HelpAge India | Fighting isolation, poverty, neglect

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DOCUMENTATION OF GOOD AGE CARE PRACTICES DURING COVID-19 PANDEMIC
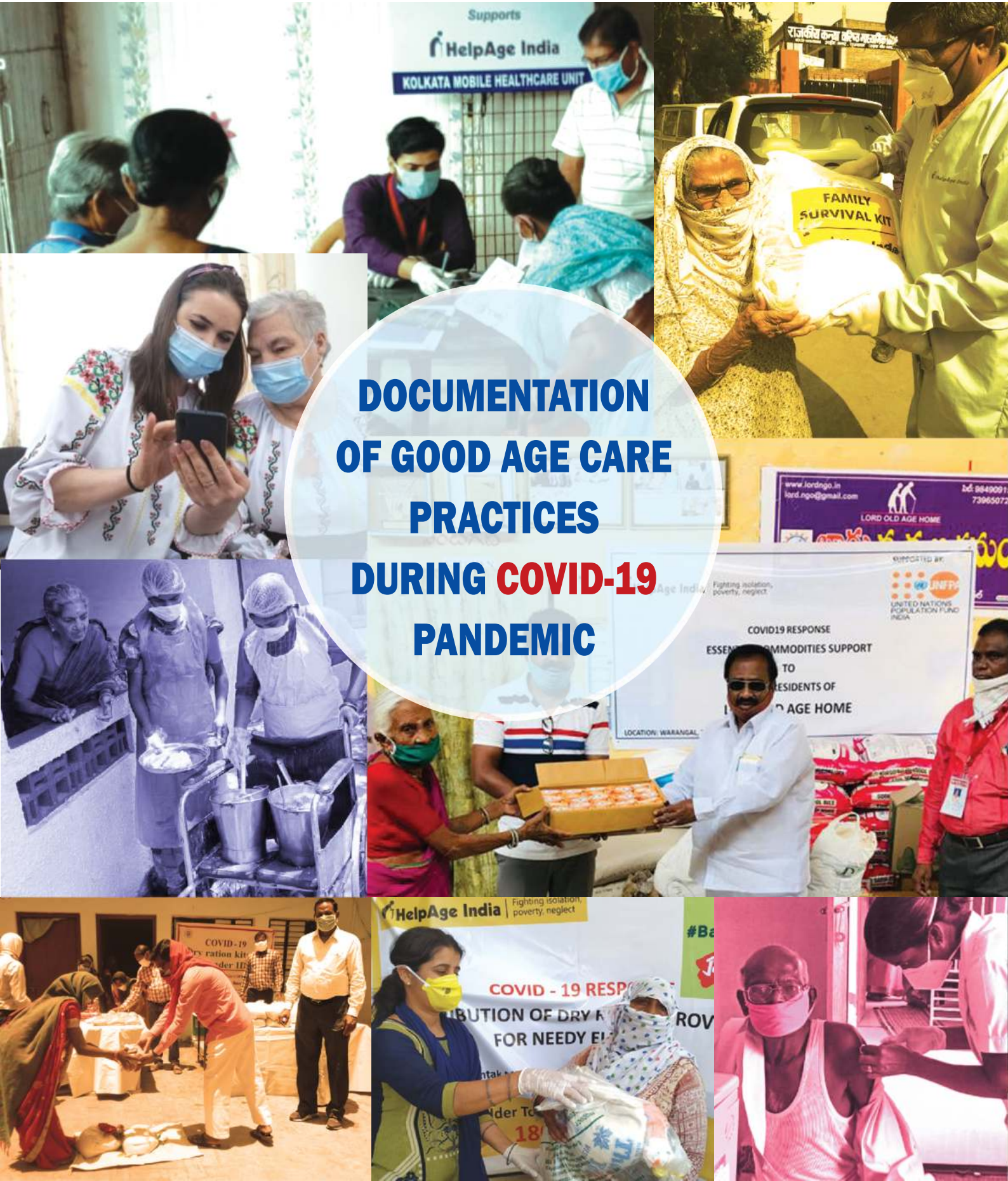
FULL REPORT ◆ **HelpAge India**
OCTOBER | 2022

PREFACE

COVID-19 pandemic presented a challenge that surpassed any other handled so far by humankind. The nature and duration of the pandemic was one dimension but the 'unknown' baffled all stakeholders. Standard protocols, standard understanding and response systems all became wanting. Everybody tried to respond to the best of their abilities. HelpAge India with its focus on elderly and experience in dealing with the challenges of ageing, especially during disaster response on the ground in many states, provided support to the older persons for food and nutrition, health, livelihood and awareness.

Human spirit, grit and determination came to the rescue, facilitated by structural factors like networks, helplines, mobile health units, presence on ground and functional factors like anticipating needs, outreach and trust of the target group and society. HelpAge India started relief operations from 3rd April 2020 and continued work till booster dose of vaccinations. In the endeavor, the corporates and institutions provided much needed funding and the government machinery enabled the administrative support. All the stakeholders together were able to provide much needed care and services to the older persons irrespective of class, caste, creed and area.

UNFPA, one of the institutional partners in the COVID 19 response, went a step further and provided support to conduct a documentation exercise with voluntary organizations including HelpAge India to focus on good age care practices during the pandemic. The report is an output of that initiative. It has helped in articulating the strengths of the voluntary sector organizations of differing nature and size with primary focus on different vulnerable segments of the population; but taking up the cause of older persons during the pandemic with same dedication and sincerity of purpose.

The highlight of this report is the description of lived experiences of the voluntary sector workers. It captures the perspectives from all levels and the common challenges that they faced irrespective of the work that they did during the pandemic. The need to respond well to the older persons guided the voluntary sector workers and they went out of their way to help. Sometimes they put themselves in harm's way too. As the nature of the pandemic changed, the organizations had to adapt to respond to these changes quickly. Many of the organizations have included concerns of the older persons in their post pandemic programmes as well. Here it is important to mention that older person were not always the beneficiaries, but in cases of Senior Citizens Organizations in urban and rural areas acted as benefactors too. A heartening example of active and engaged ageing.

The older persons were also part of the documentation effort, to know if their needs and demands were fulfilled and to what extent by whom. Of course, what more could be done was an inescapable question. This also served as the starting point for the way forward, without which the report would lose its significance for future readers. Inclusion of concerns of health and income security, digital, recreation, transportation and care of the ageing population in the architecture of the future systems so that they face less challenges in normal and emergency situations.

We can certainly look at some of the good practices in the other countries and find ways to adapt them to our reality. Therefore, basic information on good examples of change in health systems, social security, use of technology, and participation of older persons are included in the report.

We acknowledge the significant role of Dr Sanjay Kumar, Population Dynamics and Research specialist, UNFPA and the other experts for their guidance and technical support for this report. We also are grateful to UNFPA for financial support for this project.

We appreciate the invaluable contribution of all members of the voluntary organizations who participated in this documentation exercise. Most of them took time out of their busy schedules to answer all our questions in virtual sessions that often lasted for hours.

The contribution of older persons who participated in the project is most appreciable. Many of them lived in faraway places with intermittent internet connectivity and had challenges of language. Despite that they all were forthcoming and answered the questions and gave all possible details. Thanks to the volunteers who helped virtual meetings and translations.

No words can capture the enthusiasm of the state teams and State Heads of HelpAge India who participated in this project. Despite their busy work schedules, they took time out and gave all the details of the interventions. The functionaries of the other voluntary organizations that were included in the project also participated with the same spirit. Research team at HelpAge India, led by Ms Anupama Datta (Head Policy Research and Advocacy) did a commendable job to distil the immense amount of descriptive information shared by all including the older persons.

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ABBREVIATIONS

ESHG	**Elders' Self Help Group**
HI	**HelpAge India**
MP	**Madhya Pradesh**
MHU	**Mobile Healthcare Unit**
NCDs	**Non-Communicable Diseases**
SCA	**Senior Citizens' Association**
UP	**Uttar Pradesh**
VO	**Voluntary Organisation**

Older persons are more susceptible to risks during disasters as they have a very limited capacity to access and use assets in order to safeguard against disaster losses. The low resilience is further weakened by lack of social protection and the low penetration of disaster relief measures.

Executive Summary

Research has established that disasters have a disparate impact on the poor, vulnerable and marginalized. Older persons belong to this category and are more susceptible to risks as they do not figure in the list of relief and rehabilitation measures. They are hidden from plain sight. There is also considerable empirical evidence that such people have a very limited capacity to access and use assets in order to safeguard against disaster losses. The low resilience is further weakened by lack of social protection and the low penetration of disaster which mostly results in conversion of disaster impacts into poverty outcomes. The impact of the disaster coupled with low intensity disasters further diminish the capacity of poor and vulnerable people like the elderly.

The poverty outcomes of disasters include substantial reductions in income and consumption as well as both short and long-term negative impacts in human development, welfare and equality. Wherefore, disasters have long-term impacts on the poor, particularly on vulnerable groups like young children and women and elderly. The short-term impacts of disasters, such as mortality or direct economic loss are highlighted;

but the silent and slow impacts of disaster may weaken the long-term health, social improvement and productivity of the poor, worsening chronic poverty. The natural disasters in many parts of India in the recent decades including the COVID-19 pandemic bears testimony to these facts.

HelpAge India (HI) was among the frontrunners in providing relief to the community with special focus on older persons in the aftermath of COVID-19 pandemic. In its endeavour, many other voluntary organisations participated which were ranging from those running special services for older persons like old age homes and Senior Citizens' Associations (SCAs), Elders' Self Help Groups (ESHGs) to those working on disability, women, children and community development. The local government and the donors played a facilitating role in providing services to the older persons during the pandemic.

The details of the intervention efforts were captured in real time. However, it was imperative that systematic documentation be done for the interventions for age care in this unique disaster. HI undertook a study with the financial and technical support of UNFPA to document good age care practices in following states: Delhi/NCR, Uttar Pradesh (UP), Bihar, West Bengal, Odisha, Telangana, Madhya Pradesh (MP) and Chhattisgarh. A qualitative survey was done with the state teams of HI and at least one other VO in each of the states to understand the interventions in age care during the pandemic (March 2020 to March 2022), learn about the nuances of the process of identification of needs, response mechanism, collaborations with other stakeholders, and role of older persons in the process and their satisfaction level.

In depth interviews using an interview schedule were conducted with the HI state teams, office bearers and teams of the selected VOs and beneficiaries in each state.

This research revealed that the intervention responses were in line with the immediate and long term needs of the older persons i.e. supply of food, rations, other essential supplies like mask, sanitizer, disinfectant, thermal guns, oximeters, health care (medicines for NCDs, consultations, mental wellbeing, vaccination), COVID related appropriate and authenticated information on behaviour and other facts, reinforcing preventive behaviour, social and digital inclusion, access to services and essential supplies, medical supplies, admission to hospitals, local transportation, rescue, protection from abuse and violence.

HI, being the largest organisation working for the cause and care of the older persons, had the advantage of scale and reach. Its already existing network of MHUs, old age homes, helplines, and day care centres provided an efficient and effective base to identify needs and respond quickly. Its lead experts could also anticipate some needs and prepare accordingly. It provided the much needed support to the people directly and to other grass

root organisations many of which could not have survived the challenges of the pandemic and continued the much needed programmes for the poorest and destitute elderly in remote areas. The VOs operating in single or multiple states had the advantage of serving the last mile people, who are mostly outside the delivery circles. The disadvantage could be in terms of geographic area or social status. The pandemic made the well to do elderly living alone in metro cities as much disadvantaged as any older person living in a poor household in a rural area.

The community volunteers played a very significant role in the entire duration in identification of needs, beneficiaries and actual delivery of the supplies or access to services. The volunteers included students from management, medical and social work schools/institutions, community volunteers from the villages, elderly volunteers and spontaneous volunteers. The dedicated staff of HI and VOs worked tirelessly during the first two waves of the pandemic to provide the necessary assistance to the older persons living in the community and institutions despite all odds against them. They were at high risk of getting infected, many did get infected, many lost family members to the infection, many did not get enough support from the local institutions, and most did not get enough resources to help all. Many had to face challenges of walking up to the distribution sites, many had to do hard labour to load and unload food supplies due to paucity of regular labourers to do the job, the

helpline staff had to manage an overload of calls during the second wave to provide assistance in getting hospital beds, oxygen cylinders, COVID medicines that were in short supply and consequent overcharging and spurious medicines supply. Coordination of medicine availability and delivery was another challenge in times of acute infections. Their biggest grouse was not being overworked and exposed but inability to help all.

Mental wellbeing of the older persons was also addressed by HI and some other VOs dealing with mental health. HI conducted regular group counselling sessions through the MHUs. It also conducted a research-cum-intervention project to understand and deal with the mental problems, which older persons were facing in community and old age homes. HI helplines dealt with calls requesting for active listening and at times suicidal thoughts of the callers.

Community level efforts were made by HI and other VOs to deal with social isolation of older persons and many NGOs including HI trained older people to use zoom and other platforms to organise meetings and recreation programmes like film songs, bhajan programmes, etc. SCAs took active part in encouraging members to adapt to the new normal. HI and other VOs also imparted basic training in using smart phones and apps to access delivery services and bill payments. Most organisations used volunteers to register the older persons particularly the poor and women for vaccinations.

The older persons who benefitted from the intervention of the HI and other VOs were all praise for the efforts of the VOs. Most of them were of the view that during the pandemic if there was any focused help, it was from HI and other VOs. Most of them either did not have medical insurance and those who had the card, had never used it. Some poor older persons had used the government hospital in the vicinity to get treatment for acute illness. Most of them depended on HI MHU for treatment and vaccination. The vaccination in government health institutions were facilitated by most of the VOs. Some had also taken the booster dose. They were all getting food rations from the government but that was in most cases wheat or rice. Almost all of them complained of reduction in earning of self and family and needed more than just rice/wheat from the government. Expansion of medical facilities were also articulated by many older persons as an urgent need.

Those who were getting social pension from the government continued to get it during the pandemic without much problem. In some states, they were getting SMS when the amount was credited to their accounts. In others states, they had to go and find out from the bank, but the branches were not very far away. In Odisha, pension was distributed in the village panchayat office.

Those who lived in old age homes were far more satisfied with the services during the pandemic than those living in community. The old age homes were better in terms of food, sanitation, recreation and medical facilities. They were happy with the services of the care-giver staff as well, some of whom were sensitive enough to take them out in a vehicle for a round in the city just to break the monotony. TV sets provided to some old age

homes in the pandemic provided to be a good source of recreation for the residents. The old age homes that received grant for renovations and buying fixtures were also appreciative of the fact that their toilets, or water tanks were repaired. Some were able to use beds and use cupboards.

Some limited efforts were made to restore livelihood activities that got affected by the pandemic. In Bihar, the operations were not so impacted and the members of ESHGs were able to help others less fortunate. But in West Bengal and Madhya Pradesh, the income generation activities were resumed in full force. The groups were able to sustain the disruption by the pandemic. In a small effort in Delhi, poor women including older women were given push carts with the help of corporate support to start earning a living.

The research highlighted the fact that despite the risk that the pandemic posed to the older persons, not much was done by way of focused support for them. No special measures were adopted to address their social security needs, employment opportunities, expansion of health care, nutrition, care, recreation and social and digital inclusion. The concerns of older persons were addressed in a limited way by the VOs supported by the community, corporate and institutional donors. However, the impact of the pandemic is much deeper and could not be dealt with just by vaccinations and free rations.

Review of Literature

Population ageing or demographic ageing is an unprecedented event in the history of human evolution. In recent years, a trend of increasing proportion of older people concomitant with the decline in the proportion of young population has been noticed. The United Nations Population Division had predicted that by 2050, older persons in the world will exceed younger ones (United Nations, 2002). While the developed nations have had a long gestation lag in getting their population structures altered, for the developing countries who are still struggling to cope up with their developmental problems and managing resources, stabilizing population growth, a smaller interval in the exponential increase in their elderly population has posed serious problem that needs immediate care and attention.

The occurrence of natural disasters and epidemics add to the agony of the elderly, especially in the developing world; where, health infrastructure is not easily accessible, health care services involve a lot of out-of-pocket expenditure and mental health concerns of the elderly are not a priority. Such situations need special attention and needless to say the pandemic caused by the COVID-19 virus hit the elderly in the developing countries like India worst as social care got affected to a great extent and much of the impact has gone unnoticed.

(Natural) disasters which pose a great challenge to the humankind in general, make the older adults more vulnerable in comparison to the younger adults because of the decline in their sensory awareness, physical impairment, chronic ailments (Rafiey, 2016). The severity of COVID-19 has been different amongst the different age cohorts of the older adults and researches show that the fatality rate of around 8 per cent amongst the elderly in the seventh and the eighth decade of their life increases to around 15 per cent amongst the elderly in their ninth decade of their life (Klanidhi, 2021; Grills and Srinivas, 2021). The presence of chronic ailments like diabetes, hypertension, chronic kidney disease, immune-compromised state, organ transplant and cardiovascular diseases have been found to be associated with more severe consequences and the risk of hospitalization has been found to be 4.5 times higher amongst the elderly with two or more comorbidities (Klanidhi, 2021).

Disasters and Vulnerability of the Elderly- A Theoretical Framework

It is evident that the occurrence of disasters make older people more vulnerable and when the pandemic struck, the situation was no different. However, there are two different schools of thought which establish the causal relationship

between the vulnerability of the elderly and the occurrence of disasters or any other unforeseen events. The maturation theory and the inoculation theory support that though the elderly are more reactive to the disasters (natural) and the associated stress, they have mature ways to handle the situation. This is further supported by the inoculation theory which suggests that previous experiences during their lifetime protect the elderly from the strong reactions and likewise the effects of the disasters (McGuire, 1961).

The loss of functional abilities, physiological degeneration, immuno-compromised state of being make the older adults more vulnerable in the times of the disaster. Resource theory and the exposure theory support this view and suggest that the older adults being less aware of the signals are more likely to face the deprivation especially at times of disasters (Rafiey, 2016) and pandemics like COVID-19 are no exception.

The chronic physical and mental health conditions, the decline in the cognitive experience, limited access to financial resources make the older adults exposed to greater danger during the disasters, yet they can be treated as models of resilience and can act as knowledge banks for the younger generations. Their vast experience can be used in developing mitigation strategies by the planners and the policy makers. The constant

endeavor of voluntary organizations like HelpAge India who have worked with special focus on the elderly populations in disaster prone and affected areas goes a long way in informing the response mechanisms that can help alleviate the sufferings of the older person during disasters. Though COVID 19 pandemic threw up its own peculiar challenges, the existing structures and ethos did help in providing quick and appropriate response to some extent (HelpAge India, 2022)

Physical and Mental Health Concerns of the Elderly during COVID-19

Elderly population accounting for more than 9 per cent of the global population, is estimated to constitute 14.9 per cent of the total population in India by 2036 (National Commission on Population, 2020). The World Health Organization (WHO) has reported that more than 22 per cent of COVID-19 infections were seen in older adults aged 65 years or more. Moreover, summing up the situation in April 2020, the WHO Regional Director for Europe mentioned that over 95 per cent of the COVID related mortality occurred to older adults of more than 60 years of age and more than 50 per cent of them were 80 years of older (Kluge, 2020).

Studies indicate low level of pandemic preparedness in South Asia including India where

vulnerabilities of the health systems were seen, however, most countries did in bringing an appropriate response to the pandemic (Babu, et al, 2021). This was noticeable in terms of vaccinations reach out. Available data reflects higher rates of mortality and morbidity among older people compared to young as a result of the COVID-19 pandemic. The Global Health Security Index indicates score for India being below 50, considered low (Babu, et al, 2021). In India while the much of adult population was affected, the older people were disproportionately more vulnerable and for whom the societal response to normalize things was limited (Shankardass, 2021a). In addition, physical and mental wellbeing of older people was critically affected during the COVID 19 pandemic (Shankardass & Mallick, 2020).

Though age-segregated information of the morbidity and mortality was not easily available in India, West Bengal indicated a case-fatality rate of 7.45 percent amongst 75+ years and 3.41 percent for 60–75 years age groups, compared to 0.32 percent in 31–45 years as on 26th November, 2021; in Kerala too, 54 per cent of the mortality was reported amongst the senior citizens (Mona, 2021). In the country as a whole till September, 2020, 12 per cent of the COVID induced mortality was reported by the 60 years and above age group

(HelpAge International, 2020). As per estimates on 13 October 2020, 53 percent of the deaths have occurred in the age group of 60 and above, though they accounted for only 12 percent of COVID-19 positive cases as per data released in September (WHO, 2020).

The pandemic struck – people started getting infected with the Novel Corona Virus, there were disruptions in the lives and livelihoods of the people across the social groups. Though the initial impact of the ailment was more on the health of the individuals, but with the passage of time, social isolation and distancing, staying away from the family, friends and peer groups casted a lasting impact of the psychological health of the aged. Neurological disorders were on the rise, but, the access to neurological rehabilitation services was curbed to a great extent owing to the fact that most of the public and the private health care institutions were converted to dedicated COVID care centres (Surya, 2021). A segment of the aged with special neuro-cognitive disorders like dementia faced a lot of problem. The reduction in the access to healthcare facilities, fear of getting infected, limited resources in terms of healthcare provision acted as hurdles to dementia care during the COVID (Banerjee, 2020) and these were compounded by the additional burden of the stigma, abuse, ageism and the financial

dependence in many cases. Delay in the institutional care, loneliness and lack of stimulation possibly accelerated the cognitive decline and also worsened the conditions of the individuals suffering from such problems (Dala et al., 2020). On the flip side, amongst the caregivers, in a study conducted in Karnataka with the health care workers, anxiety disorder (26.6 per cent) and depression (23.8 per cent) was highest among those with frontline COVID-19 responsibilities. The prevalence was significantly higher among those with clinical responsibilities compared to those with supportive responsibilities (Parthasarathy et al., 2021).

With the nationwide lockdown being announced, the vulnerable and the marginalized were also subjected to physical and psychological abuse and the older adults were also not spared. 1 in every 6 person, 60 years and older, experienced some form of abuse in community settings during the past year and the rates of elder abuse had been much higher in the institutional care facilities like nursing homes and long term care centres (WHO, 2021). In community as well as in the institution settings, the prevalence of different forms of elder abuse had increased during COVID-19 by up to 83.6 per cent (Chang and Levy, 2021).

As businesses shut down, many people lost jobs, experienced pay cuts and also were forced to migrate to their native places. The decline in the financial means of the bread winners had its lasting impact on the care seekers (elderly in most cases) and was often manifested in both physical and mental abuse (Makaroun et al., 2020). The increase in anxiety also resulted from the increased time demand for caring for children and other family members at home who were ailing and this disrupted work-life balance as well and this is well documented in a study, where more than 23 per cent of the caregivers faced challenges in handling their anxiety during and after the COVID (HelpAge, 2021). People feared mental health concerns, regressing economy, shortage in supplies of essentials like food and medicine. It is evident from a poll conducted by the American Psychiatric Association that more than one-third of Americans (36 per cent) mentioned that coronavirus is having a serious impact on their mental health, while 57 per cent believed that it is having negative impact on their finances, and 68 per cent were of the opinion that COVID would have a lasting impact on the economy (APA, 2020).

The situation had been no different for the older adults in India. According to a recent report, 78 per cent of the elderly in India mentioned that they were victims of situations which violated the basic human rights and these included social isolation,

financial deprivation, elder abuse and neglect (Agewell Foundation, 2022). A similar study done by the HelpAge India brought forth the fact that 62 per cent of the elderly felt that the risk of getting abused has increased and disrespect and physical abuse were predominant during the COVID-19 pandemic. While 61 per cent of the elderly experienced financial abuse, 60 per cent felt emotionally abused and 59 per cent reported physical abuse (HelpAge India, 2021).

