WHO Country & Technical Guidance - Coronavirus disease (COVID-19)

Summary of references to older people.

This document serves as an index of references made to older people within the WHO Country & Technical Guidance documents available online at: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance> and at <https://www.who.int/maternal_child_adolescent/links/covid-19-mncah-resources-care-for-older-persons/en/>

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| **Name of document** | **Description / Reference to older people** | **Date** |
| Animal-human interface and food safety |
| COVID-19 and food safety: Guidance for food businesses | No specific reference to older people | 7 Apr 2020 |
| COVID-19 and Food Safety: Guidance for competent authorities responsible for national food safety control systems | No specific reference to older people | 22 Apr 2020 |
| WHO recommendations to reduce risk of transmission of emerging pathogens from animals to humans in live animal markets or animal product markets | No specific reference to older people | 26 Mar 2020 |
| Clinical care |
| Clinical management of COVID-19 | \*\*62 pg document; several references to older people with specific focus in Chapter 20: Caring for older people with COVID-19 | 27 May 2020 |
| Technical specifications for invasive and non-invasive ventilators for COVID-19 | No specific reference to older people | 15 Apr 2020 |
| Clinical care of severe acute respiratory infections – Tool kit | \*200 pg document; some clinical guidelines around older people diagnosis for various respiratory illnesses (COVID-19, influenza etc) | 11 Apr 2020 |
| Oxygen sources and distribution for COVID-19 treatment centres | No specific reference to older people | 4 Apr 2020 |
| Severe Acute Respiratory Infections Treatment Centre | \*120 pg document; no specific reference of older people | 28 Mar 2020 |
| Maintaining a safe and adequate blood supply during the pandemic outbreak of coronavirus disease (COVID-19) | No specific reference to older people | 20 Mar 2020 |
| Operational considerations for case management of COVID-19 in health facility and community | Scenario and strategic priorities* Known risk factors for severe COVID-19: age over 60 years, hypertension, diabetes, cardiovascular disease, chronic respiratory disease, immunocompromising conditions.
 | 18 Mar 2020 |
| Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts | Where to manage COVID19 patients* In situations where isolation in a health care facility of all cases is not possible, WHO emphasizes the prioritization of those with highest probability of poor outcomes: patients with severe and critical illness and those with mild disease and risk for poor outcome (age >60 years, cases with underlying co-morbidities, e.g., chronic cardiovascular disease, chronic respiratory disease, diabetes, cancer)

Home care for patients with suspected COVID19, mild symptoms* patients with mild symptoms and without underlying chronic conditions − such as lung or heart disease, renal failure, or immunocompromising conditions that place the patient at increased risk of developing complications − may be cared for at home.
* a trained HCW should conduct an assessment to verify whether the residential setting is suitable for providing care
* a communication link with health care provider or public health personnel, or both, should be established for the duration of the home care period – that is, until the patient’s symptoms have completely resolved
* Patients and household members should be educated about personal hygiene, basic IPC measures, and how to care as safely as possible for the person suspected of having COVID19 to prevent the infection from spreading to household contacts
 | 17 Mar 2020 |
| Informal consultation on prioritization of candidate therapeutic agents for use in novel coronavirus 2019 infection | No specific reference to older people | 24 Jan 2020 |
| Clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected | Background* Older age and co-morbid disease have been reported as risk factors for death, and recent multivariable analysis confirmed older age, higher SOFA score and d-dimer > 1 µg/L on admission were associated with higher mortality.

Caring for older persons with COVID-19* older people are at highest risk for fatality and one of the most vulnerable populations. It is important to recognize that older people have the same rights as others to receive high-quality health care including intensive care. Refer to ICOPE
* For older people with probable or suspected COVID-19, provide person-centred assessment, including not only conventional history taking, but a thorough understanding of the person’s life, values, priorities and preferences for health management.
* Ensure multidisciplinary collaboration among physicians, nurses, pharmacists, other health care professionals in the decision-making process to address multimorbidity and functional decline.
* Remark 1: Physiological changes with age lead to declines in intrinsic capacity such as malnutrition, cognitive decline, depressive symptoms, and those conditions should be managed comprehensively.
* Early detection of inappropriate medication prescriptions is recommended to prevent adverse drug events and drug interactions for those being treated with COVID-19.
* Remark 2: Older people are at greater risk of polypharmacy, due to newly prescribed medications, inadequate medication reconciliation and a lack of care coordination which increases the risk of negative health consequences.
* Involve caregivers and family members in decision-making and goal-setting throughout the management of COVID-19.
 | 12 Jan 2020 |
| Recommendations: Prehospital Emergency Medical Services (EMS) COVID-19 | Geriatric considerations* Elderly populations often have special needs which could affect COVID-19 pre-hospital protocol. Potential needs may include:
* Hearing deficits – patients with partial or complete hearing loss may require a provider to be in close proximity in order to communicate. This would preclude a provider from maintaining adequate distance precautions.
* Neurological or mobility disorders (e.g. Parkinson’s, hand tremors, strokes) - patients may have difficulty applying masks to their own faces, accessing the ambulance or complying with provider requests.
* Cognitive impairment (e.g. dementia, Alzheimer’s Disease) - patients may have difficulty providing reliable and accurate information regarding exposure. If caregiver is present, providers may consider including them in the assessment.
* Co-morbidity - patients may have multiple health concerns that need to be addressed during transport in conjunction with COVID-19 signs and symptoms.
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| Use of chest imaging in COVID-19. A rapid advice guide | No specific reference to older people |  |
| Critical preparedness, readiness and response |
| Investing in and building longer-term health emergency preparedness during the COVID-19 pandemic | Preparedness should be across the life-course * Sustainable empowerment of populations needs to adopt a life-course approach – from children and adolescents to adults and older people. Professionals, such as doctors, nurses, midwives and teachers, should also be educated and trained on health emergency and disaster risk management and resilience-building.
 | 6 Jul 2020 |
| Preparedness for cyclones, tropical storms, tornadoes,floods and earthquakes during the COVID-19 pandemic | No specific reference to older people | 29 Jun 2020 |
| Critical preparedness, readiness and response actions for COVID-19 | No specific reference to older people | 24 Jun 2020 |
| Monitoring and evaluation framework | Indicators have been regrouped around nine pillars and one thematic area:* Pillar 6: Infection prevention and control
	+ Percentage of countries with Long-Term Care Facilities (LTCF) that have a national policy and/or guideline on IPC for COVID‑19 in LTCF

Rationale for use:* LTCFs, such as nursing homes, are facilities that care for people who are care dependent due to physical or mental disability, some of whom are of advanced age. LTCFs are not present in all countries.
* Given the congregate nature and residents served (e.g., older adults with multiple medical conditions), nursing home populations are at the highest risk of being affected by COVID‑19. If infected, residents are at increased risk of serious illness and mortality. In countries where LTCFs exist, national policy and guidelines on IPC are essential to take special precautions to protect the older adults, employees, and visitors in the LTCF.
 | 5 Jun 2020 |
| Operational planning guidance to support country preparedness and response | Pillar 2: Risk communication and community engagement (RCCE)* Step 1: [along with other points] Prepare local messages based on the latest evidence-based messaging from WHO, and pre-test through a participatory process that specifically targets key stakeholders and is tailored to all sub-population groups (e.g., living with disability, children, women, men, and elderly people)

