Aging population and mental health vulnerability during COVID-19 in South America

Envelhecimento populacional e saúde mental Vulnerabilidade durante a COVID-19 na América do Sul

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ABSTRACT
The new coronavirus disease 2019 (COVID-19) pandemic has caused a significant impact on mental health worldwide. In South America, COVID-19 has imposed an alarming effect, being the stage of political scandals and the dangerous covid-kit panacea therapy. The objective of the present opinion paper is to give an overview of the impact of COVID-19 on some South American countries, identifying the vulnerabilities and possible areas of improvement to attend fragile senior citizens. We have examined the potential risk factors for this aging group and current programs to prevent mental health related-problems (social, financial, familiar) that were developed during the pandemic. Moreover, we were able to investigate the possible ways to contribute with local and as well regional interventions, that could positively influence the families of the elderly affected by COVID-19.

Keywords: pandemic, global health, mental health, risk group, aging population, south america.
INTRODUCTION

The emergency of the novel coronavirus disease 2019 (COVID-19) as a global pandemic has triggered the necessity of social – environment – health – and economy attitudes in most countries (Wang et al. 2020). The COVID-19 was reported to have already attracted more global discussion and pandemic uncertainty compared to SARS (2002–2003), Avian flu (2003–2009), Swine flu (2009–2010), and Ebola (2014–2016) since 1996 (Ahir et al., 2018). Surprisingly, this is the first time in history that a coronavirus has generated a global pandemic, making COVID-19 a public health enemy that poses severe threats to the life in society because of its effects on health, environmental, local, and national economies in overwhelming different conditions and intensities. In South America, COVID-19 had a major damaging effect with an escalating number of cases, such as in major cities like Manaus, in Brazil that had peaks of 200 death/day.

Regrettably, the Amazon region was also at the stage of immoral political decisions supporting the dangerous use of the covid-kit therapy (Molento, 2020; 2021a). It was not surprising that soon after the continuous use of the unproven drugs, ivermectin patients started to show serious hepatic intoxication. The “protected” people were the most exposed COVID-19 patients in our crowded Intensive Care Units. The consequences of the overuse of ivermectin and most of the other medications, including chloroquine and azithromycin will still be measured in humans, with a damaging long-term impact on the environment (Molento, 2021b).

However, in the actual pandemic scenario, some societal problems have been more dominant by the press and governments all over the world. One disturbing example is the mental health subject and its problem among ages in all countries (World Health Organization [WHO], 2021a; 2021b). The World Health Organization, WHO, has indicated that there are large gaps in public policies that do not attend everyone's mental health condition. The WHO has also reported that there is an increased demand for mental health-related services due to COVID-19 psychosocial effects (WHO, 2020c). As observed, people have experienced
events of anxiety, depression, and post-traumatic stress during and after the 2020-2021 isolation years. Yet, those who have contracted the disease or recovered from the COVID-19 have witnessed times of neurocognitive difficulties and disillusionment. Kathirvel (2020) reported that the suicide rate due to high unemployment in the post-COVID-19 pandemic may be compared to the suicide rate during the post-global economy recession in 2008.

One of the layers that we can identify amid the different shades of mental health vulnerability is when we look at age differences. Different concerns and consequences of the pandemic damage apply to the older population. Firstly, because people above 60 years old are the most injured group by the virus (Lloyd-Sherlock, 2020), and also because this group belongs to a different generation, already disregarded by western countries, their own families and some authorities (Luanaigh & Lawlor, 2008). For all these reasons, this opinion article was conceived to approach mental health problems during the COVID-19 pandemic within the oldest groups in South America. The present group of authors are from different professional areas and backgrounds from Brazil, Chile, Colombia, and Argentina, and have worked together to discuss Global Health and Global Welfare issues. We have selected this part of the world to use our regional lenses to look at how the region and its population have dealt with this undeniable problem during the hard times of the COVID-19 pandemic. We consider that it is imperative to keep an eagle eye and look for social and individual issues deeply affected by the COVID-19 and to provoke reflexive thoughts about them. Some institutions in our contemporary South American society are trying to raise awareness about the challenges of this high-risk group of people, even though people of all ages were highly vulnerable developing mental health problems, suffering the burdens of the COVID-19.

2 GLOBAL HEALTH: AN OVERVIEW OF COVID-19, AGING AND MENTAL HEALTH

The development of COVID-19 started in December 2019 with the report made by the WHO of the first confirmed case (WHO, 2020a). In the first half of 2020, WHO upgraded the level of the disease, declaring the occurrence of COVID-19 from a public health emergency of international concern to a pandemic,
recognizing that the disease had spread to more than 100 countries (WHO, 2020b). During the last 18 months of the pandemic, several measures have been put in place to curb the spread of COVID-19, such as containment measures, including 2-week quarantine for positive cases with or without symptoms, strict travel bans and border restrictions, social distance in all public occasions, and full and partial lockdown with the closing of public places, as well as the cancellation of all public events (Gautam & Hens, 2020). Currently, mortality indicators specific to COVID-19 show the impact that the disease has had to the South America’s population (Table 1).

