methods and mental health. In collaboration with the national TV channel, video clips were broadcast at peak hours to promote COVID 19 vaccination among the population and to encourage proper wearing of face masks and practice of regular hand washing and social distancing.<br><br>There was an operational hotline and radio programmes had been developed to keep the old people continuously informed about COVID-19.. | | |
| **Infection prevention and control** | | | |
| Ministry of Health and Wellness | Within LTCFs, sanitary kits containing towels, soap, sanitisers and masks were provided to inmates. They also received counselling on COVID-19 and the precautionary measures to be taken, accompanied by distribution of educational pamphlets. | | |

| Vaccine Roll out | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Ministry of Health and Wellness | The COVID-19 vaccination campaign was organized by the Ministry of Health and Wellness. Through this campaign, vaccines were available at several vaccination centres around the island, whereby the older persons could be vaccinated.<br><br>On January 26, Mauritius launched its COVID-19 vaccination program, with the first batch of 100.000 Indian-produced Oxford-AstraZeneca vaccines donated from the Government of India.<br><br>Carers of severely disabled and dependent persons were on the priority list to obtain their COVID-19 vaccines. | Older people have been included in the vaccine rollout and are on the priority list, ranking after the front-liners and people with co-morbidities There is dedicated morning slot for vaccinations reserved for people aged 60 and above.<br><br>Several vaccination sites are functional and older people have been informed about these venues through the press. The vaccination programme has been organised by the Ministry of Health and Wellness and a hotline is available for the public.<br><br>Community health workers were involved in reaching out to or registering older people for vaccinations. This age group was invited to attend the vaccination centre nearest to their place of residence and were registered, before the first dose was given. They were given an appointment for the second dose and reminders were sent to them for recall. A hotline for vaccination-related queries was in operation.<br><br>In collaboration with the Ministry of Health and Wellness, the Ministry of Social Security aimed to vaccinate the older residents of the Residential Care Homes against COVID-19. Hence, the crucial social and health needs of older people faced no interruption despite the pandemic. | Challenges included long queues for vaccination, access to sufficient amount of vaccines and sensitising this specific age group to the benefits of vaccination. Decentralising of vaccine centres has helped to address this challenge.<br><br>Only a small proportion of those vaccinated (4.5%) have been older people (see Table 10 in Section 4.2.1 of main report) as first priority has been given to tourism sector workers. |

| Long-term care provision for older people | | |
|---|---|---|
| **Entities** | **Activities specifically focused on older people** | **Challenges** |
| The Ministry of Social Integration, Social Security and National Solidarity<br><br>Ministry of Health and Wellness | There had been arrangements done at the level of the Ministry of Health and Wellness so that medicines were sent to the residences of older people. Telephone counselling had been made available.<br><br>Despite the limitations imposed by COVID-19, the Ministry of Social Integration, Social Security and National Solidarity has diligently worked its way to provide appropriate services and assistance to the older residents in need. In collaboration with officers of the Welfare and Elderly Persons' Protection Unit, and other departments of the Ministry, Officers remained on the field and at their disposal to provide help and support under strict sanitary measures. Cases of abuse were respectively dealt with through appropriate measures.<br><br>Rapid COVID-19 testing was done in 72 Residential Care Home (Charitable and Private Homes)<br>The Medical Unit is a department of the Ministry of Social Integration, Social Security and National Solidarity. This unit co-ordinates the provision of monthly Domiciliary Visits (DV) to bedridden and severely disabled older persons between 60 – 89 years and to all older people above 90 years. Despite COVID-19 pandemics in 2020 and in 2021, the Medical Unit continued to provide monthly DV to eligible older people, so that they were not deprived of their treatment. Medications are provided to these people in collaboration with the Ministry of Health, at the pharmacies in health centres and hospitals.<br><br>Carers of severely disabled and dependent persons were on the priority list to obtain their Work Access Permits during the sanitary curfew and to obtain their COVID-19 vaccines. | Movement was restricted and there was an inability to move out of homes due to lockdown and prohibited zones.<br><br>There had been some challenges caused by the pandemic for some specific homes in the reorganisation of specialised treatment in the private and public sector.<br>Provision of food and other necessities as well as dealing with increasing prices of products was a concern. |

### *Responses to the secondary impacts of COVID*

| Social services and social assistance | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Ministry of Social Integration, Social Security and National Solidarity.<br><br>NGOs | Social services and social aid were provided to all older persons by the Ministry of Social Integration, Social Security and National Solidarity.<br><br>The Ministry of Social Integration, Social Security and National Solidarity has a national programme to foster age-friendly environments, such a leisure centres and recreational centres.<br><br>Food packs were provided by civil society organisations. | Services such as payment of social benefits to the older persons have been maintained. Universal pension for the aged were given to the beneficiaries at homes in red zones so that the older people remained protected.<br><br>The Ministry of Social Integration, Social Security and National Solidarity has a data base for all persons aged above 60 years with their names and addresses, so reaching the elderly is not a challenge for the Government. The Ministry also works in close collaboration with the Senior Citizen Council which has a network of around 800 associations of older persons all around the island.<br><br>An older adult organization obtained a Work Access Permit to distribute food packs to a few deserving families. | |

# Examples of good practice

- The availability of a universal pension meant older people's livelihoods were secure throughout the pandemic.
- The registration of almost all older people on the universal social pension database made it easy to reach older people during the COVID-19 pandemic.
- Regular meetings were organised with the relevant departments within the Ministry for a continuous appraisal of any probable difficulties that older persons might have encountered, and discussions were held on how concerned officers would be required to proceed in resolving the matters.
- There was home delivery programme of old age pension to beneficiaries who have no bank accounts.
- Flu vaccine campaign continued in 2020 and 2021 seasons, even during lockdown with implementation of a door-to-door vaccination programme to protect the older people
- A mobile application, "beSafeMoris" was launched on March 26, allowing the Mauritian population to obtain real-time information about health and safety measures (Kowlessur et al., 2020).
- Healthcare systems ran smoothly and were not overwhelmed making access to health-care available to older persons.
- Inter-sectoral collaboration around ageing: The Ministry of Social Security chairs an Inter-sectoral Committee on promoting healthy ageing and organises several activities to promote health and wellbeing amongst the elderly, from activities to social outings.
- During the lockdown period while the general public was allowed to shop on some particular days and based on an alphabetical order system, an exception was made for the elderly to allow them to shop during a dedicated one-hour morning slot.. Limitations or challenges in response
- Mauritius was quick to roll-out its vaccination programme with 47.4% of Mauritians having received their first dose and 30.87% their second dose as of 14 July 2021, however older people were not prioritised. The government has kept records of vaccinations by age-group and although there is a backlog in data entry, District Health Information Data as of 14 July 2021 showed that almost 20% of people aged 60+ have received their first dose and 2.8% their second dose.

# 7.4 Mozambique case study

Mozambique has a total population of 30,888,034 with 1,349,936 persons (4.4%) aged 60 years and over. Mozambique is a low- income country, with a ranking on the Human Development Index of 181 with a score of 0.4. Absolute poverty is extremely high with an extreme poverty rate (those living under $1.90 per day) of 62.9, and there are significant levels of inequality with a GINI coefficient of 54. The country's health expenditure is 4.9 percent of Gross Domestic Product (GDP). See Tables in Annex 1 for more detailed demographic, health systems and economic data on Ghana and all 47 countries in the region.

## Level of support for healthy ageing at the country level

- There are a number of policies, instruments and programmes in place to protect the rights of older people in Mozambique, such as the National Policy of Older People, the Programa de Subsido Social Basico (PSSB) or Basic Social Subsidy Programme, the National Plan of Ageing Issues 2015-2019 and the draft Law on the Promotion and Protection of Older People's Rights (HelpAge International, n.d.).
- The (PSSB) is awarded to households including older women over the age of 55 and men over 60 years and is equivalent to between $20 and $50, with the amount varying according to the size of the household. According to HelpAge 24% of older persons are covered by this cash transfer.
- An able-bodied household member from a household containing older is also eligible to participate in the labour-intensive public work programme Programa De Acção Social Produtiva (PASP).
- Health services and medications for older people are free per law (HelpAge International, n.d.).
- A basic package of health services for older people was approved in 2020.
- However, research conducted by HelpAge highlighted possible failures by the State to take all appropriate measures to protect and promote the rights of older people. Older women and men reported that discrimination based on their age was a regular and common experience in their lives. Older persons reported that high levels of violence and abuse occurred regularly with little access for this to be addressed. They also reported considerable levels of neglect in social care and support and being treated in a degrading or humiliating way because of their age (HelpAge International, n.d.).
- The proposed National Strategy for Mandatory Social Security (ENSSO) 2019-2024 (yet to be approved) aims to enforce employees' and employers' contributory obligations and extend the coverage of the contributory subsystem to self-employed workers. Meanwhile, the National Strategy for Basic Social Security (ENSSB) 2016-2024, aims to expand the coverage of the non-contributory subsystem to more than one million elderly until 2024.However, according to population projections, 10% of the elderly will remain without any coverage, even if the targets approved by the ENSSB 2016-2024 are met (Castel-Branco and Andres, 2019).
- Generally health services are geared at communicable disease, pregnant women and children.
- According to a representative from the Ministry of Gender, Child and Social Action, very few older people have access to basic social services, due to distance, unclear eligibility criteria for registration in social protection programmes and lack of money.
- Ageism and traditional beliefs about the involvement of older people witchcraft are particularly harmful to older people's inclusion in communities.

## COVID-19 pandemic in Mozambique

- The first case of COVID-19 infection in Mozambique was reported on March 22, 2020 (World Health Organisation, 2020i). A level 3 lockdown was put in place from March 30, 2020 which was extended until September 30. Initially the stringency of this lockdown was relatively low (56.4) compared to other countries in the region, but increased to 75 during the first major wave of infections.
- As of May 27, Mozambique has had 70,673 confirmed COVID-19 cases and 834 confirmed deaths. A total of 69,227 individuals have recovered from the disease.

## Impact of COVID-19 on older people in Mozambique

Food security was a major issue and due to the remain-at-home policy people could not access their crops, fetch daily water or attend markets to sell their food.

A large portion of older people have care responsibilities, which were increased when schools closed, or are responsible for providing food and shelter, which put significant pressure on them during the COVID-19 pandemic (HelpAge International, 2020d).

Getting sick with COVID-19 or from any other condition or illness is a major worry for older people given the inaccessibility of services.

Many people who rely on chronic medication need to travel to collect it or require someone to deliver it to them.

Restrictions on travel and reduced access to public transport has directly affected access to medicines. For example, the medication delivery service by community health personnel for people living with HIV and AIDS was cancelled by the Health Department. In addition, medicine supply chains, which were already weak, have been further disrupted due to interruptions in international trade as a result of border closures and international travel bans.

Increased inter-generational conflict due to stay-at-home orders and decreased capacity of older people to contribute to households financially.

Older persons were exposed to psychological violence, and verbal and emotional abuse. The term “social distancing” resulted in damaged communications between the members of family and older persons (Interview, Older Persons Organisation, May 2021).

Older people could not access churches which are an important place of spiritual and social support.

# Responses to Covid-19 supporting older persons

The following examples of responses targeted at or specifically focused on older people by government and other stakeholders that were identified via interviews, media or literature are tabulated below – these examples are of national-level interventions unless a specific region is identified.

# Coordination of response

WHO and HelpAge International collaborated with the Ministry of Health to provided guidelines for care. Stakeholder consultation was not conducted in developing emergency response due to short time-frames in preparing the response.

