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Aging, Vulnerability and Questions of Care in the Time of COVID-19

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The 21st century, as we know it, has experienced its fair share of crises, be they civil wars, genocides, environmental catastrophes or epidemics. At present, the world is in the midst of a pandemic crisis like no other: COVID-19, a novel virus that was discovered in Wuhan, China, in December 2019. Less than four months later — at the end of March 2020 — nearly 850,000 COVID-19 cases had been recorded globally, with more than 40,000 deaths. Of these deaths, more than one-fourth were in Italy.

The situation in Italy is telling. Italy has the second highest number of elderly persons in the world after Japan, with approximately 23 percent of the Italian population older than 65 years of age.¹ In Italy, 87.9 percent of people who had died of COVID-19 by March 17 were older than 70. However, case-fatality rates were the highest for those older than 80 (20.2 percent), and especially for those older than 90 (22.7 percent).

The Italian case demonstrates the lethality of COVID-19 in an aging population. Moreover, emerging data suggest that 80 percent of global COVID-19 deaths so far have been among people age 65 and older, especially

those with preexisting conditions. In the United States, a Centers for Disease Control report indicates that 31 percent of cases, 45 percent of hospitalizations, 53 percent of intensive care unit admissions and 80 percent of deaths associated with COVID-19 were among adults age 65 and older, with the highest percentage of severe outcomes among persons age 85 and older.² Yet, in a sad and rather shocking statistic, 7 million Americans older than 60 live in counties with no intensive care unit beds, according to a Kaiser Health News report.³

Beyond Europe and America, the accelerated rate at which this virus is continuing to spread brings into sharp relief the vulnerability of the elderly in many societies around the world. Yet, in moments of crisis, the elderly⁴ often get sidelined or completely abandoned by healthcare institutions, policymakers and society at large. When aging is viewed primarily as an undesirable process of physical and mental decline, accompanied by increasing levels of burdensome care, then the elderly are seen as disposable, unworthy of our protection. This seems to be the defining rhetoric in the United States at present, where President Donald Trump and other conservative politicians have spoken openly about “sacrificing” the lives of those older than 70⁵ to keep the economy going for generations to come.

This blatantly ageist discourse — of a mass “sacrifice” of elderly people to COVID-19 — is ethically reprehensible and demographically shortsighted. Today, people age 60 and older make vital economic and social contributions in a world that is aging — and at a massive rate. Never before in human history have so many people lived for as long as they

do today. According to a report published by the United Nations, there were an estimated 703 million persons age 65 or older in the world in 2019.⁶ This number is expected to double by 2050, approaching nearly 1.5 billion elderly persons. Two-thirds of the world's elderly population now live in developed countries; for example, one in five people in Europe and North America are now older than 60. But elderly populations in other regions of the world are continuing to grow. For example, by 2050, 25 percent of those in Latin America and the Caribbean and 24 percent of those in Asia will be older than 60. Even sub-Saharan Africa, the youngest region in the world in terms of overall population structure, is graying at an accelerated rate.

Questions of Care

For more than three decades, medical anthropologists have been working on issues of aging around the globe, examining how age is defined and embodied in different ways across cultures.⁷ Medical anthropologists have also demonstrated the subjective nature of the aging process and cautioned against a homogenous understanding of aging as a set of diseases to be avoided, fought and treated. Important to note, medical anthropologists have worked hard to counter discourses that dehumanize the elderly,⁸ with some arguing that caring for the elderly is part of what makes us human.⁹

Both of the authors of this article are medical anthropologists who care about aging and the elderly. Aalyia Sadruddin is from Kenya and has parents, grandparents and other family members living in Kenya and

South Africa, all of whom are older than 60. At the time of this writing, her transnational family is spread far afield. Her sister is currently in lockdown in London, England; her elderly grandmother is in lockdown in Johannesburg, South Africa; and her parents — father a physician and head of the Ismaili community and mother a social worker — are learning how to practice social distancing while providing physical and emotional care to elderly patients and members of the already vulnerable community in Kisumu, Kenya. There, many older adults have pre-existing chronic health conditions, including diabetes, hypertension, kidney disease and cancers, that make them physically fragile.

