Impact of COVID-19 on long-term care for older persons in Kazakhstan

Rapid assessment pilot

UNECE, 2021
ACKNOWLEDGEMENTS

This report was prepared based on the two investigative pilot studies carried out respectively in Almaty and Nur-Sultan by the consultants Assiya Akanova and Bayan Akhmetzhanova. For the general overview part, Assiya Akanova also drafted sections on Social and medical services and the response to Covid-19 pandemic in the Republic of Kazakhstan. At UNECE, Lisa Warth prepared the methodological guidance for investigative studies and Maria Varlamova completed the draft on survey findings in Nur-Sultan, edited and finalised the report.
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I. General overview of ageing in Kazakhstan

The total population of Kazakhstan on 1 January 2021 amounted to 18.88 million people, 59% of whom were living in urban areas. According to demographic projections done by the United Nations Population Division in 2019, the population of the country will be growing in the next decades to reach 26.2 million in 2070. The total fertility rate is currently 2.8 and is predicted to fall below the simple reproduction level after 2055. The capital of Kazakhstan is Nur-Sultan, with a population of 1,184 thousand. The largest city in the country is Almaty, with a population of 1,977 thousand (see Figure 1 for age and sex composition).

Figure 1. Age and sex composition of the population, in Kazakhstan, Nur-Sultan and Almaty, 2020

Source: Demographic yearbook of Kazakhstan, 2020

Kazakhstan will experience an increase in the absolute and relative number of older people in the nearest future, or, in other words, demographic ageing. For example, the median age of 30.7 years in 2020 will increase up to 34.2 in 2050 and 37.7 in 2070.

According to statistical data, the average life expectancy at birth in Kazakhstan in 2019 was 73.2 years (68.8 for men, 77.3 for women), for the age 65 the remaining life expectancy in 2019 was 15.7 years (13.4 for men, 17.3 for women). There are 1.5 million people aged 65 and over, which constitutes 7.9% of the country population; in 2050, the number is expected to reach 3.4 million people and 14.1%, respectively, in 2070 – 4.1 million and 15.8%. The number of older adults will grow especially rapidly in the next ten years - by 4-5% on average per year. The age group 85+ will increase from 0.5% in 2020 to 2.5% in 2070.

Presently the statutory retirement age in Kazakhstan is 63 years for men and 60 years for women. The retirement age gap between men and women is planned to be closed by 2027 by annually raising the retirement age for women by six months. According to the official data, there were 2 million 81 thousand people after the retirement age, 11.0% of the country's total population at the beginning of 2021.

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1 https://stat.gov.kz/api/getFile/?docId=ESTAT334809
2 https://stat.gov.kz/api/getFile/?docId=ESTAT379486
3 https://stat.gov.kz/api/getFile/?docId=ESTAT357289
4 UNECE statistical database
5 Численность населения Республики Казахстан по полу и отдельным возрастным группам, 2021
There is a significant gender asymmetry among the retired persons in Kazakhstan: 1 million 425 thousand women (68.5%) compared to 656 thousand men (31.5%).\(^6\) One reason for this gender asymmetry is the high mortality of men, especially at the working age.

The average household size in Kazakhstan in 2020 was 3.4 people.\(^7\) 13% of households consist of 1 person (15.8% in the city and 7.9% in the rural areas).\(^8\) Multigenerational households respond to the preferences of the majority of the population - according to the 2020 survey "Assessment of the socio-economic situation and needs of older people in Kazakhstan"\(^9\), 49.3% of older people would prefer to live with their children, another 9% - with their grandchildren or other relatives.

**Financial situation, pension provision and employment**

The main mechanism for ensuring the income security of older people is pension provision. Today, Kazakhstan has a three-tier pension system. The first component (basic) is the state basic pension, introduced in 2005 as the main tool to prevent poverty and provide income for older people. Two payments represent the second component (mandatory): solidarity pension paid from the state budget and pension payments from the unified pension savings fund at the expense of employees' pension savings. The pension amount depends on the number of years worked since 1 January 1998, and the pre-retirement income level (the longer the length of service and the higher the income, the higher the amount of the solidarity pension).\(^10\) Finally, the third component - voluntary pension contributions underlie the personal responsibility of citizens for retirement benefits. The employment participation of older people is low: in 2019, persons aged 60 years and older accounted for 3.4% (310.6 thousand people) of the labour force, and only 0.6% (59.2 thousand people) were older than 65.

