# Vulnerability of institutionalized older people and social support in the perspective of the COVID-19 pandemic

Andiara Araújo Cunegundes de Brito[1]
Jennifer do Vale e Silva[1]
Júlia Maria Fernandes Holanda[1]
Ryssia Raynalle Magalhães Nogueira de Souza[1]
Tamires Carneiro de Oliveira Mendes[2]
Kenio Costa Lima[2]

## Abstract

*Objective:* Discuss covid-19 prevention measures in the context of the vulnerability of institutionalized elderly people and analyze the social support offered to Long Stay Institutions for the Elderly during the pandemic. *Method:* Qualitative research carried out with workers from 24 philanthropic institutions in Rio Grande do Norte. The concepts of vulnerability in health and social support supported the organization and discussion of data submitted to thematic analysis. *Results:* The institutions partially adopted the prevention measures recommended by the National Health Surveillance Agency, in evidence: cancellation of visits, use of Personal Protective Equipment and cleaning of environments. For the most part, institutions prioritized the control of viral transmission, putting the reduction of socio-psychological impacts related to social distancing and isolation in the background. Measures not recommended and without scientific evidence were observed, such as the use of ivermectin. Also, the performance of social assistance and health networks was carried out in a more integrated way, improving the social support offered to institutions in the perspective of the pandemic. The Unified Health System stood out for its sanitary recommendations, supply of supplies and attention from the Family Health Strategy, while the Unified Social Assistance System acted in a less expressive way. *Conclusion:* In general, the measures adopted were insufficient to prevent covid-19 in view of the susceptibilities of institutionalized elderly people. Although the pandemic has expanded the social support network and the visibility of Long-Stay Institutions for the Elderly, greater investments by the government are necessary to effectively reduce the vulnerability of these elderly people.

**Keywords:** Coronavirus Infections. Health Vulnerability. Social Support. Health of the elderly. Long-Stay Institution for the Elderly.

[1] Universidade Federal Rural do Semi-Árido (UFERSA), Centro de Ciências Biológicas e da Saúde, Departamento de Ciências da Saúde, Curso de Medicina. Mossoró, RN, Brasil.

[2] Universidade Federal do Rio Grande do Norte (UFRN), Centro de Ciências da Saúde, Departamento de Odontologia, Instituto do Envelhecer. Natal, RN, Brasil.

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Correspondence
Andiara Araújo Cunegundes de Brito
andiara_acm@hotmail.com

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## INTRODUCTION

In the context of the COVID-19 pandemic, a disease declared a Public Health Emergency of International Concern[1], people over 60 years of age represent one of the highest risk groups for the most severe forms of the disease, hospitalizations and deaths[2-4] due to the presence of comorbidities and weaknesses in the immune response[2-3]. In Brazil, two years into the pandemic, epidemiological data indicate that approximately 75% of deaths from COVID-19 were older people[5].

The numbers are even more expressive when it comes to institutionalized older people. Data from 21 countries in North America, Asia, Europe and Oceania account for 421,959 deaths by February 2022[6]. A study carried out in Long Term Institutions for Older People (LTIE) in 14 Brazilian states, involving almost 60,000 older residents, found that in the first six months into the pandemic, the incidence of the disease in the institutions was 6.57% and the lethality was 22.44%[7].

Given the above and the recommendations for social distancing and isolation introduced by COVID-19[8], measures to control the transmission of the virus and strategies aimed at mitigating the social and psychological impacts of the disease become indispensable for the protection of health and quality of life[9-10] of older people. In this sense, the conceptual foundations of vulnerability in health and social support are relevant, as they help to understand how relationships are established between institutionalized older people, the LTIE and society to produce measures to cope with the pandemic. In addition, these relationships adapt to the promotion of security and dynamic social exchanges, valuing the potential of older people and strengthening their contributions to the environment in which they live.

Aging, a continuous process of individual development, increases vulnerability in health due to organic, functional and psychological changes, which involve individual and social aspects that influence the way of living[11]. Understanding this vulnerability in old age is important to understand the social effects of loneliness, exclusion and prejudice, as well as to measure quality of life and susceptibility to illness or disease[12]. In this way, protecting the health of institutionalized older people during the COVID-19 pandemic goes beyond belonging or not to risk groups, and can be expanded when situations of vulnerability are considered in three dimensions: individual, social and programmatic[13].

In relation to the individual dimension, the physiological aspects, the way of life and the motivation of the older person are considered to understand the illness and the control of its determinants. The social dimension points out the sociocultural aspects and the political, economic and accessibility conditions of the older person. And, the programmatic dimension refers to the systematic efforts that public authorities and social institutions make to stimulate transformations in the performance of care[13].