Impact of COVID on the Livelihood of Elderly

Low income countries where one in every five above 70 years of age are economically active, bear the brunt of the disasters as they are prevented from doing their usual work because of a host of factors being operational (HelpAge International, ND). A nation-wide survey of older persons in June 2020 indicated that the pandemic has adversely impacted the livelihoods of roughly 65 per cent of the participants. In India, close to half of the elderly are economically active and close to 17 per cent of them are engaged in the informal sector (HelpAge International, 2020). However, the unemployment rates had soared high during the pandemic starting March 2020 and in March 2022 it is reported to be 8 per cent in urban India and 7 per cent in the rural counterparts (CMIE, 2022). All these are indicative of the agony of the elderly who are forced to work, earn their own living and in some cases even support their families.

Interventions like cash for work, income generation programs, credit support often leave the voices of the working elderly unheard and the additional disease burden, dependence on remittances, lack of access to the resources make the situation wearier. Research results indicate that COVID had a negative impact on the breadwinner of the families and along with that, there were state level regulations imposed on the aged in terms of their employment in the different states across the nation looking at their vulnerability (HelpAge India, 2020). For instance, in Kerala, elderly above 65 years of age were restricted from getting guaranteed wage employment for 100 days under the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) and this act of reverse quarantine affected almost 4 lakhs elderly in the state (Wire, 2020; Indian Express, 2020); similarly, in Maharashtra, the government restricted performers in the television and the film industries to return to work looking at their vulnerability (Deccan Herald, 2020).

COVID-19 has changed the daily routines of the family members especially the elderly in terms of the care and support they receive, their ability to

stay socially connected and how they are perceived. Older people are being challenged by requirements to spend more time at home, lack of physical contact with other family members, friends and colleagues, temporary cessation of employment and other activities; and anxiety and fear of illness and death – their own and others and therefore, it is important to create opportunities to foster healthy ageing during the pandemic situations (WHO, 2020).

Taking Care of Elderly during Lockdown

Advisories had been put across by the Ministry of Health and Family Welfare (MoHFW) to control the spread of infection during COVID-19 and most of these were targeted to all the age groups alike. These included avoiding going outside unless emergency, maintaining distance of one meter while meeting anybody in person, washing hands and face with soap and water at regular intervals, disinfecting surfaces at regular intervals, coughing and sneezing into the elbow or in tissues papers and disposing the tissues after single use, having healthy home cooked meals, and fruit juices to boost immunity, to mention a few (MoHFW, 2020). Meanwhile, the following had been prescribed to contain the spread of the infection amongst the elderly or persons with comorbidities:

✓ Postponing of elective surgeries like cataract surgery and knee replacement

✓ Refraining from visiting hospitals for regular follow ups or check-ups

✓ Refraining from visiting crowded places like parks, markets and religious place

For older adults living at home, the proactive assessment by a general physician or family nurses to evaluate the development of typical COVID-19 symptoms and of atypical symptoms, such as sudden changes in cognitive status, onset of behavioral disturbances or decline in functional status which may lead to suspect infection would be helpful and in cases where COVID-19 infection is suspected, the initiation of pharmacological treatment, evaluation of the oxygen need, educating the family members to manage the isolation and assess the need of hospitalization had been recommended (Bianchetti, 2020). Once admitted, the need for low, medium or high intensive care need to be defined and the protocols for preventing and treating delirium, behavioral and functional complications and provision of palliative care needs to be implemented and once the infection has gone away, the care after discharge needs to be planned.

For elderly living in the long term care facilities, confirmatory tests need to be performed and in cases of positive results, the infected needs to be

isolated at the earliest with the provision of supportive and specific treatment plan. The caregivers need to be monitored on a regular basis for the COVID symptoms and be provided with PPEs to safeguard them from getting infected.

Tele-consultation has become a very popular mode of seeking medical advice during the pandemic in India and the concerns like loneliness, isolation, sensory problems, impairment of cognitive abilities (memory, thinking, the use of language), psycho-social vulnerability have been evident especially in terms of the vulnerability of the old age population (Banerjee, 2020). Simple and very low-cost measures enabled the quality of non-pharmacological care to be maintained at this critical time via virtual support. Particularly during the current pandemic, elderly with ailments like dementia needed constant attention and care. The training of professionals and of informal (family and friends) and formal (hired) caregivers on providing care has been discussed as an effective strategy that can prevent the onset of comorbidities and thus reduce healthcare costs (Feretti, 2021).

On the other end, reports suggest that there has been an increase in queries regarding vacancies in the Old Age homes in response to the skepticism of the family members to keep the vulnerable older people in the house fearing that they will affect their children and also the urge to maintain the social distancing within the household (Sen, 2020).

Support Received from the Government

With the onset of the pandemic and the nationwide lockdown during the first wave, the Government of India announced a relief package of INR 1,70,000 crores covering benefit in the form of 5 kg wheat or rice and 1 kg of preferred pulses to 80 crores poor, a financial support of INR 500/month to 20 crores women of Jan Dhan account holders, increase in MGNREGA wage from INR 182 to INR 202 a day to benefit 13.62 crores, an ex-gratia of INR 1,000 to 3 crores poor senior citizen, poor widows, poor disabled and 8.7 crores farmers with INR 2,000 by PM Kisan Yojana (Ghosh et al., 2020).

Effective from the 1st of April 2020, the National Plan for Welfare of Senior Citizens was launched with an annual outlay of USD 27.4 million, which is mainly the existing funding expanded under new policy instruments (MoSJE, 2020). With four sub-schemes embedded in it, the National Plan comprises of components of financial security, healthcare and nutrition, shelter and welfare, and protection of life and property of senior citizens. It also includes establishment of a Contributory Welfare Fund for senior citizens with funding support from the central government, private

sector, charities etc., as well as a Group Pension Plan for Self Help Groups, Traders Associations, etc. that would provide income security to groups of self-employed people in old age . The sub-schemes under this umbrella scheme and their key provisions are as follows:

- **Scheme of Integrated Programme for Senior Citizens** – Targeted beneficiaries include indigent senior citizens. Some of the programmes admissible for assistance under this sub-scheme include maintenance of senior citizens' homes for up to 25-50 beneficiaries and maintenance of care homes for senior citizens afflicted with Alzheimer's disease/dementia.

- **State Action Plan for Senior Citizens** – The objective of this scheme is to support programmes that promote productive and active ageing among senior citizens. Programmes admissible for assistance include organising senior citizens into Elder Self-Help Groups, maintenance of Mobile Medicare units for senior citizens, maintenance of multi-service centres, physiotherapy clinics and the creation of a pool of trained geriatric caregivers.

- **Convergence with Initiative of other Ministries in the field of Senior Citizens Welfare –** The objective of this scheme is to ensure implementation of programmes that may require coordination of various departments and ministries, convergence activities are promoted.

- **Media advocacy, capacity building, research and other projects for welfare of senior citizens –** Programmes envisaged under this sub-scheme include awareness generation and sensitisation, training on geriatric care and capacity building programmes, organising regional level seminars, workshops and conferences, research proposals on issues relating to senior citizens, etc.

Following the announcement of the nationwide lockdown, in addition to the provisions announced by the central government, the state governments also supported the COVID hit victims through the different entitlements which are summarized below:

- The treatment of the elderly from the underserved societal and economic background were to be covered under the Ayushman Bharat scheme.

- The Government announced that pensions for the months of April, May and June would be paid in advance to the 18.4 per cent elderly poor people covered under the Indira Gandhi National Old Age Pension Scheme.

- An ex-gratia amount of INR 1,000 was announced for the older persons, differently-abled and widows under its

Pradhan Mantri Garib Kalyan Yojana (PMGKY) to be pain in two instalments for the months of April, May and June 2020 covering approximately 29.8 million beneficiaries.

- The Government of NCT of Delhi doubled the pension amount to INR 4000-5000 for the months of March and April 2020 for the elderly covered under the Old Age Pension Scheme residing in Delhi for a minimum of 5 years and with an annual family income of INR 0.1 million, thus benefitting around 0.5 million elderly.

- Free ration had been distributed in Delhi to more than 10.2 million beneficiaries with 50 per cent more entitlements of rice, wheat, pulses in April and May 2020.

- The state government in Tamil Nadu announced INR 1000 for April and free ration items in April and June 2020 for their ration card holders

- The state government of Maharashtra announced the Shiv Bhojan Thali Scheme, providing food at INR 5 to 10 million people.

- Elderly helpline numbers were established in the states of Kerala and Telangana. In Kerala, the initiative was taken under the Grand Care initiative and these call centres were meant to address the healthcare requirement of the elderly.

- Using the database of senior citizen living in each municipality, the Government of West Bengal addressed the needs of elderly assessed through home visits.

- In Manipur, the state health department set up outreach team for visiting the elderly in residential care centres and also distributed masks and sanitizers in addition to sensitizing them on the protocols of social distancing and hygiene practices.

- The state Government in Assam, set up a dedicated geriatric COVID care centre for the population aged 65 years and above.

- In Andhra Pradesh, NGOs supporting old age homes were given free ration.

One of the primary health concerns that had been reported during the pandemic was that of the mental health including issues of stress, anxiety, depression, insomnia, denial, anger and fear leaving the children and older people, frontline workers, people with existing mental health illnesses as most vulnerable. State-specific intervention strategies, tele-psychiatry consultations, toll free number specific for psychological and behavioral issues have been issued by the Government of India as listed below (Roy et al., 2021):

- The MoHFW issues a toll-free number on behavioural health which could be used by any person needing mental health

assistance during the pandemic along with publishing IEC materials for elderly and children on mental healthcare covering issues of understanding the lockdown, handling isolation and dealing with the mental health issues after recovering from the COVID infection.

- The National Institute of Mental Health and Neuro-Sciences (NIMHANS) suggested the constitution of a psychological intervention medical team which could act as a standalone team or be part of the general medical team attending to people affected by the pandemic. The staff should consist of psychiatrists, with clinical psychologists and psychiatric nurses participating and the teams should formulate interventions plans separately for different groups for example: (a) Confirmed cases who are hospitalized with severe symptoms (b) Suspected cases and close contacts of confirmed cases (c) People with mild symptoms who are in home quarantine (d) Health care personnel working with people with COVID-19 (e) General public.

- The Government of India's initiative in the name of the Aarogya Setu app helped in augmenting the initiatives of the health department in reaching out to the users informing them about the risks, best practices and the relevant advisories about the containment of the virus.

- Similar efforts were also put by the Institute of Mental Health in Hyderabad and the Tamil Nadu Psychology Association.

At the global level, bringing together the governments, civil society organizations, international agencies, professionals, academia, media and the private sector players to improve the lives of older people, their families and the communities in which they live, the United Nations have aligned itself with the last ten years of the Global Goals through a collaborative effort of The United Nations Decade of Healthy Ageing (2021-2030). COVID 19 pandemic has brought the entire world face to face with the existing gaps in the policies, systems, services, accessibility and the affordability and therefore, a decade of healthy global ageing across the world is the need of the hour. The focus of the decade will be on age-friendly environments, combatting ageism, integrated care and long term care facilities and these will be facilitated through voice and engagement, leadership and capacity building, connecting the various stakeholders and strengthening research, data and innovation (WHO, 2021).

Support Received from Private Agencies

Some of the common problems that plague the Indian public healthcare system are the poor service quality, lack of coverage in the remotest corners, lacking infrastructural support and all these together with the health crisis in the pandemic created a huge gap in terms of the demand and the responsive supply. To bridge the gap, the private players collaborated with the civil society organizations working for older people with the intent of extending support towards COVID relief. Such collaboration of Older People's Associations (OPA) have been found to be an effective model in low income countries like Bangladesh (Stubbs and Clingeleffer, 2021) and have also been popularly followed in India as well.

The social service workforce (SSW) responding to COVID-19 including the government and non-government professionals and paraprofessionals, community workers have played essential roles of promotive, preventive and responsive functions (UNICEF, 2021) during the COVID-19. While promotive functions included advocacy, coordination, educating, training, managing and monitoring, preventive functions included identifying vulnerable households, working with community leaders, provision of remote psychological support, reinforcing gatekeeping and the responsive functions included provision of protection and support, identifying emergency alternative care, carry out emergency care to different age groups, deliberating case management processes and provision of counseling etc.

A lot of COVID relief support has been received from the various corporations as a part of their Corporate Social Responsibility (CSR) initiatives. Though the interventions targeted the population in general, they also benefitted lots of elderly in their course of action. The top ten contributors who extended their support during the pandemic along with their contribution are listed in the following section (The CSR Journal, 2021):

Procter & Gamble

Procter & Gamble in partnership with government and local authorities in India pledged a contribution of INR 50 Crore towards the vaccination of over 5 lakh India Citizens along with organizing awareness sessions on safety and hygiene. Under its PG Suraksha India programme, the corporation supported the community through the donation of products, in-house manufactured masks and sanitizers especially to aid frontline and essential workers who are tirelessly working to combat the spread of COVID-19 during the second wave in addition to donating 35 lakh of health, hygiene and cleaning

products. Initiatives like Gillette Barber Suraksha Program, Whisper, P&G ThankYouMa, Vicks ShowWeCare and Tide AngelsInWhite were launched by the organization to support India's fight against COVID-19. P&G has reached more than 5 crore Indians to spread awareness on safety, health and hygiene. The Group also partnered with the government and industries to kick start an initiative called 'Suraksha Circles' and engaged with more than 1400 organizations and SMEs to lay down standards of hygiene and safety at manufacturing facilities.

Wipro

Wipro Ltd, Wipro Enterprises Ltd and Azim Premji Foundation, together committed INR 1,125 crores towards tackling the unprecedented health and humanitarian crisis arising from the COVID-19 pandemic outbreak to support the frontline workers.

Wipro Limited repurposed one of its IT campuses in Hinjewadi, Pune into a 450-bed intermediary care COVID-19 hospital in four weeks. The hospital was handed over to the Maharashtra state government in June 2020. The temporary hospital is equipped to treat moderate cases, and includes 12 beds to stabilise critical patients before shifting them to a tertiary care facility. This is an independent, isolated COVID-19 dedicated complex that also includes 24 rooms to accommodate doctors and medical staff.

HUL (Hindustan Unilever Ltd)

Hindustan Unilever Limited (HUL) pledged INR 100 crores in March 2020 to help the pandemic hit country. During the pandemic, the organization collaborated with UNICEF and other civil society organizations to distribute soaps and sanitizers to the vulnerable communities in tribal areas, flood-hit regions, COVID hit villages and slums, remote tea estates amongst others. Campaigns like BreakTheChain, VirusKiKadiTodo were organized by the corporation as a mass media campaign to sensitize the COVID infected communities. HUL also extended product donation and other support across India around its manufacturing locations and offices in West Bengal, Tamil Nadu, Karnataka, Madhya Pradesh and Uttar Pradesh.

Infosys

Infosys Foundation -- the CSR arm of Infosys committed INR 120 crore towards COVID relief in India of which more than one-third was contributed to the PM CARES Fund. The foundation directed its CSR funds in supporting the migrant labourers, their families and also the frontline workers. They also supported the 2.4 million COVID hit population by providing them with cooked meals.

Infosys and Narayana Health, one of India's largest health care providers, set up a 100-room hospital in Bengaluru, entirely for COVID-19 patients from the underserved sections in the society.

Mankind Pharma

The organization donated around INR 100 Crore to supported families who lost their dear ones to COVID. The organization also donated to the PM Cares Fund and donated ventilators, Personal Protective Equipment (PPE) and medicines to the health care facilities for the frontline workers.

Vedanta

The company imported 23 PPE machines in collaboration with the Ministry of Textiles and has teamed up with authorized apparel manufacturers to roll out over 5000 PPEs per day. Additionally it supported communities, daily wage earners, individuals engaged in preventive healthcare along with their employees, contract partners and business partners during the pandemic. The organization conducted intensive awareness and sensitization sessions alongside disinfection and sanitization drives in the villages around the business units. Safety PPEs were distributed among the community and frontline warriors. The units in Rajasthan, Chhattisgarh, Odisha converted their existing hospitals and other facilities into COVID isolation wards.

To ensure food security, CSR of Vedanta launched the 'Meals for All' programme to extend supply of meals to lakhs of daily wagers. During the first phase of the program, support was extended to stray animals as well. Besides Meals for All, the Vedanta group of companies distributed dry ration kits among thousands of the marginalized and labourers.

Reliance

Reliance industries Limited donated INR 500 crores to PM CARES Fund during the first wave of COVID and also made additional monetary contribution of INR 5 crores each to Maharashtra and Gujarat government to support their relief work against COVID. During the first phase of the pandemic, Reliance Foundation and the BMC had set up India's first COVID hospital in Mumbai, with a dedicated 225-bed facility at Seven Hills Hospital. Moreover, all the COVID patients in this hospitals were treated free of cost.

Amazon

Amazon Europe has committed $2.5 million to support India's fight against Covid-19 especially in terms of purchase of medicines and transportation of medicine supplies. The company procures oxygen concentrators from Italy, ventilators from the UK, and nebulisers and inhalation devices from Germany and provided the same to the Amazon frontline workers and local charities to help those infected with COVID-19 across multiple cities in India. The corporation worked closely with the Indian Red Cross under the guidance of Niti Aayog and the Ministry of Health and Family Welfare.

Google

Google announced a donation of USD 18 million relief fund to help the pandemic struck India. It also supported civil society organizations to extend medical supplies and sensitize the high risk communities against the vagaries of the pandemic. Direct cash transfers were made to the families hit by the crisis and urgent medical supplies like oxygen concentrators, testing equipment were also provided to the ones in need from this fund.

Microsoft

Microsoft also supported the community with essential medical supplies like oxygen concentrators to fight the difficult times in COVID.

Civil Society Organizations

Concerted efforts have been put in by the civil society organizations to bring out the concerns of the elderly in the country. One such initiative undertaken by the HelpAge India, outlines how the groups of elderly who are already vulnerable are further been marginalized and disenfranchised by the pandemic and how the state agencies are responding to the situation (Williamson et al., 2021). This study also brings into focus that despite ushering a host of challenges to the older adults, the pandemic has created opportunities for them and the organizations that work with them and the immediate action pointers include bringing in innovation to engage all older people, placing the rights and empowerment at the core of all activities, establishing and strengthening the role of the civil society organization and engaging constructively with the government to shift power relations (ibid).

On the other hand, there have been user friendly portals like the Evergreen Club have extended their online services like Seniority for senior citizens to cater to their social needs and redefine their sense of purpose and the sense of belonging (Nazir, 2022).

Conclusion

It is evident from the above discussion that the COVID-19 was altogether a new experience across the globe and for the developing nations who are yet to have an organized socio-economic space, challenges of lacking infrastructure, huge demographic pressure, lack of awareness etc. have made it much difficult for the policy makers to come up with remedial measures that would serve one and all. However, there has been no dearth of efforts from all quarters to cater to the requirements of the different demographic, social and economic groups, yet, much of the efforts have not been documented properly for a wider reach and a lesson learning. The operational frameworks, resource mobilization and the implementation plans are in themselves a repository for learning to get prepared for warding off emergencies in future and this study is a first of its kind to bridge the knowledge gap and collate the best practices of the services extended to the elderly in India by a host of voluntary organizations.

References:

1. Agewell Foundation, "Contribution of Older Persons in Sustainable Development (With a special focus on Impact of Covid-19 pandemic on old people)", (2022) available on: https://www.agewellfoundation.org/wp-content/uploads/2022/02/Contribution-of-Older-People-in-Sustainable-Development-with-a-special-focus-on-Impact-of-Covid-19-on-Older-People-February-2022.pdf.
2. American Psychiatric Association, "COVID-19 impacting mental well-being: Americans feeling anxious", (2020), available on: https://www.psychiatry.org/newsroom/news-releases/new-poll-covid-19-impacting-mental-well-being-americans-feelinganxious-especially-for-loved-ones-older-adults-are-less-anxious.
3. Babu, G R, Khetrapal, S., John, D A, Narayan, K M V., "Pandemic preparedness and response to COVID-19 in South Asian countries: (2021). *International Journal of Infectious Diseases*, March 104: 169-174.
4. Banerjee, D. "Let's care for our elderly during the coronavirus pandemic" (2020), available on: https://www.nature.com/articles/nindia.2020.64

5. Bianchetti, A., et al., "Improving the care of older patients during the COVID-19 pandemic", (2020) available on: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7352085/.

6. Chang, E.S. and Levy B.R., "High prevalence of elder abuse during the COVID-19 pandemic: risk and resilience factors", (2021), available on: https://pubmed.ncbi.nlm.nih.gov/33518464/

7. CMIE, "Unemployment in India" (2022), available on" https://unemploymentinindia.cmie.com/

8. Dalal, P. K. et al., "Emerging mental health issues during the COVID-19 pandemic: An Indian perspective", (2020), available on: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7659779/

9. Deccan Herald, "Barring senior citizens from film sets not discriminatory: Maharashtra Govt.", (2020), available on: https://www.deccanherald.com/national/west/barring-senior-citizens-from-film-sets-not-discriminatory-maharashtra-govt-865884.html.

10. Ferretti, C., et. al., "Virtual Support in Dementia: A Possible Viable Strategy for Caregivers", (2021), available on: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8409523/.

11. Ghosh, A., et al., "How India is dealing with COVID-19 pandemic", (2020), available on: https://www.sciencedirect.com/science/article/pii/S2666351120300218,.

12. Grills, N. and Srinivas, G. "CARING FOR INDIA'S ELDERLY DURING COVID-19" (2021), available on: https://pursuit.unimelb.edu.au/articles/caring-for-india-s-elderly-during-covid-19.

13. HelpAge India, "Report for Assessment of Elderly Care Challenges during Covid-19", (2021a), accessed 21st April, 2022, available on https://www.helpageindia.org/wp-content/uploads/2021/06/The-Silent-Tormentor-Covid-19-the-Elderly-A-HelpAge-India-Report-2021.pdf

14. HelpAge India, "Impacting elder policies", (2021b), accessed 21st April, 2022, available on https://www.helpageindia.org/our-work/rights-entitlements-programs/impacting-elder-policies-and-laws/.

15. HelpAge International, "Older people in emergencies and humanitarian crises", available on: https://www.helpage.org/what-we-do/emergencies/older-people-in-emergencies/.

16. HelpAge International, "COVID-19 - Older adults and long-term care in Asia Pacific", (2021), available on: https://www.helpage.org/download/5fdb7b1185a82.

17. HelpAge International, "Income security for all older people in Bangladesh during COVID-19 and beyond" (2020), available on: https://www.helpage.org/download/5fd8ea5e86005.

18. Indian Express, "Reverse Quarantine", (2020), available on: https://indianexpress.com/article/india/kerala-reverse-quarantine-for-elderly-will-keep-4-lakh-off-mgnrega-works-6449470/.

19. Klanidhi, K. B. et al., "Health care of the elderly during Covid-19 pandemic—All a family physician should know" (2021), available on https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8140280/.

