COVID-19 and older persons: Reflections on human rights, ageism, isolation, dementia care, and gender

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Abstract. COVID-19 resulted in a series of tribulations for older persons that ranged from adverse health and wellbeing effects to economic setbacks. The challenge was to not only protect older persons and ensure that essential services meet their needs but also to account for the diversity of this population group, recognise their capacities and harness their experiences to maximise the preparedness for and minimise the impact of emergencies. COVID-19 did not only take a destructive toll on the lives of many older people but also exposed the hegemony of ageist stereotypes and prejudice. There have been many reports of older persons being victims of discriminatory practices in access to health services and other critical resources in several countries, especially in residential long-term care facilities. The pandemic also showcased disparate impacts on societies' most vulnerable populations in terms of loneliness and isolation, especially persons living with Alzheimer disease and other dementias. At the same time, the COVID-19 pandemic is not devoid of gendered trends. One augurs that governments engage in four key priorities for action: (i) ensure that difficult health-care decisions affecting older people are guided by a commitment to dignity, (ii) strengthen social inclusion and solidarity during physical distancing, (iii) integrate a focus on older persons into the socio-economic and humanitarian response to COVID-19, and (iv), expand participation by older persons, share good practices, knowledge and data.

Keywords: COVID-19, ageing, human rights, ageism, loneliness, Malta.

Introduction

I first heard of an outbreak of a 'strong virus' on mainland China as soon as I landed back in Malta following a training programme in gerontology, geriatrics and dementia care in the Chinese Guangdong and Hainan provinces on 24 December 2019. A month later, I was in Frankfurt as a Visiting Professor at the Goethe University, and although news of this 'strong

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virus' was gaining traction, the consensus was that it is something not to worry about. Suffice to say that in February 2020 I was still working on organising a board meeting in Malta for six board members from five different continents. Of course, the rest is history and the travails of the COVID-19 pandemic has been documented in various articles and books (Kumar Koley & Dhole, 2020; Riegelman, 2020).

The Maltese nation - like other European small island states Cyprus and Iceland - was one of the last European countries to identify cases of Covid-19 on its soil. This occurred on 7 March 2020 as transmission occurred via residents who contracted the virus while abroad in Italy. Baldacchino (2020) captured the initial COVID-19 experience in Malta very vividly:

> All schools were locked down on March 12. All public servants, university lecturers (including this author) and anyone else who can, is now working 'from home'. All non-essential public gatherings, church functions and sport events are cancelled. Passenger flights in and out of the country are suspended. Construction and manufacturing operations, as well as the sizeable financial services and electronic gaming sectors, remain in full swing. But bars, restaurants, stationers, hairdressers, salons, etc. are closed - and the outcome of missed visits to coiffeurs is now in plain sight. Supermarkets, convenience stores and pharmacies are exempt and have even extended opening times. All businesses are encouraged to consider switching their operations online and to offer delivery services. Those individuals who are caught breaking quarantine are fined 3000 euros for every transgression. Social distancing is encouraged throughout. It has never felt so vital to wash one's hands, thoroughly and frequently. The country, one of the world's most densely populated, is strangely quiet. Traffic has eased. The level of air pollution has already gone down by 50% over the last month. Many public spaces are deserted. (Baldacchino, 2020, p. 322)

Some days after the first registered case in Malta, the World Health Organization (WHO) (2020) declared the viral infection a pandemic and as at mid-April 2021 some 2.9 million deaths were reported to be COVID-19 related (The Visual and Data Journalism Team, 2021). The search for a vaccine that would at least control the symptoms and decrease the rates of mortality, if not making one immune to COVID-19, started immediately. As of May 2021, as much as twelve vaccines were authorised by at least one national regulatory authority for public use, and despite some degree of scepticism towards either vaccination in general or towards a specific vaccine, as at 7 April 2021 about 704 million persons have been vaccinated across the globe (Statista, 2021). However, we have far from seen the end of the COVID-19 pandemic since the world continues to battle a rising tide of infections.