Having seen the data, it is obvious that the intensity of COVID-19 has affected global economic development, resulting in several fiscal measures, monetary policies, and private sector burden, which was shared across countries (Elgin et al. 2020). The economy response policy was used for social intervention programs such as social assistance, social insurance, and support labor and local markets (Gentilini et al., 2020). Furthermore, many measures were put in place to support health systems that were instituted across countries to respond to the pandemic. For example, in some countries, a part of the health budget was designated to provide monetary incentives to hospitals, temporary hospital camps, and adapted emergency care units. The announced of this funding was necessary to ensure adequate equipment and provided timely care to face the hard contingency period. In addition, emergency laws have been passed to promote the coordination between public and private health networks, with large donation campaigns to help contain the spread of the disease alleviating the suffering, establishing fines for commercial entities that fail to comply with health safety measures (Sarkodie & Owusu, 2020a; 2020b).
In terms of health policy enhancement, there has been an acceleration in research and development for vaccines and treatment across countries (Organization for Economic Co-operation and Development [OECD] 2020a; 2020b). Lately, while there was the widespread adoption of telemedicine and modern surveillance and tracking systems, mobilization and protection of healthcare professionals have also been improved (Australian Health Practitioner Regulation Agency [AHPRA], 2020). In the Dominican Republic, the government instituted a social policy of no cost for COVID-19 test for people older than 59 years, people with two or more health-related symptoms, and those with weak health conditions (Squire Patton Boggs, 2020). For its part, the protection of the elderly in the United Kingdom has been enhanced by multiple government strategies improving the availability, accessibility, and affordability of diagnostics and treatment (Sarkodie & Owusu, 2020a).

It is important to highlight that COVID-19 effects worsen in older people. Studies have shown that age is by far the strongest predictor of an infected person’s risk of dying from the infection. Also, getting COVID-19 is more than 50

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1 The case fatality rate (CFR) is the ratio between confirmed deaths and confirmed cases. The CFR is a commonly used estimate of the severity of an epidemic (Reed et al. 2013). Case fatality rates vary significantly between countries, factors such as the type of healthcare systems, patient characteristics or the prevalence of diagnostic tests may contribute to these differences (Kang & Jung 2020). It has been shown that the high COVID-19 case fatality among the elderly translates into a similarly high mortality rate at the population level (Yanez et al. 2020). Source: Our World in Data, 2021.

<table>
<thead>
<tr>
<th>Country</th>
<th>Cases per million</th>
<th>Deaths per million</th>
<th>Case Fatality Rate $^1$</th>
<th>World position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil</td>
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<td>2,645.65</td>
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<td>6,143.39</td>
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<tr>
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<td>2,062.21</td>
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<tr>
<td>World</td>
<td>46,978.73</td>
<td>717.55</td>
<td>1.53</td>
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</tr>
</tbody>
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1 The case fatality rate (CFR) is the ratio between confirmed deaths and confirmed cases. The CFR is a commonly used estimate of the severity of an epidemic (Reed et al. 2013). Case fatality rates vary significantly between countries, factors such as the type of healthcare systems, patient characteristics or the prevalence of diagnostic tests may contribute to these differences (Kang & Jung 2020). It has been shown that the high COVID-19 case fatality among the elderly translates into a similarly high mortality rate at the population level (Yanez et al. 2020). Source: Our World in Data, 2021.
times more likely to be fatal for a 60-year-old person than dying in a car accident (Mallapaty 2020). For this reason, it is noteworthy to those who want to discuss the COVID-19 pandemic to analyze this immense demographic difference of vulnerability that the disease brings with it.

2.1 AGING POPULATION

Aging is the natural course of someone’s life, but there is a multitude of facts to consider when talking about the aging of the human population. According to the WHO, the aging of the population is one of the greatest triumphs of humanity and yet also one of the major challenges to be faced by our societies (Miranda et al., 2016). Population aging must be considered as a worldwide condition but there are several cultural and economic measurements before jumping into global conclusions. The way people live, work and relate to their environment are determined by personal and local health conditions, which would reflect on how long the population will survive (Miranda et al., 2016).

Even inside the same city, life expectancy rates may vary according to income, social position, and cultural background. The main reason when thinking about longevity, authorities must look through the lens of equity (Shetty, 2012). Projections reveal that by 2050, 80% of the elderly population will be living in non-developed countries. Therefore, and considering that even in rich countries with strong health systems, growing old is not always an easy task due to the lack of independence, accessibility, and autonomy, while low and middle-income countries have a much bigger gap to fulfill (WHO, 2019).

Over the years, life expectancy has increased in many countries, mainly due to the reduction in infant mortality, but this does not mean that the number of years (young and adult) lived without disabilities measured in DALYs (daily disability-adjusted in living years) has been reduced. Globally, the mean total life expectancy is 69 years of age, while the healthy life expectancy is 62 years. Therefore, from this data a person is expected to live 7 years of his or her life in poor health conditions, requiring social attention (i.e. nutritional, emotional, and health) directly impacting the global welfare scenario. This situation varies from country to country, reaching worrying numbers. A wide difference can be observed between life expectancy and healthy life among rich and poor nations. In fact, according to the
International Center on Aging an adult in Japan at age 60 in 2019 would probably live 26 more years, but only 20 of those years were expected to be healthy. As in Afghanistan, a 60-year-old person is expected to live 16 more years, of which only 9 years would be in good health conditions (Cenie, 2021).