20. Kluge, H.H. "Older people are at highest risk from COVID-19, but all must act to prevent community spread", available on: https://www.euro.who.int/en/health-topics/health-

emergencies/coronavirus-covid-19/statements/statement-older-people-are-at-highest-risk-from-covid-19,-but-all-must-act-to-prevent-community-spread
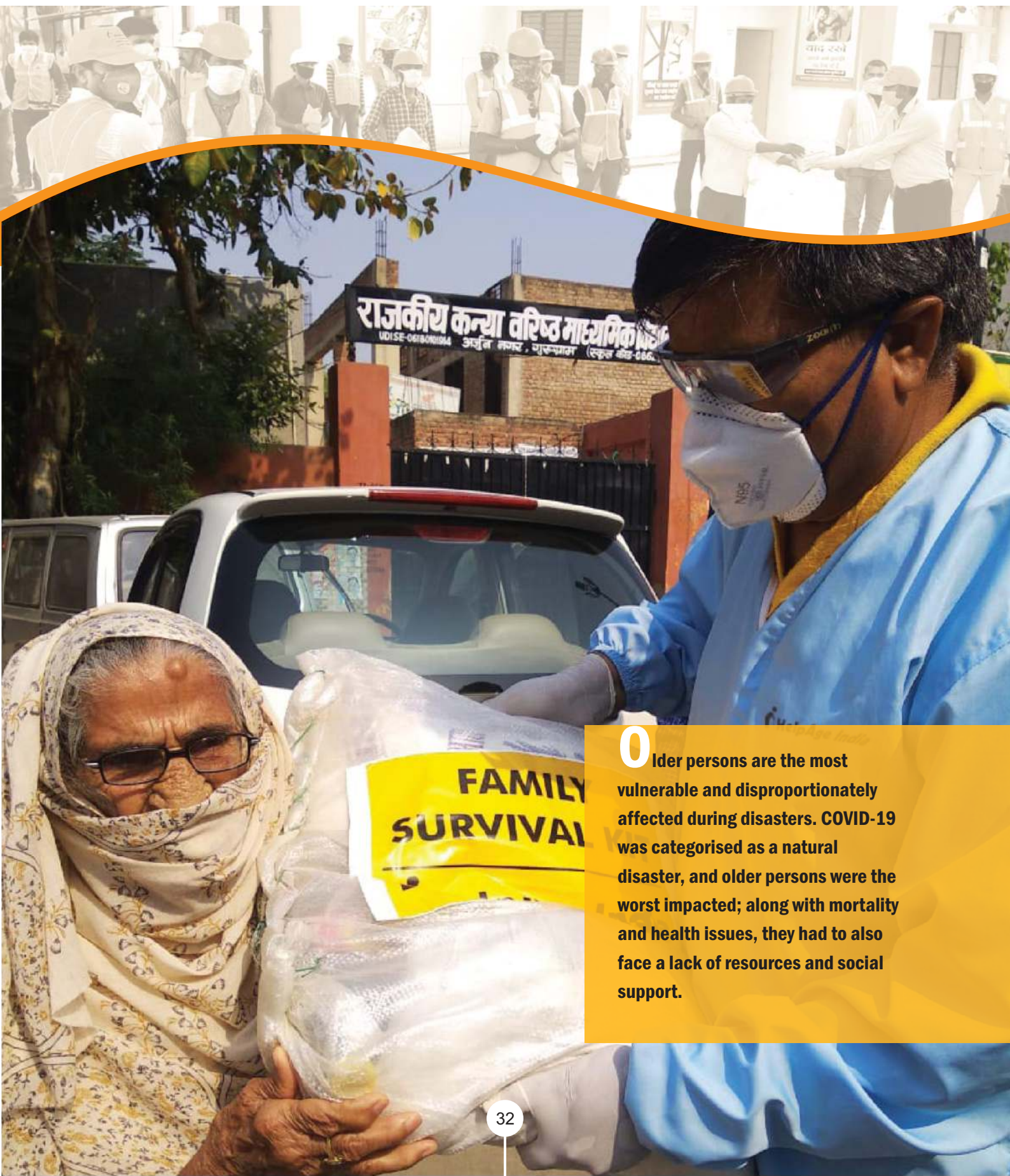
21. National Commission on Population, "Population projection for India and states", accessed 29th ", 2022, Available on
https://main.mohfw.gov.in/sites/default/files/Population%20Projection%20Report%202011-2036%20-%20upload_compressed_0.pdf.

22. Makaroun, L.K. et. al., "Elder Abuse in the Time of COVID-19—Increased Risks for Older Adults and Their Caregivers", available on:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7234937/pdf/main.pdf

23. McGuire, W. J., "Resistance to persuasion conferred by active and passive prior refutation of same and alternative counterarguments" (1961), Journal of Abnormal Psychology. 63 (2): 326–332. doi:10.1037/h0048344.

24. MoFHW, "Health Advisory for Elderly Population of India during COVID19", available on:
https://www.mohfw.gov.in/pdf/AdvisoryforElderlyPopulation.pdf.

25. Mona, "India and the elderly: Assessing the impact of COVID-19 and thinking forward", (2021), available on: https://www.orfonline.org/expert-speak/assessing-the-impact-of-covid-19-and-thinking-forward/, Health Express, December 9, 2021

26. Ministry of Social Justice and Empowerment (Govt. of India), "An umbrella scheme for senior citizens", (2020), available on: https://grants-msje.gov.in/display-napsrc.

27. Nazir, T. "How This Online Platform Is Bringing Country's Senior Citizens Together During Pandemic", (2022), **accessed 29th** March, 2022, available on:
https://thelogicalindian.com/inclusivity/evergreen-club-senior-citizens-33123

28. Parthasarathy, R. , et al., "Mental health issues among health care workers during the COVID-19 pandemic – A study from India", (2021), Asian Journal of Psychiatry, Volume 58, April 2021, 102626, available on: https://www.sciencedirect.com/science/article/pii/S1876201821000824.

29. Rafiey, H. et al., "Are older people more vulnerable to long-term impacts of disasters?", Clinical Interventions in Aging 2016:11 1791–1795

30. Roy, A., et al., "Mental health implications of COVID-19 pandemic and its response in India", available on: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7468668/.

31. Sen, S. "Amid COVID-19 Pandemic, Ahmedabad Old Age Homes Receive Increasing Queries On Vacancies", (2020), accessed 29th March, 2022, available on
https://thelogicalindian.com/news/old-age-homes-inquiries-increase-22311,

32. Shankardass, M. K. "Home, the Vulnerable and the Pandemic" in G. D Tripathy, A. Jalan, & M. K. Shankardass (Eds) Sociological Reflections on the COVID 19 Pandemic: Redefining the Normal, (2021, pp. 35 – 50). Springer Nature.

33. Shankardass, M. K. and Mallik, A. "Mental and Physical wellbeing of elderly requires special focus during pandemic" Indian Express, 24 August, 2020, available on:

https://indianexpress.com/article/opinion/columns/dignity-amid-covid-elder-people-mental-physical-health-6567010/

34. Stubbs, T and Clingeleffer, S, "Bangladesh Research Report", (2021), available on: https://www.helpage.org/download/60acfbb9e3a24.

35. Surya, N. et al. "Education, Training, and Practices of Neurorehabilitation in India During the COVID-19 Pandemic", (2021), available on: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7902936/.

36. The CSR Journal, "Top CSR Contributions for Covid Relief in India", (2021), available on: https://thecsrjournal.in/top-csr-contributions-for-covid-india/.

37. The Wire, "Reverse quarantine" (2021), available on: https://thewire.in/rights/kerala-decision-to-bar-those-above-65-from-mgnrega-work-will-deprive-4-lakh-people

38. United Nations, "World Population Ageing 1950-2050", Population Division of the Department of Economic And Social Affairs (2002)

39. UNICEF. "Social Service Workforce Safety and Wellbeing during the Covid-19 Response", (2021), accessed on 29th March, 2022, available on https://www.unicef.org/media/68501/file/Social-Service-Workforce-Safety-and-Wellbeing-during-COVID19-Response.pdf

40. WHO, "Coronavirus disease (COVID-19)", (2020), accessed 29th March, 2022, available on https://www.who.int/docs/default-source/coronaviruse/situation-reports/20201005-weekly-epi-update-8.pdf.

41. WHO, " Elder abuse", (2021) available on: https://www.who.int/news-room/fact-sheets/detail/elder-abuse

42. Williamson, C., et. al. "Are older people being heard?", (2021), available on: https://www.helpage.org/download/6006beff8485c

43. WHO, "Coronavirus disease (COVID-19)", (2020), accessed 29th March, 2022, available on https://www.who.int/docs/default-source/coronaviruse/situation-reports/20201005-weekly-epi-update-8.pdf.

INTRODUCTION

Older persons are the most vulnerable and disproportionately affected during disasters. COVID-19 was categorised as a natural disaster, and older persons were the worst impacted; along with mortality and health issues, they had to also face a lack of resources and social support.

Background

Older Persons in Disasters

A disaster is defined "catastrophe, mishap, calamity or grave occurrence in any area, arising out of natural or manmade causes, or by accident or negligence which results in substantial loss of life or human suffering or damage to, and the destruction of, property or damage to, and degradation of, environment, and is of such nature or magnitude as to be beyond the coping capacity of the community of that area."[1] COVID 19 pandemic was also in the category of a natural disaster. However, it was different from others experienced so far in recent history in its scale and duration except for HIV/AIDS. Most of the climate/weather related disasters are limited to a geographical area and for a short duration. But, the pandemic was international and was spreading through human movement and contact, was continuing in waves and still does and we are not sure even now how it will impact the human beings.

We still classify the pandemic as a disaster and see if the previous experience can help us deal with the challenges in age care any better. Experience shows that older people are generally perceived as unproductive passive recipients of assistance. This outcome of this perception is that the genuine needs of the older person are overlooked in a scenario that does not have the ability to reach and service everyone equally. In the pandemic this gap came out even more starkly. Older persons were the most vulnerable and impacted by the pandemic, whether in terms of getting infected (by logic spreaders), mortality and impacted by loss of employment opportunities, loss of income, lack of access to supplies, closure of health care facilities for non-communicable diseases, vision restoration ophthalmic operations, opportunities for socialisation, physical exercise, digital exclusion and more can be added to the list. No specific program was designed or modified to deal with the older persons as a national response despite the fact that not only were they identified as most vulnerable bout also more than 11% of the population.

Lack of resources and social support were the main challenges felt by the older persons apart from supply side gaps in terms of survival items, monetary help, healthcare, access to vaccination, counselling, outreach services. In such a scenario, the older person found some succour in the voluntary organisations that were working on the ground with them and with other segments of population for many years.

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[1] National Disaster Management Act, 2005, Govt. of India

The identified principles on which good practices of age care during the emergencies are based on:

- Consultation
- Inclusion
- Empowerment

Older person in emergencies experienced that either their needs or priorities were overlooked or not taken into consideration by relief and rehabilitation programmes. Many experienced difficulties in accessing the services provided on the ground at the time of relief and later in helping economic recovery. Corollary of older people being unproductive hence unsuitable for consideration in recovery and rehabilitation.

The priority needs of older persons in emergencies are:

- basic needs: shelter, fuel, clothing, bedding, household items
- mobility: incapacity, population movement and transport, disability
- health: access to services, appropriate food, water, sanitation, psychosocial needs
- family and social: separation, dependents, security, changes in social structures, loss of status
- economic and legal: income, land, information, documentation, skills training

Chronic problems of health, mobility and mental well-being are not seen as a priority in most emergencies, yet it is these problems that make it difficult for older people to support themselves. Physical and mental health problems, reduced income, and limited mobility can also make it difficult for older people to support themselves and their dependents in emergencies. This could lead to vulnerability to abuse, loss of self-esteem and feed on the cycle of low level equilibrium for older persons[2].

Older Persons in India

India is a country that is vulnerable to numerous natural disasters including floods, cyclones and earthquakes with varying intensity and expanse. So, the country, its people and institutional mechanisms is equipped to deal with these calamities to a certain extent. In some respects, our preparedness has improved over the last two decades. However, each time nature may present a tougher or a different challenge. The COVID-19 pandemic is an example. Just when we thought that we should be worried more about the non-communicable diseases, we had to confront a virulent communicable disease.

The pandemic has hardly left anybody untouched, but the older persons are far worse than any other segment of the population. They were at the highest risk for mortality due to infection, they could lose a young earning adult, lose earning

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[2] Older Persons in Disasters and Humanitarian Crises: Guidelines for Best Practices; HelpAge International; Accessed on www.helpage.org

(whatever limited) opportunities due to COVID norms, lose independence and care due to distancing norms, lose opportunities for regular medical treatment for non-communicable diseases for reason of lack of exposure to healthcare and conversion of medical facilities into COVID centres. The atmosphere of general fear and anxiety, inability to meet friends and relatives, lack of opportunities for physical activity and being cooped up at home in an atmosphere of all round stress; mental wellbeing was at risk. According to Longitudinal Ageing Study in India (LASI) data, overall in India, a quarter of elderly age 60 and above and a sixth of older adults age 45 and above reported poor self-rated health (SRH). More than half of elderly reported poor SRH in the states of Kerala (53%) and Tamil Nadu (53%). Among the elderly, women than men, those with no schooling than those with 10 or more years of schooling and those currently not working compared to those working are more likely to report poor SRH.

The morbidity profile of the elderly brings out these facts: 35% of elderly are diagnosed with Cardio Vascular Diseases(CVDs). More than a half of elderly in Goa (60%), Kerala (57%), Chandigarh (55%), Andaman & Nicobar (51%), and Jammu and Kashmir (51%) reported that they have been diagnosed with CVDs.14% of elderly reported being diagnosed with diabetes mellitus. Diabetes mellitus is more prevalent among elderly men than women, currently married, more educated and elderly belonging to richest wealth quintile. Among elderly, diabetes mellitus is more prevalent in the demographically advanced states/UTs of Kerala (35%), Puducherry (28%), Lakshadweep (28%), Goa (27%), Delhi (26%), Tamil Nadu (26%), and Chandigarh (25%).

CVDs, diabetes mellitus and respiratory diseases contribute to a major share of chronic health conditions among the elderly. The prevalence of heart disease, stroke, diabetes mellitus, chronic lung disease and neurological problems are higher among elderly men; whereas, elderly women are more likely to be diagnosed with hypertension, anemia, bronchitis, depression, Alzheimer's diseases and dementia, any bone/ joint disease and cancer.

23% of the elderly have been diagnosed with multi-morbidity conditions and elderly women are more likely to have multi-morbidity conditions. Overall, among the elderly, symptom-based prevalence of angina pectoris is 6%. It is much higher than diagnosed prevalence of heart disease among rural elderly and elderly women. Whereas, the diagnosed prevalence of heart disease is higher compared with symptom-based prevalence among urban elderly and elderly men; this pattern of evidence suggest that burden of undiagnosed heart diseases is much higher among elderly in

rural area and elderly women. 25% elderly have experienced any injury and/or falls. Among elderly, women, widowed and elderly living alone are more prone to injuries and/or falls.

Besides, as far as social security is concerned, according to the SECC data released by the Govt. of India in 2011, 50 million older person lived in BPL households. Pandemic just pushed millions of households below the poverty line. LASI data showed that the Monthly Per Capita Expenditure (MPCE) among older adults in India is Rs. 2,967: Rs. 2,543 in rural areas and Rs. 3,544 in urban areas. The MPCE of households with an elderly member (Rs. 3,001) is higher than that of households without an elderly member (Rs. 2,948). Some other important indicators are non-food expenditure which accounts for about half of the consumption expenditure. The per capita health spending of a household with an elderly member is Rs. 405 which is higher compared with a household without an elderly member (Rs. 352). On an average, households in India spend 13% of the consumption expenditure on health, which varies from 5% in Daman & Diu to 19% in Jammu & Kashmir.

As the research project focuses attention on few states, it is worthwhile to understand the economic and health conditions of the older persons in these states in the pre-pandemic period. LASI (Wave-1 2017-18) provides a good look into the lived realities of the older persons[3]. The data in Table 1 to 7 are compiled from the LASI Report.

It is evident that the in almost all states, income from agriculture and wages make up for the main constituents of annual income. Pension and government transfers constitute negligible proportion of their income. Agriculture and wage income both took a hit during the pandemic and even now, the wage market has not shown promise of return even to pre COVID days. The average per capita income was Rs. 44,901; Agricultural activities- Rs. 9,063; Non-agricultural or self-employed- Rs. 5,155; Wages/salaries- Rs. 20,065; pension- Rs. 3,649 and Govt. transfers- Rs. 1,513. On each count, more than 5 states in the sample are below national average. See Table 1 below.

THE PANDEMIC DEEPLY AFFECTED **OLDER PERSONS** IRRESPECTIVE OF CLASS, GENDER, CASTE AND GEOGRAPHICAL AREA

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[3] Longitudinal Ageing Study in India (LASI) Wave 1 (2017-18) India Report; IIPS, NPHCE, MoHFW, HSPH and USC 2020; International Institute of Population Sciences, Mumbai.

Table 1: Per-capita Income Of Households By Source Of Income

State	Annual per capita income	Agricultural and allied activities (in?)	Non-agricultural business or self-employed activities (in?)	Wages/ Salaries	Pension	Govt/Public transfers
India	44,901	9,063	5,155	20,065	3,649	1,513
Delhi	67,432	299	16,290	32,234	4,663	849
Bihar	26,628	6,477	3,383	11,422	2,137	698
Chhattisgarh	43,685	12,301	4,115	15,044	2,742	1,413
Madhya Pradesh	41,258	12,829	5,888	15,314	2,726	2,077
Odisha	38,697	7,308	7,519	14,021	3,970	2,137
Telangana	52,219	15,236	4,211	23,791	3,893	3,037
West Bengal	48,588	4,140	5,719	20,086	4,197	2,099
Uttar Pradesh	28,331	8,155	2,967	11,380	2,933	627

Source : Longitudinal Ageing Study in India (LASI) Wave 1, 2017-18, India Report, International Institute for Population Sciences (IIPS), NPHCE, MoHFW, HSPH and USC 2020.

If we look at the data in pre COVID time about the employment of older person; we don't see a very encouraging picture. The table given below shows more proportion of older persons in the 'not currently working' and 'never worked' than in the 'currently working' category. The states are generally around the national average on all counts. See Table 2 for details.

Table 2: Percentage Distribution Work Status Of Older Persons In Sample States

States	Currently working	Worked in the past, but currently not working	Never worked
India	35.7	37.9	26.4
Delhi	21.6	36.4	42.1
Chhattisgarh	38.2	48.4	13.4
Madhya Pradesh	35.2	45.7	19.2
Uttar Pradesh	32.9	35.0	32.1
Bihar	36.0	33.9	30.1
Odisha	37.3	30.2	32.5
West Bengal	32.5	35.1	32.4
Telangana	43.3	40.4	16.3

Source : Longitudinal Ageing Study in India (LASI) Wave 1, 2017-18, India Report, International Institute for Population Sciences (IIPS), NPHCE, MoHFW, HSPH and USC 2020.

As families are non-formal care givers of older persons it would be relevant to look at the pre COVID household level indebtedness; as it is common knowledge, that many households had to dip into their savings and take loans to survive during the pandemic. The main reason for taking loans was for agriculture, marriages and health. The country average is 32.4% when it comes to household indebtedness. 4 states in the sample had more than national average HH indebtedness. See Table 3 for Details.

Table 3: Percentage Of Households With Loan/ Debt

States	% of households who have taken any loan/debt
India	32.4
Delhi	6.9
Bihar	41.1
Chhattisgarh	29.4
Odisha	40.7
Telangana	38.7
West Bengal	32.1
Uttar Pradesh	24.3
Madhya Pradesh	34.3

Source : Longitudinal Ageing Study in India (LASI) Wave 1, 2017-18, India Report, International Institute for Population Sciences (IIPS), NPHCE, MoHFW, HSPH and USC 2020.

Health and nutrition are the other major factors in the lives of older persons. Health has many aspects that are important for the older persons, healthcare financing is one of the most important variables. When economic distress hits an already poor population, the results could be devastating.

Table 4 shows that older persons in Delhi, Telangana and West Bengal who reported 'No Morbidity' were less than national average. Conversely, these states reported more than national average for Single and Two or More Morbidities.

Table 4: Self-reported Prevalence (%) Of Diagnosed Multi-Morbidity Conditions Among Older Persons

States	No morbidity	Single health condition	Two or more health conditions
India	47.9	28.8	23.3
Delhi	38.6	30.2	31.2
Chhattisgarh	66.4	22.5	11.2
Madhya Pradesh	63.4	22.6	14.0
Uttar Pradesh	63.7	24.1	12.2
Bihar	59.7	24.8	15.5
Odisha	56.8	26.0	17.1
West Bengal	35.9	29.0	35.1
Telangana	33.8	35.5	30.7

Source : Longitudinal Ageing Study in India (LASI) Wave 1, 2017-18, India Report, International Institute for Population Sciences (IIPS), NPHCE, MoHFW, HSPH and USC 2020.

Table 5 gives a picture of the overall discrepancy in health insurance and enrolment in government schemes. The national average: Any health insurance- 26.2%, CGHS- 2.4%, ESIS- 2.1%, RSBY- 20.7%, Community/cooperative- 0.2%, Reimbursement through employer- 1.2%, Private purchased-1.4%. One glance at this data shows that health insurance gap in the country. However, the sample states are much below this national average and Bihar, Madhya Pradesh and Uttar Pradesh stands out in being much lower than the national average on almost all types of health insurance including the RSBY and similar schemes. Chhattisgarh, Odisha and Telangana had higher than national average proportion in Any Health Insurance, CGHS, ESI and RSBY and similar schemes categories. West Bengal was somewhat below the national average in RSBY and similar schemes category and Any Health insurance.

Table 5: Percentage Of Households Covered By Type Of Health Insurance In Sample States

States	Any Health Insurance	Central Govt. Health Scheme, CGHS	Employees State Insurance Scheme, ESIS	Rashtriya Swasthya Bima Yojna (RSBY) and allied schemes	Community Cooperative Health Insurance Scheme	Medical reimbursement health insurance through an employer	Privately purchased commercial health insurance
India	26.2	2.4	2.1	20.7	0.2	1.2	1.4
Delhi	22.9	11.8	3.8	0.4	0.0	2.1	7.2
Bihar	3.2	0.8	0.5	1.4	0.1	0.2	0.3
Chhattisgarh	52.6	2.4	1.6	48.3	0.1	0.9	0.7
Madhya Pradesh	8.9	1.2	1.5	3.5	0.1	1.4	1.7
Odisha	62.0	0.4	0.2	61.6	0.2	0.2	0.5
Telangana	51.8	3.7	2.9	44.4	0.0	2.3	0.7
West Bengal	24.8	1.9	1.8	18.8	1.0	1.0	2.2
Uttar Pradesh	2.9	1.4	0.4	0.6	0.0	0.0	0.6

Source : Longitudinal Ageing Study in India (LASI) Wave 1, 2017-18, India Report, International Institute for Population Sciences (IIPS), NPHCE, MoHFW, HSPH and USC 2020.

The out-of-pocket expenses on health also points to the fact that the proportion is much higher in case of out-patient care. In Telangana, West Bengal and Uttar Pradesh, the out-patient expenditure and total expenditure was higher than national average. (See Table 6 for details)

Table 6: Monthly Per Capita Out-of-pocket Expenditure For Inpatient And out-patient Care (in Rs.)

State	In–Patient Health Expenditure (30 days)	Out-Patient Health Expenditure (30 days)	Total Health Expenditure
India	98	288	386
Delhi	91	242	333
Bihar	54	237	292
Chhattisgarh	22	106	129
Madhya Pradesh	95	252	347
Odisha	49	254	303
Telangana	130	355	485
West Bengal	87	404	491
Uttar Pradesh	73	317	390

Source : Longitudinal Ageing Study in India (LASI) Wave 1, 2017-18, India Report, International Institute for Population Sciences (IIPS), NPHCE, MoHFW, HSPH and USC 2020.

The section also has data on nutrition to give us an understanding of the status of under and over nutrition; both, a cause of concern. Under-nutrition in older persons is higher than national average in all states included the research project except Delhi and Telangana. Conversely, overweight and obesity is above the national average in both the states. See Table 7 for details

Table 7:
Prevalence (%) Of Undernutrition And Over-nutrition Among Older Persons

States	Under-nutrition	Over-weight	Obesity
India	26.7	16.7	5.5
Delhi	8.4	27.3	18.2
Chhattisgarh	36.2	11.1	1.6
Madhya Pradesh	35.3	12.1	2.8
Uttar Pradesh	36.6	11.5	3.0
Bihar	31.3	10.8	3.7
Odisha	37.1	11.6	3.4
West Bengal	31.5	11.9	2.4
Telangana	19.7	21.8	7.2

Source : Longitudinal Ageing Study in India (LASI) Wave 1, 2017-18, India Report, International Institute for Population Sciences (IIPS), NPHCE, MoHFW, HSPH and USC 2020.

COVID-19 Pandemic and Older Persons in India

The pandemic was different from other natural disasters in the recent human history by its duration and expanse. It was not like a limited geography and one-time shock. Relief and rehabilitation efforts had to be on herculean scale. Even medical experts and administration at time appeared confused and at sea about what to do and at times there was no back end support to respond to the new demands. The first wave created panic and the second wave was simple havoc. It's been more than 24 months since the pandemic was acknowledged by the government and we are still not out of the woods.