The concept of social support is also considered essential because it refers to a type of interaction, expressive or instrumental[14], in which the subject feels valued, cared for and part of a wide support network, which is formed by the relationships of trust, community support and civil society, as well as public institutions and services[14-15]. Social support is, therefore, a construct that satisfies the subject's daily needs[16], minimizes the effects of stressors in crisis situations and also provides benefits for people's daily lives[14-15].

Therefore, we bet on the articulation of these two concepts with the aim of discussing COVID-19 prevention measures in the context of the vulnerability of institutionalized older people and analyzing the social support offered to Long Term Institutions for Older People during the pandemic.

## METHOD

With a descriptive, exploratory and qualitative approach, this research was carried out by intentional sampling, considering all LTIE of a philanthropic nature in the State of RN, registered in the Unified Social Assistance System (SUAS) and/or recognized by the Health Surveillance.

Data collection took place in June 2020, during the COVID-19 pandemic. The LTIEs were clarified

about the purpose of the research and received the semi-structured questionnaire by institutional e-mails and also by the personal and/or institutional telephone of managers and technical managers. The institutions were instructed to respond in written or spoken form (through audio) and to send the answers by e-mail or by telephone, via Whatsapp. To ensure data security, the survey information and the questionnaire were sent by only one sender and, equally, the responses were received through the same channel.

The semi-structured questionnaire was defined with the questions: 1- What measures does the LTIE take to protect older people from COVID-19? 2- How are the Social Assistance Secretariat and/or the services of the Unified Social Assistance System (SUAS) contributing to the LTIE during this period of COVID-19? 3- How are the Health Department and/or the services of the Unified Health System (SUS) contributing to the LTIE during this period of COVID-19?

The subjects were selected according to the following inclusion criteria: being a manager or administrative technician or health professional at the institution, as they are responsible for managing health demands and needs during the pandemic; be at the service of the institution with a workload formalized by contract or volunteer term; and, having self-declared experience in the routine practice of difficulties, conflicts and potentialities involved with the care of institutionalized older people. Subjects who sent incomplete questionnaires or after the deadline established by the research were excluded.

The answers were transcribed and analyzed using the thematic analysis method[17]. Based on theoretical assumptions, research objectives and the concepts of social support and health vulnerability, the floating reading of the data allowed the identification of units of meaning[18], which were graphically represented through two word clouds and testimonies of subjects organized into three categories of analysis. This process was initiated by the main researcher and, later, submitted to peer review and to the conclusion of the data interpretations by the other authors.

This research followed the ethical norms and was approved by the Research Ethics Committee with opinion of CAAE nº 03093418.6.0000.5292. All agreed to participate by signing the Free and Informed Consent Term.

## RESULTS



Of a total of 27 identified LTIEs, 24 participated in the study, with two losses due to lack of responses within the established deadline and another loss due to incomplete questionnaire submission. The participating institutions were: 12 private, philanthropic of a religious nature (50%); 12 private, non-religious philanthropic (50%). Regarding the operating regime, the LTIEs represented: 8 open (33.3%); 12 semi-open (50%); 4 closed (16.7%).

The testimonies of all subjects were organized according to units of meaning that were graphically represented through two word clouds. In Figure 1, it is observed that the participating LTIEs followed the main recommendations presented in technical notes from the Ministry of Health and the National Health Surveillance Agency (ANVISA), whose publications are all referring to measures for the prevention and control of COVID-19 infections[19-20].

The "cancellation of visits" to the LTIE and the "use of Personal Protective Equipment (PPE)" were the most mentioned measures by 16 institutions. The first is related to other nuclei of meanings that describe the social isolation defined, worldwide, by government bodies, namely: cancellation of tours and activities; interpersonal distancing; avoid agglomeration; and, social isolation. The second inference highlighted is a measure inherent to the prevention of COVID-19, since the mode of transmission of the disease has universalized the requirement to use, at least, masks by the entire population for individual protection.

It is noteworthy that some meaning nuclei were smaller in the word cloud because they were mentioned by few LTIEs. Some terms in Figure 1 were mentioned only once by different LTIEs, such as: food reinforcement with juices, teas and fruits; sunbath; vitamin supplementation; objects and clothes for individual use; and, recreational activities. Other terms are worth mentioning because they constitute measures adopted without health recommendations

and without scientific evidence[21], such as the use of ivermectin and vitamin supplementation.