## *Response to primary impacts of COVID-19*

| Case management | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Ministry of Health<br><br>Department of Medical Assistance | When hospitals were overwhelmed, the distribution of resources were as follows: 1) Priority was given to referred patients from other Health Units already diagnosed as COVID 19 positive who were considered to be at risk. 2) Infected people who were 60+ years with chronic diseases. 3) Patients in need of oxygen and intubation.<br><br>With support from WHO, the Ministry of Health elaborated a flow chart of actions for older person's homes and trained respective workers to implement this.<br><br>Hospitals were transformed into emergency points. Non-COVID related acute conditions were assisted if and when there was an emergency. For further follow up appointments, they were referred to larger hospitals for appropriate exams. For patients considered clinically well, they were assisted and supplied with 3 months' worth of medicines and returned to their homes.<br><br>The Hospital was equipped with considered emergency materials. This includes protection materials for health professionals and patients and staff were updated constantly with the developments and there was Covid training. | There has been criteria for admission into hospital and for ventilation or oxygen such as:<br>a) Low Saturation<br>b) Difficulties in breading<br>c) Age: Older people considered as priority and especially those with other chronic diseases.<br><br>There is an evaluation of the patients to understand their need for oxygen in terms of quantity for better allocation.<br><br>Health Units only refer patients when they were acute and people who were 60+ years. Polana Caniço Hospital was informed of these requirements and was providing the transport and appropriate staff to collect the patients. | Limited oxygen availability was a challenge for all patients in respiratory distress, resulting in inadequate care.<br><br>There was a lack of specialised staff available to manage COVID-19 patients, which challenged the health system to cover all people in need of health services especially older persons.<br><br>There was a lack of human resources to assist older persons and those specialized in older person's health. Mozambique country has only 6 geriatricians. Normally older persons are assisted by general practitioners.<br><br>There was a lack of appropriate equipment's for patients with COVID 19, which combined with the chronic diseases and weaker immunity in old age, led to poor outcomes for older people.<br><br>There was no clear information on ways of accessing medical assistance when infected. |

| Maintaining Essential Health Services | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Ministry of Health | People with chronic diseases were encouraged to visit hospitals and collect the medicines for longer periods (3 to 6 months) as per doctor prescription. | Some actions were taken such as prioritizing of older persons who attended health units. Psychologists were provided for those who were admitted who were displaying emotional issues.<br><br>Although no health centre in the areas surveyed had been closed completely as a result of COVID-19, normal consultations were halted, and only emergency services were available. Consultations once re-opened only saw 10 patients per day.<br><br>One factor that was implemented was that older persons did not have stand in queues at hospitals and they had priority in attendance. | Health staff and other health system resources were allocated to COVID-19, reducing health capacity and responsiveness in some areas.<br><br>According to research conducted by HelpAge, 23% of older people confirmed that their access to health services has reduced, 10% did not have access even before the pandemic and 39% of those who need medicines for chronic conditions reported being unable to access them. Additionally, 73% of older people did not know where to get a test or treatment for COVID-19. After being informed of their nearest facility, 76% said they were unable to access it anyway (HelpAge International, 2020d).<br><br>Only 40% of older people have been able to access their medication since the COVID-19 outbreak began. Slightly more older people with disabilities (50%) and older people aged 50-59 (60%) have been able to access the medication they need. Only 35% of the 80+ age group, and 28% of those in Maputo have access to medication (HelpAge International, 2020d).<br><br>Transport expenses to reach facilities were also significant and, together with the cost of the services themselves, the expense of receiving healthcare was a significant barrier.<br>Older people therefore often had the dilemma of weighing up their need for health services against other household needs, particularly those of their grandchildren (HelpAge International, 2017).<br>There was no specific programmes or treatment methods for prioritising older persons in the hospitals due to luck of geriatrics doctors nor where there age-friendly services. One point has been observed is that older persons do not stand in queues and receive.  priority in attendance. |
| National Institute of Social Action | Conducted COVID-19 screening<br><br>Facilitated transportation and referrals to the central hospital for all health issues<br><br>Carried out education campaigns on COVID-19 and NCD prevention | Through the health activists CHWs were able to evaluate older patients and refer them for screening. These activists were formed by the Ministry of Health with sponsorship of various partners. In Sofala the message came through community leaders. Initially older people were afraid to go to the Heath Units because they had to be infected. | There were difficulties in the process due to limited resources (Human, financial, equipment) to reach all communities. There was no clear guideline for CHWs at the community level to enable older people easily access COVID related services. |

| Risk communication and community engagement | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| ***Health Promotion Department***<br><br>***National Institute of Disaster Management***<br><br>***Ministry of Gender, Children and Social Action***<br><br>***HelpAge International***<br><br>***WHO*** | With support from DPROS, IEC materials were produced - Leaflets, messages in local languages and spread Nationally, Provincial and District levels. The was a development of educational messages which also appeared on TV and radio. Materials were distributed at a National level where each province translated these into local languages and adjusted them to the local realities. Media personnel and journalists were trained to transmit the correct prevention messages to help make people understand the disease.<br><br>There was collaboration with Ministry of Gender children and Social Action at local level for dissemination of prevention messages.<br><br>Social action community workers together with community health activists engaged in spreading educative messages to the communities, providing demonstrations of how to wash hands, cough etiquette, and handing out of masks and leaflets in some areas. | There was an elaboration of the strategy in health communication for groups at risk in general where older persons were included.<br><br>For people living with chronic diseases, preventive messages had to be adapted to encourage older people who were fearful of COVID-19 infection to resume visiting healthcare facilities.<br><br>In Sofala, solar radios were distributed by HelpAge for the old people to hear news of national stations and community on COVID19, provision of psychosocial support.<br><br>HelpAge international and WHO helped to develop IEC materials appropriate to older people. | The terminology “stay Home” on preventive messages, meant that older persons with chronic diseases stopped collecting their medication, thus government had to change the message and encouraged people to continue visiting their doctors to access necessary prescriptions and medicines. The challenge was to make people with chronic diseases return for the services.<br><br>Additionally, there were barriers to older persons receiving information. A HelpAge needs assessment showed that 29% of older people faced barriers to accessing information, with people over 80 and with disabilities reporting the greatest difficulties. Barriers included: language, illiteracy, or inaccessibility of materials and messages for people with sensory impairments (HelpAge International, 2020d). Several older people mentioned washing hands with ash, a traditional practice used when soap was unavailable. Furthermore, practices such as social distancing and avoiding group gatherings seem to be less well known, with only 43% and 46% of people mentioning these measures. |
| **Infection prevention and control** | | | |
| International Labour Organisation<br><br>National Institute for Social Action | In Manica, the government made buckets, soap and water available.<br><br>Delivered soaps and masks to communities | Early on in the pandemic, the National Institute for Economic Activities carried out an inspection of pharmacies and several were fined for charging speculative prices (up to 300% above the recommended price) for face masks, gloves, hand sanitiser, vitamin C, and even paracetamol.<br><br>In most provinces, an average of 16% of older people received donated equipment such as masks (HelpAge International, 2020d). | Research conducted by HelpAge showed that older people struggled to comply with IPC measures due to lack of WASH facilities or inability to access these facilities because of lock-down. Respondents also commented that it was difficult to keep the required 2 metres distance from others at home due to having small houses and/or large families (HelpAge International, 2020d).<br><br>Access to masks and using them correctly were also challenging for people living in poverty and in rural areas. There was resistance in using masks among older person as they said that it was difficult them to breath. |

| Vaccine Roll out | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Ministry of Health<br><br>National Institute of Social Action<br><br>Community leaders | Community leaders and community health workers and activists carried out vaccination campaigns in communities.<br><br>Mobile brigades were used to vaccinate older people. | People age 60+ were considered in the second vaccine roll-out<br><br>People in old age homes in Maputo were vaccinated in the first phase of the vaccine rollout. | Roll-out was slow and the government initially relied on donations of vaccines from China and India.<br><br>In the beginning there was resistance to vaccination by older people, with door-by-door mobilization done in collaboration with community workers demand was increased. |
| **Long-term care provision for older people** | | | |
| Long-term care facilities<br><br>WHO<br><br>Households | Older persons were left without the capacity to go to external consultations, because of the restriction of movement with the nursing homes having to close their doors to the outside world. These institutions where in some cases they had lost their sources of funding, did receive additional support from churches and individual donors.<br><br>WHO provided support in creating a flowchart of actions for older people's homes and training health and care workers. | | There were shortages of medicine's available for older people with the chronic diseases.<br><br>Older persons' organisations were not able to function effectively or run activities due to restrictions and funding pressures brought about by COVID-19. |

## *Responses to the secondary impacts of COVID*

- The COVID-19 Social Protection Response Plan was approved in June 2020. This plan aims to contribute to the mitigation of the negative socioeconomic impacts that Mozambique's most vulnerable populations are facing which includes older populations by guaranteeing income security for those that are most affected by the pandemic.

- Furthermore, the plan aims to expand coverage to more areas of the country by adjusting the existing programmes. There was a dissemination of the plan through media, debates, with massive involvement of the provincial, district and community levels. There is no specific strategy for older persons, but for a group of people in vulnerability where older people are included [15].

15 (Interview Ministry of Gender Child and Social Action, 2021)

| Social services and social assistance | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Ministry of Gender, Child and Social Action<br><br>Social Action National Institute<br><br>Older person's organisations | Existing National Institute of Social Action beneficiaries received an additional three-month benefit payment in 2020 (de Lima Vieira et al., 2020).<br><br>There was an adjustment of the current social protection programmes to assist households. Food subsidy payments were made three months in advance.<br>An established Covid-19 response emergency programme for 1,102,125 households was implemented for those in vulnerable situations. The programme aimed to pay in one instalment equivalent to USD 27.00 to each household. There was no desegregation in age or gender in this number, but beneficiaries of the food subsidy programme consisted of 89% older persons *(Ministry of Gender Child and Social Action interviewee, 2021)*<br><br>Individual donations came from some enterprises in Nampula which helped to provide access to facial masks. | Very few older people (2%) reported accessing COVID-19 related government or humanitarian assistance, although many older people do receive the PSSB.<br><br>Cash transfers are common in the communities and reach 34% of older people surveyed in communities (HelpAge International, 2020d). In some communities, water was brought to older people and food was shared.<br><br>Older person's organisations trained community monitors and community workers to do door-to-door mobilisation and to provide psychosocial support. | Patchy coverage of the social protection system in the country, which has been rolled out to tackle provincial or district poverty levels but does not sufficiently recognise the depth of poverty inequality in communities.<br><br>Challenges related to the Covid-19 response programme were 1) communication where the access of money was communicated through cell phones allocated by the programme. Many older people are mobile phone illiterate resulting in many not being able to read the messages; and network service providers had limited services to offer to all beneficiaries. 2) There was no communication plan to guide COVID 19 response plan that was transparent and easy to understand for the beneficiaries and population in general.<br><br>The fact that this response plan was implemented in the urban zones, resulted in it not covering all the population in need especially in the rural areas. The project had started late December 2020 and it was reported that funds unavailable to proceed into the 2nd phase. |

## Examples of good practice

- Community monitors and community workers were trained and used for door-to-door mobilization and psychosocial support. The distribution of hygiene ´materials were provided for older persons in some areas.
- In coordination with Health Unit activists CHWs facilitated transportation and referrals to the Central hospital (Interview, CHW, May 2021).
- Education was provided by the Ministry for CHWs on palliative care, chronic conditions and preventions measures for Covid-19

## Challenges and limitations of the response

Lack of consultation with civil society in designing the response, although stakeholders such as older persons organisations were involved in fieldwork to promote inclusion of older people in the social response to COVID-19.

Older people were not able to provide adequate support to older people or reach their families due to communication challenges brough about by COVID-19, this made it difficult to prevent or deal with abuse and neglect of older people or to support people with health services and food.

Mozambique has mounted its response to COVID-19 whilst grappling with growing armed conflict in the north of the country and attempting to recover from the devastation caused by Cyclone Idai in March 2019. It was estimated that more than 300,000 people were internally displaced as a result of conflict and climate emergency with approximately 2.5 million in need of humanitarian assistance (HelpAge International, 2020d).

COVID-19 testing and treatment centres within Mozambique are limited and difficult to access and processes for testing and treatment were poorly understood, especially for those in remote rural such as Gaza and Tete (HelpAge International, 2020d).

Additionally, water sources are now more difficult to access due to the introduction of scheduled times for each family to access to the local water source and COVID-19 preventive measures for people and their equipment, to ensure the safety of the water point. This makes this access more difficult, especially for older people (HelpAge International, 2020d).

# 7.5 Senegal case study

Senegal, in West Africa, has a total population of 16 million with 830 017 persons (5.2%) aged 60 years and over. The country's health expenditure is 4.1 percent of Gross Domestic Product (GDP). See Tables in Annex 1 for more detailed demographic, health systems and economic data on Ghana and all 47 countries in the region.

## Level of support for health ageing at the country level

- Senegal has a Strategic Plan for Healthy ageing 2018-2022, developed with the support of WHO. Among this plan's objectives are the improvement of health, and the empowerment, promotion, and valorisation of older persons.
- According to the International Labour Organisation (ILO World Social Protection Report 2020), 23.5 per cent of the older population receives a contributory pension and no non-contributory, or social, pension is available.
- Senegal implemented free Health Care through the SESAME plan, which provides free health care to older persons and has now become part of the Universal Health Coverage. However, this plan has limitations:
    - Weak financing and management methods.
    - The plan is only operational at regional hospitals.
    - The plan does not ensure availability of certain treatments and medicines.
    - Age friendly health care:
        - Efforts to reduce waiting time for older patients through prioritising them for attention.
        - Part of a strategic plan for healthy ageing is a recommendation that hospitals are built adapted to the needs of older patients.
        - Implementation has been slow.
        - Hospitals have not yet been adapted to older patients' needs, but efforts are under way.
        - A lack or shortage of adequate medical equipment: bedside chairs, medical beds, personal chairs for dependent persons.
        - No support for older patients in the toilets and corridors, no space to walk around and non-adapted medical equipment.
- Department of Social Action (Ministry) programme: "Elderly Support Program (Project d'Appui à la Promotion des Aînés) (PAPA)" aims to empower older persons through creation of income-generating activities and contributes importantly to the successful ageing process.

