Bearing the brunt

The impact of COVID-19 on older people in Eurasia and the Middle East – insights from 2020

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HelpAge International is a global network of organisations promoting the right of all older people to lead dignified, healthy and secure lives.

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Front cover photo: Umm Imad, an older refugee living in the Gaza strip. WSCR

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Syrian Expatriate Medical Association

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Executive summary

In little over a year, COVID-19 has reshaped our world and presented extraordinary challenges to countries globally. By the end of 2020, over 79.2 million cases of COVID-19 had been reported, and total recorded deaths had reached 1.7 million. It is clear that older people are among the groups most at risk of serious illness and death from COVID-19. But the indirect effects of COVID-19 – and responses to it – also present critical challenges for older people and affect their wellbeing, dignity, and rights.

HelpAge and UNFPA are working to expose the impacts of COVID-19 on older people. As part of a global Memorandum of Understanding between the organisations signed in 2020, HelpAge has, with funding from UNFPA, worked to gather evidence on how COVID-19 affects older people. UNFPA's Regional Office for Europe and Central Asia has also jointly initiated with WHO Europe, UNECE, OHCHR and HelpAge a three-year Joint Programme on Ageing to guide collaborative action over 2020–23 among UN agencies and civil society stakeholders at regional and national levels, working with governments across Eastern Europe and Central Asia to enhance preparedness and response to mitigate the risks for older persons during the COVID-19 pandemic, support delivery of health and care for older people beyond the pandemic, and promote their human rights.

This report presents an overview of emerging insights from research in different settings. The findings and recommendations are intended to inform HelpAge, UNFPA and other actors' efforts to ensure that the response and recovery effort is fully inclusive of older people and that they are able to meaningfully participate as we work to build forward better.

The report presents research undertaken on the impact of COVID-19 on older people in the Eurasia and Middle East (EME) region. It presents the context and responses to the pandemic in the region, and presents findings across key thematic areas, including official COVID-19 data in the region; health and care; violence, abuse, and neglect; income and social protection; older people in humanitarian and conflict settings; and voice, dignity, and rights.

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Key findings

Official data

Limited data and evidence on the impact of COVID-19 on older people is available in the region and globally, including the impact on older women, older men, and older people with a disability. Despite the risk that COVID-19 disproportionately poses to older people, data and evidence on the impact of COVID-19 on older people are only available for a few countries or is anecdotal. The brief review of national data systems and the availability and adequacy of official data to inform COVID-19 response and recovery for older people across 10 low- and lower-middle income EME countries highlights these gaps. While all countries in the region publish the total number of COVID-19 cases and deaths, only two-thirds publish sex-disaggregated data and one-third publishes sex- and age-disaggregated data.

Health and care

Evidence has emerged globally over the course of the pandemic to demonstrate the risks of severe illness and death for both older people and those with underlying health conditions, though limited data is available in the region. A study conducted across the Middle East and North Africa (MENA) region has shown that prior to COVID-19, health systems ignored the needs of older people. This existing disease burden, coupled with a lack of services and the stresses associated with COVID-19, may account for the high rates of mental ill health among older people. The situation appears to be particularly acute in Iraq with 74 per cent of older people reporting feeling worried or anxious all or most of the time. In addition, many older people in the region have limited awareness of where to access health services for COVID-19.

Violence, abuse, and neglect

While rigorous studies in the EME region on Violence, Abuse, and Neglect (VAN) remain scarce, it is clear that the inability of older people to escape their abuser during the pandemic has created more opportunities for the perpetration of this treatment. In the Arab States, Civil Society Organisations (CSOs) surveyed by UN Women reported an increase in domestic violence, and there are reports of a discontinuation of services and support systems for women. As many as 84 per cent of the women's CSOs participating in the survey reported that the COVID-19 pandemic had affected them either negatively or very negatively.

Income security and social protection

Older people's income security is impacted directly and indirectly by the COVID-19 economic crisis. While 95 per cent of older people in Europe and Central Asia (ECA) have a pension, this is the case for only 27 per cent of older people in the Arab States. Even before the pandemic many families struggled financially, and millions more are being pushed into poverty by COVID-19. Without adequate social protection, losses of working hours, jobs, and income is particularly concerning for households with only limited labour capacity. In the context of rising poverty, vulnerability and underdeveloped social protection systems, the regional response is wholly inadequate.

Older people in humanitarian and conflict settings

Despite the pandemic impeding data collection in humanitarian and displacement settings, it is clear that it has heightened the vulnerability of people in these settings. Some control measures have discriminated against refugees and led to adverse outcomes – for example, Syrian refugees were required to observe longer curfews and faced tighter restrictions than other residents in some municipalities in Lebanon to "prevent the aggravation and spread of COVID-19". Approximately 30 per cent of older women and men reported being unable to access their regular medication, with local variations highlighting existing inequalities in health access. Access to pensions or cash transfers in humanitarian settings has been affected by the pandemic.

Voice, dignity, and rights

Evidence and data on the impact of COVID-19 on the voice, dignity, and rights of older people is extremely limited, and there is little analysis of how older people's rights have been affected by discriminatory age-based measures imposed during the pandemic. These include the persistent framing of older people as a 'vulnerable group' and the narrow focus on health and social protection responses – necessary though these are. Governments across the region have introduced age-based public health measures to restrict the movement of older people at different stages of the pandemic. Mechanisms and spaces for older people to convene have been inaccessible in many places due to lockdown restrictions, impacting on the extent to which older people can engage in voice-related activity.

Conclusion and overall recommendations

COVID-19 has starkly exposed the inadequacy of systems at local, national, and international level to meet the needs and uphold the rights of older people, and to effectively promote their resilience and support them during crises. The pandemic has shone a light on the quality, coverage, adequacy, and flexibility of systems and highlighted their failures in many places. It has also exposed and exacerbated deep rooted ageism in our societies. Our consultations with older people and the HelpAge Network during 2020 draw attention to the critical need for public health emergency response and recovery measures that respect the rights, voice and dignity of older people.

COVID-19 is a clarion call. We need radical change if people of all ages are to be able to contribute to and share in the gains of recovery, ensuring no one is left behind. The pandemic illustrates the importance of financing and implementing the Sustainable Development Goals to build resilient and equitable systems and societies for everyone, including older people. This is essential to ensuring we all recover successfully from COVID-19, build forward better, and are prepared for the future in an ageing world.

HelpAge International

Governments, international partners, and other actors must:

- **Focus on data systems** at local, regional, and international levels, to ensure they are ageing-inclusive. Each stakeholder must independently assess its ability to successfully produce vital information on older people during the pandemic, and jointly – with other stakeholders – commit to improving the conceptualisation, collection, analysis, reporting, and public dissemination of timely data, disaggregated by age, sex and disability.
- **Conduct research and data analysis** to understand the short- and long-term health impacts of COVID-19 for older people, and to provide an evidence base to inform efforts towards health systems strengthening and the achievement of truly age-inclusive UHC.
- **Collect, analyse and use data on violence, abuse, and neglect of older people** to inform prevention and response measures. An agreed and comprehensive framework and guidance on data collection on violence, abuse, and neglect of older people should be developed to ensure cross comparable and high-quality data.
- **Use the momentum generated by COVID-19 to invest in and achieve universal social protection,** including universal pension coverage and the inclusion of older women and men in income and employment generating efforts, as a crucial mechanism to mitigate the impacts of the crisis on people's wellbeing and poverty, and to enable an inclusive and speedy economic recovery.
- **Provide leadership and proactively recognise and respond to the rights and needs of older people in emergencies.** Humanitarian actors and governments should use globally accepted Humanitarian Inclusion Standards to design response efforts that are inclusive of older people, including those with a disability.[1]
- **Call for and adopt a UN convention on the rights of older persons** which would provide a definitive, universal position that age discrimination is morally and legally unacceptable, clarify how human rights apply in older age and guide governments on how to meet their responsibilities to uphold those rights.
- **Engage with media and opinion formers to transform societal perceptions of ageing and older people within their families and communities.**

Syrian Expatriate Medical Association

Introduction

In little over a year, COVID-19 has reshaped our world, presenting extraordinary challenges to countries globally. By the end of 2020, over 79.2 million cases of COVID-19 had been reported worldwide, with total recorded deaths numbering 1.7 million.[2] No region is free from the virus and though considerable variation has been experienced over time and place, the pandemic continues to threaten the health and wellbeing of people of all ages around the world.

COVID-19 presents extraordinary challenges for all countries. Governments in every region face the task of stemming the spread of the virus while minimising the far-reaching social and economic impacts of the pandemic and preparing for vaccination procurement, prioritisation and roll-out. In many countries, ongoing humanitarian situations are exacerbated by the virus, exposing highly vulnerable people to further risks.

The evidence is clear that older people are among the groups most at risk of serious illness and death from COVID-19. Data from China following the initial few months of the outbreak in Wuhan showed the risks of serious illness and death from COVID-19 for people in older age, with a fatality rate of close to 15 per cent in people aged 80 and over, compared with an overall rate of 2.3 per cent across the population.[3] Where it is available, data from all regions of the world have supported this early finding.

The indirect effects of COVID-19, and responses to it, also present critical challenges for older people. Across the world, older people's health and wellbeing, their income and food security, and their equal enjoyment of human rights are being threatened. This is especially true for those who have experienced a lifetime of poverty, exclusion, and inequality, the accumulated impact of which places them at higher risk from the direct and indirect effects of COVID-19. The pandemic and responses to it are also limiting the extent to which older people's voices are being heard and restricting the considerable contributions they can make to our global response and recovery.

Yet, despite the impact of the pandemic on older people globally, older women and men remain chronically invisible in efforts to monitor the effects of COVID-19.[4] Older age groups are excluded from COVID-19 official data systems or are not visible within them. Even where data on older age groups is collected, disaggregated data is often not reported or made publicly available. Broader attempts to understand the ways in which the pandemic is impacting upon older age groups, meanwhile, including by collecting evidence on older people's own experiences during COVID-19, are limited and fragmented.[5] These gaps threaten the extent to which older people's needs and rights are addressed in response and recovery efforts, and prevent older people and those working with them from holding power holders to account.

HelpAge and UNFPA are working together to highlight the impact of COVID-19 on older people. As part of a Memorandum of Understanding between the organisations signed in 2020, HelpAge has, with funding support from UNFPA, been working to draw together evidence on how COVID-19 is affecting older people, both directly and indirectly. UNFPA's Regional Office for Europe and Central Asia has also jointly initiated with WHO Europe, UNECE, OHCHR and HelpAge a three-year Joint Programme on Ageing to guide collaborative action over 2020–23 among UN agencies and civil society stakeholders at regional and national levels, working with governments across Eastern Europe and Central Asia to enhance preparedness and response to mitigate the risks for older persons during the COVID-19 pandemic, support delivery of health and care for older people beyond the pandemic, and promote their human rights.

The project involved research at country, regional and global levels. At country level, case studies on older people's experience of health, care, violence, abuse, and neglect during the COVID-19 pandemic have been gathered in six countries in sub-Saharan Africa (SSA), Eurasia and the Middle East (EME) regions,[6] and the Asia region. At regional level, research focused on secondary data and emerging evidence, with a focus on countries where HelpAge has country offices and/or network member presence. A synthesis report draws together findings from the Africa and EME research whilst also drawing upon monitoring reports on the impact of COVID-19 in Asia, produced by HelpAge's Asia Pacific Regional Office with funding from UNFPA, and from insights emerging from the Latin America and Caribbean (LAC) region.

This report outlines insights emerging from the EME region (see methodology section, starting on the next page, for HelpAge's definition of region). It begins by outlining the context and responses to the pandemic in the region and presents findings across key thematic areas, including official data on COVID-19 in the region; health and care; violence, abuse, and neglect; income and social protection; older people in humanitarian and conflict settings; and voice, dignity, and rights. The report does not attempt to provide a comprehensive overview of the impact of COVID-19 across the region and the findings should in no way be interested as representative of the region as a whole nor all countries within it. Rather, the report seeks to highlight emerging impacts of the pandemic on older people in low- and middle-income countries and settings in the region, based on where evidence has been found.

The findings and recommendations are intended to inform HelpAge, UNFPA and other actors' efforts to ensure our response and recovery is fully inclusive of older people. We call on all actors to ensure that older people's needs are met, that their rights are upheld and that they can participate equally as we work together to build forward better.

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Methodology

This report outlines the findings from research undertaken over October–December 2020 on the impact of COVID-19 on older people in low- and middle-income countries in HelpAge's EME region.[7]

This region covers Eastern Europe, Central Asia, and the Middle East. The HelpAge regional definition was used so that the report could draw upon the work of HelpAge and network members at regional and country level. In some places, however, evidence and data relate to different regional definitions used by actors, including Europe and Central Asia (ECA), Middle East and Northern Africa (MENA) and the Arab States. Where this is the case, the name of the region used in the source is given.

At country level, case studies on health and care have been produced in Moldova and Ukraine and a case study on violence, abuse, and neglect, including gender-based violence against older women and men, has been produced in Moldova. The case studies have been informed by secondary data and evidence reviews and by a handful of interviews with key informants, including older people and service providers. The primary research has been light-touch and is intended to provide insight into the experiences of a small group of older people and ensure their voices are included in the research project rather than provide representative data on older people's situation generally. Country selection was based on HelpAge's and our network members' presence and capacity within countries, the scale of COVID-19 outbreaks in those settings, and government response measures in place. The selection also considered countries where HelpAge and UNFPA had existing collaborations, including Moldova and Ukraine. The inclusion of Ukraine was also intended to capture the experiences of older people in conflict-related displacement settings.

At regional level, the EME report has been informed by light-touch data and evidence reviews on key thematic areas of concern for older people. Thematic areas and key issues within each were set out in search terms in the research framework and were applied using Google Search. They included the disease situation and disease management; government responses; and socio-economic trends resulting from pandemic responses; as well as the impact of COVID-19 on older people regarding health and care; violence, abuse, and neglect; income security; voice, dignity, and rights; gender and disability inclusion; protection; and intergenerational cohesion and solidarity. Sources identified in the regional review were supplemented by information identified by HelpAge country offices and network members within EME countries.

Research materials included the following:

- **Information from the HelpAge Network (staff, network members, partners)** including COVID-19 Rapid Needs Assessments of Older People (RNA-OPs); thematic surveys undertaken during the pandemic; and internal policy and/or situation trackers.
- **Published studies:** academic, UN or international non-governmental organisations' (INGO) studies, surveys, policy briefs etc on the situation of older people in 2020; think-tank and consultancy studies and assessments etc; surveys of situation analyses that include older people; projections, statistical modelling or visioning documents.
- **Government documents:** policy, planning/implementation documents; announcements in response to COVID-19; responses from National Statistical Offices; budget information; analysis of government data etc.
- **Media:** tracking, think pieces, traditional media, social media, journals, including reports of the situation of older people and ageing from reliable media sources at national, regional, and global level; information from HelpAge's age discrimination and ageism tracker.
- **Key additional data sources:** including UNFPA's COVID-19 population vulnerability dashboard.

The findings presented here are structured by the research framework, reflecting where information and evidence emerged. Where data was limited or unavailable, this is discussed and the possible implications of the current situation for older people are highlighted.

The research also includes an assessment of the resilience of National Statistical Offices (NSOs) and their partners, including relevant ministries and UN agencies, to collect and disseminate population-related data during the pandemic, and the adequacy of the produced data to support COVID-19 response and recovery for older women and men. Again, this review is not exhaustive but rather focuses on data available from the health and social indicators drawn from the public domain for low- and lower-middle income countries.[8, 9]

The report contains key recommendations for each thematic area.

Limitations: key gaps in the availability and quality of data and evidence

Limited data and evidence on the impact of COVID-19 on older people is available in the region and globally, including the impact on older women, older men, and older people with a disability. While this was anticipated, and while the research framework sought to address the issue by being as broad as possible and considering a wide range of information across numerous themes, the limited data and evidence generated at all levels has been a challenge. Even where older people have been included in data collection efforts, data and analysis are often not disaggregated by age, sex or disability, nor made publicly available, further hindering understanding and knowledge of the impact of COVID-19 on this age group.