The concreteness of prevention strategies and compliance with government recommendations are made possible by the commitment of the LTIE. However, facing problems of a more complex nature requires a broader and more effective social support network, in which the engagement of the population and public sectors becomes indispensable. In this sense, Figure 2 depicts the LTIE's testimonies about the support received.



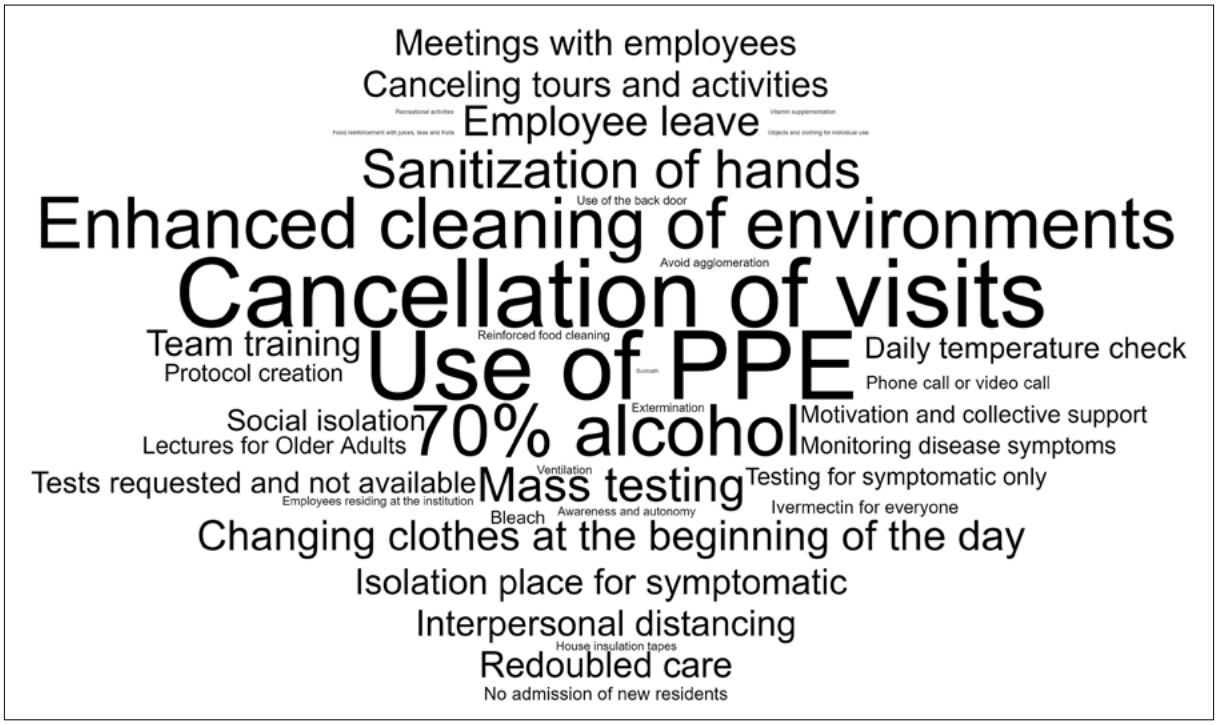


**Figure 1.** Measures taken by institutions to protect the health of older people during the COVID-19 pandemic. Rio Grande do Norte, 2020.


**Figure 2.** Social support offered to institutions by social and health care networks during the COVID-19 pandemic. Rio Grande do Norte, 2020.

Responding to the contributions made by the SUAS and SUS public services, among the 24 participating institutions, 15 of them referred to the "receipt of PPE and alcohol" and, equally, 15 of them referred to the "attention of the Family Health Strategy (ESF)". In relation to Figure 2, only one nucleus of meaning had less graphic visibility, which was the "assignment of municipal employees", since it was mentioned by only two LTIEs, which assigned workers in order to contribute to the care offered to the institutionalized older people.

In addition to the word clouds, the analysis grouped by themes was also carried out through the responses that emerged and stood out in the face of the investigated phenomenon[17]. Thus, the subjects' discourses were arranged in categories inspired by the three axes of understanding of reality, proposed by the conceptual framework of vulnerability: individual, social and programmatic dimensions[13].

## Individual dimension: the senile body craves autonomy and empowerment

For physiological reasons related to aging, older people are more susceptible to COVID-19, which was expressed in the speeches of the research participants, demonstrating their concern in carrying out disease control in the LTIE in view of the high numbers of cases and deaths among institutionalized older people.

> "We work with flexible [frail] older people. And we cannot be exposing [them] right now" (LTIE 2).

