REPORT

Impact study of COVID-19 on older people and caregivers in Armenia

November 2020

IFRC

AUSTRIAN RED CROSS

Croix-Rouge suisse
Schweizerisches Rotes Kreuz
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UNFPA

This study was commenced and conducted by the Armenian Red Cross Society, the Austrian Red Cross, the Swiss Red Cross and the International Federation of Red Cross and Red Crescent Societies.

This publication has been produced with the financial assistance of the International Federation of Red Cross and Red Crescent Societies, the Austrian Red Cross, the Swiss Red Cross and the UN Population Fund Country Office in Armenia. Special thanks are expressed to staff and volunteers of the Armenian Red Cross Society for the active engagement, guidance and participation in the study.

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Photos: SRC, Remo Naegeli (pp. II, 21, 31) and ARCS (p.5)

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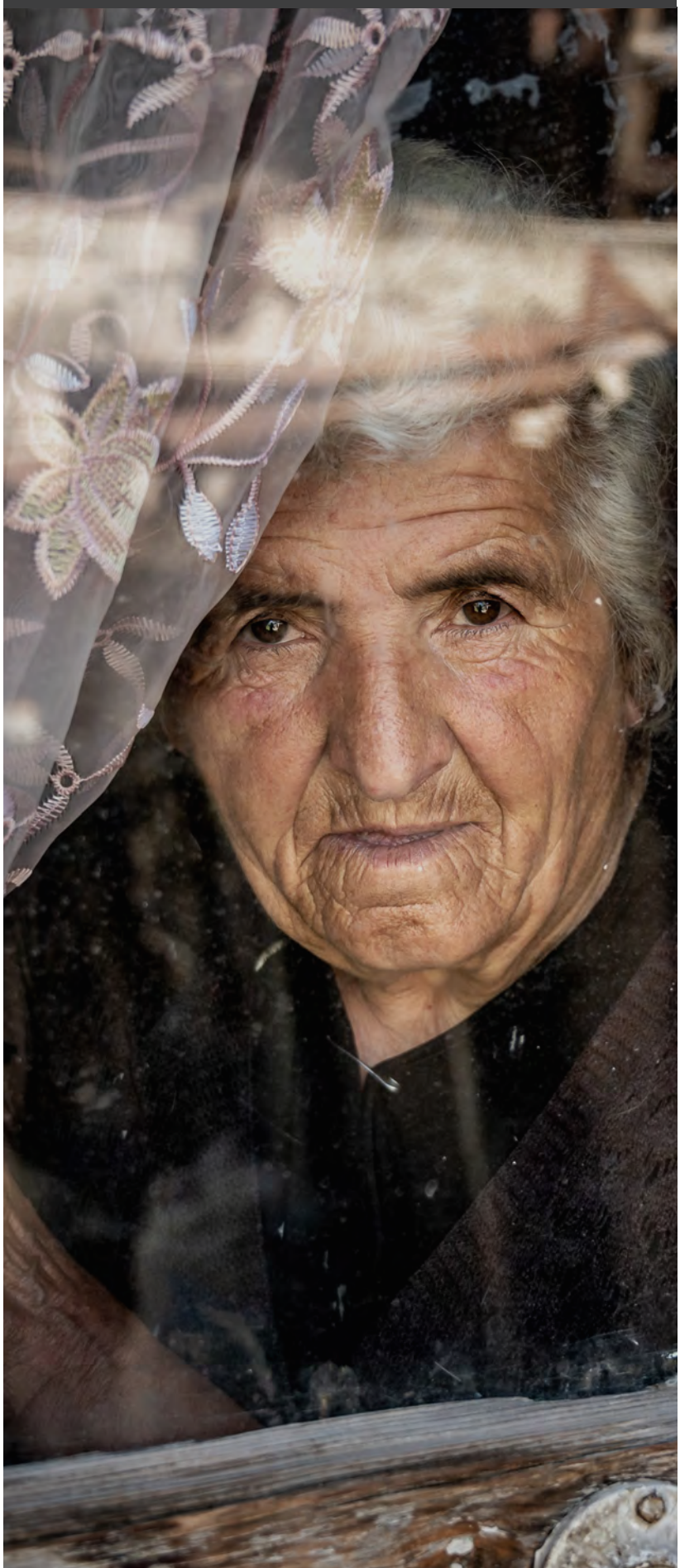


Executive Summary

The COVID-19 pandemic in Armenia has severely affected older people in terms of their life and health, social and economic situation. The outbreak in Armenia was rapid and the state of emergency was long-lasting for the entire country, later replaced by quarantine.

Inadequate provision of services for older people has compromised the effectiveness of the response to their needs in the context of the current health emergency. Fully recognizing the circumstances of ageing and its societal implications, the Government of Armenia (GoA) with the involvement of the UN Population Fund Country Office in Armenia (UNFPA), non-govermental organizations (NGO) and the Armenian Red Cross Society (ARCS), adopted *national policy frameworks* related to ageing and social protection of older people, and reorganization of the care system towards a de-institutionalized, community-based and integrated[1] approaches. However, implementation of these policies faces multiple challenges, including: applying a geriatrics and gerontology lens to medical care; introducing professional palliative care; delineating care provision and funding responsibilities among different government levels; advancing home-based care beyond pilot (although successful) experiences implemented with the support of external and non-governmental actors; ensuring older people's medical and social entitlements are less dependent on their formal qualification as "most vulnerable", and simplifying the procedures for people to access state-guaranteed free-of-charge daycare, home-based care and residential care.

The state response could not sufficiently address the needs of older people during COVID-19 in Armenia. Management of COVID-19 cases was shared between government and primary health care institutions, but lacked effective organization and coordination. Reaching out to older people was mainly left to local governments, the ARCS and its branches, and NGOs, some of which have emerged as prospective longer-term partners to work alongside government to provide professional care services to older people.

The ARCS plays an auxiliary role to the public authorities in the humanitarian field. It has been involved in home-based care for older people at the local level and is supporting the government response to the COVID-19 pandemic through risk communication, and the provision of psycho-social and food and hygiene support to people considered most vulnerable to the virus, including older people.

This study looks at the impacts of COVID-19 on older people and professional caregivers and trained Red Cross (RC) volunteers in the context of general care provision in Armenia and suggests recommendations to ARCS and other stakeholders for improving the COVID-19 response and care for older people and caregivers.

The study conducted across Armenia has revealed the following:

- ***Income and expenses.*** The retirement pension remains by far the most important source of income for older people in Armenia, followed by disability and other social allowances, and family support. The ability of older people to cover expenses, especially for household services, utilities, food, medicines and medical services has decreased since the COVID-19 outbreak. One third of older people have received extra financial or in-kind support during the COVID-19 outbreak from national and local governments, NGOs and international organizations; something that has been especially appreciated by those older people usually left out from assistance. However, the lack of a common database of those in need, and no established mechanisms of emergency response coordination at the local level between local government, public bodies, and NGOs has led to delays and uneven provision of assistance to older people.

[1] Holistic, person-centred, combining social and medical care aspects

- ***Life and health.*** A small proportion of older people report worsening health as one of the secondary effects of COVID-19. This is usually related to emotional instability, lower self-esteem and reduced physical activity. Older people's perception of their mental health and spiritual wellbeing has dropped considerably. The majority of older people surveyed were reasonably satisfied with their access to health care services both before and after the COVID-19 outbreak, although provision of health services to older people was constrained by a shift of focus to COVID-19 positive cases.

- ***Social situation and services.*** Disruption of social ties with neighbors, community and family, reinforced by limited mobility, are among the main negative social effects of COVID-19 on older people, adversely affecting their emotional state, especially in urban areas.

- ***Ageism and physical and financial violence*** appear to be a worryingly widespread phenomena in Armenia, particularly against older people in urban areas. The COVID-19 outbreak has not significantly impacted older people's access to the pensions and social services, although access to the latter was already low before the pandemic (due to poor coverage by social centers and psycho-social support), especially among people not accessing ARCS services.

- ***Access to services and public infrastructure.*** Due to COVID-19 restrictions, older people's access has been considerably reduced to such public services and infrastructure as community centers and entertainment facilities, public transport, shops and banks, which is notable especially on the background of the existing digital divide.

- ***Home-based care.*** One third of the older people interviewed for this survey were in need of home-based care, but only one fifth were able to access it, with coverage almost negligible in rural areas. Professional caregivers and trained RC volunteers managed to maintain the level of service provision across the spectrum, although the enrolment of new people for home-based care was not possible during the first several months of the pandemic. Provision of care was hampered by changes in the situation of caregivers themselves and their access to transport services. Caregivers were largely satisfied with the organization and management of care and psycho-social support they could access for themselves, but less satisfied with the training and information support available.

- ***Residential care.*** Older people in nursing homes are exposed to multiple and much higher risks than those receiving care at home, including some risks related specifically to failures to adopt COVID-19 prevention protocols. Reduced ties with families and friends was one of the hardest aspects to bear, something only partly compensated by psychological support. Nursing home personnel were stressed by both the potential exposure to the infection and the difficult emergency working conditions.

- ***COVID-19 preparedness and behavior.*** Older people have enjoyed good access to information and protection means since the COVID-19 outbreak began, to a large extent the result of awareness-raising by NGOs. The majority of older people saw the virus as either dangerous or very dangerous, with those considered high-risk demonstrating more disciplined adherence to restrictions and prevention measures by higher risk groups including older people.

- ***Civil activism.*** Half of the older people surveyed said they were interested in politics, with a quarter of them (or one eighth of the entire sample) feeling that COVID-19 had limited their civil and political activism.

The study findings and conclusions have led to both long-term and short-term recommendations to the GoA, national and international institutions, local governments, NGOs and ARCS including:

SHORT-TERM

- Adjust procedures to access state-guaranteed free-of-charge daycare, home-based care and care in residential institutions, making them more appropriate to the current COVID-19 circumstances, and more accessible to older people in need of these services.
- Build on existing positive experiences to establish coordination mechanisms and compile a database of vulnerable and older people who should be prioritized for care-related support and assistance during COVID-19 and beyond.
- While the government focuses more on COVID-19 control NGOs and the ARCS should involve in prevention, providing community and home-based care and social support to older people, including, advancing risks communication to improve older people's knowledge, awareness and adherence to recommended COVID-19 prevention actions.
- Ensure proper psycho-social support to caregivers and support to their families.
- Ensure continuous training and support related to care aspects, despite the focus shift to COVID-19.
- Capitalize on the experience of the IFRC as a global leader in implementing Cash and Vouchers Assistance (CVA), and build internal capacity of the ARCS to implement CVA as an efficient instrument to deliver tangible monetary support in emergency situations.
- Introduce innovative ways to promote community support groups and inter-generational solidarity schemes that can instigate social activities, better use of digital services by older people and help compensate for older people's isolation and it's impacts. Special approaches might be required for urban areas, where the problem of social isolation among older people is more pronounced and social ties are less developed.

LONG-TERM

- Establish mechanisms to develop plans, policies and programs by active consultations and participations of older people and organizations / institutions working with older people.
- Provide adequate guidance and establish a support system for local governments in the area of conducting needs assessments and the organization and coordination of decentralized care service provision to older people.
- To support the long-term vision for residential care in Armenia, the development of nursing care standards, along with investment, is needed to upgrade nursing home facilities as well as the overall system of preparedness for emergency situations like the current pandemic.
- To expand service coverage and ensure people are able to access integrated (medical and social) home-based care services throughout Armenia, more and stronger partnerships need to be built between public organizations, NGOs and the ARCS.
- Maintain and expand existing dialogues with multiple stakeholders, including NGOs, to include the professional community, local governments and service providers. Use these networks to advance the concepts of healthy active ageing and community-based integrated home care for older people in Armenia, as well as the de-institutionalization of care, and delineation of responsibilities for care between different levels of government and social and medical structures.
- Develop further strategies and programs on integrated care for older people based on the latest developments in geriatrics and care management.
- Expand the ARCS role in self-mobilization of older people and mobilization of communities to support them (thus investing in community resilience and ability to respond in times of emergencies/ crises).
- Conduct research on ageing and care service needs to support evidence-based policy advocacy.
- Raise awareness among older people of their rights and entitlements, including related to care.
- Support media campaigns to increase public awareness on ageing (including mental health), healthy and active ageing, prevent ageism and promote inter-generational solidarity.

1 Background

COVID-19 pandemic poses an increased risk of fatalities and indirect social consequences that are likely to affect older people and people with underlying health conditions more severely than others. In terms of age more than 353,000 people in Armenia are most at risk for COVID-19.[2]

The COVID-19 pandemic has severely affected older people in terms of their life and health, social and economic situation in Armenia.

The outbreak in Armenia was rapid and the state of emergency was long-lasting for the entire country, later replaced by quarantine. The state of emergency in Armenia lasted from March 16, 2020 to September 11, 2020. The Emergency Commandant was appointed by GoA to coordinate management of the emergency regime.[3] Quarantine was introduced, effective from September 11, 2020 to January 11, 2021,[4] whereby the Ministry of Health has defined special rules and regulations.

Restrictions during the state of emergency included: home-bound regime (leaving the house was allowed only for work, essential shopping, pharmacies and sport activities); masks and gloves were mandatory in closed and public spaces; most public services and shops (apart from basic grocery) were closed; group events were banned.

In order to overcome the social impact of the pandemic, the government organized provision of financial and in-kind support to various most vulnerable population groups. The list, however, did not explicitly include older people,[5] unless they were categorized as "most vulnerable".

The territorial bodies providing social care, based on the list of COVID-19 positive and self-isolated people received from the State Emergency Commandant or via hotline, were responsible for conducting needs assessment and distribution of food (for 10-14 days) and personal protective equipment (masks, gloves, disinfection means, etc.) to affected people. The local government bodies were supporting territorial bodies in this process and providing additional support in several cases, often financial aid to pensioners living alone.

International organizations, various local NGOs and individuals were also mobilized to support those in need, often older people left alone. They were also actively engaged in awareness-raising activities for older people related to COVID-19 risks and restrictions, safety measures, rights and entitlements.

[2] https://armenpress.am/eng/news/1011989.html

[3] RA Government Decision No. 298-N On Declaring State of Emergency in the Republic of Armenia, 2020 https://www.arlis.am/DocumentView.aspx?docid=145261

[4] RA Government Decision No 1514-N on establishing the regime of quarantine due to the situation related to Coronavirus, 2020 https://www.e-gov.am/gov-decrees/item/34748/

[5] The list included: families with children whose parents did not have jobs or lost jobs because of COVID-19; citizens that lost their job from March 13, 2020 to June, 1 2020; unemployed pregnant women as of March 30 whose husbands lost their jobs during COVID-19; individuals involved in sectors in which activities were banned during COVID-19; users of natural gas and electricity supply 10.000 drams for electricity consumption in February, 2020; socially disadvantaged families; students of educational institutions involved in graduate, postgraduate (clinical residency) academic programs.

Inadequate services for older people in the country by organized care provision has compromised effective responses to their needs in the context of the current health emergency. The state response to COVID-19 in Armenia did not sufficiently target the older population or the COVID-19 case management, which was shared with primary health care institutions and lacked efficient organization. Reaching out to the older people was mainly ensured by local governments and NGOs.