The brief review of national data systems and the availability and adequacy of official data to inform COVID-19 response and recovery for older people across 10 low- and lower-middle income EME countries highlights key challenges and gaps. While all countries in the region publish the total number of COVID-19 cases and deaths, about two-thirds publish sex-disaggregated data and one-third publish sex- and age-disaggregated data. Examination of national reporting of mortality and case data by disability was not possible with the time and resources available. While all countries had at least one survey on socio-economic impact of the pandemic on the population, out of 13 completed surveys only four identified that older people were included as respondents and one report presented age-disaggregated analysis of its findings. The majority of completed surveys lacked clear information on whether data was collected from older people and (if so) from how many. Microdata for all completed surveys is unavailable to produce age-specific analysis which would have helped to fill some of the knowledge gaps on health and income security, though others would remain on the impact of COVID-19 on older people with underlying conditions and disabilities. Beyond this, secondary data collected and now used during the pandemic to identify at-risk population groups or to predict the capacity of the systems within countries to respond is not fit-for-purpose, because it was collected pre-COVID-19.

These data challenges are reflected across thematic reviews.

HelpAge Kyrgyzstan

Health

In addition to few countries routinely reporting case and mortality data disaggregated by age, sex and disability, data on the links between specific health conditions and COVID-19 mortality is only available for very few countries or is anecdotal. Equally, little data is yet available on the impacts of COVID-19 on older people's health. The true health impacts of the pandemic will be shown by excess deaths and increases in prevalence of other health conditions, yet such data is currently only available for a limited number of countries worldwide.[10]

While evidence is starting to emerge of the disruption to health services caused by the pandemic, this is rarely systematically collected and is often not available at regional or country level. Information that does exist is focused on the changes to service provision and has not interrogated the impact of these changes on individual and community-level health. We therefore do not yet know who is missing out on health services and support and what the implications will be.

Violence, abuse, and neglect

Despite the crucial importance of understanding how and why pandemics such as COVID-19 may result in an increase in violence, abuse and neglect of older women and men, evidence is extremely limited. Key gaps include data on risk factors; how service availability for older survivors is affected; how older women's and men's access to such services and help-seeking from formal and informal sources is affected; and what new short- and medium-term needs may be arising. These gaps highlight both the challenges faced with safe and ethical population-based data collection during the acute phase of the pandemic but also the continued exclusion of older people from data systems.

Income

Older people are often invisible in assessments of the damage to jobs and labour income by COVID-19. The pandemic's impact on work and employment is a key driver of increased poverty but older people's work is often not captured in statistics. While International Labour Standards refer to a working-age population of all persons aged 15 and above, assessments sometimes exclude older people by setting upper age limits.[11] When reports on the loss of jobs and labour income from COVID-19 focus on formal employment and unemployment, they also ignore older people's work, which is mainly in the informal sector.

Social protection

The number of older people who benefitted from social protection during COVID-19 is unknown. With the global expansion of social protection in response to COVID-19, programme trackers such as the 'living paper' by the World Bank provide valuable details on the cost, timeframe, target group and benefits provided.[12] However, they do not include information on the age of recipients. The nature of the intervention (for instance, an increase of pension benefits) sometimes implies the age of the recipients. But that is not always the case, and only 29 of the 458 cash-based social protection measures recorded globally relate directly to social pensions. Without the age profile of recipients, researchers have only a partial picture of older people's inclusion in the social protection response. Furthermore, evidence points towards older people experiencing numerous challenges in accessing broader population-based income support schemes, which means that existing estimates likely overestimate their inclusion in the global social protection response.[13]

Voice, dignity, and rights

There is little evidence or analysis on the extent to which older people's rights have been denied during the pandemic and on the extent to which older people's voices have been heard. In this context, RNA-OPs and other thematic surveys conducted by HelpAge and partners provide important insights. Beyond this, information identified in regional reviews has come primarily from media articles.

Finally, not enough information was found on intergenerational activity and solidarity in relation to COVID-19 to include in this report. The implications of COVID-19 on intergenerational relations, including how COVID-19 affects how societies, think, feel, and act towards ageing and older people are important areas of future research. While examples of positive interaction and intergenerational exchange have emerged during COVID-19 in many contexts, anecdotal information and media articles also suggest worrying signs of intergenerational conflict during pandemic. This highlights the need to better understand and take action to sustain and promote intergenerational solidarity as we work to build back better, including by building consensus on a life-course approach to the social contract between the governments and citizens of all ages.

Humanitarian contexts and crises

The lack of data and evidence on the impact of COVID-19 on older people highlights the importance of work by HelpAge and partners to understand the effects of the pandemic. The report draws particularly on the results of our COVID-19 Rapid Needs Assessments of Older People (RNA-OPs). These were conducted between May and August 2020 to understand the needs of older people in a cross-section of low- and middle-income countries. In the EME region, HelpAge and local partners conducted assessments in locations within Iraq, Jordan, Lebanon, Syria and Ukraine.[14] In total, 2,652 older people over the age of 50 years were interviewed, including 605 in Iraq, 414 in Jordan, 486 in Lebanon, 777 in Syria, and 369 in Ukraine. The small sample sizes should be taken into consideration when interpreting the findings, recognising that they do not comprehensively represent the needs of older people within each country. Rather, they provide a snapshot of the needs of older people interviewed which, once triangulated with other findings, can be used to signal potential trends within this population group. Further methodological limitations are included within each RNA-OP.

Context

Countries in the EME region have been significantly affected by the pandemic. In many countries across the region the spread of COVID-19 has followed a broadly similar pattern: slowly growing case numbers and mortality between March and September 2020, followed by significant growth from late September 2020 as containment measures were relaxed.[15]

As in many parts of the world, concerns about data accuracy on COVID-19 cases and deaths make it difficult to know the full extent of outbreaks in the region and how much higher actual numbers might be. However, based on available data, Poland, Ukraine, Iraq, and Romania are in the top 25 countries in terms of **total number of COVID-19 cases and deaths,**[16] while Armenia, Bosnia and Herzegovina, Georgia, Moldova, Slovenia and Serbia are all in the top 30 countries for **COVID-19 cases and deaths per million population** (see Table 1 below).[17] Israel, Bahrain, Qatar and Lebanon are among the 30 countries with the highest case numbers worldwide, and while there are no countries in the Middle East in the top 30 for deaths per million, underreporting may be a factor for this.

Table 1: Countries in the Eastern Europe region in the top 30 worldwide for cases and deaths

Country	Cases per million		Country	Deaths per million	
	Number	Global rank		Number	Global rank
Armenia	48,618	9	Bosnia and Herzegovina	960	8
Georgia	43,714	11	Slovenia	914	10
Slovenia	43,328	12	Armenia	808	19
Serbia	35,539	20	Romania	666	26
Moldova	29,988	30	Moldova	615	29

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Health system preparedness in the EME region

Preparedness to respond to COVID-19 differed significantly across countries, particularly within Eurasia. Prior to the outbreak of COVID-19, health systems in western Balkan countries such as Albania, Bosnia and Herzegovina, and Serbia were already facing critical financing and service delivery challenges. Per capita spending on health systems (lower than the European Union average) was not well aligned with the region's disease profile, making it vulnerable to future public health outbreaks.[18] In the Middle East, health systems in Syria and Yemen were woefully underprepared to respond to the pandemic. According to the UN Population Fund (UNFPA) COVID-19 population vulnerability dashboard, Yemen has 5.3 medical doctors per 10,000 people and 3.4 intensive care unit (ICU) beds, while Syria has 12.9 and 1.8 respectively.[19] The dashboard highlights a lack of health sector preparedness across the EME region. Iraq has 7.1 doctors per 10,000 people and one ICU bed; Jordan 23.2 and 2.2; Kyrgyzstan 22.1 and 4.5; and Ukraine 29.9 and 12, respectively.

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International and national responses

UN and government response plans

The UN policy response for the region, published in July 2020, included three priorities: take immediate measures to slow the spread of the disease; end conflict and attend to the most vulnerable; and address underlying inequalities and gaps in social protection. Its recommendations to governments included shifting resources towards critical areas of sustainable development, such as universal health coverage (UHC), social protection floors and old age pensions; using COVID-19 recovery as an opportunity to invest in women and ensure their equal part in society through addressing gender inequalities, particularly in protection, employment and political/public participation; and taking a 'whole-of-society' approach that strengthens the social contract and widens participation and inclusion. COVID-19 was also seen as an opportunity to address long-standing conflicts and structural weaknesses, to support local authorities, to strengthen democracy, to safeguard human rights, and achieve and sustain peace.

Country responses in the EME region have been structured by the main pillars of the UN response and include health preparedness and responses plans, socio-economic response plans and humanitarian response plans. Countries adopting the latter two pillars are set out in Annex 3.

A range of measures has been used by governments for their pandemic response. According to the COVID-19 Government Measures Dataset provided by the Assessment Capacities Project (ACAPS, an independent humanitarian information provider), the following five categories of measures were adopted by governments across the EME region: social distancing, movement restrictions, public health measures, social and economic measures, and lockdowns. The spread and types of measures adopted by countries (excluding Arab States in North Africa) are summarised in Table 2 on the next page. Almost all EME countries (90 per cent) deployed economic measures and some form of partial lockdown, with only a third introducing full lockdowns. Almost all adopted domestic and international movement restrictions. Public health and social distancing measures varied more across countries, though all introduced isolation and quarantine policies and restricted public gatherings, and almost all closed schools. Twenty-seven per cent adopted mass-population testing.

Table 2: Number and percentage of countries in the EME region adopting COVID-19 restriction measures

Category	Measure	Number of countries	Percentage of countries*
Governance and socio-economic measures *(42 countries)*	Emergency administrative structures activated or established	34	81
	Economic measures	38	90
	State of emergency declared	23	55
	Military deployment	13	31
	Limit product imports/exports	13	31
Lockdowns *(40 countries)*	Partial	38	95
	Full	13	33
	Lockdown of refugee/IDP camps or other minorities	3: Bosnia and Herzegovina, Lebanon, Jordan	8
Movement restrictions *(45 countries)*	Border checks	18	40
	Additional health docs/requirements upon arrival	17	38
	Border closure/complete border closure	38	84
	Domestic travel restrictions	41	91
	Curfews	28	62
	International flights suspension	44	98
	Surveillance	32	71
	Visa restrictions	40	89
Public health measures *(45 countries)*	Awareness campaigns	33	73
	Isolation and quarantine policies	45	100
	Requirement to wear protective gear in public	41	91
	Strengthening the public health system	42	93
	Amendments to funeral and burial regulations	17	38
	General recommendations	37	82
	Other public health measures	42	93
	Health screenings in airports and border crossings	34	76
	Mass population testing	12	27
	Testing policy	37	82
	Psychological (e.g. helplines, counselling)	12	27
	Obligatory medical tests not related to COVID-19	1: Turkmenistan	2
Social distancing *(45 countries)*	Changes in prison related policies	10	22
	School closures	43	96
	Limits on public gatherings	45	100
	Closure of businesses and public services	44	98

* Deploying this category of measure

Responses to the pandemic have varied in each of the three subregions of EME,[20] with governments focusing on preventing the spread of COVID-19 and many recognising older people as high-risk. For example, up to November 2020 in Central Asia,[21] COVID-19 policy responses differed widely across countries, largely reflecting governments' assessment of the health situation and their fiscal capacity. Kazakhstan, Mongolia and Uzbekistan responded swiftly, implementing strict confinement measures, closing borders and designing large support packages. They implemented further sanitary and fiscal measures as the crisis worsened, before progressively lifting them over the summer of 2020. Afghanistan and Kyrgyzstan,[22, 23] acknowledged the situation early on but reacted slowly, partly due to lack of public capacity and because of more complex policy processes. The size of response was also limited by shrinking public funds, leading to greater need of international emergency support. Tajikistan and Turkmenistan officially reported few or no COVID-19 cases and responded with limited, focused policy measures, before progressively developing more. In Tajikistan, domestic political considerations may also have been an influencing factor. Only Afghanistan had reopened its borders to civilians by November 2020, with travel to Turkmenistan and Mongolia remaining suspended. Travel to Kazakhstan, Kyrgyzstan and Tajikistan was only allowed for some nationalities and with quarantine requirements. Central Asian governments' policy responses to mitigate second waves of the virus are following a more localised and targeted approach, with an emphasis on keeping certain sectors of the economy open and maximising protection of the most vulnerable in society. In Kazakhstan, for example, the government has targeted local outbreaks by restricting key socio-demographic groups, including restricting movement of people aged over 65 years in some cities.[24]

Economic, social, and political impacts of COVID-19

Containment measures to reduce the spread of the virus, coupled with the global economic recession, have led to a contraction of economies in Eastern Europe, the Middle East and Central Asia. Necessary public health responses to the pandemic, including restrictions of foreign and country-wide travel and the closing of businesses and schools, have greatly decreased mobility, and come at a significant economic cost. In October 2020, the International Monetary Fund (IMF) estimated that Gross Domestic Product (GDP) in the Middle East and Central Asia will have declined by 4.1 per cent in 2020, which is a 1.3 percentage-point larger decline then projected in April 2020. Oil-exporting countries in the region were hit hardest by the pandemic and a sharp decline in global demand for oil.[25,26] Eastern European countries were projected to see their economies decline by 4.4 per cent.[27] As a result, the International Labour Organisation (ILO) estimated a decline in working hours equivalent to 17 million full-time jobs in the second quarter of 2020 in the Arab States and Europe and Central Asia (ECA).[28]

Remittances, a key source of income for households in the region, declined significantly in 2020. Before the crisis, remittances exceed 5 per cent of GDP in 14 countries in the Middle East and Central Asia. The IMF estimates that remittances in the region declined by 19 per cent on average during the first half of 2020, compared to 2019. The decline was particularly strong in Armenia, Kyrgyzstan and Tajikistan where it was greater than 34 per cent during April and May 2020. Countries are differently affected, with contractions ranging from six per cent in Uzbekistan to over 25 per cent in Kyrgyzstan. While data is not available for fragile states, countries such as Yemen and Syria, which depend highly on Gulf Cooperation Council (GCC) remittances, are likely experiencing significant reductions, which could have sizable impacts on poverty. The IMF predicts that the drop in remittances could increase the number of new extreme poor by 1.3 million in remittance-dependent countries in the region, mainly in fragile and conflict-affected ones.[29]

In the Arab States sub-region, COVID-19 is also magnifying underlying challenges. Impacts are forecast to be deep and long-lasting, including on violence and conflict; inequalities; unemployment; poverty; inadequate social safety nets; human rights concerns; and insufficiently responsive institutions and governance systems.[30] With the largest gender gap in human development in the world, women in the Arab region have been forecast to suffer significant consequences. Migrants, around 40 per cent of the regional workforce, have also been hit hard, notably in terms of access to services, job losses and ability to return to home countries.

Conflict-affected countries face particular challenges, with vulnerable populations placed at heightened risk. The region is home to 55.7 million people in need of humanitarian assistance, including 26 million forcibly displaced people. Across the Arab region, 74 million are at a higher risk of contracting the virus due to lack of handwashing facilities.[31] Conflict has impeded health responses by destroying health infrastructure, causing death or migration of care workers and interruption of critical care. It has added to pressure on national health systems to deliver services to refugees and internally displaced persons. Overall, the UN estimates that an additional US$ 1.7 billion will have been required in 2020 to address the risks and impact of the pandemic on the most vulnerable people in Arab State countries affected by humanitarian crises or otherwise at risk. In addition, with COVID-19 lockdowns and many people interacting primarily online, some actors may seize the opportunity to reinforce extremist views or xenophobic discourse.

Syrian Expatriate Medical Association

Older populations in the region

An estimated 94 million older people currently live in the EME region[32] (56.4 million women and 37.6 million men).[33] Russia, Turkey and Ukraine all have older populations of over 10 million.