COVID-19 put many things to rest, and battered many a socio-economic realm. However, its most devastating impact was certainly on older persons. In a recent editorial, Meeks (2021) pointed out the myriad implications that the pandemic is having and will continue to have on the lives of older people and ageing in general:

> With the recognition that older people may be at higher risk for infection and mortality related to the virus, we have seen international media, social media, and public health

> officials framing "the elderly" as a homogeneous and vulnerable group, seemingly conflating physical vulnerabilities common in later life with chronological age. The pandemic has even led to hate speech in the form of monikers such as "Boomer Remover" that could promote generational conflict. (Meeks, 2021, p. 1)

The profound impact that the pandemic had on the subjective lives of older persons resulted - to use Whitehead and Torossian's (2021, p. 36) words - a "perfect storm" of stress reactivity as it combined with "pre-existing isolation, mobility limitations, financial vulnerability, or elevated heath risk" to magnify an already vulnerable phase of the life course. A mixed-method analysis concluded that the sources of stress and challenges for older adults in a time of the COVID-19 pandemic clustered around four avenues:

> (a) pandemic-related worry or anxiety, (b) pandemic-induced restrictions and resulting confinement and isolation, (c) pandemic-related changes in everyday life, (d) how others were responding to or reporting about the pandemic, and (e) overall well-being. These themes align with the features of COVID-19 expected to be stressful - uncertainty, isolation, economic volatility, and health vulnerability…but also highlight additional aspects experienced as stressful by older adults…(Whitehead and Torossian, 2021, p. 44)

Likewise, Morrow-Howell, Galicia and Swinford (2020) highlighted the series of challenges that have arisen for older persons in the wake of the COVID-19 pandemic. These include economic setbacks (older adults will have a harder time re-entering the workforce and may have lost retirement savings), adverse health and wellbeing effects (older adults have experienced disruption in usual services, lasting emotional effects from increased isolation and anxiety, and those who have contracted the coronavirus may have increased health vulnerabilities), and more than anything else, ageism. Such trends not only lead one to a debate whether older persons were negated their basic human rights during the COVID-19 pandemic, but also how older persons coped with such draconian measures and were so much resilient during a time of extreme socio-economic hardship.

Human rights

The COVID-19 pandemic highlighted how disaster risk reduction and preparedness plans were far from 'age-friendly and inclusive'. Consequently, the challenge was to not only protect older persons and ensure that essential services provide for their needs but "also to account for the diversity of this population group, recognize their capacities and harness their experiences to maximize the preparedness for and minimize the impact of emergencies" (United Nations Economic Commission for Europe, 2020, p. 1). It is noteworthy, especially for gerontologists and geriatricians, that nearly nine out of ten COVID-19 related deaths reported in the wider European region have been among adults aged 65 years and older (United Nations Economic Commission for Europe, 2020). Mitigating such a state of affairs requires espousing the Office of the United Nations High Commissioner for Human Rights (2020) decree that "emergency measures must be necessary, proportionate and non-discriminatory"

on the basis that older persons have the same rights as others, that must be equally protected even during health emergencies and pandemics. As Age Platform argued,

> We all have equal rights, regardless of age. However, the COVID-19 pandemic might pose distinct threats to the equal enjoyment of human rights by older persons. We all have a shared responsibility to help contain the spread of COVID-19 and make sure that care is delivered to those who mostly need it. Solidarity between and within generations and societal cohesion is the best answer to the pandemic. (Age Platform, 2020, p. 1)

International reports also noted that vulnerable older persons experienced double and triple jeopardies. First, older persons in residential long-term care experienced higher levels of risk for adverse outcome and for infection due to living in close proximity to others and underlying comorbidities. According to the WHO (2021), nursing homes were linked to about half of all COVID-19-related deaths in Europe so that one now finds strict guidelines for coping with the pandemic in institutional settings. Nevertheless, one finds very limited debate on the post-COVID recovery period as one expects the rates of infection to plummet due to the vaccination programme. In this respect, the management of both private and non-governmental care homes in Malta voiced their concerns on a number of issues related to the pandemic's exit strategy - namely,

