

Chapter 8

Recommendations

1. Findings

1.1. Differences for Defining Concepts and Holistic Explanation based on National Data

In international comparative studies, we often analyse quantitative data of each country. In that case, it should be noted that the terminology can be the same word or words, but the definition can differ depending on the institutional background of each country. For example, in the case of the terminology of ‘death from COVID-19,’ even in Japan, the definition under the Infectious Diseases Act differs from the definition in vital statistics.

In terms of the concept of ‘place of death,’ since welfare facilities, etc. are defined in Japan as places of living, they were treated the same as homes, but they are now separate. In Japan, the number of deaths registered at facilities for the elderly is extremely low compared to facilities for the elderly in Europe and the United States, which often have hospice functions, so deaths at facilities for the elderly also appear frequently. On the other hand, in Japanese long-term care facilities (LTCFs), hospice functions are limited, and in many cases, if a resident is infected, they are often quarantined and hospitalised, and if death is subsequently confirmed, the death is reflected in the statistics as ‘death at the hospital’.

For strengthening the international response to the pandemic, it is necessary to renew the basic definition of the terminology in each country and the method of harmonisation of international common understanding and methodology. (WHO, 2022.)

1.2. Vulnerability and Resilience of Environmental Health

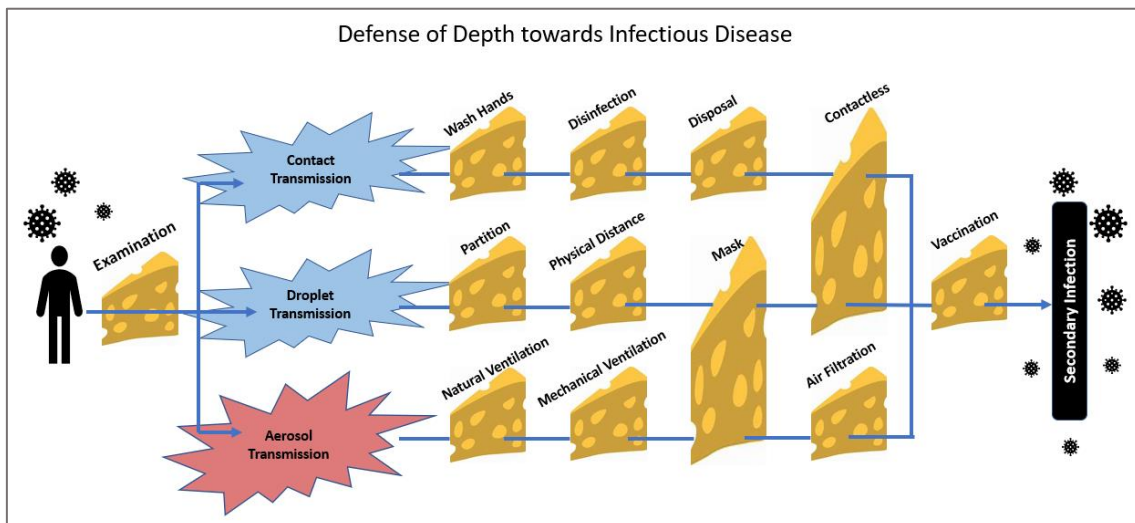
According to the World Health Organization (WHO), the route of infection of COVID-19 was initially considered as a contact or droplet transmission. To prevent these transmissions, hand washing and masks were considered effective. Later, aerosol infection close to airborne infection as an infection route of COVID-19 attracted attention. In March 2020, Japan’s Ministry of Health, Labour and Welfare (MHLW) announced ahead of the rest of the world that the risk of mass infection increases in enclosed spaces with poor ventilation. On 9 July 2020, the WHO recognised aerosol transmission, and as a countermeasure, it translated and adopted Japan’s slogan ‘Avoid 3 Mitsus’ into ‘Avoid 3Cs’ (crowded places, close-contact settings, and confined and enclosed spaces). (Japan Society for Air Conditioning and Sanitary Engineering, 2020).

LTCFs for the elderly need to be especially careful about ventilation as many vulnerable people live together. Especially, in Japanese LTCFs, to make the indoor temperature comfortable, rooms are often closed and air conditioning is used, so ventilation tends to be poor, and a carbon dioxide (CO₂) concentration measurement for ventilation was not widely used. (Figure 8.1)

In addition, LTCFs in Japan are places of daily life, not hospitals or for clinical treatment. Therefore, it is assumed that LTCFs are not designed for zoning or to have decompression rooms for quarantining infected people. Also, long-term care workers (LTCWs) wear surgical masks and gowns. However, COVID-19 has revealed that in an emergency, facilities and equipment will need to be put in place to enable medical treatment in LTCFs.

Compared to Japan, facilities for the elderly in Thailand and Indonesia are well ventilated because they were built as open facilities, i.e. without air conditioning. However, if facilities with air conditioning are developed in the future, there is a concern that ventilation problems will worsen, just like in Japan. In the future development of facilities, it is necessary to pay attention to the measurement method of ventilation management, especially, since some LTCWs did not know that COVID-19 infection was aerosol infection or airborne infection. It is necessary to emphasise the importance of COVID-19 aerosol transmission and the importance of ventilation as a skill in the prevention of infections through training programmes for LTCWs.

Figure 8.1. Infection Prevention and Control of Aerosol Transmission



Source: Ishigaki, Y., et al., 2021. A Guidebook for Practical Ventilation Measures in Hospitals and Long-term Care Facilities. [Iryo, Kaigo-shisetsu no tame no Jissen Kanki Taisaku Guidebook]. Dimensions-japan.org/share/kanki2.pdf (in Japanese)

In Japanese LTCFs for the elderly, which tend to be enclosed spaces, ventilation measures are extremely important. In addition, LTCFs in Japan are places of daily life, not places like hospitals or clinics.

People tend to assume that everyone knows about the need for ventilation, but that no one knows what to do. This sociopsychological state is called 'pluralistic ignorance'. Indeed, ventilation measures against COVID-19 were in a state of pluralistic ignorance. In response to infectious diseases, people tended to be sceptical about the effectiveness of measures that 'cannot be helped'.

In LTCFs, efforts to improve the environment have not been implemented thoroughly. Therefore, the following vulnerabilities of environmental health have occurred:

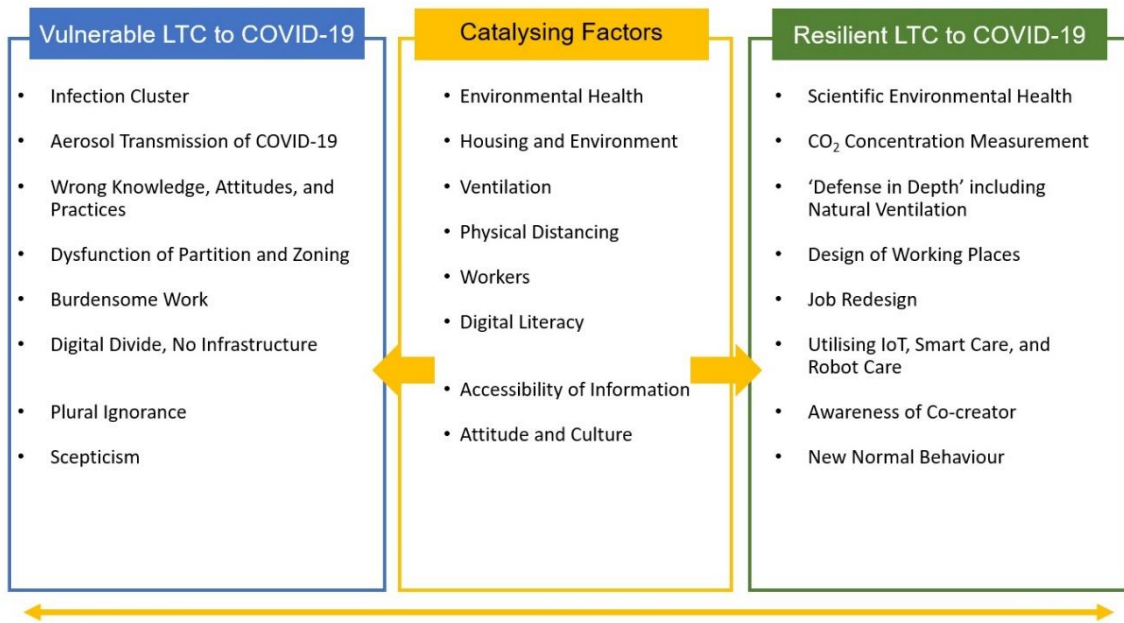
- Infection clusters in LTCFs might be caused by aerosol transmission of COVID-19.
- Mal-knowledge, attitudes, and practices of infection prevention and control might cause infection clusters. For example, an inappropriate partition caused a mal-ventilation environment.
- LTCWs felt the operation of ventilation as burdensome.
- Impossible utilisation of the internet of things (IoT) because of the digital divide and underdeveloped infrastructure.

However, some resilience is challenged:

- Measuring CO₂ concentration for evaluation of ventilation.
- Online control for measuring CO₂ concentration without LTCWs.
- Redesigning rooms and ways of control by checking ventilation conditions.
- Using natural ventilation.
- Training employees in ventilation work.

For establishing resilient LTCFs, the maintenance issues of environmental health, such as ventilation, zoning, and decompression room maintenance have been highlighted. Policymakers and care professionals should focus on disseminating and training scientific measurement methods and improving skills for environmental health (Figure 8.2).

Figure 8.2. Resilient Long-term Care with Environmental Health



IoT = internet of things, LTC = long-term care.

Source: Compiled by authors.

1.3. Vulnerability and Resilience of Family Caregivers and Volunteers

Unlike in Japan, in Thailand and Indonesia LTC for the elderly is largely provided by family members and residents. No matter how much institutional care is put in place, only 3% to 4% of the elderly are eligible for institutional care in Asia, and nearly 90% live under the care of their families.

It is also characteristic of both countries that the care activities of volunteers are flourishing as a complement to family care. In Thailand, 50,000 rural health volunteers watching over elderly people at home. In Indonesia, community health activities (*Posyandu*) are responsible for health activities in cooperation with the community health centres (*Puskesmas*) and volunteers (*Cadre*) who are responsible for these activities. Originally, maternal and child health was their main activity, but in recent years the activities of community health for the elderly (*Posyandu Lansia*) have increased. When COVID-19 began, volunteers' health efforts came to a complete halt.

Public health centres in Thailand and Indonesia have initial medical care functions, unlike health centres in Japan. For this reason, when a person is suspected of being infected in a household or the community, the function of the public health centre is first activated. However, when quarantine is sought, health centres in Thailand and Indonesia must work with the health volunteers and health posts (*Posyandu*) to perform a smooth referral function.