> "Seventeen older people tested positive. With three deaths and the other fourteen already cured" (LTIE 9).

To protect the older people and control the transmission of COVID-19, the creation of measures to disseminate information about the disease was motivated, including, as a target of actions, employees and family members of residents.

> "Meetings were held with employees to pass on the importance of wearing a mask and hand hygiene, avoiding crowds and changing clothes when they arrive at the facility" (LTIE 1).

> "We made a memo with the list of preventive measures that we are doing in the house [...] to make our employee aware, [...] together with the family" (LTIE 2).

Some LTIEs have developed protocols or technical notes to inform and emphasize the role of the worker in preventing COVID-19 and maintaining the health of residents, favoring routine care and minimizing the feeling of helplessness and anxiety of LTIE workers[22].

The feeling of fear of finitude among older people was present in the LTIE, stimulated by the deaths that occurred within the institutions themselves, being the object of attention of the workers.

> "[...] We have a lady that we know passed away from COVID. We didn't want to warn our residents so as not to generate tension. We'll leave it for later" (LTIE 14).

In addition, the importance of the bonds established from the pandemic context was perceived, which were evidenced as essential in the fight against individual vulnerabilities.

> "This is a lesson in people's lives. The people came closer. The shelter hardly receives visitors here in the city and something like this brought social action a lot closer" (LTIE 24).

In contrast to the susceptibilities of an organic nature that affect older people and the increased fear of death, the acquisition of information about the disease, the new forms of interaction and recommended virtual communication[23] proved to be essential in reducing individual vulnerability.

## Social dimension: institutionalized living strengthens care

With the advent of COVID-19, challenges emerged in the performance of care in LTIE, due to the expansion of care required by the pandemic scenario and the routine difficulties faced by institutions. Thus, the responsibility of workers and social supporters has increased in the care of older residents.

> "It is more an institutional issue than anything else, we have to take care of ourselves in the way we can" (LTIE 3).

In addition, other specific adaptations to the prevention of COVID-19 were also made, according to the recommendations of the health authorities[19-20], which was demonstrated in the following speech and listed in the cloud of Figure 1.

> "We redoubled the hygiene of bathrooms, leisure area, handrails, living room, mattresses, cafeterias, we also reinforced the use of hand sanitizer [...] and a sink at the entrance of the institution for hand hygiene with liquid soap" (LTIE 11).

Social distancing has been widely adopted to block the transmission of COVID-19. However, older people can understand on the other hand: loneliness and abandonment by family members[22]. In this bias, the suspension of visits, reported by the LTIE and guided by ANVISA, can harm the mental health of older people. They may present reactions of anxiety, fear, anguish, loneliness and annoyance, which lead to changes in sleep and appetite habits[24], as corroborated by the statements of LTIE workers.

> "Suspension of visits, with contact with family members made possible by audio or video call" (LTIE 2).

> "We try to make video calls regularly, both individually and collectively" (LTIE 14).

The use of digital technologies for interactions between older people and their family and friends was recommended and followed in the prevention of COVID-19. The relevance of social media was perceived, as they promoted virtual contact and maintained affective bonds[24]. In pandemic scenarios, older people must remain active and the LTIE must encourage them to practice tasks during this period of social isolation[20,24], in order to strengthen bonds inside and outside the institution.

## Programmatic dimension: multisectoral support promotes health transformation and protection

Several difficulties in facing the pandemic were presented by the LTIE, due to the financial limitation for the acquisition of inputs, as well as the lack of professional qualification linked to the adequate management of the cases.



> "So we try to overcome the difficulties. Also with this support from the civil sector, from people who really like to help the shelter" (LTIE 3).

> "We did not have training from the Health Secretariat, we were not presented with a measure of cases" (LTIE 11).

Even in the face of the acute scenario experienced at the beginning of the pandemic and the requests made to the municipal health management to solve the problems, the research participants highlighted the insufficiency of diagnostic tests in the LTIE, which would serve for laboratory screening using tests capable of detecting the presence of the virus (RT-PCR) and/or antibodies against the virus (rapid test)[25].

> "Two employees away, we have two older people with a fever for more than two days, but the unit says they have few tests and the symptoms do not qualify for testing. Will the first case have to die for the older people to be tested? We keep asking, talking and unfortunately they don't do anything" (LTIE 11).

Despite the funding intended for intersectoral support[26], the concreteness of the integrality of the SUAS and SUS services is still a challenge, as expressed in the speeches and in Figure 2, where the absence of social assistance and the insufficiency of the public sector were reported.