The death toll of elderly due to the infection was a grim case scenario, but those who survived the pandemic, life threw many harder challenges at them. At the bottom of the pyramid, the biggest being that of survival, destitution and neglect due to lack of opportunities to earn or beg, no savings to dip into, families being under pressure and inclined to put elderly members last, not much by way of government support. Those above the poverty line fell below it in some time. The so called well-to-do also had to face the immediate

challenges if lack of health services, costs of medicines, access to both, panic, mental anxiety, isolation, disempowerment and such other things. Women, widows, disabled, bed-ridden, dementia patients and their care givers, older persons with dependents faced innumerable challenges which are not even in the reckoning.

All the agencies including the government accepted that older persons were at disproportionate risk during the pandemic; unfortunately, there were no specific steps taken by any government to deal with the challenges that the older persons were facing except for advisories and helpline numbers that were regularly dished out. The older persons who were getting pensions got a three-month advance in the first wave and also Rs. 1000 as ex-gratia payment. It is anybody's guess how long that may have helped them survive. For the vaccination, the older persons were given priority but not much was done by way of outreach or dealing with their fears and apprehensions. Most of the services were put on digital mode for obvious reasons but no steps were taken to train the older person to use the technology or get easy and secure access to it.

In these dire circumstances, the voluntary organisations that were working in close contact with the community in cities and villages, more so in remote areas stepped up their operations and tried to respond in their micro zones to the immediate and long term needs of the older persons. Therefore, it is important that the efforts of such organisations be documented for the purpose of knowing what good happened on the ground and what more could be done to improve the situation.

According to the NGO Darpan portal (NITI Aayog), there are more than 23 thousand organisations that include age care in their list focus areas. For majority of them, age-care is just one among the many causes that they service. So, the study includes both, organisations like HelpAge India that has exclusive focus on age-care and other voluntary organisations that have elderly besides many other pressing concerns that they respond to.

Build Back Better for Older Persons

As stated earlier, older persons need special attention to recover from this disaster. The pandemic has exposed the gaps in the system not just in terms of current availability of services; but also the systemic flaws in not integrating the needs of the older person in the structures of social security, healthcare and enabled environment. The guiding principles of 'Leave No One Behind' (LNOB) and 'Build Back Better' in the post

pandemic world has given us the opportunity to ensure that the social security, health care and general environment is conducive to make the older person equal participants in the world. The social security system should ensure that all have enough to sustain themselves in old age and work only for self-fulfillment. Healthcare services should be not just limited to curative care but encourage heathy and active ageing. Environment should be such that older people feel safe, secure and included (socially, digitally) in the society. Another aspect that comes in focus every time a disaster hits apart from the gaping holes in the system, is the ability of the older person to contribute in a meaningful way to relief and rehabilitation. We need to explore it further earnestly; for if disasters are going to be a way of life in the 21st century and ageing the new demographic reality; then preparedness would be the key to success of complete coping strategy. LNOB should encourage us to look at the women, widows, disabled, oldest old and other marginalized categories of older person in sharp focus. Government and private sector may not be able to reach them as effectively as the VOs, and hence, need to strengthen them further.

To address the above-mentioned gaps and concerns and pave a suggested way forward to ward off similar situation in the coming days, this project is a first of its kind endeavor to document the best practices in aged care that were operational during the first, second and the third waves of the pandemic. The project attempts to address the objectives underlined in the following section.

Objectives

The project is undertaken with the view to document good practices for care of elderly during the COVID-19 pandemic. It posed a new set of challenges to service the needs of older persons in India. The older persons were impacted directly and indirectly during the pandemic and the lockdowns added to disruption in their lives. No elderly remained unaffected, from rich to the poor, during the period. All needed support to varying degrees from a system that was exclusively focused on the pandemic. The government and its agencies were providing help to all segments of the population and dealing with intervention at macro level. But the voluntary organisations that work at grassroots and have capacity and inclination to serve the vulnerable and marginalised sections of society are better placed to deal with ground level realities. This research project is aimed at understanding and documenting the work of such organisations during the pandemic.

This project aims to:

1. Understand the response process and practices of HelpAge India, a leading national level organisation in age care for the past four decades; other organisations that either had age-care as their only focus, or did substantial work on age along with serving other sections of society during the pandemic and the organisations of older person;

2. Understand the level of satisfaction of the older persons serviced by these organisations and their aspirations for better care; their role in the process, contribution, support by various agencies including government, felt gaps in services provided.

Methodology

Literature review was the beginning of understanding the theoretical and practical nuances of the challenges of age care during disasters particularly during the COVID-19 pandemic. It included studies on needs of older persons during disasters and COVD-19 and responses by various stakeholders. After the review of the initial corpus of literature, the logical next step was to evaluate responses to the pandemic that were instituted by various public and private actors and not limited to NGO sector as they have the greatest degree of on-ground

involvement and can be relied upon to have the most reach and capabilities to institute rapid responses as well as generate accurate and reliable literature and data reviews of the on ground situation. A thorough study of the above sources was done in a targeted manner of approaching the problem of attempting to understand the response that was instituted to provide urgent care and rehabilitative facilities to the elderly.

From charting out a theoretical framework on the vulnerability of the elderly during the disasters in general, mapping the physical and mental health concerns of the elderly during the COVID 19, socio-economic impact of the pandemic on the lives of the older people to generating a summary of the support received from the public and the private sectors, this report tries to bring together the kind of attention that the older people have

received during the pandemic across the three waves.

The second part of the project has focused on qualitative data from on 8 states /UTs: Delhi/NCR, Chhattisgarh, UP, MP, Bihar, Odisha, Telangana and West Bengal. These states are diverse and will help in understanding the nuances of age-care during the pandemic better in terms of poor, middle class, formal and informal care, rural-urban, etc. These states are those where the intervention started in April 2020 and continued. The focus was on intervention programmes of HelpAge India and that of at least one other VOs active in the field and providing specify intervention for the elderly in the state. The VOs were selected from among those that have worked in the state with HelpAge India to provide relief to the older persons including those where cause adjacencies were prominent like disability, destitution and gender.

Three or more beneficiaries were selected from each state to understand and document their experience during the pandemic. They were selected on the basis of critical significance of the project to the urgent needs of older person during the pandemic or other disasters. As far as possible a balance of gender, disability and poverty/destitution and disadvantages of access and dependence were kept in mind while including the older person in the research.

An interview schedule was developed for interviewing the VOs and older persons. The data was collected in zoom interviews with the respective HI State Head and team members and Head of selected VOs and their key team members in February and March 2022. The beneficiaries were also interviewed on zoom in the month of April 2022. HI and VOs team facilitated the interviews with the beneficiaries.

IT IS IMPORTANT THAT THE EFFORTS OF SUCH ORGANISATIONS BE DOCUMENTED FOR THE PURPOSE OF **KNOWING WHAT GOOD HAPPENED** ON THE GROUND AND **WHAT MORE COULD BE DONE** TO IMPROVE THE SITUATION.

GOOD PRACTICES IN AGE CARE DURING COVID-19 PANDEMIC: CASE OF HELPAGE INDIA

HelpAge India has been at the forefront to improve the quality of life and welfare of elderly for more than four decades. During the COVID-19 pandemic too, HI was at the vanguard with response measures ranging from food and medicine distribution, mental health support, vaccination drives to livelihood initiatives.

Profile of HelpAge India

HelpAge India (HI) came into being in April 1978, a pioneer in age care as at that time demographics and culture both were in favour of age care being in exclusive domain of the family. However, the founders of HI and its team of dedicated staff took small and consistent steps in developing it into a large organisation, over the years, to respond to the emerging challenges of population ageing in the country, while maintaining focus on poor older persons and their felt needs. HI responded to practically all the challenges posed by ageing through direct intervention and advocacy with government, private bodies and others to pay attention to ageing and aged in India. Major intervention programs are: 165 Mobile Healthcare Units, cataract surgeries, 7 Elderline projects with Govt. of India and Helpline in 17 locations, 7 old age homes, more than 8000 Elders Self Help Groups, digital literacy programme in 20 locations .Major partners providing financial support for these efforts are government departments, corporate, institutional and individual donors. HelpAge India represents the cause of older persons in many forums including National Human Rights Commission and NITI Aayog.

Disaster Interventions

The above-mentioned are some of the activities of HI in 'normal' times. However, an important area of intervention ever since has been helping older person in disaster situations i.e. natural calamities. In 1980, a disaster rescue and relief unit was established in HI. The first of its kind among voluntary organisations. It carried out its first operation during the catastrophic floods in Uttar Pradesh and did significant and conducive works in the remote villages of the Sitapur and Jaunpur districts by immediate relief activities. In the decades after the 1999, when India was affected by some major natural disasters, appropriate operations were carried out for relief during Orissa super-cyclone, the Indian Ocean tsunami, and the Gujarat and Kashmir earthquakes and later in one or two state affecting cyclones, floods and droughts like Odisha, Andhra Pradesh, Kerala, Karnataka, Bihar, Assam.

The initial interventions in Orissa and Gujarat revealed that in the struggle for survival, the elderly were last in the line and lost in the crowd, despite the fact that they were the worst sufferers. HI's work in disaster affected and prone areas developed into an integrated approach that engages with the elderly and the community in providing immediate relief in the aftermath of the disaster, provide support for rehabilitation in terms of rebuilding livelihood opportunities and also help in preparedness.

Relief and Rehabilitation Operations

As the name suggests, relief pertains to immediate survival needs of water, food, shelter and medicines. Rehabilitation includes efforts for rebuilding homes, providing necessary household items and depending on needs assistance in refurbishing livelihood equipment and capital. Due to repeated interventions in floods, earthquake, Tsunami, cyclones for more than 20 years HI developed a standardised response to such operations and capacity of staff was built by hands on experience and training in some cases.

Partnerships in Disaster Interventions

Post disaster operations just because of their sheer scale were always conducted in collaboration with community, local government, corporate and individual donors. It is during these operations that HI understood the resilience and capacity of the community especially the older persons to act for themselves and the others. In Gujarat, Tamil Nadu, Kerala, Kashmir, Bihar, HI was able to mobilise the community and actively involve the older persons in rehabilitation process. In many places they were constituted into Elders' Self Help Groups many of which continued to thrive and also help the other members of the community in disaster situations.

The disaster intervention work was carried out with strong support of institutional, corporate and individual donors. The donors were approached by HI with appeals and specific intervention plans for financial support and most of the donors were forthcoming.

COVID 19 Interventions

COVID 19 pandemic posed peculiar and unprecedented challenges like lockdown, extent and duration, physical distancing cut the contact protocols, anxiety and fear on unprecedented scale, breakdown of health system, lack of access to goods and services. Uttar chaos and confusion during the first and second wave pushed experienced organisations like HelpAge India into sudden shock, though, due to its systemic and human capital it bounced back into action swiftly.

The modus operandi remained almost the same with appropriate modifications, MHUs, Elderlines/Helplines and ESHGs continued to be the main structural strength of the organisation. The MHUs were repurposed in the initial phase to distribute food and other essential items to the older persons in the service areas, before resuming partial operations as medical service and holding special awareness camps. Elderline/helpline, in addition to receiving and resolving calls for help from seniors' also made outward calls to spread awareness and offer assistance. ESHG members acted as community volunteers to spread awareness and also stitch and distribute masks to people in the community.

Highlights of Efforts of HelpAge India:

a. Food and nutrition: 1.5 lakh cooked food packets in wave 1 including old age homes. Distributed 1.24 lakh kits (dry rations, nutrition and hygiene) across 18 states including old age homes.

b. Medical Intervention: 165 operational MHUs covering 134 districts across India managed to give a 44 lakh treatments (April 2020 to March 2022). The MHUs registered 3.36 lakh new beneficiaries of treatments of which 1.09 lakh were above 55 years of age in 2020-21 which increased to 4.34 lakh new beneficiaries in 2021-2022, managed to facilitate more than 5 lakh vaccination doses.

c. Elderline/Helpline and Helpdesk: From 1st April to 16th May 2020, Helpline staff made more than 21,205 outward calls to reinforce the message of safe practices and received more than 3,402 calls for help. About 30% calls were from the elderly asking for help to get food, medicine and hospital visits. Received a total of 46,006 calls from April 2020 to March 2021, which rose to 1.74 lakh from April 2021 to March 2022 of 904 were rescues of the elderly from abuse or abandonment. More than 10,000 rides were given to support the elderly persons in the ongoing pandemic and more than 2000 rides were utilized by

HI staff to support the elderly in dire need.

d. HI Helpdesk at AIIMS Delhi, AIIMS Rishikesh, MMC Chennai, and SGPGIMS Lucknow served 70,776 elderly people in 2020-21 and 62,503 of elderly during April 2021-March 2022.

e. Old Age Homes: HI collaborated with 300+ old age homes across the nation including 7 of them, run by HelpAge India. April 2020, HelpAge India worked with 13 old age homes in Delhi, Mumbai and Bangalore, to provide essential food commodities. These were chosen with respect to the number containment zones present around these old age homes, which limited the access to groceries and pharmacies around the homes, as well as making the residents more prone to the disease. A total of 975 monthly survival kits were provided to these old age homes; each kit having rice, pulses, masks, detergents, soaps, and other essential commodities. During the period of the first wave of COVID-19 pandemic, HelpAge India has provided survival kits to 120 old age homes from different parts of the country, with the support of various donors including UNFPA. Apart from survival kits (15 OAH in phase 1), HelpAge India has also provided monetary support for the upgradation of the old age homes and other requirements such as installation of RO water system, washing machines, coolers, and renovation of toilets (14 OAH in Phase 1). This type of support was provided to 48 OAH in Phase 2. As part of "Jeevan Suraksha," 26,450 masks were distributed in old age homes.

f. Elders Self Help Groups: 5,542 ESHGs across 11 states (Bihar, West Bengal, Telangana, MP, Odisha, Karnataka, Tamil Nadu, Rajasthan, Kerala, HP and Maharashtra) mobilised volunteers including the elderly to create awareness on the pandemic and compliant behaviour. ESHGs in 5 states (Bihar, West Bengal, MP, Telangana and Tamil Nadu) provided food and rations to 4,792 needy elders. 816 elders were provided cooked meals by some ESHGs. Distributed free over 30,000 masks to poor elderly.

HI was able to provide much needed service to the poor and disadvantaged older person throughout this challenging period with the aid and support of 56 corporate donors. 36 donors were already supporting the cause and understood the specific needs of older persons, but 20 new donors also

enlisted support and responded to call for help. Other donors included institutions, individual and donor platforms.

The non-monetary support provided by the district administration and state governments, other voluntary organisations, youth and senior citizen volunteers also provided the much needed support for community interventions. In the following chapters a detailed description of some of these partner agencies will illustrate the usefulness of such integrated approach.

Much was accomplished by HI during this pandemic along with some lessons for the future as an organisation working for the cause and care of older persons. The most important being the challenge of ageism that pervades all. Older persons and their specific requirements are not specifically targeted and are subsumed either under the general category or eth already identifies subgroups. During the pandemic, this came out much more strongly. In all intervention services except the COVID 19 vaccination, the older persons were not given any priority despite the acknowledgement that they were the most vulnerable. Providing intervention services on an even platter to the uneven groups in society is itself recipe for inequities.

The ravages of the pandemic have left the older person much more vulnerable than any other disaster that they may have faced. The interventions at the level of voluntary organisations provide succour to some; but, may not be the most effective answer for far reaching impact of the loss of income and employment opportunities, lack of access to holistic geriatric care and exclusion. The ground experiences of the VOs like HI may be useful in developing pan India responses to the challenges posed by ageing in the post pandemic world.

To deal with this challenge a collaborative effort is required. The capacity building of the older persons, voluntary organisations focusing on adjacent causes. In some states there were Inter-Agency groups that coordinated at the state level; but it would be useful for large organisations like HI to map the other VOs in the area and develop a sort of preparedness plan for swift and effective action.

Digital being the new mantra should be taken advantage of to the maximum extent possible for coordinating a better response. Existing data should be used for the purpose to identify and plan interventions on aspects like health, food and nutrition, strengthening of institutional mechanisms for age care to respond with alacrity. Building the capacity of older persons, the digital space is of critical significance and same should be

on the agenda of all stakeholders.

The details of various intervention programs undertaken by HI during the three waves of the pandemic are given below. The responses were uniform across the states and varied only in nuances. In the initial stage of lockdown cooked food, sanitizers and masks proved very useful in urban poor communities and charitable old age homes. As it became apparent that the lockdown and its impact would last longer than expected, dry rations replaced cooked food. Consumable items like masks, sanitizers and soaps continued to be distributed. Dry rations were later replaced/supplemented by immunity kits. This work was done primarily through the MHUs. MHUs also started resuming medical service to the extent possible through online/telephone consultation with doctor and home distribution of medicines for NCDS. Mental health was also added to the special services given the difficult conditions and its impact on the older persons. Spreading awareness through special efforts in all the sites for COVID 19, compliant behaviour and later encouraging older persons to take vaccination.

Elderline/helpline played the crucial role of back end coordinator for getting older person access to essential supplies, medicines, local conveyance and emotional support. Dependence on the Elderline/Helpline increased during the second wave to deal with medical emergencies and emotional support to older persons getting affected by death and destruction around them.

The older persons living in old age homes are generally left out of the purview, but HI included these facilities in all its drives from food to medicine, treatment, retrofitting, supply of consumer durable goods and vaccination drives.

Food and Nutrition

Keeping this institutional capacity and sensitivity of the organisation to respond to the needs of older person during a disaster and rich ground experience, it was obvious for HI to intervene in the unprecedented disaster of COVID 19 pandemic. The response was in the same template as always, adapted to the nuances of the current situation. Some of which were lockdown, scale and anxiety about the infection, fear of losing life and infecting others, need for social distance, sanitation, masks, repurposing of health infrastructure, vaccination and hesitancy related to it. The conventional methods of delivery had to be rethought, even though the needs remained more or less the same, but, with a strong need for effective communication and reinforcing the message.

In the initial phase, two immediate needs were responded to: food and information. From April 2020, HI started relief operations in terms of cooked food distribution to communities that it was serving as part of its regular programs like health care, old age homes, urban destitute elderly, and day care centres. In collaboration with its corporate partners this programme was able to distribute 1.5 lakh meals, 63% in Delhi/NCR and Telangana.

Motivating the staff to come out and work in the field and getting permissions for movement from the local administration posed the biggest challenge for the organisation. Human element is important for the former, and so the senior management team led by the CEO started going to the field and all staff members were covered under medical insurance. The cooked food packets in the initial phase were distributed in urban slums, semi-rural areas and old age homes. In all these places, the urgent need was due to lockdown and consequent problem of money and procurement of raw material for cooking especially the poor older persons living alone and those in poor families whose earning came to abrupt and complete halt with uncertainly of restoration.

Cooked food was no longer useful for the people that were being serviced by HI as lockdown continued and their food scarcity no longer remained a temporary situation. So, provision was made for dry rations to include wheat flour/rice, dal, cooking oil, salt and masala. The poor families/older persons could not afford sanitizers, masks and other hygiene items. So, food and non-food essential items were distributed to the poor older persons. About 8000 such kits were distributed in the first phase in the project states.

Likewise, food in the first phase, 200 hygiene kits containing hand sanitizers, hand wash, mask and vitamin C tablets were distributed in Delhi by the MHU. These were crucial for the poor older persons who had anyway lost sources of earning during the lockdown. In Bihar, 37,500 hygiene kits, each containing 2 soaps and 2 masks were distributed to poor elderly in Patna, Supaul, Madhubani and Darbhanga districts. 85 villages in the area were sanitised with bleaching powder, Dettol and phenyl solutions. ESHGs in Bihar, UP and MP helped those less fortunate by providing dry rations to others in the villages in Bihar and MP and cooked food to (reverse) migrant workers in Agra.

ICT Material on COVID 19 Protocols

Simultaneously, signifying the importance of valid and prompt information sharing, the standard behaviour protocols/guidelines issued by the government were translated and put in the form of

posters, banners for communication with the older persons in the community. The challenge here was to reach the message to the older person without breaking the COVID behaviour protocols and to emphasize its importance in remaining safe. Mobile Health Care Units staff and community volunteers played a significant role in this. Either the community volunteers communicated these messages to the older persons in the areas individually on phone or MHU staff used banners and posters to broadcast the messages while maintaining social-distance. The use of mask and washing hands were also demonstrated by the staff members. ESHGs also played important role

in this to reinforce the safe behaviour. Later, public awareness messages about the pandemic were also printed in the local language on envelops used for distribution of medicines to MHU beneficiaries. HelpAge India helpline number was also shared with all to contact for any help including information.

Helpline/Elderline

During the first phase, HI Helpline staff was deputed along with volunteers to call the members of Senior Citizens' Associations to spared awareness about the guidelines issued by the government. The helpline staff made 21,000 outward calls.

During the second wave, the pressure on helpline mounted, so much so that in Delhi/NCR alone, the staff received almost 1200 calls every day which further increased in May-June 2021. The staff was under tremendous pressure both physically and mentally as they were not able to help all. The

helpline provided information, guidance on legal aspects, counselling, moral support, direct interventions in the field and connect with other services.

The Helpline in Delhi received more than 5,000 requests for interventions for COVID treatment (vaccines, medicines, oxygen, beds, and transportation). The rest of the calls were requests on various kinds of guidance, information and links to other organizations, NGOs or govt. supply system for specific work. The magnitude of problem was enormous. Helpline managed to provide hospital beds to 60% of the older persons, followed up with them for treatment, and could also accompany those without relatives in Delhi to testing centres. For many days, the helpline was operational 24 hours. The calls from HI toll free number also landed in Delhi, so the Helpline staff linked them up with the local support organisations as and when possible.

Helpline service should be spruced up, as it is a much needed service for the older persons especially in emergency situations. There should be a single link up portal for all services to be connected at ground level. The availability of a database to answer queries and link up with organisations like State Legal Services Authority for free legal guidance makes the staff respond promptly, effectively and efficiently. For cases which require emotional support, there are trained counselling organisations.

In Madhya Pradesh, the Elderline project was launched in April –May 2021, and the staff had to struggle with the demand on it during the second wave of the pandemic. Infection had spread far and wide and even remote areas were experiencing deaths. The team was reluctant to work from office as infection rates were increasing. However, the staff did manage to gather data on stakeholders in the state. The calls were mainly for support for food rations and cooked food delivery to the patients in the hospitals, elderly at home, persons without income and access to dry rations as shops were closed or elderly were scared of venturing out. The staff collected information for the grocers who could deliver groceries at home, oxygen re-fillers, medical stores who could give medicines and could supply medicines at discounted rates. Food delivery in 23 districts was organised through providers, and medical and food emergency needs of older person living alone or with spouse only were addressed. Student volunteers were engaged in different cities for food distribution. HI staff volunteered and also arranged student and elderly volunteers for managing vaccination centres that were unable to take the

load of patients. HI team also coordinated with local police and medical units to arrange for blood plasma and oxygen for elderly patients. It also assisted the local administration in cremations.

Elderline staff were multi-tasking during the second wave. As the demands were manifold compared to the delivery capacity, Elderline in Madhya Pradesh helped by coordinating with other organisations and agencies who could provide help on ground. It started WhatsApp groups for the coordination of blood donation and oxygen cylinder supply, and at times purchased and delivered these services. These groups were used to giving information on requirement, responses and final conformations. NSS volunteers and MSW students of Barkatulla University and Nehru Yuva Kendra volunteers provided constant ground support to HI efforts to provide services to the older persons.

In Telangana, Helpline in the second wave provided free transport for the older persons to hospitals, railway stations, bus stops and any other emergency situations, etc. under HI-Uber tie up. This was very useful for the older persons, especially, poor and those living alone. They called the helpline number and raised a request for booking the cab and cab picked them up and dropped to the location safely. After the treatment,

the older person again called the helpline numbers and were picked up and dropped to the home. The Uber free services provided in collaboration with HI helped a lot of older people to access a lot of healthcare services, either for regular treatments, or emergencies, and vaccinations, without having the glimpse of safety concerns. The reluctance in using the public transport and getting exposed to the deadly virus was mitigated to somewhat extend through this service.