The ARCS as an organization with an auxiliary status to public authorities in humanitarian field has been involved in the provision of home-based care services for the older people in several regions of Armenia, and since the pandemic outbreak supports the government to address COVID-19 through risk communication, provision of psycho-social, food and hygiene support to the most vulnerable, including the older population.

The way the COVID-19 crisis is dealt with reveals both strengths and weaknesses of the country's systems generally to respond to emergency situations and health crises, as well as to protect the most vulnerable and manage the problem of population ageing.

In this context, the ARCS in partnership with the International Federation of Red Cross and Red Crescent Societies (IFRC), the Austrian Red Cross (AutRC), the Swiss Red Cross (SRC) and with contribution from the UNFPA Country Office in Armenia commissioned a study that aims to better understand the situation and needs of older people, their caregivers and the impact of COVID-19 on their lives in Armenia. Thus, provide recommendations related to improving the short-term response, as well as to policy frameworks and partnership arrangements for addressing the challenge of ageing and problems of older people for the long run.

This study is a part of the multi country study conducted across the South Caucasus region in July-September 2020.

2 Approach and Methodology

2.1. Purpose of the assessment and coverage

This study looks at the impacts of COVID-19 on older people, health and social professional caregivers and trained RC volunteers in the context of general care system in Armenia. It provides recommendations for improving both the response to COVID-19 and the care provision for older people and meeting the needs of professional caregivers and trained RC volunteers.

2.2. Levels of analysis

The study looked, on the one hand, at national frameworks, policies and strategies related to the care of older people and their implementation, while, on the other hand, analyzed the actual situation of older people and professional caregivers and trained RC volunteers before and after the COVID-19 outbreak based on their perceptions.

In analyzing the situation of older people, the study zoomed in on their economic wellbeing, life and health trends, social situation, access to public services and infrastructure, access to home-based care and residential care, civil activism – before and after the COVID-19 outbreak. It also touched upon key aspects of COVID-19 preparedness and behavior.

The survey data was analyzed by sex, age groups, rural and urban background of respondents, health condition (chronic diseases, disabilities and none of those), regions of residence and source of service provision (ARCS beneficiaries and non-ARCS beneficiaries). The report makes disaggregation by those categories only where statistically significant differences were observed.

Collection of information from professional caregivers and trained RC volunteers focused on their perception of different health and social care aspects, their personal economic and social situation and the situation of older people they serve, before and after the COVID-19 outbreak.

2.3. Methods applied and sampling

The assessment relied on a combination of qualitative and quantitative methods:

- *Desk research* of secondary data, in particular relevant policy and legal frameworks, existing analytical and research materials, relevant documents.

- *Questionnaire-based survey among older people*, aged 60 and over. It involved 668 respondents from Yerevan and seven regions of Armenia (Aragatsotn, Ararat, Kotayk, Lori, Shirak, Tavush, Vayots Dzor) and was conducted by trained ARCS volunteers (for details of the respondents profile see Annex 1 and for the questionnaire structure see Annex 2). The respondents were chosen using stratified random sampling targeting to the maximum extent ARCS beneficiaries (79%).

- *Questionnaire-based self-administered survey among caregivers* of the ARCS with 54 caregivers (nurses, home helpers and trained RC volunteers), targeting maximum professional caregivers and 12% of RC volunteers involved in care (for the questionnaire structure see Annex 3).

- *Semi-structured qualitative key informant interviews with social workers and primary medical service providers* from Yerevan and all seven regions of the country (two primary health service providers and two public sector social workers from each region).

- *Interviews with nursing home management and senior care personnel,* involving Norq nursing home, No1 nursing home and Gyumri nursing home.

- *Interviews with key national and regional informants*, including the Ministry of Labor and Social Affairs (MLSA), the Ministry of Health (MoH), the UNFPA Country Office in Armenia, the ARCS, Charitable NGO Mission Armenia, Benevolent NGO Caritas Armenia, the Association of Elderly Health and Care, regional administrations of Aragatsotn and Shirak.

- *Verification Focus Group Discussions (FDGs)*. Four FGDs were conducted with the Gyumri nursing home (two FDGs with residents and four people in each group, and two FGDs with caregivers and two in each group). Further, three FDGs were organized with the ARCS beneficiaries and one with the volunteers who administered the survey with older people.

2.4. Limitations

The assessment was organized and conducted in a very short period of eight weeks (from the middle of July to the middle September 2020) and had several limitations linked to the COVID-19 lockdown, including:

- Difficulties with accessing older people who were not already accessing ARCS' services, which resulted in a relatively small sample of people unconnected to ARCS in the survey (total 51 of the respondents). The sample approach was not entirely representative of the total population of older people in Armenia.

- Drawing on non-professional survey administrators (the ARCS volunteers who had continued access to the older people they support), although they were trained and supervised during the field work.

- Limited access to the nursing homes and ability to obtain information of a real situation in those after the COVID-19 outbreak.

- Inability of the international research team leader to travel to the region, which, however, was compensated for by involving a capable national researcher to support her.

3 Assessment of Context

3.1. Analysis of main frameworks on older people and care

While fully recognizing the phenomena of ageing and its societal implications, and based on relevant international commitments, the GoA adopted the Strategy and Action Plan for Overcoming the Consequences of Ageing and for Social Protection of the Older People for 2017-2021.

The Constitution of the Republic of Armenia[6] bans discrimination based on sex, race, skin color, ethnic or social origin, genetic features, language, religion, world view, political or other views, belonging to a national minority, property status, birth, disability and age (art. 29) and proclaims the rights of older people to decent living (art. 84). The process of elaborating relevant policies and strategies to secure implementation of constitutional provisions related to the older people are guided by the international commitments of the GoA (see the details on key international frameworks in Annex 2).

Following recommendations of the report on non-accepted provisions of the European Social Charter,[7] in 2017, with the technical support of the Network of organization working on older people issues, including the ARCS, the SRC, Mission Armenia, Caritas Armenia, and the UNFPA Country Office in Armenia, the GoA adopted the Strategy and Action Plan for Overcoming the Consequences of Ageing and for Social Protection of Older People for 2017-2021.[8]

The main principles and targets of the Action Plan are the improvement of the care and social services system, promotion of healthy and active life, ensuring economic safety and social inclusion, participation in community life and decision-making processes, creation of a sufficient basis for a longer working life for older people, as well as the training and retraining of specialists providing care services for older people. The other important component is the relevant support to the families which will enable older persons to stay in a family environment. Overall, 24 activities are envisaged by the Action Plan to be implemented under priority areas of the Strategy.

[6] https://www.president.am/en/constitution-2015/

[7] European Social Charter (revised), COE 1996 https://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168007cf93 / Table of accepted provisions of European Social Charter by the Republic of Armenia https://www.coe.int/en/web/european-social-charter/armenia-and-the-european-social-charter / The second report on the non-accepted provisions of the European Social Charter by Armenia, 2019 https://rm.coe.int/second-report-on-the-non-accepted-provisions-of-the-european-social-ch/16809661b1#_ftn3

[8] Strategy and Action Plan for Overcoming the Consequences of Ageing and for Social Protection of the Elderly for 2017-2021 (available in Armenian), RA 2017 http://www.mlsa.am/?page_id=1264

Implementation of the Strategy is supported by adequate institutional and coordination arrangements.

The implementation of the Strategy and Action Plan for Overcoming the Consequences of Ageing and for Social Protection of Older People for 2017-2021 is led by the MLSA in collaboration with the Ministry of Territorial Administration and Infrastructure, Ministry of Health, Ministry of Education, Science, Culture and Sport, Ministry of Transport, Communication and Information Technologies, as well as province administrations and municipalities. It is coordinated by the Interagency Committee established by the Decree of the Prime Minister of Armenia as early as in 2013[9] with the aim to support:

- improvement of the quality of health and social services provided to older people;
- increase of social activism of older people, their community role and integration;
- conducive environment for independent lifestyle and good quality of life;
- adjustment of social protection system to the population ageing trends;
- improvement of house conditions for older people;
- assurance of provision of lifelong learning;
- promotion of gender equality;
- aid to families with older members and solidarity between generations;
- public awareness-raising on the issues of ageing.

NGOs in Armenia are actively involved in social partnerships with the state in advancing a favorable environment and advocating for the interests of older people.

In December 2015, through the initiative of Caritas Armenia, the Network of organizations working on older people issues was established to include state bodies, international organizations and civil society. It includes the ARCS, the SRC, Mission Armenia, Caritas Armenia, OXFAM, Center for Health Care Research of the American University of Armenia, Older People Protection Association/Geriatrics, a representative of the MLSA Department of Older People and People with Disabilities, and MLSA Research Institute, along with the UNFPA Country Office in Armenia,.

The network members meet regularly to discuss legislative changes, reform packages, existing issues and gaps, as well as to generate recommendations and coordinate implementation of joint projects targeted to the needs of older people. The Network has contributed to the development of the National Strategy on Active Ageing for 2017-2020 and its Action Plan, elaborating standards for services provided to older people and a system of needs-assessment for people in need of care (including older people and people with limited abilities and mental health problems), and standards for day-care centers and healthy active ageing activities.

In 2016, the MLSA also introduced the National Agreement on Social Cooperation[10] model that united state governing bodies, communities, NGOs, various service providers (around 50 organizations in total) for better coordination and results in addressing social needs and risks and ensuring participation in public policy in social protection.

[9] The Decree No 20-A of RA Prime Minister of 2013, http://www.irtek.am/views/act.aspx?aid=68957
[10] http://www.mlsa.am/?page_id=13834

3.2 System of care provision

There is a great demand for care among older people in Armenia.

In Armenia, people aged 63 years and over account for 12.5% of the population.[11] There are a lot of people who need different types of care but do not receive it.

By law, the care of older people can be provided by:[12] social protection institutions (residential institutions), daytime social care centers, at home, medical care and services organizations, hospices (organizations providing palliative (remedial) medical assistance to persons at end-stage of disease development) and other social service organizations, centers, institutions, foster families.

In 2019, around 1,390 people were residing in 12 institutions (including 180 in four state ones) – retirement home, care center, nursing home – providing 24-hour care services for older people and people with limited abilities and mental health problems in Armenia. More than 3,800 people received home-based care services and some 2,000 people attended day care centers.[13]

Older people in Armenia are entitled to free or subsidized medical services only if they are classified as most vulnerable, which limits their access to medical services.

Certain legal acts establish provisions on health care for older people through:[14] a) primary health care institutions/policlinics providing primary and preventive health care that is more general and mainly free for everyone, and b) specialized hospitals that provide stationary medical care services, which are free to the most vulnerable groups referred by polyclinics.[15]

Some groups are entitled to free health care once a year[16] or free medicine[17], medicine with 50% discount[18] or 30% discount.[19]

[11] National Statistics Services data as of January 1, 2016

[12] The procedure and conditions of care provision to older people and people with disabilities in home conditions, daytime social care centers as well as in residential care institutions is regulated by RA Government Decision N 1112-N (RA Government Decision No 1112-N, 2015 https://www.arlis.am/documentView.aspx?docid=113868)

[13] https://www.e-draft.am/projects/2133/justification

[14] A Law on Medical Care and Services provided to Population, 1996 https://www.arlis.am/documentview.aspx?docid=144765

[15] Including beneficiaries with insecurity score higher than 28.01 that are included in the family benefit system; people with 1st , 2nd and 3rd group of disabilities; participants of the Second World War; people receiving care in residential or nursing homes and homeless people receiving care in temporary shelters; and asylum seekers and their family members (RA Government decree No 318-N on state-guaranteed free medical care and services, 2004, available in Armenian https://www.arlis.am/documentview.aspx?docid=144400)

[16] Including members of a family with insecurity score from 0.01 to 28 that are included in the Family Benefit system; single retirees aged 65 and over; family members of the participants of the Second World War; members of a refugee family; family members with 4 and more minors in a family; medical service providers whose salary does not exceed 150 thousand AMD (No 457-A order or RA Minister of Health, 2018 http://www.irtek.am/views/act.aspx?aid=98946)

[17] People with 1st and 2nd group of disabilities, participants of the Second World War; beneficiaries with insecurity score higher than 28.01 that are included in the family benefit system (RA Government decree No 642-N, 2019 https://www.arlis.am/documentview.aspx?docid=144545)

[18] People with 3rd group of disability, single and unemployed retirees; families consisting only of unemployed retirees (including those with a minor child in their care).

[19] Unemployed retirees

Quality of health care suffers from a geriatrics and gerontology lens missing from policies, health care and the training system.

There is no special policy in the health care domain focusing on geriatrics and gerontology. The focus is only now being introduced into medical education with the support of the UNFPA Country Office in Armenia, in partnership with Yerevan State Medical University. Currently, MLSA is cooperating with medical associations in order to develop the guidelines on gerontology and geriatrics. In 2020, the ARCS started the cooperation with the Ministry of Education to mainstream the principles of palliative care, home-based care, and geriatrics into the educational standards for medical nurses.

Professional palliative care is currently deficient in Armenia.

A person who is in the terminal stage of disease (with an unfavorable prognosis) is meant to be provided with palliative medical care during the last months and days of life. Standards for palliative care were introduced in 2017 in Armenia.[20] However, there are no specialized medical centers for palliative care in the country. Such care is provided either by a very limited number of medical institutions or by family members.

Social care is represented by residential, day care and home-based care components.

The Law on Social Assistance[21] envisages provision of social assistance in order to prevent or overcome a difficult life situation, traditionally in the form of consulting, rehabilitation, in-kind support, accommodation, care, legal assistance, pensions and other benefits or employment services.

Full-time care for older people and persons with disabilities[22] is provided through general and specialized residential institutions (the latter mainly host people with chronic mental illness or severe mental retardation, or with senile psychosis or severe sclerosis). The number of residents in such institutions varies from 450 to 130. Part-time social care is provided by day care centers for older people, and usually includes food, social-psychological assistance, legal advice, educational or training services, occupational and other therapies. Home-based care is provided to older people according to their individual social program and usually includes household service, health care, social and psychological assistance and consulting support.

The existing public social care system has many gaps in terms of type of services provided and geographic coverage, whereby urban communities and certain regions of the country are more privileged.

The procedures of receiving state-guaranteed free daycare, home-based care and care in residential institutions are too complex for older people.

In order to receive the right to free care supported by government, the person needs to undergo a medical examination in a polyclinic, part of which is paid for by the examinee. Meanwhile for some older people it is hard to physically go the polyclinic for the examinations.

Older people are not always aware of their rights. Often, they don't know whom to address in order to receive care or what kind of benefits they can claim. As a vulnerable group older people can easily become victim to a fraud or rights abuse.

[20] RA Minister of health 45-N order on approval of the standards for providing palliative medical assistance and service. https://www.arlis.am/documentview.aspx?docid=132500

[21] https://www.arlis.am/documentView.aspx?docid=139019

[22] RA Government Decision No 730-N, 2007 https://www.arlis.am/documentview.aspx?docid=72928

Responsibilities for social services provision are not clearly delineated among different government administration levels, which leads to uneven distribution of services and overlaps.

