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AN AGEING INDIA NEEDS AGE-RESPONSIVE TB CARE

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India is moving towards a future where the elderly will make up a significant proportion of society, primarily due to advances in health care and increased life expectancy. In 2011, about 9% of India’s population were over the age of 60. This is expected to increase to 12.5% by 2030. The elderly represent a storehouse of wisdom, and respect for their rights and freedoms benefits society. On International Day of Older Persons (October 1), we must resolve to invest in the health of our elderly population, and pay attention to their unique needs.

This is especially true in the case of tuberculosis (TB), which affects over 25 lakh Indians every year, and kills at least 1,000 every day. India’s National TB Prevalence Survey, 2021, revealed that the prevalence of TB in people over the age of 55 was 588 (per one lakh population), much higher than the overall national prevalence of 316. These findings were the starting point for a first-of-its-kind rapid assessment report on TB among the elderly, which we published earlier this year in collaboration with the National TB Elimination Programme and the U.S. Agency for International Development, highlighting TB’s impact on the elderly and the need for age-specific TB guidelines.

Interviews with older persons with TB revealed that their TB care journeys were fraught with challenges at every step, resulting in an overall sub-optimal experience. Symptoms of TB including cough, fatigue and weight loss are mistaken as signs of other diseases or dismissed as signs of old age. The risk of having a TB diagnosis delayed or missed altogether is higher for the elderly compared to other adults.

Once diagnosed, management of TB among the elderly is often complicated by multiple comorbidities, particularly diabetes. At an individual level, this means a higher pill count and an increased likelihood of side effects. At a health system level, this can result in irregular treatment adherence and poor outcomes, including death. Some older people with TB spoke about their lowered ‘will to live’, especially in the absence of social and emotional support systems.

Older people, and older women in particular, also face specific challenges in accessing health services. For instance, in rural and hilly areas, they struggle to travel to health facilities by themselves. Their access to reliable information on health is also limited — social networks inevitably shrink for the elderly. Older persons also experience infrastructure-related challenges such as lack of adequate seating. Crucially, they may not have access to high-quality nutritious food, which is critical for recovery.

All of this is augmented by a loss of economic independence. Most people over the age of 60

are no longer working; they are living off savings or they are completely dependent on families. There are some social welfare schemes for the elderly but these are limited in scope and difficult to access. Data on TB-related stigma among the elderly is sparse but we know that ageism is real and has been recognised by the World Health Organization as a cause of poor health and social isolation. Many older people we spoke to referred to their fragile mental health, accentuated by the loss of purpose and connection, loneliness from losing spouses or family, and the anxiety of not being 'useful'.

So, how can we design and deliver TB care that is elder-friendly? First, we must move away from disease-specific, vertical care programmes to holistic care models that reduce the need for the elderly to interact with multiple providers and facilities. We must also build capacity among health professionals at all levels for an improved clinical understanding of TB in the elderly and better management of multiple morbidities. Case-finding among the elderly can be improved through effective sputum collection and transportation systems, access to mobile diagnostic vans and active case finding at geriatric OPDs, residential homes for the elderly and other institutional settings.

Technical and operational protocols that provide clear guidance on diagnosing and treating TB in the elderly — for example, sample extraction protocols, comprehensive assessment of co-morbidities and drug dosage adjustments — need to be developed.

To address socio-economic needs, we must design and roll out well-considered support protocols, with inputs from elderly people with TB. Examples include an elder-focused community care model with linkages to local caregivers; doorstep delivery of medicines; age-responsive peer support and counselling for older people and their families; special help desks for the elderly at facilities; and support with documentation to access social support schemes.

At a macro level, we must ensure rigorous gender and age-disaggregated collection and analysis of data, to identify TB trends across age groups, and to make sure that the elderly are included as a separate age category in all TB reports. An important step towards building elderly-friendly systems is strengthening collaboration within the health system.

Finally, we need a stronger research agenda focused on TB in the elderly, to better understand State-specific trends in case finding and outcomes among elderly people with TB; substance use; drug-resistance and co-morbidity patterns across geographies; uptake of TB preventive therapy in the elderly; and intersectionality with other aspects of equity such as gender, disability, class, and caste.

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