During the third wave, Helpline in Delhi coordinated the needs for vaccine registrations, coordination with Uber free services for vaccination, free rations, social pensions, medical health facilities, employment opportunities and calls for active listening. In case the older person is unable to connect with services online, the staff visits the location to help and also provide support in case of hospitalisation, etc. Sometimes, the older person would ask for a particular staff member by name and only talk to him/her. During the 3rd wave, there were instances of elderlies being talked out of suicidal tendencies by the counsellors in Delhi and Madhya Pradesh.

Old Age Homes

Old age homes were assisted with grants for construction or enhancement of facilities and procurement of fixed assets. It included things like

renovation of toilets, repair of terrace, gallery, water tanks and solar water harvesting facility cupboards. Fixtures included RO water purifiers, washing machines, geysers, TV sets, steel beds, patient trolleys and fumigation machines. These interventions helped old age homes that were running on meagre resources of individual and community donation for the destitute older persons, for instance, the old age home in Chhattisgarh benefited from the upgrade in a significant way as it was able to house more comfortably with the increasing number of destitute residents of the old age home. The timing of help was crucial as it provided much needed facilities at the right time. It helped them to survive. In Telangana, family essential item kits were given to the Old Age Homes. They required immediate help after lockdown. Government aid came to old age homes after 3 months on request of State Council for Senior Citizens. In Phase I, 20 old age homes in Chhattisgarh, West Bengal, MP, Odisha, and Telangana were given ration support and infrastructure upgradation, while 49 homes were given grants for the same in UP, Gujarat, Delhi/NCR, Rajasthan, Punjab, Tamil Nadu, Telangana and Maharashtra, in phase II.

Healthcare

The MHUs are designed as primary health care units that provide services in the community. Its standard services range from primary health care, referrals, special screening camps, correction of refractive errors, distribution of disability aids, and public health awareness. Historically the MHUs have been the frontline of response during any natural disaster where HI intervened. It provides for the immediate medical needs of the affected people and carries survival supplies.

The next logical step was partial restoration of services of MHUs to distribute medication to the patients suffering from non-communicable diseases. During the COVID 19 pandemic, it played the same role in waves 1 and 2. Its staff and volunteers acted as community connects to identify needs, supply relief kits and provided medical assistance. Due to COVID protocols and lockdowns, the older people suffering from chronic diseases faced a major challenge of regular consultation with the doctors and supply of medicines. To respond to this urgent and critical need, MHU staff was instructed to connect with the beneficiaries on phone and provide telephonic consultations with the doctors and also go to the sites and home deliver the medicines as per the requirement of the patents. In Madhya Pradesh, till the time that the MHU got permission to resume operations, two volunteers per site were in regular

touch with the beneficiaries who would require medical support; they would arrange for medical consultation though video calling, the doctor would prescribe medicines and the volunteers made it available to the elderly at a discounted rate.

The doctors were always on call for any consultation. But the Social Protection Officer, pharmacist and driver of the van distributed the medicines based on the record available and authorisation of the doctor. The availability of medication was essential for people suffering from diseases like diabetes, hypertension etc. Given the lockdown and supply side bottlenecks, regular supply of medicines was crucial for the older persons. HI Helplines coordinated with the community volunteers to buy and deliver medicines for the older person who approached them with problem in going out to buy them.

The van and the staff were given cleanliness and safety protocols and materials/kits that were adhered to strictly so as to protect them from getting and/or spreading infection. HI manages Mobile health care Units in almost all states in the country. The staff was instructed to follow all the hygiene and behaviour protocols while going to the villages.

The practical challenges that the MHU team faced included travelling to the locations from homes during lockdown and restrictions on public transport, acquiring general permissions from the administration for movement and state government's predilection for intensity of lockdown.

In Odisha, the MHU operations started much later than in Delhi/NCR. The team in Madhya Pradesh faced challenges in so far as the beneficiaries in

the villages did not allow them to come into the villages as they were afraid of them bringing in the infection. Plus, the PPE kit that they wore made them even more suspicious to the villagers. It took some efforts on the part of the team to involve the village headman to convince people to allow the MHU staff to distribute medicines to the beneficiaries.

Another major contribution of the MHU was extensive awareness campaign about COVID-19 infection and appropriate behaviour during Wave. The central health team developed the ICT material and the communications team translated it into 7 vernacular languages and also depicted the practices pictorially for maximum reach. Awareness was created through posters that were displayed at publicly popular places and following all social distance restrictions. The team members also practically demonstrated use of face mask and sanitizer, social distance norms.

In Madhya Pradesh, 48 awareness sessions were

conducted in the rain-shadow areas were the MHU could not visit. These camps were mainly organized to spread the awareness for handwashing, use of masks, social distancing, etc. OPDs were also conducted for the beneficiaries. In Indore, there were regular camps even on Saturdays and Sundays.

In Uttar Pradesh, MHU volunteers coordinated with gram pradhans (village headmen) to establish connections on the mobile phones of the beneficiaries and their families to raise awareness about COVID compliant behaviour. This practice continued for 3–4 months. Stationary Health Unit in Vrindavan continued to provide medical assistance to the residents of the Ashram despite its temporary use as a quarantine facility.

In Bihar, like Odisha, the lockdown restrictions were strict and the administration did not give permission to the entire staff to operate. But there was felt and expressed needs. The awareness drive reached out to 100 villages for information on COVID-19 and compliant behaviour. Hoardings, posters and pamphlets were used to give information to the largest possible number of people. HI staff and volunteers helped people in getting tested for infection, provided much needed medical and general supplies, and helped in taking people to medical facilities in case of emergency.

The thermometers and oximeters distributed to the village groups helped in making them self-sufficient in checking the vitals. Medical councillors associated with HI would give counselling, guidance, advice as whenever needed. Raising awareness on COVID, and precautions to take, brought noticeable behavioural changes in people, becoming conscious of precautions, through village volunteers and through hoardings in almost all possible sites where it could be put, covered almost all walls with pamphlets.

The awareness program for COVID-19 pandemic started from January 2020 onwards in West Bengal. The gun thermometer and Oximeters helped them a lot. Local volunteers were trained to use them as preventive measures.

MHUs continued the fortnightly distribution of medicines till restrictions were removed and full operations were resumed. During the second wave of the pandemic, in some locations, where the administration demanded, the MHUs were also used as ambulances to ferry the COVID positive patients to the hospital and also carry dead bodies for cremation. In Faridabad, the MHU was used for the purpose for almost 45 days on the request of the local COVID hospital and the police. The MHU driver was mostly alone as even the family members refused to accompany the bodies or to touch them at the cremation ground. The HI staff was given instructions by the police to reach the mortuary and then go to a particular cremation ground where if they were unable to perform the rites, then again had to coordinate with the police to take the body to some other cremation ground. All this impacted the mental wellbeing of the driver who was given as and when required counselling and encouragement by the State Head.

Vaccination Drive

HI teams participated actively in vaccination drive started by the government after the worst was over in the second wave. The central team provided ICT material for dealing with hesitancy and other mild symptoms and precautions. In most areas, the outreach was encouraged by HI staff to help get maximum number of older persons vaccinated.

MHU sites, day care centres and physiotherapy centres were the best suited for the purpose and the Delhi/NCR team made the best use of it. In Uttar Pradesh, in one district, HI team was able to get 2.5 lakh vaccinations done and dedicated efforts were made in areas inhabited by specific communities that were averse to vaccination. The help of local influencers was sought to convince people to take the vaccine, the message was reinforced with pamphlets, and at times, ration shops were asked not to give ration unless people got vaccinated. Chief Medical Officer was also assisted in the government's efforts of vaccination. Help of other NGOs was sought to reach awareness about vaccinations and managing the ground work. In Bihar, efforts were made with the help of District Medical Officer to start camps for vaccination and HI staff managed the registration and discipline in the camps.

In Chhattisgarh, children were encouraged to convince their grandparents to take vaccine and many of them accompanied the older persons to the vaccination centres. The older people were provided with counselling, transport and refreshments for vaccinations.

Livelihoods

In Delhi, women including those over 60 years of age were selected for a livelihood intervention programme. The selection criteria were amongst women who had lost the bread earner in the family and had dependents including older persons. In the Bharat Vihar locality of Delhi which is inhabited by both Below Poverty Line (BPL) and Above Poverty Line (APL) families, this programme was initiated in March 2022. 60 push carts were given to women in the age group of 40 to 70 years to use it to earn and support themselves and their family. The HI team identified these beneficiaries in a door to door survey in the locality.

During the COVID, the income of the ESG members had decreased to a great extent, to support them in livelihood, a corporate supported program was started that provided Rs. 5000-5500 through direct transfer and they could use for income earning activities like poultry farms, mushroom cultivation, etc. They were also given a DBT of Rs. 266 per person for buying rice. The Village Level Federation and the ESHGs were also given fund to set up enterprises, seed bed preparation, masala grinding, incense stick preparation, each member of the ESHG was given 4 trees (mango, guava, lemon and coconut) to nurture these and use the fruits for generating income in future. Around 400 ESHGs were covered under these initiatives.

The proposals were sent after discussing it with the

community members in the Federation. The tentative cost and the cost of procuring raw material were also discussed. Labour cost was entered in the resolution book. The sub committees monitored the intervention taking help from the HI staff. The projects were evaluated by Deloitte.

Inclusion: Digital and Social

The elderly were feeling digitally excluded, and so some teams like in Madhya Pradesh, restarted digital literacy programme with the older persons where they were trained to access service online, through online classes. They were taught to use Zoom. This helped them in organising recreational and devotional programs online for the group and deal with the isolation and anxiety. The volunteers from NASCOM and Google supported this effort. The other active partners in this effort were the local Senior Citizens' Associations that encouraged members to learn and use the apps.

In Uttar Pradesh, after the second wave, efforts were made by the HI team in collaboration with

Senior Citizens' Associations, Retired Bank Officers' Association, student volunteers, and helpline staff to carry out many one-day training workshops for older person to learn to use various apps to access services, make payments etc.

In states like Bihar and West Bengal, where HI is actively working with ESHGs in rural areas, the situation was different. In rural communities, with dependence on agricultural and dairy farming being the main occupation, those who are not able-bodied are considered a liability. Second, as rate of infection in the rural areas was a bit low, people were not too scared to meet physically though social distance norms were on. So, in West Bengal, in Kolaghat district where HI is working with ESHGs, regular meetings were organized soon after lockdown was lifted. They met in small groups maintaining the necessary protocols, but interacted regularly. This improved their mental state as they could talk about deaths due to the pandemic, loss of livelihoods for their adult children and their own income getting affected. The cyclone during that time in Digha, Midnapore added to their problems. Though the elderly showed resilience, the field team and the volunteers played a very vital role in standing by and giving them strength and support.

Challenges Faced

The supply side problem was faced as the market rates fluctuated a lot. In order to deal with the problem, a negotiation was done with the vendors and the one who gave the lowest quote were chosen as suppliers. This helped the suppliers in getting a visibility during COVID and since the intervention was targeted to the elderly, the suppliers were very much elated to be a part of the supply network.

The staff members were fearful of catching infections so they were given proper training and sanitization materials along with PPE kit if required.

The load on the staff was far greater than they could take; but took help from the other partner NGOs, educational institutions and local administration to overcome the ground level services gaps.

Identifying and Fulfilling Needs

HI operates its programmes in close connect with the older persons and the community. So, the staff and the community volunteers were in constant touch with the older person on phone and during the awareness sessions. The need for essential items and medical treatments and medicines were ascertained by them and communicated them to the State Heads and Central Team. The team in Delhi/NCR held daily briefings with the ground staff and prepared a daily plan of action depending on need and logistics. Due to paucity of wage labour, the staff members themselves took the initiative sometimes to load and unload ration kits that weighed from 10-15 Kgs. In Madhya Pradesh, the beneficiaries were identified by the staff in consultation with the village headmen on the basis of the condition of the house in which older people lived and the kind of ailments he/she suffered. In the remote villages where people were in great trouble, as they were not getting basic food supplies and even HI staff could not reach help due to procurement and transportation challenges; the local ESHGs decided to support 70 destitute elderlies with food, vegetables for about a month.

In West Bengal, the members of the ESHGs decided on the list of people to be included in each

tranche of essential items distribution. The distribution of ration started May 2020 onwards. March and April went in planning with the district officials and reaching out to donors. Before that, in the interim stage, there was little relaxation for moving from one place to another. Initially, the federations of ESHGs helped in identifying the beneficiaries. The HI team prepared a list with the information received from the federation. This was based on the vulnerability in terms of the food and medicine requirement. The community decided in finalizing the list and the list was verified. Income loss, abandoned elderly, without any children, age, those whose children lost their jobs and had returned to native places, etc. were the criteria. The heterogeneous groups knew of the conditions of the member and therefore, the recommendations came from the ESHG members and the federation. There was a general consensus amongst the community members in selecting the beneficiaries.

The demand far exceeded supply and various ways were devised by state teams to deal with the challenge. In Telangana, the neediest were identified to be served first and then continued till supply lasted. HI team members in consultation with the Senior Citizens' Association members and local volunteers made lists of people to be included in each delivery cycle so that maximum number of older persons could be included. BPL ration card was the basic document for inclusion in the list. Another criteria was living arrangements, those who lived alone or with spouse only were given priority over those who had family to support them, Besides, the poor in the urban slums serviced by HI MHUs were also included in the lists like in Delhi/NCR.

To make the distribution COVID behaviour compliant, the kits were kept in a room and the older persons were asked to come in one at a time and pick up and leave. In the districts of UP where the administration allowed HI to distribute directly, coupons were distributed to the identified beneficiaries the previous day and specified time of distribution, in order to avoid any mass gathering or difficulty in maintaining distance. Procurement and supply challenges were dealt by the staff and in many cases the staff themselves packed the dry ration into kits for distribution.

HI Helplines helped all those who called in whether in case of abandonment, need for medicines, food items or any other essentials, counselling, or information. During the second wave of the pandemic, helplines played a pivotal role in responding to the older persons in getting oxygen cylinders, admission to COVID facilities, helping them deal with anxiety, isolation and digital challenges. In Uttar Pradesh, the toll free number

of HelpAge India's helpline was printed on the bags of essential items so that more and more people could be made aware and take benefit of the service.

The old age homes were selected on the basis of the felt needs articulated by the respective homes and an assessment made by the local HI team on the urgency of requirement.

Partnership/Support Received from Other Stakeholders

Crucial support in terms of money came from corporate and individual donors. After internal need assessment and capacity to deliver, HI approached the corporate donors with specific projects like food and dry ration distribution. For medical and health care interventions, the existing donors were already committed.

The other crucial support came from the government at state and district level. The district administration in some places was extremely cooperative and issued passes etc. during the lockdown. In Delhi/NCR, the passes were issued to almost all staff members who were on ground duty without any delay. In some places, the local police helped in maintaining order while distribution of essential supplies. In Uttar Pradesh, the district administration coordinated supply of essential items to the people.

In Madhya Pradesh, HI team worked in close collaboration with the Police Department in Morena and Indore to provide support for any intervention for the older persons. The department and HI coordinated on various aspects of providing services to the older persons. The local Senior Citizens' Associations were also involved in the process.

The community volunteers played crucial role in connecting with the older persons in the community, articulating their urgent requirements and explaining to them the rules of the new normal. Their activities were significant in the rural and peri-urban areas where elderly depended on human agency for information and intervention. In Madhya Pradesh, the HI team also collaborated with other VOs to fulfil needs of the older people that could not be included in HI programmes especially for food and medicines.

In West Bengal, volunteers are selected from the community itself. The physically and mentally fit older persons and others who are not aged but are related to the field activity or to the elderly population in the community/ village are enrolled as volunteers. In each village, the number of volunteers is dependent on the number of groups i.e. for 10 groups there is 1 volunteer.

The training of the volunteer is carried out in phased manner for different topics depending on

the project deliverables. It starts with basics of maintaining groups, stages of group formation, maintaining books of records, as a volunteer what they should see in the community and at an advanced stage, in *panchasutra or saptasutra,* how they will take care of the destitute, social activities to be involved in. The volunteers are an integral part of any project.

During the pandemic, the volunteers played the most important role of maintaining connect between HI and the ESHGs. Even when staff of HI could not reach the villages, they acted as medium between beneficiaries and HI. They contributed in checking the vitals of health for the beneficiaries, visit their houses, and counsel them on COVID protocols.

Relevance of Work Done for Older Persons

The responses of HI to the needs of older persons was informed by the experience during natural disasters and ground reality as known to its staff and volunteers. As stated in the guidelines for age care during disasters developed by HelpAge International, HI responded to immediate survival needs in terms of access to food, medicines, treatment, safety items, information and awareness, and mobility. The food response was

not just in terms of cooked food for hunger but later included nutrition kits that would also help build immunity. The distribution till the third wave of masks and sanitizers helped prevention of diseases in many elderly who could not afford it otherwise. Customized awareness about COVID protocols helped poor older persons in preventing infections.

The health care programme covered entire range of needs from that of regular supply of medication to NCD patients to counselling for mental wellbeing to actively promoting vaccination. In a way, it actually ensured that nobody was left behind in the entire range of needed services.

Helplines ensured that older people are reached out for quick and adequate response to their emergency and emotional needs. Act as coordination point for facilitating access to older person especially those living without the support of young adults.

Lessons Learnt

HI used its experience in disaster relief and rehabilitation, its current programme interventions, its partner agencies expertise to develop and implement a comprehensive intervention programme for the older persons during the

pandemic. Due to these strengths it could provide timely and appropriate responses. This good practice should be documented and further strengthened by mapping well in advance for any such eventuality.

The capacity of VOs for intervention is limited, so there should be a cadre of trained and sensitised community volunteers, along with the staff members of the other VOs with adjacencies.

Health is an important aspect of the lives of older persons and older persons access public services, of which there is dearth especially in rural areas. VOs may service these demands in pockets but cannot ensure maximum coverage. So, there should be effort to integrate the services to maximise the impact. Health concerns of older persons should be included in all health care programs at district level and also have facilities for digital access. The vaccination drive and its success demonstrated the need for a focused approach for the geriatric care.

National programmes like Elderline should be strengthened to deal with 'normal' time issues and have some capacity for dealing effectively with the emergency situation. The experience of the

currently operational Elderline may be used for the purpose.

The bottom-line is to develop capacity of the older persons and their communities to respond to such calamities. Senior Citizens Associations and ESHGs are a good starting point for this. ESHGs and SCAs model for capacity building of the rural and urban elderly to be independent and interdependent groups should be also explored further. So, the AGRASAR programme of Govt. of India should be taken forward with zeal.

Digital inclusion of older persons is as useful as social and economic inclusion and efforts should be made to train them in bias and advanced skills for accessing services and goods and for better employment opportunities. Corporate may contribute to this in a major way to align the older persons to this much needed skill.

The ground experiences of the VOs in providing care to the older person during the pandemic should be documented to highlight it to the policymakers and legislators to include older persons as one of the segments of the population requiring attention for becoming independent and equal partners.

CUSTOMIZED **AWARENESS ABOUT COVID PROTOCOLS** HELPED POOR OLDER PERSONS IN PREVENTING INFECTIONS.

GOOD PRACTICES IN AGE CARE DURING COVID-19 PANDEMIC: CASE OF VOLUNTARY ORGANISATIONS

At a time when proximity and access of services had to face blockade, community based organisations who had deep connect with the ground were the only source of hope to many marginalised and vulnerable sections of the population Many of them worked dedicatedly for the social, medical, nutritional, emotional, and financial needs of the older persons.

Introduction

This chapter highlights the role of voluntary organizations (VOs) other than HelpAge India (HI) in responding to needs of older persons during the COVID pandemic. It takes into account the workings of community based organizations including senior citizens' groups. The difficulties faced by older people and their families during the pandemic were identified by many voluntary organizations involved with age care. Based on their mission, aims, available resources and partnerships, some of these worked dedicatedly in rural and urban areas, towards meeting the social, health, emotional, financial and nutrition needs of older people during the 3 waves of the pandemic. These organizations were the critical lifelines to communities, in particular to older people especially from lower economic strata, in providing resources and services that improved the ability of communities to handle the crises due to the spread of the corona virus. Many older people benefited especially those living alone or only with spouse. Given below in the first section in alphabetical order of the States they represent are the profiles

of 9 different VOs selected for this research project in terms of their geographies, goals, focus, and operations. The second section of this chapter specifies the respective interventions by each VO in terms of their reach out and support received through networking partners. The third section discusses the Operational Mechanisms and the chapter ends with concluding remarks.

Profile of Voluntary Organizations

Voluntary organizations working independently and with support from HI as well as other organizations selected for this research were based in Bihar, Chhattisgarh, Delhi/NCR, Madhya Pradesh (MP), Odisha, Telangana, Uttar Pradesh (UP) and West Bengal (WB). Most of the selected VOs with a community outreach focus have an experience of working in the field of age care since 1980s or 1990s with the help of young and older volunteers, who maintain close contact with older people, families and the community. The other primary target groups serviced by these

organisations include women, youth, disabled and community development, preventive health care including mental health. They all had very strong community presence and worked closely with the communities for a long time and had good sense of the social and economic dynamic. The style of operation and structures varied from highly participative and grass-root structured in Odisha to simple dedicated people led service organisations in Chhattisgarh and MP. The sample also includes an organisation of recent origin started by a group of dedicated mental health professionals who adopted unique method of training the community volunteers to identify the symptoms of the diseases also that of mental stress and help the older persons and other members of the community to access health care in pre and post COVID times. The organisations led by the seniors themselves were simple service delivery organisations that worked primarily for the older persons did not shy away from serving the needs of other segments of the population. These were conventional voluntary organisations that were led by dedicated retired older persons who were able to mobilise the support of the local supporters and government machinery to help people in need. These apparently disparate VOs were able to bring their own unique organisational and thematic understanding to the cause of the older persons especially in the pandemic to help them deal with

challenges ranging from access to information to getting survival benefits including access to government schemes. The most outstanding feature of these VOs is that they serve the cause of the older persons with same dedication as their chosen primary cause and in the process some encouraged other segments of society like women, youth to be sensitized to the cause of the elderly. The best example was organisation from Delhi that had specially designed programmes for intergenerational nature that helped deal with the social and emotional isolation of older persons. A mention must be made here of the seniors' organisation that tried to encourage older person to learn and use digital technology for social interactions.

One common thread was extensive experience, sensitivity and connect with the disadvantaged older persons in the community thus making it easy for them to assess and fulfil needs of older people, in particular of the vulnerable among them such as women, disabled, those alone and in more disadvantaged situation than others. The functioning of these VOs helped in many ways particularly during the lockdowns because of COVID-19 even though each VO's service goal and mode of operations is unique as outlined below in meeting specific needs of those poor, those whose incomes got disrupted, those on their

own or living alone, disabled, staying in OAHs, or migrants. Yet the similarities in the interventions on meeting the needs of the vulnerable on an emergent basis in terms of distribution of food, medicines, hygienic and other needed products and services, is commendable in reaching out to many older people and their families in rural, remote and also urban areas. The following profile of the organizations along with the specific interventions during the pandemic would illustrate their contribution in reaching the last mile older persons and responding to the needs of immediate survival and preventive health care specific to the pandemic.

In Bihar, the Koshish Charitable Trust (KCT) based in Patna since 1997 works with a right based approach through its network of 1800 trained volunteers to meet the needs of children, women including older women and older men. It is also involved with research studies with funding from various institutions. One of their studies done in 2000 on old age issue and migration impacts was

significant for their operations as it made them realise the vulnerability of older people with children migrating and families getting divided. This inspired their work for older people (includes 50+) especially for older women vis a vis care and social security. KCT facilitates enrolment of older persons especially women in schemes for social pensions, admission to older widows in government old age homes and settling property disputes by providing legal assistance. They have been associated with HI in village level awareness programmes on pensions and food security by reaching out to members of senior citizens' associations, training them to access government services, facilitating older people get pensions and to be part of PDS. Documentation of their operations reflects their success and these reports are shared with the government and HI. Their experience of working on social security concerns and disaster management especially after floods in terms of distribution of food, medicines, hygienic products and drinking water, helping people shift to safer areas and providing health care was useful

during pandemic when they were involved with similar exercise. Funded by individual donations of associated members, money generated through running of their cooperative society and fees collected as part of their training programs helps them in their community reach out operations.