Several factors place older people in the region at risk from COVID-19. Alongside limited access in some countries and contexts to adequate water, sanitation and hygiene services, which limit the extent to which older people are able to follow handwashing advice to prevent the spread of COVID-19, many older people are likely to face challenges in social distancing.[34] In Arab countries, the majority of older people live with their families and many have economic and social responsibilities as heads of households.[35, 36] In Eastern European countries it is traditional for older people to live in multigenerational households, though increasing numbers are living independently until older ages.[37] A lack of access to pensions and social protection leads to older people's extended participation in the labour market across the region, mainly in the informal sector.[38] While 95 per cent of older people in Europe and Central Asia (ECA) have a pension, this figure is only 27 per cent in the Arab States.[39]

The COVID-19 risks to older people in the region must also be understood in the context of extremely weak health systems in some locations and limited access to health and care services – including for the rising numbers of older people with non-communicable diseases that place them at higher risk of COVID-19 complications. Out-of-pocket payments for health care correspond to over 80 per cent of total health expenditure in Yemen, and to around 50 per cent in Iraq, Syria and Ukraine.[40] These issues place older people in the region at risk from both the direct and indirect impacts of COVID-19.

Official data collection on older people during the COVID-19 pandemic

Statistical agencies in the EME region have struggled to continue producing statistics during the COVID-19 pandemic.

Over 50 per cent of National Statistical Offices (NSOs) in the EME region that took part in the first wave of a global COVID-19 survey said they experienced either severe or moderate disruption in production of administrative data and essential monthly and quarterly statistics.[41] The majority of NSOs – 71 per cent in northern Africa and western Asia, and 67 per cent in central and southern Asia – identified the need for additional external support to ensure continued operation.[42] During the second round of the survey in July 2020, 63 per cent of low- and lower-middle income NSOs identified the need for financial support as a priority, followed by equipment/infrastructure and technical assistance, at 56 and 55 per cent respectively.[43]

Public health surveillance and civil registration and vital statistics systems

The review of the collated data on COVID-19 cases and deaths in 10 low- and middle-income countries in the EME region demonstrates that all countries were able to collect and publish aggregate figures as part of their health surveillance, though reporting of case and mortality data by age and sex falls sharply to only three and two countries respectively (see Table 3 below).

Data on cases and mortality was collated by Global Health 50/50 and focuses on gender and age disaggregation,[44] and does not include disaggregation by disability. An additional review of primary sources would be required to establish whether countries have been collecting information on disability during the pandemic.

Countries that published age- and sex-disaggregated data report it in different ways. The presentation of data on people aged 50 years and over varies: Ukraine reports on two broad cohorts, 50–69 and 70+, while Moldova reports on four cohorts, 50–59, 60–69, 70–79, and 80+.

Limited information is available on the impact of the pandemic on the operation of the civil registration and public health surveillance systems in the EME region. However, it is likely that the paucity of sex- and age-disaggregated case and mortality statistics is partially attributable to weak CRVS systems. Four countries where such data is not available (Morocco, Syria, Yemen, and West Bank and Gaza), register less than 75 per cent of their deaths, and have either low, very low or undetermined quality of cause-of-death data.[49, 50] At the other end of the spectrum of the limited sex- and age disaggregated data are countries with over 75 per cent of deaths registered, and high or medium quality of cause-of-death data, including Kyrgyzstan, Ukraine and Uzbekistan. However, their lack of published data may highlight the type of information that member states choose to share with the public and UN agencies.[51]

Data collection by National Statistical Offices and UN agencies

Annex 1 presents data collection efforts by UN agencies and NSOs to assess the impact of COVID-19 on populations.[52] Each of the 10 countries has at least one survey planned or completed, and numerous countries have three or more different surveys planned or completed. According to the Inter-secretariat Working Group on Household Surveys (IWGHS), only two countries administered surveys by NSOs as a primary implementer (Morocco and Tunisia). For most of the countries, UN agencies are the principal implementer. This speaks to the importance of intergovernmental organisations (IGOs) and member state partnerships to coordinate and enable data collection in low-income contexts during emergencies.

Table 3: Number of countries in the EME region reporting and disaggregating data on COVID-19 cases and mortality

Total cases	Cases reported by sex	Cases reported by sex and age	Total deaths	Deaths reported by sex	Deaths reported by sex and age
10	7[45]	3[46]	10	6[47]	2[48]

Sources: Global Health 50/50, The COVID-19 sex-disaggregated data tracker, dataset updated 16 November, 2020, https://globalhealth5050.org/the-sex-gender-and-covid-19-project/dataset/ (20 November 2020). WHO Coronavirus disease (COVID-19) dashboard updated 19 November, 2020, https://covid19.who.int/table (20 November 2020)

Despite the number and range of COVID-19 surveys, and the UN framework's explicit reference to older people as one of the disproportionately affected groups, this has not translated into availability of data on older women and men.[53] Among 13 completed surveys only four specified that data was collected from older respondents, including UN Women Kyrgyzstan and Moldova, World Food Programme Kyrgyzstan, and a survey by the National Statistical Office of Morocco. The rest of the surveys (nine) lack detailed information to establish whether older people were included in their respective samples. Furthermore, only one summary report of the four surveys mentioned above, UN Women Kyrgyzstan, consistently presented analysis of the results for the population aged 65 and over.

It would be possible to establish the inclusion of older people in survey samples and to produce the 'missing' ageing-sensitive analysis if collected microdata were made available. However, by the end of November 2020, none of the 13 completed surveys had microdata in the public domain. In one case a data provider's explicit commitment to publish anonymised data has not been realised more than seven months since the data was collected. This raises questions about good standards and accountability for data-sharing during emergencies and what support is needed to enable data producers to safely release microdata.

Given the time-sensitivity and restrictions on face-to-face interaction, approaches to data collection have also had to adapt. For example, in numerous countries data was gathered using an online survey, completed either via a smartphone or a personal computer. The latest data for West Bank and Gaza, for instance, shows that there is an age and gender digital divide, as only 27 per cent of people aged 60 and older use the internet, and older women are less likely to be online than older men (16 and 38 per cent respectively).[54] Additionally, if a number of older people interviewed for the survey is small, it raises questions about appropriateness of data collection methods to capture different groups of older women and men, and the limitations of the insights generated from this data.

What is and is not being collected

Surveys differ in the topics they cover, stages of readiness, frequency, and duration. For example, some surveys only focus on a labour market or an informal sector, while others gauge broad social and economic impacts. Some surveys collect information at a household level, while others at an individual level. Some surveys are tentatively proposed while others are in a planning stage or have been completed.[55]

Most surveys asked about access to health care services, changes in employment status and income security, access to food, goods, and coping strategies. Fewer assessments asked about COVID-19 related impact on physical and mental health, and considerable gaps exist in relation to respondents' disability status, health insurance coverage and pre-existing health conditions. Given that each country has at least two surveys, it is possible to build a broader understanding of the situation of different population groups. However, for some countries, for example, Yemen, West Bank and Gaza, Ukraine, and Syria, the picture of available data is patchy due to lack of published questionnaires or detailed methodology.

Secondary data

Secondary data collected pre-COVID-19 offers an opportunity to identify at-risk population groups and assess systems' capacity to respond. UNFPA's COVID-19 Population Vulnerability Dashboard and the UN DESA's World Population Ageing 2020 use census data to build an understanding of older people's potential exposure to the virus across different types of living arrangements (for example, single person household, multigeneration or skip generation households) and dwellings (for example, one bedroom house, dwelling with no access to running water, etc.) at a sub-national levels.[56, 57] The data is drawn from the Integrated Public Use Microdata Samples (IPUMS-International) that collates and harmonises census microdata from around the world. This is an important initiative, but it highlights challenges of relying on census data at the time of an emergency.

For six of the 10 countries, data on the number of older people, living arrangements and access to amenities is not available as the census data was not shared with the IPUMS.[58] Even if microdata were available, it would be more than 10 years old for numerous countries, for example Syria and Yemen, where the last census was conducted in 2004. This means that alternative sources with comparable geographic coverage and administrative granularity could provide more timely data. Relevant household surveys could be one option, though robust administrative data could provide near-instant population statistics at the time of emergency at a fraction of the cost of surveys and census.

A similar situation is found with an indicator on number of hospital beds per 1,000 population with the data available for all 10 countries, though for half of them it is from 2013. A review of Ukraine's national COVID-19 dashboard shows a wealth of information published since May 2020 that is updated daily.[59] Released data includes the total number of allocated and occupied beds by COVID-19 patients, availability of doctors, nurses and volunteers, availability and use of ventilators, stock of different types of personal protective equipment (PPE), etc. Not every country publishes this data but where it is available it should be included in global monitoring efforts in a more efficient and timely way.

Recommendations

As member states, UN agencies, donor agencies and the data community work to build back better, ageing-inclusive data systems must be part of the recovery. Intergovernmental organisations (such as the UN), in partnership with the data community, must raise greater awareness among member states of the importance of age-, sex- and disability-disaggregated data on COVID-19 to inform pandemic preparedness, response and recovery efforts, and identify actions to support NSOs in producing and disseminating data on older women and men.

- Data producers should:
  - Ensure that data collection initiatives assessing the situation of population groups cover older women and men, including those residing outside 'traditional' households. In addition to data on age, sex, and disability, personal information on location and living arrangements, ethnicity, income, and other characteristics should be collected where possible and appropriate.
  - Ensure that primary or secondary data used to measure inequality and identify at-risk population groups is analysed, disaggregated, and publicly reported in summary reports. As a minimum data should be reported in five-year cohorts (if not possible, in 10-year cohorts) across sex and disability, and other characteristics where appropriate.
  - Be transparent about how the older population and other marginalised groups are considered in relation to methodology, sample design, development of new indicators, data collection and analysis, and make collected data, analysis, and findings publicly available.
  - Provide opportunities for older people or their representative organisations, human rights institutions, relevant Civil Society Organisations (CSOs), and national focal points on ageing to participate in data processes to advise on data needs, appropriate methodologies, and approaches, and to empower individuals to use data for evidenced-based advocacy on their rights and needs.
- The international community must review guidance and standards for production and dissemination of data on older people during emergencies with a specific focus on:
  - A minimum set of indicators for rapid assessment of the situation of older women and men, including older people with a disability, in crises.
  - Appropriate approaches and methodologies for including older people in survey samples and interviewing older respondents.
  - Analysis of data on older women and men and older people with a disability.
  - Protocols on safely sharing microdata for public good during emergencies.
  - Strengthening country reporting to IGOs with the aim of improving timeliness and range of reported data.
- The international community and donor agencies must increase financing to build National Statistical Offices' resilience and to strengthen their local, national, and regional capacity to produce statistics on older populations at times of crisis with special focus on investment in improving coverage and quality of CRVS and administrative data.
- NSOs in partnership with relevant ministries should take advantage of the 2020 census round to produce a stand-alone summary report on the state of older people in a country and share microdata with IPUMS-International to enable production of harmonised data on older people.
- NSOs in partnership with relevant ministries, academia and UN agencies should undertake an in-depth study of short and long-term health and socio-economic impacts of COVID-19 on current and future generations of older people, recognising the intersectional and compounding nature of marginalisation.

HelpAge International

The impact of COVID-19 on older people

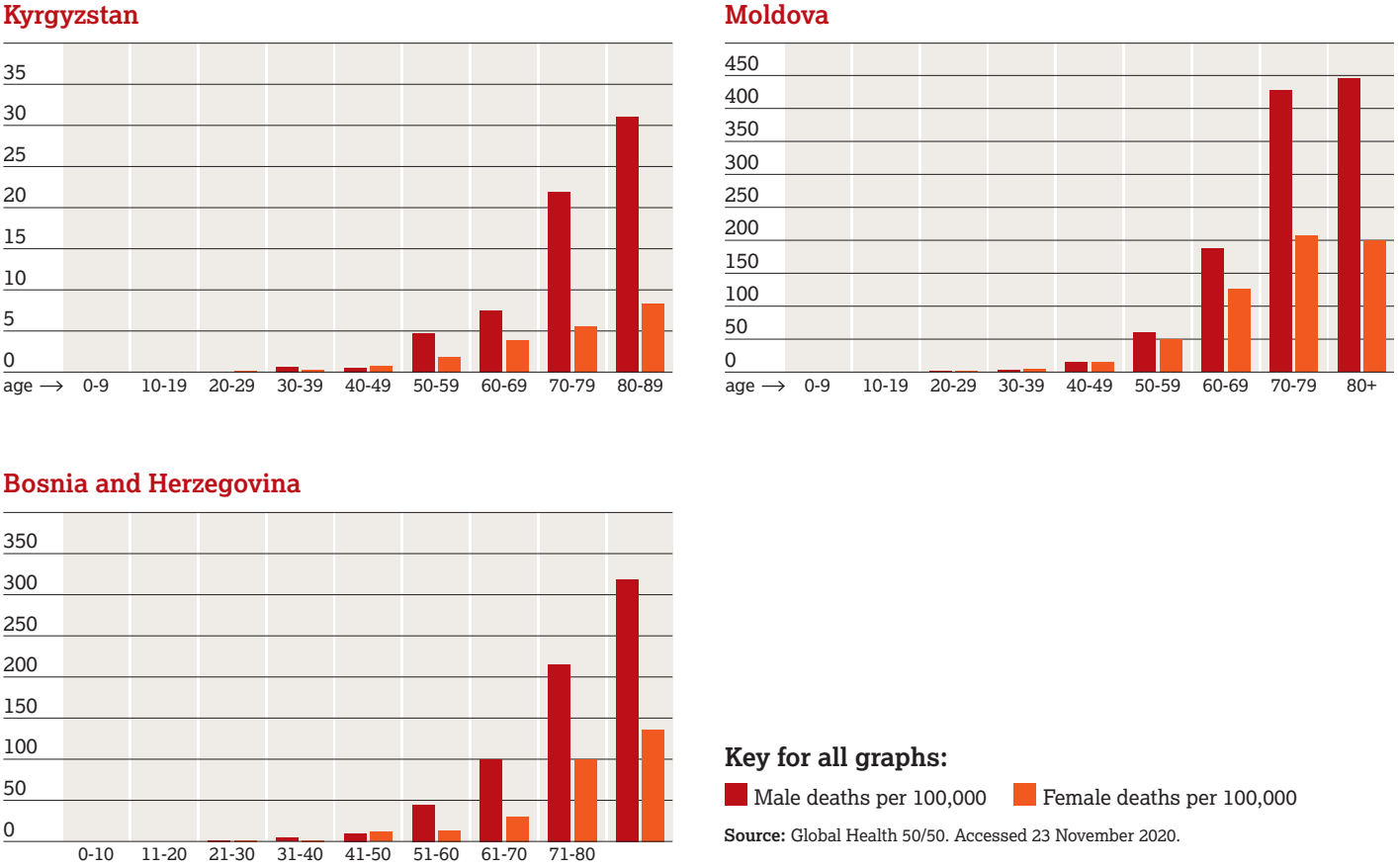
Health and care

As elsewhere in the world, older people in countries in the EME region have faced high risks of serious illness and death from COVID-19, though it is difficult to get a detailed picture of the extent of infection, serious disease, and mortality among different age groups due to a lack of age- and sex-disaggregated data.

Data available from a limited number of countries in Eurasia aligns with experience in other parts of the world. In Bosnia and Herzegovina, Kyrgyzstan and Moldova, death rates rise rapidly with age, with the highest rates seen in those aged 80 years and over (see Figure 1 below).[60]

Data from these three countries is consistent with data from other regions in showing far higher mortality rates among men than women. Data on confirmed cases of COVID-19 is more mixed. In Ukraine, for example, the highest rates are seen in women aged 50–69 years, with 712 cases per 100,000 population reported at the end of September 2020.[61] In Moldova, confirmed cases rise with age, peaking in women aged 50–59 and men aged 70–79, before declining.[62] In the Arab region, age- and sex-disaggregated data on confirmed cases and deaths is extremely limited. WHO data for Iraq and Egypt based on 1,443 cases suggests 67 per cent of reported cases are among people aged 20–59 years and 24 per cent are among people aged 60 years and over.[63]

Figure 1: COVID-19 deaths by age and sex in select countries in the EME region



Source: Global Health 50/50. Accessed 23 November 2020.

COVID-19 is posing serious challenges for fragile countries in the Middle East region, including Syria and Yemen where health systems are underprepared to respond to the pandemic and living conditions place people at high risk of infection. Data from Yemen shows over 25 per cent of confirmed COVID-19 cases have died. This is the highest case fatality rate in the region.[64] However, data, particularly from fragile contexts, must be treated with a degree of caution as it is likely to only tell a partial story. Low levels of testing and diagnosis may be inflating the fatality rate, while it is also possible that deaths are going unreported. While age- and sex-disaggregated data is not available, given the higher death rates among older people seen in countries around the world, it is likely that a significant number of older people in Yemen have died of COVID-19.