## COVID-19 pandemic in Senegal

The first case of COVID-19 infection in Senegal was reported on March 2, 2020. The country was in 2019 ranked as Level 3 (≤70%) on the Capacity Preparedness Index and Operational Readiness Index (using 18 different indicators from the International Health Regulations (IHR) State Party Self-

Assessment Annual Report (SPAR), level 1 is ≤30% and Level 5 is >90%.)

As is the trend globally, case fatality from COVID-19 infection is highest in the older population. According to data provided by the WHO African region Epidemiological team, the Case Fatality Ratio (CFR) in Senegal has been 2% in those aged ≥ 60 years, compared to 0.2% in persons younger than 60 years.

Senegal used its experience in dealing with the Ebola outbreak in its COVID-19 response. Senegal is reported to have responded efficiently to the pandemic, with a score of 90.1 on the COVID -19 Global Policy response. The country is ranked second in the world, after New Zealand (Shesgreen, 2020). In a survey conducted by IPSOS, the overwhelming majority of Senegalese people supported the government response (89%) and supported measures taken to restrict spread of the disease (Ipsos, n.d.).

## Impact of COVID-19 on older people

**Interviews with older persons organisations indicate that the pandemic has greatly disrupted health and social service provision to older people and has interrupted activities for active older people who have struggled with confinement brought about by the need to protect themselves from COVID-19 infection.**

> *During the first wave, the pandemic led to a decrease in hospital visits by patients living at home for fear of the disease. For many elderly people, their state of health deteriorated due to an imbalance in their comorbidities. Thanks to a good communication on the respect of good measures and the necessity to follow up appointments, the influx of patients has resumed at the hospitals. (Interview, Older persons organisation 1)*
> *Even before the crisis, life was very difficult for the elderly, who had no social or economic assistance, and even the "Sesame plan" for free care for the elderly was only available at the regional hospital, not in other health facilities. So you can imagine that in times of pandemic, access to health services is more difficult for the elderly and what little activity there was is slowing down or coming to a halt. . The reduction or cessation of our activities leaves us without resources and no specific help is given to us…Poverty was even more marked among the elderly, and the armed conflict did not help the situation at all since activities such as farming could no longer be carried out. (Interview, older persons' organisation 2)*

In the absence of government-funded long-term care services, older people rely heavily on older person's organisations for support. These activities have been particularly affected by the pandemic, with significant consequences for wellbeing of older people:

> *The interruption of our services has been very hard on the elderly, especially on a socio-economic level. In Senegal, most elderly people are heads of households (more than 50%). Faced with the decrease in aid linked to our activities, the massive unemployment of young people and the awareness campaigns recommending the confinement of the elderly, most of them found themselves without resources to take care of their families, thus creating a social malaise that is sometimes profound within the family. (Interview, Older Persons' Organisation 1)*

> *If the pandemic continues, it will considerably affect our activities, which will result in the persistence and even the aggravation of socio-economic and health problems of the elderly: increase in morbidity and mortality linked to difficulties in accessing care, increase in poverty and disruption of the social network. Interview, older persons organisation. (Interview, Older Persons Organisation 2)*

# Responses to COVID -19 supporting older persons

The following examples of responses targeted at or specifically focused on older people by government and other stakeholders that were identified via interviews, media or literature are tabulated below – these examples are of national-level interventions unless a specific region is identified.

## *Coordination of response*

The COVID-19 response was coordinated by the National Epidemic Management Committee (NEMC) (regional and departmental committees). A coordinating body for the response to COVID of all government sectors, civil society, and the private sector. Older persons organisations were not involved in developing or commenting on any of the government response strategies, but have collaborated with the Ministry of Health and Social Action on risk communication and vaccination campaigns.

## *Response to primary impacts of COVID-19*

| **Case management** | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Office for Older Persons at the Ministry of Health and Social Action | Opened COVID 19 treatment centres throughout the country.<br><br>Training of staff at the centres in geriatric care.<br><br>Set up of community mobile units for early detection, care, and follow-up of cases at home Home-based management integrating specificity of older person called PECADOM strategy.<br><br>Developed a decision algorithm for home or hospital management depending on case severity | The NEMC works collaboratively with the University Hospital Geriatric Service of Fann and the National Council of the Elderly to identify needs of older persons. | Shortage of hospital beds, resuscitation beds and oxygen noted during the period of high community transmission.<br><br>Decrease in hospital visits by patients living at home for fear of the disease.<br><br>State of health deteriorated due to poorly managed chronic comorbidities.<br><br>*Note: With improved communication regarding infection protection measures and the need for follow-up appointments, the influx of patients at hospitals resumed* |
| National Emergency Medical Service (SAMU)<br><br>Hospital has a Head of Department of COVID -19 Treatment Centre | Regulating and transferring cases to various treatment centres depending on availability of places | Availability of oxygen and 12 resuscitation beds. Criterion for administering oxygen to patients is a SaO2 desaturation of less than 95%, **regardless of age.** The resuscitator determines when to administer oxygen.<br><br>Criteria for administration of oxygen based on clinical signs of respiratory distress and desaturation. **Advanced age is a priority criterion.** | Hospitalisation for COVID infection in older patients is at 36%. (968/2687)<br><br>Death rate of older patients of 16% (154/968), compared to 7% for the total population (190/2687)<br><br>*Note: A shortage of oxygen and resuscitation beds during the period of high transmission* |

| | | | |
|---|---|---|---|
| Hospital care team (infectious diseases physicians, resuscitators, general practitioners, nurses, care assistants, etc.) | The health team provides hospital care, but a caregiver (family member) is permitted to be at the bedside. Caregivers are tested for COVID -19 on entry and exit. They follow good practice (mask, gown, hygiene) and are monitored regularly.<br>Palliative care provided even at the height of the pandemic. Care taken of pain and other signs of suffering, including psychological suffering, Doctors prescribe treatments (analgesic, antibiotic, oxygen) | A multidisciplinary team in the COVID unit follows up with each patient. Each patient is assigned a paramedical carer and a family carer is permitted at the bedside | |
| Family caregivers | Family caregivers are encouraged to assist functionally dependent older patients with hygiene, food, and passive mobilization. | Presence of a caregiver is reassuring to an older patient and continuing relationship with family is facilitated. | |

**Maintaining Essential Health Services**

| Entities | Activities inclusive of older people | Activities specifically focused on older people | Challenges |
|---|---|---|---|
| Ministry of Health and Social Action | Policies, plans and mechanisms to maintain essential health services<br>• The essential health service package is to be maintained but no additional funding was allocated for the services.<br>• Senegal had no essential health service package prior to COVID -19 pandemic.<br><br>Strategies to mitigate essential health service disruptions<br>• Recruitment of additional staff.<br>• Provision of home-based care where appropriate.<br><br>There is monitoring of continuity of essential health services by:<br>• Collecting and collating data on COVID -19 and comorbidities but there has been no addressing of infodemic and health misinformation.<br>• Monitoring of implementation of mitigating strategies | Existing networks such as NGOs were used to reach out to vulnerable groups such as older people was used as a mitigation strategy. | Routine scheduled visits were somewhat disrupted (5-25%), as were visits for undifferentiated symptoms and prescription renewal s for chronic medications (5-25%)<br><br>Management of all non-communicable diseases were disrupted (5-25%)<br><br>Emergency unit services were limited, but access to the rest of service delivery platform (outpatient and inpatient, community-based care, mobile clinics, pre-hospital emergency care) services was normal |
| Mobile Team Community Health Services Team | Following the recommendations of the National Centre for Epidemic Management, simple cases of COVID -19 in non-frail older persons are followed up at home by a mobile team to ensure management (control of medication) and follow-up (visits and telephone) at home | Home visits are a specific programme of care for older persons, during which they are interviewed, examined, monitored for medication, educated, and followed up.<br><br>Home visits are an additional opportunity to raise awareness among older persons and their family. | |

| | | | |
|---|---|---|---|
| Community Health Workers (CHWs) | Conduct home visits. An opportunity to screen, advise, refer, and facilitate access to acute and chronic care for older patients | Specific to the pandemic, facilitated for older persons through provision of support for hospital or home care.<br><br>A mobile team facilitates access to COVID services if hospitalisation is indicated. If places are limited, older patients are prioritised | CHWs have not been trained in health care for older persons, and neither provide palliative care or other care in the context of COVID. The care is carried out by doctors and nurses. CHWs only detect, raise awareness, and refer. |
| **Risk communication and community engagement** | | | |
| Older persons organisations | Raising awareness through the media and door-to-door campaigns on hygiene measures and good practices, and the registration and implementation of vaccination | COVID 19 awareness campaigns. Some TV and radio channels offer dedicated time slots to reach older persons. Themes addressed are awareness of hygiene, hand washing, use of sanitiser, wearing of masks and encouragement of young people to protect older people by protecting themselves<br><br>#AarSunuMaakYi #Shield3age campaign run by Action Solidaire International aimed at raising awareness around the vulnerability of older people and the importance of practising social distancing to protect them | |
| **Infection prevention and control** | | | |
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Healthcare facilities<br><br>Community health workers<br><br>NPOs | For non- COVID -19 related acute or chronic health conditions. In these hospital wards, prevention and screening measures for patients and health staff are in place: mandatory wearing of masks, hand washing, sanitising, systematic temperature taking, social distancing of one metre in waiting rooms and offices, and staff rotation. | | |

| Vaccine Roll out | | | |
|---|---|---|---|
| National vaccination coordinator | Organised programme to register persons for vaccination.<br><br>Registered older persons are contacted by short message, phone service or by a phone call to set an appointment.<br><br>Registration is done through a digital platform. Older persons unable to access the platform are assisted with registration at service centres.<br><br>Associations of older persons have played an important role in raising awareness, having good mapping of members.<br><br>Mobilisation of members to register at centres and awareness raising through local campaigns, door-to-door and through the media | Persons aged 60 years and over have been priority target for vaccination after health care workers, before expanding to other target groups. | Difficulties in registration for those without access to digital technology.<br><br>Rejection of vaccination by some. Hesitancy to be vaccinated. Doubts and fears regarding the reliability of the vaccine. Fear the vaccine was developed too quickly. Fears following adverse events reported in some countries. |

| Long-term care provision for older people | | |
|---|---|---|
| **Entities** | **Activities specifically focused on older people** | **Challenges** |
| Households | Long-term care is mainly provided by family.<br><br>Existing health structures are not adapted to provide care for older persons (no geriatric service). Access to care remains difficult | No long-term care facilities in Senegal<br><br>Neglect, in the case of COVID -19 infection, is typically detected only post-mortem |

## *Responses to the secondary impacts of COVID*

| Social services and social assistance | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Director of Protection and Promotion of Vulnerable Groups (collaborates with other state social services and a partner (UNICEF)) | Prior to the pandemic, 50% of older persons were household heads.<br><br>Their main challenge was food insecurity due to lack of financial resources. | Distribution of foodstuffs (rice, sugar, oil) and protective equipment (sanitiser, mask, and soap) | Although social services remain available during the pandemic, there is limited staff and a decrease in access through fear of contracting the disease |
| Department of Social Action (Ministry) "Elderly Support Program (Project d'Appui à la Promotion des Aînés) (PAPA)" | Aims to empower older persons through creation of income-generating activities. | Plays an important role in the process of successful aging | Functioning of this programme was disrupted due to lockdown requirements. |

| | | | |
|---|---|---|---|
| National Council of Elders (federation of associations of the elderly) collaborates at national level with the Network of Multi-Actor for Social Protection (REMAPS) for access to basic social services (a platform of several organizations working in synergy for inclusive social protection for all) | Intergenerational programmes<br>Health education programmes<br>At international level, is part of the International Federation of the Elderly | COVID 19 awareness campaigns. Some TV and radio channels offer dedicated time slots to reach older persons. Themes addressed are awareness of hygiene, hand washing, use of sanitiser, wearing of masks and encouragement of young people to protect older people by protecting themselves. | All these activities have been disrupted by the COVID 19 pandemic.<br><br>Associations of elderly have not received government funding for support of COVID -19 related activities,<br><br>Other than food aid, no other support has been provided to older people during the pandemic. NGOs have provided hygiene and protection equipment.<br><br>Lack of support has impacted negatively on the welfare of older people, aggravating socio-economic and health problems. Increase in morbidity and mortality linked to difficulties in accessing care. Increase in poverty and disruption of the social network.<br><br>Decreased links to social service activities. Massive unemployment of the youth.<br><br>Awareness campaigns recommend confinement of older persons, the majority without resources to care for family.<br><br>Mediation with stakeholders to end conflict between the Government of Senegal and the Movement of Democratic Forces of Casamance (MFDC) has stalled.<br><br>Older persons in Ziguinchor report feeling forgotten by politicians, continuing to experience difficulty in accessing health care. Poverty more marked among older persons than other age groups. Armed conflict continues to impact activities such as farming |

## Efficacy of the responses

Senegal has well organised COVID -19 management teams at all levels to respond to the impact of COVID -19, from the level of Government down to community level, through non-governmental organisations, and older persons and their family.