Global health needs to adapt to this demographic change, which can be observed as a significant increase in the percentage of elderly people. Moreover, we need to increase the healthy life expectancy and ensure successful aging in an overpopulated world. Lifestyle changes are mandatory nowadays, starting from regular physical activity, which may change the physiological and psychological relationship of aging, and eating habits, considering not only quality but also food and water security to the population. Moreover, meat consumption, single-use plastic, and industrial pollution are risk factors intimately connected to stress that must be correlated with the limiting conditions of aging populations and to the absolute safety of the world's population (United Nations, 2019). The arrival of the new generation of alternative protein; plant- and cell-based food will allow us to transition and reshape the entire farming systems and the food industry with healthier nutritional diets, respecting animal lives and helping to protect the environment (Willett et al., 2019; Herrero et al., 2020). Therefore, ensuring a better global welfare, in all its broad sense, including human and animal welfare, may assist our aging population in gaining more healthy years of life.

2.2 MENTAL HEALTH

The condition to determine mental health problems is variable, but it can be defined as a coupling of irritating or abnormal behavior and thoughts. These factors would directly contribute to a change in an individual's lifestyle, passing through personal and professional life conditions, which can be influenced by social and economic aspects of a country or society. A calculation done by the World Economic Forum (Broom, 2020) reported that between 2011 and 2030, mental illness would cost US$ 16 trillion in losses of economic output. A report from the WHO (2021a; 2021b) has also highlighted that for every US dollar spent on treating mental disorders, it returns US$ 5,00 in improved health and local product performance. In the UK, depression and anxiety already accounts for 44% of all cases of work-related illness and 54% of all workdays lost due to these illnesses.
in the population (Health and Safety Executive [HSE], 2020). In this context, it is notable that the challenges of mental disorders not only affect the psyche of the individuals but are also detrimental to the surrounding environment. Thus, mental health diseases must be dealt considering the significant social-economic impact that crosses geographical barriers, impacting all levels of development in low, middle, and high-income countries.

The WHO reported an increase demand for mental health-related services during the new pandemic (WHO, 2020c). COVID-19 has disrupted or halted critical mental health services in 93% of the countries worldwide (survey with 130 countries) (WHO, 2020c). The survey data provided the first global evaluation of the devastating impact of COVID-19 on access to mental health services, highlighting the urgent need to increase funding. The data covered before the pandemic was already showing a difficult situation. In the United States of America, for example, only two out of ten adults with common mental illness would be treated by a professional each year as the majority would be seen by Primary Health Care workers (Wenceslau & Ortega, 2015). In a much worse scenario, in low-income countries, more than 80% of the patients with mental health problems would receive no medical attention at all (Broom, 2020).

The inequality can be presented in many aspects, influencing the development and the impact to each country. Although depression affects people of all ages, from all lifestyles, the risk of becoming depressed is increased by poverty, abandonment, and unemployment. These categories are very common to the oldest populations in middle and low-income countries (WHO, 2018; VIJ, 2019). In this sense, it is conceivable to say that, the more socio-economic fragile conditions a country has, the more financial distress related to mental health care it will be. To illustrate, Roberts (2018) reported that 35 to 50% of people with several mental health disorders in the North hemisphere receive no treatment, but that figure increased to 76 to 85%, for people of the South part of the globe.

In the elderly population segment, mental problems are usually linked to symptoms of depression that have become an exacerbated risk because of the rapid transmission of COVID-19. As a consequence, the fear of getting infected and the data reporting higher death rates in elderly people caused even greater isolation (Mukhtar, 2020). The elderly population has one more aggravating factor,
which is to manage issues of digital services and differently from the young people, old folks do not have a great ability to work their situation and use virtual communication. Only a small part of the old population has access to internet services, which distances most of them from health services, filling reports, making appointments, amplifying even more their social isolation. This condition is been called "infodemic" by the WHO (Clark-Ginsberg & Petrun-Sayers, 2020).

Related to social vulnerability, we say that certain groups are vulnerable because of their disproportionate exposure to risk. In the pandemic context of COVID-19, the various facets of vulnerability have been shown to include the elderly, those with comorbidities, the homeless, the black and indigenous communities, and the socioeconomically groups in disadvantage (The Lancet, 2020). Still, many questions can be asked from the restraint measures practiced by nations around the world. i.e., Did the COVID-19 control measures intrinsically considered some of the most vulnerable groups? How did the "old and poor" societies would face the disease? Did the government measures have focus on a more holistic health approach, instead of focusing on only physical health? And lastly, How long will the collateral effects of the new coronavirus last to an individual or community?

3 FRAMEWORK AND LIMITATIONS TO CONFRONT COVID-19 IN SOUTH AMERICA

Responses to strengthen health systems and protect populations in South America followed a common pathway. Benítez et al. (2020) pointed out that some countries were challenged by the need of implementing containment and mitigation actions in an attempt to expand the operational capacity of hospital networks in Latin American. However, pre-pandemic conditions, like basic structural problems as the lack of potable water, sewage systems, etc., and fundamental policies were not considered for the effectiveness of active case-tracking and socioeconomic support government policies in vulnerable groups in South America and other countries at risk (Greer et al., 2021; Rocha et al. 2021; Ramírez de la Cruz et al., 2020).

Social and health policies were characterized, among other things, by the adoption of models from countries in North America and Europe, largely Italy,
Spain and the United Kingdom that had been facing the crisis, or from multilateral organizations (Antognini & Trebilcock, 2021). It should be noted that integrating methods at the different levels of territorial management may play an considerable role in resolving problematic needs and could reduce major crisis. Ramírez de la Cruz et al. (2020) stated that on the one hand, the subnational level provides favorable health conditions, while the national level stabilizes the course of the economy. In the following section, we will discuss the current framework of some countries to support health, the economy, and society, emphasizing their performance and policies for improving their population’s health and sustainability. For a better analysis of social and public health policy initiatives in South America, we will look at a few countries in the region.