Social services provided by social territorial bodies focus generally on vulnerable households. All benefits (apart from the old age benefit) are oriented towards families. Based on a needs assessment and assignment of an insecurity score, vulnerable older people can be entitled to home-based care service, residential care, daycare services or humanitarian support, free health care in the polyclinics and hospitals.

Local government bodies[23] are responsible for identifying families and persons in need of social assistance, for taking measures to help families and persons in need of social assistance and for discovering and using their abilities to overcome difficulties. They are also responsible for satisfying the social needs of persons that require social assistance in their communities through territorial bodies providing social services or other specialized organizations.

The mayor[24] organizes the activities of urban social security institutions and organizations, as well as supporting the implementation of state social security programs. The head of the administrative district[25] carries out the registration of those in need of social assistance, carries out the distribution of humanitarian aid, supports the registration of the unemployed and supports the solution of the problems related to the employment of the population, organizes the provision of social assistance (services) in the territory of the administrative district, as well as the activities of territorial bodies of local government bodies providing social services.

The care system in Armenia is being reorganized towards a de-institutionalized, community-based and integrated approach.

In the framework of the GoA's Program of Activities 2019-2023,[26] the draft Strategy of deinstitutionalization of older people's care services and development of alternative community services"[27] was elaborated in 2019 and its adoption is pending. The Strategy aims to create a favorable and safe environment for older people, ensuring their dignified ageing process, and at the same time implementing a gradual transition from residential care services to community service delivery, including increasing participation of older people in community life and decision-making processes, as well as the role of the community and the family in the lives of older people.

It is expected that by the end date of the Strategy implementation, the number of people applying for nursing homes will be halved. As a result of reviewing the conditions of admission procedure the number of people receiving care services in nursing homes will be reduced by 60%. It is expected that older people will be provided with alternative care services (small community houses, older people family foster care, day care centers of different directions etc.) in at least three communities each year. Based on an assessment of individual people's needs, it is expected that at least 5% of nursing home residents will return to their families each year. The communities will develop and strengthen their capacities and resources in the context of the development and implementation of local social programs.

In order to create a more favorable and safer environment for older people, ensure their dignified ageing process and provide more needs-oriented services, there is a need to provide care in the form of community services in small nursing homes with 10-15 people. Meanwhile there is also a need to develop the institution of foster families and develop those projects aimed at strengthening the families of older people.

[23] RA Law on local self-governance, 2002 https://www.arlis.am/documentview.aspx?docid=143946
[24] RA Law on local self-governance in Yerevan, 2009 https://www.arlis.am/documentview.aspx?docid=143944
[25] RA Law on local self-governance in Yerevan, 2009 https://www.arlis.am/documentview.aspx?docid=143944
[26] RA Government's 2019-2023 Program of Activities, available in Armenian https://www.arlis.am/DocumentView.aspx?DocID=131287
[27] The draft of "RA Government decision on approval of the Strategy of deinstitutionalization of elderly care services, as well as of introduction and development of alternative community services", available in Armenian https://www.e-draft.am/projects/2133/about

Although an integrated approach to care is recognized as an important principle of care provision, its implementation is still hindered by silos in which the medical and social public care system is organized. It is basically the ARCS and a handful of NGOs who are piloting this approach now in partnership with public institutions.

NGOs emerge as prospective professional care service providers to older people.

In recent years, the MLSA has been delegating social services in the form of grants to certified NGOs for provision of home-based care, day care in social centers and residential care.[28] The number of such grants doubled from five in 2019 to ten in 2020. Among key non-governmental service providers are:

- The ARCS[29] that since 2016 with the support of the SRC and the Monacco RC has provided integrated home-based care in three regions – Shirak, Lori and Vayots Dzor – by teams of professional nurses, home helpers and trained volunteers. The ARCS also provides humanitarian aid, food packages and support with the organization of social and entertainment events for older people in four regions – Ararat, Aragatsotn, Kotayk and Tavush. The ARCS promotes the concept of Healthy Active Ageing by supporting older people groups in Lori, Shirak and Vayots Dzor regions.

- Armenian Caritas Benevolent NGO[30] runs its home-based care program in four regions – Gyumri (Shirak region), Vanadzor (Lori region), Gavar (Gegharqunik region) and Artashat (Ararat region), along with two day-care centers in Tashir (Lori region) and Gyumri (Shirak region). It also implements the "Dry Food for 200 Beneficiaries Living in Gyumri" program, which aims to improve the life quality of 200 older people in Gyumri city through provision of dry food rations, and the "Warm Winter" project covers the cost of heating for vulnerable older people during three months of winter. Trained nurses of Caritas are involved in training gerontology in medical colleges.

- Mission Armenia Charitable NGO[31] provides home-based care and day care services to older people and people with disabilities in Yerevan and six regions of Armenia: Ararat, Lori, Shirak, Kotayk, Gegharqunik and Syunik.

- The Association of Healthcare and Assistance to Older People,[32] established in 2016, operates in three main fields: healthcare, social care and continuing education of physicians, nurses, caregivers and family members of older person. In 2018 its sister organization Armenian Association of Geriatrics and Gerontology was founded to focus on the development of geriatric and gerontological services, promoting the recognition and formation of the disciplines of geriatric medicine and gerontology as independent specialties in Armenia, supporting measures to enable older people to remain active, independent and involved in their community, facilitating social engagement, and promoting the development of an integrated care system. In cooperation with the UNFPA Country Office in Armenia, the Association also organizes the school for caregivers. The school aims to provide knowledge about gerontology and geriatrics, as well as the particularities of older people care. The Association provides home-based care services in Ijevan (Tavush region) (75 people) and in Vayq (Vayots Dzor) (75 people) and Yerevan (85 people who are meant to receive daycare services – the plan having been delayed by COVID-19).

The general system of health and social care of older people in Armenia was rated 3.4 points out of 5 on average by six experts and informants in the field (key informant interviewees).

[28] RA Government Decision No 1078-N on social services provision certification cases and procedure, 2015 available in Armenian http://www.irtek.am/views/act.aspx?aid=82128
[29] Official website of Armenian Red Cross Society https://www.redcross.am/en/home.html
[30] Official website of Armenian Caritas Benevolent NGO http://www.caritasarm.am/en/
[31] Official website of Mission Armenia Charitable NGO http://www.mission.am/NEW/?iL=1
[32] Official website of the association of healthcare and assistance to older people, https://www.gerontology.am/en/

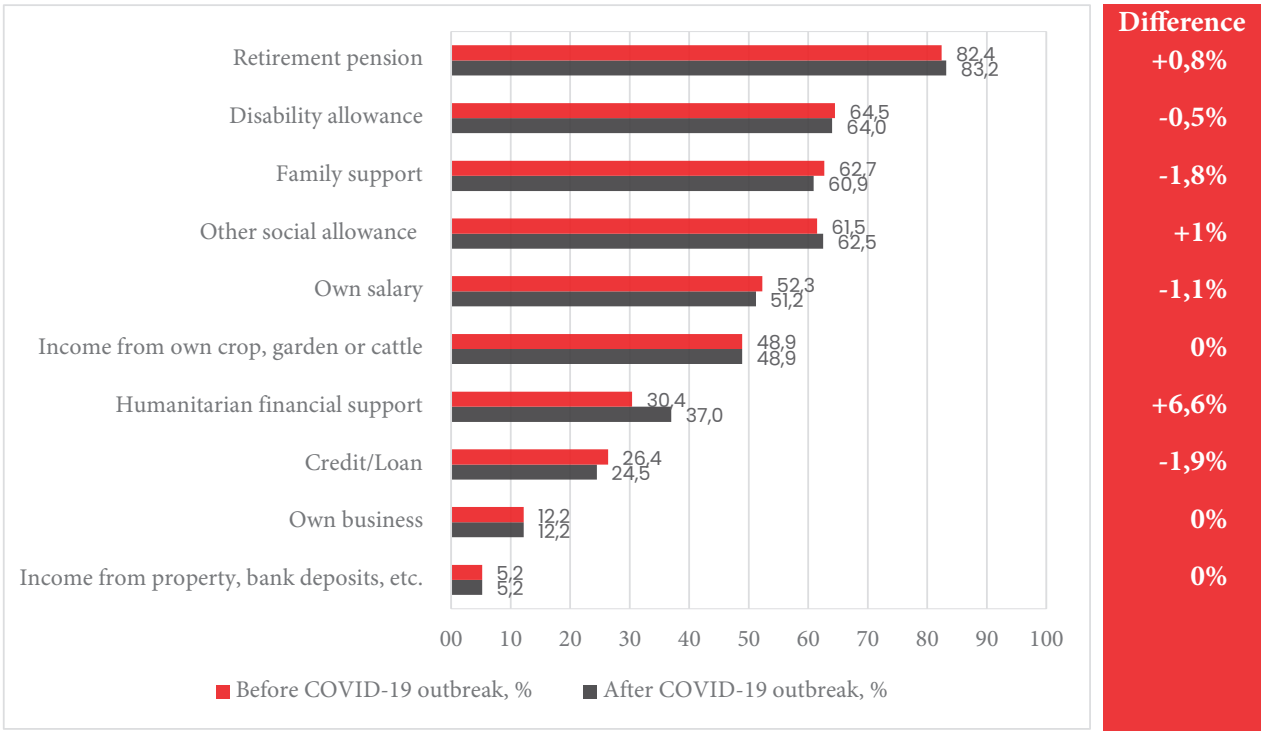
4 Impact of COVID-19 on older people: Findings and Conclusions

4.1. Income and expenses

The structure of the importance of income sources for older people in Armenia remained the same with the retirement pension being by far the most important one, followed by disability and other social allowances and family support.

The existing legislation allows employers to terminate the labor contract of persons above the age of 63 (if they are entitled to a retirement pension) or 65 (if they are not entitled). Thus, many older people are unemployed even if they are still capable of work; they have to rely on their retirement pension and other sources of income, including family support and other social allowances, as well as some income from their own crop, garden or cattle. The survey also revealed that humanitarian financial support is also important for one third of the respondents and grew slightly in importance during COVID-19.

Graphic 1. Importance of the source for income levels (% for ratings 4 and 5 "important" and "extremely important")



Loss of jobs by respondents' family members due to COVID-19 explains the slight decrease in family support in rural areas and a notable decrease in urban areas.

> *"My son lost his job during the pandemic. This is the case of many families where children used to support their older parents, like me"* – says an old woman.

For those living alone, the retirement pension, disability and other social allowances are a more important source of income than for those living with family, and for whom family support is the most important source of income. For younger groups of older people (60-65 years old mainly) living in rural areas the salary is a more important source of income. In rural areas the income from their own garden and crop was rated as more important than in the urban areas.

One third of the respondents had received extra financial or in-kind support during the outbreak from central and local governments, NGOs and international organizations, with the latter assessed as most useful as they mainly provided to people left out of other aid schemes and were focused on personal protective equipment.

Such support was reported by 33% of the respondents. The financial support was provided to the respondents only once by international organizations, NGOs, central and local government bodies. The one provided by international organizations was rated as much more useful (apparently, the ARCS is associated with an international organization for many), due to the fact that it was mainly provided to people left out of other aid provision schemes and due to its focus on personal protective equipment which was especially deficient in the beginning of COVID-19.

Table 1. Effectiveness of the extra financial support from different organizations (% for ratings 4 and 5 "useful" and "extremely useful")

By providers	**%**
International organization	95,5
Central government	33,3
NGOs	33,3
Local governments	30
Religious organizations	0
Private people/ business	0
By type of support	**%**
Food	85,5
Medications	80
Clothes	0

The vast majority of in-kind support was food, protective means and in some cases medication. The food support was provided by the ARCS, other NGOs and local government bodies and was rated mostly very useful. Satisfaction rate is also high among people who received personal protective equipment and food through the ARCS (total 24,000 individuals from March 2020).

Lack of a common database of people in need, and established mechanisms of emergency response coordination at the local level between public bodies, local governments and NGOs led to delays and uneven provision of assistance to older people.

The ARCS, Mission Armenia and Caritas Armenia provided in-kind support, food and personal protective equipment to both older people they already worked with and other older people in need.

Some organizations used their hotlines for identifying people for both financial and in-kind support and for volunteer social and household assistance.

Examples of a coordinated approach in aid provision were rather exceptional.

However, in general the lack of a consolidated database of vulnerable people, and lack of a coordinated response led to such problems as overlaps and duplication, people in need left without support, uneven distribution of support across regions and within the regions, overburden of territorial bodies and local government staff involved in rapid needs assessment. The survey also proved that people living in urban areas received more support than those living in rural areas.

> *"Older people in need were usually identified based on the lists of vulnerable people provided from the territorial bodies, receiving which took some time due to needs assessment procedures"* – says one NGO representative.

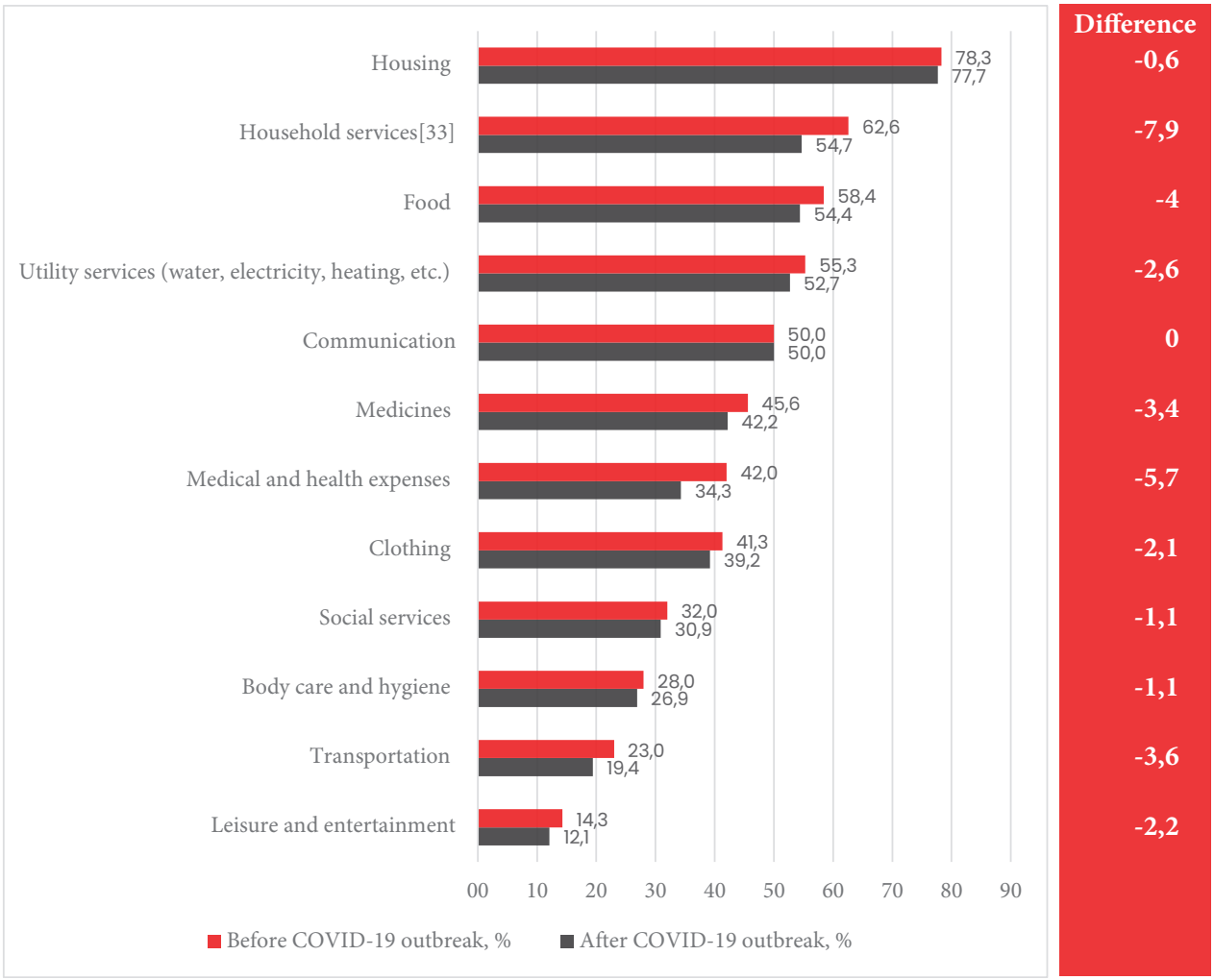
> *"In Kotayk region, the municipality of Hrazdan, as early as in March 2020 set up a network of all organizations and individuals providing or willing to provide social assistance or other aid, like food and household support"* – says a local government representative.