Two-thirds of people reported receiving food aid from government, the highest proportion across all African Union countries surveyed in the Partnership for Evidence-Based Response to COVID-19 (PERC) survey (PERC, n.d.).

## *Challenges and limitations of the response*

Despite the efforts made through the multiple response strategies, gaps remain in ensuring older persons are fully supported during and after the pandemic, as are indicated as challenges in the fourth column in the tables above.

Key among these challenges, across the responses of all the entities, are infrastructure not being adapted to the needs of older persons, and a lack of equipment and skills training in care for older persons for health workers at all levels in health and social systems. Strategic plans and policies to enhance the well-being of older people are slow to implement.

Despite efforts to maintain health systems continuity, Partnership for Evidence-Based Response to COVID-19 (PERC) reported significant health interruptions, especially during early lockdowns in the pandemic: 22% of respondents who needed medical care had difficulty accessing health care visits or medicines (37%) and those with chronic health issues (many or which are likely to be older) were particularly affected (PERC, n.d.)

Other gaps, and thus challenges, include:

- The free health care SESAME plan is not fully operationalised and therefore does not cover the majority of the older population whom it is meant to support.
- The external environment both external and within health care facilities is not age friendly and is a barrier to access to health and social services.
- Associations of older persons are not involved in decision-making process, nor were they given the opportunity to provide input into strategic plans to fight COVID-19.
- Non-governmental organisations that support and render services close to the people are not adequately supported by internal structures within government. As has been demonstrated during the pandemic, interruption of these services has a direct impact on the well-being and quality of life of older persons.
- A lack of formal long-term care exposes poorly supported dependent older persons to abuse and neglect.
- Poor representation of the older person on decision making bodies for issues that affect older persons.

# 7.6 Rwanda case study

Rwanda has a total population of 12.9 million with 596 813 persons (4.6%) aged 60 years and over. The country's health expenditure is 6.6 percent of Gross Domestic Product (GDP). Rwanda is classified as a low-income country and has a Human Development Index (composite index of life expectancy, education, and per capita income) ranking of 160 of 189 with a score of 0.543 (low). Absolute poverty is high with an extreme poverty rate (those living under $1.90 per day) of 55.5 and has a GINI coefficient (a measure of degree of inequality) of 43.7 (2016). Using the Universal Health Measures of Service Coverage and Out of Pocket Payments for 2017, the country is classified as Category 2 that is has low service coverage (<50%) and low out of pocket payments (0-40%) Their health system capacity coverage of essential health services is 57 percent. See Tables in Annex 1 for more detailed demographic, health systems and economic data on Ghana and all 47 countries in the region.

## Level of support for health ageing at the country level

Rwanda's draft policy for older people has been developed by the Ministry of Local Government with consultation and participation of different stakeholders, namely relevant ministries, agencies, Local Government Authorities, Civil Society Organizations and Faith Based Organizations. However, the policy is still awaiting passage into law. There is no policy for age friendly environments.

## COVID-19 pandemic in Rwanda

The first confirmed case was reported on March 14, 2020. The government implemented a range of containment measures in response to the pandemic including border closure, suspension of domestic travel, cancellation of public gatherings, institution of teleworking, closure of schools, places of worship and non-essential businesses, and mandatory wearing of face masks. Indeed, the Government Stringent index (stringent lockdown measures) was 90.74. Rwanda had one of the highest containment and health index of 85.12, second only to Mauritius.

The country was in 2019 ranked as Level 3 (≤70%) on the Capacity Preparedness Index and Operational Readiness Index (using 18 different indicators from the International Health Regulations (IHR) State Party Self-Assessment Annual Report (SPAR), level 1 is ≤30% and Level 5 is >90%.) According to data provided by the WHO African region Epidemiological team, in Rwanda has been3.8% infection rate in those age 60 years and older but a Case Fatality Ratio (CFR) of 8.2% in those aged ≥ 60 years, compared to 0.3% in persons younger than 60 years

# Impact of COVID-19 on older people

Interviews with stakeholders in the fields of health, social development and ageing showed the following impacts on older people in Rwanda:

- In the absence of social pensions for older people, labour market participation among older people in Rwanda is high and older people's income and food security, which was already tenuous, was further affected by the pandemic. This is supported by the findings of the HelpAge International Rapid Needs Assessment which found that 88% of people had to reduce the quality and quantity of food they consumed. (HelpAge International and Nsindagiza Organization, 2020)
- During periods of lockdown people have struggled to access basic goods and services, including access to health services, with HelpAge International reporting that women have had greater difficulties in accessing these services than men (e.g. 66% of women reported struggling to access food). (HelpAge International and Nsindagiza Organization, 2020)
- Family caregivers and financial providers lost their jobs or experienced reduced income, which had implications for the care that could be provided to older people and resulted in a reduction in remittances to older people.
- Older people believed they were the target of the pandemic and high levels of fear were present in the population.
- No abuse of older people was reported in interviews, but limitation in movement reduced family support to older people. HelpAge international reported anecdotal reports of ageism in terms of de-prioritisation (for example in receiving medicine) and financial abuse by family members.
- Older people experienced loneliness and isolation, with negative impacts on their wellbeing.

# Responses to COVID-19 supporting older persons

## *Response to primary impacts of COVID-19*

| Case management | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Ministry of Local Government<br><br>The Ministry of Health (Rwanda Biomedical Centre (implementing department))<br><br>Ministry of Local Government at community level | Country's COVID-19 response: meetings at all levels involve Ministry of Health representatives and Ministry of Local Government representatives.<br><br>Rwanda has designated hospitals for COVID -19 patient management. A coordinating doctor receives SMS or WhatsApp message on the patient. Management decision are made by the doctor based on clinical status. There is no policy decision based on age.<br><br>COVID -19 Hospitals were not overwhelmed as COVID 19 case management was decentralised. Patients could be transferred to other hospitals. Had a system for rapid assessment and discharge of patients.<br><br>The Rwanda Joint Task Force for COVID-19 served as a robust platform where the projections of cases and planning were taking place on daily basis, and the leaders would timely decide on where to allocate more resources and the content of extra support needed (staff, space, beds, PPEs, medications etc.)<br><br>Multi-disciplinary patient management: The goals of care are always discussed with patients' families, and the decision to do invasive therapies such as e mechanical ventilation are taken in full consultation with the patients' family.<br><br>Palliative care was provided. | The Rwandan Biomedical Centre (RBC) launched free COVID-19 tests in the capital city Kigali on the elderly people aged 70 years and above and those with chronic diseases to ascertain the COVID-19 transmission among them (Zinhua, 2021). | Diminished support services from volunteers as only health care professionals could travel during lock down and curfew.<br><br>Hospitals turned into a COVID 19 treatment centre, only COVID 19 patients were treated and non-COVID patients had to seek care at other health facilities.<br><br>COVID-19 testing and treatment facilities were clustered around the capital, limiting access to care in rural areas. |

| Maintaining Essential Health Services | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Ministry of Health | The essential health service packages were maintained, but no additional funding was allocated for the services.<br><br>Community communication was the strategy used to mitigate essential service disruption<br><br>Digital health technologies were used for primary care and chronic care consultations<br><br>There is monitoring of continuity of essential health services by addressing the infodemic and health misinformation and collection and collating data on COVID -19 and comorbidities<br><br>Few disruptions were reported except for community-based care[16] | Existing networks such as NGOs was a mitigating strategy used to reach out to vulnerable groups such as older people. | Draft policy on ageing Not implemented. As a result, there is generally poor access to health services for older people.<br><br>Community based care was limited to 55% capacity.<br><br>Mobile clinics were suspended, limiting access in more rural areas. |
| Non-Governmental organizations | The Rwanda Biomedical Centre (RBC) facilitated appointments for patients with cancer to a closer health facility: they usually to Butaro Hospital to receive services and they could receive services from Kanomber Military Hospital during the lockdown period.<br><br>One NGO, Al Ama, organised for beneficiaries to continue receiving palliative care and cancer treatment in health centres/hospitals even during the lockdown | | During the lockdown movement was restricted and older people were not able to attend their regular elderly support groups nor to go to health facilities for health services.<br><br>Older persons organisations reported that older people were not able to access chronic medication. Difficult for the community-based volunteers to organize home visits for older people during that period. |
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Community Health Workers (CHWs) | Calling ambulances for people in need of care<br><br>Provision of and disposal of masks. | Health services decentralised to health post and community level for easy access | Community health workers are largely responsible for working with under 5's and pregnant women – limited focus on older people. |
| Non-governmental organisations | Community Volunteers were given protective equipment including face mask and hand sanitizers.<br><br>Community Health Volunteers provided with funding support for interacting with Professional Health workers.<br><br>WhatsApp Group created to allow Community Volunteers, Health Professionals and older persons organisations to have virtual discussions. | No interruption in funding for service for NGOs funded externally (Doctors Worldwide)<br><br>Some NGOs have had financial difficulties as donors were unable to support them. | Interruption of services during lockdown<br><br>A lack of psychosocial support of distressed older people about their increased infection risk<br><br>Diminished funding support to NGO community activities |

16 WHO Pulse Surveys Rounds 1 & 2

| Risk communication and community engagement | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Ministry for Local Government, Executive directors of sectors and village leaders (Mutwarasibos). | | Mutwarasibos have households' registers that allow older people to be reached – for providing food aid, cash transfers, vaccination, and communication campaigns.<br><br>Ministry of Local government disseminated down to the village (50 households) the instruction of facilitating access to health services for the people in need, especially for older people.<br><br>The community-based volunteers were supported to call some older people's family members to ask their news, provide some educative information, and share relevant information with decision makers and media.<br><br>Two International webinars organized to discuss the issues of older people (older women and older people with disabilities) and COVID-19 | The Government provided general information but there was poor reach to older people who have no access to information devices. |
| **Infection prevention and control** | | | |
| | *No notable activities mentioned in interviews* | *No notable activities mentioned in interviews* | Older people did not understand physical distancing or the need for IPC measures such as face masks. |
| **Vaccine Roll out** | | | |
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Ministry of Health | | Older people aged 60 years and above were prioritised in the vaccine rollout in the Country and everyone with non-communicable diseases (including high blood pressure, cancer, diabetes, and other diseases that are often age related).<br><br>Older people were reached by Mutwarasibos (community leaders).<br><br>NGOs that worked with older people pre- COVID pandemic, interacted with the ministry of health and civil society to ensure that older people were included. | Reaching vaccination sites was often difficult for older people (vaccinations provided at the health post level – so even hard for some to get to this service at the lowest level)<br><br>Insufficient vaccine doses to cover all needy people, some might have not been vaccinated. |

| Long-term care provision for older people | | | |
|---|---|---|---|
| | No notable activities to report | No notable activities to report | |

## *Responses to the secondary impacts of COVID*

| Social services and social assistance | | | |
|---|---|---|---|
| **Entities** | **Activities inclusive of older people** | **Activities specifically focused on older people** | **Challenges** |
| Ministry of Local Government | Due to COVID -19 pandemic: Vulnerable households (27,945) including older persons involved in agricultural activities each received 30,000 francs for seeds and fertilizers to boost their productivity.<br><br>Around 53,016 vulnerable households including older persons received cash transfer as relief during lock down and beyond. | | |

## Efficacy of the responses

Rwanda had a well-co-ordinated response to the COVID -19 pandemic the achievements confirmed by the attainment of a high Containment (stringent lockdown) and health index (the extent of contact tracing, requirements to wear face coverings, and policies around vaccine rollout) of 85.12.

## *Examples of good practice*

- Good planning for management of the pandemic involving all stakeholders including non-governmental organisations working with older people at a community level.
- Older persons over the age of 70 years and those with chronic non-communicable diseases are offered free COVID testing.
- Mutwarasibos (community leaders) have household registers that allow older people to be reached – for providing food aid, cash transfers, vaccination, and communication campaigns.

