Jun 9

An Emergency Strategy For Managing COVID-19 In Care Homes In LMICs: The CIAT Framework (Version 1*)

Updated: Jul 31

Authors: Peter Lloyd-Sherlock, João Bastos, Leon Geffen, Karla Giacomin, Nélida Redondo, Siriphan Sasat and Lucas Sempe.

June 2020 (drawing on contributions made to Global Platform blogs and seminars).
*Note: this is the first iteration of a "live document", to be developed and updated over time.

The Global Platform has hosted a number of webinars and blogs which draw attention to the high vulnerability to COVID-19 of older adults in residential care facilities in low and middle-income countries (LMICs). Links to these at the end of the paper.

This paper reviews emergency strategies that are rapidly emerging in some LMICs to manage the challenges of COVID-19 in residential facilities for older people. It draws on several Global Platform contributions, studies that pre-date the pandemic and more informal engagement with academic experts, policy-makers and other stakeholders.

There is considerable policy invocation taking place across LMICs. Many of these new measures relate to the specific context of residential care for older people in such countries. The paper starts with a brief and general review of some of these contextual features. It then categorises innovations that are occurring or being planned within a loose analytical framework consisting of four key, connected elements: the CIAT Framework.

General features of residential care provision for older adults in LMICs

It used to be the case that care homes were a rarity in these countries, but that is no longer true. In most LMICs, this is a fast-growing sector, albeit one that has not received much attention from either policy-makers or academics. For example, in 2010 Argentina's Union of Gerontological Service Providers estimated the country contained 6,000 residential care homes. There is considerable diversity in service provision, both within and across LMICs. However, studies conducted across South Africa, Thailand and Argentina shortly before the pandemic identify a number of shared features and there is limited evidence that some of these features extend across other LMICs. This section provides a brief and general summary of these commonalities, and illustrative examples.

1. Limited direct government provision of residential care for older people.

Many LMIC governments directly run small numbers of facilities, but often these deny admission to older people with complex care needs such as dementia. For example, there are just two government-operated care homes in Bangkok, with a combined capacity of around 350 residents. Older people seeking admission to these two homes must not suffer from communicable diseases, any psychiatric problem, or serious functional impairments [1].

2. Although religious organisations and NGOs have historically run care homes in some counties, provision is increasingly dominated by private for-profit organisations.

For example, a study of residential care homes for older people in the Argentine city of La Plata, conducted in 2016 identified over 60 facilities, of which all but two were run by private organisations [2]. These ranged from informal "boarding house" care homes with untrained staff, to luxury nursing homes, which claimed to have a full range of therapeutic services [1]. Across LMICs, the private provision includes a few luxury facilities for the very rich. However, these are well beyond the financial means of most older adults and so most provision consists of much more basic facilities, often operating on a highly informal basis.

These more informal homes tend to be weakly regulated, if at all. In many cases, they are not even listed or registered with the responsible government agencies. In some LMICs, it is estimated that there are at least as many unregistered, "invisible" facilities as there are official ones. The main form of evidence that these invisible care homes exist is from media reports. For example, in February 2018, it was reported that of 30 care homes operating in

the Argentine city of Tres Arroyos (population 57,000), 27 were completely unregulated. And there are also many establishments that we might call "de facto care homes", such as casual hostels with permanent populations that have aged over time. These facilities may not define themselves as care homes, but they are for the purposes of this pandemic.

A Global Platform blog about care homes in Bangkok, co-authored with Siriphan Sasat and Aree Sanee, referred to rapidly growing numbers of such informal, small-scale facilities. It quotes a local official:

> "There are thousands of them. You can find them in every corner of Bangkok."

A study on South Africa [3] notes that, whilst over 400 care homes were registered with Official agencies, it is thought that there are also growing numbers of informal, unregistered care homes. According to a representative of the South African Human Rights Commission:

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

The study of care homes in Bangkok [1] includes this quote from a key informant:

> "These days, nursing homes are not legally certified by any laws, so it's a kind of unofficial. If it is established by doctors or nurses themselves, maybe there will be fewer problems. There "These days, nursing homes are not legally certified by any laws, so it's a kind of unofficial. If it is established by doctors or nurses themselves, maybe there will be fewer problems. There are places set up by non-experts who lack professional knowledge… It's unclear who is responsible for registration or control. So it's a kind of freestyle opportunity for any entrepreneur if they have a budget. It's not important whether these services are good or not [DCH 2]".