Pillar 7: Case management* Special considerations and programs should be implemented for vulnerable populations (elderly patients; patients with chronic diseases; pregnant and lactating women; children; and residents of long-term facilities)
	+ Evaluate implementation and effectiveness of case management procedures and protocols (including for pregnant women, children, elderly patients, and immunocompromised patients), and adjust guidance and/or address implementation gaps as necessary
 | 22 May 2020 |
| Overview of Public Health and Social Measures in the context of COVID-19 | Special protection measures aim to protect special populations and vulnerable groups: * Persons at risk for more serious illness from COVID-19 (e.g. older people, persons with underlying medical conditions)
* Shelter-in-place advice for older age groups
* Protect closed settings - seniors’ residences, long-term or psychiatric care, prisons
* Limit visitors or allow visits only with safe distancing
* Plan for migrants, refugees, displaced or homeless
* Separation from others if appropriate to context and can be done safely and voluntarily
* In special settings, identify and plan for those at higher risk, e.g. in shops, public transport, hospitals
* Encourage communities to support the elderly, sick, or vulnerable
* Encourage social interaction by virtual means
* Orient social and community services to enhance resilience of communities
* Establish priority access to shops, markets for those who need it, e.g. early morning hours reserved for the elderly and the vulnerable
 | 18 May 2020 |
| Public health criteria to adjust public health and social measures in the context of COVID-19 | No specific reference to older people | 12 May 2020 |
| Considerations for public health and social measures in the workplace in the context of COVID-19 | * Avoid assigning tasks with high risk to workers who have pre-existing medical conditions, are pregnant, or older than 60 years of age.
 | 10 May 2020 |
| Considerations for school-related public health measures in the context of COVID-19 | * Advise against crowding during school pick-up or day care, and if possible avoid pick up by older family or community members (e.g. grandparents)
 | 10 May 2020 |
| Preparedness for cyclones, tropical storms, tornadoes, floods and earthquakes during the COVID-19 pandemic | No specific reference to older people | 29 Apr 2020 |
| Strengthening Preparedness for COVID-19 in Cities and Urban Settings | To be effective, any public health measure must be implementable and designed in a way that will promote willingness to comply. Urban authorities should:* identify and equitably protect vulnerable subpopulations at risk of poorer outcomes (see Table 1) and identify partners who may be able to reach out to these people. This includes considering the likely impact of the pandemic and public health measures on mental health and introducing safeguards, as well as the continued provision of essential social services.
* The presence of pressing health vulnerabilities and social disparities requires that they address the needs of the most vulnerable populations and build resilience in an inclusive manner

Why urban settings are unique* Urban areas also have diverse subpopulations and neighbourhoods with different sociocultural needs and vulnerable groups with regards to public health emergencies, including COVID-19, i.e.:
	+ Older persons, especially those at risk of isolation
	+ Persons with underlying medical conditions

Risk and crisis communication and community engagement that encourage compliance with measures* Municipal police in some cities in Turkey have been taking food orders from elderly people and delivering them to their homes. Likewise, the Tunis municipality has been home delivering essential food to vulnerable populations to strengthen compliance with the general lockdown
* Communications should be paired with active community involvement and the co-creation of solutions, such as the mobilization of volunteers through civil society organizations, civil protection and universities for the rapid deployment of knowledge and innovation. These can improve the chances of compliance, especially among vulnerable populations.
* Cities and other urban settlements should consider leveraging their advantage in the delivery of essential services, including food supply, WASH, health and social services in densely populated neighbourhoods, especially for vulnerable groups.
* Local authorities should also work with organized community groups (e.g. micro-credit groups, women’s and youth networks, those engaged in informal settlements) to identify the most vulnerable within communities, combat misinformation and stigma, and enable access to medical and other essential services.

Contextually appropriate approaches to public health measures, especially physical distancing, hand hygiene and respiratory etiquette* Develop and test possible innovative but pragmatic solutions to limiting physical contact in social settings. This includes alternatives to handshakes, hugs and cheek kissing, as well as closures of schools, religious centres, entertainment venues, and limiting visits to elderly and chronic care centres and prisons
* Cities and urban settings can explore coordination with non-profit and private sectors to mitigate losses in food and agriculture while maintaining access to food, especially for vulnerable subpopulations.
* The Municipality of Barcelona, Spain, finalized an agreement with the Touristic Business Association to allocate 200 apartments, originally destined for tourism, as emergency housing for families in vulnerable situations and homeless29. Rio de Janeiro, Brazil has made rooms available in local hotels to host elderly residents of informal settlements to enable proper physical distancing

Preparing for future emergencies* In the transition to recovery or to periods between epidemic peaks, cities and urban settlements should ensure that the phased transition away from measures for COVID-19 is conducted in keeping with the considerations described above, and will enable the sustainable suppression of transmission at a lowlevel whilst enabling the resumption of some parts of economic and social life, prioritized by carefully balancing socioeconomic benefit and epidemiological risk. This includes assessing the sustainability and impact of measures, especially for vulnerable groups.
 | 28 Apr 2020 |
| Considerations in adjusting public health and social measures in the context of COVID-19: interim guidance | Guiding principles when considering the adjusting of public health and social measures* Protection of vulnerable populations should be central in the decision to maintain or lift a measure.

Specific measures for workplaces and jobs at high risk* Avoid assigning tasks with high risk to workers who have pre-existing medical conditions, are pregnant, or older than 60 years of age

School setting and ability to maintain COVID-19 prevention and control measures* When schools are fully or partially open, COVID-19 prevention and control strategies2 should be maintained. Risk assessment could be guided by the considerations below, while recommended actions and requirements are outlined in the following section:
	+ Are policies and procedures in place for the safety of all school personnel, including considerations to protect high-risk individuals (older persons, persons with underlying medical conditions)?
	+ Advise against crowding during school pick-up or day care, and if possible avoid pick up by older family or community members (e.g. grandparents)
 | 15 Apr 2020 |
| Strategic preparedness and response plan | No specific reference to older people | 14 Apr 2020 |
| Assessment tool for laboratories implementing COVID-19 virus testing: Interim Guidance | No specific reference to older people | 8 Apr 2020 |
| Origin of SARS-CoV-2 | No specific reference to older people | 26 Mar 2020 |
| Laboratory testing strategy recommendations for COVID-19: interim guidance | Prioritized testing strategies* Testing in areas with community transmission and in settings where testing capacity cannot meet needs must be prioritized. This prioritization should focus on the early identification and protection of vulnerable patients and health care workers. Focused testing in health care facilities ensures that infection prevention and control measures can be correctly implemented such that vulnerable patients who do not have COVID are protected from nosocomial COVID-19 infection. Testing among vulnerable populations and risk groups will be important for early treatment to minimize progression to severe disease.
 | 21 Mar 2020 |
| Responding to community spread of COVID-19 | Case management and health services* Triage systems will be needed to reduce the risk of exposing other persons or patients to COVID-19, to prioritise treatment for severe and high-risk patients and to manage demands on staff, facilities, and supplies
 | 7 Mar 2020 |
| Preparing for large-scale community transmission of COVID-19 | Assess IPC practices and compliance in healthcare settings and other relevant facilities (for example elderly homes, long-term care facilities, points of entry). Address identified gaps | 28 Feb 2020 |
| National capacities review tool for a novel coronavirus | No specific reference to older people | 9 Jan 2020 |
| Draft operational planning guidance for UN country teams | Pillar 1: country-level coordination, planning and monitoring (pg 6)* [step 1 actions to be taken] Conduct initial capacity assessment and risk analysis, including mapping of vulnerable populations