3.1 BRAZIL

After the first report of COVID-19 as a Public Health Emergency of International Importance, Santos et al. (2021) affirmed that, in Brazil, the Federal Government has activated a multilateral ministerial executive group (GEI). In the pre-decisional demands, the GEI have evaluated, tracked, monitored, and discussed few mitigation strategies to disease contingency strategies. The same author reported the Federal Government presented the PCN ("Plano de Contingência Nacional"), proposing containment strategies for pandemic alleviation. The PCN was based on eight pillars: monitoring, laboratory support, assistance, pharmaceutical assistance, health surveillance, risk communication, and management (Santos et al. 2021). The decisions were taken as items of national importance that were applicable at the national level, focusing on maintaining, improving, and supporting the actions and the performance of the hospital systems, focusing on clinical emergencies.

In this sense, the actions to respond to the pandemic showed an ambivalent behavior (Santos et al. 2021; Rocha et al. 2021). On the one hand, a tendency to benefit from the reorganization and structuring of hospital processes, national coordination in terms of official communications, decentralized management concerning local laws, and state policies of social distancing. On the other hand, there were deficiencies in the program planning, the lack of perspective towards containment, the failure in the control and monitoring of resources allocated to
public health interventions. Although the infected/cases data was not always refined or assertive, appropriate mathematical models were established to estimate the cost-effective support for the health system that was refined every week.

This diversified management of the pandemic strongly affected the vulnerable population, increasing pre-existing socioeconomic inequities (Rocha et al., 2021). Santos et al. (2021) warned that the problem could persist due to the underfunding of health systems, health legislation, the insufficient number of professionals, and the privileges granted to the private sector. Furthermore, public risk communication by the Federal Government affected citizens' behavior due to the president's thoughtless support of unapproved treatments and interventions during COVID-19, conflating misinformation with disclosure of care (Molento 2021a; Rocha et al. 2021). Brazil has been presenting a consistent increase in life expectancy, despite deep social inequalities. The increase of health access to everyone, and the prevention and improvement of basic care health and care quality is noticeable (De Azeredo Passos, 2020). At the same time, in the last two years with the catastrophic Governmental management of the COVID-19 pandemic crisis, life expectancy in the country has been estimated to go as far back as twenty years in some states (i.e. Amazonas) (Castro, 2021).

Furthermore, Brazil is a country marked by racial disparities, which may reflect inequalities in life expectation, quality of life, and welfare within white, indigenous, black, and other minority populations (Oliveira et al, 2020). In this scenario, growing old in Brazil can have a few challenges when compared to other South American countries, such as the difficulty to maintain a stable social security system. At the same time, Brazil has the peculiarity of a continental non-developed country with an overcrowded and underfunded health care system. The parallels with other countries in South America include the difficulty of safe access to water, sanitation, and food (Pan American Health Organization, PAHO, 2020a). As a continental country, health access to populations living in rural areas of Brazil, similarly to rural communities and indigenous tribes is also quite a great challenge (Food and Agriculture Organization, FAO, 2019).
3.2 COLOMBIA

In Colombia, three types of measures were adopted to deal with the crisis: a) sanitation and sanitary emergency measures, b) social, economic, and ecological emergency measures, and c) public order measures and other ordinary strategies (Ministerio de Salud y Protección Social, 2020). The Ministry of Health and Social Protection, has issued a resolution "whereby mandatory health measures are adopted for the careful (preventive) isolation of the senior communities in long-stay housing and the partial closure of activities of life- and day-centers" to reduce the increasing impact on the most susceptible populations (Resolución 470, 2020). On the other hand, other measures were also approved, such as the approval of a law that would give a one-year grace period for payment of creditors, the suspension of evictions and the freezing of mortgage loan rates, as well as payment agreements; an expenditure close to US$ 40 million was reported to low-income families and some assistance conditions for student study payments (OECD 2020c).

The first preventive mandatory isolation was decreed from April 13th to 27th 2020, avoiding restricting the mobility of important labor subjects such as health personnel, among others, to prevent the spread of the pandemic (Decreto 531, 2020). However, the restrictive measures implemented have not been sufficient and in the current context, Colombian legislation have encountered some different barriers to effectively guarantee the rights it had granted (García-Echeverry et al. 2020). Thus, different situations have shown in the Colombian context the same conditions suffered by most Latin American countries, resulting from a chronic state of inequity.

The inequality in the quality of healthcare in the different regions of the country was exacerbated during the pandemic, and has been seen in the lack of biomedical equipment and trained human talent in the most vulnerable areas (Acosta, 2014); in health professionals with harmful, discontinuous types of labor, contractors and postponed bills (Colegio Médico Colombiano, 2019), and the long-standing corrupt practices in the management of the funding allocated for pandemic materials (Arévalo & García, 2020). All these led to a situation in which there was also the contradiction that, in a context of structural inequity, institutions and health workers were demanded to fairly settle decisions on the allocation of
In addition to the difficulty in the care of the most serious patients in the most remote regions of the country, the measures implemented have generated delays in the timely care of patients with conditions other than COVID-19 and the inefficiency of the state response for risk management and the development of containment and mitigation strategies for indigenous peoples, Afro-descendants and other widely marginalized populations, without ignoring the risk involved for the elderly populations due to their comorbidities. It should be noted that 13.5% of the Colombian population is over 60 years of age (Cubillos et al. 2020).