Eight LTIEs were identified as actively searching for COVID-19 cases with mass testing. Some LTIEs

found it difficult to carry out this measure due to a lack of multisectoral support. It is noteworthy that four institutions performed the test only on symptomatic older people and/or workers and another five institutions requested tests from the municipal health departments and were not available, causing feelings of anxiety and concern.

The transformation of routine during the pandemic was possibly made possible by the LTIEs themselves. But, according to the wishes expressed in the testimonies, the institutions need more forceful support from the public power to overcome economic and structural barriers.

> "We are seeing with this coronavirus that the financial situation has worsened. If we receive help, it is supplies, protection aid, etc. But not financial" (LTIE 14).

> "Alert to the financial sector about the increase in the acquisition of PPE's and some inputs" (LTIE 18).

> "The health secretariat sent a nursing technician to assist in the isolation area" (LTIE 9).

Programmatic efforts should make it possible to replace workers or transfer others from intersectoral public services[20,25], in addition to reinforcing social monitoring, technical and health visits and even other systematizations, such as support in the adaptation of rooms or provisional assignment of places to welcome and isolate older people sick with COVID-19.

> "A big team came to do 56 tests. There were five residentes and one employee contaminated. Without feeling anything. We immediately provided isolation, the City got us a house" (LTIE 24).

> "Measures were taken, such as adapting a room for isolation, if COVID-19 is suspected" (LTIE 21).

Finally, the importance of building the contingency plan for each LTIE was observed, with adaptations to the demands and structural and cultural peculiarities.

## DISCUSSION

LTIEs have challenges in institutionalizing older people, even more so in the face of the COVID-19 pandemic, whose social distancing is one of the main forms of prevention, even where they live collectively. Within the scope of the individual dimension, although it has no direct connection with illness, aging is accompanied by physiological changes that progressively make the individual more susceptible to diseases[27]. In particular, comorbidities and greater functional dependence of institutionalized older people led, in synergy with SARS-Cov-2 infection, to a higher morbidity and mortality rate in LTIEs[25].



If the physiological factors are often difficult to modify, on the other hand, the cognitive and behavioral aspects of individuals are more easily manageable[13], which can empower the older person to self-care in the prevention of COVID-19. In this sense, clinical and scientific evidence assume a prominent role so that the individuals can protect themselves and mobilize themselves against structural conditions that make them susceptible to illness[13]. Quality information about the disease is also necessary in the pandemic context, so that LTIE professionals can adequately recognize the vulnerabilities of the older people and, above all, act in health protection beyond the walls of the institution[28]. The dissemination of information favored the prevention of COVID-19 in the care of the older residents.

Still in the individual context, the fear of death was something relevant. The way in which temporality and death are viewed depends on the cultural and singular references of the older person[28]. The experience of death and mourning can contribute to the formation of an ideology linked to the preservation of life. On the other hand, the denial or lack of communication of the death of close ones, as perceived in the speeches of the participating subjects, can remove from the older person the stage of coping with grief and even the awareness and appreciation of self-care about the health-disease process. There was no management policy for this problem in the investigated reality, which should be the object of greater institutional investments.

On the other hand, strengthening bonds proved to be important. The impossibility of psycho-affective relationships in person, due to the indulgence of social isolation, expanded social support in the LTIE, favoring opportunities for listening, welcoming, empowering and encouraging the older person to self-care with the dissemination of preventive behaviors.

In terms of the social dimension, it is understood that coping with a health-disease process depends on material, cultural, political and moral aspects that concern life in society[13]. This is equivalent to older people who have a specific way of living and coexisting when they are institutionalized.

The pandemic scenario has increased the vulnerability of older people, even when not affected by the disease. It should be considered that, historically, emerging situations in public health sometimes generate stigma and discrimination against risk groups or more susceptible people[29], which occurred at the beginning of the pandemic. Added to the prejudices that affect aging, such as ageism[30], this context has changed the routine of the older residents by compelling them to distance and social isolation, reviving feelings and psychological repercussions of adaptation to a new condition[31]. However, it was seen that reducing vulnerability to face COVID-19 is possible in institutionalized living, depending on the social commitment of the LTIE and the effectiveness of care provided.

In the programmatic dimension, it is considered that the LTIE should analyze what are, at any given moment, the resources available to intervene in the illness caused by COVID-19, through strategies that allow reconstruction and social transformation[32]. Likewise, in order to maintain comprehensive and longitudinal care for residents, interdisciplinary and multisectoral interventions are indispensable and, in emergency situations, social support is even more necessary.