Pillar 7: case management (pg 12)[step 1 actions to be taken] Map vulnerable populations and public and private health facilities (including traditional healers, pharmacies and other providers) and identify alternative facilities that may be used to provide treatment |  |
| Essential health services |
| Maintaining essential health services: operational guidance for the COVID-19 context | Section 2: Identify context-relevant essential services * Countries should identify essential services that will be prioritized in their efforts to maintain continuity of service delivery. High-priority categories include:
	+ Care of vulnerable populations, such as young infants and older adults;
* The selection of priorities will be guided by health system context and the local burden of disease, but should initially be oriented to preventing communicable disease, averting maternal and child morbidity and mortality, preventing acute exacerbations of chronic conditions by maintaining established treatment regimens, and managing emergency conditions that require time-sensitive intervention.

[updated document: 62 pg with reference to older people throughout]Part 2: Life course and disease considerations - Chapter on older people* Older people, particularly those with underlying health conditions, are at higher risk of serious health outcomes and death from COVID-19 and are more vulnerable to many of the indirect consequences of the pandemic. They are more likely to have ongoing needs for medication and care, including home-based visits and community care, so movement restrictions may disproportionately affect them
* Specific WHO technical guidance is available about caring for older people with COVID-19, providing home care and community-based health care, and implementing IPC in long-term care facilities.
* WHO recommends that older people, their households and caregivers are informed about preventive measures and the importance of promoting physical and mental health in the COVID-19 context. Older people should be proactively engaged in adapting their care plans, and specific mechanisms should be put in place to ensure that they have safe access to integrated health and social care, including support, monitoring and follow up

Table recommending programme activities and service delivery: | 1 Jun 2020 |
| Framework for decision-making: implementation of mass vaccination campaigns in the context of COVID-19 | No specific reference to older people | 20 May 2020 |
| Immunization in the context of COVID-19 pandemic | Is adult vaccination recommended during the COVID-19 pandemic?* Countries with existing pneumococcal, influenza, or pertussis vaccination programmes for older adults and individuals with high-risk conditions should maintain those programs while implementing measures to avoid the spread of COVID19, especially for those at higher risk of severe disease such as older adults, Preventing respiratory illness and hospitalization from pneumococcus, influenza, and pertussis through vaccination will allow respiratory medical equipment, medications, and health care workers to be more available to support patients with COVID-19, While there is currently limited information on whether COVID-19 is associated with an increased risk of pneumococcal infection, pneumococcal vaccination can prevent both primary and secondary bacterial infections and the unnecessary use of antibacterial medications (antibiotics),

Are there ways to organize the immunization service site to minimize the risk of COVID-19 virus transmission?* Establishing immunization sessions exclusively for vaccination of older persons and those with pre-existing medical conditions (such as high blood pressure, heart disease, respiratory illness, or diabetes).
 | 15 May 2020 |
| Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic | \*\*43 pg document with reference to older people throughoutPart 2: Older people* Recognize non-specific signs and symptoms of COVID-19 in older people, including fatigue, reduced alertness, reduced mobility, diarrhoea, loss of appetite, delirium and the absence of fever (42).
* Reach out (for example, by phone or telehealth connection) to older people who have additional risk factors (6) for developing severe illness from COVID-19, such as those with chronic lung disease, cardiovascular disease including hypertension, immunodeficiency including HIV, diabetes, renal disease, liver disease, chronic neurological or neuromuscular disease, malignancy, or undernutrition.
* Advise older people to have at home, if possible, at least 2 weeks of critical medicines and supplies. Provide repeat prescriptions and mechanisms for delivering refills.
* Discuss advanced care planning and the possibilities of palliative care, including end-of-life care, to allow informed, inclusive and autonomous decisions, if appropriate.
* Follow up (for example, by phone or with a home visit) if the older person fails to attend appointments.
* Recognize that older people, particularly those in isolation and with impairments (such as visual impairment, hearing loss, cognitive decline or dementia), may become more anxious, angry and stressed (18).
	+ Adapt communication (verbal and written) to older people with impairments so that information is accessible and clearly understood (5).
	+ Provide practical advice in a clear, concise, respectful and calm way, and repeat simple facts as frequently as needed.
	+ Be mindful that wearing a mask prevents lip reading and decreases vocal clarity for those with hearing loss (43).
* Ensure that assistive devices are provided, such as wheelchairs and walkers, to those older people who need them, and communicate the importance of ensuring that these are disinfected before and after use.
* Ensure that older people who live alone or are institutionalized have access to nutritious food. Consider individual preferences and underlying physical limitations when ensuring this access (such as problems with chewing, swallowing or digestion) (44).
* Engage the community health workforce to help older persons who depend on care (45).
* Discuss with the older person and their household an alternative plan to ensure continuity of care in case the main caregiver is unavailable (46):
	+ identify alternative caregivers and prepare a readily available care plan for handover;
	+ identify possible facilities (such as long-term care facilities, community centres) for short-term admissions.
 | 5 May 2020 |
| Recommendations to Member States to improve hand hygiene practices to help prevent the transmission of the COVID-19 virus | WHO recommendations* The quantity and usability of the hand hygiene stations should be adapted to the type (e.g. young children, elderly, those with limited mobility) and number of users to better encourage use and reduce waiting time.
 | 1 Apr 2020 |
| Guiding principles for immunization activities during the COVID-19 pandemic: interim guidance | Guiding principles: “Where feasible, influenza vaccination of health workers, older adults, and pregnant women is advised” | 26 Mar 2020 |
| Guide to local production: WHO-recommended handrub formulations | No specific reference to older people | 7 May 2020 |
| Essential resource planning |
| Emergency Global Supply Chain System (COVID-19) catalogue | No specific reference to older people | 18 Jun 2020 |
| COVID-19 Essential Supplies Forecasting Tool | No specific reference to older people | 29 Apr 2020 |
| List of priority medical devices for COVID-19 case management | No specific reference to older people | 9 Apr 2020 |
| Forecasting health workforce requirements | No specific reference to older people |  |
| Infection prevention and control / WASH |
| Infection prevention and control during health care when coronavirus disease (‎COVID-19)‎ is suspected or confirmed | No specific reference to older people | 29 Jun 2020 |
| Advice on the use of masks in the context of COVID-19 | Advice to decision makers on the use of masks for healthy people in community settings* Decisions makers should consider …Vulnerability of the person/population to develop severe disease or be at higher risk of death, e.g. people with comorbidities, such as cardiovascular disease or diabetes mellitus, and older people