## *Challenges and limitations of the response*

Despite the efforts made through the multiple response strategies, gaps remain in ensuring older persons are fully supported during and after the pandemic, as are indicated as challenges in the fourth column in the tables above.

Key among these challenges, across the responses of all the entities, are infrastructure not being adapted to the needs of older persons, and a lack of equipment and skills training in care for older persons for health workers at all levels in health and social systems. Strategic plans and policies to enhance the well-being of older people are slow to implement.
Other gaps, and thus challenges, include:

- Whole hospitals turned into COVID -19 management centres meant that patients had to go to alternative centres for non- COVID health conditions, taking them out of their zone.
- The external environment both external and within health care facilities is not age friendly and is a barrier to access to health and social services.
- Non-governmental organisations that support and render services close to the people are not adequately supported by internal structures within government. As has been demonstrated during the pandemic, interruption of these services has a direct impact on the well-being and quality of life of older persons.
- Community health workers are largely responsible for working with under 5's and pregnant women – limited focus on older people.
- A lack of formal long-term care exposes poorly supported dependent older persons to abuse and neglect.
- The geriatrics programme is yet to be developed, no training in care of older persons.
- A lack of funding and lockdown measures caused interruption to community services.
- During lockdown older people felt lonely as no one could visit them and they did not understand why all those measures such as social distancing, wearing face masks.
- The COVID -19 pandemic has highlighted the disadvantage older persons have experienced, particularly in remote areas, through an inability to access digital technology.

# 7.7 Summary of experiences and lessons learnt across case studies:

Interviews conducted in the six countries revealed some best practices implemented in some countries that took cognisance of including and reducing risk of the effects of the COVID-19 pandemic on the older population.

- Including older people in planning and carrying out age-inclusive responses to COVID-19
- Door-to-door outreach programmes using existing community networks for information sharing (e.g., Mutwarasibos and community registers Rwanda)
- Programmes with better social protection coverage were better able to reach older people
- Use of telemedicine not requiring complex technology for COVID management or NCD service continuation
- Innovative models of medication delivery (SA) drawing on local networks and resources
- Well-planned and clear communication campaigns to communicate about vaccine drives and fight vaccine using multiple media platforms and using spokespeople, influencers, partner organizations and community leaders (World Health Organisation, 2021e).
- Alternative methods of pension delivery to prevention interruptions
- Caregivers allowed at bedside (Senegal) to support COVID-sick older people and alleviate pressure on health team
- Having disaggregated data on the older population is critical to including them in the COVID-19 response.
- Need to target older people with food aid/social protection specifically as they are not necessarily included in general responses
- Information campaigns specifically designed to reach older people and present information in an accessible way are critical as older people who may be excluded from more general campaigns, particularly those using digital media.
- Need for social interventions to support older people suffering from loneliness, depression etc. especially in LTC facilities
- Reallocation of funding away from older person's organizations has long-term negative effects on services for older people
- Poor reach of health services at community level makes it hard for older people to reach services – CHWs working in child and maternal health need to be trained to screen older people
- Only offering care at certain health centers creates delays in seeking care (especially if testing is required before transfer) and forces people with non-COVID issues to seek care outside of their areas

# 8. Summary of overall key findings and discussion

- Country populations in the African region are ageing rapidly and the burdens of NCDs are growing, but little provision has been made in planning for this demographic and epidemiological transition from a health and development perspective and the region is lagging behind others globally in terms of putting systems and structures in place to support healthy ageing. This left many countries ill-prepared for responding directly to older people's particular needs during the pandemic. The massive economic impact of the COVID-19 pandemic on the region is likely to slow progress in policy development and implementation around healthy ageing and has already resulted in disinvestment in older persons' care in some contexts with negative long-term consequences on the health, wellbeing and long-term care of older people.
- Older people are vulnerable to poverty and informal labour market participation remains high among older people due to weak social and contributory provision coverage in most of the region (22%). The inability of working older adults to earn an income during COVID-19 lockdowns and the need to continue physical distancing due to high-COVID risk increases poverty rates and food insecurity among those without access to social protection and increases dependence on younger people for their financial security (a particular challenge given disruptions in remittances and income of younger household earners during the pandemic).
- Levels of education and competence with digital technology leaves older people behind in terms of access to information about COVID-19, as well as services and forms of social interaction that have increasingly gone online during the COVID-19 pandemic, leaving older people increasingly isolated and challenged in terms of accessing resources and services.
- Health systems in most countries were poorly prepared for COVID-19 and the lack of critical care resources has impacted older people who are more likely to require such care. Case fatality rates and excess mortality rates have been high among older people in the region and, given low testing rates and poor-quality data, the impact on older people has likely been underestimated in many countries.
- Widespread interruptions to health service access, particularly in primary care, that have happened as a result of lockdowns and older person's fears of infection in health facilities, have implications for the management of chronic conditions and longer-term consequences for efforts to maintain intrinsic capacity and functional ability of people as they age.
- COVID-19 has highlighted the need for early planning and communication for alternative management of comorbidities in older patients in any future pandemic, thereby avoiding related exacerbation of chronic illness or loss in IC or FA that may result from treatment failure.
- Long-term care services for older people have been heavily impacted by COVID-19, both at the community level and in residential care facilities, with implications for the health of older people wellbeing of both older people and their caregivers (both formal and informal).
- Societal ageism and abuse of older people has increased in the region over the period of the COVID-19 pandemic, with longer term implications for how older people are perceived and included in economic and social life and efforts to "build back better" after COVID-19.
- There has been poor inclusion of older people in national-level COVID-19 response planning and implementation, both in terms of stakeholder consultation and efforts focused on including older people in health system and socio-economic response. Vaccination roll-out efforts being a significant exception in terms of specific efforts to target older people but vaccination programmes in the region have lagged behind other regions due budgetary and logistical challenges and vaccine hesitancy, and a large proportion of the older people remain unvaccinated.
- Older people who continued to receive pensions over the course of the pandemic were likely less impacted by the economic impact of COVID-19, and countries with existing social protection for older people were better equipped to respond to older people, while those without these systems struggled to reach older people with cash transfers, food parcels or other in-kind support
- Countries where existing networks of older persons organisations or other community-based networks were strong, were better-able to reach older people in terms of targeted and appropriate messaging and provision of socio-economic support but community provision of long-term care services to older people are threatened by budget cuts and the additional costs of operating during the COVID-19 pandemic.
- The COVID pandemic has revealed real gaps in data on older people and this has made it hard to include older people in the response.

As the findings of this report show, COVID-19 pandemic has had severe impacts on older people. Although many countries in the region have been somewhat shielded by the impact of the pandemic in terms of mortality by their current demographic structures, the pandemic has shown the region's significant lack of preparedness for an ageing society, with long-term negative consequences for economic growth.

More positively, as stakeholder interviews, the desktop review of reports and documents have shown, the disproportionate effect of COVID-19 on older people has brought a deeper focus on older people across the region. Previously neglected in the human development agenda, COVID-19 and the increased attention on health and long-term care systems strengthening in the region, brings about opportunities to accelerate capacity building and policy development to build health and social systems that meet the needs of older people, both during COVID-19 and in the recovery period. Furthermore, the UN Decade of Healthy Ageing 2021-2030 presents an opportunity to sustain the conversation and demand actualisation of promises made in the current crisis period.

As populations in Africa age rapidly, we need to ensure that they do so as healthily as possible. Health systems need to take a life-course approach to reduce the cumulative effects of ill-health from birth to later life and reduce inequities in health by addressing social determinants of health through the life course and focusing on prevention and early intervention (World Health Organisation, 2000).

In refining COVID-19 responses and looking beyond the pandemic, it is critical that we take a human rights-based and inclusive approach that considers the rights, dignity, participation and voice of older persons. Older people should be considered important contributors to economic and social life and that they be included in socio-economic development efforts and that health systems should be geared to maintain intrinsic capacity and functional ability to allow people to live long, healthy and productive lives in the region.

# 9. Recommendations

Based on the findings of this study, member states, as well as regional and international partners, should take into account the below recommendations. Priority actions based on these recommendations are outlined in Section 10.

### *Coordination of responses to COVID-19 and any future pandemic*

*Finding: Countries where there was collaboration between government ministries and relevant stakeholders had more effective responses to the COVID-19 pandemic including responses to specific needs of older people.*

- Meeting the needs of older people requires coordination of different ministries e.g., health, labour and social protection and partnerships with NGOs, the private sector and research and academic institutions to achieve optimal care to individuals, families, communities and the wider society and a central coordination mechanism is required to achieve this. Deliberate efforts must be made for a Whole-of-Government Approach ("WGA") to mainstream age friendly strategies and interventions into all sectors, ministries and departments involved in COVID response and beyond.
- Older persons and the associations working for/and with them should be involved in the planning of policies to meet older people's needs during the pandemic and to inform and guide collaboration around the design and implementation of integrated and responsive health and social welfare systems.
- Support community-based organisations which work to maintain and promote the physical, mental, and psychosocial well-being of older people and integrate them into formal health, long-term care, and social protection systems.
- Greater support and resource allocation from governments is required for IPC in long-term care facilities and long-term care in community settings, both in the context of COVID-19 and other outbreaks. Such support is to cover the cost of PPE, staff shortages, challenges of implementing physical distancing and managing the high rates of infection and mortality among residents in LTC facilities, and infection and shortages of care workers, and to address the psychosocial impact on both older persons and care workers.

### *Development and implementation of policy related to ageing*

*Finding: Member states in the region are signatories to regional and international frameworks on ageing, and policies and plans on ageing, but adoption of the policies into law has been slow. For example, on 31 January 2016, the African Union adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons which has had only 17 signatories of the 55 member states. As of July 2020, only three countries have ratified the protocol. Positive steps are required for the inclusion of older people's needs in societies.*

- Bring to the forefront and advocate for the realization of older people's human rights, including to health, social protection, non-discrimination, and protection from abuse, neglect, and violence, as enshrined in country constitutions, existing legislative frameworks, and global and regional treaties.
- Provide opportunities for older people to have a representation so that they may have a voice on programme and policy development and implementation, not only on issues explicitly related to ageing, but also on cross-cutting issues such as gender, disability, health and social protection.

- WHO, UN agencies and other stakeholders should support governments to develop and implement cost effective, evidence-based policies, strategies and plans to advance issues of older persons in line with their commitments around the decade of healthy ageing; including monitoring and reporting progress.
- Governments need to develop consolidated action plans for advancing issues of older people, along with mechanisms for tracking and reporting progress.
- Develop monitoring systems at the national and sub-national level by engaging and building capacity in civil society organisations to work in a coordinated manner and civil society to hold governments accountable for implementing policies.
    - One component may be engaging older people to act as monitors of policy implementation and programme roll-outs. For example, HelpAge international has trained "Older Citizen Monitors" in Uganda, Kenya, Mozambique and Zanzibar to monitor roll-out of pension programmes for older people (HelpAge International, n.d.).
    - Link existing community-based systems and mechanisms to development and government interventions, both to reach older people and build capacity within these systems.
    - Develop leadership capacity within older persons' organisations to strengthen capacity to engage with government and development partners and advocate for older people's needs and rights in the public domain.
- Special attention should be given in contingency plans and strategies to address the amplified threats faced by older refugees or IDPs and provide access to healthcare services in regions affected by conflict or displaced persons.

### *Increased funding and technical support for healthy ageing*

- The WHO, African Union and other partners should jointly support resource mobilisation for the implementation of healthy ageing policies, plans and programmes.
- Greater resource allocation for healthy ageing is needed by governments across the region, including investments in contextually appropriate long-term care services, primary healthcare, NCD-management, improving age-friendliness of healthcare services and investments in social protection systems.
- Development partners to assist governments to engage in cost effectiveness exercises to build investment cases for policies and programmes focused on ageing to build political will and assist governments in allocating budget for appropriate interventions.

### *Research and data to support planning and implementation of healthy ageing policies and plans*

*Finding: There is scant research and data focused on ageing in the region and the limited research conducted does not frequently provide age disaggregated data.*

- New demographic and health data collection models need to be in place to allow African countries to plan for an ageing population and adequately include older people in responses to any future health, economic or social crises.
- Address information gaps on the health and well-being of older people by carrying out cross-sectional and longitudinal surveys and studies on ageing.
- Develop guidelines for consistent analysis and reporting of data across the region.
- Build data collection capacity in the region to enable better gathering and analysis of data relevant to ageing and health and support innovation that is grounded in the needs and realities of older people in the region.