In the midst of institutional challenges and difficulties in dealing with COVID-19, important initiatives were taken to integrate social and health care networks, which culminated in greater attention from the ESF to the LTIE, resulting in the active search for patients, risk assessment, coordination of care in identifying signs, symptoms and clinical severity of COVID-19[19].

In addition, as already discussed in the individual dimension, the importance of access to information by everyone, including the older people and workers, in carrying out health care is highlighted. The support of the government, the interest of the LTIE in the acquisition of means of communication, such as the internet, and the implementation of communication strategies proved to be essential. Information is essential for controlling risks, reducing vulnerabilities and overcoming the economic, political and cultural obstacles that sustain the lives of older people. However, the experiences of disinformation and infodemics that accompanied the pandemic reveal that informational strategies and policies should focus not only on access, but also on the quality of information[33-34].

Therefore, the three dimensions of vulnerability are interrelated: more general social aspects impact institutional efforts and individual possibilities for reducing vulnerability, as well as individual transformations and initiatives are dependent on and influence institutional and social scenarios.

In this sense, it is important to emphasize how social support contributes to maintaining the health of the older people and LTIE workers, who are exposed to situations that trigger physical and emotional exhaustion, mainly due to the fear of getting sick and transmitting the disease to family members and residents. Protective and social isolation actions were guaranteed by the institutions and should continue whenever recommended by the health authorities, aiming to control the transmission of the virus, even with all the older people and workers immunized by vaccination.

As a limitation of the research, it is observed that the virtual format of data collection may hamper the participant's comfort and confidence when sharing information and, occasionally, may have weakened the quality of the responses. Also, sending audios does not guarantee a private environment that provides reliability in the testimony and, mainly, sending written responses also does not ensure

adequate analysis of the speech, either because of lack of expression in the intonation of words, or because spelling is saturated with language vices. However, given the impossibility of face-to-face meetings due to the need for social isolation, especially in the LTIE environment, the importance of virtual data collection is highlighted to enable research in a timely manner, even at the beginning of the pandemic, avoiding a possible memory bias.

## CONCLUSION

In view of the recommendations against social agglomeration and the scientific evidence on the greater susceptibility of the older people to the aggravation of COVID-19, the established context highlighted the essential role of public health and social assistance systems (SUS and SUAS) in protecting older people. In addition, the reality during the pandemic has somehow increased the visibility of LTIE and institutionalized older people, creating a social support network, which was not well integrated in the past, made up of family members, the community, public authorities, social assistance and health services and, above all, by the LTIEs themselves.

Nevertheless, the difficulties still faced to implement the recommended health measures - which translated into expressive indicators of morbidity and mortality in the LTIE - showed that the efforts made were insufficient for an adequate prevention of COVID-19, while revealing the chronic Brazilian problems, such as the underfunding of those public systems.

Therefore, greater investments by the government in LTIE are necessary, enabling effective transformations and reduction of vulnerabilities of institutionalized older people in the individual, social and programmatic dimensions, as well as investments in research that can help public managers in the coordination of health crises.



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## REFERENCES


1. Organização Pan-Americana de Saúde. OMS declara emergência de saúde pública de importância internacional por surto de novo coronavírus [Internet]. 2020. [acesso em 23 dez. 2021] .Disponível em: https://www.paho.org/pt/news/30-1-2020-who-declares-public-health-emergency-novel-coronavirus
2. Shahid Z, Kalayanamitra R, Mcclafferty B, Kepko D, Ramgobin D, Patel R et al. COVID-19 and older adults: what we know. J Am Geriatr Soc. 2020;85(5):926-29. Disponível em: https://doi.org/10.1111/jgs.16472
3. Ishikawa RZ. I may never see the ocean again: loss and grief among older adults during the COVID-19 pandemic. Psychol Trauma. 2020;12(1):S85-S86. Disponível em: http://dx.doi.org/10.1037/tra0000695
4. Brasil. Boletim Especial: Balanço de dois anos da pandemia COVID-19 [Internet]. Rio de Janeiro: FIOCRUZ; 2022. [acesso em 10 mar. 2022]. Disponível em: https://portal.fiocruz.br/sites/portal.fiocruz.br/files/documentos_2/boletim_COVID_2022-balanco_2_anos_pandemia-redb.pdf
5. Levy B. Estudo analisa registro de óbitos por COVID-19 em 2020 [Internet]. Rio de Janeiro: FIOCRUZ; 2021. [acesso em 10 mar. 2022]. Disponível em: https://portal.fiocruz.br/noticia/estudo-analisa-registro-de-obitos-por-COVID-19-em-2020
6. Comas-Herrera A, Zalakaín J, Litwin C, Hsu AT, Lane N, Fernández JL. Mortality associated with COVID19 outbreaks in care homes: early international evidence. International Long-Term Care Policy Network [Internet]. 2020. [acesso em 14 Mar 2022]. Disponível em: https://ltcCOVID.org/2020/04/12/mortality-associated-with-COVID-19-outbreaks-in-care-homes-early-international-evidence/
7. Wachholz PA, Moreira VG, Oliveira D, Watanabe HAW, Boas PJFV. Estimativas de infecção e mortalidade por COVID-19 em lares de idosos no Brasil. Geriatr Gerontol Envelhecimento. 2020;14:290-293. Disponível em: https://doi.org/10.5327/Z2447-212320202000127
8. Garcia LP, Duarte, E. Intervenções não farmacológicas para o enfrentamento à epidemia da COVID-19 no Brasil. Epidemiol Serv Saúde. 2020;29(2):e2020222. Disponível em: https://doi.org/10.5123/S1679-49742020000200009