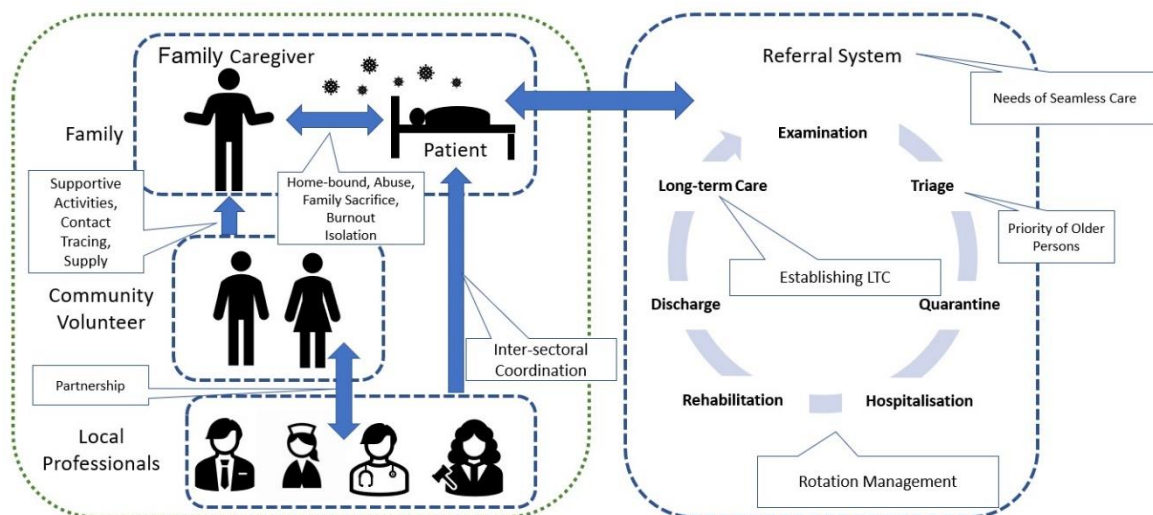
The referral system is a system that smoothly transitions between testing, arranging admission to isolation facilities or hospitals depending on the severity, follow-up, rehabilitation after treatment, returning home, and long-term care. If this does not go smoothly, the health centre will triage and request that patients stay at home. Even if institutional care is maintained to a certain extent as in Japan, if infectious diseases overshoot, similar situations will occur, and there will be cases where the

seriously ill are not treated. In addition, if a path to care after treatment is not created, the patient may not be discharged from the hospital and the hospital may not be able to accept new patients.

As the concept of LTC means a service for people who live with disabilities after an injury or illness, if there are no institutional care facilities, families and communities and also hospitals will become dysfunctional. In addition, when family members and residents care for infected people, close contacts, and people cured of infectious diseases, appropriate knowledge, attitudes, and practices (KAP) standards are required.

In Thailand and Indonesia, religious activities are deeply rooted in daily life. For this reason, it is considered meritorious for families and volunteers to care for elderly people. But at the same time, religious behaviour sometimes runs the risk of creating problems such as outbreaks of infection clusters at religious gatherings, family sacrifice, abuse within families, and caregiver burnout (Figure 8.3).

Figure 8.3. Situations of Family Caregivers and Volunteers during Infection



LTC = long-term care.

Source: Compiled by authors.

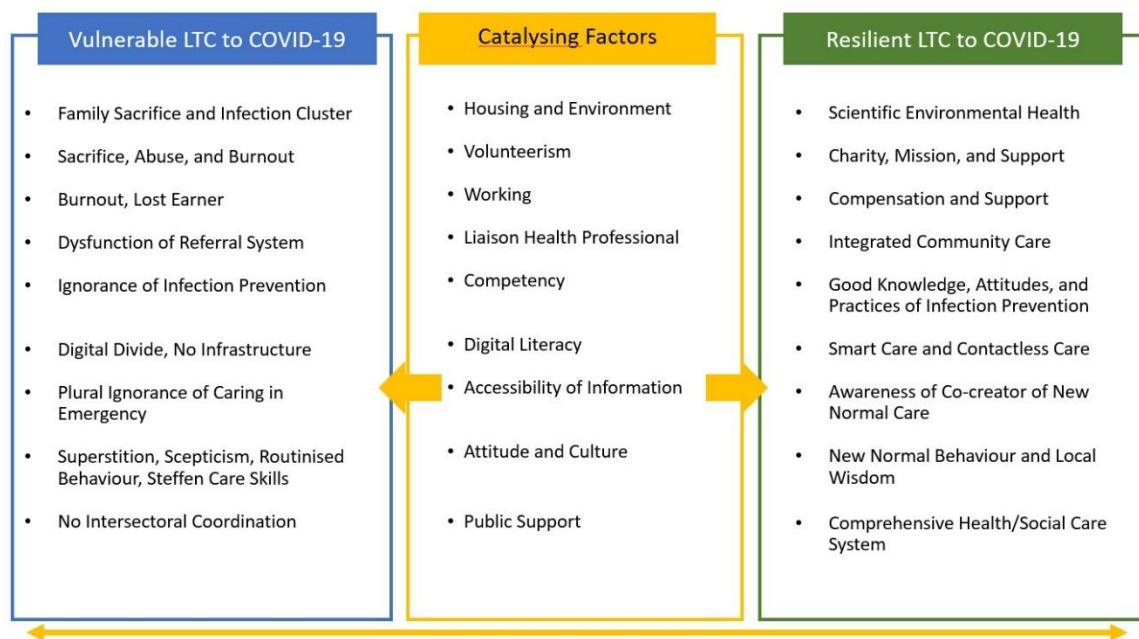
When the COVID-19 pandemic hit, societies dependent on care by the family and volunteers showed the following vulnerabilities:

- In general, there is a sense that infection transmission is through insects such as mosquitoes and small animals such as rats, but there is a low sense of infection transmission through droplets and aerosols.
- Older people are at greater risk of transmission through young family members who work outside.
- Infection cannot be prevented due to faith in religious gatherings, traditional medicine, and scepticism of government policies.

- Infected elderly people are quarantined together with their primary family caregivers.
- There are risky situations of family sacrifice, abuse, discrimination, and burnout.
- KAP of COVID-19 infection amongst family caregivers is not widespread.
- Households with infections are at high risk of losing their breadwinners.
- Social distancing was called for and volunteering was suspended.
- Since the infrastructure for information communication and technology (ICT), IoT, etc. information transmission is not in place, it cannot be used for long-term care.
- Because appropriate information cannot be delivered, families and residents are placed in a situation of so-called pluralistic ignorance, believing that ‘someone must be doing something’ or ‘no one knows what to do’, and the response is delayed when a person becomes infected .
- The referral system of testing, isolation, treatment, healing, rehabilitation, and back home for infected people does not work smoothly.

However, even during the COVID-19 pandemic, attention was drawn to the resilient activities of volunteers in supporting family care (Figure 8.4). In Thailand, health volunteers conducted contact tracing surveys, communicated information, distributed relief supplies, and helped with polymerase chain reaction (PCR) testing.

Figure 8.4. Resilient Long-term Care served by Family Caregivers and Volunteers



LTC = long-term care.

Source: Compiled by authors.

Indonesia's *Rama Lancia* (friendly to the older adult) West Java chapter launched comprehensive and sustainable assistance efforts to support older persons in communities. Volunteers monitor vital signs (blood pressure, temperature, etc.) and record health complaints, which are then reported to health workers for further action. In cooperation with the *Puskesmas*, they work to ensure that older

persons with chronic diseases are getting the medicine they need, and they distribute multivitamins recommended by geriatric doctors. They also provide additional nutrition for those older persons who are physically weak. The visits also include guidance on how to do at-home exercises to improve immunity, balance, and physical fitness. These visits also offer an opportunity to educate the community about the pandemic and how to prevent the spread of COVID-19. Volunteers distribute educational flyers and masks, and they teach older people how to wear masks correctly. They also use social media platforms that are popular amongst older people to provide education and dispel erroneous information circulating in the community. Volunteers have used WhatsApp to solve the problem of not being able to watch over social distancing. Then, the Ministry of Health, in collaboration with the Ministry of Home Affairs, launched the challenge of service standardisation and digitisation in *Puskesmas* and *Posyandu* in 2022. Attempts at tele-medicine have been made where human contact is avoided, highlighting the need for legal arrangements to disseminate these new initiatives (AHWIN, 2021).

Resilient care through volunteer work by families and residents can be summarised as follows.

- A dedicated family caregiver cared for the daily lives of the infected elderly.
- Abundant health volunteers in Thailand and Indonesia were responsible for activities that reduced the work of public health centres, such as watching, assisting with PCR testing, research of contact tracing, information transmission, and delivery of relief supplies for older residents.
- Volunteers can prevent rumours and misunderstandings amongst residents.
- Family caregivers and resident volunteers who received professional guidance and training were able to contribute to infection prevention and control.

In this way, resilient LTC that utilises the bonds of family and local communities as social capital is an issue that should be developed not only in Thailand and Indonesia but also globally, including Japan. Policymakers and LTC professionals should develop the support measures for family caregivers and volunteers.

1.4. Vulnerability and Resilience of Long-term Care Facilities

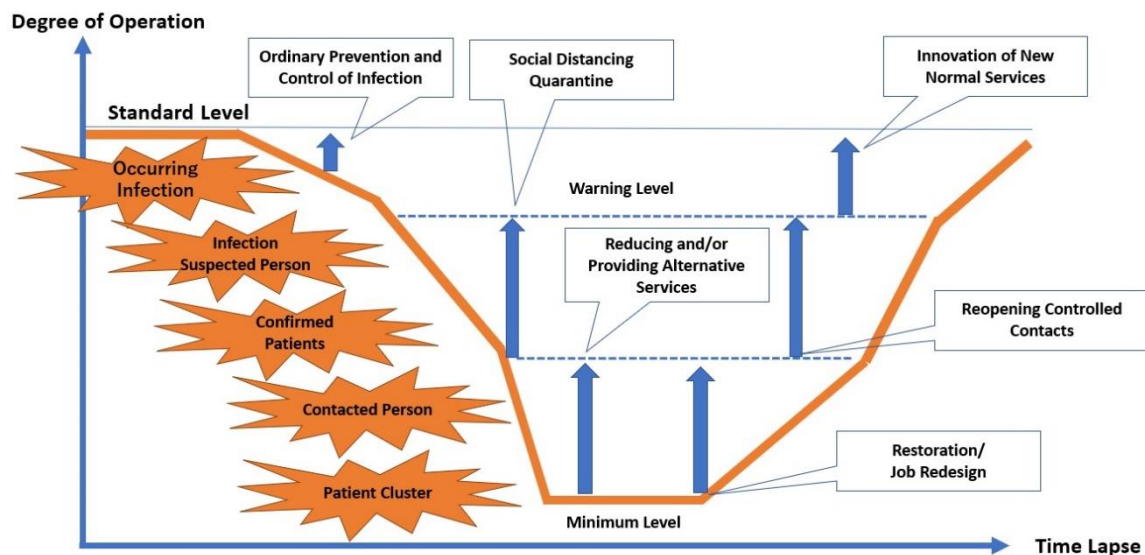
In Japan, where LTCFs for the elderly have been developed, the COVID-19 pandemic threatened their business continuity. The risk of business continuity has increased due to the outbreak of infection clusters in facilities, the suspension of attendance and securing substitute personnel due to infection of LTCWs, the suspension of recruiting new residents, the lowering of the level of services, and the securing of infection prevention management goods.