Guidance on the use of masks for the general public* Older people and immunosuppressed patients may present with atypical symptoms such as fatigue, reduced alertness, reduced mobility, diarrhoea, loss of appetite, delirium, and absence of fever. It is important to note that early symptoms for some people infected with COVID-19 may be very mild and unspecific;

WHO advises decision makers to apply a risk-based approach focusing on the following criteria when considering or encouraging the use of masks for the general public:* Vulnerability of the mask wearer/population: for example, medical masks could be used by older people, immunocompromised patients and people with comorbidities, such as cardiovascular disease or diabetes mellitus, chronic lung disease, cancer and cerebrovascular disease

Use of medical mask recommended for:* People aged ≥60 years
* People with underlying comorbidities, such as cardiovascular disease or diabetes mellitus, chronic lung disease, cancer, cerebrovascular disease, immunosuppression
 | 5 Jun 2020 |
| Cleaning and disinfection of environmental surfaces in the context of COVID-19 | No specific reference to older people | 16 May 2020 |
| Water, sanitation, hygiene, and waste management for the COVID-19 virus: interim guidance | No specific reference to older people | 23 Apr 2020 |
| Rational use of personal protective equipment for coronavirus disease (COVID-19) and considerations during severe shortages | No specific reference to older people | 6 Apr 2020 |
| Infection prevention and control for the safe management of a dead body in the context of COVID-19: interim guidance | Funeral home/mortuary care* Adults >60 years and immunosuppressed persons should not directly interact with the body.
 | 24 Mar 2020 |
| Considerations for quarantine of individuals in the context of containment for coronavirus disease (COVID-19) | Quarantine of persons* Persons who are quarantined need to be provided with health care; financial, social and psychosocial support; and basic needs, including food, water, and other essentials. The needs of vulnerable populations should be prioritized.

Ensuring an appropriate setting and adequate provisions* Older persons and those with comorbid conditions require special attention because of their increased risk for severe COVID-19.

Minimum requirements for monitoring the health of quarantined persons* Groups of persons at higher risk of infection and severe disease may require additional surveillance owing to chronic conditions or they may require specific medical treatments.
 | 19 Mar 2020 |
| Risk assessment and management of exposure of health care workers in the context of COVID-19: interim guidance | No specific reference to older people | 19 Mar 2020 |
| IPC guidance for long-term care facilities in the context of COVID-19 | Background* The people living in LTCF are vulnerable populations who are at a higher risk for adverse outcome and for infection due to living in close proximity to others. Thus, LTCFs must take special precautions to protect their residents, employees, and visitors. Note that infection prevention and control (IPC) activities may affect the mental health and wellbeing of residents and staff, especially the use of PPE and restriction of visitors and group activities

System and service coordination* Facilitate additional support (resources, health care providers) if any older person in LTCFs is confirmed with COVID19.

Prevention* [IPC focal point should]: Provide information sessions for residents on COVID-19 to inform them about the virus, the disease it causes and how to protect themselves from infection
* Encourage and support residents and visitors to perform hand hygiene frequently, in particular when hands are soiled, before and after touching other people (although this should be avoided as much as possible), after using the toilet, before eating, and after coughing or sneezing.
* Provide annual influenza vaccination and pneumococcal conjugate vaccines to employees and staff, according to local policies, as these infections are important contributors to respiratory mortality in older people

Physical distancing* Restrict the number of visitors (access to visitors in the LTCFs should be restricted and avoided as much as possible.)
* For group activities ensure physical distancing, if not feasible cancel group activities
* Stagger meals to ensure physical distance maintained between residents or if not feasible, close dining halls and serve residents individual meals in their rooms
* Enforce a minimum of 1 meter distance between residents
* Require residents and employees to avoid touching (e.g., shaking hands, hugging, or kissing)

Visitors* All visitors should be screened for signs and symptoms of acute respiratory infection or significant risk for COVID-19 (see screening, above), and no one with signs or symptoms should be allowed to enter the premises.
* allowed entry to long-term care only on compassionate grounds, specifically if the resident of the facility is gravely ill and the visitor is their next-of-kin or other person required for emotional care.
* Visitors should be limited to one at a time to preserve physical distancing.
* Direct contact by visitors with residents with confirmed or suspected COVID-19 should be prohibited.
* Note that in some settings, complete closure to visitors is under the jurisdiction of local health authorities.

Response* Surveillance of residents:
	+ Assess new residents at admission to determine if the resident has signs of a respiratory illness including fever 2 and cough or shortness of breath. (note: Older people, particularly those living with co-morbidities or frailty often present non-specific signs and symptoms in response to infection, including reduced alertness, reduced mobility, or diarrhoea and sometimes do not develop fever: this may be true for COVID-19, so such changes should alert staff to the possibility of new COVID infection.)
	+ Assess each resident twice daily for the development of a fever (≥38C), cough or shortness of breath
* Source control
	+ If a resident is suspected to have, or is diagnosed with, COVID-19, the following steps should be taken:
	+ Notify local authorities about any suspected case and isolate residents with onset of respiratory symptoms.
	+ Place a medical mask on the resident and on others staying in the room.
	+ Ensure that the patient is tested for COVID-19 infection according to local surveillance policies and if the facility has the ability to safely collect a biological specimen for testing.
	+ Promptly notify the patient and appropriate public health authorities if the COVID-19 test is positive
	+ Assess for potential patient transfer to an acute health facility. If this is not possible or indicated, confirmed patients can be isolated and cared for at the LTCF.
	+ If possible, move the COVID-19 patient to a single room.
	+ If no single rooms are available, consider cohorting residents with suspected or confirmed COVID-19. – Residents with suspected COVID-19 should be cohorted only with other residents with suspected COVID-19; they should not be cohorted with residents with confirmed COVID-19. – Do not cohort suspected or confirmed patients next to immunocompromised residents.
	+ Clearly sign the rooms
	+ Dedicate specific medical equipment (e.g. thermometers, blood pressure cuff, pulse oximeter, etc.) for the use of medical professionals for resident(s) with suspected or confirmed COVID-19.
	+ Clean and disinfect equipment before re-use with another patient.
	+ Restrict sharing of personal devices (mobility devices, books, electronic gadgets) with other residents.
* Restriction of movement
	+ Confirmed patients should not leave their rooms while ill.
	+ Restrict movement or transport of residents to essential diagnostic and therapeutic tests only. – Avoid transfer to other facilities (unless medically indicated).
	+ Isolate COVID-19 patients until they have two negative laboratory tests for COIVID-19 taken at least 24 hours apart after the resident’s symptoms have resolved. Where testing is not possible, WHO recommends that confirmed patients remain isolated for an additional two weeks after symptoms resolve.
	+ LTCFs should be prepared to accept residents who have been hospitalized with COVID-19, are medically stable and are able to care for the patients in isolated rooms.