The health crisis is also framed in situations of violence that remained latent or were already rooted in society, reflected in the social commotion due to confrontations between civilians and state forces with numerous deaths and injuries, as well as in the increase of cases of family-related violence, which should also be understand as a condition of mental health effect for the elderly. In the first two weeks of quarantine calls to Colombia’s domestic violence helpline increased by 130% (OECD 2020c). According to the latest SABE-Colombia survey, 12.9% of elderly people have reported having suffered some psychological, physical, financial, and/or sexual abuse. This is a very important rate with increasing incidence in women, at aging people, low socioeconomic groups and rural communities (Ministerio de Salud y Protección Social, 2018).

3.3 ARGENTINA

In Argentina, the first recorded case of COVID-19 was in March 2020 and emerged in a complex context due to the monetary recession and the succeeding government. On the one hand, Frers et al. (2020, p. 21) stated that the Argentine economy had serious aggravating factors such as hyperinflationary indexes, the exacerbation of poverty, and the increase in foreign debt. On the other hand, Ramírez de la Cruz et al. (2020) recorded that nearly 2000 localities and 21 provinces elected new governors, so the governments were still setting up with the duties. Likewise, the Federal government faced difficulties in recentralizing the decisive process over national power. Ramírez de la Cruz (2020) points out that subnational autonomy prevails in Argentina and this condition does not cover the
inefficiencies of the multi-governmental working groups for the development of health and social laws that could contribute to the protection of a larger population.

According to Ramírez de la Cruz et al. (2020), it is possible to state that the Argentinean municipalities focused their work plans on psychosocial care measures, income maintenance, and business cooperation. In this way, the local authorities promoted the development of call centers for psychosocial care in mental health and domestic violence. Special credit lines were made available for the refinancing of organizations, subsidies were provided for companies whose profits were reduced to a minimum, and subsidies were also given to the most affected households (Ramírez de la Cruz et al., 2020).

Regarding the maintenance of the health system, Ramírez de la Cruz et al. (2020) assert that an arsenal of preventive COVID-19 measures was deployed by the State. These measures had the focus of giving free cleaning and disinfection products, providing disinfection areas for surfaces and vehicles, preparation of isolation areas and expansion of cemetery capacity, construction of modular temporary hospitals, and increasing intensive care and intermediate care beds. Despite these preventive measures, jurisdictional problems of the applicability of mitigation and containment policies coexisted with informal mechanisms for social sustainability. Thus, a network of volunteers participated in the provision of food and medicines to the elderly population in Argentina (Ramírez de la Cruz et al., 2020). It should be noted that, although the measures helped to mitigate the alarming effects of the pandemic, Ochoa and Albornoz (2022) reported that vaccination has not reached sufficient high levels of coverage worldwide.

In South America, Argentina is one of the countries along with Chile that has the oldest population, although it will soon be overtaken by Brazil. It has been projected that by the year 2050 when Argentina will have 50 million inhabitants, 1 in 5 Argentineans will reach 64 years old or approximately 10 million people (Regazzoni, 2010).

3.4 CHILE

Since COVID-19 arrived, the government presented in March 2020 an Economic Emergency Plan that committed an investment of US$ 11.750 million to support businesses and households facing the negative impact of the pandemic.
The measures provided for the emergency under COVID-19 were mostly of a subsidiary nature with a predominance of the private sector and focused coverage where the State's attention was centered mostly only on the most vulnerable population (Antognini & Trebilcock, 2021). The main axes of the emergency plan were: (a) to reinforce the health system's budget under the constitutional 2% to meet the urgent expenses, (b) to ensure the income of workers, through the access of contributory workers to their resources from unemployment insurance, and the delivery of a monetary transfer (Bono Covid 19) to lower-income households and informal workers, which was aimed at 2 million people with an expenditure of US$130 million, and c) the third axis, aimed at small and medium-sized companies, considered tax measures, including deferrals of tax payments such as monthly provisional payments, corporate income tax, and contributions, among others (Gobierno de Chile, 2020).

One of the most controversial policies was the policy called Labor Protection Law (Law 21.227 of April 6, 2020) aimed at workers governed by the Labor Code and affiliated to the unemployment insurance, which considered the temporary suspension of the effects and obligations of the employment contract, i.e., the worker was not obliged to provide services and the employer was not obliged to pay the respective remuneration (Antognini & Trebilcock, 2021). This strategy was strongly criticized by opposition sectors of the government, mainly because of the use of unemployment insurance funds to supplement the income of workers who, due to the health emergency, had to remain at home without the possibility of performing work remotely, as the elders (Antognini & Trebilcock, 2021).

In addition, the dynamic lockdown, based on circulation restrictions were applied as a containment measure in some neighborhoods, based on the rate of spread, rather than in entire municipalities, which was considered a complete failure and it contrasted with the violence of the armed forces in the streets. The aim was alleged to prevent disease circulation and looting, but it blocked the mounting wave of political protests (Peres & Cardoso, 2021). The reduced adherence to group or individual isolation, as people were required to keep working (Julian, 2020), combined with less than sufficient consumables of new rooms for hospitalization for COVID-19 and other diseases, resulted in the failure of hospitals with a consequent increase in the death rate, the fact that experts had been alerting
even before (Bacigalupe et al., 2020). The major effects were the increase in the percentage of poverty and informal jobs and settlements that increased > 70% since the year before (Fundación Vivienda & Centro de Estudios Socioterritoriales, 2021).