Self-employed persons, farmers and family members working in farms, and persons who do not receive formal income (unemployed, stay-at-home spouses, mothers with many children, volunteers in public organizations) have difficulties with pension savings. Women are at higher risks of poverty at older ages because of the care responsibilities, shorter working periods, and higher frequency of part-time employment. Employment rate by gender also differs in the older ages: in the group over 65 years old it was 10% for men and 5.6% for women.\(^11\)

In their responses to the 2020 socio-economic survey of older persons, about 6% of people aged 55+ stated that there was not enough money for necessities, 13% - that money is barely enough from pension to pension and another 13% that money is only enough for food. Almost every fifth senior citizen was in a difficult financial situation since it was impossible to pay for utilities and eat well, not to mention other expenses. Lonely older adults, according to the survey, have even fewer financial opportunities.\(^12\)

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\(^{6}\) https://stat.gov.kz/official/industry/61/statistic/5
\(^{7}\) https://data.egov.kz/api/v4/ui_sharuashlyktarynyn_ortasha2/v3?apiKey=yourApiKey
\(^{8}\) Unfortunately, no statistics on the structure of households depending on the age of the respondent could have been found.


General legal regulations related to ageing in Kazakhstan

Table 1. Legal framework of ageing in the Republic of Kazakhstan

<table>
<thead>
<tr>
<th>Law Title</th>
<th>Article</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitution of the Republic of Kazakhstan</td>
<td>Article 28</td>
<td>A citizen of the Republic of Kazakhstan is guaranteed a minimum wage and pension, social security at old age, in case of illness, disability, loss of a breadwinner and for other legal reasons. Article 14, second point, stipulates that no one can be subjected to discrimination. The ground of age is not distinguished, as opposed to &quot;origin, social, official or property status, sex, race, nationality, language, attitude to religion, beliefs, place of residence or any other circumstances&quot;.</td>
</tr>
<tr>
<td>Labour Code of the Republic of Kazakhstan</td>
<td>Article 53</td>
<td>It is not allowed to terminate an employment contract with employees before reaching the established retirement age, who have less than two years left, without a positive decision of the commission created from an equal number of representatives from the employer and employees.</td>
</tr>
<tr>
<td>Marriage (Matrimony) and Family Code</td>
<td>Article 145</td>
<td>Able-bodied adult children are obliged to support and take care of their disabled parents who need help.</td>
</tr>
<tr>
<td>Code &quot;On the health of the people and the health care system&quot;</td>
<td></td>
<td>The standards for organizing the provision of geriatric and gerontological care in the Republic of Kazakhstan have been regulated.</td>
</tr>
<tr>
<td>Law &quot;On Pension Provision in the Republic of Kazakhstan&quot;</td>
<td></td>
<td>The legal and social foundations of the pension provision of citizens in the Republic of Kazakhstan are regulated; the law regulates the participation of state bodies, individuals, and legal entities in the implementation of the constitutional right of citizens to pension provision.</td>
</tr>
<tr>
<td>Law &quot;On Veterans&quot;</td>
<td></td>
<td>Determines the organizational, economic, and legal basis for the provision of social support measures to veterans and other persons who are subject to this Law.</td>
</tr>
<tr>
<td>Domestic Violence Prevention Law</td>
<td></td>
<td>Aims to prevent domestic violence in the form of physical, psychological, sexual and/or economic violence, including against older citizens, which nevertheless are not specified separately.</td>
</tr>
<tr>
<td>Law &quot;On Special Social Services&quot;</td>
<td>Article 6, P 8</td>
<td>Provides the foundation for receiving special social services in case of inability to self-service due to old age resulted from disability or illness.</td>
</tr>
</tbody>
</table>

Social and medical services

In general, in Kazakhstan, specialized medical and social services for older people are at an early stage of development. Therefore, creating the long-term care (LTC) system that would compensate for the gradually developing loss of the ability to self-service not only for older people with disabilities but also for physiological reasons is a challenging task. Geriatrics was included in the country's nomenclature of medical and pharmaceutical specialities in 2009, and in 2015 a standard for the organization of geriatric and

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13 Taken from adilet.zan.kz.
gerontological care was approved.14 Current hospice services mainly focus on oncological and to a lesser extent geriatric pathology; services are not provided to people with HIV/acquired immune deficiency syndrome, somatic diseases at the terminal stages.