Minimizing effect on mental health * Older people, especially in isolation and those with cognitive decline, dementia, and those who are highly care-dependent, may become more anxious, angry, stressed, agitated, and withdrawn during the outbreak or while in isolation.
* Provide practical and emotional support through informal networks (families) and health care providers.
* Regularly provide updated information about COVID-19 to residents, employees, and staff.
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| Q&A on infection prevention and control for health care workers caring for patients with suspected or confirmed 2019-nCoV | No specific reference to older people |  |
| Laboratory and diagnosis |
| Laboratory biosafety guidance related to coronavirus disease (COVID-19) | No specific reference to older people | 13 May 2020 |
| WHO reference laboratories providing confirmatory testing for COVID-19 | No specific reference to older people | 19 Apr 2020 |
| Laboratory assessment tool for laboratories implementing COVID-19 virus testing | No specific reference to older people | 8 Apr 2020 |
| Guidance for laboratories shipping specimens to WHO reference laboratories that provide confirmatory testing for COVID-19 virus | No specific reference to older people | 31 Mar 2020 |
| Laboratory testing strategy recommendations for COVID-19: interim guidance | Prioritized testing strategies* Testing in areas with community transmission and in settings where testing capacity cannot meet needs must be prioritized. This prioritization should focus on the early identification and protection of vulnerable patients and health care workers. Focused testing in health care facilities ensures that infection prevention and control measures can be correctly implemented such that vulnerable patients who do not have COVID are protected from nosocomial COVID-19 infection. Testing among vulnerable populations and risk groups will be important for early treatment to minimize progression to severe disease.
 | 21 Mar 2020 |
| Laboratory testing for 2019 novel coronavirus (2019-nCoV) in suspected human cases | No specific reference to older people | 19 Mar 2020 |
| WHO R&D Blueprint: novel Coronavirus: prospects for evaluating cross-reactivity of nCoV with SARS-CoV | No specific reference to older people | 27 Jan 2020 |
| Prioritized Laboratory Testing Strategy According to 4Cs Transmission Scenarios | Prioritized testing strategies* In the setting of limited resources in areas with community transmission, prioritization for testing should be given to:
* people who are at risk of developing severe disease and vulnerable populations, who will require hospitalization and advanced care for COVID-19
	+ the first symptomatic individuals in a closed setting (e.g. schools, long-term living facilities, prisons, hospitals) to quickly identify outbreaks and ensure containment measures.
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| Mass gatherings |
| Key planning recommendations for mass gatherings in the context of the current COVID-19 outbreak | Risk assessment* Specific features of the event that should be considered include: age of participants; because elderly people who have co-morbid conditions appear to be more seriously affected, mass gatherings composed principally of this cohort may be associated with increased transmission;
 | 29 May 2020 |
| Considerations for mass gatherings in the context of COVID-19: annex: considerations in adjusting public health and social measures in the context of COVID-19 | Guiding principles when considering the adjusting of public health and social measures* Protection of vulnerable populations should be central in the decision to maintain or lift a measure.

Specific measures for workplaces and jobs at high risk* Avoid assigning tasks with high risk to workers who have pre-existing medical conditions, are pregnant, or older than 60 years of age

School setting and ability to maintain COVID-19 prevention and control measures* When schools are fully or partially open, COVID-19 prevention and control strategies2 should be maintained. Risk assessment could be guided by the considerations below, while recommended actions and requirements are outlined in the following section:
	+ Are policies and procedures in place for the safety of all school personnel, including considerations to protect high-risk individuals (older persons, persons with underlying medical conditions)?
	+ Advise against crowding during school pick-up or day care, and if possible avoid pick up by older family or community members (e.g. grandparents)
 | 14 May 2020 |
| Safe Ramadan practices in the context of the COVID-19: interim guidance | Advice to high-risk groups * Urge older people and anyone with pre-existing medical conditions (such as cardiovascular disease, diabetes, chronic respiratory disease, and cancer) not to attend gatherings, as they are considered vulnerable to severe disease and death from COVID-19.

Promoting mental and psychosocial health* Ensuring that family, friends, and elders are still engaged in light of physical distancing needs to be considered; encouraging alternate and digital platforms for interaction is paramount.
 | 15 Apr 2020 |
| Considerations for sports federations/sports event organizers when planning mass gatherings in the context of COVID-19: interim guidance | Demographics * Pre-travel and pre-event health checks are highly encouraged/mandatory to ensure exclusion of those with potential additional risks (comorbidities, medications, allergies) Spectators can include vulnerable groups so consider advising some at-risk groups not to attend
 | 14 Apr 2020 |
| Decision tree for risk assessment for mass gathering | No specific reference to older people | 8 Apr 2020 |
| Decision tree for risk assessment tool for Religious Leaders and Faith-based Communities in the context of COVID-19 | No specific reference to older people | 7 Apr 2020 |
| Practical considerations and recommendations for religious leaders and faith-based communities in the context of COVID-19 | * Religious leaders are a critical link in the safety net for vulnerable people within their faith community and wider communities.

Safe burial practices * As modifications to burial and funeral rites are adopted, particular attention should be paid to protect children and older adults in attendance

Keeping the community connected * Religious leaders and faith-based organizations can strengthen their communities and combat self-isolation through regularly checking in on individual members, preferably via phone. This is particularly important to account for individuals who may be living alone, who are elderly, who have disabilities or are otherwise vulnerable
* Faith communities can identify ways that their members can help others, depending upon individual risk levels (checking on the elderly, people with disabilities, and vulnerable neighbors by phone and offering to deliver groceries, etc.).

Responding to domestic violence* Existing vulnerabilities associated with age, religion, migration status, sexuality and ethnicity may be exacerbated. Religious leaders can actively speak out against violence and can provide support or encourage victims to seek help

Faith leaders’ role * Stay informed about risk; older people and people with underlying medical conditions are more at risk of severe illness.
* By drawing on language within their own faith tradition, religious leaders can promote positive messages that affirm the dignity of all people, the need to protect and care of the vulnerable, and inspire hope and resilience in those affected by, or vulnerable to, COVID-19
 | 7 Apr 2020 |
| How to use WHO risk assessment and mitigation checklist for Mass Gatherings in the context of COVID-19 | Information to collect about the meeting* Estimated percentage of participants who may be considered at risk (age > 65, pre-existing conditions, health care workers, or other responders).

COVID-19 Assessment tool* Will the event include a significant number of participants at higher risk of severe disease (e.g. people > 65 years of age, people with underlying health conditions)?
 |  |
| Handbook for the Management of Public Health Events in Air Transport | No specific reference to older people |  |
| Risk communication and community engagement |
| Addressing violence against children, women and older people during the covid-19 pandemic: Key actions | * 10x increase in abuse and neglect of older people in some settings

Why is violence in the home likely to increase during and after the COVID-19 pandemic?* Stay-at-home measures may put older people living in abusive relationships at even greater risk of violence because of increased time spent with and exposure to their abusers
* Stressors including economic uncertainty, job losses and over-crowded settings, where physical distancing is not feasible, are likely to increase the perpetration of violence in the home
* Limited or no access to protective support networks – both informal (e.g. family, relatives, friends, neighbours, school teachers or support staff, colleagues) and formal (e.g. protection services, hotlines, social services, shelters) during mobility restriction/ lockdown may further contribute to the risk of increased violence
* Perpetrators of intimate partner violence may use COVID-19-related concerns to exercise greater power and control over their victims, including limiting access to critical information and resources, and monitoring communication (e.g. telephones, mobile/sim cards, internet), thus making it difficult to contact support services, and access health services
* Confinement can result in increased consumption of alcohol and other substances, which is associated with the perpetration of violence

Who will be at higher risk of violence during confinement?* Mobility issues can limit opportunities to seek help.
* Face barriers to accessing trustworthy information using newer technologies, including the internet.
* May be encouraged or forced to stay in quarantine much longer, because of their higher risk of infection, which may prolong social isolation, increase abuse, and reduce opportunities to seek help
* Physical dependence on other household members (e.g. for food, getting dressed, using the bathroom).
* COVID-19 has led to staff reductions in long-term care facilities, due to illness or self-isolation (staff), and the suspension of family visits, increasing the isolation of residents and the already high risk of violence and neglect.