### *Person-centred healthcare for older persons and a life-course approach to health systems*

*Finding: Older people face a number of barriers including the environment and steps need to be taken to support the extension of healthy life expectancy in the region.*

*Finding: There is a growing burden of NCDs in the region, which are particularly prevalent among older people, but these are poorly funded. The high NCD prevalence and poor management put older populations at increased risk of COVID-19 mortality.*

- Extension of Universal Health Care across the region, with older people as a priority group for roll-out, or implementation of National Health Insurance or affordable healthcare initiatives for older people where UHC is not yet feasible. Coverage should include primary healthcare and specific coverage of health conditions affecting older people, including mental and cognitive health conditions. This coverage also needs to include reliable access to affordable essential medications for age-related conditions as well as assistive technology.
- Strengthen the healthcare workforce's ability to provide responsive and person-centred care to older people through greater investment in training on care of older people in the region, both of specialists and health workers within the primary health care system.
- Improve health literacy among older persons to enable them to understand health-related messaging and take actions to manage their health and lead healthy lifestyles that preserve functional capacity as they age.
- Early healthcare investment (in-line with life-course approach) to reduce the burden of NCDs and promote and maintain intrinsic capacity and functional ability in old

age for as long as possible, to limit health and care costs as population in Africa ages and to ensure quality of life for older people and reduce their vulnerability to diseases such as COVID-19.

- Make healthcare services available to older people at the community level by leveraging the community health workers already working in the field of maternal and child health in the region, and through investing in community-based organisations with existing networks on the ground.
    - The use of community health workers for outreach, screening and service delivery has benefits in terms of protecting vulnerable older persons during COVID-19 and improving health care services for older persons more generally.
    - Community Health Workers should have specific training and skills in working with older persons living in the community, who typically have a number of age related health and social needs.
    - Capacitate Community health workers to provide information about COVID-19 vaccinations and assisting older persons in communities to register for vaccination programs.
    - Community level care for persons in this age group should be strengthened generally, to buffer staff shortages as witnessed during the COVID-19 pandemic.

- Strengthening primary healthcare and extending reach into communities to remove challenges of access that older people experience.

- Drive implementation of the WHO UHC Packages of care for older persons (including the Integrated Care for Older Persons (ICOPE) package), which provide valuable frameworks for strengthening health systems for older people and providing integrated care that maintains IC and FA (see Annex 2 for details on these programmes).

### *Long-term care:*

*Finding: Formal long-term care in the region for the older population is poorly developed and largely reliant on families to provide care with little support from governments and services have been further undermined by COVID-19, with long-term consequences for the health and wellbeing of older people.*

- Long-term care (LTC) policies need to be developed to address the needs of older persons requiring LTC services and should be integrated into the health system.
- Policies and programmes in place should maximise older people's agency with regards to their care and COVID-19 responses in LTC settings should continue to support those ideals and give older people opportunities to have input on how their care and risk is managed.
- Long-term care is and should be seen as a continuum of care which provides health promotion, prevention, treatment, rehabilitation and palliation. Community services, where most care in the subregion takes place, are key to ageing in place, reducing need for institutionalisation while promoting appropriate de-institutionalisation.
- LTC resource allocation at the community level during the COVID-19 pandemic and beyond could improve the health and social status and living conditions of older people in communities. This could be achieved through funding older persons organisations or extending the work of community nurses and of CHWs to include older people.
- Focus interventions on the family unit, particularly multi-generational family units to support care provision by families.
    - Provide respite care, training, financial, and psychological support to informal (family) caregivers, to allow older people to remain in community settings for as long as possible, while also reducing the burden of care on low-income households and improving the quality of care for care dependent older people.

### *Promoting Mental health and Physical Well-being during COVID-19 pandemic*

*Finding: Older people have struggled with physical distancing requirements.*

- Provide social support for older persons, particularly those in isolation and with impairments (such as visual impairment, hearing loss, cognitive decline or dementia) who may become more anxious, angry and stressed via regular check-ins and calls by community-based organisations and volunteers.

- Screen older persons for the negative effects of social isolation

### *Social and economic inclusion post-COVID*

*Finding: Social protection for the older population is the lowest globally and the region has the highest number of informal sector economically active older people, who have little protection against shocks such as COVID-19.*

- In some countries, COVID-19 has highlighted the need to provide social protection to older people and this moment should be used to advocate for the introduction or extension of universal pension programmes in the region, which assist older people in the economic recovery period and support income security of older people in the longer-term.
- Older people in the region remain highly likely to participate in the labour market and agricultural activities and need to be included in post-COVID economic development efforts.

- Interventions to support age-appropriate income generating activities may reduce poverty within this group and enable older people to remain socially and physically active for as long as possible.
- Educational and skills development programmes that allow older people to understand and use new digital technologies may increase opportunities for social and economic inclusion by reducing the "digital divide". This may also open up further opportunities to reach older people, for example via telemedicine or digital communication campaigns, which are particularly useful in the COVID-19 context.
- Communication campaigns to breakdown societal assumptions about older people as weak and vulnerable that have been reinforced by the pandemic. There is a need to highlight the social and economic contributions people continue to make in old age and to address ageism and stigma around mental and cognitive health problems such as dementia in communities. In rural areas in some countries campaigns are required to reduce negative cultural practices such as accusing older women – particularly those with mental health issues - of witchcraft.
- Make environments more age-friendly through improved accessibility of the built environment, which will benefit all people with disabilities, including older people.

# 10. Priority Actions

The below priority actions should be implemented by all member states in the region with the support of regional and international development partners.

1. **Expedite policy implementation**. Governments in the region are signatories to international frameworks on ageing, and policies and plans on ageing but adoption of the policies into law has been slow. Governments are urged to ratify such policies as it has been demonstrated that where there were existing programmes for older people, coordination of managing the COVI-19 pandemic was more efficient and such mechanisms will have relevance to services for older people and to future pandemics.

2. **Strengthen the health care systems and service delivery**
   - ***Strengthen infrastructure and services provided at all levels of care including at the primary and community care.*** Well-developed community and primary care services enhance the mobilisation and information dissemination to communities including older persons and are linked to primary and tertiary care.
   - ***Implement Universal Health Coverage*** to support the health and hence productivity of the population by enabling access to services for health promotion, disease prevention, diagnosis, treatment, rehabilitation and palliation. The WHO ICOPE model (see Annex 2) should be used to deliver integrated primary care.
   - ***Training and education of care professionals.*** To improve quality of services for older people, curricula in education and training institutions need to include training in caring for older persons. Management of conditions of older persons including optimizing IC and FA requires specific knowledge and skill.
   - ***Promote and support research on ageing and data collection*** across the lifespan with age and gender disaggregation of data. There is scant research focused on ageing in the region and the limited research conducted does not frequently provide age disaggregated data. Quality data is essential for planning and service development for older people, within both the health system and the social sector and is key to developing innovative approaches to ageing that are grounded in the realities of the region.
   - ***Develop long-term care system and services***, training and support to families providing care to older people to promote human right and reduce abuse of older persons. The number of older persons is increasing rapidly in the region. Internal and external migration and mortality due to epidemics and pandemics is changing family structure and available support.

3. **Strengthen and support community-based associations and networks of older people** that can advocate for older people's right and needs, support the provision of long-term care and social services, and provide a link between government and older people.

4. **Provide age friendly environments** that promote access to health care and community participation for older people. Older people face several barriers including the environment and steps need to be taken to support extending health life expectancy and productivity in the region.

5. **Develop social protection mechanisms** to support older people and vulnerable populations. Social protection for the older population is the lowest globally and the region has the highest number of informal-sector economically active older people, some working with disabilities due to lack of formal support.

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# Annex 1: Data Tables

## Table A: Demographic and Life Expectancy Data

| Country | Total population | Population 60+ | Proportion of population >60 | Life expectancy | Old Age Dependency ratios (65+) | HDR adjusted life expectancy index | HALE at birth | HALE at 60 | Age standardised mortality rate attributable to NCDs (per 100 000) |
|---|---|---|---|---|---|---|---|---|---|
| ALGERIA | 43 576 691 | 4 275 061 | 9.8% | 77.79 | 10.4 | 0.875 | 66.39 | 16.02 | 445.8 |
| ANGOLA | 33 642 646 | 1 261 007 | 3.7% | 61.71 | 4.3 | 0.633 | 54.84 | 12.64 | 621.2 |
| BENIN | 13 301 694 | 509 444 | 3.8% | 61.82 | 6 | 0.643 | 55.52 | 13.01 | 634.4 |
| BOTSWANA | 2 350 667 | 195 543 | 8.3% | 65.24 | 7.1 | 0.763 | 53.89 | 11.79 | 728.3 |
| BURKINA FASO | 21 382 659 | 1 014 630 | 4.7% | 63.06 | 4.5 | 0.64 | 54.86 | 12.61 | 647.8 |
| BURUNDI | 12 241 065 | 615 589 | 5.0% | 67.07 | 4.4 | 0.64 | 55.58 | 12.66 | 651.6 |
| CABO VERDE | 589 451 | 51 784 | 8.8% | 73.47 | 7 | 0.815 | 64.8 | 14.87 | 512.8 |
| CAMEROON | 28 524 175 | 1 382 004 | 4.8% | 62.79 | 5 | 0.604 | 54.52 | 12.77 | 660.5 |
| CENTRAL AFRICAN REPUBLIC | 5 357 984 | 284 452 | 5.3% | 55.07 | 5.3 | 0.512 | 46.37 | 9.95 | 911.1 |
| CHAD | 17 414 108 | 675 394 | 3.9% | 58.73 | 4.9 | 0.527 | 52.02 | 12.26 | 626.2 |
| COMOROS | 864 335 | 55 949 | 6.5% | 66.9 | 5.3 | 0.682 | 58.95 | 13.69 | 577.9 |
| CONGO | 5 417 414 | 284 614 | 5.3% | 61.69 | 4.9 | 0.686 | 56.25 | 12.25 | 642.9 |
| CÔTE D'IVOIRE | 28 088 455 | 1 246 174 | 4.4% | 61.8 | 5.2 | 0.581 | 54.81 | 12.68 | 618.1 |
| DRC | 105 044 646 | 4 113 704 | 3.9% | 61.4 | 5.9 | 0.626 | 54.09 | 12.53 | 652.9 |
| EQUATORIAL GUINEA | 857 008 | 52 550 | 6.1% | 66.35 | 4 | 0.596 | 53.86 | 12.92 | 637.1 |
| ERITREA | 6 147 398 | 350 996 | 5.7% | 66.51 | 8.4 | 0.713 | 55.73 | 11.41 | 713.6 |
| ESWATINI | 1 113 276 | 64 928 | 5.8% | 59.1 | 6.9 | 0.618 | 50.06 | 10.98 | 917.1 |
| ETHIOPIA | 110 871 031 | 5 970 440 | 5.4% | 67.9 | 6.3 | 0.717 | 59.89 | 13.87 | 511.3 |
| GABON | 2 284 912 | 144 810 | 6.3% | 69.37 | 6 | 0.715 | 57.56 | 12.77 | 613.3 |
| GAMBIA | 2 221 301 | 128 878 | 5.8% | 66.15 | 4.8 | 0.647 | 57.04 | 12.64 | 595.5 |
| GHANA | 32 372 889 | 2 075 275 | 6.4% | 69.01 | 5.2 | 0.678 | 57.98 | 12.94 | 618.3 |
| GUINEA | 12 877 894 | 778 458 | 6.0% | 63.53 | 5.5 | 0.64 | 53.32 | 12.31 | 660.2 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| GUINEA-BISSAU | 1 976 187 | 89 603 | 4.5% | 63.26 | 5.2 | 0.59 | 52.62 | 11.38 | 672.1 |
| KENYA | 54 685 051 | 2 673 153 | 4.9% | 69.32 | 4.2 | 0.718 | 57.68 | 13.06 | 587.1 |
| LESOTHO | 2 177 740 | 171 939 | 7.9% | 58.9 | 7.9 | 0.528 | 44.24 | 9.79 | 1137.2 |
| LIBERIA | 5 214 030 | 223 982 | 4.3% | 65.1 | 5.9 | 0.678 | 54.91 | 12.85 | 506.4 |
| MADAGASCAR | 27 534 354 | 1 567 367 | 5.7% | 67.86 | 5.4 | 0.724 | 57.31 | 12.64 | 665.2 |
| MALAWI | 20 308 502 | 1 109 560 | 5.5% | 72.16 | 4.9 | 0.681 | 57.06 | 12.78 | 589.8 |
| MALI | 20 137 527 | 944 152 | 4.7% | 62.01 | 5 | 0.605 | 54.63 | 12.8 | 611.4 |
| MAURITANIA | 4 079 284 | 259 585 | 6.4% | 64.86 | 5.5 | 0.691 | 59.76 | 14.28 | 476.2 |
| MAURITIUS | 1 386 129 | 240 012 | 17.3% | 76.7 | 17 | 0.846 | 63.94 | 14.5 | 581.5 |
| MOZAMBIQUE | 30 888 034 | 1 349 936 | 4.4% | 56.49 | 5.5 | 0.628 | 50.36 | 11.59 | 778.6 |
| NAMIBIA | 2 678 191 | 158 835 | 5.9% | 65.87 | 6.1 | 0.672 | 56.06 | 12.72 | 627.9 |
| NIGER | 23 605 767 | 966 822 | 4.1% | 59.7 | 5.5 | 0.653 | 55.52 | 12.99 | 599.7 |
| NIGERIA | 219 463 862 | 11 249 530 | 5.1% | 60.87 | 5.1 | 0.534 | 54.39 | 13.54 | 530.2 |
| RWANDA | 12 943 132 | 596 813 | 4.6% | 65.48 | 5.3 | 0.754 | 60.21 | 13.6 | 579 |
| SÃO TOMÉ AND PRÍNCIPE | 213 948 | 10 345 | 4.8% | 66.72 | 5.4 | 0.775 | 61.6 | 13.15 | 613.2 |
| SENEGAL | 16 082 442 | 830 017 | 5.2% | 63.83 | 5.7 | 0.738 | 59.37 | 13.14 | 551.4 |
| SEYCHELLES | 96 387 | 13 288 | 13.8% | 75.84 | 11.4 | 0.822 | 64.01 | 14.07 | 569.9 |
| SIERRA LEONE | 6 807 277 | 364 800 | 5.4% | 60.19 | 5.2 | 0.534 | 52.92 | 12.61 | 636.3 |
| SOUTH AFRICA | 56 978 635 | 5 353 216 | 9.4% | 65.04 | 8.3 | 0.679 | 56.15 | 13.86 | 618.4 |
| SOUTH SUDAN | 10 984 074 | 468 762 | 4.3% | 58.6 | 6.1 | 0.582 | 53.66 | 12.66 | 481.1 |
| TOGO | 8 283 189 | 511 828 | 6.2% | 70.99 | 5.1 | 0.631 | 56.19 | 12.78 | 649.4 |
| UGANDA | 44 712 143 | 1 626 251 | 3.6% | 68.58 | 3.8 | 0.667 | 58.21 | 13.4 | 572.2 |
| UNITED REPUBLIC OF TANZANIA | 62 092 761 | 3 085 172 | 5.0% | 69.9 | 4.9 | 0.699 | 58.46 | 13.37 | 496.5 |
| ZAMBIA | 19 077 816 | 799 697 | 4.2% | 65.92 | 4 | 0.675 | 54.4 | 12.58 | 679.4 |
| ZIMBABWE | 14 829 988 | 964 336 | 6.5% | 62.83 | 5.4 | 0.638 | 53.07 | 11.48 | 735 |