COVID-19 in older people with underlying health conditions and those living with disability

Increasing evidence has emerged globally over the course of the pandemic to demonstrate the risks of severe illness and death for both older people and those with underlying health conditions, though limited data is available in the region. Hypertension, diabetes, cardiovascular disease, lung conditions and dementia have been linked to poor outcomes. Data from the WHO European region, which includes countries in Eastern Europe and Central Asia, shows that 93 per cent of all deaths from COVID-19 had at least one underlying health condition.[65] Table 4, below, shows the most common conditions among people who have died from COVID-19.

While data disaggregated by disability is scarce, it is likely that people living with disability face higher risks from COVID-19. Older people with disabilities have high rates of underlying health conditions and poor access to health services. People with disabilities are three times more likely to have heart disease, stroke, diabetes, or cancer than people without disabilities.[66] They are twice as likely to find health services inadequate and three times more likely to be denied healthcare.[67] It is therefore likely that significant impacts of COVID-19 are being experienced by older women and men living with disability.

A UN report on the impact of COVID-19 on older people in the Arab region recognises that disability is a compounding factor elevating COVID-19 risks and impacts for older people. Older people with disabilities may face multiple functional difficulties in carrying out daily routines, increasing their vulnerability and dependency. It is estimated that 46 per cent of older people globally have disabilities, with more than 7 million in the Arab region suffering from moderate to severe disabilities, including 4 million older women.[68]

Table 4: The most common underlying health conditions among people who have died with COVID-19

Condition	Per cent of deaths
Cardiovascular disease	83
Diabetes	61
Renal disease	25
Lung disease	24
Neurological disease and dementia	20
Obesity	12
Liver disease	7
Immune disorder	5

Source: WHO Euro weekly surveillance report

Another emerging group facing high risks from COVID-19 is people in need of long-term care and support, particularly those living in residential care facilities. Data from these settings is limited, leading to challenges in determining the impact of the pandemic, and making comparison between countries difficult. However, in contexts where residential care is more common and some data is available, the challenges appear to be acute, with high rates of infection and deaths among residents and staff. Data analysed from 21 countries suggests 46 per cent of all deaths from COVID-19 have been among care home residents.[69] In some contexts, this figure is significantly higher. In many low- and middle-income countries, residential care remains relatively limited, but where facilities do exist, they are often unregulated due to absent or weak care and support systems.

Alongside the high risks of serious illness and death experienced by residents in care facilities, evidence is also emerging of multiple other impacts, particularly because of measures to control COVID-19 outbreaks. In countries around the world, people living in care homes have found themselves essentially locked in, unable to leave the facility except in specific circumstances and without contact with their families and friends due to a ban on visitors. This is likely having a pronounced impact of residents' mental health and wellbeing and has implications for their human rights.

In Jordan, for example, measures have been put in place to prevent and manage COVID-19 outbreaks in residential care settings. These have included a ban on all but essential family and other visits to homes except for health visits by GPs and Ministry of Social Development senior officials; new shift patterns for staff, including staying overnight, to minimise contacts; and daily monitoring of both residents and staff.[70]

Given the lack of data on the impacts of COVID-19 on older people on residential care settings, and the fact that their voices are very rarely heard, HelpAge International undertook small-scale case studies in eastern Ukraine and Moldova to explore the potential impacts of the pandemic on older people in residential care. These studies aimed to explore the following research questions: what are emerging as the likely trends in relation to the implications of COVID-19 for older people's health and wellbeing? How is COVID-19 changing the day-to-day lives of older people in residential care facilities? In both countries 24 interviews were conducted (15 in Ukraine and nine in Moldova) with residents and staff at eight care homes (five in Ukraine, three in Moldova). Due to the small numbers and the limitations of interviewing people in these settings during COVID-19, the findings presented in Boxes 1 and 2 should not be interpreted as representative of older people's situation in such settings. Rather, the interviews offer insights into the experiences of a small group of individual older people whose voices have not been heard during the pandemic.

Syrian Expatriate Medical Association

Box 1

Experiences in care homes in Moldova and Ukraine during COVID-19: residents' views

In residential homes in Moldova and Ukraine, discussions with residents and their responses to questions were limited. In Ukraine in particular, residents often gave one-word answers and did not appear willing or comfortable to elaborate. While some residents in homes in Moldova spoke in more detail, this lack of engagement raises concerns about residents' sense of empowerment and autonomy and the extent to which they felt able to share their views and raise concerns. The presence of care home staff in interviews in some places and the necessity of relying on telecommunications is likely to have been a significant factor in this.

However, staff at facilities in Moldova shared some of the dissatisfaction being expressed by residents about the restrictions on movement. In some cases residents also chose to share their concerns informally after the interviews were concluded. For example, residents in one facility raised specific questions about their human rights and how these were being violated during the pandemic. This suggested greater levels of awareness of rights and entitlements among some residents and perhaps a willingness to voice their concerns and challenge what was being done.

"We may go out subject only to the consent of the director. The gate is closed and guarded."
Care home resident, Moldova

"Nothing has changed much, only control, masks are worn, if we are taken to the hospital, they monitor so that we do not go anywhere else."
Care home resident, Ukraine

A difference was seen in terms of the perceived health impacts of the pandemic being reported by residents. The majority of residents at facilities in Ukraine said they were not experiencing particular changes to their health, in contrast with the views of residents of facilities in Moldova. This may be because two out of three facilities involved in the study in Moldova had experienced COVID-19 outbreaks, while there had been no cases of the virus among residents in any of the five homes in Ukraine.

Residents in Ukraine spoke about feeling protected and well cared for during the pandemic. In Moldova, numerous residents noted that the quality of care in their homes had improved. While this is positive, examples given by residents of increased access to hot water and improved nutrition raise concerns about the general standard of care.

"Things have changed for the better. It's not bad, it's good. They wash us, change our bedding. They cut our nails. The food is good for us. They disinfect us."
Care home resident, Moldova

Fewer residents than expected in both countries shared experiences of a significant change in their mood during the pandemic. However, the interviewer in Moldova observed quite high levels of anxiety and emotional distress in a number of residents.

"I don't recognise myself. I don't know how long I will withstand if we don't have freedom. It was very well before COVID. Since this fear appeared, I can't even read. Unintentionally, I have an extraordinary depression. My health has worsened and I'm no longer the human I used to be. Before the pandemic, I used to go for walks in the town and go to shops. It was another life. I knew I was somewhere and I saw something."
Care home resident, Moldova

"Sometimes I was in a bad mood, I felt anxiety, the feeling of depression worsened. The worry of what will happen next…"
Care home resident, Ukraine

In Ukraine, low levels of loneliness and isolation were reported by residents, despite restrictions on visits. This issue should be explored further to understand if living in a care home and having the opportunity to communicate with fellow residents and staff on a daily basis where this has been possible during the pandemic may be a protective factor in terms of the impacts of feelings of loneliness compared to older people with care and support needs living in other settings.

Box 2

Experiences in care homes in Moldova and Ukraine during COVID-19: the views of staff

Interviews with residential care home staff in both Moldova and Ukraine gave an insight into the impact of the pandemic on staff. Staff in both countries talked about the emotional distress they were experiencing. This was particularly pronounced in care homes in Moldova where facilities included in the study had experienced COVID-19 outbreaks among both staff and residents. Staff in these homes became visibly upset during interviews and shared feelings of guilt, stress, and anxiety.

"Since the pandemic, I've been suffering from insomnia. Every time someone called me from the Retirement Home, I wondered if there were any cases. I felt like I was always on alert."

Care home employee, Moldova

"We are experiencing severe psychological discomfort, I have worked here for 25 years, everything here is dear to me."

Care home employee, Ukraine

Consistent across facilities in both Ukraine and Moldova was the lack of training provided to staff to ensure they were equipped to respond to the pandemic. In both countries it was clear that a systematic government-led approach to staff training in the long-term care and support sector was lacking. Any training received was ad hoc and had been organised by the facilities, either working with NGOs or finding information online.

"No, we had no training during the pandemic. It would be very welcomed for some medical specialists to give us such training."

Care home employee, Moldova

The lack of training for staff likely explains inconsistencies in approaches taken in different facilities. The interviews suggested varying prevention and protection measures had been put in place to manage COVID-19.

Another area of inconsistency and concern was how facilities were able to engage with the health system and the support they were receiving to look after their residents. One staff member in a facility in Moldova reported that residents in their facility were not tested and diagnosed with COVID-19, and that some may have died as a result of the virus because of a denial of care by health facilities.

"One patient has recently died of a stroke. She had diabetes and a very high level of blood sugar. In addition, she had signs of pneumonia. I think COVID caused all these. The medical nurses called the ambulance, but I can't explain why she remained here. They said it was due to age, as she was 87, and had complications caused by diabetes. This was at the start of the pandemic. The hospital said she would get COVID if she was taken there."

Care home employee, Moldova

"Hospitals, as you know, are not free now, and many people do not have money on hand. … A medical institution may refuse to treat a patient if he has no money. Any operation or examination is paid. I have not come across this, but I doubt that the hospital would take an elderly person with COVID-19 for treatment, so we will have to keep such a patient in an isolator and treat them on our own… the hospitals are not very welcoming for the elderly."

Care home employee, Ukraine

Access to information

Given the high risks of COVID-19 for older people, a key question is the extent to which all groups can access clear and accurate information in accessible formats. Studies have shown that different population groups access information through different channels, pointing to the need for targeted risk communication and community engagement (RCCE) strategies during the pandemic. Evidence on the success of these strategies for older people is mixed. UNFPA research in the Arab States, for example, has shown that women are more likely to face challenges in accessing accurate information, and the situation may be exacerbated for older women with mobility issues.[71]

Access to health services and support

Many older people across the EME region have limited awareness of where to access health services for COVID-19. HelpAge's rapid needs assessments for older people (RNA-OPs) identified challenges in relation to awareness of where to access COVID-19 testing and treatment, and the accessibility of these facilities. In Lebanon, 39 per cent of older people were unaware of their nearest COVID-19 referral facility, with lower levels of knowledge in older women (45 per cent).[72] Of those who did know where to go for COVID-19 services, 29 per cent said the facility was not accessible. Similar challenges were seen in Jordan and Iraq. In Jordan, 27 per cent of older people did not know where to access COVID-19 services and 12 per cent said they did not have access to the relevant facilities.[73] In Iraq, 20 per cent of older people lacked knowledge of COVID-19 services (rising to 39 per cent in Dybala) and 43 per cent among older women in particular.[74]

Evidence from Central Asia highlights access barriers to care and support because of health systems being overwhelmed by the first wave of COVID-19. Shortages of hospital beds, PPE, ventilators, and medications meant thousands of people with COVID-19 went without facility-based care.[75] Given high fatality rates among older people, it is likely many were older.

The pandemic is also affecting older people's access to health and care services and support for non-COVID-19 services. Data collected from 105 countries through a WHO survey reveals widespread disruptions to health systems and services around the world, and that almost 90 per cent of countries had experienced some disruption, with higher rates seen in low- and middle-income countries.[76] The most frequently disrupted services were routine immunisation, reported by 70 per cent of countries, followed by NCD diagnosis and treatment (69 per cent), family planning and contraception (68 per cent), treatment for mental health disorders (61 per cent), antenatal care (56 per cent) and cancer diagnosis and treatment (55 per cent).

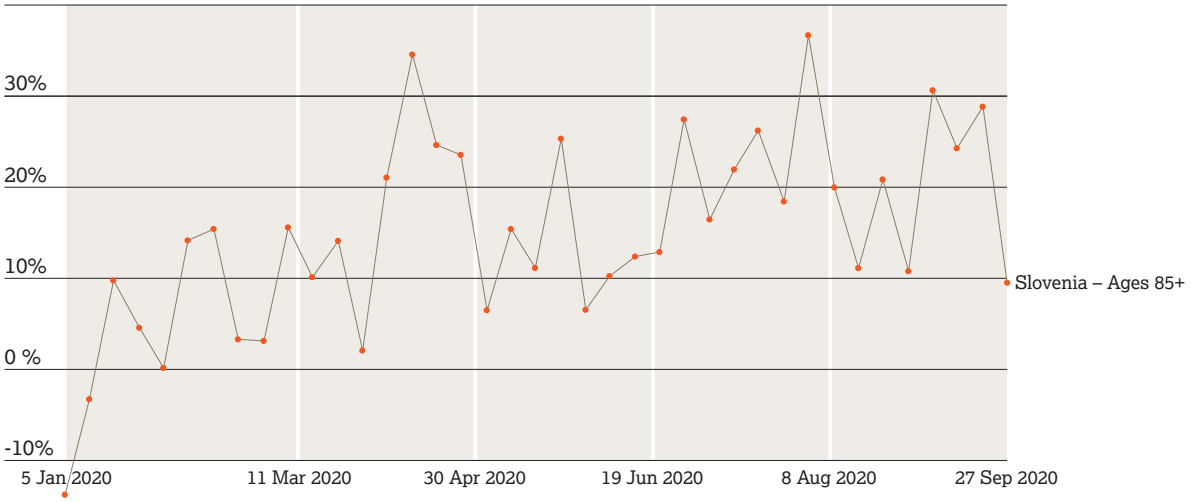
These findings are reflected in results of the RNA-OPs conducted by HelpAge and its partners, which found significant declines in access to health services among older people. In Jordan, 56 per cent of older people reported challenges in accessing health services and medicines and 44 per cent of older people with disabilities reported a change in their access to health services since the start of the outbreak.[77] In Iraq, 32 per cent of older people taking medication had not been able to access it since the start of the outbreak.[78] The figure was 24 per cent in Lebanon.[79]

The challenges experienced by health systems in responding to COVID-19 are likely to have a significant impact on those who rely on essential health services, including older people. Central Asia faces a double burden of communicable diseases and NCDs, and services for both have been disrupted. There are high rates of HIV, hepatitis, and tuberculosis (TB) and services for these conditions have been significantly affected by COVID-19. Substantial decreases in TB case notification have been observed since April 2020.[80] Management of chronic diseases such as cancer has also been disrupted, and suicide rates have increased.[81] Given the high rates of NCDs in older people and the clear link between NCDs, ageing and risks from COVID-19, a shortfall in NCD care will also have a significant impact for older people across the region. In Kyrgyzstan, cancers account for 18 per cent of deaths in people aged 50–69 years compared with 11 per cent in those aged 15–49 years.[82] In Kyrgyzstan and Uzbekistan, older women aged 65 years and over have a high incidence of TB, with higher rates only seen in women aged 15–34 years in Kyrgyzstan and 25–34 years in Uzbekistan.[83] Prevalence of HIV is also likely to be higher among older people in the region than officially recognised. In Kazakhstan, people aged 50 years and over account for 16.4 per cent of people living with HIV, while in Kyrgyzstan and Uzbekistan, the figure is 14.5 per cent.[84]

Although not available in the EME region, data on excess deaths from European and high-income countries provides a clear indication of the likely indirect impact of COVID-19 on people's health and wellbeing. Data collected from 24 European countries and a few other high-income countries shows significant spikes in excess deaths between March and May 2020. The vast majority of these were among people aged 65 years and over.[85] A second spike is now beginning as many European countries tackle subsequent waves of COVID-19. For example, data from Slovenia for people aged 85 years and over shows death rates have been higher throughout 2020 compared with the same weeks in 2019. Spikes can be seen in April, August, and September 2020, when deaths were 30 per cent higher than in 2019 (see Figure 2 on the next page). While it is likely that some excess deaths will be linked to undiagnosed COVID-19, others are likely to reflect the impact of the pandemic on wider health systems.

Figure 2: Excess mortality during COVID-19: Deaths from all causes compared to previous years, by age

Shown below is how the number of weekly deaths in 2020 – broken down by broad age groups – differs as a percentage from the average number of deaths in the same week over the previous five years (2015–2019). This metric is called the P-score.