In Chhattisgarh, the Rehab Foundation (RF) started in 2012 with the objective of working for the disabled, children, women and older people is connected with the National Trust in raising awareness on disability issues in different villages. They as an organization are in the forefront to be concerned on disabled older people and this was particularly significant during pandemic times. The day care centre with a team of doctors, physiotherapists and counsellors opened by them in 2018 for disabled older people with provisions for physiotherapy, counselling, healthcare check-ups, and guidance on nutritional matters was useful during all phases of the COVID-19. The centre helped not only older people but also family members who provided care to them. The old age home (OAH) Babu ki Kutia Virdh Ashram for destitute and abandoned disabled older persons was specially catered to during the pandemic. Their work comprises of facilitating older disabled people to use public services, counsel families to understand their vulnerabilities which were more acute during the COVID waves and involve police when required in reinstating older people with their families became more focused during the pandemic especially with financial support from individual and institutional donors.

Representing **Delhi** were 2 organizations, 1) **Chetanalaya** and 2) **Public Health Empowerment and Research Organisation (PHERO).**

Chetanalaya with focus on community development through work for children, youth, women, people with disability, and older people started operations as an NGO in 1970 but

registered with the government in 1994. Supported by HI for the last almost 20 years, it is working with 600-800 older people by organizing Teerth yatra's (pilgrimages), cultural programs, giving monthly pensions of Rs. 100 and helping them register with different government schemes. They run a day care centre in Sangam Vihar and an OAH in Rohtak. They have facilitated organizing 1500 self-help groups of women who helped in many ways to deliver interventions to those in the communities during the pandemic.

PHERO with main operations in Delhi and few in Bihar started work in mental health 7 years ago. In Delhi, with an office at Peeragarhi, they cover localities in the radius of 12-15 kms. They were especially active during COVID times in empowering people to meet their specific health and related needs as per their culture and language.

In Madhya Pradesh, Anand Service Society with head office in Indore has many operations in central India and also a national outreach. It started in late 1990s by 7 members among whom 4 are disabled, a parent of a disabled child and along with 2 others who all had strong intention of serving the needs of vulnerable persons, especially aged who are impaired with different disabilities. Absorbing people with disabilities as office bearers

they collaborate with other organizations working with older people by providing inputs on disability issues. Since 2016, they are supported by HI in their activities.

In Odisha, the Centre for Advocacy and Research (CFAR) with focus on older people, single women, transgender, construction, domestic, sanitation and manual workers, rag pickers, scavengers, migrant workers etc. started its operation in 8 districts in 1980. They are part of the Social inclusion project and the WASH Project.

In Telangana, the charitable Senior Citizens' Service Trust was started by older persons in the age group of 69 to 88 as trustees and 350 older persons as members with the goal of working for all segments of the population that needs help. The main decisions regarding the functioning of the association are taken by the Trustees though members are consulted and involved in different projects as per their desire to organize cultural, recreational and relief programs with participation of older people. Since 2008, the Trust works with support from HI in age-care activities but also get funds from business houses and private donations including from their members contributing, many of whom are senior retired government officers who also use their connections in state government to help others.

In Uttar Pradesh, Manav Sewa Kendra (MSK) since 1987 is working for children, women and older persons at grass root level in 3 districts in Chandoli, Mirzapur and Varanasi with focus on making them independent to meet their basic needs and manage their welfare. They also facilitate poor older labourers who don't have strong family support especially if they have disability and cannot earn in linking with government schemes on social security, PDS, pensions. Their major work focus is in Chandoli, a remote area.

In West Bengal, Sundarban Social Development Centre (SSDC) started in 1986 but registered in 1989 does charitable relief work for disaster affected communities especially in Sundarban, a remote area with 600 staff strength and 2000 volunteers spread over. Its programs address community dwellers' felt need for health care in 20 villages. In 2002, when disaster disrupted livelihood of people in this region SSDC targeted specifically meeting needs of older people by starting a hospital on campus with major task being restoring vision through conducting cataract operations. SSDC receives support for various healthcare programs from HI.

Interventions

The focus of these VOs is to cater to various needs of older people besides other vulnerable segments especially by taking into account gender and economic considerations, disability issues, single status, disruptions in family relationships due to loss of jobs and incomes, return of migrants, breakdown of social and healthcare mechanisms including of social security measures which became particularly critical during the pandemic in all the three waves of the pandemic. Many of these VOs with financial support and organizational assistance from HI, other NGOs and civil society members such as individual and institutional donors and private bodies supported government tasks of reaching to communities with or without their assistance.

There were 3 main tasks required as part of interventional strategy and the VOs delivered all 3 or specific ones based on organizational and financial resources available, namely 1) addressing basic needs for food, social and healthcare; 2) providing and facilitating financial, income and social security; and 3) raising awareness on the COVID virus from a preventive and curative perspective.

All the VOs focused on catering to the emerging needs of older people besides for other vulnerable groups from a right based perspective by distributing food, medicines, hygiene related products such as masks, sanitization products,

health services including addressing mental health and disability issues, care provisions at the community level, awareness about the pandemic, precautionary practices within the social distancing guidelines and accessing vaccinations as well as securing social protection on a priority basis. Facilitating use of digital technology for accessing services and provisions in the social and health care sectors along with registrations for 1st, 2nd and booster does of vaccination were the main operational task of most of these VOs. Some of these organizations also catered to meeting the needs of special groups such as those in prisons, living in institutions and other particular segments of the population, for instance those affected by leprosy or transgender communities.

a) Distribution of food, medicines, hygiene kits, healthcare and legal aid

The pandemic and especially the lockdown period was a difficult time for older people in accessing food items, medicines, social and health care. Most VOs working in the field of age care concentrated on providing the much needed dry rations to the older persons by making special arrangements with wholesalers or retailers to procure materials and then delivering these often at their door steps or at central reachable community outlet. Besides delivery of dry rations few VOs were also involved with arranging community kitchens to make cooked food available to those who could not manage on their own due to various reasons, mainly health. Many VOs by arranging mobile units and services with the help of volunteers distributed medicines, provided health services through team of medical professionals including counseling and guidance on medicines for different ailments. Also the infectious nature of the pandemic brought focus on the need to maintain certain levels of hygiene and precautions thus many VOs got involved with the distribution of hygiene kits which included masks, sanitizers, soaps, etc.

Some illustrations in this context can be seen in the activities of **Chetanalaya in Delhi** which

throughout the pandemic is involved with distribution of food, hygiene kits, medicines, oxy meters and setting up community kitchens. During the three waves of the COVID, through community kitchens they supplied 50,000 plus meals and gave 200 medical kits. Moreover, their team of volunteers helped older people in procuring rations, medicines, get guidance through online consultations for health care.

Similarly, in MP, **Anand Service Society** helped more than 1000 older disabled people across the country by providing free food rations, hygiene kits, facilitating delivery of food, admission in hospitals for COVID treatment. They launched a helpline and widely shared the number through social media, created a YouTube channel giving information on special communication tips for deaf and mute patients with health workers and others. They also facilitated communication of deaf and mute people in hospitals with the doctors and staff through video calls. They shared tutorials on using Google locations to facilitate delivery for food and other services for disabled particularly for older people.

In Odisha, Centre for Research and Advocacy also was involved with distribution of ration kits and survival kits as a special drive in the slum colonies where they also helped people get vaccinated by facilitating their registration. 3000 older people

benefited by free distribution of relief kits. Help desks managed by volunteers were set up in their areas of operations and supply of food, medicines, counselling were timely delivered. In addition, they organized 3 health camps to get cataract operations done, provide counselling and provide services in any emergency. At the community level 100 vaccination camps were organized which catered to about 100-120 persons every time and among them 30%-40% were older people. The importance and awareness on vaccinations was also promoted by the **Public Health Empowerment Organization** through a culture appropriate approach to deal with physical and mental health needs. A separate healthcare unit was set up to provide services, consultations, do small surgeries either free or at nominal costs, and distribute medicines and survival kits. All distress calls were attended to and older people were provided, through mobile and telephones, information related to COVID, self-care tips, nutrition related guidelines as well for exercises, remaining actively involved, dismissing fears of getting affected, or fearing death. The young members in the family and the community were trained to give injections, dispense medicines for basic health needs and deal with emergencies, provide care and emotional support. During the course of their activities of providing health services they many times received appreciative

feedback from the beneficiaries.

In Telangana, Senior Citizens Service Trust in 2020 was actively involved with distribution of food, medicines but their main activities remained in facilitating health workers to reach out to older people in the community by doing door to door survey for identifying specific needs especially for those living alone, for older women and catering to those with disabilities by providing suitable assistive devices. They initiated a dialogue with the authorities in having a vaccination drive in the community and helped many get vaccinated by taking them to the vaccination centres. 1000 older people were vaccinated through their help for the 1st and 2nd dose and 90 for the booster dose. They also helped jobless slum dwellers by food distribution with support of HI and managed to provide 87 food kits to avoid starvation. Through their network of contacts, they facilitated older people getting admitted in government and private hospitals when required. They also took help of police in organizing movement of certain older people in case of emergencies. To meet the special need of many older people for physiotherapy they set up a centre with free services for BPL and for APL provided services at a nominal charge of Rs. 50. Realizing the difficulty of older people in seeking legal aid, they also provided legal guidance especially in terms of

protection under Maintenance and Welfare of Parents and Senior Citizens' Act. In terms of their success with this measure, they helped in solving 22 of 33 registered cases. Besides this, they realized the special needs for help of older people with children abroad and provided food services to them during lockdown by charging Rs. 200 a day for meals.

In UP, Manav Sewa Kendra's main interventions were also in terms of supply of dry rations, medicines and linking older people with PHCs and CHCs for meeting health care needs. They established a small hospital in the community through which basic care and medicines were delivered and acute cases referred to government hospitals. Many older people didn't want to get tested when they showed symptoms of COVID but testing was facilitated and proper medications given after medical consultations at PHCs. Arrangements were made for isolating affected older people in houses and all advised to take necessary precautions. Casualties were high in 2nd wave, in every village from 5 to 10 would die. Counselling need was high and a team of 2-3 counsellors was hired with one female and male counsellor. Also, links were established with government scheme of family counselling to remove isolation of older people. Phone numbers of counsellors were widely shared and special

needs were catered to, for instance some could not cook so neighbours were approached and help arranged. Mobile linkages between counsellors and people were set up in villages. Cataract operations were restarted and also blankets distributed to help older people deal with winters.

In West Bengal, Sundarban Social Development Centre facilitated supply of food rations and medicines to the poorest older people through continuous support of HI. With the help of volunteers, the organization identified many older people affected by COVID and then necessary interventions of sending them to hospitals for treatment and isolating them to avoid spread of the virus was done. They reached out to around 2000 older people living in the community in 20 villages in four gram panchayats for distributing masks, soap, sanitizer, phenyl, detergent, bleaching powder, etc. through their team of volunteers and staff by maintaining the COVID protocols. When restrictions relaxed, the beneficiaries were called to open places and distribution took place. They were also successful in providing tele-services for counselling to 2000 older people besides during the 2nd wave they actively facilitated registrations for vaccination by putting a fear in older people of being deprived of governments benefits if unvaccinated. They covered more than 10,000 people with vaccines. With the help of the

government they procured oxy-meters and oxygen concentrators to be provided to the needy during the second wave. At this time, they also helped in getting 500 cataract surgeries for the most vulnerable and poor older people to whom also food and hygiene kits were distributed by better off older people who underwent an orientation programme organised by the Rural India Supporting Task (RIST).

b) Providing and facilitating financial, income and social security

Many older people experienced economic difficulties during the pandemic and few VOs took up special initiatives for older persons to overcome financial problems by providing certain livelihood opportunities, raising awareness on getting connected with government schemes for food and social security mechanisms. For instance, Patna based KCT involved older people in 15 districts of Bihar to receive food security measures from the government as well by networking with other organizations. They also provided financial help and training to older people to start livelihood activities such as growing mushrooms, making phenyl, hand wash products and provided help in marketing these products. Similarly, Chetanalaya in Delhi helped those who lost jobs but had labour card to avail government scheme of receiving Rs.

5,000 in their bank accounts as well as ration card holders to avail government rations. Through funds received from donors they supported 88 families going through financial difficulties by giving Rs 10,000 to each and facilitated 2,800 families to get government rations. Chetanalaya was also successful in teaching many older people living in their outreach communities, use of mobile apps to get pensions. On the same path, in Odisha, Centre for Research and Advocacy gave guidance for availing pensions and government benefits by registering older people for Aadhar card, etc. They also organized a special reach out to transgender communities to avail various government benefits as part of their entitlements. Till December 2020 for 13,276 older people who wanted social security, through this VO's help, 12,677 person's applications were submitted and 10,824 got the support. The cases of 1800 people are pending due to lack of proper documents or details mismatch. All these are supported through interventional work with support from different partner agencies. Another VO, Manav Sewa Kendra in UP helped older people in getting pensions and availing government schemes like PDS which had got disrupted during the pandemic. The emphasis on older people being able to support themselves financially became quite strong during COVID days when many as

individuals faced economic difficulties. In this context in West Bengal, Sundarban Social Development Centre's work with 1300 farmers to support them with organic fertilizers was a positive contribution and in addition giving 200 households small chicks for poultry farming were initiatives much appreciated by the communities. The need to provide livelihood opportunities to households with older people was seen as an urgent need during the pandemic.

c) Awareness on the COVID-19 from a preventive and curative perspective

Another unprecedented requirement was communicating appropriate and adequate information, neutralizing false and information overload to older persons during COVID. Added to these challenges were ever changing protocols and new needs because of the pandemic in each wave. The good faith and trust that these VOs had generated through the years with the community helped them in debunking myths and reinforcing behavior change pertaining for instance to social distance and wearing mask. Later, the same experience was repeated when government started vaccination. Some illustrations of VOs undertaking the task of raising appropriate awareness regarding COVID virus from a preventive and curative perspective can be seen in

Rehab Foundation in Chhattisgarh emphasising on proper COVID protocol for residents in their OAH and on keeping older people happy by making provisions for their recreations such as taking them for drives and outings with precautions and celebrating birthdays. They provided shelter to younger women, victims of domestic violence and trained them to provide for care of older persons at OAH. Also, Chetanalaya in Delhi made special efforts to dispel fears by counselling, guided families to take care of affected older people, in use of oxy meters and adopt preventive measures. Their special reach out was in slum areas such as Jahangirpuri, Seemapuri, Shastri park facilitated the full process of vaccination with the help of youth volunteers in the ratio of 1 for every 10 older persons. Similarly, Public Health Empowerment Organization, dispelled scare about coronavirus especially in the 1st and 2nd wave by building the confidence of older people, their inner strength through counselling; by adopting preventive measures of distancing and guiding them to be involved in activities at home. They also worked in bringing an attitudinal change which could strengthen the coping mechanisms especially of older persons.

The change was visible much to the satisfaction of the VO when they set up many outreach programs and the change was seen in terms of older people willingly wanting to be vaccinated. Further the outreach program was seen to have an impact as fear of the corona virus lessened among the community dwellers in the 2nd and 3rd wave. As staff of Public Health Empowerment Organization stated focus on prevention and promoting self-care was seen as being more beneficial in the long run as it equipped older people with confidence to face the adverse situation. The provision of free health care or at nominal rates was welcomed along with providing simple health care tips in conversational mode. Strengthening intergenerational relations was seen by community dwellers as a positive contribution along with making older people self-sufficient in managing their affairs. These empowerment strategies adopted led to communities being happier and in a better state of mind. This was assessed on the basis of feedback received from people by the organization. A change was seen for the better among older people as per VO staff in practices related to nutrition, eating habits and maintaining health. Discouraging people to watch TV to avoid receiving too much of negative information and spending more time in recreational activities helped people in coping during COVID. In Odisha too, Centre for Research and Advocacy took initiatives to raise awareness on preventive protocols and trained older people

on these measures. In Telangana, Senior Citizens Service Trust raised awareness on adopting precautionary measures with help of ICDS workers by going door to door, holding gram sabhas and distributing pamphlets. As like other VOs in West Bengal too Sundarban Social Development Centre's main interventions were raising awareness on the COVID, Community sensitization programs on prevention were undertaken in 6 Gram Panchayats by covering around 2000 old people.

Operational Mechanisms

All the VOs organized systematically assessment of needs and based on that allocated duties to their staff members and volunteers for catering to the problems of older people and delivering the services and resources. Since all of them work in communities, their familiarity with the needs of older people and their families helped in providing services and reach out in delivering to the vulnerable. However, some organizations have not properly documented their relief operations

and thus do have hesitation in stating whether all needs were met but feedback received from beneficiaries is appreciative of their efforts.

As illustration of the operational mechanisms adopted by Koshish Charitable Trust in Bihar through their volunteers does an assessment of the needs of older people in the districts in which they work. They send a list of demands for action to the government and at times receive a response as it happened during COVID. As a positive outcome, many doctors of Patna Medical College along with medical students came forward to provide medical assistance at the community level. Certain government officials along with other people contributed donations for reach out to specific needs of older people. Student volunteers from different institutions supported and carried forward their work. Many interns who couldn't go home became their volunteers and helped in identifying the needy older people, specifically older women in about 7- 8 districts of Bihar. Based on this assessment of age and gender, accordingly distribution of food packets was done. Health

needs were identified through visits by professionals and paramedical staff as part of MHUs and online consultations through mobiles and helplines set up by the organization. Increased use of services provided by the organization was a reflection of right measures being taken.

On the other hand, Rehab Foundation from Chattisgarh depended on few dedicated workers to deliver personalized services and make assessment of needs. Dissatisfaction among the recipient of services was not seen. In Delhi Public Health Empowerment organization's interactions with older people both physically and online led to understanding their fears, needs and requirements which were strategically met; but, with more emphasis on empowering older people by adopting preventive measures and adopting appropriate behaviour. The assessment of needs was also made by attending to phone calls and these were always addressed appropriately. The 2nd and 3rd wave brought fear of death due to COVID and this was reflected by older people developing certain syndromes as having post

traumatic conditions/disorders and going into depression. However, the trust level of people in approaching the organization for solutions was seen as an encouragement of their efforts as much as it was seeing a change in people's attitudes of being less fearful. This was reflected during the vaccination drive when people came forward willingly to get vaccinated. In Odisha, CFAR did an analysis of the needs and on the basis of information collected from home visits and help desks at the *basti* were set up. Each desk was managed by five women beneficiary/volunteers selected to manage these and look into concerns related to pensions, rations, grievances, water supply and toilet facilities. They reported to the community help desk which is a single unit system to address these concerns in collaboration with the competent authority. The Helpdesk successfully addressed the concerns and one such help desk would cater to the needs of 5 bastis. For creating awareness about new schemes volunteers are given training from the respective government departments, then have community level meetings

for setting up camps and disseminate relevant information in the community. They maintain a proper chart about the timelines, beneficiary history etc. and prepare a proper dashboard. They help the government in verifying the real requests and submitting it to the relevant departments. There is regular planning and review of the existing situation with the helpdesk members and accordingly actions are taken.

Telangana Senior Citizens Service Trust used a more streamlined method by emphasising on meeting the needs of the vulnerable older people through their identification from the ration card and the white card. An outreach plan is formulated especially for those living alone and older women for distributing food, medicines and taking them to hospitals if required. Health camps are organized especially for this segment on the basis of their felt needs and free medicines, reading glasses, wheel chairs for the needy are supplied. They did face certain cultural barriers in terms of identifying needs of the vulnerable older people. In UP, Manav Sewa Kendra made need assessment list of vulnerable poor older people in the districts and villages. Then a reach out was planned for helping 500-600 poor older people in getting dry rations. Through a team of 100 staff members, provisions were made to meet the health needs especially with free distribution of medicines. CMO and MOIC

at PHCs helped in linking older people requiring health services through referrals provided by the ANMs. A need assessment for older people was done in the beginning of the lockdown and support given thereafter by first starting with limited supplies and then increasing the process of distribution in a phased manner. Proper documentation of relief operations and provision of health care is done to assess the reach out to beneficiaries and capture gaps. Also older people on receiving relief are asked to sign or put thumb impression on the receipt documents.

In West Bengal, Sundarban Social Development Centre Board members decided on the interventions depending on requirements in the community and available resources. Also ASHAs workers helped in the need assessment of the vulnerable population. The relief kits were provided to people identified by them. In some cases, the procurement of food is done through the purchase committee which calls for quotations from different vendors and followed transparent process for selection. A proper stock inventory is maintained while distributing the kits. The staff is trained for maintaining COVID protocols and go to the community on cycles. The local panchayat also plays a role in the process of selection and distribution. The satisfaction of the beneficiary is seen as measure of success.

All VOs take support from larger organizations along with HI in generating funds for their operations besides enrolling volunteers often after training generally from younger age groups. KCT is supported also by Action Aid, Oxfam and Disaster Management Authority. Rehab Foundation along with generous support from HI in financing facilities for older people with disabilities such as upgrading the facilities in their OAH or help with rations and delivery of other provisions gets financial aid from Jindal Foundation and other private donors. Chetanalaya gets financial support from Caritas Germany. Anand Service Society gets support from Rotary International. Manav Sewa Kendra got support from Child Fund, Impact and Kiran Society for distribution of provisions. Sundarban Social Development Centre has support from Sight Savers International, CBM India and KFV Australia.

Government support has been mainly in terms for vaccinating older people and in setting up community kitchens. Government health officials also helped in getting COVID affected older people hospitalized and taking care of them till recovery. Government also provides guidelines for COVID appropriate behaviour which VOs follow and promote. Besides, state governments and local municipalities help with providing social security and health care benefits under various schemes which makes the task of VOs easier.

Concluding Comments

These VOs, despite various challenges of lockdown, especially in terms of getting permissions for movement of staff, limited financial resources and scarcity of things managed to deliver health care including services such as checkups by professionals, delivering medicines, taking care of specific health problems including physical and mental health concerns, providing counseling, raising awareness on precautions for COVID, making arrangements for delivering oxygen cylinders and facilitating vaccinations by helping people in registering and commuting them to vaccination centers. In delivering health care they used online resources and mobile health units.

They distributed rations, supplied cooked food where required, facilitated getting pensions, provided financial help to those in drastic need, tried reducing isolation, loneliness and fears of older people. They promoted use of helplines/telephones and engaged older people through cultural and recreational programs with strategic focus on empowering them to look after their needs, bring in intergenerational bonding and facilitate use of government schemes. Few VOs were involved with creating livelihood opportunities for older people and their family

members too. The major contribution of these VOs is the sense of security they offer to older persons who are sure of reliability and help when even at times the family is not of assistance.

The most significant learning from these examples of involvement of VOs working in adjacent thematic areas was importance of collaboration to deepen and extend the reach during normal and emergency situations. It helped sensitize many other segments of the population particularly the youth, women to include concerns of older persons in the community, thus helping integration. It helped in extending perspective and services in areas like mental wellbeing, digital inclusion for the older persons and role that youth may play in making it work. Innovative practices like training young community volunteers to help identify symptoms for preventive health care and providing the older person appropriate information in this day and age of information overload. At a subterranean level it helped in dealing with challenges of ageism that considers older person comparatively less worthy of efforts.

VOLUNTARY ORGANISATIONS WERE THE **FIRST RESPONDERS** AND CONTINUED THEIR SUPPORT TILL THE LAST MAJOR PHASE OF THE PANDEMIC.

GOOD PRACTICES IN AGE CARE DURING COVID-19 PANDEMIC: EXPERIENCE OF OLDER PERSONS

Faced with an unprecedented crisis and extreme restrictions, the pandemic increased the financial, social and medical vulnerability of older persons. While the impact was immeasurable and will continue to reveal itself in the time to come, it is essential to understand the lived experience of elders; their coping mechanisms, anxieties, needs and even their hopes for the future.