The mental health situation for the elderly is highly affected by the characteristics of this complex social and political context that has been put in practice since before the pandemic. This is as evidenced by the results of the Fifth National Survey of Quality of Life in Old Age (Pontificia Universidad Católica de Chile & Caja Los Andes, 2020), which indicate a setback in the indicators compared to 2016, particularly shows that the conditions of Chile should advocate to secure good aging, must be deeply discussed. Thus, regarding concerns, older people having to depend on someone else and becoming seriously ill obtained the highest levels, similar to previous years, but also increases the concern about the own illness and not having enough income. Perceptions of loneliness also increased slightly. Several activities were already badly impacting this population in 2019, both indoors (reading, listening to the radio, watching tv, etc) and outdoors (workshops, visits) events that focused by this population. Participation in any type of social organization also declined (Pontificia Universidad Católica de Chile & Caja Los Andes, 2020).

In Chile, according to the National Institute of Statistics in 2017, there were approximately 2 million people older than 65 years old. This figure represents more than 11% of the population. The progressions are that by 2035, this number is expected to reach 18%. A study in the COVID-19 scenario between May 30 and June 10, 2020, conducted by Duarte and Jimenez-Molina (2021) with a significant sample of 1078 people who participated in a telephone survey, revealed that in the case of people older than 60 years of age, the expectation of reduced or no income was the variable with the most important association with social and psychological distress. Chile has also been developing policies to assist the elderly for the last two decades, and in 2002 the country created the National Service for the Elderly. The mission of this program was to promote and contribute to positive aging through the implementation of policies and programs, fostering the articulation of intersectoral and public-private partnerships (Gobierno de Chile, n. d.).
3.5 PERU

With its first confirmed case on March 6, 2020, an inflexible quarantine policy was initially established with armed forces barriers between municipalities, police patrols, mandatory use of masks, the establishment of fines, closure of economic activities except those related to food, and gender-specific days for the population to leave the house to buy goods or essential services (Peres & Cardoso, 2021). This last measure was eliminated after one week for being counterproductive (Gonzales-Castillo et al., 2020). Similar to other Latin American countries, such measures have generated high social costs (mental illness, family violence, child abuse, femicide, depression) and economic damages (unemployment, poverty, loss of income, business insolvency), due to the previous existence of struggled health and solid political power, such as insufficient national services and a hopeless civil society (Gonzales-Castillo et al., 2020).

Peru’s economic activity has a productive structure that represents more than 50% of the GDP, and 70% of the economically active population is composed of informal workers who live on income generated only by their work and do not count on social benefits. These structural characteristics allow us to understand the behavior of a large mass of the population that did not adhere to the containment protocols, putting their lives at risk for their own survival and their families. At the same time, this transgression of norms could be explained by the diversity of ethnic groups with low level of social identification, and different communal behavior in comparison with high income and more homogeneous countries (Gonzales-Castillo et al., 2020). Regarding the health sector, all these measures have not been enough to mitigate its collapse. This was evident due to the deterioration of their system in which historically the State has not fulfilled its function of offering a good quality of public service on health and education.

Regarding the population of older adults, the articulated actions of the country’s public management were aimed at safeguarding their health, withdrawing them to the private sphere. Many of them were put in rest homes or shelters that provide protection services, some in pensions mixed with other age groups, yet most of them kept their physical activities and work. The need for the actual identification and location of this population was also a major problem to improve help during the COVID-19 alarming situation in 2020 (Llerena & Sánchez,
In addition, it is worth mentioning that there was a clear lack of coordination between national and regional authorities (Schwalb & Seas, 2021), and, as a consequence, the population found some peculiar ways to fight the virus. Among these were the use of ineffective drugs such as hydroxychloroquine and ivermectin, which were easily bought in drugstores without a prescription, affecting the elderly much more because of the need for official preconditions (Schwalb & Seas 2021; Molento, 2020; Peres & Cardoso, 2021).

3.6 BOLIVIA

Like other Latin American countries already addressed in the paragraphs above, during 2020, Bolivia was simultaneously facing a series of political, economic, and public health crises (Borges, 2021). However, despite this context and being one of the poorest countries in Latin America, in response to COVID-19 Bolivia has managed better than other health systems in the region and offered insights regarding the implementation of subnational non-pharmaceutical interventions and support for workers without social protection (Hummel et al., 2021).

After the first case of COVID-19 was confirmed in the country on March 10th, 2020, the government quickly decreed a national quarantine (the violation of which could lead to imprisonment for eight hours), limiting public and private transportation schedules, establishing specific opening hours for essential services with use limited to one person per family according to the ending of the ID card number and only persons between 18 and 65 years of age. Subsequently, the government prohibited the suspension of services such as water, electricity, and internet for non-payment, and reduced electricity tariffs (Peres & Cardoso, 2021; Wanderley et al., 2020). These initial measures were important to mitigate contagions, however, the labor situation of the Bolivians, that have a large rate of informal jobs (>70%), made strict isolation very difficult to achieve (Hummel et al., 2021). COVID-19 cases were concentrated in these informal workplaces. In Cochabamba, market and transport workers and their families accounted for 40-50% of positive cases, despite very low testing on these groups (Aruquipa, 2020; Hummel et al., 2021).
Additionally, the underfunded and decentralized Bolivian Health system was severely lacking in areas of particular relevance to COVID-19. Bolivia has had the lowest relative level of ICU beds per 100,000 population in Latin America (PAHO, 2020). The government borrowed large sums of money from multilateral banks to purchase the necessary equipment, but the lack of transparency in the locating process started a series of corruption outrages that steered the arrest of high-level public health officials (Chuqimia, 2020). Social actions were offered within the package of the country's previously existing international cash transfer for the elderly, school children, and pregnant mothers. These programs were the very base for the "bonos", which were important and successful components of the government's strategies. Thus, cash transfers help, a legacy of > 14 years of the Movement Toward Socialism, worked extremely well (Borges, 2021). So, the "Renta Dignidad / Honorable fund", that covered a monthly payment of BO$ 350 or almost US$ 51 to every citizen over 60 years of age, regardless of their income, certified Bolivia's important cash-transfer decision (Anria & Niedzwiecki, 2015).