In 2020, there were 931 medical and social care institutions servicing 122 thousand people.15 The Republic of Kazakhstan's social service system is represented by 88 day-care departments, 482 departments of social assistance at home, and 113 hospitals.16 As of 1 January 2021, in Kazakhstan, there were 45 Social Service centres of the general type for the older people and people with disabilities and 48 psychoneurological social service centres with total coverage of 22 thousand people with no specific data by age group.17

Local state bodies and state institutions are the main social services providers for older people; the non-state sector is almost not involved in providing social services. The current system covers very basic needs, and the range of social services is limited.

The order of the Minister of Health and Social Development of the Republic of Kazakhstan dated 26 March 2015, No. 165 "On approval of standards for the provision of special social services in the field of social protection of the population" indicates that in socio-medical institutions, eight types of services should be provided: socio-welfare, socio-medical, socio-psychological, socio-pedagogical, socio-labour, socio-cultural, socio-economic, and socio-legal services.

For home-based social care, the list of social services guaranteed by the state includes catering (including home delivery of food); assistance in purchasing medicines, food, and essential industrial goods; assistance in obtaining medical care, including escort to medical institutions; maintaining living conditions under hygienic requirements. Besides, each general community practice18 has two nurses, a health visitor with medical education and a social worker. A nurse usually visits patients once a week to provide medical services; a social nurse brings medicines, accompanies them to the clinic, and delivers pensions, food, etc.19

Pensioners who do not have able-bodied adult children and persons with disabilities use institutional and home-care services largely at the state's expense. The government charges 70% of the basic pension; the amount is non-differentiated depending on employment history and other parameters; pensioners in institutions are not entitled to any additional payments and benefits paid to the older adults by the government. Older people who have children can use social services on a paid basis only, as according to the Family and Marriage Code, children over 18 years of age must provide care for their older parents. In practice, this can cause difficulties when older people cannot receive services from the state. Formally, they have children who, however, do not support them or cannot provide regular support due, for instance, to their work conditions (irregular working hours or shift work, frequent work-related travel, etc.).

The population of Kazakhstan, in general, demonstrates elevated expectations of family care for the older persons - according to the 2019 Generations and Gender Survey (GGS), about 90% of respondents, indicated that children should live with the parents if the older adults cannot take care of themselves (93%); take responsibility for caring for parents when they need it (92%); provide financial support to parents when they

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14 https://adilet.zan.kz/rus/docs/V1500012310
16 https://adilet.zan.kz/rus/docs/P1900000326
18 Medical and social assistance is provided at the level of the district polyclinic and district departments of social work under district akimats: a doctor, a patronage nurse is attached and financed by a district polyclinic, however, for the delivery of medicines, escort to a polyclinic, the district department of social work under the akimat is attached to the patient.
are in financial difficulties (91%). Furthermore, regarding caring for the older persons in need of at-home care, more than half (59%) of the respondents indicated that "this is the task of the family rather than the community," and only 12% believe that providing at-home care is more a task of the community than that of the family.

When asked about the need for residential care for single older persons and couples, 73.1% of the respondents answered positively, 22.6% indicated no need for such institutions, the rest found it difficult to answer. However, only 10.7% of respondents aged 18-79 admitted that they might need social services in the future, 64.3% categorically rejected this possibility. Most older persons rely on their children, grandchildren, spouses, and relatives to not abandon them. Older people believe that family will not allow older persons are placed in the institutions, providing care inside the family. Some respondents noted that they are looking for life partners to jointly create a marriage union to support each other in old age. Only 0.3% of older persons expressed a preference for living in a nursing home over other options.

The attitude towards private, paid institutions remains wary – only 38.8% of the respondents gave a positive answer to whether private institutions are needed (8.4% found it difficult to answer).

In general, according to the results of the 2020 study, every fifth older person surveyed needs some kind of help (21%), 13% need help around the house, 10% for visiting places that are far from home, 10% with shopping for groceries and essential goods, 9% for visits to government agencies and institutions, 7% for receiving pension and benefits, 7% for help with food preparation, and 3% for personal hygiene.