Before COVID-19, LTCFs in Japan had begun working on measures against known infectious diseases and business continuity plans for natural disasters such as earthquakes and floods that would come to an end in the short term. However, LTCFs' responses to COVID-19 were much more difficult because it attacked repeatedly and for longer.

In LTCFs, communication with various agencies became frequent and complicated according to

various stages, such as the stage where it occurred in a foreign country, the stage when an infected person appeared in the community, the stage when a close contact appeared amongst the staff and residents, the stage when an infected person appeared in the facility, the stage where a person discharged from quarantine was accepted, etc. Figure 8.5 conceptualises and illustrates how LTCFs respond to the COVID-19 pandemic to ensure business continuity.

Figure 8.5. Business Continuity Plan of Long-term Care Facilities



Source: Compiled by authors.

LTCFs were unable to demonstrate effective business continuity management, exposing the following vulnerabilities:

- Outbreak of COVID-19 infection cluster
- Progress of resident frailty due to prolonged prevention of COVID-19 infection
- Restrictions on the acceptance of elderly people who need long-term care
- Turnover of LTCWs and difficulty in securing a labour force
- Medical response to residents during the period of rapid increase in infections
- Deterioration of management, etc.

LTCFs in Japan are considered as places to live. Therefore, as a rule, residents with injuries and illnesses are transferred to hospital for treatment. However, due to the rapid increase in COVID-19 infections, it has become an issue to strengthen the health care functions of LTCFs; they need to be able to give health care to infected residents who are recuperating in facilities and accept elderly people who have completed treatment in hospital.

Under such circumstances, business continuity plans were advanced at LTCFs for the elderly in Japan. In addition to simply preventing and controlling COVID-19 infections, many care service providers have introduced devices for contactless care, such as online visitor interviews, and communication

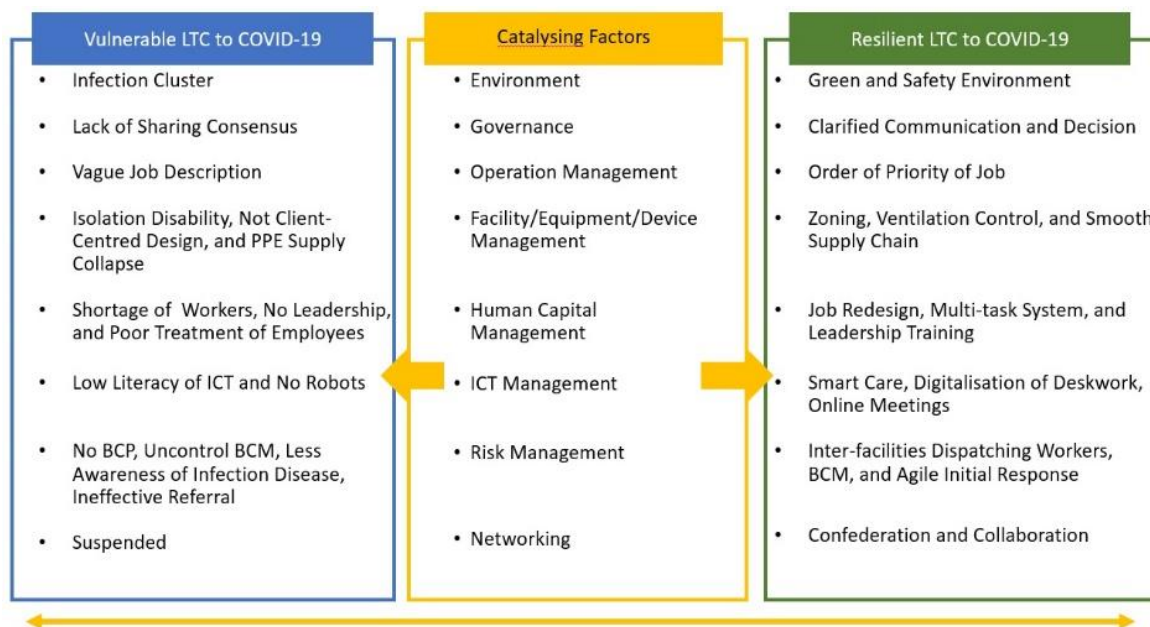
devices to reduce unnecessary conversations. In terms of employee management, various efforts were also made, such as securing substitute personnel, support personnel, and foreign migrant care workers. In terms of facility management, zoning in the event of an outbreak of an infected person, introduction of decompression equipment, allocation of LTCWs, and securing of accommodation facilities were also planned.

Although the formulation of business continuity plans for LTCFs for the elderly is mandatory in Japan, it is important for Asian countries that are likely to develop LTCFs in the future to formulate business plans and to the actual management methods. Thailand has adopted this idea and published a manual of business continuity plans (BCPs) for LTCFs in the Thai language.

Institutional care in LTCFs has the following vulnerabilities:

- Confused responses to infections were occurring because there was not shared consensus amongst staff.
- Disabilities for assessing primacy of job competencies because of vague job descriptions.
- LTCFs do not have isolation functions or space for isolation treatment. Also, the shortage of PPE supplies occurred, because LTCFs are not recognised as medical institutions.
- Overload of work caused by LTCW shortage, no leadership, and poor treatment of employees.
- Impossibility of digitalisation because of low literacy of ICT and care robots, digital divide of staff, and under-developed infrastructure of information.
- Failures of risk management such as business continuity, infection prevention and control, and ineffective referral system of infected residents.

Figure 8.6. Resilient Long-term Care with Business Continuity Management



BCP = business continuity plan, BCM = business continuity management, ICT = information and communication technology, LTC = long-term care, PPE = personal protective equipment.

Source: Compiled by authors.

However, our research in Japan revealed the following resilience:

- Clarifying information channels and decision-making structure in emergency based on a BCP.
- Instructing staff and sharing of information within the organisation.
- Prioritising the services according to the staff attendance rate. Ordering priority of care jobs.
- Redesigning job places: zoning, installation of a decompression chamber, ventilation control, and smooth supply chain of PPE.
- New style of working such as a multitasking is available for long-term care in the emergency. For actualising new work styles, training of management leaders is a prerequisite.
- Coping with increased workload and staff shortages: Utilising ICT, smart care, video conferencing systems (e.g. ZOOM), digital work by staff.
- Dispatching workers amongst facilities, agile responses, and timely modification of services onsite in emergencies. Strengthening of management system and staff training from 'normal times' for risk management.

The government has instructed LTCFs in Japan to develop business continuity plans. The BCP considers infectious diseases as well as natural disasters. While each LTCF needs to act immediately on this plan, they also need to respond to events that could not have been anticipated in the plan, act quickly, and later verify their actions and provide feedback to the BCP.

Policymakers and LTC professionals need to address structural issues (building standards, staffing standards, emergency support systems, new technological innovation, etc.) related to the resilient LTC system in a medium- to long-term manner.

1.5. Vulnerability and Resilience of Care Workers in Facilities

In Asian countries where the population is ageing, it will be necessary to establish certain LTCFs in the near future. Already, in Thailand and Indonesia there are welfare facilities for the elderly who have no relatives, who are poor, and who cannot work. There are also private fee-based assisted facilities that provide residential care for the wealthy elderly.

However, facilities that provide LTC services in line with the living functions of the elderly (activities of daily living [ADL], instrumental activities of daily living [IADL], and dementia) regardless of income or family structure are still a long way off in Asia, except for Japan, Singapore, the Republic of Korea, and China. That said, Thailand is considering it. For example, in July 2020, the Thai Ministry of Health issued a 'Ministerial Ordinance on Elderly Care Business Outside Medical Institutions' and has begun issuing licences to long-term care providers. In the future, securing the quality and quantity of care workers responsible for institutional care will become a policy issue.

For improving LTC in facilities, it is important to ensure a certain level of quality and quantity of work. Japan has been promoting institutional improvements such as a public long-term care insurance

system, standardisation of training for LTC professionals, the establishment of national qualifications, staffing standards for LTC facilities, and career paths for LTC positions. Even so, it is difficult to secure LTCWs. Disparities in working conditions with other occupations are a constant problem.

For ensuring the quality of LTCWs, a comprehensive support system of administrative agencies is necessary. However, in reality, there is a risk that multiple administrative agencies related to long-term care will fall into a lack of coordination. Measures against infectious diseases that occur internationally and regionally require mechanisms to complement community-based medical care, health, and welfare systems. When LTCWs in institutions are exposed to unknown infectious diseases, they might burnout if proper guidelines are not presented. The Ministry of Social Development is responsible for managing public facilities for the elderly, the Ministry of Health tackles measures against infectious diseases, and the Ministry of Family Affairs takes responsibility for the elderly within a family. It is said that such inter-ministerial coordination did not work well at first. In addition, private residential care homes had no choice but to completely cut off contact with the outside world.

With the spread of COVID-19, care workers have become recognised as essential workers. However, unlike medical professionals such as doctors, nurses, and pharmacists, the position of LTCWs is by no means high. Usually, a job description of an LTCW for the elderly is a service that deals with frailty or life impairment from non-communicable diseases. For this reason, the knowledge, attitudes, and practices of emergency response work such as the spread of infectious diseases are required.

Our research adopted a methodology, the KAP survey. The survey is a method to measure the ability of LTCWs to achieve their competencies. It is a method of checking whether they have the knowledge, attitudes, and practices necessary for achieving the task or not. Knowledge, attitudes, and practices of LTCWs in Japan (Appendix 1), Thailand, and Indonesia were investigated in their respective KAP surveys, and the following vulnerabilities were revealed.