> (a) extra costs incurred towards COVID-19 measures, (b) the increased overtime costs as more care workers were needed for cleaning or to coordinate video calls between older persons and their relatives, (c) the extra costs towards adapting spaces into living quarters, providing laundry facilities, food, and transportation of health care workers, (d) the income for private service providers dropped as admissions and respite services had stopped, (e) active older persons within the care homes inquired when they would be able to go out again. (Fenech, Vella & Calleja, 2020, p. 27)

A second vulnerable category constitutes older persons who live alone, and hence, at higher risk of isolation and lack of access to necessary services during the pandemic. Indeed, older people who live alone do not always have family members nearby, to share information about the 'barrier gestures', to look after them in case of symptoms, and to call for help if needed. Women, who represent the lion's share of widowed persons, are extensively affected. A final vulnerable category refers to older persons who rely on care and assistance at home and in the community to cover daily tasks. As Age Platform noted,

> Day and respite care centers and other services in the community have been closed. In some cases, home support has been cancelled due to fears that allowing home care workers to visit the house will increase the risk of infection. Caregivers are sometimes reassigned to residential care. Migrant caregivers are stranded in their home countries due to lockdown restrictions, leaving the people they care for without help and themselves without work. Home care workers are also not reporting to work due to illness, family care duties or fear of infection. Likewise, some families chose not to provide formal care due to fear of infection. (Age Platform, 2020, p. 29)

Since even before the pandemic many social and health care services were already stretched to the limit and characterised by various failings, it followed that during the COVID-19 pandemic older persons and other people with disabilities tended to be left further unattended and non-serviced. It is augured that in their efforts to protect all citizen's human rights, governments take special measures to ensure that older persons are also protected from COVID-19 related social problems such as discrimination, prevention of abuse, exclusion from essential social and health care services, and special care for people in vulnerable situations such as those living in residential long-term care facilities, others living alone in the community, people receiving care in the community, older persons at the risk of digital exclusion, and those highly at risk of experiencing neglect and abuse.

Ageism

COVID-19 did not only take a destructive toll on the lives of many older people but has also exposed many ageist stereotypes and prejudice. During the pandemic, there have been many reports of discriminatory practices in access to health services and other critical resources, especially among older people living in residential long-term care facilities. In a recent global report on ageism, the WHO reported that

> COVID-19 has affected people of all ages, in different ways. But beyond the impacts of the virus itself, some of the narratives about different age groups have exposed a deep and older malady: ageism. Older people have been often seen as uniformly frail and vulnerable, while younger people have been portrayed as invincible, or as reckless and irresponsible. Stereotyping (how we think), prejudice (how we feel) and discrimination (how we act) based on age, are not new; COVID-19 has amplified these harmful attitudes. (WHO, 2021, p. ix)

Indeed, who has not come across of newspaper columns reporting how scarce resources, such as ventilators or access to intensive care units, have been allocated according to chronological age? This is ultimately unethical and ageist "given that chronological age is only moderately correlated with biological age or short-term prognosis, and that older people have been most affected in terms of severe outcomes in this pandemic" (WHO, 2021, p. 24). It is also extremely perturbing to read that chronological age has been consistently determined to underpin physical isolation measures in many countries. For example, while in the United Kingdom adults aged 70 and older were initially instructed to self-isolate for four months (Paton, 2020), in Bosnia and Herzegovina older adults were not allowed to leave their homes for several weeks during the outbreak (Cerimovic, Wurth & Brown, 2020). Many countries, such as Colombia and Serbia, targeted their lockdown measures solely to pensioners (So et al., 2020; Jackson, 2020). Even, strategies for lifting lockdown measures were based on chronological age. In several cities in the United Arab Emirates, it was disconcerting to read that many people aged 60-plus were not allowed to enter shopping malls or restaurants once they reopened following the end of lockdown measures. Likewise, in the Philippines older people were not allowed to take Metro Manila's four railway systems once these resumed operations with the lifting of community confinement (Subingsubing, 2020). For Ehni and Wahl (2020),

the fact that the risk of developing severe illness from COVID-19 and dying from it increases with age, has led to