The second author, Marcia C. Inhorn, is technically in the COVID-19 “risk group,” having entered her early 60s. As she shelters at home with her family, her major concern lies with her elderly parents — who, at the ages of 94 and 91, are at the highest risk in terms of COVID-19 mortality. Inhorn's parents live in a comfortable senior retirement community in a midsize university city. Yet, these senior communities are themselves potential “hot spots” of COVID-19 infection. Of the first 100 COVID-19 deaths in the United States, the deadliest cluster occurred in a Kirkland, Washington, nursing home. Many of the other victims, mostly 60–90 years of age, were living in nursing facilities.¹⁰ Given this grim scenario, Inhorn and her physician brothers made the decision to move their parents from the retirement center to one of their own homes in a different state. There, Inhorn's parents are sheltering in place with her retired brother until the epidemic abates.

Inhorn has never worked on aging as a medical anthropological issue. But she has worked in postconflict settings in the Middle East, where the COVID-19 epidemic is beginning to take its deadly toll, including in refugee camps filled with civil war survivors.¹¹ Sadruddin, however, has been working directly on aging in the postconflict setting of Rwanda. Since 2014, she has been undertaking ethnographic research on how life is being reconstituted in the aftermath of the Rwandan genocide, a conflict that is estimated to have killed 800,000 to 1 million Rwandans (primarily ethnic Tutsis) between April and June 1994. In Rwanda, persons older than 70 lived through the genocide but also survived multiple waves of ethnic and political conflict between the late Belgian colonial (1957–1962) and postcolonial (1963–1994) periods.

Sadruddin conducted interviews and participant observation with elderly women and men and members of their families and communities from different class and ethnic backgrounds across Rwanda. She noted the complex and often inventive ways in which they were navigating their physical, emotional, social and economic vulnerabilities through the practice of “care” (*kwitaho*, in Kinyarwanda, the most widely spoken language in Rwanda). There, care — and specifically everyday intimate care (e.g., toileting, bathing, feeding) — was described as the “small things” (*utuntu dutu*) that elderly Rwandans were doing *for* and *with* each other in an attempt to reconcile, heal and cultivate dignity at the individual and collective levels. This form of care was considered the most challenging to provide and to receive because of its affective depth. This included

the need to lay bare various physical, emotional, social and financial vulnerabilities. According to the elderly Rwandans with whom Sadruddin worked, the care of small things compelled them to reflect on their haunted pasts and to configure new ways of being in the world, often in the absence of children and extended kin members.

Sadruddin has managed to check in frequently, via WhatsApp, with many of her elderly interlocutors, the majority of whom live in rural areas of Rwanda. This communication has been facilitated through medical doctors and community health workers she encountered and befriended during fieldwork. Through these interactions, Sadruddin has learned that the first case of COVID-19 in Rwanda was reported on March 8, 2020. As of March 31, a total of 75 Rwandans had tested positive for the virus.¹²

In an attempt to prevent a full-fledged epidemic, Rwanda’s president, Paul Kagame, implemented a nationwide shutdown on March 21, 2020, enforcing various preventive measures across the country. This included closing all houses of worship, schools and higher education institutions and encouraging those who could work from home to do so. Although in line with World Health Organization and Centers for Disease Control and Prevention guidelines, the practice and maintenance of this distancing in Africa’s most densely populated country is likely to be challenging. Moreover, Rwanda is a “young” country, in terms of both its population (close to 50 percent of residents are between 15 and 24 years of age) and infrastructure (most has been built postgenocide). Even though Rwanda follows a universal healthcare model, through which health

insurance is provided under the auspices of the *Mutuelles de Santé* program, the majority of the rural-dwelling population depends on family and community members for care (health or otherwise). Prior to COVID-19, Rwandans were already under increased pressure to search for employment as a way of feeding their families. Thus, many Rwandans cannot help but wonder how long this controlled way of living will last and what the consequences will be for the health and well-being of their families.

As is the case across the world, the fear of a pandemic virus in Rwanda is beginning to mount. For example, one of Sadruddin's physician friends, who lives with his 60-year-old mother and 85-year-old grandmother in a town in Eastern Rwanda, has been communicating with local *umudugudu* (village) officials via his mobile phone, encouraging them to remind people of the severity of the virus and the need for Rwandans of all ages to practice protective measures. As he texted Sadruddin on March 20:

Aal! Hey. I just got back from the village. Everyone is fine ... I am finding it difficult to explain the etiology of the disease to people. Yesterday, I read that even virologists are still trying to learn more about this thing [COVID-19]. Things are not going to be easy and the hospital is going to be on high alert but we will have to try and protect our people. I will be in touch. *Komera* [Be strong].