Currently, the UN is investing in creating a rapid response platform in order to prevent these problems in the future.

Ability of older people to cover expenses, especially for household services, utility services, food, medicine and medical services has decreased.

Generally, a decrease has been reported for all most basic expenses although to different degrees.

Graphic 2. The assessment of ability to cover expenses (% for ratings 4 and 5 "satisfactory" and "very satisfactory")



Covering basic expenses after the COVID-19 outbreak turned out to be more difficult for older people living in Yerevan (capital) and Kotayk (close to Yerevan) due to higher prices and expenses in these areas, and for older people living alone and not having family, as well as older females (compared to males) and older people of more senior age (above 70).

> *"The government covered our gas and electricity costs in February but sustaining this support would not be realistic in the longer-run. Some of us are not living but just surviving."* – says an old man.

The ability to cover housing related expenses is the same for all the age groups since the vast majority (96%) of the respondents are living in their own houses (or in the houses of a family member) and do not have to pay rent.

People the ARCS works with find such expenses related to medicine, transportation, body care and social services less stressful for their budget, since they benefit from home-based care services.

[33] Like cooking, cleaning, budgeting, and other household care or maintenance tasks.

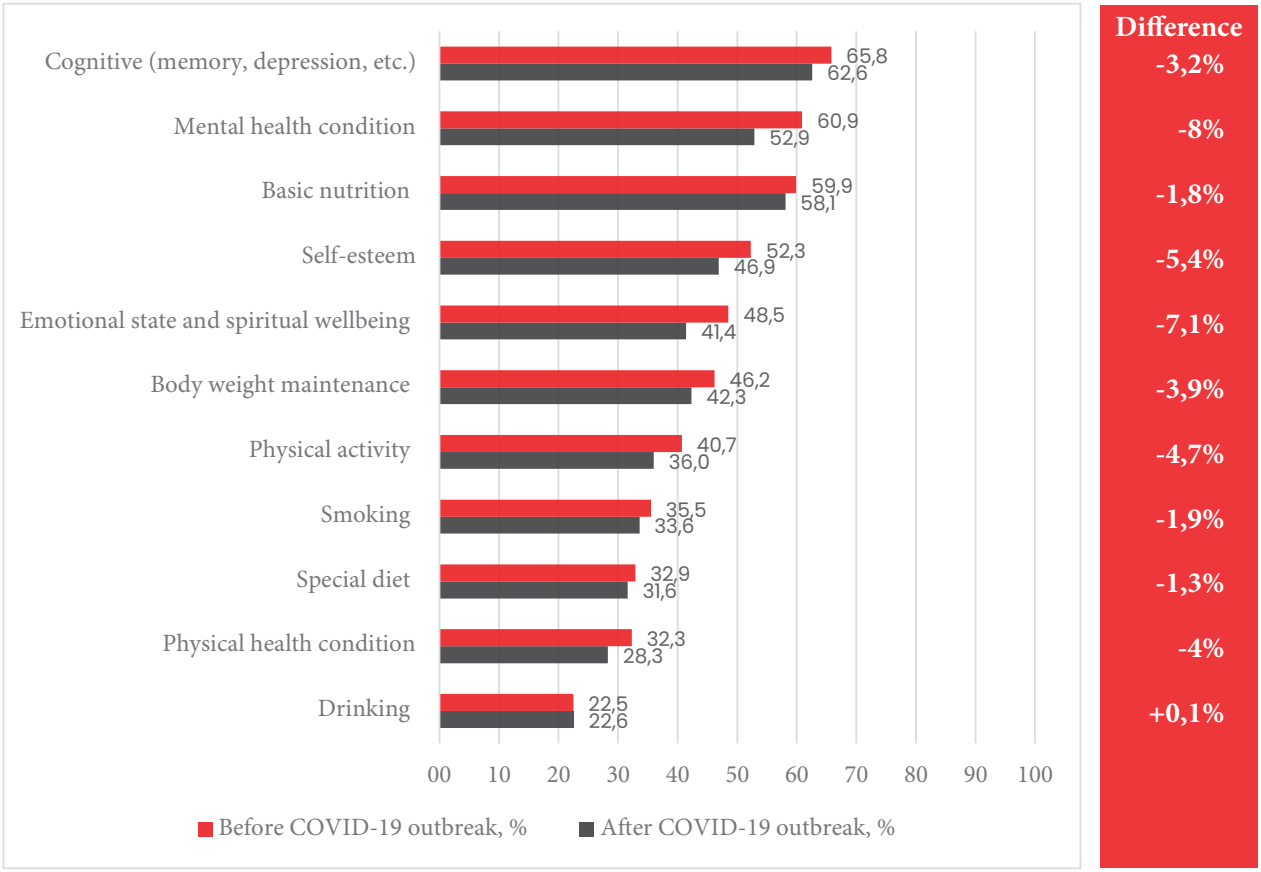
4.2 Life and health trends

Forty percent of respondents have chronic illnesses, 38.5% percent have a disability and the remainder have no obvious diseases or disability. Most of the respondents with chronic illnesses or disabilities, access ARCS services.

Worsening of health status has been registered among a small part of respondents as a result of COVID-19. Main health-related effects of COVID-19 on older people are generally related to emotional instability, lower self-esteem and less physical activity.

Nine percent of respondents reported worsening health during COVID-19, resulting in decreases in mental and cognitive abilities, physical health condition and poorer ability to maintain body weight. Notable decrease was registered in physical activity, as well as some decrease reported in basic nutrition and special diet, which apparently influenced overall physical condition of older people and their ability to maintain body weight.

Graphic 3. Situation with regards to the following health and healthy lifestyle aspects (% for ratings 4 and 5 "very good" and "excellent")



The major difference in older people's perception of their health was reported in such aspects as mental health, emotional state and spiritual wellbeing and self-esteem. Although the link between overall worsened health and COVID-19 is not entirely linear, older people think that their health (often manifesting in emotional instability, aggression and depression) is affected to a large extent.

> *"Current restrictions and the lockdown at home, isolation from people, a need to wear masks outside and constant fear of being infected – all are too hard to bear"* – says an old woman.

According to medical staff, the primary impact of COVID-19 on older people's emotional state and mental health can be dramatic when they are diagnosed positive.

The effect of COVID-19 is felt less by the younger group of older people (60-65 years) and male respondents (who are younger on average).

> *"In case of COVID positive diagnosis, the older patients usually become very nervous and depressed"* – says a medical doctor.

The majority of respondents were and remained satisfied with their access to health services before and after the COVID-19 outbreak (apart from hospitals), although provision of health services to older people was constrained by a shift of attention to COVID-19 positive cases. It is also generally compromised by missing a geriatrist lens.

Only 48% of respondents had excellent or good access to hospital services before COVID-19. This is mainly explained by the financial situation of the patients. As previously mentioned, the free medical services are provided only to some categories of older people; the rest are meant to pay, but not all of them can afford it. Access to hospitals declined further to 44%, after the COVID-19 outbreak.

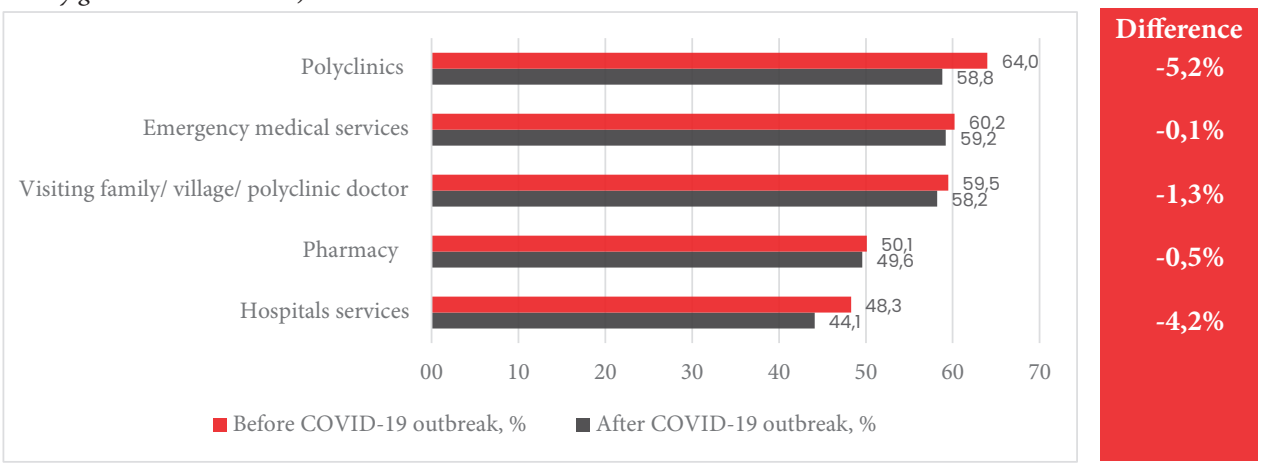
Before the outbreak, 64% of the respondents had excellent or good access to the polyclinics. After the COVID-19 outbreak it dropped to 59%, which is still relatively high. During the pandemic, because of the fear of infection most people withdrew from using public transport and visits to polyclinics, and also on the discouragement of doctors who were reoriented to remote service provision. At the same time, people contact polyclinics more often by phone.

> *"Older people see hospitals as not entirely safe during the COVID-19 and now avoid using hospital services unless really necessary"* – explains a medical doctor.

Patients, especially those in the risk groups, were visiting primary medical care institutions only to receive their medicines. The access to family doctor, emergency medical services, medicines and pharmacies is almost the same.

> *"The number of calls we receive daily at the polyclinic has increased a lot. Especially older people often call in a panic as soon as they have light symptoms of cold"* – says a medical doctor.

Graphic 4. Assessment of the situation with regards to access to the health services and infrastructure (% for ratings 4 and 5 "very good" and "excellent")



Interestingly, for respondents living in rural areas accessibility generally is higher for hospitals and polyclinic services, emergency medical services, visits of family doctor and pharmacies (as noted earlier, access to free medications was restricted to the group of older people classified as most vulnerable), both before and after the COVID-19 outbreak.

People the ARCS assists use less health infrastructure as many receive home-based care services. Hospitals, polyclinics are equally accessible for respondents with chronic illnesses, with disabilities and those respondents without any obvious disease or disability. Family/village doctors' services are more accessible for people with chronic illnesses and those without any obvious disease/disability than for people with disabilities. The emergency medical services are more accessible for people with disabilities and people without any obvious disease/disability.

> *"Unfortunately, geriatrics is not sufficiently integrated either in the concept of care, or in training of doctors and nurses in Armenia. There are many pediatricians in polyclinics, but there are no geriatricians. Each age has its own diseases. Specific knowledge is needed to address conditions and diseases related to age",* - says an NGO care manager.

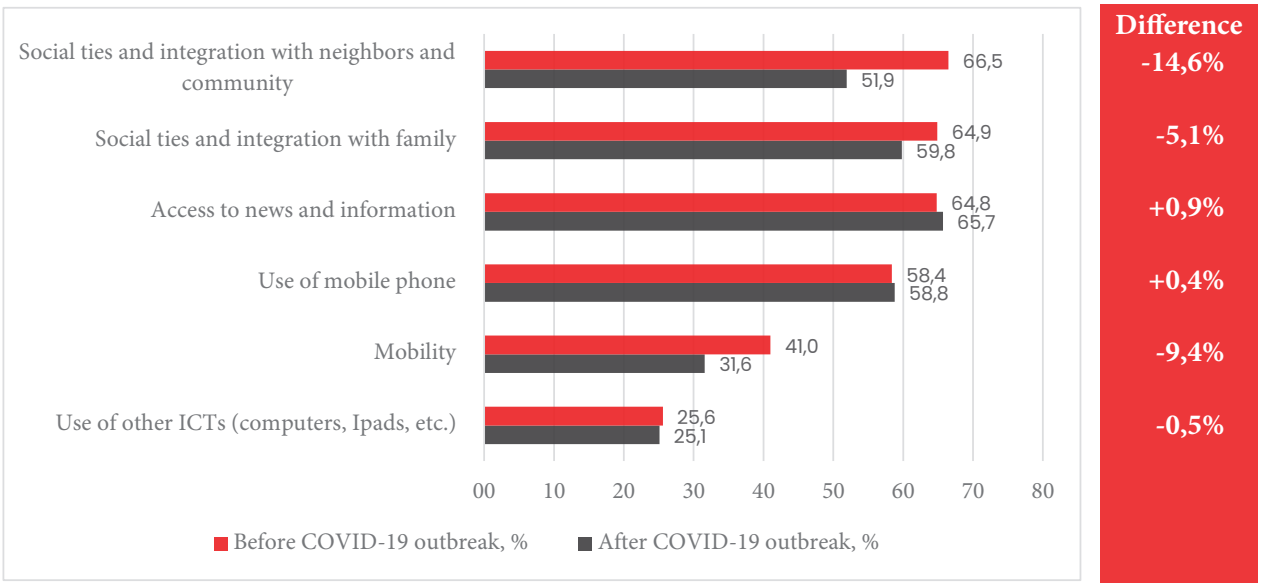
At the same time, the experts on care interviewed during the survey confirm that the quality of health care services in the country is generally compromised.

4.3 Social situation

Disruption of social ties with neighbors, community and family, reinforced by limited mobility, are among the main negative social effects of COVID-19 on older people. Older people residing in urban areas are generally less satisfied with their social situation than those residing in rural areas.

The survey registered a 15% drop in satisfaction regarding the relationship with neighbors and community and a 5% drop in satisfaction related to ability to maintain family ties.