Source: Human Mortality Database (2020)

Impact on older people's mental health and psychosocial wellbeing

Around the world, concerns have been raised about a secondary mental health pandemic emerging from COVID-19. People's mental health and psychosocial wellbeing is being adversely affected by the virus itself and by the measures taken to reduce its spread. Data from a cross-sectional study in China has shown that over 50 per cent of those surveyed have experienced moderate-to-severe psychological distress during COVID-19.[86] There are multiple causes, including concerns about becoming infected, losing loved ones, and social isolation.

Social isolation was already significant among older people before the pandemic and is likely to have been exacerbated by lockdown and physical distancing measures. In Lebanon, social isolation has been shown as the most significant predictor of developing mental disorders in older people.[87] In contexts where stringent lockdowns have been applied based on age, there are significant risks for older people's mental health. In Serbia, where a complete lockdown was imposed on all people aged 65 and over, there have been reported increases in feelings of anxiety, loneliness, and depression, including among the 300,000 older people who live alone.[88]

HelpAge's RNA-OPs from Iraq, Jordan, Lebanon, and Syria demonstrate the mental health impacts older people are experiencing because of the pandemic. The situation appears to be particularly acute in Iraq with 74 per cent of older people saying they feel worried or anxious all or most of the time and 68 per cent reporting feeling depressed. Rates are higher among older women than men (80 per cent for anxiety and 72 per cent for depression).[89] In Jordan, 45 per cent of respondents report feeling worried or anxious all or most of the time, with rates significantly higher for Syrian refugees (67 per cent).[90]

Figures on the impact of the pandemic on mental health are particularly concerning when considering the lack of services and support available to older people. A study conducted across the Middle East and North Africa (MENA) region[91] has shown that prior to COVID-19, health systems ignored the needs of older people who had to rely on family or community-based social support.[92] Research in MENA indicated a high prevalence of depression among older people prior to the pandemic, with prevalence rates varying between 10 per cent and 46 per cent. This existing disease burden, coupled with a lack of services and the stresses associated with COVID-19, points to the likely causes of the high rates of mental ill health among older people.

While many countries are providing mental health support in response to COVID-19, this has been focused on the general population, with little attention given to the specific needs of older people. Only two of 13 countries across the MENA region (Egypt and Qatar) have established a task force for geriatric mental health during COVID-19.[93] The importance of interventions specifically targeting older people has been highlighted in Lebanon, where uptake of remote services, including telepsychiatry, has been slow among older people and has only started to increase with significant support from family caregivers.[94] This may be due to poor access to, and understanding of, how to use technology; lack of awareness of these services; and hesitancy to access care in a new way. Significant efforts will be needed to support older people and their families to make this shift.

Fedaa Qatatshsah/HelpAge Jordan

Recommendations

- Age-, sex- and disability-disaggregated data on COVID-19 cases and deaths should be collected and reported at global, regional (country), and local levels by governments and UN agencies.
- Research should be conducted into the impacts of COVID-19 (and the measures taken in response to it) on older people's health and wellbeing, including on the physical and mental health implications of reduced access to, or use of, health and care services over a prolonged period and of isolation and lack of participation and engagement.
- Research should be conducted on the long-term health implications for older people who have and who survive COVID-19, including 'long COVID',[95] to ensure health and care systems are equipped to respond to older people's complex and changing needs.
- Ministries of health must put in place specific systems and measures to ensure essential health services are maintained during COVID-19 outbreaks and that older people have continued access to the services and support they need. This should include a focus on diagnosis, treatment, care, and management for NCDs, and older people's inclusion in services for communicable diseases.
- Ministries of health should develop targeted interventions to enable older people to access remote services and support, including for mental health issues, recognising the potential challenges for older people in adapting to new modes of service delivery.

Violence, abuse, and neglect

Evidence and data on violence, abuse, and neglect of older people during the pandemic

Data on violence, abuse, and neglect of older people during the COVID-19 pandemic is extremely limited. This highlights both the continued exclusion of older people from official datasets as well as the challenges faced with safe and ethical population-based data collection during the acute phase of the pandemic. Despite several initiatives that challenge this systematic exclusion of older people from official data on violence, abuse and neglect,[96] few countries in the EME region have gender- and age-disaggregated systems in place for monitoring, recording, and reporting on violence, abuse, and neglect. WHO estimates that before the pandemic as many as one in six persons aged 60 years and older have experienced some form of abuse.[97]

A few studies have measured an increase in violence against women, specifically domestic and intimate partner violence, since the start of the pandemic, though in the EME region, rigorous studies remain scarce, evidence remains patchy and anecdotal, and the situation for older women is unclear. Even where data has been collected on older age groups, disaggregation or analysis is limited. For example, in Lebanon, an assessment on the sexual and gender-based violence (GBV) situation shows that since the first outbreak of COVID-19, 54 per cent of interviewed GBV service users reported observing an increase in harassment, violence or abuse against women or girls in their household or community.[98] The following types of violence were observed: emotional (79 per cent), denial of resources (53 per cent), physical (55 per cent), sexual (32 per cent), discrimination (31 per cent) and threat of deportation/eviction (15 per cent). In total, 57 per cent of respondents said they felt less safe at home and 44 per cent felt less safe in their communities. In Kyrgyzstan, 32 per cent of respondents (including 29 per cent of men and 34 per cent of women) said they heard about an increase in domestic (family) violence or experienced it themselves.[99] The number of urban respondents who chose this answer is double that of rural areas. However, no age disaggregation or analysis of the experiences of older women or men is provided in either study. In Ukraine, a rapid analysis of actions taken by local services for the prevention of violence in the family and risks faced by victims during social isolation related to COVID-19 in the communities of Donetsk and Luhansk regions demonstrated an increase of physical and psychological violence in conjunction with the escalation of domestic economic violence during the pandemic.[100] Domestic violence against older people is reported to have increased, though, again, detailed analysis is not provided.

Increased fear of violence abuse and neglect among older people

RNA-OPs conducted by HelpAge and partners in the EME region highlight older people's fears of increased abuse and isolation during the pandemic. COVID-19 RNA-OPs conducted in Jordan and Lebanon reveal that older men and women feel they are at increased risk of several protection issues since the beginning of the pandemic.[101] When older women were asked what they felt were the increased risks for older women during this time, the top three responses were: neglect (34 per cent); isolation (26 per cent); and financial abuse (20 per cent). The risk of neglect was perceived to be more pronounced for older women living in Lebanon (47 per cent) and the risk of financial abuse perceived to be less by older women with disabilities in Jordan (12 per cent). When older men were asked what they felt were the increased risks for older men during this time they identified the same top three risks: neglect (33 per cent); financial abuse (29 per cent); and isolation (25 per cent). The risk of neglect was perceived to be more pronounced for older men living in Lebanon (38 per cent) and the risk of financial abuse was perceived to be greater by older men living in Lebanon and by older men with disabilities in Jordan (both 37 per cent). However, it is important to note that the question asks about the interviewee's perception of the protection concerns experienced by others to avoid putting individuals at risk and, as such, the results are difficult to interpret.

"The reported numbers of older people affected by abuse during the COVID-19 pandemic do not reflect the reality as many don't know how to report incidents – or even if they do, they may not have a telephone and they are scared. Often abuse is perpetrated by family members that they are dependent on; they have no means to support themselves and they fear they would be threatened or worse if they asked for help."

Asma Khader, CEO of Sisterhood is Global Institute (S.I.G.I), Jordan

Changes in risk factors during the pandemic

Restrictive measures introduced by many countries in the EME region in response to COVID-19 created conditions likely to increase risk of violence, abuse, and neglect of older people. This is particularly the case for those who were already experiencing violence, abuse, and neglect before the pandemic.

The inability of older people to escape their abuser during the pandemic has created more opportunities for the perpetration of violence, abuse, and neglect. In the Arab States, CSOs surveyed by UN Women reported an increase in domestic violence.[102] Unable to leave the house they share with their abusers or reach out to families for support, women have been forced to endure violence. Increased confinement with and exposure to abusers and reduced opportunities to seek help, are likely to have put older people living with abusive caregivers or family members at greater risk of violence. In some countries, age-based measures, such as stricter isolation measures for older people than other population groups, may further heighten the risk of violence, abuse, and neglect.[103]

Measures leading to social isolation are likely to contribute to violence, abuse, and neglect. Isolation limits the occasional monitoring of an abusive situation and makes it more difficult to seek help. Reduced or no access to social support networks such as family, friends, relatives and neighbours, and support services due to restrictive measures may contribute to isolation and an increased risk of violence, abuse, and neglect. In the Arab States there have been reports of a discontinuation of services and support systems for women.[104] Support services, which have shifted to new models of delivery, including remote, mobile, and online provision,[105] present challenges for older people who face barriers using newer technologies, such as the internet,[106] or do not have consistent access to a phone or the internet.[107] Eighty-six per cent of surveyed CSOs that work with women have changed how they reach out to communities by using more technology-based platforms, such as social media and mobile applications.[108]

Stresses on households caused or aggregated by the pandemic may increase the risk of violence, abuse, and neglect. During the pandemic stressors may include increased financial hardship caused by confinement,[109] increased economic uncertainty, health-related worries, and a lack of social support for those providing care.

Ageism, pervasive before the onset of the crisis, has been exacerbated during the pandemic and is a risk factor for violence, abuse, and neglect of older people.[110] HelpAge has collected a range of evidence of ageism throughout the pandemic, including discriminatory practices and stigma experienced by older people. According to responses to the HelpAge voice survey in June–July 2020, older people were seen as "passive, frail and dependent" in Kyrgyzstan.[111]

"During quarantine, my son and daughter-in-law began to neglect my needs. Previously I did not notice their behaviour, but since all family members must stay home, I started feeling their bad attitude to me. They don't give me food and medicine on time, and they don't even talk to me. Sometimes my daughter-in-law yells at me. I feel like a burden to my family."

Older woman, Osh province, Kyrgyzstan

Older people's help-seeking behaviour

The pandemic may have further created challenges for older survivors seeking help. For older people, reporting rates and help seeking is affected by the lack of prioritisation of violence, abuse, and neglect of older people, the surrounding shame and stigma, and the lack of adequate services.[112] WHO estimates that only four per cent of cases of elder abuse were reported before the pandemic.[113] Access to information about where to access support services can be a major barrier for help seeking during the pandemic. In Kyrgyzstan, for example, 46 per cent of men and 59 per cent of women said they did not know where to find help (such as hotlines, psychological support, or the police) if they experienced domestic violence.[114] Women from urban areas are slightly better informed, with 52 per cent knowing where to seek help and support compared to 35 per cent of women from rural areas. In rural areas, the best informed are women aged 18–24 years (25 per cent) while in urban areas these are women aged over 50 years (32 per cent). However, 33 per cent of women and 30 per cent of men said they would not seek help if they experienced or witnessed domestic violence, perhaps indicating that people do not expect any real support in cases of domestic violence.
In Lebanon, 25 per cent of women and girls did not know where to access support[115] and, of those that accessed support, 94 per cent received the service over the phone. Of those who accessed the service over the phone, 16 per cent had no consistent access to a phone or the internet and 15 per cent did not feel safe talking over the phone.

Older people most at risk

Little data is available on who is most at risk of violence, abuse, and neglect during the pandemic, though we know certain characteristics, including age, gender and disability status, and their intersection put some groups of older people at heightened risk.[116] UNFPA states that both women and men with disabilities can be up to three times more likely to experience violence[117] while women with disabilities are often more likely to face challenges when seeking services, lose their support mechanisms as well as their access to caregivers, and experience violence.[118] With the closure of special care centres, these women have also been stigmatised as 'dependents' and as representing an additional burden for households during the pandemic. These groups can be further constrained in seeking services as they may rely on their abuser for mobility. Protective measures should be adopted to support women with disabilities during the pandemic, including monitoring systems with emergency hotlines and social service-based house calls and check-ups.

HelpAge Ukraine

Adequacy, relevance and coverage of violence, abuse, and neglect support services

Existing data gaps have translated into a lack of protection mechanisms, limited access to tailored services and a lack of effective prevention programmes for older people. Even where essential services for survivors of violence exist, these have been disrupted by restrictive pandemic measures.[119] In a UN Women survey on the impact of COVID-19 on violence against women and girls in the Arab States (conducted through women's CSOs) 39 per cent reported that legal services had been affected by the pandemic, with courts being closed and several procedures for legal redress put on hold.[120] The disruption of legal services has forced the police and other actors to resort to informal justice mechanisms to ensure the protection of women survivors. Thirty-five per cent also indicated that during the pandemic it has been easier to access informal or traditional justice mechanisms such as community mediation, or alternative dispute resolution through family or traditional leaders.[121] The potential lack of privacy and confidentiality of informal justice systems may present a barrier for older people reporting violence, abuse and neglect perpetrated by family and caregivers and it has the potential to put their safety and wellbeing at risk. The same report found 15 per cent of women's CSOs indicated that shelters for women survivors have been impacted by the pandemic. Implementing social distancing in shelters has proven difficult as confinement or quarantine spaces are not always available or require more space, while testing for the virus is expensive and often not affordable for shelters.[122] This is worrying for older women survivors who are at higher risk of serious illness and death from COVID-19.[123] Almost one-third (29 per cent) of participating women's CSOs indicated that hotlines, which provide key services during the pandemic, have also been affected by higher call numbers, and needed to adapt to provide counselling services remotely.[124]

Overall, CSOs are at risk of not being able to continue providing services to survivors. As many as 84 per cent of the women's CSOs participating in the survey reported that the COVID-19 pandemic had affected them either negatively or very negatively, and 67 per cent stated that if their organisation did not receive necessary funding, they would remain only partially operational; another six per cent noted that they would have to close down.[125] The inability of CSOs to continue their work could have important consequences as, in a number of contexts across the region, these organisations are sole providers of direct support to women, including older women, facing violence.

Box 3

Gender-sensitive measures to target violence against women

The COVID-19 Global Gender Response Tracker compiled by UNDP and UN Women monitors policy measures enacted by governments to tackle the COVID-19 crisis, and highlights responses that are gender sensitive. Key measures tracked include those that target violence against women.

Seventy-five per cent of all gender-sensitive measures (52 measures across 11 countries in which HelpAge Global Network has presence) in the EME region focus on preventing and/or responding to violence against women and girls (VAWG). The tracker registers next to no measures targeted at the most marginalised women such as older women and women with disabilities.

The majority of the measures include those aimed at strengthening services for survivors, including through helplines and other reporting mechanisms, shelters, and police and judicial responses to address impunity. This includes examples such as implementing female emergency response teams in Jordan; establishing domestic violence helplines in Lebanon, Kyrgyzstan, Palestine, and Ukraine; setting up remote systems for testimonies and case management in Lebanon; establishing crisis centres in Kyrgyzstan; and providing legal aid and psychosocial support in Ukraine.[126]

There are also several measures related to awareness-raising and campaigns, including in the Syrian Arab Republic, Kyrgyzstan, Palestine, and Albania.[127] In Albania, the Ministry of Health and Social Protection produced a video to raise awareness on violence against women, narrated in Albanian, with sign-language provided to ensure greater reach among people with hearing disabilities, as well as English subtitles.

A small number of countries have taken measures to improve the collection and use of violence against women data in the COVID-19 context.[128] This includes Kyrgyzstan, Palestine, and Serbia. Improvements in relation to the collection and use of age-disaggregated data are not explicitly mentioned.

Services to respond to and prevent VAWG must be treated as essential services and as an integral part of national and local COVID-19 response plans, though according to the tracker, only a few countries have taken this step (including Kyrgyzstan and Palestine). This is concerning, since the pandemic will have long-lasting consequences that increase the risk of violence for women and girls – including older women. Only commitments that are part of governments' sustained and long-term planning and policies can help to address these.

Given the lack of data on the impacts of COVID-19 on violence, abuse, and neglect of older people, HelpAge undertook a small-scale case study in Moldova to explore the potential impact of the pandemic on older survivors. The study aimed to explore the impact of COVID-19 on violence, abuse, and neglect of older people, with a focus on gender-based violence. It also explored the extent to which support services are accessible to, and inclusive of, older survivors. The case studies were informed by a review of secondary evidence at country-level; and key informant interviews with representatives from frontline support services and government service providers, and with three older women. Due to the small numbers of interviews, the findings presented in Box 4, below, should not be interpreted as representative of the situation of older people at risk of violence, abuse, and neglect in this context or in this setting. Rather, the interviews offer insights into the experiences of a handful of service providers and three individual older people that have not been heard during the pandemic.