The overwhelming majority of respondents, 69%, indicated that when they need physical assistance, they ask their children; least of all, older people receive help from neighbours (3%), friends (2%), social workers (1%), NGOs and volunteers' organizations (0.1%), about 6% of respondents stated that no one assists them in everyday matters.

Regarding the availability of the medical services in the rural areas, according to the Ministry of Health report, in 2020, the existing 49 secondary medical centres in rural areas provided services to 595,244 people, amongst which 215,740 diagnostic tests, 210,653 laboratory tests, 524,520 medical consultations. To increase the availability of medical care, 3,676 mobile teams were introduced in the countryside. Old patients, pregnant women and children, the patients in urgent conditions were remotely examined through telemedicine, whereas mobile and medical teams made home visits for the sampling of biomaterial for analysis, PCR, general clinical and biochemical blood tests, and medicine delivery.

Still, the accessibility of medical care for older persons remains a challenge, exacerbated by the COVID-19 pandemic, especially in rural areas. In general, 18.3% of respondents aged 55 and older, over the past 12 months, were in a situation where they needed a medical examination or treatment but could not get it. The most common reason for this situation was lockdown (36.1%) when restrictions on movement and visits to crowded places were introduced. Other most frequently mentioned reasons were the necessary treatment was offered only on a paid basis - 16.7%; long waiting lists - 12.3%; lack of the required specialist - 9.6%; lack of necessary medicines or equipment - 7.1%. A slightly smaller number of respondents (13.8%) over the past

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20 Основные результаты анализа данных первой волны обследования «ПОКОЛЕНИЯ И ГЕНДЕР» в Республике Казахстан, 2019
24 See chapter on COVID-19 containment measures.
year found themselves in a situation where they needed a dental examination or treatment but could not get it. The most common reasons for this situation were paid basis/too expensive cost (51%) and quarantine for COVID-19 (23.6%).

In 2020, the digitalization of the social and labour sphere services was carried out; in particular, for 40 out of 44 services electronic format was introduced, 12.4 million services were provided, and 7.8 million from them were e-services. Unfortunately, the statistics on the usage of e-services by older adults was not monitored.

Experts also drew attention to such problems as indifference on the part of medical personnel, lack of involvement in the problems of the older adults, and the weak professional ethics of doctors and medical personnel.

The digitalization of the social and medical services

In addition to medical e-services in 2020, MLSP introduced a social services portal, aleumet.egov.kz, for people with disabilities, on the principle of services like Amazon and Alibaba. According to the aims, this digital resource should allow choosing the required means and services of rehabilitation independently; reducing the timing of getting the service from 6 months to 15 days; and ensuring transparency of business processes, elimination of intermediary services; unification of prices, efficient use of budgetary funds; equal access for providers of technical aids and rehabilitation services.

However, the pertinent digital divide and lack of skills can lead to the exclusion of some older people from the benefits of e-services, especially older age groups and people living in rural areas. It is necessary to ensure that services continue to be available to people who do not use the Internet.

Internet use remains fairly polarised - 54% of respondents indicated that they use the Internet every day or almost every day, while 31% do not use it at all. Daily Internet use was more widespread among women (59%) than among men (46%), among the 55-59 age group (67%) than among the 60-69 age group (51%) and 70 years and older (34.5%); and in big cities (60%) and small towns (58%) than in villages (45%).

Many people of the older generation who did not master online services are not sufficiently informed about the opportunities, lack the devices, or do not trust modern technologies. E.g., during the pandemic, some older persons feared fraud with electronic services and home delivery of pension, preferring to receive pensions at a post office or bank physically, despite health risks.

The Digital Kazakhstan Program was approved by Resolution No. 827 of the Government of the Republic of Kazakhstan dated 12 December 2017, but no specific targets were set for older persons. With the move towards digitalization, it is unclear how older persons get information, use "paperless" services in the polyclinics, and how and where they can get training. Meanwhile, the rapid digitalization of everyday life makes digital skills and accessibility of digital technologies a basic necessity for access to goods and services, education, employment, and social interaction. Creating inclusive digital environments is essential to ensure...
people of every age can benefit from the new initiatives in social and medical e-services, but traditional alternatives are still provided.

**COVID-19 pandemic in the Republic of Kazakhstan.**

The WHO statistics show several waves of COVID-19 infection in Kazakhstan, with peaks in August 2020 and April 2021 (see Figure 2).