Introduction

The pandemic and the subsequent lockdown and restrictions brought along a lot of chaos and uncertainty. While the government officials were engaged in spreading awareness on the safety and hygiene practices, there were voluntary organisations like HelpAge India, Smile Foundation, The Akshaya Patra Foundation and many more who tried continually bridging the demand-supply gap of the daily essentials like food, medicines and other hygiene requirements and clothes, etc. Though concerted efforts have been put from the different quarters of the society, somewhere down the line, the needs of the elderly population was never a priority area of focus and had been neglected. Furthermore, efforts seem to be scanty in documenting the best practices that emerged in extending services to the different age groups, especially to the vulnerable and the marginalized population.

As part of the current initiative, selected beneficiaries have been interacted with and their insights have been noted down through the medium of experience sharing as responses to an open ended questionnaire. The present chapter collates the insights derived from the discussion with the beneficiaries spread across in the states of Bihar, Chhattisgarh, Delhi, Odisha, Madhya Pradesh, Telangana, Uttar Pradesh and West Bengal.

Beneficiaries at a glance

A total of 27 beneficiaries were interviewed for the project and had almost same number of men and women in the sample. Most of the older beneficiaries were in the age group of 60 to 75 years. All of them except those in old age homes were living with their family. Many of them were getting old-age/ widow pension and very few had health insurance under government schemes. Unlike few of the older men, who were working to earn a living, women were mostly unemployed, barring the ones who were associated with the ESHGs.

Most of the beneficiaries reported to be suffering from NCDs most of which were age-induced. Very few had to go to hospital in the past one year for major treatment. Those who did, either paid out of pocket for some expenses or got treated in the government hospital for free. They all got food rations distributed by the government and other voluntary organizations like the HI. Additionally, free medical care and information about COVID

appropriate behaviour were also provided by the HI MHUs. In some states, the ASHA workers visited door to door for sharing information on COVID and also checking temperature and oxygen-concentration levels. All the older person interviewed were vaccinated through the drives initiated by the government and HI staff played a crucial in mobilizing the beneficiaries.

Almost all of them felt that due to loss of jobs and earning opportunities for self and family members, government should have a schemes to provide monetary assistance, just getting food grains in ration would not help them sail through such crucial times. The other top unfulfilled need was comprehensive health care facilities in the villages and small towns. The older persons from urban middle class spoke about facing challenges of lack of social support and unavailability of care givers. They also mentioned that the pandemic increased their loneliness which in turn impacted their mental wellbeing.

Those in (free) old age homes were satisfied with the support that they received in the form of essential food supplies, health care facilities and recreation. They were appreciative of the services provided by the staff during the lockdown and later during the pandemic. They did not fear the pandemic as much as those in the community.

Based on the insights shared by the beneficiaries, certain commonalities of trends have been observed and these have been summarized under the following broad sub-heads:

- Information about the pandemic
- Life during the pandemic
- Supports received during the pandemic and
- Difficulties faced during the pandemic

The following section highlights the reflection of the beneficiaries from the sampled states on the above mentioned aspects.

Information about the Pandemic

In this day and age of information revolution, the older persons even in poor and remote areas had no problem in percolation of information about the diseases as it set in. TV and print media being the first sources and then the local sources including word of mouth. So, everybody knew that there was a health threat, some degree of difference in percolation of information was reported from men and women, men being able to get it before women. However, authentic information about the precautions and behaviour were given by either the ASHA workers or staff members of the voluntary organisations. Older persons did not report calling up any helpline number that was set up by the government or other agencies for getting more information or clarification. They often

reported calling the community worker or the staff of eth voluntary organisation that they were comfortable with.

The older population in the villages and towns got to know about the pandemic from the digital and the print media. Once the pandemic struck, community members were discussing about it and this along with concerted efforts by the government and other voluntary organizations helped in spreading awareness about the pandemic.

In Bihar, for example, the beneficiaries mentioned that they got to know about COVID-19 only after the lockdown was announced by the government, and learnt more about the disease soon when people and other members of the village started talking about it. Men received the information first and later sensitized women in their households and community about the disease.

Similarly, in Delhi, the beneficiaries came to know about COVID-19 as it was widely discussed in the communities they were dwelling. They received a lot of help from the HI staff on the precautionary measures for preventing the spread of the infection.

The beneficiary in Madhya Pradesh mentioned that he got to know about COVID-19 on television when he was at a friend's place. He came to know more about it through word of mouth as well as from the awareness spread by the different media. Likewise, in Odisha, the beneficiary, a member of the ESHG, mentioned that he got to know about the disease through news as well as when ASHA workers and anganwadi members alerted the villagers on it. He followed the instruction given and meetings were called in the community to spread awareness about the hygiene practices and even demonstrating social distancing practices.

In Telangana, the residents of the old age home mentioned that as soon as they came to know that the pandemic had spread in the country along with their state from the local media and the

government notifications, the authorities put restrictions on visitors visiting them. The OAH administration tried to spread awareness amongst the residents so that they did not panic.

Life during the Pandemic

Lack of authentic information, over information about the pandemic the lockdowns and norms of social distance disrupted everybody's life more so of the older persons. Those who had a permanent source of income were more concerned about accessing goods, services, isolation and death. The poor and those older persons who didn't have a permanent source of income, or were dependent on family, those dependent on daily wage low paying unskilled work in urban areas were most concerned about bread and butter issues. Those living in small tenements in urban areas with other family members were worried about infection, and being burden on the meagre and dwindling source of family income.

There were no specific interventions focused on needs of older persons in health care, food and nutrition or mental wellbeing. Those older persons who were dependent on public health facilities for treatment and medication of NCDs were left high and dry once the public health facilities were repurposed for pandemic services and shifter to tele mode. Economic stress and inability to earn

from daily wages restrained their ability to continue treatment. Very few older persons were enrolled in PMJAY and even those who were enrolled had never used the services. The free rations provided by the government was the only silver lining for many of them. This was particularly true for the economically backwards states.

Those in old age homes were comparatively more satisfied with the care and other services than those living with families especially in poor areas. They did not report and major challenge and also reported helping each other during the stressful period. The old age home managers were complimented for the services even in case of infections in the home.

The experience urban/rural and poor/ middle class older persons were different. The stress was felt more by the urban than rural and poor than middle class. There was also a stark difference in needs. People in rural areas did not face much difficulty in accessing goods and services as most of it was available in the village and till the time that reverse migration happened the rate of infection was low. The social interaction continued to be thick despite the disruptions, so less mental agony. The reverse was true for the urban and even those who were able to afford services but living alone or with spouse only.

With the lockdown measures and restrictions being extended, in the urban areas (in community or institutions) the elderly felt confined at home as they could not go out and interact with their peer groups or even visit markets during the first wave of the pandemic. This was not so much the case in rural areas where initially there was not so much of panic about spread of disease. Though as long as there was lockdown in force movement outside the village was restricted. Many of the rural beneficiaries reported meeting others while maintaining the social distance.

One of the beneficiaries in Bihar, mentioned that the problem was much more severe as all her 5 sons suffered problem with their jobs and could not send money to her. The financial stress increased for all the villagers, and most of the beneficiaries, who were dependent on agriculture for income, had no work during the pandemic, which further limited their income.

During the second wave, in Bihar, the village where the beneficiary lived, had lots of return migrants and as a safety measure, the migrants had to stay in the quarantine centres set up in the village. Following the COVID protocols helped them ward off the infection and no one got infected during the first two waves.

In Delhi, the beneficiaries mentioned that they received widow pension which is not at all sufficient for survival. However, they were usually intimated by the text message on their telephone about the pension being credited to their account. Walking down to the bank during the lockdown posed to be a challenge for the elderly as no vehicles were available and the heat outside was intolerable.

In Madhya Pradesh, the beneficiary mentioned that during the first wave, there was no work done to help them and nobody asked about their need, nor did any organization came to help. However, he also mentioned that there was no scarcity of ration at this time. He met with an accident during the second wave of COVID. He is a recipient of the government's Ayushman Bharat scheme and has got his X-ray done from the OAH and hospital. He was admitted to the government hospital after his accident and got his treatment there. The Mobile Healthcare Unit of HelpAge India visited the old age home regularly, and helped the residents to be examined and screened medically. The medicines provided by the MHU kept the resident safe as well as reduces the burden on them to go out to buy medicines especially when the disease was spreading inexorably.

In the OAH in Telangana, precautions were taken, and the first and second vaccine doses were also

given to the beneficiaries. They were also the first OAH in the state to complete the vaccination of the 2nd dose for all the residents with Covishield from the local PHC. There were regular doctor visits to the OAH and the protocols were followed. Outside food was prohibited and the sanitation measures were strictly followed during the pandemic. As a precautionary measure, outsiders were not allowed to enter the OAH unlike the pre-COVID days when visitors came to meet and celebrate different occasions with the elderly. The residents were taught to use the sanitizers and other hygiene measures and therefore no one was impacted. The rehabilitation centres and doctors were also available and they had adequate measures to support in case somebody was infected with the virus. They tied up with COVID centres and also had private rooms to take care if anyone got ill. At the OAH in Uttar Pradesh, the residents were advised on the measures to take care of themselves and other COVID appropriate behaviours by HI staff, old age home staff and ASHA workers as well. Family members would talk over the phone at times but the care that the HI officials extended, compensated for the absence of the family members close by. All the residents have been vaccinated with both the doses, and HI staff arranged vehicles to go to the vaccination camps during the first and the second waves.

Support received during the Pandemic

Most of the older persons benefited from the services of the VOs whether for food, medicine, treatment, protocol awareness or that of the community and facilitation of vaccinations. Those who were getting social pension also continued to get the amount without delay. The services of ASHA and health workers in creating awareness and precautionary measure like checking temperature and oxygen levels was reported by some older persons. All the older persons were fully vaccinated at the time of interview. Most of them did not face any major difficulty in getting the shots and in rural areas with ESHGs the older persons volunteered to encourage others to take the shots.

In the initial days, when the pandemic struck, it took some time for the government to assess the need of the community and reach out to them with relief. However, the voluntary organizations played an exemplary role in the last mile supply of the essential commodities and the efforts of HelpAge India deserves special mention when it comes to serving the marginalized older persons.

Volunteers from HelpAge informed the community members about the COVID appropriate behaviour like regular hand wash, wearing masks, social distancing, etc. and they kept on spreading the

awareness through the telephonic calls or at times by physically visiting the villages.

In Bihar like many other states, the government distributed relief kits and provided assistance through fair price shops. The elderly beneficiaries received pension of INR 400 per month. The panchayat members organised vaccination camps at their villages and all the beneficiaries have received the two doses of vaccine. The volunteers from HelpAge also helped them a lot to get vaccines on time. They would also provide transportation support and often accompany them to the vaccination centres in case if there was nobody to take them along.

In Delhi, the HI volunteers helped the beneficiaries with information on the hygiene practices like hand washing, using of masks and sanitizers which were also distributed for free to the beneficiaries in different localities. The beneficiaries also mentioned about the health awareness spread by

the HelpAge India (HI) staff on the preventive measures that they could take to ward off the lifestyle diseases like diabetes, hypertension, etc. Apart from these, the Mobile Healthcare Units run by HelpAge India visited each locality once a week, and these were assisted with doctors making it easy for people to have regular check-ups. The HelpAge staff helped them in getting vaccinated as well. During the second wave, older people in Delhi, also received nutrition kits from the HI staff. Additionally, they also received health and hygiene kits and blankets from the HI officials. One of the beneficiaries mentioned that the ration which she received from the government was not sufficient and they had to purchase the same on their own. One of the help that a beneficiary mentioned to have received was the cataract operation done with the help of HI. During the interview, he mentioned that the HI staff took him to a hospital for the surgery in a cab and after the operation got the lens fixed.

HelpAge India staff in Delhi used to organise recreational activities for the elderly keeping in mind of their mental well-being as well. They would conduct games, yoga sessions, cycling and other exercises at their centres for the elderly, and many would attend them with enthusiasm. These sessions helped the elderly with a chance to connect socially. However, during the lockdown,

these centres were not open and the elderly could not visit and meet each other making them feel suffocated at home. HelpAge India wanted these centres to be opened again as it played a vital role in the mental well-being of the elderly especially when all the social interactions were shunned for them. Soon after the centres opened, the elderly mentioned that it brought joy in them. The centres conducted devotional music (*Kirtans),* games, and other recreational activities as gatherings for them to participate, which the participation would often reach around 400 people at times. The HI team supported the older persons in all needs, and they liked to connect with them personally, and even had numbers saved on their mobile phones to access whenever required. The beneficiaries mentioned about the efforts put by HelpAge India to vaccinate all the members in the community irrespective of their age and also make sure that the beneficiaries receive benefits of various government schemes. The HI helped them in making labour/job cards, voted ID cards and disability cards which ensured their enlistment to the beneficiary list of the government schemes.

For instance, people who had job cards in Delhi, got INR 5000 as Direct Bank Transfer (DBT) from the state government.

The government in Madhya Pradesh distributed cooked meals which benefitted the poor and the underserved people in the villages to a great extent.

In Odisha, the HI staff helped the beneficiary with the supplies and even attended her whenever she fell sick. She would call HI number whenever she required any help, and also received calls and personal visits from the staff of HI to check on her health status. As she was staying alone, during the pandemic and lockdown, she had to face the risk of suffering from loneliness, which eventually led her to feel depressed. The counselling sessions provided by HI helped her a lot in restoring her mental well-being. In addition, HelpAge India provided Uber facilities to the older persons in Bhubaneshwar and with the help of that she, like many other older persons, could visit doctors and hospitals. She lost many friends and at times when she was utterly depressed, she would often ask HelpAge volunteers to accompany her to the doctor. At times, when she could not go out to purchase medicines, she would receive adequate help from the HI. Most of the old people benefitted a lot from the Uber services during the COVID. She appreciated the Uber service provided by the HI officials to the elderly during the COVID and felt

that such services should be continued in the long run to support the older persons.

In West Bengal, the community, as mentioned by another beneficiary who is a member of an ESHG, did not receive much help from the government. The machine fund available with the group along with the money collected from door to door had been used to support the villagers. The ESHG members went from door to door to accumulate people and take them to the vaccination camps and also spread the awareness about the centres where vaccination was being done. They would arrange for vehicles to transport the ones who could not arrange on their own to the vaccination centres. Everybody used mask at home. In the village, they got information from HI and got thermal gun and oximeter. They visited house of a COVID patient to support the household financially. The thermal gun and the oximeter was really helpful, though they did not suffer from any abnormalities in the readings. They were receiving ration from the shops free of cost. They did not get any special facilities during COVID and would ask for the medicines delivered at home which was sufficient.

Once in every 15 days, a doctor was doing tele-consultation. The volunteers were mainly from the village. One of the volunteers mentioned that in the first wave of COVID, people were not understanding the importance. The volunteers would use art paper to create awareness about use of masks and sanitizers which would help them to ward off COVID through the safety practices. The elderly were scared initially. They would meet only once in a week and made people understand to stay at home.

Challenges Faced

Despite the various supports that were extended to the elderly in the different states, older people mentioned about a vast array of difficulties that impeded their daily lives during the pandemic. From scarcity of essential supplies to income loses, losing near and dear ones to COVID were some of the challenges mentioned by the beneficiaries.

In Bihar, the older persons mentioned that on some days they would visit the market and realize that the shops were closed and even on the days when the shops were open, stocks of essential items would not be there. A decline in the income often compelled them to use up much of their savings. The income loss made situations worse for them as they faced difficulties in repaying the loans or debts, they had taken earlier. Apart from all these, the prices of the commodities shot up, which further elevated their hardships to meet their daily needs.

In Uttar Pradesh, the beneficiary mentioned about his difficulty in accessing the pension schemes, for which he had to travel 3-4 kms. The summer heat and the unavailability of transportation facilities made the situations worse. Loss of income heightened their already poor conditions, plunging them into more troubles. In the initial phase of the lockdown during the first wave, older persons faced difficulty in withdrawing the pension as the banks would often remain closed.

In Odisha, the villagers hesitated to get vaccinated due to the lack of proper knowledge and other social stigma was prevalent here. The villagers were a bit nervous initially but the HI staff along with other volunteers helped them overcome the hesitancy to get vaccinated. The volunteers tried to spread awareness on vaccination through various means as in posters, pamphlets, or ESHGs, etc. Residents of the OAHs mentioned that one of the critical challenges faced during the COVID was the scarcity of ration and grocery supply. There was also a demand supply gap for medicines.

In West Bengal, the beneficiaries mentioned that there was minimal support from the government which made the situation more difficult for the beneficiaries to survive. The second wave was challenging as shops opened and some of the workshops also opened. People were scared about the uncertainty and there were discussions about protection, sanitization and cleanliness at the village level. It was more critical for children than the elderly, as they were more susceptible to the disease. During COVID the elderly women were not speaking to each other and there was no communication. Even when somebody fell ill, nobody was there to take her to the hospital,

doctors also did not attend women. The regular practice of meeting each other was lost. The pensions they received from the government's end became uncertain and irregular. And those who relied on labour works, like MGNREGA, got delayed payments too, which in turn affected their financial conditions.

Need vis-à-vis the available support

The articulation of needs and available support varied with area, class and availability of social support to the older persons. All older persons from poor and APL background expected the government to intervene in a major way to ensure economic security in old age given the continuation of stress in the job market and their inability to earn also the shrinking of opportunities and wages of the able bodied family members. Many of them stated that just bare ration of cereals and pulses will not be much help in the dire circumstances. Secondly, the expansion of public health care services for the older persons, in terms of type of services, access and affordability. For health care they also appealed to the voluntary organizations already working in their area to expand services beyond minimal.

Those in relatively secure economic background felt the urgent need for social and digital support. The unfulfilled needs were mostly around emotional security and access in case of those living alone and with spouse only. They needed expansion of services that were akin to helplines that could be accessed in coordination of services and emotional and digital connect. Many of them were impacted due to isolation and neglect and wanted human company. Many who were unable to take stress wanted services to ensure metal wellbeing.

It is evident from the insights received from the interactions with the beneficiaries that the one of the pertinent requirement among the older person was the psychological support. The loss of family members, friends, and other relatives to COVID along with the agony of staying at home unable to interact with others had been a cause of anxiety and depression amongst the elderly in almost all the cases considered in the present study. However, the Helpline or the Elderline services extended by HelpAge India and some of the state governments proved to be very helpful and the beneficiaries could ward off their anxiety to a great extent. Volunteers would come, cheer them up and walk them through positive case stories which in turn offered them a reason to thrive.

On the other hand, with the lockdown being announced and shops and markets being closed, the availability of essential goods like ration and medicines appeared to be a great concern for many elderly. Some of the elderly self-help groups

(ESHGs) also identified households that had members who were unable to cook for themselves because of their frail health. In response, the members of the ESHGs distributed cooked food to the vulnerable households. In almost all the states, dry ration kits consisting of rice, pulses, oil, salt and sugar were distributed and supported the families to some extent. Such kind of support really helped the residents in the Old age homes who would otherwise depend on donations and charitable contributions.

Even in the geographies, where the access to medical services appeared to be a challenge, the Mobile Health Unit came to help. Alongside with the distribution of necessary medicines, the MHUs were phenomenal in spreading awareness about the safety practices and the health and hygiene protocols that could save the infection from spreading.

The older persons expected the government and the voluntary organisations to play appropriate roles in providing long term and limited purpose solutions to their existing unfulfilled needs that got exacerbated due to the pandemic.

Disasters and Recommended Age Care Practices

Evidently, the magnitude of COVID-19 in the different countries across the globe led to the unanimous decision of referring it to as a pandemic and a disaster. It is striking enough even the octogenarian and the elderly who had seen nine/ ten decades in their lives have never experienced anything as horrifying as the COVID-19. However, the as every cloud has a silver lining, COVID also taught the communities a lot and this is reflected from the interaction with the different beneficiaries, voluntary organizations and other volunteers who were directly involved in COVID relief – either at the giving or at the receiving end. The following are some of the good age care practices that can be followed during the disasters or pandemic situation especially with the older members in the community:

➢ It is evident that keeping a tap on the vulnerable elderly in the community has played a crucial role is delivery of the essential services. Members of the elderly self-help groups, senior citizen associations and other federations should have a note of the vulnerable older population in their close vicinity. This could include frail and sick elderly, persons with no income, economically dependent, single elderly, men/ women without their spouses etc. Whenever, such disasters occur, these groups should be targeted for the initial relief support. Community and grass roots VOs being the first responders, when sanitized about the needs of the

older persons were better placed for intervention.

➢ Self-help by the older persons when organised as groups improved chances of being assets than liability. Such groups could take care of the members in need and better negotiate with the system to bring benefits to them.

➢ Isolation and neglect appears to be one of the pertinent problem amongst the elderly population irrespective of their socio-cultural background. Efforts need to be delegated at the community level to engage the elderly members through recreational activities at least once in a month, when they can gather together and share their thoughts. Interacting with fellows and peer groups can help a lot in tackling the issue of loneliness and the concomitant depression in the older persons.

➢ The Helpline numbers generated to support the elderly and address their problems need to be more active. A discrete workforce needs to be engaged to take the calls and provide instant/ quick solution to the problems that come to them. The services should be expanded to rural areas as well with the involvement of community volunteers and VOs.

➢ Efforts may also put to reduce the digital literacy gap among the elderly population. More awareness sessions can be organized, to teach the older persons use the digital devices, increase their digital financial literacy levels, so that when situations like COVID-19 strikes they can carry on with their transactions for daily living with much ease. The access to financial machineries can also be improved by increasing the digital literacy rates.

➢ Meaningful social security should be available to all older persons so that they are independent and have confidence to deal with any challenge.

Conclusion

The preceding sections highlight the vast array of insights received from the beneficiaries in the different states. It also highlights the different supports received by the beneficiaries in these states and also the role of the different agencies in addressing the requirement. The following pointers summarizes the identified gaps, best practices and the way forward:

➢ The communities in all of the states were supported with ration and other essential commodities supply. However, because of the varying family sizes, the ration supply

did not last for long at all the places. So a continued and supply would have helped the beneficiaries combat the crisis in a better manner.

➢ The elderly seems to have been out of focus for the government interventions as in almost all the states, the non-governmental agencies were the first to intervene. In some of the states like, Delhi and West Bengal, the government had provided support, but the criteria for identifying the household was the economic bases. Older people living alone, or the ones who did not receive any support also need to be a priority while planning such interventions along with the economically disadvantaged ones.

➢ Services like the pickup and drop facility extended by Uber in collaboration with the HelpAge India was found to be beneficial in some of the cities. Such services could be provided for a long time irrespective of the prevalence of the emergency situations.

➢ More support can be planned to be extended to take care of the psycho-social wellbeing of the older persons. This could be done by making the ESHGs and the Senior Citizen Associations more interactive with regular recreational activities being organized.

It may be mentioned in this regard, that if the above mentioned solutions are ensured, the lives of the elderly would be much better even in circumstances where a pandemic like COVID strikes the country.