3. Some other general features of the sector in Latin America, South Africa and Thailand (among other countries) are:

- A high % of residents have little or no care dependency.
- Resources are often limited and residents usually share rooms
- Some directors and staff have little understanding of the human rights of residents.

A survey of 1,840 old age care homes conducted in Argentina found 20% reported they would not admit people with any level of care dependency and fewer than 60% of residents with any level of care dependency [4]. It reported that over 60% of facilities did not offer individual rooms, that only 17% required the consent of older people to be admitted into the home and in 43% of cases residents were not allowed to personalise their bedrooms in any way. This survey did not include invisible, informal care homes, where it is thought conditions are often considerably worse.

4. Even for officially registered care homes, information and quality assurance are very weak (even compared to high-income countries).

In the Bangkok study [1], one local informant, a primary health care professional mentioned that they were not permitted to visit providers, even if they had concerns about particular residents. A care home director observed:

> "Yes, an [MoPH] official comes, but not more than once a year. Usually, we just need to submit some documents to

> show that we comply with their standards. The documents are mainly about the services we offer and the design of the building. They don't go into any detail". (H-FS2)

The study of a local government regulatory agency in Argentina conducted in 2016 found that, due to concerns about staff absences, all staff were prohibited from working outside the city centre office [2]. This reduced capacity to regulate care homes: auditors' only option was to interview care home managers by 'phone. One key informant observed that several care homes providing sub-standard services were in fact owned by former directors of this same regulatory agency.

A study on South Africa published in 2019 [3] reported that state oversight of registered homes would appear to be very limited. For example, in its 2012-2015 Strategic Plan, the Department of Social Development reported that only 13 of 412 registered homes had been assessed for compliance with norms and standards (Department of Social Development, 2012). A national survey of 405 regulated homes in 2010 found that only a quarter of staff knew about official norms and standards (Department of Social Development, 2010). Most homes reported they did not feel suitably equipped for residents with complex care needs such as dementia. Over a fifth of care homes never had access to a trained nurse (Department of Social Development, 2010).

5. Most responsibility is at the local government level, but coordination between health and social departments is even weaker than in high-income countries.

The 2016 study of La Plata, Argentine found: there was little evidence of integration or coordination between the many actors and components of the LTC system [2]. When stakeholders were asked about the meeting, let alone working with, their counterparts in other organisations, all responded that this had not been actively considered. This lack of coordination was striking given the small size of La Plata, the close proximity of offices, and strong informal networks (for example, several informants had been trained in the same department of the local university).

The CIAT Framework

The CIAT Framework combines and summarises broad elements for an emergency strategy to address the potential effects of COVID-19 in LMICs which share some of the features set out above. It has been developed by an informal network of experts and draws on actual experiences in different countries and cities.

The different steps and components for the Framework are summarised in Figure 1.

Step 1: COORDINATE

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

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

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

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

Coordination between local government social and health agencies responsible for residential long-term care facilities has, historically, been even more limited than in many high-income countries. In his Global Platform webinar presentation on 1 May, Leon Geffen referred to the refusal of South Africa's Western Cape's Departments of Health and Social Development to work together to ensure that care homes were provided with PPE. Inter-sectoral collaboration is never easy, but it is essential if LMIC governments are to develop effective responses to the current crisis.

Past experience shows that inter-agency cooperation happens most quickly when it is given full backing from the highest levels of government (such as the president's or mayor's office). Care homes must be seen as a national priority: just as important as "mainstream" health services. High-income countries have learned this to their cost. Developing countries seem to be repeating this mistake.

The Task Force must urgently develop a basic and feasible set of guidance, suited to the realities of local care homes. Some LMIC governments have been slow to provide information and emergency guidance for care homes.

Organisations such as WHO have published detailed guidance and increasing numbers of LMIC governments are doing the same. These are very good in technical terms, but limited funds, resources and infrastructure mean that many of their recommendations will be unfeasible for the large majority of care homes in LMICs. Instead, the Task Force should quickly identify the simplest and most affordable measures that can realistically be implemented in all care homes, including the most precarious and poorly resourced. This should be specific to your own context and updated as you learn more.