Figure 2. The development of COVID-19 pandemic in Kazakhstan


On 27 January 2020, in Kazakhstan, as a response to the COVID-19 threat, the Commission to Prevent the Spread of COVID-19 was established. The first cases of the identified disease were reported on 13 March. All public events were cancelled in the country, later schoolchildren were sent on early holidays, and students - for distance learning.

A state of emergency was introduced from 16 March 2020 with several prolongations. From 19 March, the lockdown was introduced in the cities of Almaty and Nur-Sultan - entry and exit from cities were limited; from 28 March, quarantine measures were strengthened: residents could only leave their homes to shop for groceries, to a pharmacy and to work. In addition, older people 65+ were instructed not to leave the house unless absolutely necessary.

The lockdown was extended several times, including the restriction on movement of the older persons: e.g., Chief State Sanitary Doctor’s Decree No. 65 of 26 October 2020.

After the COVID-19 outbreak, country-level measures to increase the accessibility and quality of medical help were introduced. For instance, according to the Ministry of Health report, in 2020, the average salary of doctors has been increased by 30%, nurses by 20% that helped to retain medical staff on duty. Moreover, it is reported that better readiness for new infection challenges was managed at the strategic level.

https://www.covid19healthsystem.org/countries/kazakhstan/livinghit.aspx?Section=1.4%20Monitoring%20and%20surveillance&amp;Type=Section
In particular, 100 mobile medical complexes have been delivered to the regions with the provision of 51,126 beds care to patients with coronavirus infection, 100 mobile medical complexes have been delivered. Furthermore, 16 prefabricated infectious diseases hospitals were built in the republic during the past year, and three infectious diseases hospitals were reconstructed by re-profiling. In addition, medical organizations have been supplied with 3,264 units of artificial lung ventilation devices, including 1,500 domestically produced.

Mobile medical teams (so-called Transport medicine) for remote rural areas was also revived, and the telemedicine network was revised. The provision of advisory services through the national telemedicine network, to which 259 health organizations were connected, began to develop actively. This, in turn, resulted in the development of rural medicine; in particular, 30 medical facilities in rural areas opened. In 2020, mobile medical complexes covered 1,105 remote rural settlements, and more than 35,000 consultations were given.\(^{30}\)

As of January 2021, a total of 19,089 beds for infectious patients were deployed throughout the country; bed occupancy was 28% (5,367 beds). The number of intensive care beds in infectious diseases hospitals was 1,738; bed occupancy was 21% (362 beds). The bed capacity of quarantine hospitals was 6,666 beds, bed occupancy in the republic - 6.2% (464 beds). In infectious diseases hospitals, as of January 2021, there were 5,222 artificial lung ventilation devices available; 42,838 beds were provided with oxygen. These measures were aimed at improving the quality and accessibility of medical services.\(^{31}\)

During the pandemic, new jobs were created for health workers. According to the data of regional health departments, as part of the implementation of state and government health development programs, as of 1 December 2020, 15,373 new jobs were created for medical workers, of which 5,274 were permanent, and 10,099 were temporary. Most jobs were created in the city of Nur-Sultan (3,614, of which 807 are permanent and 2,807 are temporary) and the Aktobe region (1,480 new temporary jobs). In addition, social support was provided for young specialists who arrived in rural settlements (as of 1 December 2020, within the framework of the republican budget, 12.4% (89 out of 717 specialists) were paid welfare benefits, housing - 3.6% (26 out of 717 specialists).

The coronavirus pandemic also introduced changes into the system of medical personnel training. In particular, the Ministry of Healthcare strengthened topics on biological safety, particularly in such disciplines as childhood infectious diseases; general hygiene; general epidemiology; clinical epidemiology; infectious diseases; ambulance emergency medical aid; internal illnesses; childhood diseases; pulmonology. Within the centralized republican budget framework, more than 15,000 medical workers were trained, including more than 8,000 people in courses in the epidemiology of infectious diseases and biosafety, prevention, and effective treatment of non-infectious diseases. In addition, the plan was to train 150 epidemiologists, 100 infectious disease specialists to replenish the reserve already in 2021. Therefore, medical education also changed due to COVID-19 pandemics.\(^{32}\)

According to the experts from the government, during the lockdown, most older people in major cities had the necessary medicines and protective equipment delivered to their homes, while payments of pensions and benefits in cash were delivered home to the oldest age groups.