In terms of knowledge, the following vulnerabilities were concerning:

- Lack of knowledge of aerosol transmission
- Lack of knowledge of ventilation control
- Lack of knowledge of professional response to infectious diseases
- Lack of knowledge of intersectoral coordination of administrative information

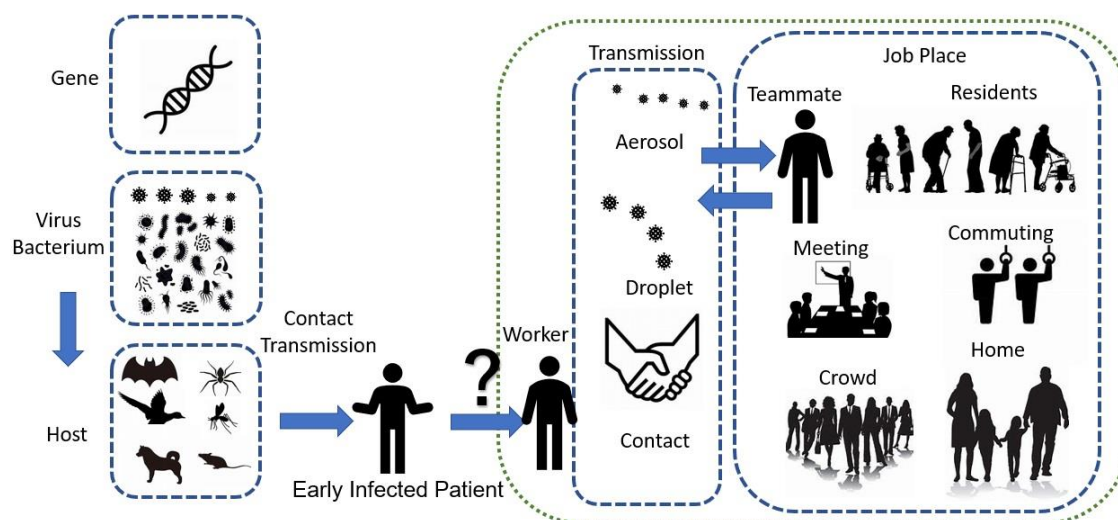
In terms of attitudes, the following vulnerabilities were worrying:

- Apathy of self-management of health conditions
- Apathy of preventive health in home
- Apathy of quarantine/hospitalisation
- Apathy of contact tracing
- Apathy of alternative care for residents with COVID-19
- Apathy of professional teamwork
- Apathy of the essential worker

Figure 8.7 illustrates the infection mechanism that care workers in LTCFs must know. Care workers must act based on this knowledge to prevent and control infection diseases.

Figure 8.7. Situation of Long-term Care Workers in Facilities

Various Risks of Infection Transmission around Workers



Source: Compiled by authors.

In terms of practices, the following vulnerabilities were concerning:

- Unskilled implementation on how to take responsibility during a crisis. No job redesign on discretionary acts, immunity from responsibility, agile response, and inevitability.
- Unskilled implementation on how to use PPE. Lack of equipment, unsuitable use of masks, and careless dumping of equipment.
- Unskilled implementation on how to control ventilation. Undeveloped ICT environment, mal-utilisation of equipment, and layout of room.
- Unskilled implementation on how to contact the infected, close contact, and/or asymptomatic persons physically. Diffuseness of quarantine, yellow zone, and physical distance.
- Unskilled implementation on how to care for dementia residents. Dis-communication with patients, easy physical restraint, and abuse.
- Unskilled implementation on how to improve work. Normal shortage of labour force, and labour-intensive business.
- Unskilled implementation on how to prevent frailty. No alternative idea of onsite preventive LTC exercise and oral care.
- Unskilled implementation on how to refer infected residents. Inefficient referral system, and nothing to do.
- Unskilled implementation on how to work for infected clients. Co-stay in institutions, behaviour restrictions not only in the business place, but also in public places and at home.

However, these vulnerabilities are mostly avoided. By tackling COVID-19, care workers in institutions have demonstrated the following resilience:

In terms of knowledge

- Strengthen knowledge of environmental health.
- Frequent ventilation and introduction of CO₂ concentration measurement equipment.
- Job description for infection risk management. Clarification of job descriptions for medical care workers and LTCWs.
- Agile response to risks and immunity from responsibility.

In terms of attitude

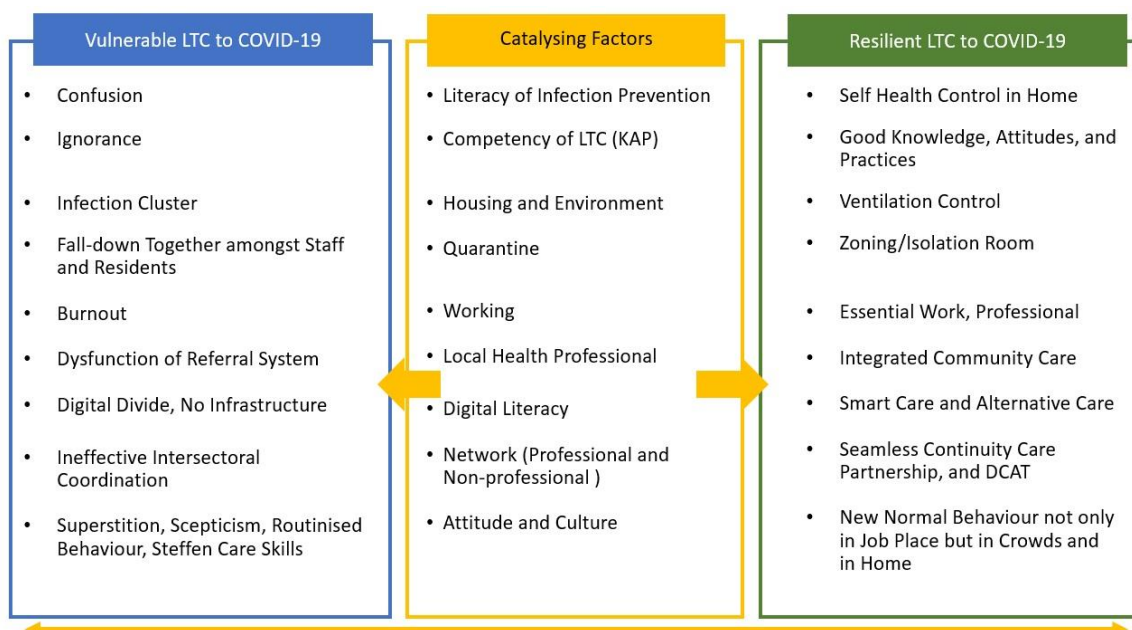
- Self-health management. In the workplace, in public places, and at home.
- Positive attitudes to infection prevention. Acceptance of PCR tests and vaccination.
- Cooperative attitudes to contact tracing. Willingness to collaborate with other professionals beyond the division of labour.
- Innovative willingness to build a new normal LTC. Utilising hotline, information platform, directory organisation, smart phone, social networking services, and other complementary LTC technologies.
- Awareness of a professional and an essential worker. Staff members in institutional care were required to stay in LTCFs and engaged in LTC work, their quarantine was designed together with the elderly residents of the facility.

In terms of practices

- Managing infection prevention in the working place, in public places, and at home.
- Competency of long-term care. Take responsibility, use own discretion on the job.
- Handmade PPE. Masks, face shields, gowns, and partition goods.
- Frequent ventilation. Diligent control of natural ventilation and operating mechanical ventilation.
- Implementation of contactless care. Follow zoning, keep physical distance, avoid 3 Cs, and apply new technologies.
- Dementia-friendly care. Effective non-verbal communication with clients.
- Partnership with other facilities and organisations. Requiring human replacement from other LTCFs and outsourcing of operations.
- Development of diverse preventive care programmes. Online training exercise.
- Awareness of the integrated community-based care system. Improving referral system, development of new back-referral programme, seamless care, intersectoral coordination, collaboration of medical and LTC and social welfare staff.

Figure 8.8 summarises catalysing factors of vulnerability and resilience imposed on Care Workers in LTCFs during the COVID-19 pandemic.

Figure 8.8. Resilient Long-term Care Served by Care Workers in Facilities



KAP = knowledge, attitudes, and practices, LTC = long-term care, DCAT = Disaster Care Assistant Team.

Source: Compiled by authors.

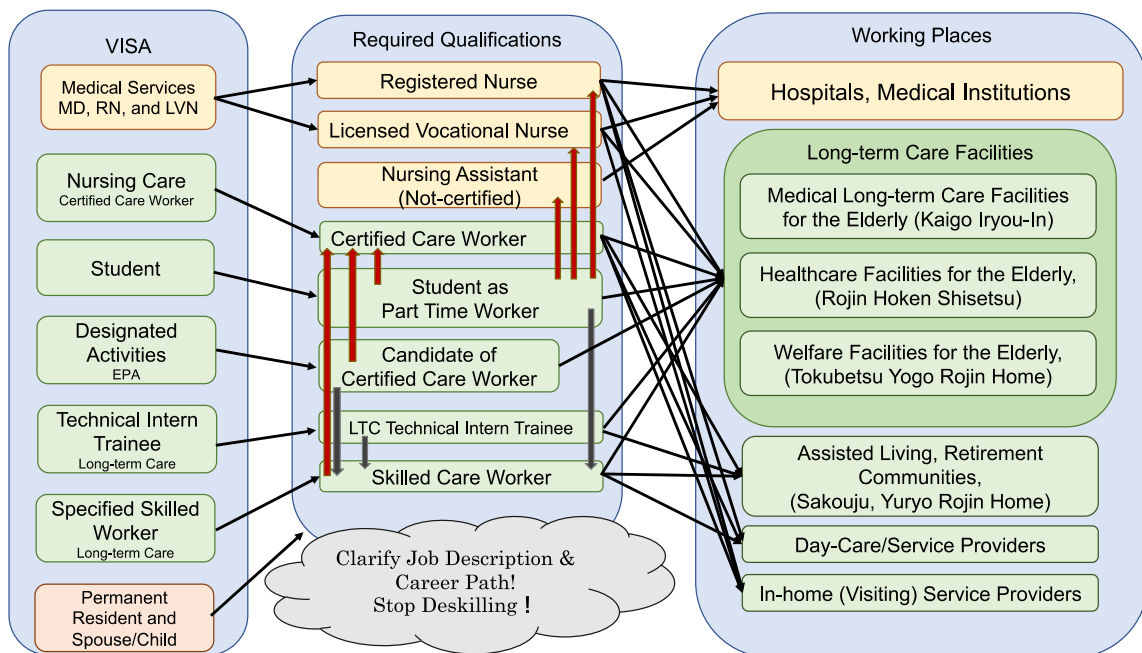
1.6. Vulnerability and Resilience of Migrant Care Workers in Japan

In Japan, the number of workplaces where foreigners are caring for the elderly is increasing. Their status of residence is diverse, such as nursing care (it does not mean nurse but certified care worker who engages in long-term care for the elderly and the disabled), economic partnership agreement (Indonesia, Philippines, Viet Nam), international students (permission to engage in activities outside the status of residence), technical intern trainees, specific skilled workers, and permanent residents. However, in Japan, except for 'permanent residents' and 'nursing care', it is considered that most foreigners will eventually return to their home countries.

In the future, countries with advanced population ageing will face a situation such as an increase in the number of elderly people who need long-term care, and a shortage in the labour force. Therefore, the introduction of migration care workers (MCW) will be planned. However, there are a lot of unresolved issues internationally. Is it possible for each country to provide LTCWs as a profession by regulating it internationally? How should we nurture and send them out? What kind of residence permit system should be used to accept the applicant? How do you evaluate their careers internationally? How can we develop their smooth career paths domestically and internationally? Several other issues remain unresolved.

Unable to return home due to COVID-19, MCWs will once again be considering what categories of visa to extend or change. Figure 8.9 shows the different status of residence in Japan and the change between them. The relationship between the status of residence, vocational status, and the workplace where MCWs can work is illustrated, but it is complicated. If MCWs themselves do not know what kind of career path they are aiming for, they will have a risk of losing way.