Box 4

Violence, abuse, and neglect towards older people in Moldova during COVID-19

COVID-19 and the response to prevent its spread triggered a series of adverse consequences for individuals and communities in Moldova, including creating the conditions for increased risk of violence, abuse, and neglect of older people. Restrictions enforced by government created circumstances where older people were spending more time with their families and partners – a situation likely to put some older people at greater risk of violence and abuse. Specific restrictions on movement, particularly during the lockdown period where older people over the age of 63 years were unable to leave their homes, further heightened the risks they faced.

"He was even more nervous and aggressive… especially since he didn't go out much and stayed at home longer. We met more often. Now it's good that I'm going to work."

Older woman, rural area

Social isolation can contribute to stress, anxiety, and mental health issues, which may have been a trigger for violence or behaviours that might be related to violence, such as increased alcohol consumption.

"… The hardest part was when we weren't allowed to go out. She had become very aggressive then. When there was no pandemic, we would go out for a walk, we would go here and there, and I would keep it under control. But in those months, March, April and even May, when we were locked in the house [during the lockdown period] the situation got out of hand. … She has got upset, annoyed, namely when she had to stay at home."

Older woman, urban area

continued over

The physical isolation of older people has been accentuated by their digital isolation in Moldova.[129] When the activities of institutions and authorities transferred online they became inaccessible to most older people, including their ability to get to critical information on how to access services.

Interviews with older survivors revealed changes in the nature, forms, and severity of violence compared to before the pandemic but also at different periods during the pandemic.

"The first time he kicked me… I left him and went to a sister and stayed with her for most of August. But he called me to come home. Then [it happened] in September, but in September he was already more aggressive, I do not know why. … I came [home]… and he suddenly jumped… [at] me… and beat me."

Older woman, rural area

There were reports that only cases of physical abuse, where severe and obvious bodily injuries can be demonstrated, are reported, and referred to specialist services. This diminishes other types of abuse and neglect, especially economic and psychological, which remain unrecognised, perpetuating authorities' inaction to prevent them.

"If I hadn't been bruised, I wouldn't be… where I am."

Older woman, rural area

In Moldova, discriminatory, age-based, stay-at-home orders introduced during the pandemic – justified by the risks of complications from COVID-19 faced by this group – limited the movement of people over the age of 63 years in public spaces. This appears to have increased the risk of older people experiencing ageism and violence, abuse, and neglect in their homes and communities. One older woman revealed verbal harassment from neighbours:

"My neighbours screamed at me from their balconies for leaving the house, but I told them I needed to get food."

Older woman, urban area

Interviewees also said older people diagnosed with COVID-19, those who are sick, and those who have been treated for COVID-19, and also their relatives have been stigmatised in their communities, especially by neighbours.[130] Speeches by government representatives and media communications exacerbated pre-existing ageism by promoting negative stereotypes of older people being worthless and dispensable.

"Television says that the elderly are not important. All they [older people] hear is that nobody needs them, that financially they are already useless. There were messages that were perceived as 'nobody needs you anymore'."

NGO frontline support service provider

During the pandemic it became clear that services were not prepared for such a crisis.[131] The centres for violence survivors were not equipped with isolation chambers, though minimum quality standards provide for this; they have not been allocated additional financial resources for the minimum needs related to the pandemic; and no response strategy has been developed for such situations by central and local public authorities. In addition, not all services remained active throughout the pandemic. The main factors for suspending activities were the inability to shift to remote working in relation to systems and culture; inadequate knowledge of online platforms; a lack of necessary protective equipment; and insufficient staff numbers. However, many NGOs providing services to survivors of violence have been able to shift online and provide remote support and advice. Others continued to operate and provide support in the usual or modified way. State institutions continued to operate, though they could not provide the full range of support services for survivors of violence, including psychological and legal counselling, shelter, and recovery. At the time of the research, there were a few state institutions and staff specialising in providing support to survivors of violence, but their funding was said to be insufficient. However, some interviewees reported relatively good cooperation between governmental and non-governmental institutions in providing support services to both survivors of violence and older people at risk of violence, abuse, and neglect.

"I can't say that the pandemic found us ready… we [moved to] online services which was difficult. Unfortunately, many centres were closed because they did not have disinfectants, masks, and the necessary equipment. All were oriented to online services, but the [survivors] were placed in an apartment, which we have received from donors. For two–three weeks they received psychological services [via] telephone and other assistance services. Later, if the person did not show symptoms of illness, [they] were placed at the Placement Centre. The situation has not changed even now, we continue in the same way."

Representative of Ministry of Labour, Health and Social Protection

"We did not allow… [psychological counselling services] to be affected. We applied a mechanism for solving the problems that appeared, we were equipped with everything necessary, we made home visits… or we gave consultations by phone."

Representative of local government support services

Recommendations

- Data producers in the EME region, including governments, NSOs, UN agencies, multilateral agencies, service providers and donors must collect, analyse, and use data on violence, abuse, and neglect of older people to inform prevention and response measures. This must adhere to methodological, ethical, and safety principles in the context of the restrictive measures imposed. National data gaps must be addressed beyond this as countries seek to build back better.
- Governments, policy makers, service providers and UN agencies must recognise older women and men as at risk of violence, abuse, and neglect during the pandemic, and prevention and response measures for older survivors must be included and adequately resourced in national COVID-19 response plans and risk mitigation communication across the EME region.
- Governments, UN agencies and donors must ensure the capacity of key service providers to identify and respond to cases of violence, abuse and neglect is enhanced, and coordination of support to older survivors improved – for example through virtual multidisciplinary teams, including care providers, healthcare and social workers, the judiciary, and law enforcement.
- Governments, UN agencies, service providers and donors must ensure support services are maintained, with efforts to ensure appropriate levels of PPE for staff. Services moving to remote delivery models must employ digital tools and technologies that are accessible to all older people, including older people with disabilities.
- Governments, UN agencies, service providers and donors should establish helplines where they do not already exist and ensure the sustainable support for those that already exist. They should be free and accessible to all older survivors with multiple means of contact. Staff should be trained to identify and respond to cases of violence, abuse, and neglect, and refer older people for support without compromising their safety.
- Governments and service providers must ensure older people and community members are trained to recognise the signs of violence, abuse, or neglect, the increased risks during threats such as the COVID-19 pandemic, and the availability of support services. This information must be provided via multiple channels (including radio, television, internet, print media, including notices in grocery shops or pharmacies) and in accessible formats that respond to different levels of literacy, language barriers and disabilities.
- Governments and UN agencies should prioritise public prevention and awareness raising campaigns that target harmful gender stereotypes, and ageist and discriminatory attitudes towards older people. Campaigns should advise people to reduce their consumption of alcohol and other substances and include advice on how to manage stress.
- Support services should prioritise regular home visits and contact with older people at risk of violence, abuse, and neglect, including older people with disabilities, with attention to their safety, because perpetrators of abuse are likely to be at home.

HelpAge Ukraine

Income security and social protection

Impact of COVID-19 on older people's income security

Older people's income security is impacted directly and indirectly by the COVID-19 economic crisis. While 95 per cent of older people in Europe and Central Asia (ECA) have a pension, this is the case for only 27 per cent of older people in the Arab States.[132] In all of the world's regions, women are less likely to have a pension and the Arab States have the world's largest pension gap between men and women.[133] In the absence of universal pension coverage and adequate benefits, older people rely on work and support from family members who may already be poor or slipping into poverty because of the economic impact of the pandemic.

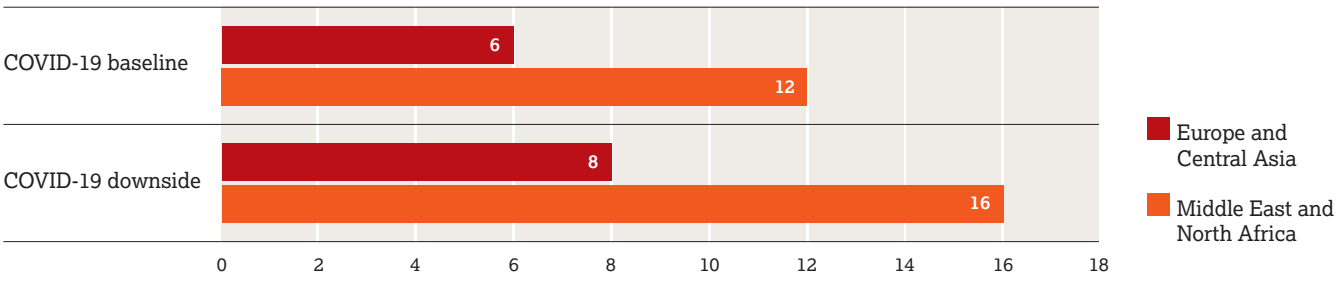
Even before the pandemic many families struggled financially, and millions more are being pushed into poverty by COVID-19. Before the crisis, seven per cent of all people in the Middle East and Northern Africa (MENA) region and just above one per cent in the ECA region lived below the international extreme poverty line of US$ 1.90 per day. Largely driven by conflicts in Syria and Yemen, the percentage has more than doubled in MENA since 2014. People aged 55 years and over made up around eight per cent of those in extreme poverty in MENA and 12 per cent in ECA. In MENA, women are slightly more likely to live in poverty, whereas poverty skews towards men in ECA. Looking beyond extreme poverty reveals the widespread levels of economic vulnerability, with 45 per cent of all people in MENA and 12 per cent of people in ECA living on less than US$ 5.50 a day.[134] The World Bank estimates that the pandemic will push between six and eight million more people in ECA into poverty (measured at US$ 5.50-a-day) and between 12 and 16 million in MENA (see Figure 3 below).[135]

The economic crisis also impacts older people directly as workers. In MENA, over 22 per cent of men aged 65 years and older, but only three per cent of older women, are in the labour force. In ECA, around 10 per cent of older men and five per cent of older women are in the labour force. The higher levels of work in older age in MENA is likely explained by the region's significantly more limited pension coverage compared to ECA. Older people's work mainly takes places in the informal sector, which provides little protection against income shocks and has been hit particularly hard by COVID-19. Before the pandemic, 79 per cent of older people's work took place in the informal economy in Central and Western Asia and 71 per cent in the Arab States.[137]

We know that people with disabilities are also significantly exposed to economic shocks but assessments often do not include them. A report from Humanity & Inclusion found that most assessments of the pandemic's socio-economic impacts make no attempt to explore the situation of persons with disabilities during COVID-19, including in the Middle East's humanitarian contexts.[138]

As a result of gendered productive and reproductive roles across the life course, older women and men in Central Asia are affected differently. Data collected in April and May 2020 by UN Women across Central Asia suggests that women of all ages and across socio-economic strata have been affected by employment and income losses. Over 15 per cent of female respondents said they lost their jobs and another 41 per cent reported reduced paid working hours. Among all groups of employed women, self-employed women were most affected, as around 70 per cent faced reductions in paid working hours or job losses.[139] It is worth noting that generally, and especially in the Arab States, that self-employed workers tend to be older and less educated.[140] While women in Central Asia appear to have suffered less than men in terms of job losses, they are more affected by changed working arrangements, reductions in paid hours of work and increased unpaid work and care.[141]

Figure 3: Millions of people newly at the US$ 5.50-a-day poverty line, MENA and ECA[136]



Without adequate social protection, losses of working hours, jobs, and income is particularly concerning for households with only limited labour capacity. In Kyrgyzstan, 43 per cent of older people's households and 68 per cent of households of people with special needs reported deterioration of their financial situation between May and June 2020.[142] In the Arab States, the UN considers 'single or small households, typically with older people and/or persons with disabilities' among the most vulnerable and least protected by social protection systems.[143]

In the Middle East, COVID-19 worsens already desperate situations for older people. HelpAge RNA-OPs in the Middle East consistently highlight the widespread food and income security experienced by older people.

Social protection responses

Social protection has been an integral component of governments' responses to COVID-19. Virtually all countries in ECA and 91 per cent of countries in MENA have adapted or expanded their social protection systems to protect livelihoods, people's wellbeing, and economies from the impact of the pandemic.[144] Countries are providing extra or higher transfers, scaling-up coverage through new schemes or expansions of existing ones or adapting implementation systems to reduce risk of infection and improve access. Some of these interventions target households while others are designed for specific groups such as older people.

Twenty-five countries in ECA and MENA have responded to COVID-19 with social protection reforms specifically targeting older people. Fourteen countries have temporarily and permanently increased pension payments in response to the crisis. Kosovo* and Kyrgyzstan advanced pension payments early in the crisis. Nine countries have adjusted their pension systems' administration to reduce older people's exposure to the virus. Seven countries explicitly include older people in cash transfers and another seven do the same for in-kind transfers.

In the context of rising poverty, vulnerability and underdeveloped social protection systems, the regional response is wholly inadequate. Before the crisis, only 47 per cent of older people in North Africa and just 27 per cent in the Arab States had some level of income security through a pension.[146] Against this backdrop it is concerning that governments' COVID-19-related social protection spending in MENA is substantively lower than that of other regions. By December 2020, MENA governments were spending just US$ 115 per capita, compared to US$ 300 in ECA and US$ 361 in East Asia and the Pacific.[147]

Expanding comprehensive social protection systems, including pensions, in response to COVID-19 is particularly important as many older people face difficulties accessing emergency cash transfers. A global survey of HelpAge network members in found that older people face significant challenges in accessing emergency social protection and cash transfer programmes.[148] Challenges stem from the rapid implementation of large-scale cash transfers to broad segments of a country's population with limited consideration to the needs and capacities of specific groups, such as older people and persons with disabilities. These are often compounded by the reliance on ineffective and exclusionary pre-existing programmes – including out-of-date registries, strict quotas, and unreliable payment systems – as the foundation for a country's social protection response to COVID-19. In some contexts, public health measures have also limited older people's access to social protection.

Table 5: National social protection responses to COVID-19 targeting older people in ECA and MENA (December 2020)[145]

Higher pensions (14)	Advance of pensions (2)	Safe pension delivery (9)	Cash transfers to older people (7)	In-kind support to older people (7)
Albania	Kosovo*	Algeria	Israel	Albania
Bahrain	Kyrgyzstan	Armenia	Mauritania	Armenia
Egypt		Belarus	Russia	Bosnia and Herzegovina
Hungary		Egypt	Tunisia	Jordan
Lithuania		Kosovo*	Ukraine	Bulgaria
Kosovo*		Montenegro	Uzbekistan	Russia
Russia		Russia	West Bank and Gaza	Uzbekistan
Serbia		Serbia		
Slovenia		Turkey		
Tunisia				
Turkey				
Turkmenistan				
Ukraine				
Uzbekistan				

* UN Security Council resolution 1244.

Box 5

Gender-sensitive fiscal and economic, social protection and labour market measures

The COVID-19 Global Gender Response Tracker compiled by UNDP and UN Women monitors policy measures enacted by governments to tackle the COVID-19 crisis and highlights responses that are gender sensitive.[149] Key measures tracked include gender-sensitive social protection and labour market measures that target women's economic security or address unpaid care, and fiscal and economic measures providing support to feminised sectors of the economy.

Overall, the low number of employment, fiscal, and economic measures in the region aimed at strengthening women's economic security or support to the sectors that employ them signals a major gap in the response so far. Stronger action is needed to ensure that women, including older women, can keep their jobs or re-enter the labour market if they have become unemployed because of the pandemic. Out of the 104 fiscal and economic, social protection and labour market measures registered in 11 countries and territories across the EME region where the HelpAge Network has a presence, only 10 measures in five countries and territories address women's economic security. This amounts to just 10 per cent of the total response and represents 15 per cent of all gender-sensitive measures.

Most of these measures fall into the social protection category. They include mostly cash transfers or food assistance and other forms of in-kind support that prioritise women as the main recipients, or provide benefits to all citizens or members of an age group including older women and men. In Lebanon, for example, vulnerable families (which include those with chronic diseases) suffering the effects of lockdown measures are targeted with financial support.[150] Household applications for assistance are subject to a gender lens that prioritises women's socio-economic vulnerability, meaning that 15 per cent of such assistance is targeted at female-headed households.