9. Freitas MAV, Scheicher ME. Qualidade de vida de idosos institucionalizados. Rev Bras Geriatr Gerontol. 2010;13(3):395-401. Disponível em: https://doi.org/10.1590/S1809-98232010000300006

10. Barbosa LM, Noronha K, Camargos MCS, Machado CJ. Perfis de integração social entre idosos institucionalizados não frágeis no município de Natal, Rio Grande do Norte, Brasil. Cien Saúde Colet. 2020;25(6). Disponível em: https://doi.org/10.1590/1413-81232020256.19652018

11. Barbosa KTF, Oliveira FMRL, Fernandes MGM. Vulnerabilidade da pessoa idosa: análise conceitual. Rev bras enferm. 2019;72(Supl 2):337-44. Disponível em: https://doi.org/10.1590/0034-7167-2018-0728

12. Rinco M, Lopes A, Domingues MA. Envelhecimento e vulnerabilidade social: discussão conceitual à luz das políticas públicas e suporte social [Internet]. Rev Kairós. 2012;15(6):79-95. [acesso em 14 Ago 2021]. Disponível em: http://revistas.pucsp.br/index.php/kairos/article/view/17288/12828

13. Ayres JRCM. Prevenção de agravos, promoção da saúde e redução de vulnerabilidade. In: Martins MA, Carrilho FJ, Alves VAF, Castilho CG, Wen CL, org. Clínica Médica. Barueri: Manole; 2009.

14. Gracia E. El apoyo social en la intervención comunitaria. In: Fernández I, Morales JF, Molero F. Psicología de la intervención comunitária. Barcelona: Desclée De Bremador; 2011.

15. Pizzinato A, Pagnussat E, Cargnelutti ES, Lobo NS, Motta RF. Análise da rede de apoio e do apoio social na percepção de usuários e profissionais da proteção social básica. Estud Psicol. 2018;23(2):145-56. Disponível em: https://doi.org/10.22491/1678-4669.20180015

16. Rodrigues AG, Silva AA. A rede social e os tipos de apoio recebidos por idosos institucionalizados. Rev Bras Geriatr Gerontol. 2013;16(1):159-70. Disponível em: https://doi.org/10.1590/S1809-98232013000100016

17. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. São Paulo: Hucitec; 2008.

18. Rosa LS, Mackedanz LF. A análise temática como metodologia na pesquisa qualitativa em educação em ciências. Rev Atos Pesq Educação. 2021;16:e8574. Disponível em: https://dx.doi.org/10.7867/1809-0354202116e8574

19. Brasil. Plano nacional de contingência para o cuidado às pessoas idosas institucionalizadas em situação de extrema vulnerabilidade social [Internet]. Brasília: Ministério da Saúde; 2020. [acesso em 14 Ago. 2021]. Disponível em: https://www.mpma.mp.br/arquivos/CAOPID/nota_plano_nacional_contingencia_cuidado_pessoas_idosas_v1-MS.pdf

20. Brasil. Nota técnica nº 05/2020. Orientações para a prevenção e o controle de infecções pelo novo coronavírus (SARS-COV-2) em Instituições de Longa Permanência para Idosos (ILPI) [Internet]. Brasília: Agencia Nacional de Vigilância Sanitária; 2020. [acesso em 14 Ago. 2021]. Disponível em: https://coronavirus.rs.gov.br/upload/arquivos/202006/25092432-nota-tecnica-05-2020-24-06-2020-1.pdf