Figure 8.9. Residential Visas, Job Qualifications, and Working Places in Japan



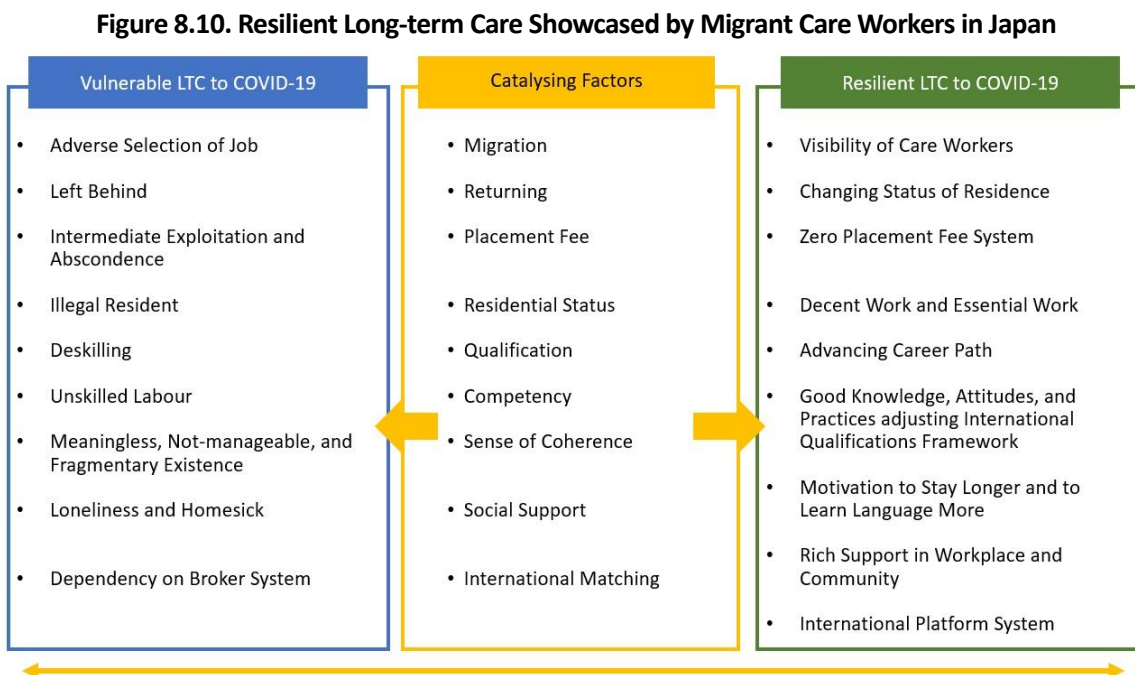
LTC = long-term care, MD =medical doctor, RN =registered nurse, LVN =licenced vocational nurse, EPA = economic partnership agreement,

Source: Compiled by authors.

The global COVID-19 pandemic has exposed the vulnerability of foreign care workers as follows:

- When international students work shorter hours at LTCFs, they may be placed at a disadvantage as an ‘employment safety valve.’ In occupations other than LTC, the risk of contract cancellation increased.
- COVID-19 has forced MCWs to leave and be unable to return home.
- There was a concern that technical intern trainees and international students from Viet Nam would be forced to carry a large amount of debt in the sending country for arranging employment and study in Japan, so they would be forced to exploit the intermediate fee.
- There was a risk of becoming an illegal resident due to the length of stay for each complicated status of residence and the procedure for change.
- In order to get an LTC job in Japan, a high level of education and work experience such as a university degree and a nursing qualification were required, but in practice there was no appropriate treatment and was exposed to the risk of the deskilling.
- The risk of being left unskilled in an LTC job achievement and language learning has increased.
- When measured by sense of coherence as one of the indicators of resilience, social support, short-term stay, and language ability were strongly related.
- Without the support of a manager at workplace, an instructor at an educational institution, or a preceptor for a countryman, MCWs will be lonely and prone to homesickness.
- The matching method between technical intern trainees and LTCFs under the broker system caused over debt cases such as in Viet Nam.

Figure 8.10 summarises catalysing factors of vulnerability and resilience imposed on migrant care workers during the COVID-19 pandemic.



LTC = long-term care.

Source: Compiled by authors.

COVID-19 has forced many businesses to scale back or abolish operations in areas other than LTC. Many foreign workers were left behind with nowhere to go. Even so, Japanese LTCFs had a public responsibility to secure business continuity, and LTCWs were guaranteed work opportunities as essential workers. As a result, even during COVID-19, foreign care workers have been able to continue to be employed. In addition, some people who worked under a different status of residence switched their status of residence and were hired at LTCFs.

Therefore, foreign care workers demonstrated the following resilience:

- Conditions of employment for MCWs, which were stable under COVID-19, were protected by the public long-term care insurance system.
- Efforts were made to deregulate the terms of residence for MCWs, who are unable to return to their home countries, and to change their status of residence.
- In the Philippines and Indonesia, a zero placement fee system was worked on for MCWs.
- The recognition of MCWs as essential workers and the need to improve them internationally as the amount of decent work has increased.
- The career path as the LTC professional from the unskilled to the highly skilled has been highlighted for MCWs.
- The acquisition of knowledge, attitudes, and practical skills in LTC work progressed, and the necessity of an international LTC qualification framework was realised.

- MCWs' Sense of Coherence as a resilience index was found to correlate with long periods of stay and language proficiency in the destination countries.
- MCWs were highly esteemed in the workplace, school, and community, and social support was provided.
- The need to build a platform for international matching, rather than relying on a brokerage system, began to be discussed.

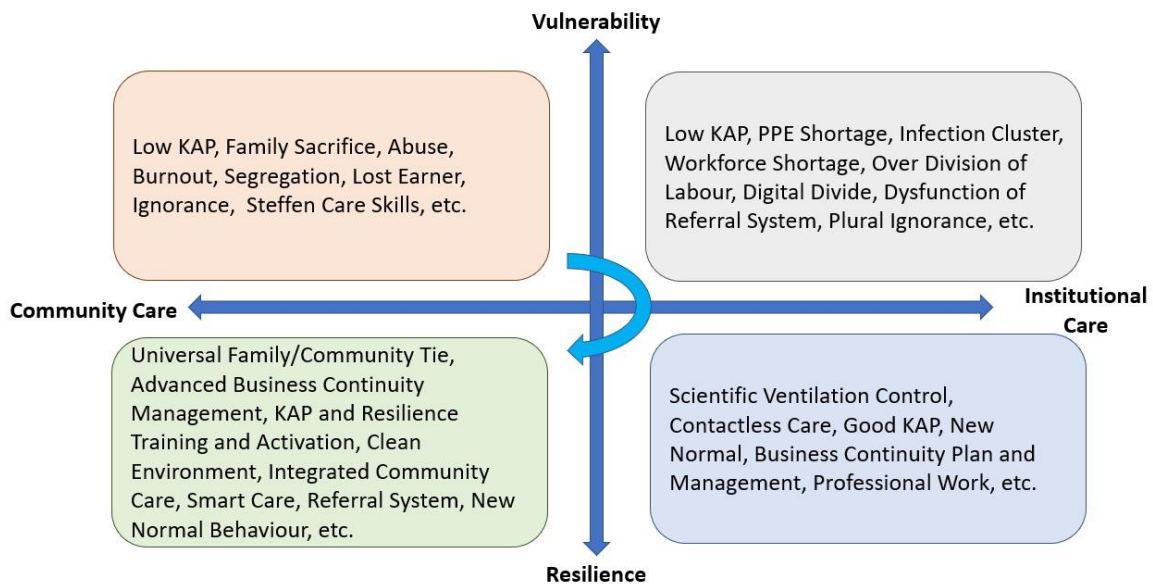
In the near future, international training and circulation of LTCWs will be a common issue for ageing Asia. Within the professional qualifications' framework of each country, LTC-related competencies have a diverse position. For this reason, the smooth international occupational migration of LTCWs tends to be hindered. The qualifications of LTCWs in Japan does not exist in other countries' professions. For unlocking the potential of foreign LTCWs reaffirmed by COVID-19, efforts should be made to define long-term care internationally in the professional qualifications' framework.

2. Lessons Learnt and Recommendations for Policymakers and Long-term Care Professionals

2.1. Lessons Learnt on our Research Framework

A summary of the revealed vulnerability of LTC for the elderly and the resilience to overcome it is shown in Figure 8.11.

Figure 8.11. Overview of Resilient–Vulnerable Long-term Care



KAP = knowledge, attitudes, and practices, PPE = personal protective equipment.

Source: Compiled by authors.

When LTC for the elderly is entrusted to family members and residents, there is a high risk of vulnerability appearing as age discrimination, abuse, household breakdown, family sacrifice, burnout, and segregation. All relevant agencies have not only taken infection prevention and control measures against COVID-19 but have also taken immediate action against such vulnerabilities.

When LTC for the elderly is entrusted to institutional care, its vulnerability manifests in the following phenomena: lack of efficient control due to lack of data on LTCFs as the basis of scientific research, susceptibility to infection clusters, burnout of care workers, workforce shortages, lack of literacy in infectious diseases, lack of guidelines, collapse of medical care occurred due to confused referral systems and lack of intersectoral coordination, no legal basis for introducing new technologies, interruption of service provision, inadequacy of PPE supplementation, etc. For alleviating these vulnerabilities in institutional care, facility managers and care workers will need to respond flexibly and ask regulators for alternatives and mitigation measures.

However, there is resilience seen in institutional care: possibility of data collection and analysis by preparing LTCF-related statistics, management technology of environmental health such as ventilation, business continuity planning, necessity of back-referral programmes, and the development of training programmes based on KAP surveys, etc. Such resilience will be ensured not only by the discretionary management of facility managers and care workers, but also by the government's legal arrangements.

In addition, there is resilience demonstrated in terms of community care. Everywhere there are many elderly people who are being cared for by their families. Activities by residents serve as complementary family care. Some of the resident volunteers use social networking services to watch over the residents. There is a widespread perception that not only facility managers but also community healthcare and social care businesses need business continuity management skills. Governments and medical, health, and welfare stakeholders recognise the need for a referral system and intersectoral coordination within the region. In the future, based on such knowledge, skills and attitude, a comprehensive regional care system should be constructed.

2.2. Recommendations for Standardising Statistical Procedures Internationally

In the event of an unknown infectious disease such as COVID-19, data collection methods to understand the actual situation should be standardised internationally. The number of new infections is affected by the number of cases that have undergone PCR testing. However, the number of people who are seriously ill or die is greatly influenced by other factors, such as age, chronic illness, and the time required for referral. The definition of statistical concepts and the methods of collecting their data should be standardised internationally. In particular, the concepts of LTC, LTCFs, and LTCWs vary from country to country. The challenge is to share international concepts amongst countries.