Step 2. IDENTIFY

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

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

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

The recent case of an Argentine care home demonstrates the need to change from business as usual approach to a more pragmatic and flexible one. Following the deaths of five residents from Covid-19, the Director (who had notified the authorities of the first case several weeks previously, but had received almost no external assistance) was put under investigation for failing to comply with highly demanding and detailed official care standards that pre-dated the epidemic. This approach will have discouraged other homes from cooperating with official agencies and for unregulated homes to come out of the shadows. It may well also lead to under-reporting of Covid-19 deaths by care homes. Despite the controversial nature of care home amnesties, some local governments have already introduced emergency legislation to permit this, including the Province of Buenos Aires on 9 May 2020.

Step 3. ASSESS

- The Task Force should conduct an emergency survey of local care home preparations and vulnerability to COVID-19.
- This survey information can be used to:
  - Identify homes at greatest risk, based on simple criteria.
  - Identify specific issues of concern for all care homes (equipment, information, space limits, hospitals dumping infected patients, etc.), to prioritise local actions.

This emergency survey should entail a short, focussed and simple questionnaire collecting the most immediately relevant information. Some local governments in LMICs have already run limited surveys along these lines. An example from the Brazilian city of Fortaleza was presented in the Global Platform webinar on 1 May and was also described in a linked blog:

"Unlike countries such as the UK, the city health department paid particular attention to the situation in local care homes. Liaising closely with the city's department for social assistance (which has overall responsibility for care homes), they visited all the city's old age homes and conducted a quick survey in order to identify those at most risk. The survey (conducted back in mid-April) found that all care homes were facing serious challenges. But a small number were especially vulnerable, lacking any capacity to screen for potential symptoms and struggling to access daily food and medicines. These high-risk care homes

were targeted for priority support and the city's health and social assistance departments continue to work closely with them".

In the case of Fortaleza, the total number of care homes in the city was not large and they were all already registered with local government agencies, which had carried out a thorough survey the previous year. This greatly helped the process of conducting an emergency survey.

In cities where numbers of care homes are sometimes large, many are unregistered and local government capacity is limited, conducting surveys like Fortaleza's will be less easy. In these cases, NGOs and other organisations may play a key role in identifying and engaging with local care homes. This has been done in the Argentine city of La Plata, where Red Mayor (an NGO run by Silvia Gascón) co-developed a website for monitoring and sharing information about both registered and informal care homes. In May they collaborated with academics and local care homes to run an online survey of Covid-19 preparations. Some of the results were presented in a Global Platform webinar on 22 May and in a related blog. The survey revealed that most care homes in the city lacked any protective equipment or capacity to meet new official pandemic care home legislation. They shared their findings with local government agencies who promised to prioritise this issue. Following this, the local government established a new norm that testing should be provided for all care home employees.

Step 4. TARGETED SUPPORT

- Homes identified as high-risk should be given priority status for targeted support.
- Focus on cooperative support rather than punitive measures.
- It may be necessary for high-risk homes to be put under the direct control of the Task Force if their management is very weak.

There is growing evidence that the effective protection of care home residents requires repeated testing of all residents, including those who do not present symptoms. The Global Platform blog by Sanghwa Lee shows how a comprehensive approach to screening, testing and isolating residents in South Korea's care homes kept the pandemic at bay. Sadly, this ideal response is far from feasible for most care homes in most LMICs (as well as some high-income countries). Nevertheless, other quite simple and cheap actions can potentially mitigate care home vulnerability, including providing adequate protective equipment and improving general hygiene practice.

Karla Giacomin presented an excellent example of this targeted support approach being applied in the Brazilian city of Belo Horizonte in a Global Platform webinar on 22 May. In late April the city government conducted an emergency survey which reached 179 facilities. It applied a number of criteria, including the number of residents per room, access to protective equipment and capacity to isolate cases to identify those establishments most in need of support. These care homes have received priority support from multi-disciplinary teams, including monitoring of residents for potential Covid-19 symptoms and developing realistic emergency protocols.

Less orthodox strategies include relocating residents with no/low dependency to other locations away from the care home, such as hotels, even before any cases are detected there. Where necessary, these relocated residents could be offered an element of care support in the new setting. This would reduce the risk of infection for relocated residents and would increase space and resources available for remaining care home residents. A version of this strategy has already been implemented on a limited basis in Chile, with assistance from religious organisations.

Sustaining the CIAT Framework.