Only a handful of countries in the region register fiscal and economic measures to support feminised sectors of their economies. Feminised sectors are those that absorb a higher proportion of women's employment compared to that of men. Very few measures aim to address women's economic security through labour market measures such as financing for small- and medium-sized enterprises and loans targeting feminised sectors. Where measures do exist, they likely benefit older women, however they do not explicitly mention age as an inclusion factor.[151]

Measures to address unpaid care are wholly inadequate to address the severe care crisis during the pandemic. Out of the 94 social protection and labour market measures registered in 11 countries and territories across the EME region where the HelpAge Network has a presence, only seven measures in four countries and territories address unpaid care – amounting to just seven per cent of the total response and 10 per cent of all gender-sensitive measures. In addition, these policies do not specifically recognise older people as providing unpaid primary and secondary care during the pandemic. Where measures have been introduced, they include social protection measures such as the provision of paid family leave and cash-for-care programmes. They also include employment measures, including reduced working time and extra wage subsidies for workers with care responsibilities, and action to strengthen care services. This includes both childcare and long-term care for older persons and persons with disabilities.

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Recommendations

- Governments should prioritise investment in social protection as a crucial mechanism to mitigate the impacts of the crisis on people's wellbeing and poverty, while also enabling an inclusive and speedy economic recovery. Research and experiences show that basic level of social protection throughout the life-course is affordable for almost all countries[153] and international support should be provided to countries unable to fully finance sufficient levels of social protection. Governments should recognise the **cost of under-investing** in social protection, which will lead to slower and more unequal recoveries, permanent loss of businesses and human capital, as well as widespread and deep poverty.
- In the short term, governments should expand the coverage of existing social protection schemes, including cash transfers to poor and vulnerable populations. The region's responses should be tailored to reach those most vulnerable to COVID-19 and its socio-economic impact. These include persons with disabilities, older women and men, and those experiencing increased levels of violence and abuse as a result of the crisis.
- Governments should further ensure the safe and continued access to pensions and other forms of social protection, including for older women and men.
- Governments should integrate response measures in overall social protection reforms as part of a new post-COVID-19 social contract that leaves no one behind, promotes inclusion and social equality and helps realise social and economic rights for all. As part of these reforms, social pension coverage should be rapidly expanded with adequate transfer levels to ensure income security for all older women and men.
- Older women should be targeted in longer term efforts to improve women's incomes, livelihoods, and access to social protection, including pensions, and to recognise, reduce and redistribute their unpaid care work across the life course.
- In the medium term, it will be fundamental that governments increase investments in critical areas of human development, including universal health coverage (see section on Health and care, starting on page 20) and social protection floors, including universal coverage of old-age pensions, not only to mitigate the impact of COVID-19 but also to foster long-term and sustainable development.

Older people in humanitarian and conflict settings

At the end of 2019, over 168 million people globally were predicted to need humanitarian assistance in 2020 and almost 80 million people were forcibly displaced.[154] Globally, four per cent of the refugee population and 17 per cent of internal migrants are over the age of 60 years but with regional and country variations.[155] In Eastern Ukraine, older people make up 30 per cent of the affected population, while in Jordan only four per cent of Syrian refugees are over 60 years of age.[156]

Despite the pandemic impeding data collection in humanitarian and displacement settings, it is clear that it has heightened the vulnerability of people in these settings.[157] Challenges brought on by displacement or humanitarian crisis include overcrowded living conditions, poor nutrition, and untreated or underlying health conditions. Refugees typically face administrative, financial, legal and language barriers to accessing health care, which in many countries in crisis (or hosting large numbers of refugees or internally displaced persons) was limited before the pandemic.[158] Internally displaced persons are also at greater risk of anxiety, depression and other forms of distress which may be aggravated by control measures such as lockdown.[159] Loss of employment, livelihoods and income have been reported by internally displaced persons in Iraq,[160] Libya, Syria, and Yemen, while food prices have risen steeply.[161] A Humanitarian Access to Aid overview in July 2020 reported nine countries in the region with high or extreme difficulties in accessing aid, with eight of those having been further impacted by COVID-19.[162, 163] Access is affected by travel restrictions and border closures, closure of non-essential services such as community facilities, and social distancing.

Some control measures have discriminated against refugees and led to adverse outcomes. Syrian refugees were required to observe longer curfews and faced tighter restrictions than other residents in some municipalities in Lebanon to "prevent the aggravation and spread of COVID-19".[164] Refugees are also victims of xenophobia and often accused of contributing to spreading the virus.[165] This further jeopardises public health, as refugees may be fearful of seeking treatment or disclosing symptoms. It has been reported that in Yemen the pandemic triggered displacement of more than 10,000 people who feared contagion and that communities have exposed internally displaced persons to fake news about the pandemic, making them turn away from their preferred destination.[166]

There is limited analysis by age in reports of COVID-19 in humanitarian settings in the region, although recognition of the primary and secondary risks for older women and men can be found in global and regional humanitarian response plans. In this context, COVID-19 RNA-OPs carried out by HelpAge and partners in humanitarian settings in the region, including Iraq, Jordan, Lebanon, Syria, and Ukraine provide some insight into the situation facing older people.

HelpAge COVID-19 RNA-OPs highlight food and income/livelihood security as top priorities, alongside access to medicines and health services as top priorities for older women and men. In Iraq, 70 per cent of older people interviewed reported being unable to access sufficient food – older women more so than men – and 64 per cent lost their livelihoods due to COVID-19.[167] Close to half of older Jordanians reported having only insecure income, and 29 per cent of older people reported difficulties in accessing food, especially older women (35 per cent) compared to older men (17 per cent). Forty per cent of older women and men interviewed reported having to reduce the quantity they eat due to the crisis, while the same percentage reduced the quality of food.[168] After nutrition, the most important concern for older people in Lebanon was the loss of livelihoods and income.[169] In Syria, older people were most concerned with accessing medicines and income.[170]

The RNA-OPs revealed good knowledge of prevention measures though there is limited access to prevention materials among some older people. The preferred information source across all five countries is television, followed by word of mouth. However, despite information reaching older people through these channels, over a quarter (26 per cent) of older people surveyed in Iraq and almost half (48 per cent) of older people surveyed in Syria reported they were unable to afford to buy soap, masks, and gloves.

Access to health services has been affected by movement restrictions, travel bans and the realignment or closure of hospitals. Approximately 30 per cent of older women and men reported being unable to access their regular medication, with local variations highlighting existing inequalities in health access. In Salah al-Din in Iraq, 41 per cent of older people said they were unable to access healthcare prior to the COVID-19 pandemic. In northwest Syria, some older people are not seeking medical assistance due to fears of contracting COVID-19 or being unable to visit health clinics unaccompanied, as required.

Access to pensions or cash transfers in humanitarian settings has been affected by the pandemic. In Ukraine, people with disabilities, including older people, living in territory controlled by armed groups lost access to bank services in government-controlled territory and could not cash their pensions and social allowances due to COVID-19 related restrictions on freedom of movement through the contact line introduced by the government and armed groups.[171]

Older people interviewed perceived themselves to be at high risk of neglect, isolation and/or financial abuse. In Syria, when older people were asked about the increased risks for older women during this time, the top two risks were neglect (62 per cent) and isolation (54 per cent). Older women rated neglect as a higher increased risk for themselves (66 per cent) compared to how older men rated it (57 per cent). The risk of isolation was rated as considerably higher in Idlib (66 per cent), where there are more internally displaced persons, than in Aleppo (35 per cent), while for both men and women, the risks of neglect or isolation were perceived as higher by people living in camps compared to people living in the community. In camps, the risks of financial abuse and denial of resources are also considered to be higher than in the community.

Older people report high levels of anxiety. In Iraq, with 160,000 reported cases of COVID-19 at the time of the RNA-OP, 74 per cent of older men and 80 per cent of older women reported feeling anxious most or all the time. In Lebanon, 51 per cent of older people reported being anxious, with some location-specific spikes – for example, in Akkar, where 85 per cent (and women in particular) reported feeling anxious.

Multiple risks are created by the intersection of disability, gender, and age. A report by Humanity & Inclusion on the impact of COVID-19 has identified persons with disabilities as the most affected population group in the 63 countries covered by the Global Humanitarian Response plan.[172] The report notes that people with disabilities fall between the cracks of humanitarian response. Other risk factors include ethnicity, displacement, access to documentation, or health status. In Lebanon, 74 per cent of households (regardless of nationality – Lebanese, Palestinian or Syrian) with at least one member of the household with a disability reported purchasing food on credit.[173] Over half (53 per cent) of households reported reducing spending on essential non-food items including hygiene products, 28 per cent used savings and 23 per cent sold household assets such as jewellery and phones to purchase food. The assessment shows greater impact of COVID-19 on refugees and displaced persons with disabilities.

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Recommendations

- Governments, UN agencies and other actors in the EME region should use the Humanitarian Inclusion Standards for older people and people with disabilities, and Inter-Agency Standing Committee Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action, to ensure fully inclusive responses that address the needs and rights of older people, including those with disabilities.
- EME governments must ensure that displaced people, including older men and women, can access government services regardless of their legal status.
- Governments, UN agencies and other actors in the EME region must address ongoing systemic issues that create barriers for older people in humanitarian and conflict settings to access health and other services in plans to build back better. These must recognise the changing needs of an ageing population and respond to risk factors associated with gender, disability, and other characteristics.
- Governments and UN agencies must integrate analysis of the pandemic's primary and secondary impacts on older people into humanitarian, health, and socio-economic recovery plans, and include specific actions to address risks they face. Corresponding monitoring frameworks should be developed to capture how response and recovery plans meet the needs of at-risk groups, including older people and people with disabilities.

Voice, dignity, and rights

Evidence and data on the impact of COVID-19 on the voice, dignity, and rights of older people is extremely limited, meaning there is little analysis of how older people's rights have been affected by discriminatory age-based measures imposed during the pandemic. Unlike other sections of this report that are based on published studies, and government documents and data, this section of the report is based on information primarily from HelpAge's consultations with older people, and from media articles. A human rights perspective was missing from the overall response at the outset. This shifted over time with leadership from different quarters on the need to act in accordance with international rights standards and principles.

COVID-19 responses have had a significant impact on the voice, dignity, and rights of older people, exposing and exacerbating existing challenges older people face and giving rise to new ones. In HelpAge, the term 'voice' is used to refer to activity related to participation, empowerment, agency, autonomy, and accountability. At its core, voice is about older people being able to influence decisions that affect their lives, claim, and enjoy their rights and challenge ageism and inequality. Dignity – our inherent value and worth as human beings, which manifests itself as our own self-worth and other people's respect for us – is central to our wellbeing. Human rights instruments set out the minimum standards necessary for everyone to live a life of dignity. Consultations with older people carried out by HelpAge during COVID-19 have shown that older people's understanding of their rights varies. Some feel that governments are unaware of them.

"I'm not certain that the authorities know what our rights are. They probably know that we have to get our pension on time, and that's why it's paid on time, but they don't know how our other rights are being violated because they're not interested. If the authorities understood our rights better, there would be fewer patients and people would not be dying."
Older woman, Kyrgyzstan[174]

However, there were and continue to be huge challenges in recognising older people as full rights holders. These include the persistent framing of older people as a 'vulnerable group' and the narrow focus on health and social protection responses – necessary though these are. Virtually no attention is paid to the impact of public health measures on rights such as access to justice, autonomy and independence, or participation as equal members of society. Equally, there is little available data or analysis on the impact the pandemic has had on older people's ability to exercise their voice. Reports that do focus on older people do not focus on their empowerment and agency or on their access to accountability mechanisms. In this context, activity carried out by HelpAge and partners during the pandemic, including a voice survey of global staff, network members and partners conducted by HelpAge between June and July 2020 and consultation with older people on their rights during COVID-19 in 10 countries[175] (including Jordan and Kyrgyzstan from the EME region) provide important insights on the impact of the pandemic.

Access to information

A key concern is the extent to which older people have access to reliable and accurate information and guidance about their rights and entitlements in the context of COVID-19. Access to information is critical to enabling people to make decisions about their lives, to claim their rights, and to effectively monitor and hold governments to account. In this context, the decline in freedom of information and freedom of expression in the region is a key concern.[176] In Egypt and Turkey, for example, journalists and others have been arrested and detained for reporting on or expressing opinions about COVID-19 on social media.[177]

Fedaa Qatatshsah/HelpAge Jordan

Box 6

UNFPA and HelpAge Moldova: An intergenerational approach to digital inclusion

In Moldova, COVID-19 restrictions have limited older people's ability to move around and have face-to-face meetings with other older people. While other age groups have turned to online communication to prevent loneliness and isolation, only three per cent of older people in Moldova use digital devices and information technologies. This compares to 40 per cent across all European Union countries.

In response, HelpAge Moldova launched the project 'Hack Your Age! Creating digital and social connections between young and old in Moldova', funded by UNFPA in Moldova and Moldcell Foundation. Fifty younger volunteers from 10 communities were trained to support older people to use a smartphone and 200 older men and women received free mobile phones with monthly credit included. Using tailored approaches that responded to older people's needs, older women and men have learned how to use online communication tools and to use the internet to access information, books, and videos. Some have also started accessing online public services and making online payments.

"My daughter lives abroad. I can rarely talk to her, as international phone conversations are costly. Some years ago, my daughter gave me a simple mobile phone, to have it, but it cannot connect to internet. Now I received a smartphone. I like that the screen is larger and it has colours, it is easy to read. I can talk to my daughter whenever I want to and even see her."

Older woman, Basarabeasca, Moldova

"Most important for me is to talk to my friends, even if virtually and of course to read news and find out what is going on in the country."

Older woman, Moldova

"I felt really sorry for some older people in our village who could not communicate with their relatives who live and work abroad and could not travel due to the pandemics […] I have some free time and I want to help older people learn to use the mobile phone, so they can see their children and grandchildren, exchange pictures and just keep in contact. It is very important for them."

Young volunteer, Moldova

Older people face barriers to accessing information, though this varies across countries and settings. The HelpAge voice survey found that older people in numerous settings had limited access to information. Barriers included limited availability, accessibility, quality, and accuracy of information on COVID-19 and their rights. Many faced language and/or literacy barriers, or barriers related to information not being tailored to different communication needs. Often, information was reported to only be available on the radio, television or online. Internet use ranges from 30 per cent to 80 per cent in the MENA region.[178] There is inequality in internet use, as fewer women have access to the internet and a gap in access in almost all countries between rural and urban areas. There are also age disparities in internet use. For example, data from the West Bank and Gaza shows only 27 per cent of people aged 60 and older use internet, with older women less likely to be online than older men (16 and 38 per cent respectively).[179] A reliance on online communications for sharing information during the pandemic is therefore likely to exclude many older people.[180]

"If the authorities better understood our rights they would improve internet and mobile connection in our village. People there, including older people, wouldn't feel isolated. They would get all the information about prevention measures during the pandemic via the internet."

Older woman, Kyrgyzstan[181]

Some groups of older people are likely to be more affected by barriers to accessing accurate and reliable information during COVID-19. A Rapid Gender Assessment carried out by Care International in MENA, reported that men had more access to official communications from local authorities and public spaces than women[182] with women more likely to report using informal social networks to receive information.[183] In Iraq, movement restrictions were reported to be higher for older women (80 per cent) compared with older men (71 per cent) and older people with health conditions (80 per cent)[184] which is likely to affect their access to information. In Turkey and Kyrgyzstan, women aged 35–54 and 55–64 years reported feeling less clearly informed than men.[185]

"In the pandemic, the isolation of the elderly from sources of information about their rights has increased, only those elderly who are active in social networks can learn something from peers online."