\(^{31}\) Ibid.

Volunteers and NGOs also delivered medicines and essential products to older and disabled people, provided assistance and support. Still, the number of volunteers has decreased over time, according to the expert, which was caused by the possibility of moving around the city without obtaining a special pass and general fatigue from the pandemic. Partly the loss of volunteers was compensated by the development of private delivery services.

The government introduced several anti-crisis measures to support the financial well-being: payments due to the loss of income, social payment, food and household kits, utility cost reimbursement, benefits to veterans on the Victory Day and invalids of the Great Patriotic War and other persons equated to them.
II. Almaty pilot survey results

Methodology and General Overview

To evaluate the initial impact of the global pandemic on the long-term care services in Almaty, the adapted questionnaires drawing from the WHO Europe Technical Guidance #6 on Preventing and managing the COVID-19 pandemic across long-term care services in the WHO European Region, the UN Inter-Agency Group on Ageing (IAGA) Checklist for the inclusion of Older Persons in COVID-19 Socio-Economic Response Plans (SERPS) as well as HelpAge rapid assessment on the impact of COVID-19 on older persons were used.

The study design involved various key players, such as representatives of government and local authorities dealing with LTC issues, district/community social workers and informal caregivers - grouped under a general heading of the "main care providers" and older persons themselves - care recipients.

Component 1. The main care providers

The study sample included 156 caregivers in Almaty: 52 district social workers, 52 social workers from the residential care facility - Centre of Special Social Services #3 ("Shanyrak"), and 52 informal caregivers. The survey was voluntary and anonymous and conducted in the form of interviews; all social workers signed written consent.

Group I involved 52 district/community social workers (SW) providing care for older persons at home. According to the Standard of social services #165, district social workers visit care recipients three times a week to provide special social services at the care recipient's request. The mean age of SW was 41.8 years, SD 10.2; all 52 SW were female. In terms of SW care recipients, their mean age was 78.0 years, SD 7.1 years.

Group II involved 52 social workers from the Centre "Shanyrak", where social workers provide mainly socio-labour, socio-cultural and socio-pedagogical care. The medical assistance is under the control of the general practitioner and a medical nurse. Socio-welfare services are provided by nurses. The mean age of SW at Shanyrak was 37.8 years with SD 10.0; all SW were female. The mean age of their care recipients was 75.1 years, SD 9.6 years.

Group III involved 52 informal caregivers; the mean age was 47.1, SD 14.9. Among surveyed informal caregivers, 51 were female, one male. The mean age of their care recipients was 77.5 years, SD 7.8 years.

For the qualitative part of the study, officials from the Ministry of Labour and Social Protection, Almaty city akimat, district akimats, and health care institutions were interviewed. In addition, to evaluate the quality and access to medical help for older people in need of LTC, the interviews were also conducted with the head of palliative care in Almaty and the head nurse at the residential care home Shanyrak.
Component 2. The main care recipients

The surveyed care recipients were older people living alone and in need of LTC according to the law of Special Social Services from 29.12.2008 #114-IV or with the disability group I and II according to the rules of medical and social expertise established by Decree #44 from 30.01.2015 by the Minister of Healthcare. The participants were sampled to have the close average age between the groups (300 respondents in total). The survey was anonymous; the respondents signed the written consent.

Group I involved 100 older persons from 2 districts in Almaty: Zhetisu and Almaly. The database of older people who live alone and who are in need of long-term care was taken from local akimats. Depending on the respondents' preference, they were interviewed either by phone or in person.

Group II involved 100 residents from the Centre of the Special Social Services #3 "Shanyrak". The criteria for being accepted to Shanyrak are defined by the Standard of social services #165.

Group III involved 100 retired people who come to the Centre of Active Ageing (AAC), who live alone but can move independently.

The gender proportion and mean age of the respondents were taken approximately similar for the groups to be comparable (Table 2).