INTERNATIONAL BEST PRACTICES FOR AGE CARE DURING DISASTERS: SOME EXAMPLES
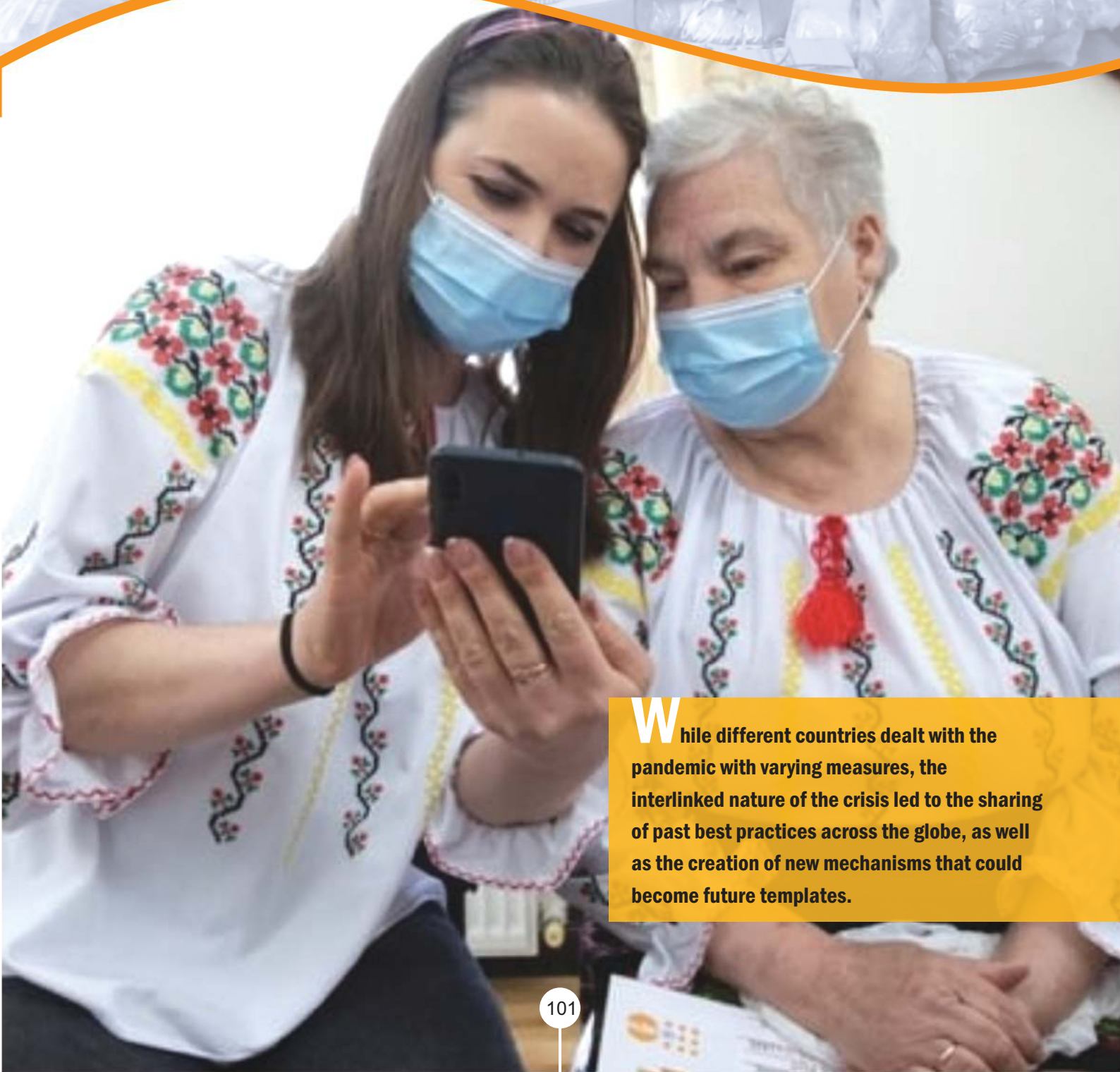
While different countries dealt with the pandemic with varying measures, the interlinked nature of the crisis led to the sharing of past best practices across the globe, as well as the creation of new mechanisms that could become future templates.

Disasters in general and the COVID 19 pandemic in particular, exposed many gaps in the system vis-a-vis the vulnerable and marginalized segment of the population like the older persons. The older persons were most at risk of death due to the pandemic, but short of that there were serious challenges of survival and right to life with dignity. The disasters and the pandemic by exposing the gaps also direct our attention to solutions. In this context it would be good to list out a few such good international examples from which humankind may learn and rebuild.

The challenges are similar to the point that in both natural disasters and the COVID pandemic older persons required immediate attention for food, medicines, mental wellbeing/ Trauma counselling, shelter and mobility. However, as stated above the pandemic added to the challenges access to food, basic needs, including the new needs in terms of protective gear and sanitization; information and appropriate behaviour, access to regular health care and specific COVID related care, emotional support, digital inclusion.

In natural disasters like floods, earthquakes and cyclones, we see the response in terms of role of community and special volunteers to ensure that older persons' needs are fulfilled, they play an active role in helping the community, social security and health needs are fulfilled.

Effective Targeting of Older persons

In disaster situations, poor and vulnerable are at much higher risk so require focused efforts. In 2011, within 10 days of the floods in 279 municipalities of Brazil, Bolsa Familia, a conditional cash transfer program, provided in-kind and cash benefits to 162,000 families. The registry (cadastro unico) and identification cards were used to identify affected families, disbursing payments through the program's banking arrangements with branches of the Caixa Economica Federal. Conditional cash transfer programs in Colombia (Familias en Acción) and Mexico (Oportunidades) used their registries and extensive networks of social workers to identify and verify people in need and deliver in-kind and cash assistance to people affected by floods in Colombia in 2010 and droughts in Mexico in 2011.[4]

Some examples of good practices during the disasters as developed by HelpAge International (HAI) are listed below. The focus was on capacity building of older persons to help each other and the community in disaster risk reduction and post disaster situations.

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[4] Available on: http://web.worldbank.org/archive/website01536/WEB/IMAGES/1319044_.PDF, accessed om 8th May, 2022

In Philippines, efforts were made to involve the older persons in resilience building. Older peoples' associations motivated members to play an active role in disaster preparedness and climate change adaptation activities.

In the aftermath of Typhoon Haiyan, COSE identified a huge need for trauma counselling. COPAP members volunteered to travel from the capital, Manila, to the worst-hit province of Leyte. In just three months, they provided psychosocial support through peer counselling to 1,645 people in Ormoc hospital. They provided comfort and a listening ear to victims of the typhoon.

Older Peoples' Association (OPA) in Bangladesh organised activities to encourage physical exercise, sports, indoor games, singing, gatherings, or attending cultural and spiritual celebrations to ensure physical and mental wellbeing of older persons. Many OPA members replicated these health promotion activities in their own communities or households.

OPAs also organized homecare for their most vulnerable members. They were helped with

Source: SENAMA, Gobierno De Chile. 2021, www.senama.gob.cl/noticias/nueve-adultos-mayores-se-recuperan-satisfactoriamente-en-residencia-espejo-transitoria-de-san-pedro-.

[6] Available on: https://socialprotection.org/sites/default/files/publications_files/Bangladesh%20Research%20Report_OPA%2_0Health%20and%20Care%20%281%29.pdf, accessed on 9th May, 2022

activities of daily living (ADL) like bathing, cooking, hygiene and clothing, taking medicines and Instrumental Activities of Daily Living (IADLs) like shopping, going for prayers, recreation, meeting relatives, attending social functions, often with a rotation of care givers.[6]

An inclusive disaster risk reduction (DRR) programme was implemented in Myanmar in 2012. Here the village disaster management committee (VDMC) a community-based organisation managed by a group of community members that include representatives of vulnerable groups plays lead role in disaster preparedness at the village level. In May 2013, when cyclone Mahasen was approaching the Myanmar coast, the early warning task force of the VDMC in Kyu Taw village listened to the radio and kept close phone contact with village authorities to get updated information. They informed villagers every hour through loudspeaker and used red flags to show the level of risk. In Ka Nyin Kwin village, early in 2014, in preparation for the upcoming rainy season, the VDMC mobilised villagers to widen the village's main road in case of evacuation. Some villagers agreed to donate their land and many participated in the ground work.[5]

In Ethiopia, community resilience was built in drought prone Borena zone. Using an intergenerational approach, the most vulnerable groups within each community were asked to express their most pressing needs and participate in finding solutions. They were given a leading role in selecting the most vulnerable as beneficiaries of the project, while prioritizing interventions that would be beneficial in building community resilience (such as restocking of livestock and rangeland rehabilitation). The project empowered the most vulnerable members of the community, developed mutually acceptable solutions and strengthened community "ownership" of project activities.

As part of a disaster risk reduction programme in flood prone Jacobabad in Sindh province of Pakistan, members of OPAs in the villages were trained in a mock drill. They were given materials including digging equipment, first aid and search and rescue items. Just before the floods, the communities noticed signs of impending flood and informed the district disaster management authorities After the authorities confirmed, the OPAs decided to mobilise the community to block the canals to their villages and divert some of the water using the digging materials they had been given. Because of their actions, 50 per cent less water reached their villages when the flooding happened in comparison to previous floods. In

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various places, OPAs called on local government to take flood mitigation measures like dredging of rivers before the rainy season begins.

Following the earthquake in Haiti in 2010, a buddy system was developed. It relied on a network of volunteers/older people known as "friends", who were identified through older people's associations. Their role was to accompany vulnerable older people to distribution sites and ensure they received the humanitarian assistance they were entitled to. Later in 2011, when Hurricane Thomas threatened the camps that had been erected after the earthquake, the "friends" warned older people of the upcoming danger and helped them evacuate. HAI also relied on these "friends" during initial assessments following Hurricanes Isaac and Sandy in 2012. HelpAge has provided training for "friends" on subjects such as cholera sensitization, disaster preparedness, evacuation, needs assessments, and psychosocial support. The "friends" report feeling valued by giving their time to others who are vulnerable. Their enthusiasm has been instrumental in guaranteeing sustainability, as they remain engaged with their community on everyday matters (not just in emergency situations).

Developing Good Practices in Age Care during COVID-19 Pandemic:

Indonesia

The provision of long-term care (LTC) for older people consists of social security mechanisms and healthcare services. Institutional care in the form of senior or nursing homes are provided by the government for the poor. LTC service focuses primarily on strengthening home care. The frontline providers are Puskesmas, the state-funded primary care centres and the services are covered the National Health Insurance System (Jaminan Kesehatan Nasional).[7] LTC is partially dependent on volunteers' home-care visits which had to be stopped after COVID pandemic. Health monitoring efforts continued through checking on older people who are known to be unwell or have not been seen or contacted for a while. Groups of volunteers were organised WhatsApp to report on local circumstances in real-time. The in-person visits that take place require all volunteers to wear gloves and a mask.

The Ministry of Women Empowerment and Child Protection has issued a guideline on Gender-perspective Protection of Older People during the COVID-19 Outbreak which highlighted the

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[7] Available on: https://ltccovid.org/wp-content/uploads/2020/06/The-COVID-19-Long-Term-Care-situation-in-Indonesia-30-May-1.pdf, accessed on 8th May, 2022

increase of abuse cases among older women and provides advice and pathways to support for older women during this outbreak. Specific guidelines were also issued for Protection of Women with Disabilities during the COVID-19 Pandemic Situation.

Korea

Korea has had national health insurance with universal coverage since 1989. a universal, public long-term care insurance (LTCI) for the older population was introduced in 2008. Home- and community- based services (HCBS) as well as institutional services are covered by the LTCI. During the pandemic, the Korean National Health Insurance Services (KNHIS), the insurer of the public LTCI, developed and released a response manual for all welfare and LTC facilities against COVID19 on February 20, 2020. The Korean Ministry for Health and Welfare (KMOHW) and KNHIS posted a series of temporary reimbursement guidelines for LTC facilities and home-based LTC agencies, taking into account social distancing measures and staff shortages due to COVID-19. Service providers in the "special disaster zone" were excluded from payment cuts. [8]

Source: "SENAMA Coordina Traslado De Personas Mayores De Los Andes a Residencia Espejo Transitoria - Elinformador." Elinformador, 8 June 2020, www.elinformador.cl/comunas-de-aconcagua/senama-coordina-traslado-de-personas-mayores-de-los-andes-a-residencia-espejo-transitoria.

Chile

In Chile, the COVID-19 response with a focus on older people started in early March 2020, involving several actors. The Ministry of Health (MoH), the National Service of Older People (Servicio Nacional del Adulto Mayor, SENAMA), the Chilean Geriatrics and Gerontology Society (GGS), and several non-profit organizations started a working group to coordinate the implementation of prevention and control measures.

The MoH led the creation of local guidelines that included non-enforceable measures such as the recommendations for personal protective

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[8] Available on: https://ltccovid.org/wp-content/uploads/2020/05/The-Long-Term-Care-COVID19-situation-in-South-Korea-7-May-2020.pdf, accessed on 9th May, 2022

[9] Available on: https://ltccovid.org/wp-content/uploads/2020/07/The-COVID-19-Long-Term-Care-situation-in-Chile-24-July-2020-3.pdf, accessed on 8th May, 2022

equipment (PPE) utilization. On the other hand, since early March, SENAMA led a public-private cooperation that raised approximately $USD 15 million for COVID-19 related measures for the 250 public and SENAMA-affiliated nursing homes. The main purpose of this project was to prevent and control the spread of COVID-19 and its consequences through on-site technical support, ensuring the availability of PPE and staff availability, temporary transfer of COVID-19 residents to sanitary houses, and RT-PCR testing.[9]

For those nursing homes affiliated with SENAMA, a series of measures were implemented: (i) a centralized monitoring system with active epidemiological vigilance based on daily phone calls to collect data on COVID-19 suspected, confirmed and deaths cases; (ii) Case management of all suspected and confirmed cases by an interdisciplinary team which includes; a territorial team (nurses and physiotherapists)

Source: Ministerio De Desarrollo Social Y Famila. Gobierno de Chile. 2021, www.desarrollosocialyfamilia.gob.cl/noticias/ocho-adultos-mayores-son-dados-de-alta-en-residencia-espejo-transitoria-de-senama-en-curico.

and a centralized team (administrative team, geriatrician, epidemiologist).

Moreover, through a non-profit human resources organization, SENAMA ensured replacement care givers and health professionals in the case of COVID-19 sick-leave. When isolation of suspected and confirmed COVID-19 cases is not possible due to infrastructure or human resources capacity, residents were transferred to sanitary houses. These sanitary houses also called *residencias espejo transitorias* were different from those run by the DoH and exclusively focussed on older people living in nursing homes. SENAMA created a hotline for emotional support and mental health guidance.

To provide technical support to the increasing number of unpaid care givers, a best practice caring manual was developed ("Yo me Cuido y te Cuido"). Furthermore, free online training is being offered through a user-friendly platform in which weekly teaching video conferences are offered to give carers tools for caring for others and themselves.

China

In order to prevent the further spread of COVID-19 in China, a Central Leadership Group for Epidemic Response had been established and response

mechanism was initiated with multi-sectoral involvement in joint prevention and control measures. These included the Guidelines for prevention and control of COVID-19 in care homes, which was quickly issued and circulated since the spread of COVID-19 and updated in early February 2020. The Guidelines mandated a high level of cross-sectoral collaboration and prioritization of LTC services for older people.[10]

An integrated IT system for information and data sharing between service providers and local governments was also introduced in China. Care providers were encouraged to share experiences and exchange information promptly by messaging app, online meeting or phone contacts. An emergency medical service plan for care homes residents was launched locally to provide prompt medical care.

Older people who live alone, with intensive care needs, or whose family care givers was in quarantine or a healthcare worker were provided with a service such as home-based or temporary residential care. Psychological support services for older people requiring care and their family care givers were strengthened, with prompt assessment and intervention.

In Hubei province and other regions heavily impacted by the COVID-19, interdisciplinary teams consisting of mental health professionals, social workers and other staff provided mental health services and support to persons who have confirmed, suspected, or cured COVID-19, and to their families and the general public.

European Countries

In France, tele-consultations and a geriatric telemedicine platforms were established to maintain quality of care to residents for non-related pathologies by the residential units. Admission channels for older persons were established to give the older population special attention.[11] The Facility directors were encouraged to call on medical volunteers, such as medics, and retired practitioners, to guarantee continuity of care. Treatments provided by independent caregivers were reimbursed by the health insurance, if residential care facilities were no longer able to provide the service themselves due to staff shortage.

For older persons living at home, several pharmacies offered free delivery. The organization Mon Emile provided free nursing care. Health insurance fully covered the cost of such tele-

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[10] Available on: https://ltccovid.org/2020/04/18/report-from-mainland-china-policies-to-support-long-term-care-during-the-covid-19-outbreak/, accessed on 8th May, 2021

[11] Available on: https://unece.org/fileadmin/DAM/pau/age/Policy_briefs/ECE_WG1_36_PB25.pdf, accessed on 9th May, 2021

consultations until the end of the state of health emergency. Intervention rules of mobile geriatrics and palliative care teams were made more flexible and at-home treatment was facilitated.

In France, Israel and Spain, personal protective equipment such as masks, gloves, and sanitizer were distributed to residential care institutions, and staff were trained on infection prevention and special procedures for quarantine of older persons, to limit the spread of COVID-19.

In Portugal, in order to address the concern of isolation among the older persons, and ensure their social activeness, the 5th edition of the Digital Social Innovation Contest was dedicated to the creation and adaptation of digital tools that responded to the needs of older persons affected by the COVID-19 crisis, whether living in

Source: Digital technologies unite generations: new phase of UNFPA intergenerational project launched in Moldova. (2021, July 12). UNFPA Moldova. https://moldova.unfpa.org/en/news/digital-technologies-unite-generations-new-phase-unfpa-intergenerational-project-launched

institutions or at home. There were participants from Portugal and elsewhere in Europe.[12]

In the Republic of Moldova, efforts to protect the older persons by the younger generations were initiated by the young volunteers from Youth Centres and the National Youth Council Network. Through this initiative, 300 older persons over the age of 65 received essential food products and emotional support from a team of fifteen youth volunteers. The group of volunteers were trained by an epidemiologist and psychologist on how to talk with older persons by phone in order to inform them about measures of protection against COVID-19 and how to provide emotional support during the period of social isolation.

In September 2020, HAI Moldova launched with support from the UNFPA, an innovative project aimed at developing the digital skills of older women and men. In order to encourage intergenerational dialogue and the setting up of a communication bridge between young and older people, especially during the pandemic, 200 older persons were given mobile phones. [13]

Conclusion

It is evident from the preceding examples that the older persons need to be treated as a resource

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[12] Available on: https://www.slideshare.net/Ruiteixeirasantos/social-inovation-misericordia-de-lisboa-prof-doutor-rui-teixeira-santos, accessed on 9th May, 2022

[13] Available on: https://moldova.unfpa.org/en/news/older-people-10-communities-will-receive-mobile-phones-and-learn-young-people-how-use-them, accessed on 9th May, 2022

when it comes to disaster risk mitigation strategies. Countries like Bangladesh, Pakistan and China, for instance have actively involved the older persons in planning service delivery during the pandemic. The following pointers may be summarized as a lesson learning from the review of the international best practices:

✓ Intergenerational collaboration is a good way to address the socio-psychological wellbeing of the older persons and the younger generations at the times of emergencies. Both the age groups can cross collaborate and help each other through knowledge sharing based on their experience and exposure. The younger age cohorts are the best resources who could be utilized to increase the digital literacy coefficient amongst the older age cohorts.

✓ The experience of the members of the senior citizen association can be used in planning and implementing disaster risk mitigation strategies.

✓ The option of tele-consultation need to be promoted so that the concerns of accessibility to health care services and their availability at the time of disasters is taken care of. The digital literacy along with the availability of tele-consultation services would be of great help to ensure that the old, frail and vulnerable with comorbidities are neither exposed to further infections nor they become the spreaders.

Source: The 'Digital Skills Connect Generations' project has been extended to other 10 communities of the Republic of Moldova. (2022, April 19). UNFPA Moldova. https://moldova.unfpa.org/ro/news/%E2%80%98digital-skills-connect-generations%E2%80%99-project-has-been-extended-other-10-communities-republic

THE PROJECT EMPOWERED **THE MOST VULNERABLE MEMBERS** OF THE COMMUNITY, DEVELOPED MUTUALLY **ACCEPTABLE SOLUTIONS** AND STRENGTHENED COMMUNITY **"OWNERSHIP"** OF PROJECT ACTIVITIES.

WAY FORWARD

The pandemic was a shock to our collective systems at both a global and national level. The most important lesson it served was of the need for outreach - to 'build back better' systems can no longer be based on a 'wait and watch' approach but need to proactively ensure last mile reach and access.

Disasters are part of life of older persons in India, scale may vary. Floods, droughts, cyclones, landslides are experienced more frequently at local level. Disasters like earthquake, Tsunami are less frequent and impact larger landmass. But both have impact on the loves of older persons especially those on the margins. However, the COVID 19 pandemic proved to be a major disruptor.

It impacted older person in more ways than one and is likely to have lasting impact on the lives of older persons and those on the threshold of old age. Older persons in India face challenges of income and health security, lack of opportunities, lack of specific schemes and polices for their benefit. But, most important being that of indifference from family, community and government. The specific concerns of older person especially their requirements during and after the disaster are overlooked either in design or in implementation of any relief and rehabilitation process.

This indifference in the face of the demographic fact that older persons are the fastest growing segment of the population. Here too, the women and oldest old will be relatively larger proportion of the segment should add to the challenge of providing them life with dignity especially during trying times like the disasters.

Disruption and chaos is expected to pave the way for innovation and better practices. So, if that be true COVID-19 pandemic is the right opportunity to Build Back Better for the Older Persons who will be about 20% of the total population in the not so distant future.

The experience of the COVID-19 pandemic showed gaps in terms of social security in old age that led to many older persons being dependent on charity or welfare schemes. The older persons could not survive the lockdown and had to be given cooked food in urban areas. The need for free food continued and became acute as time elapsed. The government continued to distribute free rations and so did the voluntary organisations. So, the need for adequate social security cannot be overemphasized.

Second, need for availability of health care system that does not get disrupted, as happened during the pandemic. Older person suffering from NCDs need continuous treatment. Most of them could not

bear the cost of medication. So, an outreach system should be developed to take care of these needs. It could be based on technology, but, in that case it should be available from community sources accessible to the older persons. The need for mental wellbeing and counselling cannot be underestimated and should be available as much as the curative health care. The older persons need focussed mental health services that help them deal with loneliness, anxiety and depression that may be caused by the disasters.

The only effort that paid special attention to the older person was COVID 19 vaccination and that proved to be successful. The same approach needs to be adopted for other needs as well.

Third, care and lack of it due to disruption in services both paid and unpaid should be woven into the system. The pandemic lockdown and lack of access and inability to use smart phones and IT Apps posed a lot of problems to those living alone or taking care of incapacitated spouse or parent. There should be a system of community volunteers to provide services.

Helplines proved to be useful in times of the disaster to get linked to services and other needs. So, there should be a better equipped network of helplines that can provide information and services including active listening or coordinate with service providers, volunteers and older persons.

Special targeting of older person in any welfare scheme is one of the way to ensure that they get what is due without much problem. The priority that was given to older persons in COVID 19 vaccination and adaptable ways of reaching them by the local state administration to those in the last mile proved to be a success.

Last but not the least, more and more VOs should be encouraged to work for the ageing population.

The sensitivity of the VO to the cause of older persons, their continuous contact with them and speed of response make them more than useful for the older persons.

Older person and their organisations should be encouraged to play a positive role in disaster situations. The associations and groups of older persons were able to provide much needed service to the older persons and others in their community. With increasing longevity, it is desirable for the society to allow older persons to play a positive contributory role in community development and disaster response.

The biggest lesson learnt during the pandemic was that its time that India paid attention to its ageing population and reorient its systems to look beyond demographic dividend to 'demographic bonus'. If demographers are to be believed, then very soon India will have a population of older persons that would be more than the total population of many countries. If their demands and needs are not part of the architecture and their right to life with dignity is not respected; then we will be doing disservice to a major segment of the population. Therefore, it is of utmost significance that in all programmes that are undertaken by the government or private bodies should factor in the concerns of older persons. It will not suffice to leave these serious issues of social, income and health security in old age to few piecemeal measures and voluntary efforts.

THE ASSOCIATIONS AND GROUPS OF OLDER PERSONS WERE ABLE TO PROVIDE MUCH NEEDED **SERVICE TO THE OLDER PERSONS** AND OTHERS IN THEIR COMMUNITY.

THE BEST WAY TO FIND YOURSELF IS TO LOSE YOURSELF IN THE SERVICE OF OTHERS

Mahatma Gandhi

HelpAge India | Fighting isolation, poverty, neglect