Graphic 5. Situation with regards to different social aspects of life (% for ratings 4 and 5 "very good" and "excellent")



General lower satisfaction with social life was predictably high among younger groups of respondents (age 60-70), men (surveyed older men are on average younger than surveyed older women) and people accessing the ARCS services (since the ARCS serves mainly the most vulnerable categories through its home care services)

> *"I do not have any contacts with people apart from Red Cross workers and volunteers", -* says an old man.

However, the survey also revealed that urban residents generally rated their situation lower in all aspects of social life before and after the COVID-19 outbreak than rural residents. This is explained by less developed social ties and neighborhood relations in an urban setting.

> *"We had a case in the city when an older dweller made a false advertisement about selling his apartment, just for the sake of someone knocking at his door and talking to him"* – says a caretaker.

The services of daycare centers were most affected.

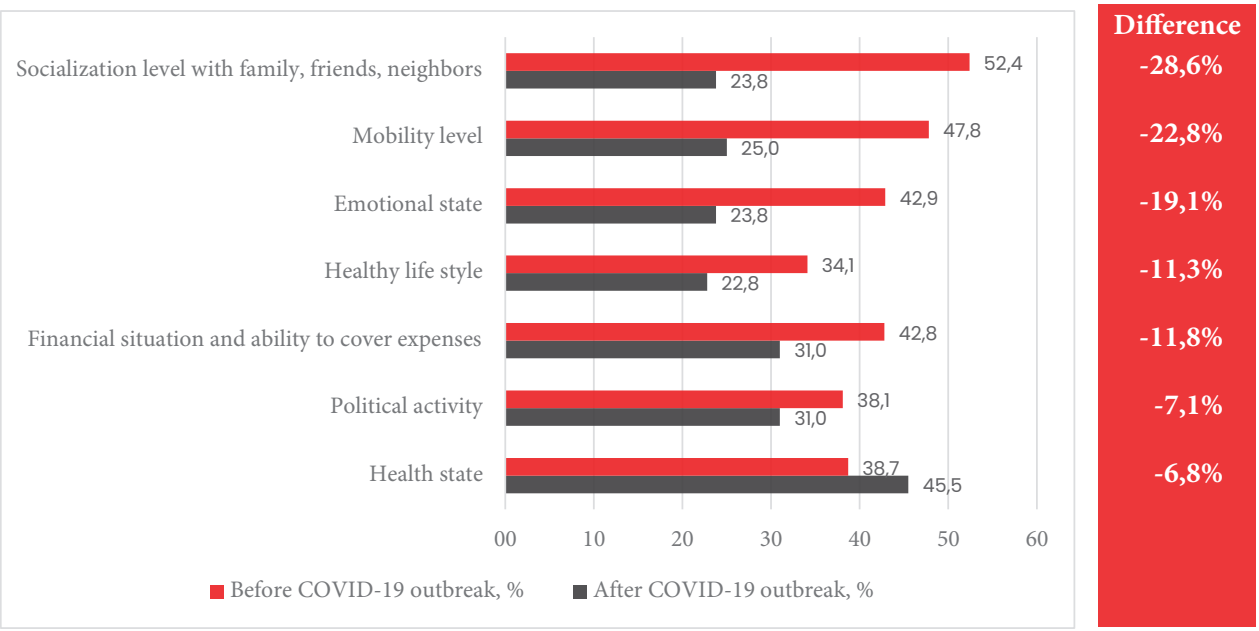
> *"During the first months of the pandemic the centers stopped all social activities and were limited to food delivery support. However, after the strict restrictions were removed it became possible to organize daycare services with smaller groups"* – says a social worker.

The caregivers confirm worsening of the situation of older people in relation to the decrease in socialization and mobility, adversely affecting their emotional state; there was also some worsening of their financial situation.

According to caregivers, older people's health state, life-style, financial situation and ability to cover expenses, political activity, socialization levels with family, friends and neighbors, mobility level and emotional state became much worse as a result of COVID-19 and subsequent restrictions.

> *"I have no family to help me and no finances, my neighbors used to buy me medicine during the quarantine", -* says an old woman.

Graphic 6. Assessment of the situation of older people by caregivers (% for ratings 4 and 5 "very good" and "excellent")



Many link the worsening of the situation with the general weakness of the existing social protection and social care systems.

> *"Several NGOs are doing a great job in supporting older people in the country, but the social protection system overall is very weak"*, - says an NGO care manager.

> *"The older people are being ignored in Armenia. Often they do not need so much financial support, but rather care – someone to buy bread for them, to purchase medicine, someone to talk to"*, - say a regional administration representative.

Ageism and physical and financial violence seem to be a widespread phenomenon in Armenia generally, especially in urban areas.

Although many respondents did not understand questions related to their experience of different forms of violence, around one third of older people have experienced physical and psychological violence as well as financial abuse before the COVID-19 outbreak. However, the situation regarding ageism, physical, violence, psychological and financial abuse, has not changed significantly since the COVID-19 outbreak.

> *"The high rate of ageism is related to employment difficulties for older people"* - says an NGO worker.

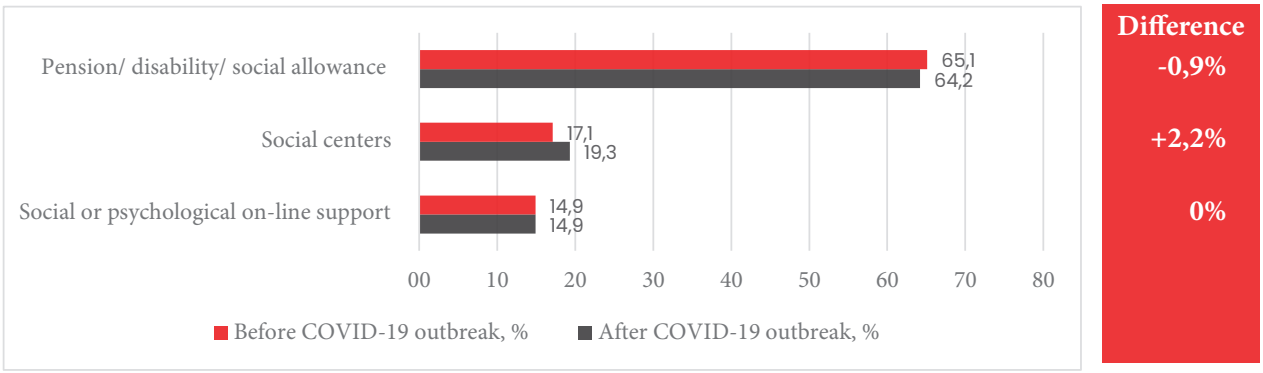
Notably, the situation related to ageism, financial abuse, physical and financial violence is worse in rural areas, among more senior respondents and among older women.

> *"There is a problem of protection of the rights of older people in Armenia – no one takes care of it. There are cases of older people being deceived, like when they put their house in someone else's name, and then they are left without property"*, - say a regional administration representative.

COVID-19 has not influenced older people's access to the pension and social services, although access to the latter was rather low before the pandemic, especially among those whom ARCS does not assist.

Access to social services, social or psychological online support, retirement pension, disability and other social allowances remained almost the same.

Graphic 7. Assessment of the situation with regards to access to the social services and infrastructure (% for ratings 4 and 5 "very good" and "excellent")



For people ARCS assists, social centers and social or psychological on-line support services are more accessible.

> *"When I talked to Red Cross volunteers on the phone during the quarantine, I felt safer"*, - says an old woman.

The low rate of access to the pension and disability and other social allowances are mainly interpreted as "low amount of pension and other benefits" and explained by limited categories of older people who are eligible for social allowances.

> *"Only the most vulnerable people are entitled to social allowance. Disability and other social benefits are available mainly to people with limited abilities and chronic diseases"* – explains a local government representative.

Furthermore, people's access to social assistance provided by territorial agencies was somewhat complicated during COVID-19: most centers, located in regional administration buildings, could not be entered by citizens, and employees received them outside. The older respondents reported lengthy information verification (employees going in and out for information and documentation), difficulties in communicating with protective masks and social distancing.

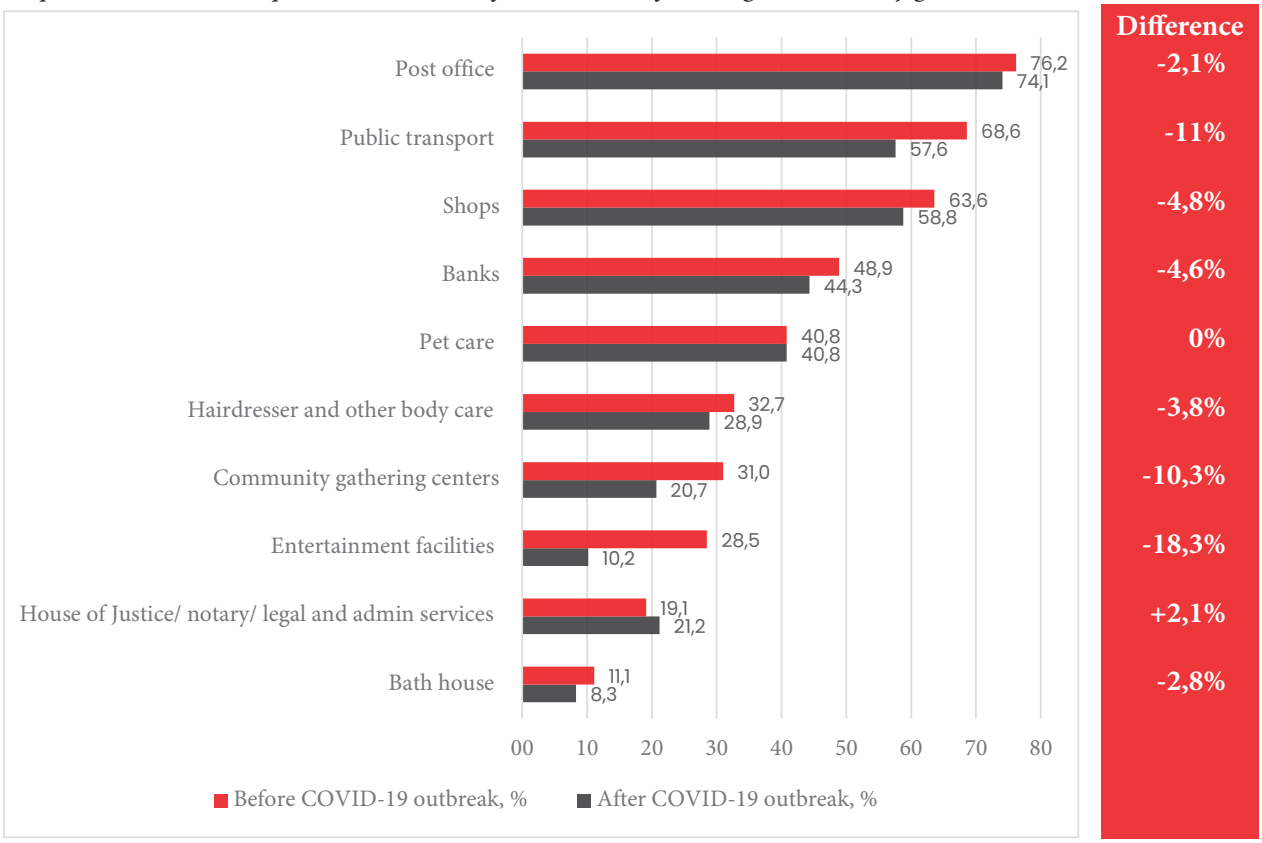
> *"In regions where there are no care centers for older people, care for older people is provided only through territorial agencies that are serving all vulnerable people in generally and not older people specifically"*, - says a regional administration representative.

4.4 Access to public services and infrastructure

Older people's access has been considerably reduced to such public services and infrastructure as community centers and entertainment facilities, public transport, shops and banks.

Access to shops, transport services, banks, community gathering centers, entertainment facilities, hairdressers and other body care services was limited during the pandemic. Access to post offices, house of justice/ notary/ legal and admin services remained almost the same, however people were afraid to go out of their homes and visit any public place.

Graphic 8. Access to other public services and infrastructure (% for ratings 4 and 5 "very good" and "excellent")



Access to supermarkets, post offices, banks and other public infrastructures was significantly reduced during the lockdown, although these facilities were open to provide services specifically to people over 63 years from 10am to 12pm.

Visits to those facilities also decreased due to availability of humanitarian aid and organized delivery in some cases by neighbors, volunteers, NGOs.

> *"We hardly went to supermarkets as we were afraid of getting infected. We asked other people to buy food for us"* – explains an old couple.

Banks and shops in general are less accessed by the older people of more senior age (over 70) and people with limited abilities. The latter claim good access, however, to post offices and public transport.

Digitalization of public services is not yet well advanced in Armenia. Neither are digital services widely used by older people.

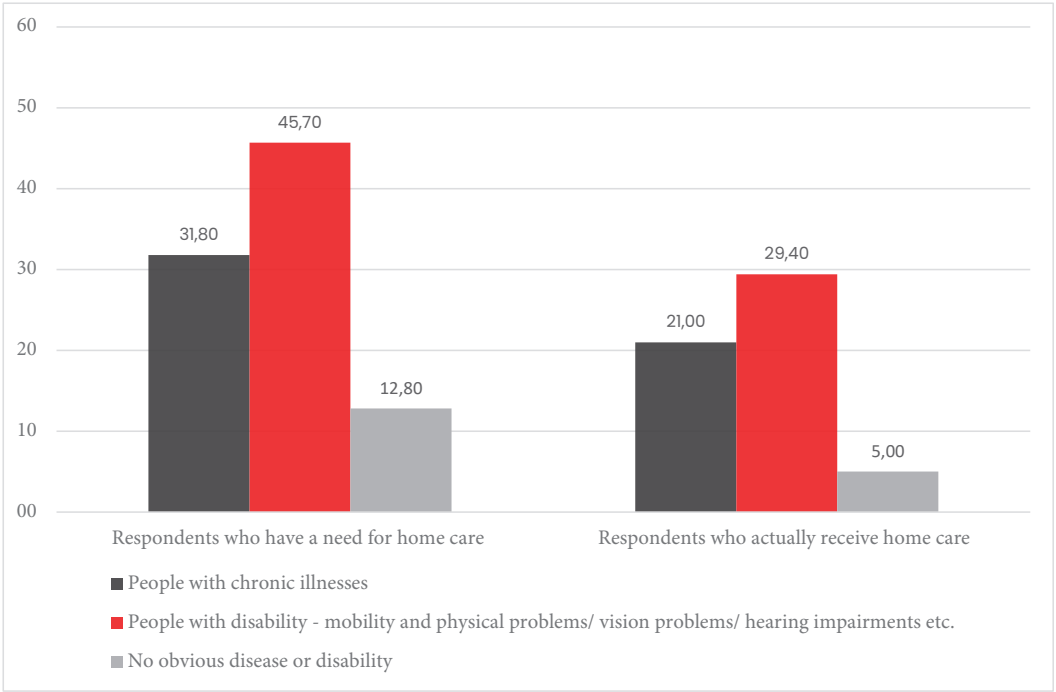
> *"I have no idea of computers, I have been using a simple mobile phone for years. Why do I need anything else?"*, - says an old woman.