> …numerous highly problematic policy suggestions and comments revealing underlying ageist attitudes and promoting age discrimination. Such attitudes are based on negative stereotypes on the health and functioning of older adults. As a result, the lives of older people are disvalued, including in possible triage situations and in the potential limitation of some measures against the spread of the pandemic to older adults. These outcomes are unjustified and unethical. We develop six propositions against the ageism underlying these suggestions to spur a more adequate response to the current pandemic in which the needs and dignity of older people are respected. (Ehni & Wahl, 2020, p. 1)

Fraser and colleagues (2020) noted how ageism reached unprecedented levels during the early days of COVID with the hashtag #BoomerRemover, a vulgar concept that highlighted two prevalent ageist attitudes in the pandemic response. These attitudes included

> [1] Older adults are 'sitting ducks', vulnerable and helpless against COVID-19. High mortality rates amongst older adults are considered an 'inevitable' and 'normal' outcome of this pandemic. [2] Healthy younger adults may perceive themselves as invulnerable to COVID-19 and, as a result, may not realise the importance of following public health advice and policies on infection prevention. (Fraser et al., 2020, p. 694)

Looking back, there is no doubt that the COVID-19 pandemic manifested a suspected surge of ageism, while enforcing critical health and safety behaviour modifications for people of all ages but especially persons aged 60 years and older (Vale et al., 2020). While on one hand older adults are a high-risk group, and it was understandable that maintaining their safety was paramount during the pandemic, on the other hand policy initiatives also purported a view of older adults as weak (Ayalon et al., 2020). During the COVID-19 pandemic, the world experienced an exacerbation of ageism whereby the use of chronological age was taken as an unjustified threshold for the creation of public policies to control the spreading of the virus, with Previtali (2020, p. 507) and colleagues concluding that in "doing so reinforces intrapersonal and interpersonal negative age stereotypes and violates older persons' human rights to autonomy, proper care treatment, work, and equality".

Social isolation

Notwithstanding that prior to COVID-19, social isolation - that is, the state of having minimum social contacts and lacking a sense of belonging - in later life was a major public health issue gaining international recognition as being detrimental to quality of life, the pandemic has showcased disparate impacts on societies' most vulnerable populations in terms of loneliness and isolation. The negative impacts of such experiences on physical and mental health have been incessantly acknowledged in research studies, with some scholars as far as to state that loneliness can be comparable to physical malnutrition (Berg-Weger & Morley, 2020). There are multiple factors that can cause loneliness in later life, ranging from frailty to illiteracy to a diagnosis of dementia, with widowhood being certainly amongst the

primary triggering indicators for both men and women. Smith and colleagues (2020) argued that COVID-19 brought a 'social connectivity paradox' as a common set of actions simultaneously protected and harmed older adults:

> …as the level of an older adult's physical interactions with others increases, it can protect against social isolation and disconnectedness, although it can increase the risk of COVID-19 exposure. Conversely, as the level of an older adult's physical interactions with others decreases, it can increase risk for social isolation and disconnectedness, although it can protect against risk of COVID-19 exposure. (Smith, Steinman & Casey, 2020, p.3)

Older residents in care homes and long-term care facilities are certainly at most risk of isolation in later life. Despite not referring to the 'social connectivity paradox', Marshall and colleagues' (2021) study on care homes in England elicited very clearly the challenges that managers of residential long-term care facilities experienced during the first wave of the pandemic:

> One manager spoke of her devastation at accepting a previously unknown resident as a new admission to the home, only for the virus to spread through the home with the loss of 7 residents and 1 member of staff to COVID-19: "I blame myself for every death. I didn't turn them away. A 96 years old in the back of the ambulance at 11pm at night. They knew we had a bed. But we only had a bed in the green zone. I could only use the green zone. Two days later their test came back positive. Too late then". (Marshall et al., 2021, p. 4)