21. Melo JRR, Duarte EC, Moraes MV, Fleck K, Arrais PSF. Automedicação e uso indiscriminado de medicamentos durante a pandemia da COVID-19. Cad Saúde Pública. 2021;37(4):e00053221. Disponível em: https://doi.org/10.1590/0102-311X00053221

22. Freitas AVS. Long stay institutions for the elderly and COVID-19: emergency in the debate. Research, Society and Developm. 2020;9(7):1-11. Disponível em: https://doi.org/10.33448/rsd-v9i7.4398

23. Oliveira WK, Duarte E, França GVA, Garcia LP. Como o Brasil pode deter a COVID-19. Epidemiol serv saúde. 2020;29(2):1-8. Disponível em: https://doi.org/10.5123/s1679-49742020000200023

24. Nunes VMA, Machado FCA, Morais MM, Costa LA, Nascimento ICS, Nobre TTX, et al. COVID-19 e o cuidado de idosos: recomendações para instituições de longa permanência. Natal: EDUFRN; 2020.

25. Moraes EN, Viana LG, Resende LMH, Vasconcellos LS, Moura AS, Menezes A et al. COVID-19 nas instituições de longa permanência para idosos: estratégias de rastreamento laboratorial e prevenção da propagação da doença. Cien Saúde Colet. 2020;25(9):3445-58. Disponível em: https://doi.org/10.1590/1413-81232020259.20382020

26. Brasil. Lei 14.018, de 29 de junho de 2020. Dispõe sobre a prestação de auxílio financeiro pela União às Instituições de Longa Permanência para Idosos (ILPIs), no exercício de 2020, em razão do enfrentamento da emergência de saúde pública de importância internacional decorrente do coronavírus (COVID-19). Diário Oficial da União. [Internet]. 2020 [acesso em 31 Jul. 2020]. Disponível em: https://pesquisa.in.gov.br/imprensa/jsp/visualiza/index.jsp?data=30/06/2020&jornal=515&pagina=3&t

27. Cruz RR, Beltrame V, Dallacosta FM. Envelhecimento e vulnerabilidade: análise de 1.062 idosos. Rev Bras Geriatr Gerontol. 2019;22(3):e180212. Disponível em: https://doi.org/10.1590/1981-22562019022.180221

28. Maia FOM. Vulnerabilidade E Envelhecimento: panorama dos idosos residentes no município de São Paulo [tese]. São Paulo: Universidade de São Paulo. 2011.

29. Organização Pan-Americana da Saúde. Abordagem de Direitos Humanos, essencial na resposta à COVID-19 [Internet]. 2020. [acesso em 31 Jul. 2020]. Disponível em: https://iris.paho.org/bitstream/handle/10665.2/52369/OPASWBRACOVID-1920081_por.pdf?sequence=1&isAllowed=y

30. Kalache A, Silva A, Ramos L, Louvison M, Veras R, Lima CL, et al. Pandemia da COVID-19 e um Brasil de desigualdades: populações vulneráveis e o risco de um genocídio relacionado à idade. [Internet]. 2020. [acesso em 31 Jul. 2020]. Disponível em: https://www.abrasco.org.br/site/gtenvelhecimentoesaudecoletiva/2020/03/31/pandemia-do-COVID-19-e-um-brasil-de-desigualdades-populacoes-vulneraveis-e-o-risco-de-um-genocidio-relacionado-a-idade/

31. Fundação Osvaldo Cruz. Saúde Mental e Atenção Psicossocial na Pandemia COVID-19: recomendações aos trabalhadores e cuidadores de idosos. [Internet]. 2020. [acesso em 31 Jul. 2020]. Disponível em: https://www.arca.fiocruz.br/bitstream/icict/41686/2/CartilhaIdoso.pdf

32. Ayres JRCM, Castellanos MEP, Baptista TWF. Entrevista com José Ricardo Ayres. Saúde Soc. 2018;27(1):51-60. Disponível em: https://doi.org/10.1590/s0104-12902018000002

33. Organização Pan-Americana da Saúde. Entenda a infodemia e a desinformação na luta contra a COVID-19 [Internet]. 2020. [acesso em 18 Mar. 2022]. Disponível em: https://iris.paho.org/bitstream/handle/10665.2/52054/Factsheet-Infodemic_por.pdf?sequence=16

34. Mata ML, Grigoleto MC, Lousada M. Dimensões da competência em informação: reflexões frente aos movimentos de infodemia e desinformação na pandemia da COVID-19. Liinc Ver. 2020;16(2):e5340. Disponível em: https://doi.org/10.18617/liinc.v16i2.5340