4.5 Access to home-based care

Of one third of the surveyed older people in need of home-based care only one fifth receive it. The percentage of people in need of home-based care is almost negligible in rural areas.

33% of the respondents reported that they need home-based care, of which only 21% receive it. The need for care has slightly increased after the COVID-19 outbreak.

Graphic 9. Respondents in need of home care and those who actualy reveive it



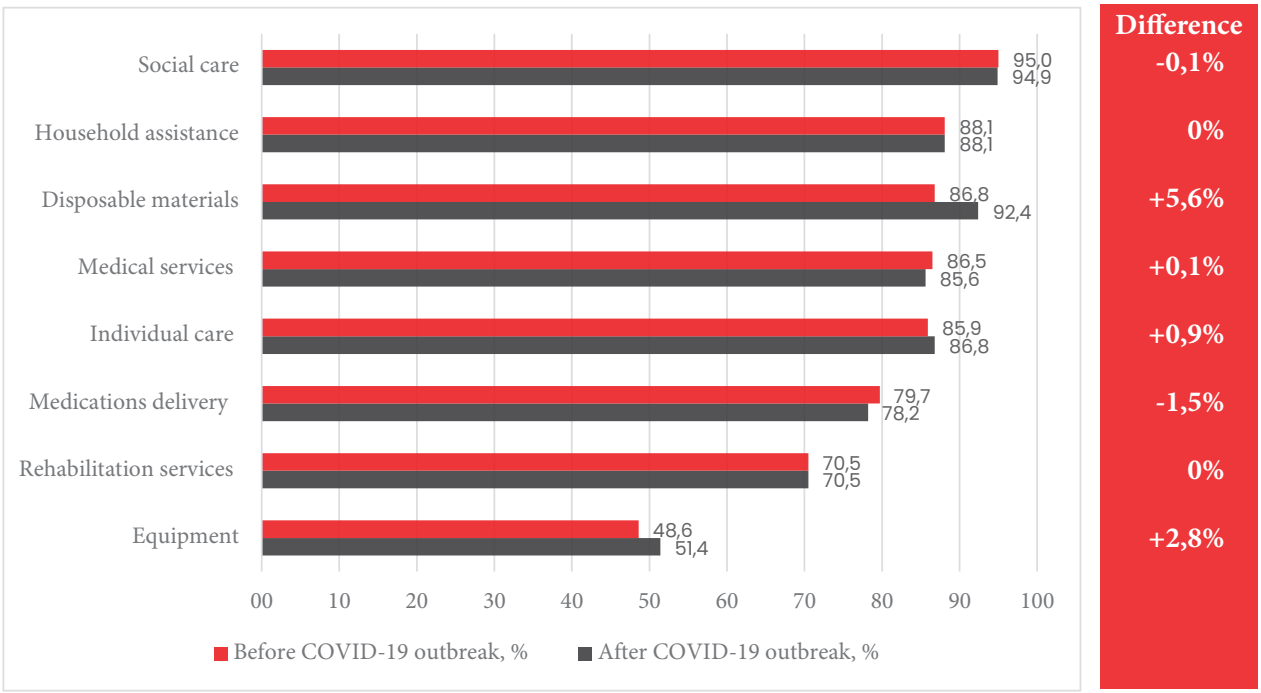
According to the survey, the need for home-based care and accessibility of home-based care increases with age. Access to home-based care is much lower.

While 29.4% of respondents living in urban areas receive home-based care, in rural areas it is as low as 3%.

Those receiving home-based care services continued enjoying access to the full spectrum of services and care materials after the COVID-19 outbreak, and even better access to disposable materials.

Among those who receive home-based care, the situation regarding access to health and rehabilitation services, individual care, medications delivery, equipment (crutches, wheelchairs, walking sticks, hearing devices, oxygen or breathing devices, etc.), disposable materials (pampers, positioning material, anti-bedsore materials, etc.), social care and household activities is almost the same before and after the COVID-19 outbreak. The majority of respondents (70-95%) enjoyed good or excellent access to the above-mentioned services.

Graphic 10. Assessment of access to different types of home care services (% for ratings 4 and 5 "very good" and "excellent")

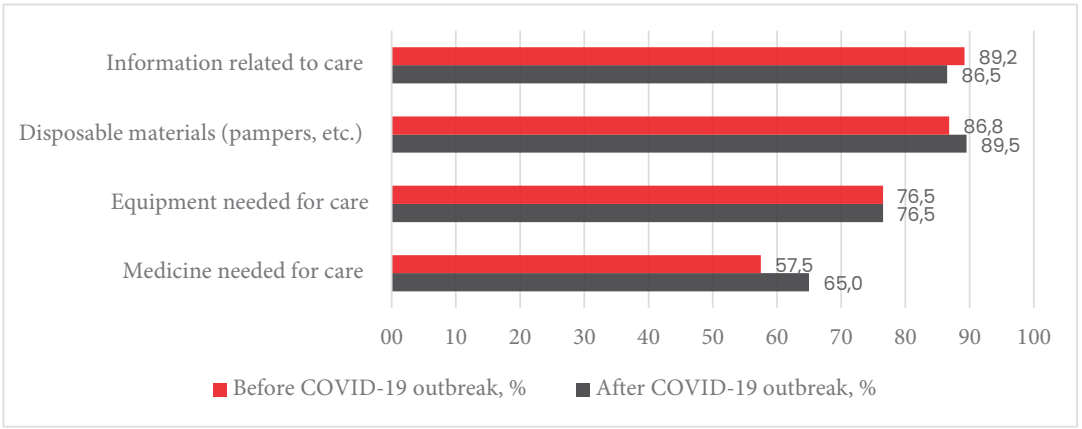


Caregivers managed to maintain the level of service provision across the spectrum, although the enrolment of new residents for home-based care was not possible during the first several months of the pandemic.

All ARCS caregivers continued provision of services during the COVID-19 period.

According to the caregivers, the situation regarding equipment needed for care was maintained. Access to protective materials for themselves and beneficiaries, to the medicine needed for care, to disposable materials, has slightly increased. Access to information on care has slightly decreased during the pandemic due to information input priorities shifting to the topics of COVID-19 prevention.

Graphic 11. Assessment of access by caregivers (% for ratings 4 and 5 "very good and excellent")



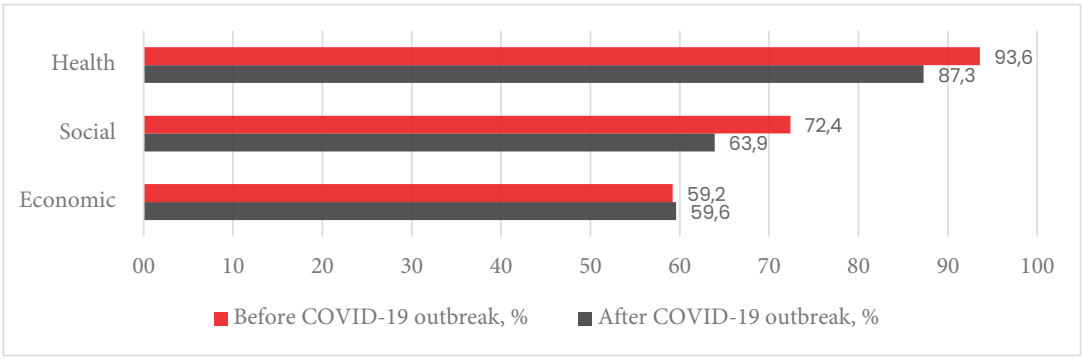
However, new enrolment became complicated during COVID-19 for both home-based care and day care centers, also due to difficulties related to carrying out medical examinations of potential new enrollees. Additionally, the risk of getting infected for older people was real.

> *"Not in all primary medical facilities was it possible to provide separate entrances for general patients and COVID related patients"* – says a policlinic worker.

However, provision of care was challenged by changes in the situation of caregivers themselves, their access to transport services and ability to cover some expenses.

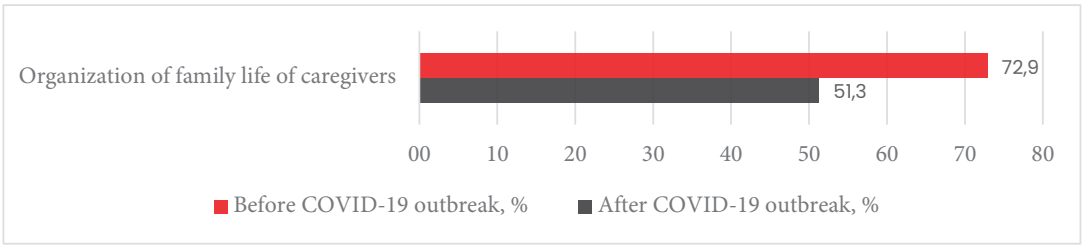
The economic situation of the caregivers is almost unchanged. The social and health situation became slightly worse, although there are hardly any older people among caregivers, and it is due to caregivers' own challenging family situation and work-related stress.

Graphic 12. The assessment of caregivers' personal situation (% for ratings 4 and 5 "very good and excellent")



Many caregivers were challenged by the need to reorganize their family life after the outbreak.

Graphic 13. Assessment of organization family life by caregivers (% for ratings 4 and 5 "very good" and "excellent")

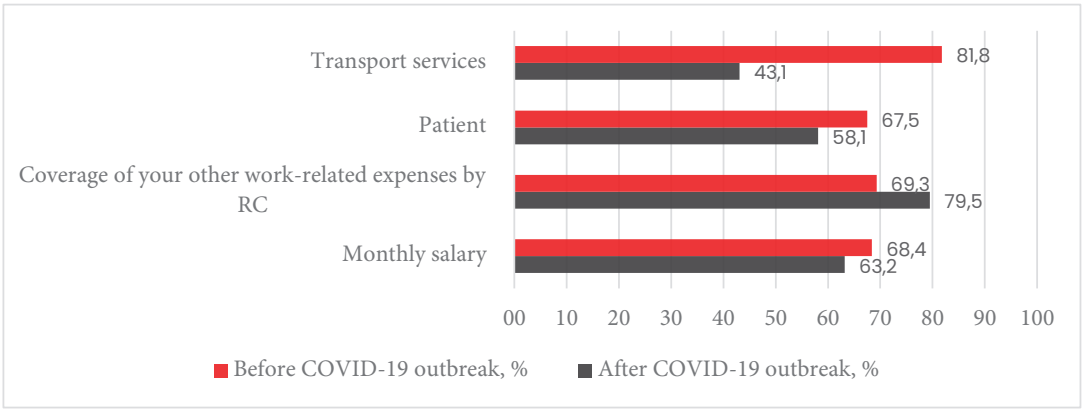


Difference
-21,6%

The situation regarding access to the patients and transport services worsened due to the restrictions.

> *"During the first 2-3 months of the outbreak public transport was not operating, and people were supposed to go to work by walking or by taxi, which is unaffordable for many"* – says a caregiver.

Graphic 14. Assessment of the ability to access the following (% for ratings 4 and 5 "very good" and "excellent")



Difference
-38,7%
-9,4%
+10,2%
-5,2%

Although the polyclinics generally prioritized management of COVID-19 positive cases over general medical care provision, the medical workers of the polyclinics monitored chronic diseases among patients by telephone. Older people have been receiving the necessary medication in person or through a representative. The COVID-19 patients required constant care and attention, including periodic checkups by phone.

> *"Many health workers were working seven days per week, 18-20 hour per day. The situation was especially tense in June and July, with 500-700 new cases appearing every day."* – says a health worker.

The situation became even worse when COVID-19 spread among medical workers (in some polyclinics whole teams were infected).

> *"We deal with the patients 24 hours a day, we constantly call and check the temperature, give them other instructions. We make all those calls at our own expense"*, - says a policlinic nurse.

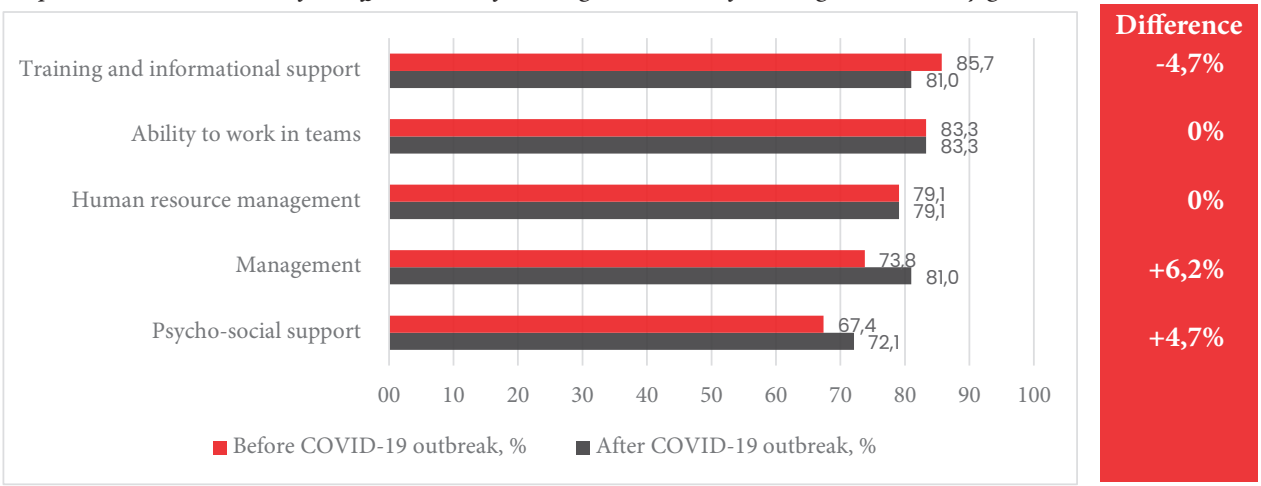
Moreover, the public sector doctors and nurses felt they were not adequately compensated.

> *"We worked very hard, day and night. We received a small bonus twice, but the salary did not increase. The doctors should be better motivated"*, - says a policlinic doctor.

Caregivers remained largely satisfied with the organization of management of care and provision of psycho-social support to themselves and less satisfied with the training and information support.

According to the caregivers, the management of home-based care services, effectiveness of psycho-social support improved after the COVID-19 outbreak. The human resource management and ability to work in teams was almost the same. Some minor decrease in the ability to work in teams is explained by the requirement to keep social distance between team members. The volunteers rated the effectiveness of the general home-based care organization system more highly than nurses. The effectiveness of training and information support decreased across all types of caregivers, due to priority attention shifting to emergency management needs.

Graphic 15. The assessment of the effectiveness of care organization (% for ratings 4 and 5 "very good" and "excellent")



4.6 Access to residential care

Older people in nursing homes are exposed to multiple and much higher risks than those receiving care at home, with some related to failures to adopt care in the situation of epidemiological emergency.