Indeed, the prevalence of severe loneliness among older persons in residential care settings is at least double that of community-dwelling populations, as much as 22% to 42%, sometimes even reaching 50%, for such a population compared with 10% for older persons dwelling in the community (Victor 2012). More recently, a study in Malaysian nursing homes using the UCLA loneliness scale even found that all residents felt lonely, 25% moderately and 75% severely (Aung et al., 2020). At the same time, one cannot but be sceptical at the often-heard claim that following COVID-19 'we are all online now'. As it was recently noted,

> Since the very beginning of the lockdown, the gap between those with good and *available* internet connection, and between those owning electronic devices and others lacking such tools (which have suddenly become *essential* goods), was apparent. As COVID-19 spurred many more people to use the internet in new ways compared to before the outbreak, it has also further exposed and deepened the divide between the digital haves and have nots. (Formosa, in press [a])

In fact, many older persons have noted their frustration in failing to communicate online as they had difficulties staying connected at all times, either because their internet was unreliable or slow, or due to outmoded computers (Formosa, in press [b]). Some also had sudden malfunctions in their computer, and due to the COVID-19 health emergency situation, it was

not possible to get it fixed as quickly as they wished. This meant that even when online communication triumphs, older persons can suddenly find themselves cut off due to technological hiccups, that may take weeks to be resolved without a solution in sight. One must therefore heed the advice of Ipsos MORI & The Centre for Ageing Better (2020) for good practice for quality digital competency in later life: (i) making provisions for older persons who are not online by ensuring that in the event of future lockdowns one finds ways of directly contacting those individuals who are not able to leave their home; (ii) ensuring that technology is accessible so that hardware and software can be used by as many people as possible, regardless of environment, device being used, age, social class, gender, digital competence and/or cultural background; and (iii), providing equipment and internet access by working to expand access to broadband, data packages, and to computer and ICT packages, in particular for individuals and families on low incomes who are most likely to be digitally excluded.

Dementia

The COVID-19 pandemic had, and is still having, a unique impact on people living with Alzheimer disease and other dementias. People living with dementia are at high risk of infection because cognitive symptoms cause difficulty with following safeguarding procedures and living arrangements in care homes tend to facilitate viral spread (Canevelli, Bruno & Cesari, 2020). Once infected older adults living with dementia are more likely to experience severe virus-related outcomes, including death, than are people without dementia. However, as research into this impact has accumulated throughout the past 13 months, the resulting consensus is that this population is particularly susceptible not only to SARS- CoV-2 infection and its effects, but also to the negative effects of the measures taken worldwide to control the spread of the virus. Indeed, older adults living with dementia, but especially those in care homes, are at high risk of worsening psychiatric symptoms and severe behavioural disturbances as a result of social isolation during the pandemic (Numbers & Brodaty, 2021). In Portugal for instance, most day-care centres were closed on March 16th for an undetermined period without specific guidelines or recommendations - thus, imposing persons living with dementia to stay at home without premeditated support care (Barros et al., 2020). The situation was the same in Malta. As reported by Farrugia,

> …dementia patients [sic] are the latest to have to miss out on crucial services because of decisions to move staff around to deal with shortages compounded by the spike in covid-19 cases. A specialised unit for patients with dementia that provided daily care to help them with their condition was shuttered a few weeks ago, leaving patients and their caregivers in the dark. Relatives who spoke to *Times of Malta* said the service provided at the centre was an essential part of the patients' well-being. Those who visited the centre lived in the community and so relied on the care they received there. "Why is it that other places have continued to operate normally but not this unit? Other places introduced measures to control the spread but kept going. "Dementia patients, as well as their families, need all the help and support they can get and stopping a service like this one could have dire consequences on their well-being" one relative said. The centre

> offers an activity programme for dementia patients who still live at home or with relatives. It also serves as a respite service for informal caregivers. (Farrugia, 2020 - online version)

This is extremely perturbing because several studies have shown that, where older adults living with dementia are concerned, psychiatric symptoms caused by social isolation are linked to more severe neuropsychiatric and behavioural disturbances:

> Social isolation combined with confusion in care home residents with dementia might result in even greater agitation, boredom and loneliness than in residents without dementia, thereby leading to more severe neuropsychiatric symptoms. These neuropsychiatric symptoms seem to arise directly from social restrictions, as longer lockdown periods result in more severe neuropsychiatric symptoms. Furthermore, some experts have suggested that behavioural complications that result from prolonged periods of lockdown in older adults with dementia could become chronic. Some consequences of neuropsychiatric disturbances, such as increased aggression and agitation, can be particularly challenging for carers and care home staff to manage. (Numbers & Brodaty, 2021, p. 69-70)

Another perturbing issue concerns statistics. Focusing again on Portugal, Barros and colleagues (2020) noted that as at 27 June 2020 nearly 86% of the total deaths from COVID-19 were in people aged 70 or more, and 40% of the total deaths were in nursing homes settings. Yet, it is unknown how many of these fatalities were persons living with dementia, and as the world is entering the post-emergency phase, it is urgent to determine the impact of COVID-19 on parameters that influence the disease's trajectory and quality of life of both persons living with dementia and carers. The situation in Malta is not so different as no statistical information was kept on the number of COVID-19 related deaths of older persons in residential long-term care and how many of such deaths were persons living with dementia. The *Times of Malta* was forthcoming on the failure of Maltese authorities on collecting a wide range of data on COVID-19 trends in Malta, and in an editorial noted:

> Information about new COVID-19 cases, recovered patients, deaths and swab tests is provided every day, but only as an infographic and with no historical context. The only central repository of data available is a spreadsheet hidden away on developer site Github, which is updated by dedicated staff at the Superintendence of Public Health. Contrast that to the wealth of information made available online by other EU member state governments. Even some of Europe's smaller countries seem to be able to provide more – and more useful – COVID-19 data than Malta does. (Times of Malta, 2021 - online version)

It is positive that many non-governmental and professional organisations released a number of expert recommendations and disseminated key messages on how to provide mental health and psychosocial support for persons living with dementia (Wang et al., 2020). Moreover, many multidisciplinary teams started counselling services free of charge for people living

with dementia and their carers to minimise the complex impact of both the COVID-19 outbreak and dementia care (Wang et al., 2020). It augured that governments and health authorities follow such advice and implement more complimentary social and health services so that the quality of life and wellbeing of persons continues to be safeguarded during the COVID-19 pandemic and even during the recovery period.

A note on gender

The COVID-19 pandemic is not devoid of gender trends. Women are on the frontline of pandemic since the majority of the planet's healthcare and social care workers are female (the WHO puts this figure at 70%) (Boniol et al., 2019). Moreover, considering that women perform over 75% of all of the world's unpaid work (International Labour Organization, 2018a), it was unsurprising that Matthewman and Huppatz (2020) comparative analysis of submitted articles for possible publication at the *Journal of Sociology* from March to May in 2019, with the same period in 2020, found a 12.5% increase for men and a 25% decrease for women:

> Women scholars have been unable to produce as much research as their male colleagues while caring for relatives with the virus and while schools and childcare centres have been closed…This has resulted in significant falls in their article authorship during the pandemic. It has been reported that there is up to a 50% drop in article submission by women authors in astrophysics and more than a 50% increase in submissions from men in political studies…(Matthewman & Huppatz, 2020, p. 678)

Moreover, women have experienced more job losses due to COVID than men since their jobs are in sectors such as tourism, hospitality, or retail which were affected extremely negatively by lockdown and social distance measures. As Crabb (2020) surmised, the Covid-19 economic downturn can be easily declared a 'pink recession' as more than half of those who have lost their jobs are women. Bringing age into the picture, Goujan and colleagues' (2020) study found that in Europe the number of diagnosed cases was higher among women below 55 years than among men in the age-group 55-80, although more COVID-19 related deaths were registered for men aged 60-plus compared to older women:

> In Italy and Belgium, men aged between 60 and 80 are respectively 1.5 and 1.4 more likely to be reported as positive as women…The higher number of cases for men could be linked to the fact that testing, especially in the early phases, of the pandemic was primarily performed on critical cases. Since elderly men face more serious consequences than women, they could, as a result, be more likely to be tested. For some other countries like Germany and Portugal, the male to female cases ratio is close to 1 around the 60-75 age groups. When related to the total population by age groups, the proportion of diagnosed with COVID-19 patients is higher among women under the age of 50…(Goujan et al., 2020, p. 5)

There are two key reasons for such gendered trends. On one hand, one finds higher rates of female health workers so that when outbreaks in residential care homes occurred there was a higher rate of spill over on infection towards women than men (Goujan et al., 2020). On the

other hand, the male disadvantage in COVID-19 fatality may derive from gender-based immunological differences or be associated with comorbidities, including hypertension, cardiovascular diseases and drinking alcohol more commonly observed among men (Goujan et al., 2020). Loneliness in times of COVID-19 also followed gendered lines. One study examined the interaction between age and gender in relation to loneliness during the pandemic and found that "women faced greater odds of loneliness than men, but only among the youngest adults, who were the age group at highest risk of loneliness, and among the oldest adults, who were the age group at lowest risk of loneliness" (Wickens et al., 2021, p. 107). This contrasted greatly the studies of gender over the lifespan conducted prior to the pandemic which generally found that boys and men had greater odds of loneliness (Maes et al., 2019). For Wickens and colleagues,

> It may be that younger women (more commonly single and never-married) and older women (more likely to be previously married or widowed) typically reach out to multiple others beyond their immediate family for social support, whereas middle-aged women typically rely on a spouse or common-law partner, who is still present throughout the pandemic and available to provide support. Thus, among younger and older women, physical distancing may have restricted access to their sources of social support, interfering with emotion-focused coping that would otherwise be a primary means to alleviate stressors associated with the pandemic. (Wickens et al., 2021, p. 107)

Looking at the post-COVID recover period, a study published by the European Parliament (2020) reported that women's economic empowerment will continue to be significantly affected for many months and years in the future due to the sector wide effects of COVID-19 interventions. Since the sectors of the economy which have been most significantly affected by lockdown measures are hospitality, recreation, tourism, and education/childcare are highly feminised, this risks significant unemployment for women, to the extent that the COVID-19 related recession has been dubbed as 'she-cession' (European Parliament, 2020).

Conclusion

The COVID-19 pandemic is causing untold fear and suffering for all people across the world, especially older persons. Although all age groups are at risk of contracting COVID-19, older persons are at a significantly higher risk of mortality and severe disease following infection, with those over 80 years old dying at five times the average rate (Clark et al., 2020). An estimated 66% of people aged 70 and over have at least one underlying condition, placing them at increased risk of severe impact from COVID-19 (Clark et al., 2020). At the same time, some older people face additional vulnerabilities. For instance, the spread of COVID-19 in care homes and institutions is taking a devastating toll on older people's lives, with distressing reports indicating instances of neglect or mistreatment, and community-dwelling older persons who are being quarantined or locked down with family members or caregivers may also face higher risks of violence, abuse, and neglect (United Nations, 2020). Finally, the virus is not just threatening the lives and safety of older persons, but is also threatening their social

networks, their access to health services, their jobs and their pensions. Indeed, those who normally receive care at home and in the community - such as women over 80 years of age who are more than twice as likely to live alone as men - risk being disproportionately affected by physical distancing measures. Prolonged periods of isolation could have a serious effect on the mental health of older persons, with older persons less likely to be digitally included. The income and unemployment impacts will also be considerable given that, at a global level, the share of older persons in the labour force has increased by almost 10% in the past three decades (International Labour Organization, 2018b). Looking back at the reflections put forward in this article, as well as the data reported herein, one augurs that governments engage in four key priorities for action as far as that interface between ageing and COVID-19 is concerned: (i) ensure that difficult health-care decisions affecting older people are guided by a commitment to dignity and the right to health, (ii) strengthen social inclusion and solidarity during physical distancing, (iii) integrate a focus on older persons into the socio-economic and humanitarian response to COVID-19, and (iv), expand participation by older persons, share good practices and harness knowledge and data (United Nations, 2020).

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