NGO representative, Russia[186]

However, in other settings there were reports of older people having good access to information on COVID-19 and efforts to meet the communication needs of different groups. As many as 94 per cent of older people surveyed in HelpAge's RNA-OPs in Lebanon and Syria reported that they had encountered no barriers in accessing COVID-19 health messaging, despite older people not having been directly targeted.[187, 188] In Georgia, government briefings have been translated into sign language, and brochures and posters have been distributed in minority languages. COVID-19 information has also been adapted for older people, people with disabilities, and residents of care institutions.[189]

It should be noted that even where older people are able to access information about COVID-19, it is unlikely they receive information about their rights, how to make complaints or how to seek redress. The HelpAge voice survey found that in some contexts there was limited transparency with decision makers and older people had limited or no access to make complaints or access redress mechanisms. However, in other contexts, older people reported examples of special hotlines being established by government to make complaints.

Older people's voices not being heard

Lockdown measures are affecting the extent to which older people can make their voices heard. Mechanisms and spaces for older people to convene have been inaccessible in many places due to lockdown restrictions, impacting on the extent to which older people can engage in voice-related activity. With limited non-physical alternatives, many older people do not have opportunities to share their experiences, identify challenges and solutions to the issues they face, or take action to amplify their voices and influence change.[190] In some cases older people and those working with them have been able to adapt to using new technologies to overcome some of these barriers, but this is likely to exclude some older people and further marginalise particular groups.

"Members of groups of seniors communicated with each other by phone, instant messengers, Skype [and] on social networks."

NGO representative, Kyrgyzstan

"First of all, it was visible, this is an online space – members of groups of seniors communicated with each other by phone, instant messengers, Skype, on social networks; the situation was worse, in my opinion, among single elderly people aged 85-plus."

NGO representative, Russia

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HelpAge's voice survey found that in many settings there were no opportunities for older people to participate and have influence in decision-making processes during the pandemic. CSOs reported that governments were adopting top-down, centralised approaches that do not allow consultation with key stakeholders, including older people. For example, a HelpAge network member from Russia reported that the government was not considering the voices of older people within response planning. This not only reduces the likelihood of older people's needs and rights being addressed in short- and long-term response plans and efforts but also limits the extent to which older people can offer their own expertise and experience to contribute to those plans.

Discriminatory age-based public health measures

Governments across the region have introduced age-based public health measures to restrict the movement of older people at different stages of the pandemic. These include banning people from leaving their homes who are over the age of 60 years in Jordan;[191] over 63 years in Moldova;[192] over 65 years in Azerbaijan,[193] Bosnia-Herzegovina,[194] Lebanon,[195] Romania,[196] Russia,[197] Serbia,[198] Tunisia,[199] and Uzbekistan;[200] and over 70 years in Georgia.[201] In Moscow, those over the age of 65 years were not allowed to use free public transport.[202] In the North Macedonia Republic, people over the age of 67 years were subject to longer weekend curfews than younger adults.[203] People over the age of 60 years were not allowed to go to restaurants in Dubai, Abu Dhabi, and Ras Al Khaimah or to shopping malls in Dubai.[204] In Israel, a measure to stop people over 67 returning to work was proposed but not introduced.[205]

Under international law, public health measures may restrict some human rights, but they are not allowed to discriminate.[206] Discrimination is treating people differently, based either directly or indirectly on any characteristic such as age, gender, or disability, with the intention or result of denying them their human rights on an equal basis with others. Although age-based public health measures have been introduced to stop the spread of the virus, protect health services, and reduce the death rates amongst the older population, they fail to acknowledge the diversity among older people and the negative impact that long periods of isolation have on older people's physical, mental and cognitive wellbeing. Based on age alone, age-based public health measures have restricted older people's rights more than those of people in other age groups and, as such, they are discriminatory.

"They [the government] only stressed the home isolation measures and preventing older people from going out of the house. They treated us like children who needed to be taken care of. But what serious action did they take for older persons? Deaths from heart attacks increased due to loneliness and being distanced from people. They should have considered the psychological wellbeing of older persons as a priority."

Older man, Jordan[207]

Box 7

Rights-based public health measures

Public-health measures that restrict our rights must be based on scientific and medical evidence. They must be temporary and regularly reviewed so they are used only when strictly necessary and in accordance with the law. They should be proportionate and cause the least possible harm to our wellbeing. They should not discriminate.

Denial of rights

Restrictions of older people's movement have not only denied their right to freedom of movement but also limited their enjoyment of other rights, including their right to participation as equal members of society in social, religious, and economic life. In Lebanon, not being allowed to participate in family gatherings and religious services had a negative impact on older people's mental health.[208]

Older people's right to social security has been limited. Those with no ATM bank cards in Russia, and the closure of banks, denied older people their right to social security as they could not access their pensions.[209] Travel restrictions in Ukraine blocked older people's access to pensions for four months, forcing them to reduce their food, medication, and necessary hygiene products.[210]

Azzam al-Zubairi/DEC

Older people's right to health has also been negatively impacted. Insurance companies in Ukraine set upper age limits to deny those over 60–65 years access to health insurance against COVID-19.[211] Older people have reported delays in getting appointments, not accessing health services for fear of getting the virus and being unable to access the medication they need due to drug shortages and price rises. Where non-COVID-19 health services have been suspended or reduced to free up the capacity of health services to respond to the pandemic, older people have been left with unmet health needs. In Serbia, the risk for older people of having to pay for private healthcare for non-COVID-19 services increased as public health services covered by their insurance were adapted to respond to the pandemic.[212] In other cases, broader public health measures affected older people's right to health. For example, the driving ban in Jordan prevented older people accessing the health services they need.

"I found some difficulty in transportation due to the driving ban and the fact that I cannot walk long distances because of my age. They didn't think about us when they made this decision."

Older woman, Jordan[213]

"As for my medication, I struggled a lot to get it with the drug shortage in hospitals. We also had difficulty booking appointments, as it took too long to get one. How could they give a person who suffered a stroke a check-up appointment after three months?"

Older woman, Jordan[214]

"It was difficult to get to medical specialists, for example, to a neurologist or an eye specialist, because they were mostly engaged in mobile groups, worked in hospitals on coronavirus or were also sick. … The services were reduced because there might be a burden on the health system."

Older woman, Kyrgyzstan[215]

In Serbia, the risk for older people of having to pay for private healthcare for non-COVID-19 services increased as public health services covered by their insurance were adapted to respond to the pandemic.[216]

Older people's right to care and support services to enable them to live autonomous and dignified lives has been denied. In Kyrgyzstan and Serbia, volunteers or informal caregivers were prevented from making home visits and not supported to safely continue providing care through the provision of PPE, guidance, and access to testing.[217, 218] In Russia, social service departments have had insufficient funding to deliver care during the pandemic.[219] In Serbia, older people in care homes were denied the right to see family members when they were prevented from leaving the care homes and visitors were prevented from entering, increasing their psychological stress and risks to their mental health.[220, 221] This highlights the importance of ensuring older people in care homes are involved in discussions about restrictions being imposed, and that their ability to participate in social and family life is supported through alternative means of communication where visits are not possible.

Older people's right to freedom from violence, abuse and neglect has also been under threat where authorities have failed to take awareness-raising prevention measures, as for example, in Lebanon.[222] Older people have reported increased neglect and conflict with family members during lockdown. In Serbia, the restrictions placed on the movement of older people have increased their risk of financial abuse as they became dependent on others.[223]

Ageism and stigma

The categorisation of COVID-19 as an older person's disease, ageist language used throughout the pandemic, and the use of age-based measures in some contexts, has led to stigmatisation and discrimination towards older people, and fear among them.[224] HelpAge has been collecting information throughout the pandemic on examples of ageism and has uncovered a range of evidence of discriminatory practices and stigma experienced by older people. In Serbia, a UNFPA report on the impact of COVID-19 highlights that the ageist paternalism that accompanied the narrative on protecting older people's lives reduced them to objects of protection and overlooked the role they could play in the response, including providing support to others.[225] Responses from Kyrgyzstan to the HelpAge voice survey highlighted that older people were seen as "passive, frail and dependent". Not only is this discriminatory but it can also lead to self-stigma which reduces self-esteem and is likely to have an impact on older people's confidence to exercise their voice and claim their rights.[226] For example, HelpAge's voice survey found that older people's motivation to engage in voice activities has been affected by their fear of the virus and the way it has been communicated by the media.

"Disturbing rumours, gossip, unverified information are being spread like a virus, including by my friends. The media speak of older people as a risk group. They try to warn, explain, scare us. But apparently younger people get sick too."

Older woman, Russia[227]

Recommendations

- Governments should ensure all age-based public health measures that deny older people their rights on an equal basis with others are withdrawn. Alternative public health measures should be introduced that minimise the risk of infection for everyone, including older people. They should be informed by gerontological knowledge and lessons learned from the current pandemic on wellbeing and mental health. They should also recognise older people's own judgement when provided with information and advice.
- Governments must regularly assess all public health measures to ensure they are based on human rights principles,[228] that they are necessary, in line with the law, and do not have a disproportionate impact on older people. If they do, amendments must be made to ensure older people's enjoyment of their rights on an equal basis with others. Governments must ensure measures adopted to respond to the social and economic impact of the pandemic guarantee older people's enjoyment of their rights on an equal basis with others.
- States should adopt a UN convention on the rights of older persons that would provide a definitive, universal position that age discrimination is morally and legally unacceptable, clarify how human rights apply in older age, and guide governments in meeting their responsibilities to uphold those rights.
- Governments must recognise older people's own agency and decision-making competencies and ensure they receive health messaging and information in formats that are appropriate for them so they can weigh up risks and benefits in their specific circumstances.
- Older people should receive information about their rights, how to make complaints and seek redress, with a focus on more marginalised groups.
- Older people must be able to actively participate in and contribute to shaping responses and recovery efforts.

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Conclusion

COVID-19 has starkly exposed the inadequacy of systems at local, national and international level to meet the needs and uphold the rights of older people, and to effectively promote their resilience and support them during crises.

The pandemic has shone a light on the quality, coverage, adequacy, and flexibility of systems and highlighted their failures in many places. It has also exposed and exacerbated deep rooted ageism in our societies. The shocking numbers of deaths of people in older ages that we have witnessed have, in too many settings, been accepted, and the human rights of older people ignored and violated.

COVID-19 is a clarion call. The pandemic illustrates the importance of financing and implementing the Sustainable Development Goals to build resilient and equitable systems and societies for everyone, including older people. This is essential to ensuring we all have the opportunity to recover successfully from COVID-19, that we can build back better and that we are prepared for the future in an ageing world.

Annex 1:

Inclusion of older people in COVID-19 surveys by UN agencies and NSOs

This table presents data collection efforts by UN agencies and National Statistical Offices to assess impact of COVID-19 on populations and their inclusion of older people. For a discussion on the information included in this table, see the section of this report starting on page 17, Official data on older people during COVID-19.

	FAO Food Insecurity Experience Scale					ILO					NSO					UN Women Rapid Gender Assessment					UNDP Household Social Economic Impact Survey					WFP					World Bank				
	S	C	O	D	A	S	C	O	D	A	S	C	O	D	A	S	C	O	D	A	S	C	O	D	A	S	C	O	D	A	S	C	O	D	A
KGZ	P															C	1	0	1	1	T					C	1	0	1	0					
MDA	P															C	1	0	1	0	I	1		1											
MAR	P					O					C	1	0	1	0	C	ni	0	1	0											I	1			
SYR	T																				C	ni	0	1	0										
TJK	P															O	ni				C	ni	0	1	0						C	ni	0	1	0
TUN	P					O					O					C	ni	0	1	0											C	ni	0	1	0
UKR	P																				O														
UZB																					C	ni	0	1	0						O	ni	0	1	0
PSE	T															C	ni	0	1	0															
YEM	T															C	ni	0	1	0															

Source: Task force on COVID-19 and household surveys, COVID-19 impact surveys updated 5 November 2020, https://unstats.un.org/iswghs/task-forces/covid-19-and-household-surveys/COVID-19-impact-surveys/ (18 November 2020

Key:

ni – no information

Survey status (S): P – in preparation, I – implementation started, C – completed, T – tentative, O – ongoing.

Sample coverage (C): 1 – older people were interviewed, 0 – older people were not interviewed.

Open data (O): 1 – dataset available to public for further analysis, 0 – data is not available.

Dissemination (D): 1 – summary report of findings is available, 0 – summary report of findings is not available.

Analysis (A): 1 – analysis of data on older people is consistently presented throughout the summary report, 0 – the summary report either doesn't include or has very limited analysis of data on older people.

Annex 2:
COVID-19 surveys – collected data relevant to older people

This table highlights the data collected and gaps in available questionnaires and summary reports outlined in Annex 1. This evidence is for illustrative purposes as some of the surveys, both those that have been completed and those that are still planned or are ongoing, have limited accessible documentation. For a discussion on the information included in this table, see the section of this report starting on page 17, Official data on older people during COVID-19.

		Demographic characteristics of the respondent			Household roster		Health and care						Personal experience or perception of violence, abuse and neglect	Income security and livelihood				Voice, dignity, rights	
		Age	Disability	Sex	Older people	Other members of household	C19 impact on physical health	C19 impact on psychological, mental health	Underlying conditions	Health insurance coverage	Access to health services	Access to medication		Employment	Government benefits, pension	Income, savings, loans	Access, consumption, expenditure on food & goods	Knowledge of C19	Sources of information on C19
KGZ	FAO																•		
	UNW	•		•	•	•	•	•	•	•	•	•	•	•	•	•		•	•
	UNDP*																		
	WFP	•		•		•								•	•	•	•		
MDA	FAO																•		
	UNW	•		•			•	•		•	•	•		•	•	•	•		•
	UNDP*						•				•		•	•	•	•	•	•	
MAR	FAO																•		
	ILO*																		
	NSO							•	•		•	•		•	•	•	•	•	•
	UNW°												•						
	WB	•		•	•	•					•	•		•	•	•	•	•	•
SYR	FAO																•		
	UNDP°			•												•	•		
TJK	FAO																•		
	UNW*																		
	UNDP°	•	•	•	•	•	•	•	•		•			•		•			•
	WB°										•			•		•	•	•	•
TUN	FAO																•		
	ILO*																		
	NSO*																		
	UNW°												•						
	WB°										•	•		•		•	•		

continued over

		Demographic characteristics of the respondent			Household roster		Health and care						Personal experience or perception of violence, abuse and neglect	Income security and livelihood				Voice, dignity, rights	
		Age	Disability	Sex	Older people	Other members of household	C19 impact on physical health	C19 impact on psychological, mental health	Underlying conditions	Health insurance coverage	Access to health services	Access to medication		Employment	Government benefits, pension	Income, savings, loans	Access, consumption, expenditure on food & goods	Knowledge of C19	Sources of information on C19
UKR	FAO																•		
	UNDP*																		
UZB	UNDP°			•	•	•		•			•								
	WB°										•		•	•	•	•	•	•	•
PSE	FAO																•		
	UNW°												•						
YEM	FAO																•		
	UNW°												•						

Key:

* Surveys that are either tentatively planned or ongoing and where limited information is available.

° Survey has been completed (or where applicable, at least one survey round has been completed) and no questionnaire or extensive methodology information is available.

Annex 3:

Country governments in the EME region with humanitarian and socio-economic response plans

Response plans	Countries adopting	
Humanitarian response plans (HRPs)	Countries included in Global HRP by May 2020	**Countries with ongoing national HRPs**: Iraq, Occupied Palestinian Territories, Syria, Ukraine, Yemen, and Lebanon (also part of Regional Refugee and Resilience Plan for Syria crisis)
		Countries part of Regional Refugee Response Plans (RRPs): Egypt, Iraq, Jordan, Lebanon, Turkey
		Countries with a country-specific response plan: Iran
Socio-economic response plans (SERPs)[229]	Countries with SERP (or equivalent) in place by 29 Nov 2020	**Eastern Europe:** Albania (Aug 2020), Bosnia and Herzegovina (July 2020), Kosovo* (Oct 2020), Moldova (July 2020), Montenegro (Aug 2020)
		Arab States: Bahrain (Nov 2020), Iran (July 2020), Jordan (Aug 2020), Kuwait (July 2020), oPt (Aug 2020), Saudi Arabia (July 2020), Syria (Sept 2020)
		Central Asia: Georgia (Sept 2020), Kazakhstan (Aug 2020), Tajikistan (Aug 2020), Turkmenistan (Aug 2020), Uzbekistan (Sept 2020)

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