*Sources: [1]US Census 2021[17] ;* UNDESA (2019a). [2]World Population Prospects: The 2019 Revision; *[3]Global Health Observatory 2019*

*Life expectancy at birth expressed as an index using a minimum value of 20 years and a maximum value of 85 years. HDRO calculations based on life expectancy values from UNDESA (2019a). World Population Prospects database.

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# Table B: Economic data

| Country | GDP per capita (2017 PPP$) | GINI co-efficient | Extreme poverty rate - those living under $1.90 | Unemployment total (% of labour force) | Human Development Index (F/M) | HDI ranking globally | World Bank categorisation |
|---|---|---|---|---|---|---|---|
| ALGERIA | 11 350 | 27.6 (2011) | 0.5 | 11.7 | 0.671 / 0.782 | 91 | LMI |
| ANGOLA | 6 654 | 51.3 (2018) | 47.6 | 6.9 | 0.611 / 0.552 | 148 | LMI |
| BENIN | 3 287 | 47.8 (2015) | 49.5 | 2.2 | 0.502 / 0.587 | 158 | LMI |
| BOTSWANA | 17 766 | 53.3 (2015) | 16.1 | 18.2 | 0.734 / 0.735 | 100 | UMI |
| BURKINA FASO | 2 190 | 35.3 (2014) | 43.7 | 6.3 | 0.418 / 0.482 | 182 | Low |
| BURUNDI | 752 | 38.6 (2013) | 71.8 | 1.4 | 0.432 / 0.432 | 185 | Low |
| CABO VERDE | 7 172 | 42.4 (2015) | 3.2 | 12.2 | 0.655 / 0.672 | 126 | LMI |
| CAMEROON | 3 653 | 46.6 (2014) | 23.8 | 3.4 | 0.521 / 0.603 | 153 | LMI |
| CENTRAL AFRICAN REPUBLIC | 945 | 56.2 (2008) | 66.3 | 3.7 | 0.351 / 0.438 | 188 | Low |
| CHAD | 1 580 | 43.3 (2011) | 38.4 | 1.9 | 0.342 / 0.448 | 187 | Low |
| COMOROS | 3 081 | 45.3 (2014) | 17.6 | 4.3 | 0.519 / 0.583 | 156 | Low |
| CONGO | 3 298 | 48.9 (2011) | 37 | 9.5 | 0.555 / 0.598 | 149 | LMI |
| CÔTE D'IVOIRE | 5 238 | 41.5 (2015) | 28.2 | 3.3 | 0.476 / 0.586 | 162 | LMI |
| DRC | 1 098 | 42.1 (2012) | 76.6 | 4.2 | 0.439 / 0.52 | 175 | Low |
| EQUATORIAL GUINEA | 18 558 | - | - | 6.4 | - | 145 | UMI |
| ERITREA | - | - | - | 5.1 | - | 180 | Low |
| ESWATINI | 8 688 | 54.6 (2016) | 28.4 | 22.1 | 0.609 / 0.611 | 138 | LMI |
| ETHIOPIA | 2 220 | 35.0 (2015) | 30.8 | 2.1 | 0.442 / 0.527 | 173 | Low |
| GABON | 14 870 | 38.0 (2017) | 3.4 | 20 | 0.67 / 0.731 | 119 | UMI |
| GAMBIA | 2 207 | 35.9 (2015) | 10.1 | 9.1 | 0.448 / 0.53 | 172 | Low |
| GHANA | 5 413 | 43.5 (2016) | 13.3 | 4.3 | 0.582 / 0.639 | 138 | LMI |
| GUINEA | 2 564 | 33.7 (2012) | 35.5 | 4.3 | 0.428 / 0.524 | 178 | Low |
| GUINEA-BISSAU | 1 989 | 50.7 (2010) | 67.1 | 2.5 | - | 175 | Low |
| KENYA | 4 330 | 40.8 (2015) | 36.8 | 2.6 | 0.518 / 0.581 | 143 | LMI |
| LESOTHO | 2 768 | 44.9 (2017) | 26.9 | 23.4 | 0.529 / 0.522 | 165 | LMI |
| LIBERIA | 1 428 | 35.3 (2016) | 40.9 | 2.8 | 0.453 / 0.509 | 175 | Low |
| MADAGASCAR | 1 646 | 42.6 (2012) | 77.6 | 1.8 | 0.513 / 0.539 | 164 | Low |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| MALAWI | 1 060 | 44.7 (2016) | 70.3 | 5.7 | 0.493 / 0.5 | 174 | Low |
| MALI | 2 327 | 33.0 (2009) | 49.7 | 7.2 | 0.388 / 0.473 | 184 | Low |
| MAURITANIA | 5 197 | 32.6 (2014) | 6 | 9.5 | 0.5 / 0.579 | 157 | LMI |
| MAURITIUS | 22 989 | 36.8 (2017) | 0.2 | 6.7 | 0.791 / 0.811 | 66 | High |
| MOZAMBIQUE | 1 280 | 54.0 (2014) | 62.9 | 3.2 | 0.435 / 0.476 | 181 | Low |
| NAMIBIA | 9 637 | 59.1 (2015) | 13.4 | 20.3 | 0.648 / 0.643 | 130 | UMI |
| NIGER | 1 219 | 34.3 (2014) | 44.5 | 0.5 | 0.321 / 0.443 | 189 | Low |
| NIGERIA | 5 135 | 35.1 (2018) | 53.5 | 8.1 | 0.504 / 0.572 | 161 | LMI |
| RWANDA | 2 226 | 43.7 (2016) | 55.5 | 1 | 0.528 / 0.558 | 160 | Low |
| SÃO TOMÉ AND PRÍNCIPE | 3 964 | 56.3 (2017) | 34.5 | 13.4 | 0.59 / 0.651 | 135 | LMI |
| SENEGAL | 3 395 | 40.3 (2011) | 38 | 6.6 | 0.475 / 0.546 | 168 | Low |
| SEYCHELLES | 29 056 | 32.1 (2018) | 1.1 | - | - | 67 | High |
| SIERRA LEONE | 1 718 | 35.7 (2018) | 40.1 | 4.4 | 0.423 / 0.479 | 182 | Low |
| SOUTH AFRICA | 12 482 | 63.0 (2014) | 18.9 | 28.2 | 0.702 / 0.712 | 114 | UMI |
| SOUTH SUDAN | - | 44.1 (2016) | 42.7 | 12.2 | 0.384 / 0.456 | 185 | Low |
| TOGO | 1 596 | 43.1 (2015) | 49.8 | 2 | 0.464 / 0.565 | 167 | Low |
| UGANDA | 2 181 | 42.8 (2016) | 41.7 | 1.8 | 0.503 / 0.582 | 159 | Low |
| UNITED REPUBLIC OF TANZANIA | 2 660 | 40.5 (2017) | 49.1 | 2 | 0.514 / 0.542 | 163 | LMI |
| ZAMBIA | 3 479 | 57.1 (2015) | 57.5 | 11.4 | 0.569 / 0.593 | 146 | LMI |
| ZIMBABWE | 2 836 | 50.3 (2019) | 33.9 | 5 | 0.55 / 0.59 | 150 | Low |