These procedures, which were preceded on a relatively short financial freeze, proved unsatisfactory as the disease dragged on. The country's deep administrative division and pending election prevented the administrative and the government from agreeing on an urgently needed second round of relief during the middle of 2020 (Borges, 2021). On the other hand, although the most successful strategy was the programs representing a policy to fight poverty, electronic distribution of vouchers was impossible. Most benefits were collected in person and crowds formed at the distribution sites, making the absence of strict social distancing protocols increase the health risk (Hummel et al., 2021).

3.7 PARAGUAY

Paraguay registered its first case on March 4th, 2020, and, similarly to the neighbors Argentina and Uruguay, after just a few days, the government decided to implement the first health measures. A strict policy was established regarding the closure of educational institutions and workplaces, public events were suspended, and public transportation and mobilization within the country were limited. These strategies were complemented with a strong contact of policymakers over the internet.
The population of Paraguay is represented by young people, and its geographic borders are difficult to cross, which also had influenced the slow rate of new cases. This means that although Paraguay recorded the first infection almost at the same time as other countries in the region, the infection/positive curve kept stable and low for longer periods. The economic compensation policy, in this case, has been similar to that of Argentina and Uruguay. Contrary to other countries, Paraguay first made a compensation of less than or equal to 50% of their national salary, keeping the same price for water and electricity, delaying business/monetary obligations (Ratto & Azerrat, 2021). Social measures implemented for the most vulnerable population included the allocation of approximately US$ 72.00 to more than 28,000 low-income inhabitants to provide economic support. Later, the allocation of the third wave of subsidy payments started with a US$100 million emergency social welfare program, the disbursement of US$100 million to 1.2 million given to informal workers; the allocation of US$100 million to private hospitals, US$20 million for the elderly and US$10 million to 160,000 low-income families, among others (OECD 2020c).

3.8 URUGUAY

On March 14th the first case of COVID-19 was identified in Uruguay. It had been 12 days since a new presidency had assumed the power, initiating a new political party from that of the last 15 years. The president, Ms. Lacalle proposed to move towards new normality based on four pillars: progressiveness, regulation, monitoring, and evidence (Nieves, 2021). It was within this context that a series of containment policies similar to those of other Latin American countries were implemented at an early stage to mitigate contagion within the framework of the declaration of a health emergency (Nieves, 2021). As a result, during 2020, while many countries were overwhelmed by the pandemic, Uruguay was the country with the best epidemiological level in the region (Ratto & Azerrat, 2021).

The main strategy that was implemented by Uruguayan authorities was the closure of educational institutions between March, April, and May of 2019, with flexibility in June. There was a stringent policy regarding restricting public events, however, meetings were not prohibited. The experts’ attention was drawn by the fact that a flattening of the curve was achieved without resorting to mandatory
preventive confinement and, at the initial moment of the opening of economic activities, there was no generalized outbreak of the virus, as had occurred in other bordering countries. As of June 15th, Uruguay had only 848 accumulated cases, 34 active cases, and 23 deaths. In the health context, there was a strong communication policy on health policies, supporting communal obligation and personal awareness, achieving a high positive adoption by the entire population (Ratto & Azerrat, 2021). Additionally, an intense testing program for symptomatic people was carried out, researchers developed testing kits so as not to depend on those sent by other countries. Thanks to those measurements the country was able to break the chains of transmission before it could grow exponentially (Taylor, 2021). In terms of social policies, Uruguay was the fastest responder among Latin American countries, and four days after the first case was identified, it carried out a reimbursement of half of the salary or a reduction of wages and a general freeze of tariffs and regular bills (Ratto & Azerrat, 2021). In the first days after COVID-19 was really confirmed, the government of Uruguay announced the "Coronavirus Fund", a finance plan to battle against the COVID-19.

It is worth mentioning that among the pre-existing conditions before the pandemic, Uruguay had an informality rate of 25%, one of the lowest, along with Chile, among the countries in the region (OECD 2020c). It was also one of the countries with more hospital beds per inhabitant, which according to experts was considered a favorable predictor for achieving a better ratio between the number of infections and their lethality (Fernández, 2021), which justifies the fact that, even with voluntary quarantine, Uruguay managed to have the lowest number of deaths from COVID-19 per million people despite having the highest rate of infections per million (Ritchie et al., 2020). Once considered a global model for how to respond to the COVID-19 pandemic, since early 2021, Uruguay evidenced loss of control of the virus and was one of several countries that struggle to control an upsurge of infections. Uruguayan scientists blame a mixture of lax measures and overconfidence in the successful course the pandemic had taken in the country, as well as the challenges posed by SARS-CoV-2 variants especially transmissible in hard-to-control areas such as the bi-national borders with Brazil and the borders with Argentina. However, although Uruguay was one of the last countries in Latin America to receive its first vaccines, the process began on March 1, 2021 and after
a short time, the disease rebounded in the country with the second-fastest
vaccination program in the region (Taylor, 2021).