Numerous restrictions were imposed in order to keep the residents of nursing homes for older people safe during the pandemic. Multiple cases of COVID-19 have been confirmed in nursing homes. For instance, as of July, in Gyumri nursing home (managed by ARCS) of 111 residents aged 60 and above, 38 were infected by COVID-19, of which five died. In Norq nursing home (managed by the MLSA) of 150 residents (with most aged above 60) around 60 people were confirmed COVID-19 positive with 20 fatal cases. General statistics on positive and fatal cases in nursing homes is not publicly available.

The residents with mild and moderate forms of COVID-19 were isolated within nursing homes, while more severe cases were hospitalized. Thus, In N1 nursing home (managed by the MLSA) of 175 residents aged 60 and above, 34 were confirmed COVID-19 positive, while others had symptoms, but the virus was not confirmed by tests. Only two of the infected residents were hospitalized, while others received care in the nursing home.

The isolation was not easy to organize in every nursing home because of the lack of suitable conditions. For example, in Gyumri nursing home, the isolation rooms have no toilets.

Furthermore, the nursing homes that usually keep long waiting lists (as they provide services to their residents for a lifetime and turnover is not very high), completely stopped enrollment during this period.

> *"Another problem was linked to the absence of an epidemiologist and a need to sign separate contracts with outsider epidemiologists to consult at the nursing homes"* – explains the nursing house manager.

Reduced ties with families and community were among the hardest of aspects to bear, which was only partly compensated for by on-line psychological support that intensified after the COVID-19 outbreak.

While before the pandemic residents were able to go out during the day or even visit their families for a period of up to three months, after the COVID-19 outbreak it was not possible. Visits and parcels were banned. The residents had to wear masks inside the building and keep social distance. All meals were served inside their rooms instead of in canteens. All social and entertainment events were forbidden. Most restrictions are still in effect.

For the residents it was hard to adapt to the new rules.

In this situation, a crucial role was played by the psychologists and social workers, who organized individual and small group meetings with the residents in order to deal with stress and overcome the situation.

> *"All this time being inside the same building without visitors, social events and with fear of the virus is hard for many older residents to overcome"* – says a caretaker.

Nursing homes personnel were stressed by both exposure to the infection and hard emergency working conditions.

A special working regime was defined for the caring personnel. One shift was from 7 to 14 days during which the staff had to live and serve in the residential homes. Personnel were tested before and after their shifts.

Stress related to exposure to COVID-19 positive cases (and risks of self-infection and then infecting their own family and associated people) combined to increase personal, family, social and health difficulties.

> *"It was hard for many to bear the increased volume of work under emergency circumstances, especially on the background of stress we have at home"* – says a nursing home nurse.

4.7 COVID-19 preparedness and behavior

Older people have enjoyed good access to information and protection since the COVID-19 outbreak, which to a large extent was a result of awareness-raising by NGOs.

While the state response was mainly focused on control measures, the NGOs were actively engaged in prevention through awareness-raising activities among older people related to COVID-19 risks and restriction, safety measures, rights and entitlement, etc.

90.3% of participants of the survey reported excellent or good access to the information on protection during COVID-19, and 95% to the information on care provision during COVID-19. 82% of respondents had good or excellent access to the information and instructions on COVID-19. The received information was extremely or very useful for 88% of respondents. 80% of respondents had good or excellent access to the personal protective equipment.

The majority of older people see the virus as either dangerous or very dangerous, although more disciplined adherence to restrictions was registered among those in a high-risk group.

3.9% of the respondents do not see the virus dangerous for them at all. For 5.2% it's not very dangerous, for 19.8% it's rather dangerous and for 71.1% it's very dangerous. Older people with chronic diseases and no obvious diseases rated COVID-19 more dangerous than those with disabilities.

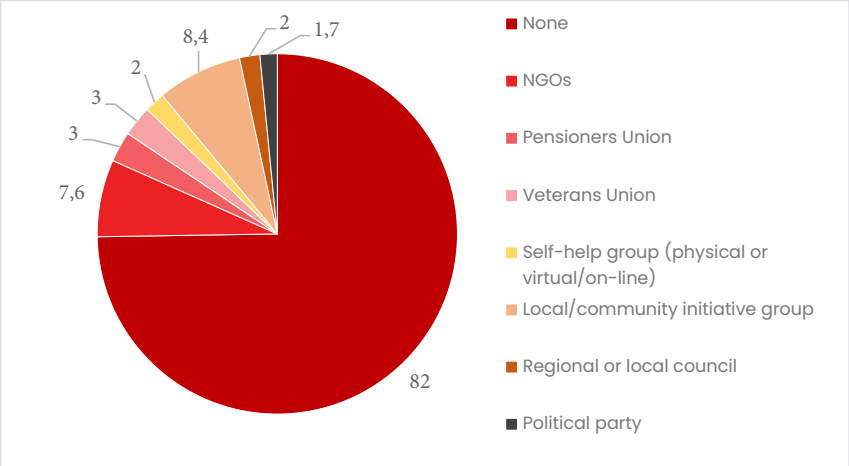
Only 1.7% of the respondents never follow the instructions and restrictions regarding COVID-19. 10.3% rarely follow, 19.8% often and 68.3% always. At the same time, the ones with no obvious illnesses follow the instructions more closely than others.

4.8 Civic activism

From half of the respondents interested in politics one quarter feel that COVID-19 limits their civil and political activism.

Almost half of the respondents (49.8%) are not interested at all in politics, 16.8% are not very interested, 15.3% are rather interested and 18.1% are very interested. At the same time, the survey registered a low level of respondents who are members of some civil activism groups or organization.

Chart 1. Respondents membership in organizations



Access to civil activism possibilities and political rights has decreased for 20% of respondents, because of the COVID-19 restrictions and fear of infection. During the strict regime gatherings in groups of five and more were forbidden and older people's mobility was very limited. After the strict restrictions were lifted, some became active again in their communities.

> *"Our initiative group was formed with the Red Cross support and became very active in the community. When the pandemic broke out we decided to sew and distribute masks among older people in our village"* – says an older woman.

5 Recommendations

Based on the findings and conclusions presented in this report, the following recommendations can be made to key stakeholders and the ARCS in Armenia:

State

SHORT-TERM

- Consider adjusting procedures of receiving state guaranteed free-of-charge daycare, home-based care and care in residential institutions more sensitive to the current COVID-19 circumstances, in order to enable admission of older people in need of care.
- Provide adequate guidance and support system to local governments in the area of conducting needs assessment and organization of decentralized care service provision to older people.
- Define long-term vision for residential care in Armenia and its positioning vis-à-vis home-based care.
- Conduct research on ageing and needs (including related to mental health) for care services in the support of evidence-based policy advocacy.

LONG-TERM

- In order to expand coverage by home-based care services and to ensure access to integrated home-based care services throughout the regions and Yerevan, further advance instruments of partnership between public organizations and non-governmental service providers, including the ARCS (which already has an auxiliary role to the state and is advancing the professionalization of home-based care through the network of its regional branches).
- Further maintain the dialogue with multiple stakeholders, including NGOs, and extend it to professional community, local governments and service providers, on advancing the concepts of healthy active ageing and community-based and integrated care for older people in Armenia (including meeting older people's mental health needs), as well as on de-institutionalization of care, and delineation of responsibilities for care between different levels of government and public bodies.
- Develop further strategies and programs on integrated care for older people based on cutting-edge knowledge in geriatrics and care management.

State education and training institutions

LONG-TERM

- Systematically integrate geriatrics into education and training programs for care professionals. Ensure that care is integrated properly into professional education and training of caregivers.

Local governments

SHORT-TERM

- Building on existing positive experiences, make functional the mechanisms for coordinating compilation of a database of vulnerable and older people in need and provision of efficient response (various types of assistance and care-related support) during COVID-19 and beyond.

LONG-TERM

- Develop a program for integrated care provision (home-based care and residential care) to older people co-funded from local budgets with the involvement of non-governmental service providers to expand coverage of those in need of care, especially in rural areas, using the community-based approach.

NGOs and ARCS

SHORT-TERM

- Joint efforts in promoting coordination arrangements to support older people as a response to COVID-19 in particular and to emergency situations in general.
- While the government is focusing more on COVID-19 control measures, put emphasis on prevention and social support to older people (including meeting their mental health and psycho-social support needs), COVID-19 prevention and risk management communication. This needs to be done with proper consideration of communication preferences of older people and the existing digital divide.
- Ensure that focus on COVID-19 prevention and action does not interrupt provision of training and other support to caregivers related to care.
- Work on digital inclusion of older persons through education, including through their support by younger people and provision of access to technical means.

LONG-TERM

- Engage more actively in joint advocacy and policy dialogue with the state on the rights, entitlements and integrated care provision of older people.
- Work on raising awareness among older people on their rights, entitlements, including integrated care provision.
- Work on raising awareness of local governments about possible partnership arrangements in securing provision of integrated care to older people.
- Support media campaigns to increase society awareness of issues related to ageing, promote the concept of healthy active ageing, mental health, address and reduce ageism and promote inter-generational solidarity.
- Develop sensitive strategies to work on preventing violence against older people, including awareness-building and development of a referral and support systems.

ARCS

SHORT-TERM

- Ensure further psycho-social support to caregivers.
- Advance work in the area of risks communication, in order to improve older people's knowledge, awareness and discipline related to COVID-19 risk management.
- Use the experience of the IFRC as a global leader in implementing Cash and Vouchers Assistance and build internal capacity of the ARCS to implement it as an efficient instrument to deliver tangible monetary support in emergency situations.
- Experiment further and introduce innovative approaches to promote community support groups and inter-generational solidarity schemes that can engage in social activities and compensate for older people's isolation and fear, as well as focus on decreasing the digital divide. Special creative approaches might be required for urban areas, where the problem of social isolation among older people is more pronounced and social ties are traditionally less developed. They can also include livelihoods improvement and small income generation schemes.
- Support the nursing home in Gyumri in quickly assessing and upgrading its facilities to meet the challenge of managing the situation during the pandemic with respect to older residents' rights, dignity and a need to socialize (use of space, sanitary facilities, common areas, etc.).

LONG-TERM

- Following the existing pilot experiences, expand the ARCS role in self-mobilization of older people and mobilization of communities to support them (thus investing in community resilience and ability to respond in times of emergencies/ crises).
- Enter dialogue with relevant stakeholders on positioning of residential care vis-à-vis home-based care.
- Use the opportunity to support the nursing home in Gyumri for advocating for conceptual ideas for residential care in Armenia, and demonstrating professional standards in the framework of this concept.
- Ensure robust system of support to caregivers (both staff and RC volunteers) involved in care provision to older people.
- Develop capacities for community-based care for older people and systems in support of healthy and active aging during and beyond COVID-19.

Nursing homes

SHORT-TERM

- Invest in upgrading nursing homes facilities and system of preparedness for emergency situations like the current pandemic.
- Ensure proper communication (including risk communication) and psycho-social support to the nursing homes staff undergoing stress due to the lockdown at the nursing homes.

LONG-TERM

- Develop and introduce clear standards of care for nursing homes, including COVID-19 management protocol.

IFRC, AutRC and SRC and other International Organizations

Provide technical assistance to the GoA, NGOs, the ARCS and local governments in advancing the above-listed recommendations, more specifically by drawing on the support of:

SHORT-TERM

- The IFRC in enabling transfer of rich experience and expertise to Armenia from other members of the RC family, and further investing in organizational development of the ARCS.
- The AutRC in positioning residential care in Armenia and demonstrating good residential care standards.

LONG-TERM

- The SRC and its regional home care exchange networks for advancing understanding of integrated care, home-based care standards and professionalization of home-based care provision.
- The UNFPA Country Office in Armenia in advancing important national level policy agendas related to healthy and active ageing and care for older people through evidence-based advocacy and stakeholders' dialogue (using the leverage of UN and with reference to the GoA's international commitments).

A participatory approach and involvement of older people will be an important underlying principle in the implementation of the above listed recommendations.

Table of Abbreviations

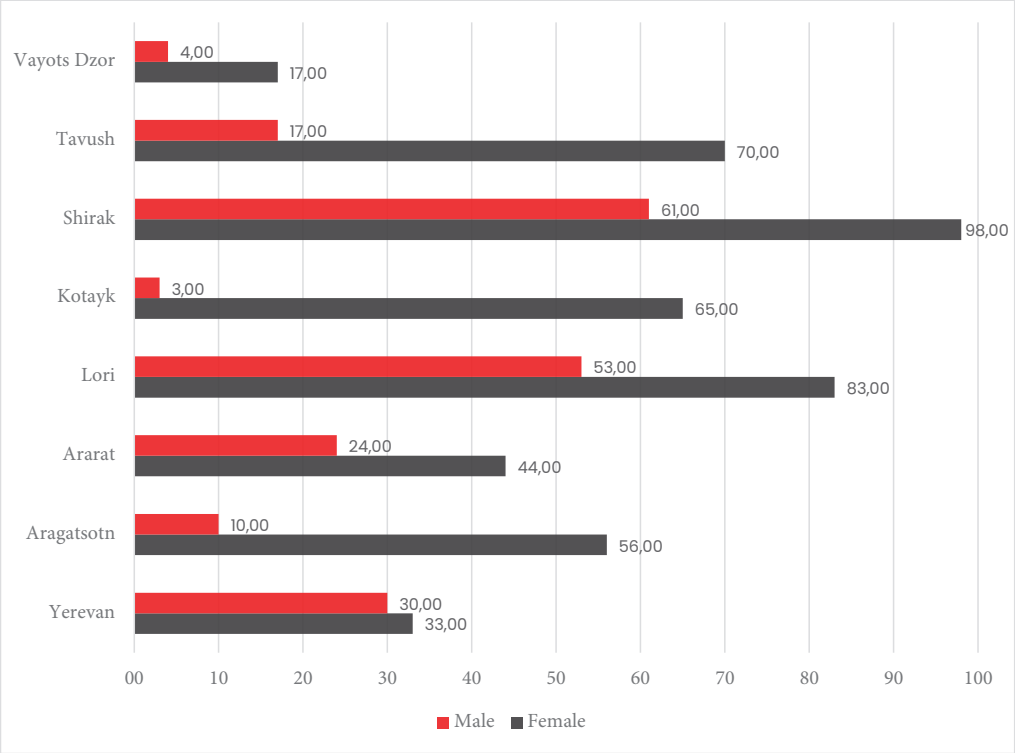
ARCS	Armenian Red Cross Society
CoE	Council of Europe
COVID	Corona Virus Disease
FGD	Focus Group Discussions
GoA	Government of Armenia
ICT	Information Communication Technology
IFRC	International Federation of Red Cross
MIPAA	Madrid International Plan of Action on Ageing
MoH	Ministry of Health
MLSA	Ministry of Labor and Social Affairs
NGO	Non-governmental Organization
SDGs	Sustainable Development Goals
UNFPA	United Nations Population Fund
WHO	World Health Organization

Annex 1. Respondents' Profile

Older people profile

In total 668 older people (466-female, 202-male) were involved in the survey. The older people respondents were from 7 regions of Armenia and capital Yerevan.