# Table C: Health systems (grouped by coverage of essential health services)

| Country | Coverage of essential health services (%) | Total net official development assistance to medical research and basic health sectors per capitav (US$), | Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis (%) | Density of medical doctors (per 10 000 population) | Density of nursing and midwifery personnel (per 10 000 population) | Compliance with International Health Regulations core capacity scores | Current health exp (percentage GDP) |
|---|---|---|---|---|---|---|---|
| ALGERIA | 78 | 0.007 | -. | 17.19 | 15.48 | 80 | 6.4 |
| ANGOLA | 40 | 1.47 | -. | 2.15 | 4.08 | 63 | 2.8 |
| BENIN | 40 | 4.95 | -. | 0.65 | 3.03 | 35 | 3.7 |
| BOTSWANA | 61 | 6.78 | -. | 2.89 | 54.57 | 30 | 6.1 |
| BURKINA FASO | 40 | 5.76 | 0 | 0.94 | 9.27 | 44 | 6.9 |
| BURUNDI | 42 | 9.05 | 0 | 1 | 6.63 | 48 | 7.5 |
| CABO VERDE | 69 | 8.97 | -. | 7.81 (2015) | 12.98 | 48 | 5.2 |
| CAMEROON | 46 | 2.9 | -. | 0.88 (2011) | 0.058 (2013) | 42 | 4.7 |
| CENTRAL AFRICAN REPUBLIC | 33 | 8.52 | -. | 0.72 (2015) | 2.06 (2015) | 17 | 5.8 |
| CHAD | 28 | 3.26 | -. | 0.54 | 1.38 | 30 | 4.5 |
| COMOROS | 52 | 8.26 | -. | 1.7 (2012) | 6.29 | 27 | 7.4 |
| CONGO | 39 | 2.26 | 0 | 1.06 | 9.31 | 33 | 2.9 |
| CÔTE D'IVOIRE | 47 | 3.92 | -. | 1.62 | 6.56 | 44 | 4.5 |
| DRC | 41 | 5.14 | -. | 0.9 (2013) | 11.1 | 35 | 4 |
| EQUATORIAL GUINEA | 45 | 1.11 | -. | 4.02 | 5.02 | 22 | 3.1 |
| ERITREA | 38 | 8.74 | -. | 0.79 (2004) | 14.4 | 49 | 2.9 |
| ESWATINI | 63 | 13.91 | -. | 0.96 | 41.42 | 40 | 6.9 |
| ETHIOPIA | 39 | 4.22 | -. | 0.77 | 7.14 | 63 | 3.5 |
| GABON | 49 | 1.76 | -. | 6.82 | 29.46 | 27 | 2.8 |
| GAMBIA | 44 | 20.92 | -. | 1.07 | 6.06 | 38 | 3.3 |
| GHANA | 47 | 5.54 | 12.5 | 1.06 | 27.11 | 49 | 3.3 |
| GUINEA | 37 | 5.85 | 12.5 | 0.83 | 1.24 | 44 | 4.1 |
| GUINEA-BISSAU | 40 | 13.53 | -. | 1.27 | 6.85 | 25 | 7.2 |
| KENYA | 55 | 3.42 | -. | 1.57 | 11.66 | 43 | 4.8 |
| LESOTHO | 48 | 12.09 | -. | 0.69 (2010) | 32.57 | 29 | 8.8 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| LIBERIA | 39 | 12.84 | -. | 0.38 (2015) | 5.32 | 46 | 8.2 |
| MADAGASCAR | 28 | 4.4 | -. | 1.81 (2014) | 2.98 | 29 | 5.5 |
| MALAWI | 46 | 13.38 | -. | 0.36 | 4.39 | 35 | 9.6 |
| MALI | 38 | 6.86 | 0 | 1.29 | 4.41 | 48 | 3.8 |
| MAURITANIA | 41 | 4.14 | -. | 1.87 | 9.25 | 35 | 4.4 |
| MAURITIUS | 63 | 0.74 | -. | 25.33 | 35.15 | 64 | 5.7 |
| MOZAMBIQUE | 46 | 5.9 | -. | 0.85 | 4.73 | 60 | 4.9 |
| NAMIBIA | 62 | 6.97 | -. | 5.91 | 19.54 | 59 | 8.6 |
| NIGER | 37 | 4.63 | -. | 0.43 | 2.23 | 39 | 7.7 |
| NIGERIA | 42 | 2.43 | -. | 3.81 | 15.01 | 51 | 3.8 |
| RWANDA | 57 | 4.98 | -. | 1.18 | 9.48 | 71 | 6.6 |
| SÃO TOMÉ AND PRÍNCIPE | 55 | 13.9 | -. | 3.16 (2015) | 19.24 | 32 | 6.2 |
| SENEGAL | 45 | 5.59 | 7.69 | 0.88 | 5.4 | 54 | 4.1 |
| SEYCHELLES | 71 | -. | -. | 24.72 | 98.46 | 53 | 5 |
| SIERRA LEONE | 39 | 9.15 | -. | 0.74 | 7.53 | 40 | 13.4 |
| SOUTH AFRICA | 69 | 2.59 | -. | 7.92 | 13.08 | 70 | 8.1 |
| SOUTH SUDAN | 31 | 9.11 | -. | -. | - | 34 | 9.8 |
| TOGO | 43 | 2.96 | -. | 0.78 | 4.64 | 39 | 6.2 |
| UGANDA | 45 | 5.54 | -. | 1.68 | 12.38 | 66 | 6.2 |
| UNITED REPUBLIC OF TANZANIA (Zanzibar) | 43 | 4.24 | 0 | 0.6 (2014) | 5.84 | 51 | 3.6 |
| ZAMBIA | 53 | 11.34 | 16.67 | 0.93 | 10.23 | 60 | 4.5 |
| ZIMBABWE | 54 | 7.8 | -. | 2.1 | 19.35 | 50 | 6.6 |

# Table D: COVID-19 data in the African Region as of 31 March 2021

| Country | Infections (cumulative cases) 31 March 2021 | Infections (cumulative cases per million) | Mortality (cumulative cases) | Mortality (cumulative per million) | Case fatality rate |
|---|---|---|---|---|---|
| ALGERIA | 117061 | 266.95 | 3089 | 7.04 | 2.64 |
| ANGOLA | 22182 | 67.49 | 536 | 1.63 | 2.42 |
| BENIN | 7100 | 58.57 | 90 | 0.74 | 1.27 |
| BOTSWANA | 39848 | 1694.49 | 568 | 24.15 | 1.43 |
| BURKINA FASO | 12717 | 60.84 | 146 | 0.7 | 1.15 |

| | | | | | |
|---|---|---|---|---|---|
| BURUNDI | 2810 | 23.63 | 6 | 0.05 | 0.21 |
| CABO VERDE | 17279 | 3107.81 | 168 | 30.22 | 0.97 |
| CAMEROON | 47669 | 179.57 | 721 | 2.72 | 1.51 |
| CENTRAL AFRICAN REPUBLIC | 5161 | 106.86 | 67 | 1.39 | 1.30 |
| CHAD | 4523 | 27.54 | 164 | 1 | 3.63 |
| COMOROS | 3696 | 425.02 | 146 | 16.79 | 3.95 |
| CONGO | 9681 | 175.44 | 135 | 2.45 | 1.39 |
| CÔTE D'IVOIRE | 43542 | 165.07 | 242 | 0.92 | 0.56 |
| DRC | 28141 | 31.42 | 743 | 0.83 | 2.64 |
| EQUATORIAL GUINEA | 6914 | 492.81 | 102 | 7.27 | 1.48 |
| ERITREA | 3279 | 92.46 | 9 | 0.25 | 0.27 |
| ESWATINI | 17333 | 1494.01 | 667 | 57.49 | 3.85 |
| ETHIOPIA | 204521 | 177.9 | 2841 | 2.47 | 1.39 |
| GABON | 19140 | 859.94 | 114 | 5.12 | 0.60 |
| GAMBIA | 5420 | 224.28 | 164 | 6.79 | 3.03 |
| GHANA | 90552 | 291.42 | 742 | 2.39 | 0.82 |
| GUINEA | 19908 | 151.59 | 125 | 0.95 | 0.63 |
| GUINEA-BISSAU | 3648 | 185.37 | 61 | 3.1 | 1.67 |
| KENYA | 132646 | 246.69 | 2147 | 3.99 | 1.62 |
| LESOTHO | 10686 | 498.82 | 315 | 14.7 | 2.95 |
| LIBERIA | 2053 | 40.59 | 85 | 1.68 | 4.14 |
| MADAGASCAR | 24264 | 87.62 | 394 | 1.42 | 1.62 |
| MALAWI | 33525 | 175.25 | 1116 | 5.83 | 3.33 |
| MALI | 9998 | 49.37 | 384 | 1.9 | 3.84 |
| MAURITANIA | 17824 | 383.34 | 449 | 9.66 | 2.52 |
| MAURITIUS | 963 | 75.72 | 10 | 0.79 | 1.04 |
| MOZAMBIQUE | 67466 | 215.85 | 772 | 2.47 | 1.14 |
| NAMIBIA | 44051 | 1733.67 | 520 | 20.47 | 1.18 |
| NIGER | 5003 | 20.67 | 186 | 0.77 | 3.72 |
| NIGERIA | 162762 | 78.96 | 2056 | 1 | 1.26 |
| RWANDA | 21645 | 167.11 | 306 | 2.36 | 1.41 |

| | | | | | |
|---|---|---|---|---|---|
| SÃO TOMÉ AND PRÍNCIPE | 2221 | 1013.42 | 34 | 15.51 | 1.53 |
| SENEGAL | 38618 | 230.64 | 1049 | 6.26 | 2.72 |
| SEYCHELLES | 4114 | 4183.15 | 20 | 20.34 | 0.49 |
| SIERRA LEONE | 3970 | 49.77 | 79 | 0.99 | 1.99 |
| SOUTH AFRICA | 1546735 | 2607.94 | 52788 | 89.01 | 3.41 |
| SOUTH SUDAN | 10119 | 90.4 | 108 | 0.96 | 1.07 |
| TOGO | 10249 | 123.8 | 109 | 1.32 | 1.06 |
| UGANDA | 40839 | 89.28 | 335 | 0.73 | 0.82 |
| UNITED REPUBLIC OF TANZANIA (Zanzibar) | 509 | 0.85 | 21 | 0.04 | 4.13 |
| ZAMBIA | 88199 | 479.76 | 1202 | 6.54 | 1.36 |
| ZIMBABWE | 36858 | 247.99 | 1521 | 10.23 | 4.13 |

*Sources: [1]WHO Coronavirus dashboard; [2]Data from Table 1 provided by the WHO; [3] Oxford COVID-19 Government Response Tracker 2021; [4] Our world in data; [5] Oxford COVID-19 Government Response Tracker 2021.*

*Codes: 0- No data, 1 No testing policy. 2- Only those who both (a) have symptoms and also (b) meet specific criteria (e.g. key workers, admitted to hospital, came into contact with a known case, returned from overseas). 3-Testing of anyone showing COVID-19 symptoms. 4-Open public testing (e.g. “drive through” testing available to asymptomatic people).

** This is a composite measure based on nine response indicators including school closures, workplace closures, and travel bans, rescaled to a value from 0 to 100 (100 = strictest). If policies vary at the subnational level, the index is shown as the response level of the strictest sub-region.

# Table E: GDP Growth in the African Region 2020

| Country | GDP estimated growth 2020 (%) |
|---|---|
| ALGERIA | -6.5 |
| ANGOLA | -4 |
| BENIN | 2 |
| BOTSWANA | -9.1 |
| BURKINA FASO | -2 |
| BURUNDI | -2 |
| CABO VERDE | -11 |
| CAMEROON | -2.5 |
| CENTRAL AFRICAN REPUBLIC | 0 |
| CHAD | -0.8 |
| COMOROS | -1.4 |
| CONGO | -0.6 |
| CÔTE D'IVOIRE | 1.8 |
| DRC | -1.7 |
| EQUATORIAL GUINEA | -9 |
| ERITREA | -0.6 |
| ESWATINI | -3.5 |
| ETHIOPIA | 6.1 |
| GABON | -2.4 |
| GAMBIA | -1.8 |
| GHANA | 1.1 |
| GUINEA | 5.2 |
| GUINEA-BISSAU | -2.4 |
| KENYA | -1 |
| LESOTHO | -5.3 |
| LIBERIA | -2.9 |
| MADAGASCAR | -4.2 |
| MALAWI | 1.3 |
| MALI | -2 |
| MAURITANIA | -0.6 |
| MAURITIUS | -12.9 |
| MOZAMBIQUE | -0.8 |
| NAMIBIA | -7.9 |
| NIGER | 1 |
| NIGERIA | -4.1 |
| RWANDA | -0.2 |
| SÃO TOMÉ AND PRÍNCIPE | -6.5 |
| SENEGAL | -0.7 |
| SEYCHELLES | -15.9 |
| SIERRA LEONE | -2.3 |
| SOUTH AFRICA | -7.8 |
| SOUTH SUDAN | 9.3 |
| TOGO | 0 |
| UGANDA | 2.9 |
| UNITED REPUBLIC OF TANZANIA (Zanzibar) | 2.5 |
| ZAMBIA | -4.5 |
| ZIMBABWE | -10 |

# Annex 2: WHO packages for older persons

***Integrated Care of Older Persons (ICOPE).*** The Integrated Care of Older Persons (ICOPE) package of tools offers an approach that helps key stakeholders in health and social care to understand, design, and implement a person-centred and coordinated model of care for older persons. This is achieved by the provision of evidence-based interventions and integration of care. ICOPE thus helps support health systems by maximising older adult's IC and FA.

***World Health Organization mHealth for Ageing***. mHealth for Ageing (mAgeing) is an mHealth (mobile health) programme designed to complement the WHO ICOPE package. mHealth refers to the use of mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants, and other wireless devices to support medicine and public health practice. mAgeing supports evidence-based patient self-management and self-care for people at risk of physical and functional decline and is designed to complement and augment advice given by the healthcare worker.

***World Health Organization Age-friendly Toolkit.*** The WHO approach to healthy ageing places significant emphasis on primary care. In order to make PHC facilities accessible and appropriate to the needs of older populations, the WHO has developed the Age-Friendly toolkit to guide PHC clinics in modifying their structure to better fit the needs of their older patients. The toolkit is based on primary research at PHC clinics on factors contributing to effective, age-friendly facilities. Guidelines focus on the three key areas of: 1) information, education, communication, and training; 2) healthcare management systems; and 3) the physical environment of the PHC centre.

# Annex 3: Regional stakeholder interviews

| | |
|---|---|
| Dr Emem Omokaro | Stakeholder Group on Ageing Africa ((SGA Africa); International Institute on Ageing UN- Malta, (INIA) Satellite Centre for sub-Saharan Africa, Dave Omokaro Foundation |
| Dr Gislaine Ngaska | UNHCR |
| Ms Ida Ameda | UNICEF |
| Dr Shanta Ghatak | International Federation of the Red Cross |
| Ms Lillian Matemu | Kenya Red Cross Society |
| Ms Roseline Kihumba | HelpAge International |
| Mr David Kimosop | Action Against Hunger |
| Mr Sadik Mohamed | Action Against Hunger |
| Dr Vivian Nzeusseu | International Organization for Migration |

World Health Organization

REGIONAL OFFICE FOR Africa