Contact tracing is an important health methodology, but there have been cases where public health centres in Japan suspended their practice temporarily due to disruption to the spread of the virus. Contact tracing methods, as in Thailand, need to be improved, such as the mobilisation of health

volunteers and the use of smartphone applications. Policymakers and care professionals should seek legislation to innovate research methods.

2.3. Recommendations for Promoting Ventilation Strategies in Urbanised Environment

COVID-19 is said to have become a pandemic when a bat-derived virus mutated to the point where it caused 'human-to-human' transmission. The WHO advocates the concept of 'One Health', which integrates animal health and human health. COVID-19 is a prime example. COVID-19 is a series of mutations that will hit humanity for a long time in waves of epidemics. In the 'animal-to-human' stage, COVID-19 spreads by the transmission route of contact infection, but when it enters the stage of human-to-human infection, it spreads by droplet infection and/or aerosol infection. It is also worth noting that COVID-19 has changed its infectivity and mortality rate with mutation.

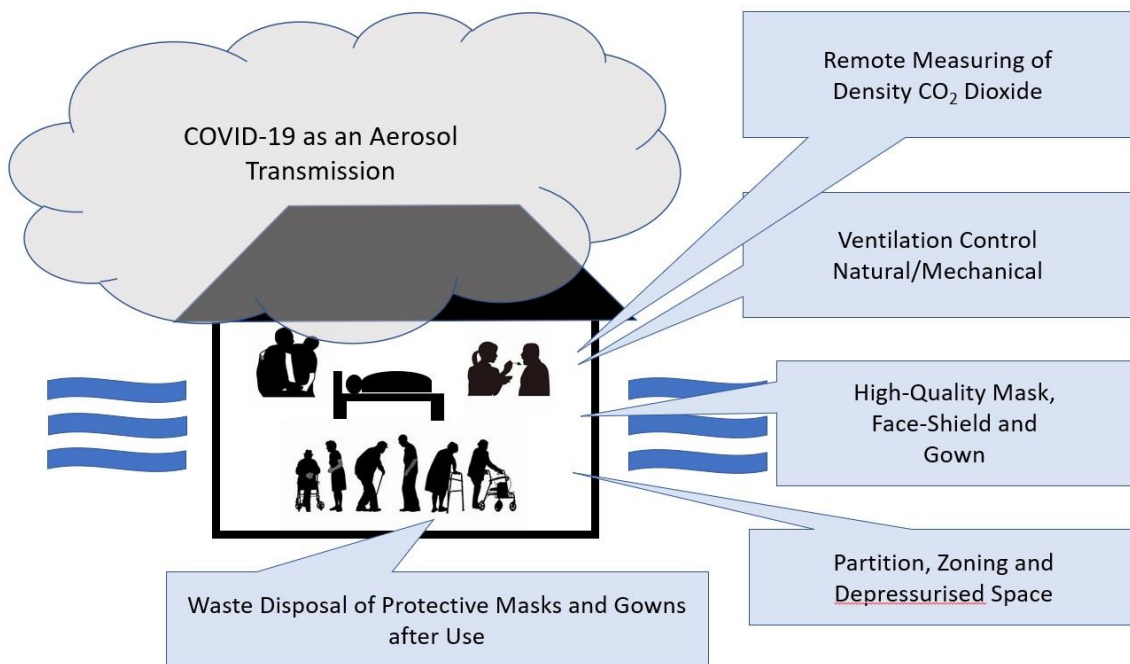
The WHO initially said COVID-19 was spread through contact and droplet transmission. However, in Japan, it was pointed out from an early stage that it spreads due to aerosol transmission, and a behaviour regulation called Avoid 3Cs (crowded places, close-contact settings, and confined and enclosed spaces) was announced. Particularly, for LTCFs where it is easy to create enclosed spaces, it is important to undertake ventilation control to prevent aerosol infection. In urban environments where not only LTCFs for the elderly but also various facilities are being developed, the risk of virus infection increases if ventilation is not good.

Regarding ventilation, there is a method for measuring the CO₂ concentration as an index. The application of ICT technology to telemetry to contribute to its implementation may be developed in the future. However, for making this possible, there are issues such as improving the information and communication situation of facilities and legal development that makes it possible to operate from the outside.

In addition, environmental health such as wearing highly-functional masks, face shields, and gowns; zoning facilities and installing decompression rooms; and sealing waste will be important to combat aerosol infection with COVID-19.

In this area of environmental health, policymakers and LTC professionals should sort out the issues surrounding COVID-19 and contribute to advancing the concept of One Health in the future (WHO, 2022). Policymakers and LTC professionals should introduce scientific control of environmental health technologies (remote sensors of CO₂, photocatalytic coating, etc.). Figure 8.12 illustrates the environmental health aspects under infection control.

Figure 8.12. Environmental Health under Aerosol Infection Control



Source: Compiled by authors.

2.4. Recommendations for Supporting and Empowering Long-term Care Service Providers

In China, the share of LTC is said to be '973'. This means that 90% of the care will be provided by families, 7% of the remaining 10% in communities, and 3% in institutions. Even in a society like Japan, where institutional care is conspicuous, the ratio of sharing is almost same. However, once institutional care is put in place, measures against new infectious diseases peculiar to facilities are required.

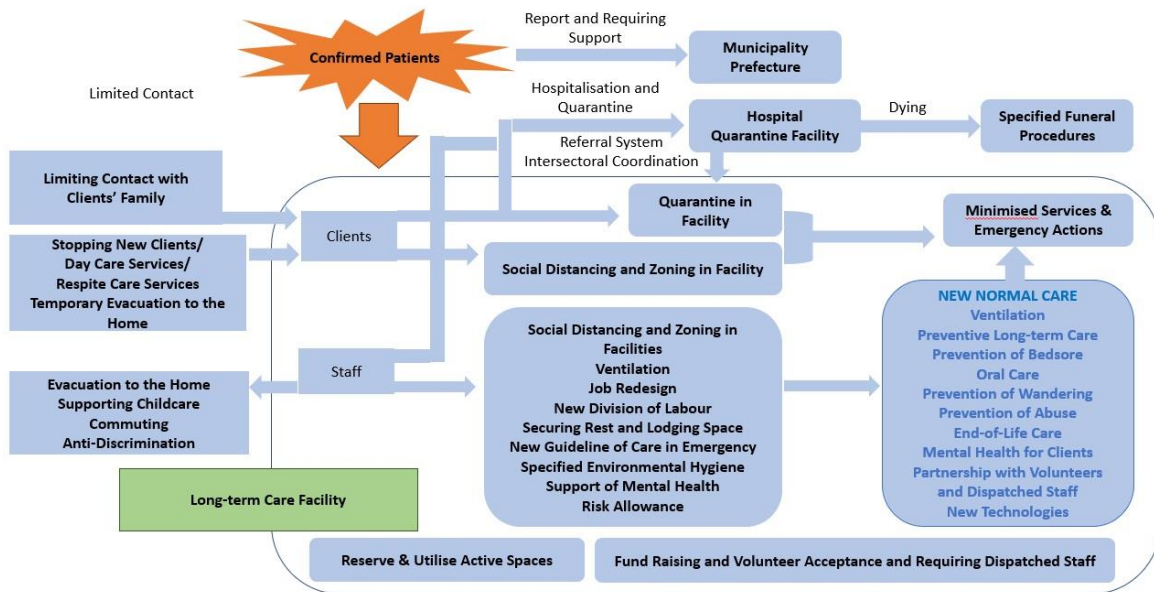
An LTCF is a home for elderly people with weakened ADL and IADL and cognitive decline. They are extremely vulnerable to infectious diseases. Therefore, elderly care facilities have been working on measures against infectious diseases in their normal work. But when it comes to responding to unknown infections like COVID-19, challenges have come to light.

Even if LTCFs are not medical institutions, similar efforts must be taken during periods of COVID-19 outbreaks such as PCR testing of elderly residents in the facility, onsite zoning for quarantine, mechanical ventilation, maintenance of decompression rooms, etc.

In terms of human resources, if residents or staff are identified as infected or close contacts, it will be necessary to select persons in charge of caring for such people. Even for PPE, personnel guidelines as essential workers are necessary, such as when wearing high-performance masks etc. equivalent to those of medical workers and shortening the quarantine period in case of close contact.

Figure 8.13 illustrates whether a chain of behavioural changes occurs between care workers and related people when an infected person appears in a LTCF.

Figure 8.13. Behavioural Contacts and Referral System of Patients in Long-term Care Facilities



Source: Compiled by authors.

With the spread of COVID-19, LTCFs will have increased liaison work with health centres, medical institutions, and various government departments. However, such intersectoral coordination tends to be confusing and dysfunctional. Rapid information sharing is necessary for referrals and quarantine in the event of an infected person or close contact in LTCFs, or for a back referral from the hospital to LTCFs after treatment is completed.

In order to enable the business continuity of LTC in response to such infectious diseases, policymakers and LTC professionals should not only support service providers in formulating a BCP, but also take measures to strengthen the power of business continuity management (BCM), as well as to improve the referral system and intersectoral coordination. These findings should also be utilised in the development of institutional care in Asian countries (UN-HABITAT, 2020).

2.5. Recommendations for Supporting and Empowering Long-term Care Workers

Family caregivers and volunteers provide normal care in line with customs. However, under the social imperative of social distancing, normal care has become impossible. Family caregivers had no choice but to confine themselves at home with the elderly, and residents had no choice but to stop volunteering. In addition, rules such as customs and traditional ways of life unique to families and communities were excessively applied, leading to family sacrifice and abuse. Nonetheless, family care and care by resident volunteers will be able to provide a powerful support function for infected people and close contacts who tended to live in isolation.

Employed LTCWs are subject to a workplace's regulations, and, in some cases, norms based on national qualifications. If the profession is well established, the knowledge, skills, and professional ethics necessary to satisfy the competency are known, and those who have mastered it are certified.

For example, core LTCWs in Japan are trained as professionals and certified with a national qualification. Therefore, standard KAP was provided for measures against non-communicable diseases and known infectious diseases on the elderly requiring LTC.

However, Japan's LTCWs are vulnerable to new infections like COVID-19. Nonetheless, LTCWs were working to create resilient LTC in the workplace. For confirming such a movement, a KAP survey will be useful. The KAP survey is designed to clarify the competency of LTCWs, for example, how much 'knowing' about infectious diseases and how much 'accepting' the attitudes required for them, and specifically how much 'doing' the skilled practices. Table 8.1 shows examples.