What can be done to address violence in the home during the COVID-19 response?[recommendations to government and policy-makers, programme managers, facility managers and health care providers] | 18 Jun 2020 |
| Gender and COVID-19 | No specific reference to older people | 14 May 2020 |
| COVID-19 message library | Messages for/about older people:* Older people are valued and valuable members of our families and communities. But they are at higher risk of the more serious complications of COVID-19.
* Older people need to keep in contact with family, friends and neighbours and ask for help with shopping, or picking up medicines or other necessities if needed.
* Older people should keep the house stocked with at least two weeks of essential food and supplies, including prescription medicine.
* Older people can keep healthy by establishing a routine to keep active and positive. This may include online courses, physical activities, and reading.
 | 28 Apr 2020 |
| Working with Community Advisory Boards for COVID-19 related clinical studies | Depending on the study and context, several types of CAB/Gs may be needed, together with wider stakeholder engagement, including: * CAB/Gs composed of relatively well known, confident, prominent and outspoken leaders speaking on behalf of their communities, such as religious elders, local chiefs or elders, or leaders of women’s groups and other community-based or nongovernmental organisations. For studies involving health workers, representatives may be team leaders or managers. These members are usually confident to voice their views and opinion, and their involvement may be reassuring to members of their communities.
* CAB/Gs made up of members more typical of their communities (such as representatives of an age group, illness, or a type of health worker), who potentially have better awareness of everyday issues and concerns than more outspoken leaders.
* CAB/Gs – perhaps differently constituted and organized – made up of relatively vulnerable and marginalized groups in relation to the research in that particular context (e.g. the elderly, people with disabilities, or out-of-school youths), who would otherwise find it difficult to voice their views and be heard.
 | 23 Apr 2020 |
| COVID-19 and violence against women | Violence against women tends to increase during every type of emergency, including epidemics. Older women and women with disabilities are likely to have additional risks and needs. Women who are displaced, refugees, and living in conflict-affected areas are particularly vulnerable. | 7 Apr 2020 |
| Mental health and psychosocial considerations during the COVID-19 outbreak | Messages for older adults, people with underlying health conditions and their carers* Older adults, especially in isolation and those with cognitive decline/dementia, may become more anxious, angry, stressed, agitated and withdrawn during the outbreak or while in quarantine. Provide practical and emotional support through informal networks (families) and health professionals.
* Share simple facts about what is going on and give clear information about how to reduce risk of infection in words older people with/without cognitive impairment can understand. Repeat the information whenever necessary. Instructions need to be communicated in a clear, concise, respectful and patient way. It may also be helpful for information to be displayed in writing or pictures. Engage family members and other support networks in providing information and helping people to practise prevention measures (e.g. handwashing, etc.).
* If you have an underlying health condition, make sure to have access to any medications that you are currently using. Activate your social contacts to provide you with assistance, if needed.
* Be prepared and know in advance where and how to get practical help if needed, like calling a taxi, having food delivered and requesting medical care. Make sure you have up to two weeks of all your regular medicines that you may require.
* Learn simple daily physical exercises to perform at home, in quarantine or isolation so you can maintain mobility and reduce boredom.
* Keep regular routines and schedules as much as possible or help create new ones in a new environment, including regular exercising, cleaning, daily chores, singing, painting or other activities. Keep in regular contact with loved ones (e.g. via telephone, e-mail, social media or video conference).

Messages for people in isolation* Stay connected and maintain your social networks. Try as much as possible to keep your personal daily routines or create new routines if circumstances change. If health authorities have recommended limiting your physical social contact to contain the outbreak, you can stay connected via telephone, e-mail, social media or video conference.
* During times of stress, pay attention to your own needs and feelings. Engage in healthy activities that you enjoy and find relaxing. Exercise regularly, keep regular sleep routines and eat healthy food. Keep things in perspective. Public health agencies and experts in all countries are working on the outbreak to ensure the availability of the best care to those affected
* A near-constant stream of news reports about an outbreak can cause anyone to feel anxious or distressed. Seek information updates and practical guidance at specific times during the day from health professionals and WHO website and avoid listening to or following rumours that make you feel uncomfortable.
 | 18 Mar 2020 |
| Risk Communication and Community Engagement (RCCE) Action Plan Guidance COVID-19 Preparedness and Response | The process* Identify key audiences and influencers Identify target audiences and key influencers. These include policy-makers, influential bloggers or other social media leaders, local leaders, women and youth groups, religious and elders’ groups, local and international NGOs health experts and practitioners, volunteers, and people who have real-life experience with COVID-19 (those who have had COVID-19 or their family members have contracted the virus). Match audiences and influencers with channels and partners that reach them.

Defining and prioritising your RCCE audiences and other stakeholders* Add categories for key audiences, partners, and stakeholders who are important to your country that may not be included in the list below.
* All people at-risk of acquiring COVID-19, for example: elderly, people with underlying health conditions, health care workers, travellers, etc.
 | 16 Mar 2020 |
| A guide to preventing and addressing social stigma associated with COVID-19 | No specific reference to older people | 24 Feb 2020 |
| The COVID-19 risk communication package for healthcare facilities | No specific reference to older people |  |
| Schools, businesses and institution |
| Operational considerations for COVID-19 management in the accommodation sector: interim guidance | COVID-19 transmission* Although most infected people develop mild symptoms, severe disease may result in older people and/or people with other medical conditions and they may require rapid hospitalisation.

Reception and concierge* Reception desk staff, if possible, should not be older or with underlying health conditions
 | 31 Mar 2020 |
| Operational considerations for COVID-19 surveillance using GISRS: interim guidance | No specific reference to older people | 26 Mar 2020 |
| Getting your workplace ready for COVID-19: How COVID-19 spreads | Before travelling* Avoid sending employees who may be at higher risk of serious illness (e.g. older employees and those with medical conditions such as diabetes, heart and lung disease) to areas where COVID-19 is spreading.