Graphic 16. The structure of respondents by regions (percentage)



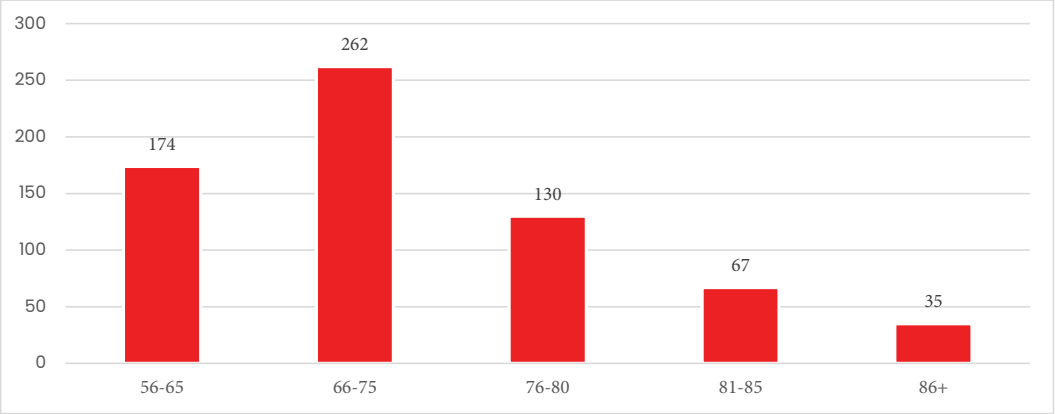
Amongst the older respondents, 617 had already accessed ARCS services and 51 had not.

Of the older respondents – 67.2% are living in urban areas and 32.8% are living in rural areas of Armenia.

Among the survey participants, 40.1% of older people have a chronic illness; 38.6% have a disability and 21.3% have no obvious disease.

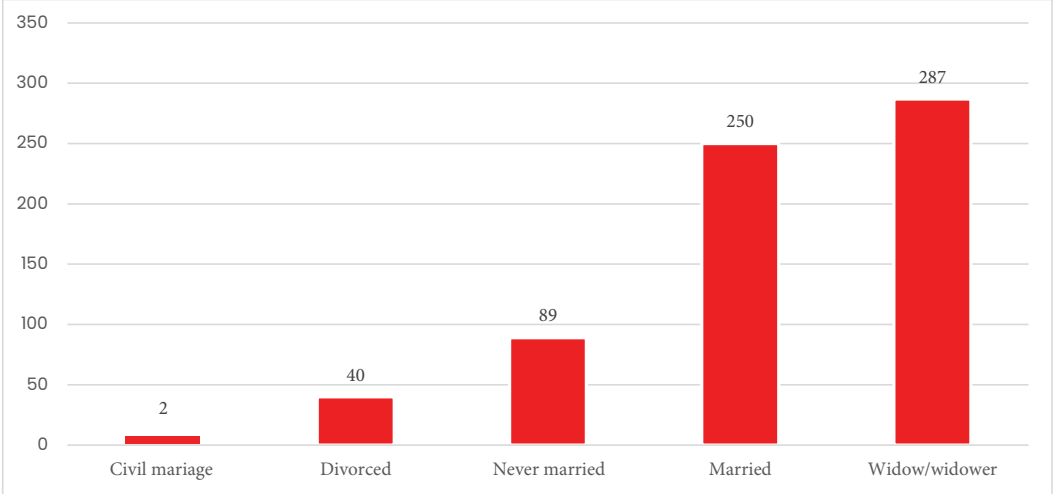
Age of participants varies from 56 to 93.

Graphic 17. Age distribution of respondents



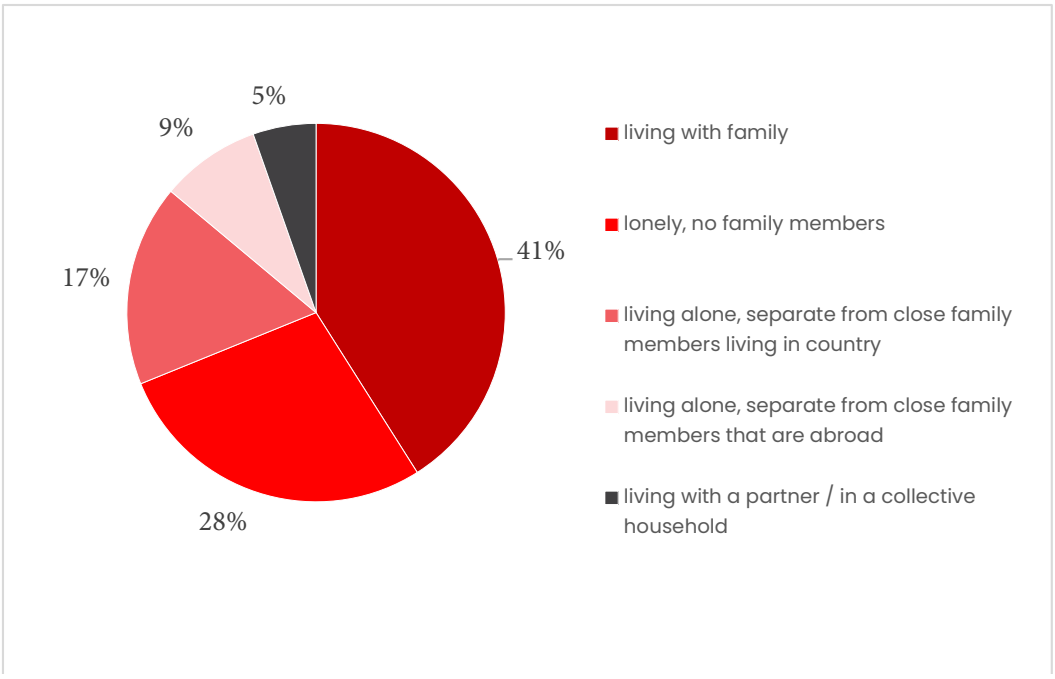
The civic status of the respondents is as follows: widow/widower – 43%; married – 37.4%; never married – 13.3%; divorced – 6%; civil marriage – 0.3%.

Graphic 18. Family situation of respondents



Among participants of the survey the majority 41% live with their family, 27.8 % live alone, they don't have family members, 17.2% live alone, but separate from close family members living in the country, 8.5% live alone, separate from close family members that are abroad, and only 5.4% live in collective households.

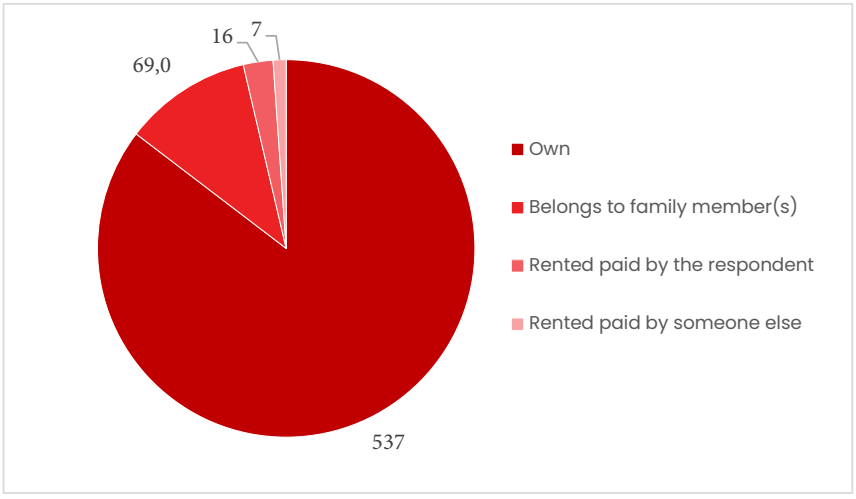
Chart 2. Living situation of respondents



Most of the participants are living in their own property – 84.4%; 11% of the participants are living in a property which belongs to family members, 2.5% of the respondents are renting property and paying for them and 1.1% are renting a property but someone else is paying.

54.6 % of participants live in houses, 39.5% live in apartments, 5.4% live in carriage houses and 0.4% in commune houses.

Chart 3. Respondents' property status



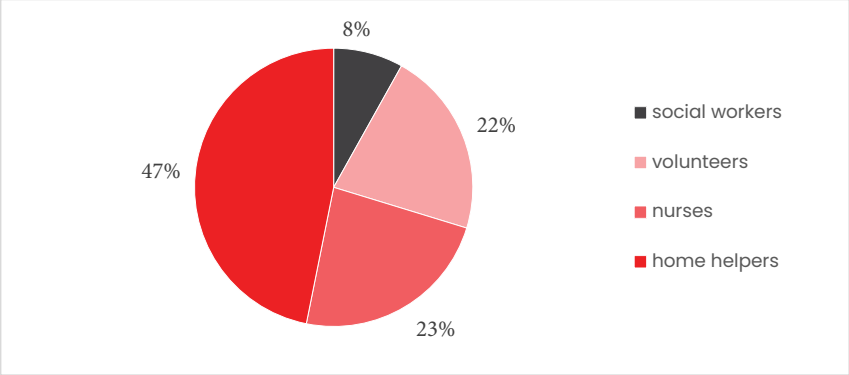
Caregivers profile

In total 54 caregivers (49-female, 5-male) were involved in the survey. The ARCS provides services through three categories of caregivers:

- Professional nurses, responsible for medical actions, like injections, blood pressure measurement, wound treatment etc., following prescription of a polyclinic doctor;
- Home helpers who provide household services for people, help them with cooking, personal hygiene, house cleaning, etc.
- Trained Volunteers helping with small household services, make purchases, make various payments on behalf of the people, or socialize with them.

The caregivers were from 3 regions (Lori, Shirak, Vayots Dzor) of Armenia where the ARCS provides home-based care services. The caregivers are nurses, home helpers and volunteers. Amongst respondents 12 were Volunteers, 3- social worker, 26 home helpers and 13 nurses.

Chart 4. Distribution of caregivers from RC by profession



Ages of caregivers ranged from 17 to 60, with 49 females and 5 males.

For 87% of the respondents ARC is the only place of employment, and for 13%- not.

5.6% of the respondents have been working more than 5 years in RC, 40.7% up to 5 years and 53.7% up to 1 year.

As for the civic status, 55% of caregivers are officially married, 25.9% never married, 9.3% are divorced, 7.4% are in civil marriage an another 7.4% are widow/ widower.

According to 96.3% of the respondents they are not in the risk group of chronic diseases, high blood pressure, diabetes etc., while 3.7% are in the risk group.

Annex 2. Questionnaire Structure: Older People

Introduction

Information about the respondent and living situation
Country. Region. Urban or rural area
Benefiting or not from ARCS
Age
Sex
Family situation and number of living children
Living situation

Economic Situation
Sources of income
Access to extra financial and/or in-kind support
Ability to cover expenses

Health situation
Presence of illness or disability
Health and healthy lifestyle assessment

Social situation
Social situation assessment
Information access
Experience with ageism, violence and abuse

Services and infrastructure
Access to health services and infrastructure
Access to social services and infrastructure
Access to other public services and infrastructure

Home-besed care
Access to home-based care services
Home-based care services assessment

Civil activism and access to political rights
Interest in civic activism
Membership in organizations
Access to political rights

COVID preparedness and behavior
Access to information
Access to protection means
Perception of risk behavior

Annex 3. Questionnaire Structure: Caregivers

Introduction

Basic information
Category of caregivers
Age
Sex
Family situation
Place of employment and experience
Working in rural or urban areas
Number and type of clients

Personal situation
Economic situation
Social situation
Health situation

Ability to provide care
Access to clients
Access to care means

Organization of care
Assessment of different aspects of care management
Key problems of care organization

Situation and needs of clients
Key problems of clients
Priority support clients need

Annex 4. Key International Frameworks and Concepts

UN 18 Principles for Older Persons adopted by General Assembly resolution 46/91 of 16 December 1991[34] promotes elderly independence, participation, care, self-fulfillment and dignity.

Madrid International Plan of Action on Ageing (MIPAA)[35] signed by the GoA in 2002 promotes: mainstreaming ageing; integration and participation; economic growth; social security; labor markets; lifelong learning; quality of life; independent living and health; gender equality; support to families providing care; regional co-operation.

MIPAA's Regional Implementation Strategy[36] provide a roadmap for responding to opportunities and challenges of population ageing and promoting the development of a society for all ages.

Vienna Ministerial Declaration adopted by the GoA in 2012.[37] Its policy goals are: a longer working life is encouraged and the ability to work is maintained; participation, non-discrimination and social inclusion of older persons are promoted; dignity, health and independence in old age are promoted and safeguarded; inter-generational solidarity is maintained and enhanced.

WHO Global Strategy[38] and Action Plan[39] on ageing and health elaborated in 2017 in line with the Sustainable Development Goals (SDG), make a commitment to: action on healthy ageing in every country; developing age-friendly environments; aligning health systems to the needs of older populations; developing sustainable and equitable systems for providing long-term care (home, communities and institutions); improving measurement, monitoring and research on healthy ageing.

Lisbon Ministerial Declaration 2022[40] "A Sustainable Society for All Ages: Realizing the potential of living longer", adopted in 2017 after the third review cycle (2012-2017) of MIPAA/ Regional Implementation Strategy, promotes: recognizing the potential of older persons; encouraging a longer working life and ability to work; ensuring ageing with dignity.

CoE Recommendation 2014 on the promotion of human rights of older persons[41] calls for promoting, protecting and ensuring the full and equal enjoyment of all human rights and fundamental freedoms by all older persons, and respect for their inherent dignity.

CoE 2017 Resolution 2168 on Human rights of older persons and their comprehensive care[42] calls for protection of the rights of older people, measures to combat ageism, improvement of care for older persons and prevention of their social exclusion.

[34] United Nations Principles for Older Persons, resolution 46/91, UN 1991 https://www.ohchr.org/en/professionalinterest/pages/olderpersons.aspx
[35] Madrid International Plan of Action on Ageing, UN 2002 https://www.un.org/en/events/pastevents/pdfs/Madrid_plan.pdf
[36] Regional Implementation Strategy for Madrid International Plan of Action on Ageing, UN 2002 https://www.un.org/esa/socdev/documents/ageing/unece-ris.pdf
[37] Vienna Ministerial Declaration, UN 2012 https://www.unece.org/fileadmin/DAM/pau/age/Ministerial_Conference_Vienna/Documents/ECE.AC.30-2012-3.pdf
[38] WHO's policy framework on active ageing, 2002 https://apps.who.int/iris/bitstream/handle/10665/67215/WHO_NMH_?sequence=1
[39] Global strategy and action plan on ageing and health, WHO 2017 https://www.who.int/ageing/WHO-GSAP-2017.pdf?ua=1
[40] Ministerial Declaration "A Sustainable Society for All Ages: Realizing the potential of living longer", Lisbon 2017 http://www.unece.org/fileadmin/DAM/pau/age/Ministerial_Conference_Lisbon/Declaration/2017_Lisbon_Ministerial_Declaration.pdf
[41] Recommendation CM/Rec(2014)2 on the promotion of human rights of older persons, COE, 2014 https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805c649f
[42] UResolution 2168 on Human rights of older persons and their comprehensive care, COE 2017 https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=23768&lang=en

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