Table 8.1. Training Outcomes of Resilient Long-term Care (tentative)

Level	Competency	Knowledge	Resilient Attitude	Skills
Level 6	Manage complex technical or professional activities or projects, taking responsibility for decision-making in unpredictable long-term care contexts; take responsibility for managing professional development of individuals and groups.	Advanced knowledge of a field of long-term care, involving a critical understanding of theories and principles. e.g. understanding business continuity plan and management, understanding environmental health, job descriptions, referral system, recruitment of care workers, etc.	Transformative attempts towards creativity/alternativity of long-term care in long-term risks.	Advanced skills, demonstrating mastery and innovation, required to solve complex and unpredictable problems in a specialised field of long-term care. e.g. enhancing smart care, contactless care, ventilation system architecture, comprehensive care system, harmonising qualifications framework, etc.
Level 5	Exercise management and supervision in contexts of long-term care activities where there is unpredictable change; review and develop	Comprehensive, specialised, factual and theoretical knowledge within a field of long-term care and an awareness of the boundaries of that knowledge. e.g. understanding priority of long-term care services, Inter-sectoral	Adaptive attempts towards flexibility of long-term care in mid-term risks.	A comprehensive range of cognitive and practical skills required to develop creative solutions to abstract problems. e.g. outsourcing jobs, accepting

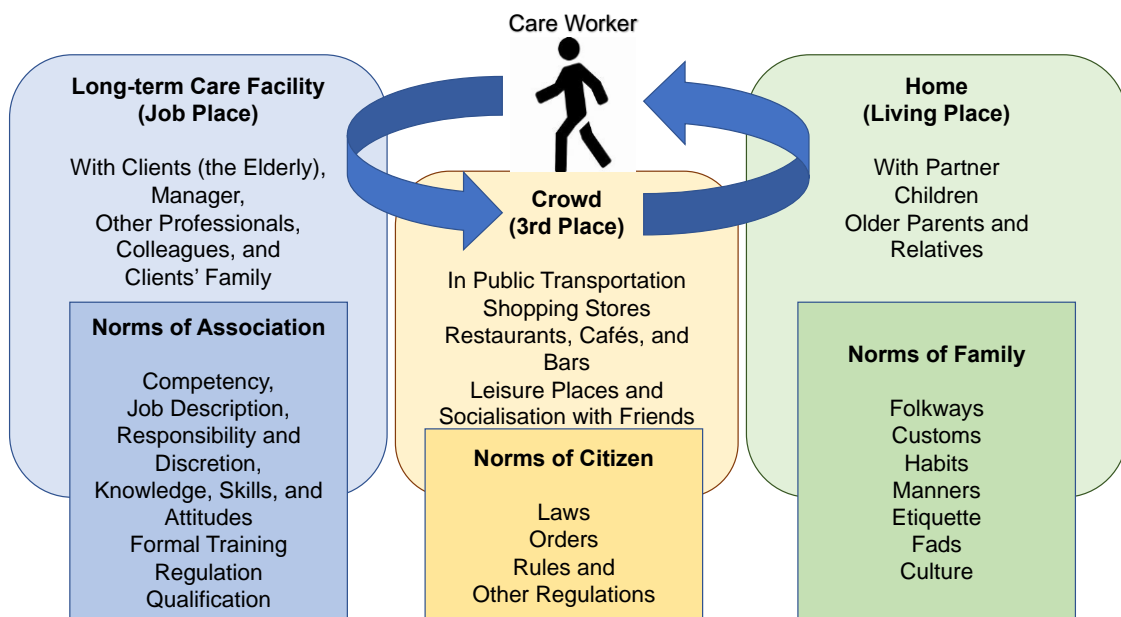
Level	Competency	Knowledge	Resilient Attitude	Skills
	performance of self and others.	coordination amongst long-term care, nursing care, medicine, public health and social work, etc.		assistant human resources, possible agile decisions, deregulation of care, practical quarantine management, etc.
Level 4	Exercise self-management within the guidelines of long-term care contexts that are usually predictable but are subject to change; supervise the routine work of others, taking some responsibility for the evaluation and improvement of long-term care activities.	Factual and theoretical knowledge in broad contexts within a field of long-term care. e.g. understanding self-health control, anger management, mindfulness, etc.	Mitigative attempts towards stability and/or persistency of long-term care. Measured on the sense of coherence and/or resilience quotient score.	A range of cognitive and practical skills required to generate solutions to specific problems in a field of long-term care. Possibility of multitasking, self-regulation of everyday life, quick awareness of emergency, etc.
Level 3	Take responsibility for completion of tasks in long-term care; adapt own behaviour to circumstances in solving problems.	Knowledge of facts, principles, processes, and general concepts in a field of long-term care. Understanding long-term care as complementary of ADL/IADL, etc.	Maintain universal precaution against infection. Avoid crowded places, close-contact settings, and confined and enclosed spaces (3 Cs). Respect human rights. Support for older persons to act in an autonomous or independent way.	A range of cognitive and practical skills required to accomplish tasks and solve problems by selecting and applying basic methods, tools, materials and information.
Level 2	Work or study of long-term care under supervision	Basic factual knowledge of a field of long-term care. e.g. understanding older persons those who	Response to expectations as an essential worker.	Basic cognitive and practical skills required to use relevant

Level	Competency	Knowledge	Resilient Attitude	Skills
	with some autonomy.	are living with some disfunctions.		information in order to carry out tasks and to solve routine problems using simple rules and tools.
Level 1	Work or study of long-term care under direct supervision in a structured context.	Basic general knowledge.		Basic skills required to carry out simple tasks.

ADL = activities of daily living, IADL= instrumental activities of daily living.

Source: Compiled by authors based on European Qualifications Framework and ASEAN Qualifications Reference Framework and Japan’s Qualification Framework of Professional Long-term Care (Kaigo Professional Dan’i Seido) (in Japanese).

Figure 8.14. Social Norms of Long-term Care Workers under an Infectious Disease Outbreak



Source: Compiled by authors.

LTCWs working in institutions move back and forth between workplaces, home, and crowds. For them, the risk of infection lies not only in the workplace, but also at home and in crowds. How to observe social norms in such places of commuting should also be dealt with in training programmes (Figure 8.14).

Considering the above, policymakers and care professionals should once again appropriately position support for family caregivers in the integrated system of community healthcare, and health and welfare systems.

As for volunteers, there were examples such as in Thailand where they actively played a part in health services, and in Indonesia, where they used social networking services apps to watch over the elderly. For disseminating such activities, it is necessary to develop legislation that makes it easy to do so. Policymakers and care professionals should pave the way for the challenges of protecting personal information and sharing public health and welfare information.

To establish the decent work of care workers, policymakers and LTC professionals should share the situation in Japan. This is because, in Japan, LTC is socially recognised as a specified business, LTCFs have been established, and the vocational qualifications of LTCWs employed there have been established. Considering the lessons learnt from Japan's COVID-19 response, support should be given for LTCWs to sharing infectious disease prevention and control training programmes not only in institutions but also in crowds and training in contactless care and smart care.

- The concept of LTC will be systematically established, and a referral system will be put in place so that people can return to their families and communities after receiving treatment after being quarantined from their families and communities.
- Researching and optimising delivery system of long-term care services, whether older persons live with their families or live in residential aged care.
- Disseminating the right knowledge, attitudes, and practices of resilient long-term care for family caregivers, community volunteers, and leaders.
- Income compensation should be provided to family caregivers.
- Developing infection-free environments for caring older persons.
- Aligning health systems and welfare systems to the LTC needs of older persons.
- Developing sustainable and equitable systems for LTC.
- Developing and qualifying LTC training programmes for family caregivers and community volunteers.

For enhancing the power of KAP against infectious diseases amongst LTCWs, policymakers and care professionals should clarify the job descriptions of LTCWs, and then enhance the knowledge, skills, and attitudes necessary through recurring education to fulfil their competency (responsibility, discretion) as following:

- Enhancing the competency of environmental health against infection disease.

We recommend that care workers in facilities strengthen their environmental health KAP, such as knowledge of aerosol infection, attitude of avoiding 3Cs, and practice ventilation.

- Clarifying the discretion during infection emergency for LTCW.

In the LTC workplace, each job is usually carried out by a strict division of labour and cooperation amongst professionals. However, in the event of an emergency, not only facility managers but also professionals will not be able to overcome the situation unless a certain degree of deregulation and voluntary discretions are recognised. We recommend that the disclaimer in such cases be clearly indicated by improving the wide-area support system such as the disaster care assistant team (DCAT), the disaster medical assistant team, and the disaster psychiatry assistant team.

If care workers are certified with a national qualification as in Japan, they should consider mobilising the DCAT in the event of an infectious disease pandemic on a broad scale. Even when associations of private nursing homes are organised, as in Thailand, a system of mutual support by dispatching the DCAT to each other would be effective. We propose that a system be put in place to register LTC workers trained in infectious disease control as reservists and to dispatch them in the event of an emergency.

2.6. Recommendations for Supporting and Empowering Migrant Care Workers

In Asia, where the population is ageing, it will no longer be possible to leave elderly care to family members and resident volunteers alone. If that happens, it will be necessary to develop institutional care on a certain scale and cultivate LTCWs who will work professionally there. However, since the degree of population ageing in each country is different, there is a time lag in the development of LTCFs for the elderly. Therefore, the issue of training and circulation of migrant care workers becomes an issue.

This challenge has already been recognised all over the world. In Asia, Singapore, Japan, and Thailand are host countries for such migrant care workers, whilst countries such as the Philippines, Indonesia, and Viet Nam have gained experience as sending countries. However, the education, training, and qualification of migrant care workers vary from country to country. In addition, the guidelines for status of residence, evaluation of occupational qualifications, and career paths in the host country are also different. As a result, issues such as deskilling and status of residence issues in the event of a situation such as COVID-19 will surface.

The European Qualifications Framework, which was developed with the integration of the European Union, an attempt to harmonise international vocational qualifications, has led to the establishment of the ASEAN Qualifications Reference Framework in Asia as well. However, the work of LTC for the elderly has not been harmonised internationally in accordance with this framework. In the first place, it can be said that job descriptions for LTC for the elderly are not also shared internationally.

Japan has established a qualification system for LTCWs which are certified national qualifications and is building an LTC system that uses certified care workers as a core specialised human resource. The career path within LTC called the LTC professional career rank system based on the European Qualifications Framework has also been clarified. In addition, Japan accepts a variety of migrant care workers such as certified care worker candidates through bilateral economic partnership arrangements, technical intern trainees, international students who have obtained the 'Japan certified care worker' qualification, and specified skilled workers. COVID-19 made it impossible to travel to and from the sending countries, measures such as extending the period of stay and switching the status of residence were taken in Japan.