Getting your workplace ready in case COVID19 arrives* Consider how to identify persons who may be at risk, and support them, without inviting stigma and discrimination into your workplace. This could include persons who have recently travelled to an area reporting cases, or other personnel who have conditions that put them at higher risk of serious illness (e.g. diabetes, heart and lung disease, older age).
 | 19 Mar 2020 |
| Coronavirus disease (COVID-19) outbreak: rights, roles and responsibilities of health workers, including key considerations for occupational safety and health | No specific reference to older people | 18 Mar 2020 |
| Key Messages and Actions for COVID-19 Prevention and Control in Schools | No specific reference to older people | 10 Mar 2020 |
| Preparedness, prevention and control of COVID-19 in prisons and other places of detention | No specific reference to older people |  |
| Scientific briefs \*not included |
| Surveillance, case investigation and epidemiological protocols |
| Surveillance protocol for SARS-CoV-2 infection among health workers | No specific reference to older people | 28 May 2020 |
| Ethical considerations to guide the use of digital proximity tracking technologies for COVID-19 contact tracing | Reliance on digital proximity tracking for contact tracing, to the exclusion of the traditional approaches, will reduce access to essential services for the marginalized populations, especially the elderly and people living in poverty. | 28 May 2020 |
| Assessment of risk factors for coronavirus disease 2019 (COVID-19) in health workers: protocol for a case-control study | No specific reference to older people | 26 May 2020 |
| Population-based age-stratified seroepidemiological investigation protocol for coronavirus 2019 (COVID-19) infection | No specific reference to older people | 26 May 2020 |
| Surveillance strategies for COVID-19 human infection | Essential surveillance for COVID-19* Surveillance for vulnerable or high-risk populations should be enhanced. This will require a combination of surveillance systems including contact tracing in the entire health care system, at the community level, as well as in closed residential settings and for vulnerable groups.

Enhanced Surveillance for Residential Facilities and Vulnerable Groups * Dedicated enhanced surveillance for some high-risk groups is necessary to ensure the prompt detection of cases and clusters, faster than through primary-care or hospital-based surveillance. People who live in closed environments, such as prisons, or residential facilities, such as retirement communities or care homes for persons with disabilities, can be especially vulnerable because they may not be able to seek help themselves. Vulnerable groups may also live in settings where the probability of transmission is higher than in the general population or have health conditions or predisposing factors that increase their risk of severe illness. Enhanced surveillance includes the use of active case finding, as through daily screening of signs and symptoms, including daily temperature monitoring, and daily zero-reporting for all individuals in high-risk groups under surveillance
 | 10 May 2020 |
| Contact tracing in the context of COVID-19 | Background* For contact tracing to be effective, countries must have adequate capacity to test suspect cases in a timely manner. Where this is not possible, testing3 and contact tracing strategies may instead focus on specific high-risk settings with vulnerable individuals, such as hospitals, care homes, or other closed settings (e.g. dormitories)

Engaging communities* Communication about contact tracing should emphasize solidarity, reciprocity, and the common good. By participating in contact tracing, communities will contribute to controlling local spread of COVID-19, vulnerable people will be protected, and more restrictive measures, such as general stay-at-home orders, might be avoided or minimized

Epidemiological scenarios* community transmission: contact tracing may be difficult when transmission is intense but should be carried out as much as possible, focusing on household contacts, health care workers, high-risk closed settings (dormitories, institutions, long term-care homes), and vulnerable contacts, as well as maintaining strong contact tracing capacity in areas with smaller clusters of cases.
 | 10 May 2020 |
| Global surveillance for COVID-19 caused by human infection with COVID-19 virus: interim guidance | Recommendations for reporting surveillance data to WHO* Weekly number of new confirmed cases by age-group in years (using: 0-<5, 5-14, 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75-84, 85 and above, age missing)

Weekly number of new confirmed case deaths by age-group in years (using: 0-<5, 5-14, 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75-84, 85 and above, age missing) | 20 Apr 2020 |
| Considerations in the investigation of cases and clusters of COVID-19 | No specific reference to older people | 2 Apr 2020 |
| Household transmission investigation protocol for 2019-novel coronavirus (COVID-19) infection | No specific reference to older people | 28 Feb 2020 |
| COVID-19 Early Epidemiologic and Clinical investigations for public health response | No specific reference to older people | 24 Feb 2020 |
| The first few X cases and contacts (‎FFX)‎ investigation protocol for coronavirus disease 2019 (‎COVID-19)‎, version 2.2 | No specific reference to older people | 23 Feb 2020 |
| Surface sampling of coronavirus disease (‎COVID-19)‎: a practical “how to” protocol for health care and public health professionals | No specific reference to older people | 18 Feb 2020 |
| Protocol for assessment of potential risk factors for 2019-novel coronavirus (COVID-19) infection among health care workers in a health care setting | No specific reference to older people | 25 Jan 2020 |
| Travel, points of entry and border health |
| Controlling the spread of COVID-19 at ground crossings |  | 29 May 2020 |
| Operational considerations for managing COVID-19 cases or outbreaks on board ships: interim guidance | No specific reference to older people | 29 Apr 2020 |
| Management of ill travellers at points of entry – international airports, seaports and ground crossings – in the context of COVID -19 outbreak | No specific reference to older people | 19 Mar 2020 |
| Operational considerations for managing COVID-19 cases or outbreak in aviation: interim guidance | No specific reference to older people | 18 Mar 2020 |
| Handbook for the management of public health events on board ships | No specific reference to older people | 2 May 2016 |
| Handbook for the inspection of ships and issuance of ship sanitation certificates | No specific reference to older people | 15 June 2011 |
| Vulnerable populations and fragile settings |
| Public health and social measures for COVID-19 preparedness and response in low capacity and humanitarian settings | * Link the community heath workforce with trained and engaged community level social service and protection actors to help identify and address risks to vulnerable populations (including single parent households, children, older people, homeless people, those affected by violence etc.) and support referral pathways for multi-sectoral support.
* Existing collective accommodations for older people should be monitored closely for potential cases and staff working in these accommodations need to fully comply with the required IPC measures. Additional placement of individuals at high risk of poor outcomes in a separate facility or location should be avoided. The risk of introduction of the virus into such facilities is most likely unmanageable, as shown by experience in high resource settings. This measure is also most likely unsustainable in the long run given available resources, which should be prioritized for critical measures that are known to be working
* Modalities of isolation and treatment should be voluntary to minimize avoidance and consider greater protections or alternative measures for those who are at highest risk of poor outcomes if infected, including older caregivers or individuals with underlying health conditions

Key special considerations for inclusion in national and local COVID-19 readiness and response operations:* Make provisions so that essential informal services such as food selling, provision of water, hygienic articles, care for children, persons with disabilities, older persons, and those with illnesses, can be sustained in the safest possible way, including during lock down
* Monitor the protection needs of pregnant women, gender-based violence survivors, indigenous people, refugees, migrants, internally displaced persons, people with disabilities and older people
 | 7 May 2020 |
| Preparedness, prevention and control of coronavirus disease (COVID-19) for refugees and migrants in non-camp settings | Guiding principles * Health systems should aim to deliver culturally, linguistically and child-, gender- and age-responsive COVID-19 services that are accessible to all populations. Refugees and migrants are particularly vulnerable to public health risks and some of them may need special service provisions. These include provisions for people with underlying conditions and/or disabilities, the elderly, people experiencing sexual violence, abuse and exploitation and other forms of gender-based violence, as well as unaccompanied or separated children, as well as people in detention