Likewise, in Rwanda's capital of Kigali, three of Sadruddin's friends with cars have been attempting to deliver basic supplies — consisting of maize flour, beans and bars of soap

— to poor members of communities who live on the peripheries of the city and for whom these items are difficult to procure. In other instances, families and friends are banding together by sharing food. As of March 28, 2020, the Rwandan government has started to distribute food relief to socially and economically vulnerable Rwandans across Kigali's three districts most affected by the virus — Gasabo, Kicukiro and Nyarugenge. Addressing the nation, President Kagame vowed that his government will do "everything possible to support vulnerable Rwandans during the coronavirus containment period." This includes developing effective ways of transporting relief packages to secondary cities across the country.¹³

Conclusion

Like many around the world, Rwandans are doing their best to practice empathy and be a source of hope for others during these uncertain COVID-19 times. As a global pandemic, COVID-19 has created room for humans to rethink their place in the world. It has provided a moment of pause. The inexorable global spread of COVID-19 — with its ability to infect and kill family members, friends and colleagues — makes it an issue that is close to home. Slogans such as "We are in this together" and "Together we can beat this" are messages of solidarity. "Small things" — such as delivering food and supplies to neighbors — are reminders of our empathic side as humans. It is important not to forget that such everyday acts of kindness carried out in times of crisis can become an enduring way of life when crises come to an end.

Such is the case in postgenocide Rwanda. There, elderly Rwandans' lives have been repeatedly disrupted by episodes of political and ethnic violence. In this regard, COVID-19 represents yet another episode of crisis. With a still nascent healthcare system, especially in rural areas, elderly Rwandans are in the midst of confronting a new death threat. That said, Rwanda has managed to rise from such crises. For example, in 2019, when the country was under "high risk" of the rapid spread of Ebola virus disease, the government put in place a robust set of preparedness mechanisms, making available handwashing stations and taking the temperatures of every person entering the country via ThermoScan thermometer checks. Immediate responses such as these prevented Ebola virus disease from spreading to Rwanda across its borders with Democratic Republic of Congo (the epicenter of the virus) and Uganda.

Despite the Rwandan government's ability to respond to crises, the real severity of COVID-19 in Rwanda will truly reveal itself when the need for intensive care units, ventilators and trained medical staff will increase. Yet, in Rwanda, it is highly unlikely that individuals who are sick will be abandoned in their suffering. Family and community members, including other elderly people, will undertake small things to care for those with COVID-19. By doing so, they may put themselves in harm's way. But this is how they have endured, by caring for one another in crisis.

In a world riddled with inequalities, it will be important for medical anthropologists to follow the path of COVID-19 into multiple sites around the globe, to understand what

has happened to the elderly in places such as Rwanda. COVID-19 is not an equal opportunity killer. The elderly are most at risk, and caring about their fates is critical. This message seems to have fallen on deaf ears, including some United States politicians who find the "sacrifice" of the elderly to be a warranted solution to prevent an economic meltdown.

With no end in sight to COVID-19, at least for now, it is crucial that humans take stock of the lessons from this pandemic. Based on what scientists and environmentalists have been emphasizing over the past decade, the occurrence of new pandemics is as much a feature of our present as it is of our future. In a world that is rapidly aging, our experiences of COVID-19 in real time can prepare us for what are bound to be new ways of living and caring, including for elderly citizens in Rwanda and beyond.

Notes

1. Graziano Onder, Giovanni Rezza, and Silvio Brusaferro, "Case-Fatality and Characteristics of Patients Dying in Relation to COVID-19 in Italy," *Journal of the American Medical Association* (2020), Last modified April 16, 2020. doi:10.1001/jama.2020.4683
2. Centers for Disease Control and Prevention, "Coronavirus (COVID-19)," <https://www.cdc.gov/coronavirus/2019-ncov/index.html>.
3. Fred Schulte et al., "Millions of Older Americans Live in Counties with no ICU Beds as Pandemic Intensifies," *Kaiser Health News*, March 20, 2020, <https://khn.org/news/as-coronavirus-spreads-widely-millions-of-older-americans-live-in-counties-with-no-icu-beds/>.

4. For the purposes of this article, however, we consider older persons as any individual who is 60 years of age or older, because this is the age limit used in COVID-19 risk assessments and case-fatality reports.

5. Potentially this could include Trump himself, who is older than 70.

6. United Nations, Department of Economic and Social Affairs, Population Division, "World Population Ageing 2019: Highlights" (ST/ESA/SER.A/430), 2019, <https://www.un.org/en/development/desa/population/publications/pdf/ageing/WorldPopulationAgeing2019-Highlights.pdf>.

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12. Worldometer, "Reported Cases and Deaths by Country, Territory, or Conveyance" (table), March 28, 2020. <https://www.worldometers.info/coronavirus/#countries>.

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Suggestions for Further Reading

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