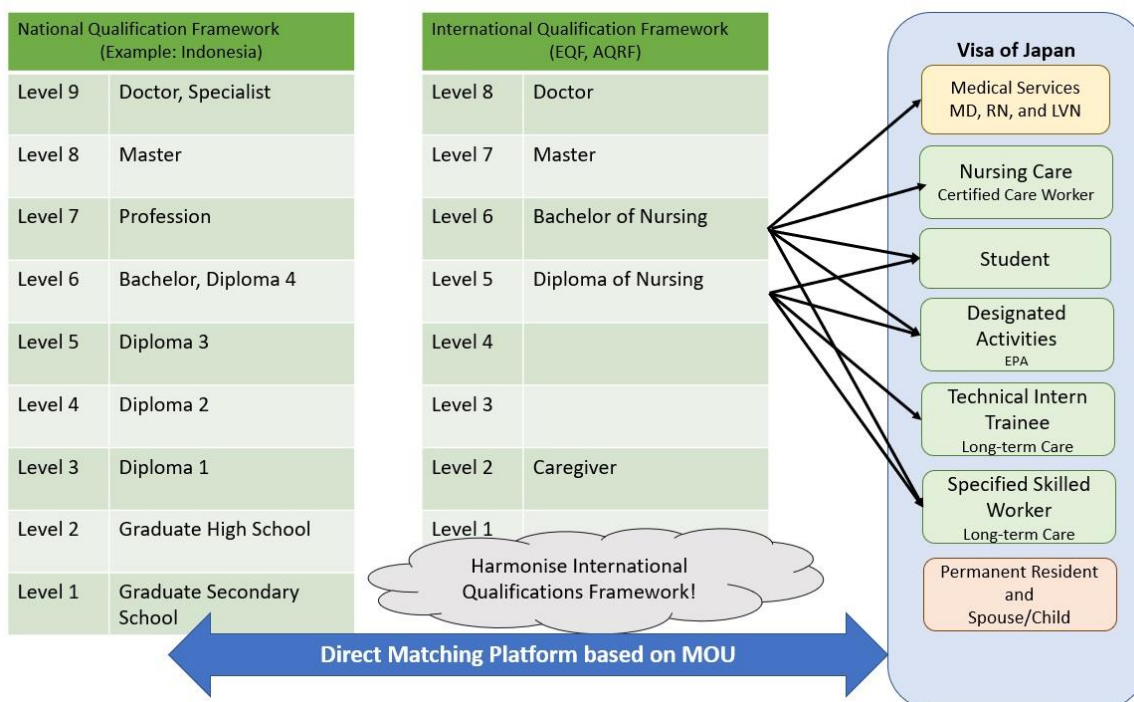
COVID-19 has confirmed the reputation of LTCWs as essential workers. It was also strongly recognised that migrant care workers are indispensable in Japan, the host country, as the labour force responsible for essential workers. Despite the challenges they faced, migrant care workers demonstrated their KAP abilities that were appreciated by those around them.

Japan's unique vocational qualification system, which is centred on certified care workers, is fraught with various misunderstandings with nurse qualifications in other countries. In Japan, certified care workers are positioned as social (welfare) workers, and there is a clear distinction between nurses in medical professions. Even within the same workplace, the responsibilities and discretionary powers of both groups are different. However, in response to COVID-19, attention has focused on the activities of migrant care workers, who received nursing education in the sending country and work as LTCWs in Japan. In the future, as collaboration between medical care, health, and welfare is strengthened and efforts to engage in medical practice by welfare professionals are fostered in society, expectations for migrant care workers who have received nursing education will increase.

Considering this reality, policymakers and LTC professionals in sending and receiving countries of migrant care workers have positioned LTC in the international qualifications' framework towards the establishment of decent LTC work and career paths in which deskilling should not occur. Also, without a placement fee, MCWs should get employment information directly through an international platform that is managed by an authorised organisation on bilateral or multilateral memorandum of agreements.

Figure 8.15 illustrates the mechanism of harmonising the qualification framework for MCWs. There are various coordination issues between the qualification framework of each home country and the international qualification framework and the status of residence in Japan. A future issue will be to harmonise qualifications frameworks and exchange MOUs so that direct employment matching can be conducted.

Figure 8.15. International Harmonisation of Qualifications Framework of Long-term Care



EQF = European Qualifications Framework, AQRF = ASEAN Qualifications Reference Framework, MD = medical doctor, RN = registered nurse, LVN = licensed vocational nurse, EPA = economic partnership agreement, MOU = memorandum of understanding.

Source: Compiled by authors.

2.7. Recommendations for Policymakers and LTC Professionals to Promote Resilient Long-term Care for the Elderly

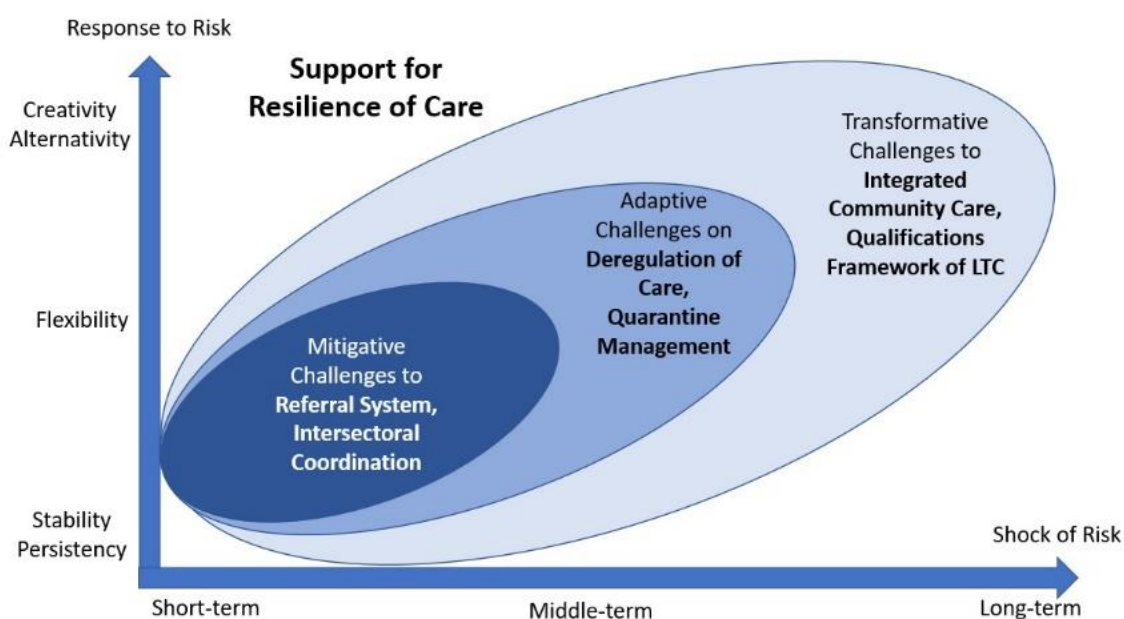
Overcoming the vulnerabilities of LTC for the elderly that have emerged under COVID-19, the movement to showcase resilience is certainly beginning to take shape. From now on, policymakers and LTC professionals will be asked how to establish and disseminate these movements as ‘the new normal’ of LTC. Therefore, towards the establishment of resilient LTC against infection disease pandemic, we recommend the following to policymakers and professionals in LTC for the elderly in Asia.

In the short term, policymakers and care professionals need to disseminate existing guidelines of infectious disease control, to support designing business continuity plans for public/private LTC service providers, and to engage in online training programmes aimed at improving the competencies of LTCWs. Specifically, policymakers and care professionals in each country should work on the following for international collaboration:

- Standardisation of statistical methods related to basic infectious diseases on long-term care.
- Scientific measurement method of environmental health maintenance issues in LTCF settings (e.g. remote-controlled CO₂ concentration measurement) and improvement technology (e.g. mechanical ventilation) and training of ventilation methods.

- Development of LTC training programmes tailored to the pandemic.
- Formulation of business continuity planning guidelines for LTCFs against infectious diseases and measures to improve management capabilities.
- Sharing knowledge, skills, and attitudes of LTC learned from best practices for the COVID-19 response.
- Exploring the regional realities of the referral systems and intersectoral coordination of families, volunteer organisations, facilities, and medical institutions involved in LTC and medical care.
- Spread of literacy of infectious disease control not only in the workplace but also in families and regional areas.

Figure 8.16. Recommendations for Policymakers and Professionals to Support Resilient Long-term Care



LTC = long-term care.

Source: Compiled by authors.

In the medium term, policymakers and care professionals will need to address the challenges that LTC administrations have been unable to respond flexibly to COVID-19. After sorting out issues related to the existing division of labour, standards of references, and monopolies of professional services, LTCFs and LTCWs should be able to respond flexibly and promptly to changes.

- Sorting out cases where existing LTC standards could not be met and considering room for deregulation and exemption. (e.g. facility standards, staffing standards, work arrangements, and the length of stay at home for LTCWs who have become infected or close contacts, etc.).
- Establishment of various measures to respond to situations in which quarantine of infected residents and close contacts must be implemented in the facility. (e.g. securing dormitories for LTCWs, installing compulsory ventilation systems, outsourcing of environmental sanitation and

waste disposal work, changing the layout of zoning in the facility, additional measures to the zoning, etc.)

- Standardisation of temporary measures for health management and work capacity improvement for LTCWs (e.g. infectious disease testing and vaccination in the facility, additional measures for the work of care workers in charge of infected people and close contacts, relaxation of monopoly on work of professionals, remuneration for external human support, etc.)
- Arrangement and legal development of issues related to the status of residence of MCWs (e.g. measures to extend the period of stay, change of status of residence, etc.).

In the long term, the prolonged COVID-19 pandemic has highlighted structural weaknesses in existing aged care. The ambiguous positioning of LTCFs within the community comprehensive care system, the unclear job description of care work, complex professional collaboration, the division of the infectious disease task force in LTCFs, the qualification framework of migrant care workers and in career development deskilling risks, etc. To overcome these vulnerabilities and establish resilient LTC, policymakers and care professionals should take the following steps:

- Establish a comprehensive continuous and seamless system amongst medical care, healthcare, LTC, and welfare for the elderly.
- Strengthen medical functions in elderly care facilities (e.g. test, quarantine, visiting medical care, tele-medicine, hospice, etc.).
- Support for the development and implementation of ICT and robot technologies to enable contactless care in the field of LTC.
- Clarify grading of job descriptions of competencies of care workers and systematisation of training programmes.
- Promote common national efforts to harmonise the Occupational Qualifications Framework to facilitate the career paths of migrant care workers. Also, for enhancing MCWs' career paths without placement fees, develop an international platform for introducing LTCFs and job seekers. Develop memorandums of cooperation for employing migrant care workers beyond memorandums of understanding.

References

Asia Health and Wellbeing Initiative (AHWIN) (2021), 'Accompanying the Elderly to Face the COVID-19 Pandemic'. <https://www.ahwin.org/accompanying-the-elderly-to-face-the-covid-19-pandemic/>

Japan Society for Air Conditioning and Sanitary Engineering (2020), 'Operation of Air Conditioning and Sanitation Equipment as a Countermeasure against New Coronavirus Infection', <http://www.shasej.org/oshirase/2103/covid19-%EF%BC%94.pdf>

UN-HABITAT (2020), *COVID-19 Response Report of Activities*. https://unhabitat.org/sites/default/files/2020/10/covid-19_response_report_web26.10.20.pdf

World Health Organization (WHO) (2022), 'Better Health with Better Information ICD 11 2022 Release', 11 February. <https://www.who.int/news/item/11-02-2022-icd-11-2022-release>