Surveillance, case investigation and management, and infection control* Include refugees and migrants in COVID-19 surveillance and health information systems. New cases of COVID-19 infection should be rapidly detected and reported, and the resulting data should be disaggregated by age and gender.
 | 17 Apr 2020 |
| Scaling up COVID-19 Outbreak Readiness and Response in Camps and Camp Based Settings (jointly developed by IASC / IFRC / IOM / UNHCR / WHO) | No specific reference to older people | 17 Mar 2020 |
| COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement | Why include a protection, gender, and inclusion lens in risk communication and community engagement? * Women, the elderly, adolescents, youth, and children, persons with disabilities, indigenous populations, refugees, migrants, and minorities experience the highest degree of socio-economic marginalization. Marginalized people become even more vulnerable in emergencies. This is due to factors such as their lack of access to effective surveillance and early-warning systems, and health services. The COVID-19 outbreak is predicted to have significant impacts on various sectors. The populations most at risk are those that:

• depend heavily on the informal economy; • occupy areas prone to shocks; • have inadequate access to social services or political influence; • have limited capacities and opportunities to cope and adapt and; • limited or no access to technologies. * By understanding these issues, we can support the capacity of vulnerable populations in emergencies. We can give them priority assistance, and engage them in decision-making processes for response, recovery, preparedness, and risk reduction.

What have we learned about protection, gender, inclusion, and risk communication and community engagement in other epidemics? * As primary caregivers to children, the elderly, and the ill, we must recognize and engage women in risk communication and community engagement.

Populations at disproportionate risk in public health emergencies, and key implications for risk communication and community engagement* Women and girls
	+ Women make up large parts of the health workforce.
	+ Most primary caregivers to the ill are women.
	+ Women are more likely to be engaged in the informal sector and be hardest hit economically by COVID-19.
	+ Women experience increased risks of gender-based violence, including sexual exploitation.
	+ Cultural factors may exclude women from decision-making spaces and restrict their access to information on outbreaks and availability of services.
	+ In some cultural contexts, gender roles may dictate women cannot obtain health services independently or from male service providers.
	+ RCCE actions to include this group:
	+ Ensure that community engagement teams are gender-balanced and promote women’s leadership within these.
	+ Provide specific advice for people - usually women - who care for children, the elderly and other vulnerable groups in quarantine, and who may not be able to avoid close contact.
	+ Design online and in-person surveys and other engagement activities so that women in unpaid care work can participate.
	+ Take into account provisions for childcare, transport, and safety for any in-person community engagement activities.
	+ Ensure frontline medical personnel are gender-balanced and health facilities are culturally and gender sensitive.
* The elderly
	+ The evidence for COVID-19 shows they are the most vulnerable group with higher fatality rate.
	+ Not always able to go to the health services or the services provided are not adequate for elderly.
	+ May have difficulty caring for themselves and depend on family or caregivers. This can become more challenging in emergencies.
	+ May not understand the information/ messages provided or be unable to follow the instructions.
	+ Elderly in assisted-living facilities live close to each other and social distancing can be difficult.
	+ RCCE actions to include this group:
	+ Tailor messages and make them actionable for particular living conditions (including assisted living facilities), and health status.
	+ Engage the elderly to address their specific feedback. Develop specific messages to explain the risk for elderly and how to care for them, especially in homecare
	+ Target family members, health care providers and caregivers.
 |  |
| Q&A: Older people and COVID-19 | (<https://www.who.int/news-room/q-a-detail/q-a-on-on-covid-19-for-older-people>) |  |
| COVID-19 and Violence Against Older People | * Violence against older people – which includes physical, psychological, and sexual violence, financial abuse, and neglect – can have devastating physical and mental health consequences for older people and can even lead to death.
* Violence against older people, who are already bearing the brunt of this pandemic, has risen sharply since the beginning of the COVID-19 pandemic and imposition of lockdown measures.
* Violence is occurring in homes, in institutions such as long-term care facilities, and online, with a surge in scams directed at older people.
* Lockdown and “stay-at-home” orders, likely to last longer for older people, exacerbate those factors which put older people at particular risk of violence – social isolation and loneliness, mental health problems (depression and anxiety), financial dependency of caregivers on older people, dependency of older people on caregivers, and alcohol and substance use in caregivers. COVID-19 has led to staff reductions in longterm care facilities, due to illness or selfisolation, and the suspension of family visits, increasing the isolation of residents and the already high risk of violence.
* Ageism - the stereotyping, prejudice and discrimination towards people because of their age - pervasive before the pandemic and a risk factor for violence against older people, has worsened during this pandemic. For those women already in abusive situations, gender inequalities and prolonged exposure to their abusers increases the risks of genderbased violence against older women.

What can be done to address violence against older people during the COVID-19 response* Governments and policy makers should:
	+ Create awareness of increased risk of violence against older people in the public and provide information via radio, TV, print media, and the internet on how victims can seek help and receive support safely.
	+ Work with essential services such as grocery stores or pharmacies to display information about violence, existing services, and reporting mechanisms.
	+ Maintain national helplines for violence against older people or, where they don’t exist, seek to extend helplines for violence against women and/or against children to cover violence against older people.
	+ Where movement is restricted, allow older people to leave their place of residence in the case of violence.
	+ Alert older people and trusted others to the main types of financial scams being perpetrated and provide information on how to avoid them and what to do if targeted e.g. putting phone down/deleting emails or seeking advice from a trusted other before responding.
	+ Collaborate with other sectors to address violence against older people, such as criminal justice, health, and social services by setting up virtual multidisciplinary teams that can provide coordinated consistent support.
	+ Increase awareness of violence against older people among community workers and volunteers dealing with COVID-19 and train them to identify and respond to it.
* Health care and COVID-19 testing facilities should:
	+ Provide information about local services (e.g. helplines, counselling services, adult protective services) for victims of violence against older people, including opening hours, contact details, whether available remotely, and referral pathways.
* Health providers and social services should:
	+ Watch for/be alert to objective signs of elder abuse.
	+ Provide information, support and, if possible, respite care to caregivers, particularly those caring for older people with dementia, including about how to manage stress, to reduce the likelihood of violence.
	+ Be aware of the risks and health consequences of violence against older people and offer support and medical treatment to those who disclose violence.
* Residential and nursing facilities for older people should:
	+ Be more closely monitored by relevant authorities; facilitate residents’ contact with family and friends by phone, internet, or via written messages if access is restricted; review staffing procedures (e.g. flexible schedules, work breaks) to better manage the burden of care; and seek to prevent the use of physical restraints.
	+ Provide guidance and a checklist to help family members and older adults to make decisions about whether to leave residential and nursing facilities.
* Community members should:
	+ Keep in touch and encourage others (family members, friends, neighbours) to keep in touch with older people online or by ‘phone to reduce social isolation and to provide support safely to those subjected to violence.
* Older people experiencing violence may:
	+ Find it helpful to reach out to supportive family and friends, obtain support from a helpline (including how to access emergency services), or seek out local services for victims.
 |  |