Over time, the Task Force should revise its guidance and conduct repeat surveys of care homes at regular intervals. Also, it should attempt to share and receive useful knowledge with similar Task Forces in other local governments.

Figure 1: The CIAT Matrix.

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

Resources on Global Platform related to long-term care and Covid-19.

COVID19 and Older People In Argentina: Developing Alliances Between Government and Civil Society https://www.corona-older.com/post/covid19-and-older-people-in-argentina-developing-alliances-between-government-and-civil-society

Letter from Brazil: COVID-19 And Older People in Fortaleza, Brazil's Worst-Hit City https://www.corona-older.com/post/letter-from-brazil-covid-19-and-older-people-in-fortaleza-brazil-s-worst-hit-city

South Africa: How We Are Dealing With COVID-19 In Care Homes https://www.corona-older.com/post/south-africa-how-we-are-dealing-with-covid-19-in-care-homes

Care Homes And Coronavirus In Thailand: How Long Will They Remain Unscathed? https://www.corona-older.com/post/care-homes-and-coronavirus-in-thailand-how-long-will-they-remain-unscathed

Letter From South Korea: COVID-19 Response And Questions On Quality Long-Term Care For Older Adults https://www.corona-older.com/post/letter-from-south-korea-covid-19-response-and-questions-on-quality-long-term-care-for-older-adults

COVID19 in Kerala: Grassroots Responses, State Initiatives and an Inspirational Care Home Initiative https://www.corona-older.com/post/covid19-in-kerala-grassroots-responses-state-initiatives-and-an-inspirational-care-home-initiative

COVID19: Ensuring Care Homes in Low And Middle-Income Countries Are Prepared For The Pandemic https://www.corona-older.com/post/covid19-ensuring-care-homes-in-low-and-middle-income-countries-are-prepared-for-the-pandemic

Global Platform Weekly Webinar 4: May 1: Care homes and COVID19 in developing countries https://drive.google.com/drive/folders/1nU3Xq7Or6QaJh9S1f0nEbh93s5tKavig

Global Platform Weekly Webinar 7: May 22: Estrategias de emergencia para mitigar impacto del COVID-19 en América Latina https://drive.google.com/drive/folders/1DZzFeXi0xfZWQUWWMAUBcKNQI02TD0x6

References cited:

1. P.Lloyd-Sherlock, S.Sasat, A.Sanee, Y.Miyoshi, S. Lee The rapid expansion of residential long-term care services in Bangkok: a challenge for regulation. School of International Development, University of East Anglia, Working Paper 55.

https://www.uea.ac.uk/documents/6347571/6504346/WP-55/2a384864-5397-53e6-751e-d2484c9e7af7

2. Lloyd-Sherlock, P, Penhale, B & Redondo, N 2019, 'Evaluating the quality of long-term care services in the city of La Plata, Argentina', Ageing and Society. https://doi.org/10.1017/S0144686X1900103X
3. Lloyd-Sherlock, P 2019, 'Long-term Care for Older People in South Africa: The Enduring Legacies of Apartheid and HIV/AIDS', Journal of Social Policy, vol. 48, no. 1, pp. 147-167. https://doi.org/10.1017/S0047279418000326
4. Roqué, M., Fassio, A., Arias, C. and Croas, P. (2016). Residencias de larga estadía para adultos mayores en Argentina. Relevamiento y evaluación. Ministerio de Desarrollo Social. Buenos Aires.

Other studies and resources that link to this blog:

World Health Organisation IPC guidance for long-term care facilities in the context of COVID-19. https://apps.who.int/iris/handle/10665/331508

LTCCOVID. International Long-Term Care Policy Network. Resources to support community and institutional Long-Term Care responses to COVID-19. https://ltccovid.org/

Lloyd-Sherlock, P, Ebrahim, S, Geffen, L & McKee, M 2020, 'Bearing the brunt of covid-19: older people in low and middle income countries', BMJ (Clinical research ed.), vol. 368, p. m1052. https://doi.org/10.1136/bmj.m1052

Recent Posts See All

Uma estratégia de emergência para o manejo…

20 Write a comment 3

Problems Of Data Availability And Quality For COVID-19…

262 Write a comment 3

10 Ways Churches And Other Faith-Based Community…

53 Write a comment 5

Log in to leave a comment.

Email: info@corona-older.com

Supported by the University of East Anglia and the contributions of our network of experts

University of East Anglia