4 OTHER SOUTH AMERICAN COUNTRIES AND THEIR SITUATION OF
VULNERABILITY

COVID-19 has caused a major impact in Ecuador, Venezuela, Guyana, Suriname, and French Guiana as well with somewhat similar emergency official plans. In most countries, politics has been playing a central role in the pandemic, causing more damage than bringing relief to the populations. The fact that governments have allowed a fast-tract cash flow to buy tons of hospital disposables and very expensive equipment have legitimate major irregular operations. To make matters worse, some of these countries do not produce medicines or basic consumable supplies, therefore, they had to wait until some would be available for shipping or adapt local conditions. Even vaccination took longer in some places in South America, due to the lack of political priority and corruption by central governments.

5 CONCLUSIONS

The biodiversity that inhabits earth is being framed and heavily damaged by humankind in the search of the never-reaching progress or simply by ways of survival in some places. These changes have a deep root affecting Global Health and Global Welfare, impacting community safety and animal and human lives. We are also immersed in social media, which has the power of invading our private life, causing an involuntary phenomenon of comparison of one another with an inevitable social crash. Nowadays, the many new fields of study and work require us to be extremely specialized and efficient, being greatly dependent on internet access. Plus, the need to be always the best person/professional brought an eternal and exhausting search for self-improvement, producing a machine way of thinking. These and other Western characteristics create an almost impossible target to young individuals, who mostly need to pay their monthly bills with no extra dream. We are also seen that it has been difficult to overcome alone such a powerful economic and cultural structure, being hard to break the cycle (Held et al., 2008; Chakravartty & Silva, 2012).
Although the proposals to solve mental health problems are available in several ILO and WHO documents, it depends a lot on local and national (health, education, housing) infrastructure and communal support. The person is advised to do meditation, look for friendship bonds, find a new job, search for a therapist, exercise regularly, and limit his/her social media time, for example (WHO, 2019). However, when thinking structurally in our society, most of these suggestions are far from being accessible to the regular person, particularly to the elderly. Therefore, aging in low-income countries is a very hard condition with multiple layers of social, cultural and financial difficulties.

According to Byung Chul Han (2018; 2021), people nowadays are losing their sense of community and familyhood. The arguments by the author are that individualistic prospects and efficiency are considered the most valuable things in our modern society, which makes us more isolated from each other as competition matters. Moreover, in his last book “The Palliative Society: Pain Today”, Ms. Han discusses that humans do not know how to address sadness anymore, once everything valuable in our society is related to egotistical happiness and anesthetic fun. It is important to highlight that it is impossible to fix physical health without also treating mental health (Kolappa et al., 2013). Moreover, this complex situation makes mental health even more dangerous because people usually suffer a lot without admitting to being called weak or a failure (looser).

For all of this, we as humanity, need to reaffirm community and civil society proactive participation to think collectively for the sake of us all. Initiatives that have been described in South America showed that governments, although in serious economic difficulties, went beyond individualistic plants taking important actions to help communities in need, acting ethically (most of the time), during such difficult times. We need institutions that secure healthy aging, and prepared the entire community for this inexorable situation, adapting cities to the increase in the elderly population. Moreover, there are essential aspects that must be better covered, such as improving the accessibility of buildings, streets, and buses to ensure free movement to people with reduced mobility.

It would be vital that wealthier countries provide assistance and resources to developing nations, as a way to reach the goal of economic and social equity, relieving possible injustice. We still have a large number of vulnerable nations and
groups that need mental and social attention, such as political and war refugees, among others. In the last years, refugees represented a population of approximately 82 million people, according to the International Migration Crisis (UNHCR, 2020). The experience of being forcibly displaced due to natural disasters, religious, political, or war threats, worsens not only mental health, but general health, and security all over the globe. The aging population will suffer the most in situations such as refugee camps having the highest death rate.

Also, the gap that exists around mental health issues is complex and reflects our multilateral societies. One of the most important gaps is related to the lack of strategic methods for measuring the quality of mental health care, which makes it more difficult to improve health systems. Once this information is available, it would be easier to assess whether the patient improved with the purpose, if necessary, of new planning in care or adjustments in treatment options. To help solve some of these problems, a few countries have adopted ways of collecting data to measure and improve the quality of mental health care (WHO, 2021b).

Good living means different things among different nations and citizens within cities. Aging during COVID-19 is being looked like a terrible situation, but most of it, it is regarded as a cry from a silent community. The elderly people that are living in isolation due to the much higher risk of infection, accepting the social distance recommendations, do not have an active voice. These people are responsibly assuming their individual condition and are seriously struggling during this period. Facing the scenario of population aging, it is indispensable to consider a safe epidemiological age transition that will imply in a greater demand for health services for the elderly. The main challenges now are to establish strategies aimed at reducing the risk for chronic non-communicable diseases. It is also essential that countries achieve greater equity in health care, reduce health, social and economic disparities, for older people in particular. This is the responsibility of everyone in every country, all around the world.
REFERENCES


Gobierno de Chile. (2020, March 19). Presidente Piñera Anunció Un Plan De Emergencia Económica Para Proteger Los Ingresos Laborales, El Empleo Y Las


Han, B. (2018). La sociedad del cansancio. HERDER.