Table 2. The age and gender distribution of respondents

<table>
<thead>
<tr>
<th>Group</th>
<th>Average age</th>
<th>SD</th>
<th>% of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living alone disabled older people</td>
<td>82.4</td>
<td>5.6</td>
<td>65.0%</td>
</tr>
<tr>
<td>Shanyrak residents</td>
<td>81.2</td>
<td>5.6</td>
<td>61.0%</td>
</tr>
<tr>
<td>AAC visitors</td>
<td>81.9</td>
<td>5.3</td>
<td>78.0%</td>
</tr>
<tr>
<td>Total average</td>
<td>81.8</td>
<td>5.5</td>
<td>68.0%</td>
</tr>
</tbody>
</table>

In general, the interviewers note the respondents' distrust in the survey, especially at Shanyrak. Older people were worried about the safety of their personal data and the possible consequences of the survey as harassment for reported information, fraud, etc. The survey was conducted in the form of an interview, and the expert acknowledges that 2.5 hours of open questions were difficult to handle for both the respondents and interviewers.
Component 1. The main care providers, survey results

As mentioned above, Component 1 involved 156 caregivers: district social workers, institutional care providers and informal caregivers of different ages.

The respondents noted a great burden on the staff of institutions (especially medical and social workers) when one worker has a considerable number of patients to serve daily. Because of this, the quality of service delivery may suffer. The pandemic situation exacerbated the challenges. All district social workers and 94.2% of institutional care providers indicated the changes in their working schedules. Employees were more anxious, burn out quickly (98.1% of formal carers indicated burnout). All formal carers indicated negative changes in their mental health since the start of the pandemic, while medical or social services provided no psychological/social support. At the same time, all unanimously stated the need for such support. The results for the informal carers give almost the same picture.

76.9% of the social workers and institutional care providers have children (59.6% of the staff indicated that there are children of school age in the household), while no childcare support was provided during the lockdown. Many indicated facing challenges as their children were on home-schooling, which required a lot of time and effort from the caregivers. SW from Shanyrak could not communicate with their children in person, only through video calls, which was a considerable challenge as the lockdown period lasted several months, and no assistance for the families was available. Among the informal carers, the presence of children was indicated for 81.5% of the respondents (and 53.7% of all informal carers stated that their children are of school-age).

District social workers had to work sometimes regardless of the risks to get infected – 42.3% indicated no access to the PPE. It should also be noted that half of the respondents indicated that they live in the rural area; thus, they could not enter the city during the first months of the lockdown. Community SW indicated that they changed their working schedule, as additional time was required to provide their services, e.g., getting medicines as there was a shortage of drugs. So, it took time to find the drug, find reasonable prices and extra-funds on additional travel expenses. During the pandemic, people bought up many drugs "just in case", on the other hand, the private pharmacies took advantage raising the prices on medicines, which led to an artificial drug shortage. Another challenge for district social workers related to the loss of income from the beginning of the pandemic (51.9%).

Care providers from Shanyrak indicated that they were supplied with the food and lived at the Centre, so they did not have to spend on travel expenses, PPE, masks, and internet access for themselves (in terms of families left at home, no support was provided neither for medical workers nor for the social workers). On the other hand, living with residents, providing 24/7 care was morally exhausting. All care providers at Shanyrak indicated increased aggression amongst the residents due to isolation: physical attacks, biting, scratching, and others. No psychological support was provided either to the staff or to the residents. Care providers from the Shanyrak did not indicate any humanitarian support but are considered to be on the public provision that supplies main living conditions.

Group III involved informal caregivers (IC), particularly siblings, nephews/nieces, and living spouses. There were 65.4% main caregivers; 36.5 % of informal carers were family-paid nurses. 46.2% were living in the same household with the person in need of care. All the IC indicated that socio-welfare (75.0%), socio-medical (7.7%), socio-psychological (11.5%), socio-cultural (5.8%) services were carried out daily. During the lockdown, nurses could not come due to movement restriction, so the informal caregiver indicated that they had to provide all necessary care themselves. 67.3% of IC indicated that they experienced financial constraints (51.9% lost in income since the beginning of the pandemic). Only 32.7% could afford PPE (but no
one from IC wore masks when caring for older persons). Moreover, IC indicated that getting medical assistance was difficult as hospitals were transformed into COVID-hospitals. Informal carers indicated moral exhaustion due to increased workload as there was no support in helping with home-schooling, online working, and household tasks. Social and medical services were provided with interruptions - 67.3% indicated that persons in need of care received them irregularly during the pandemic, which influenced their well-being. On the other hand, only 15.4% of the IC indicated that the person in need of care required medical help and could not get it, and no lack of medicine was indicated. All IC indicated that they were unaware of the nearest COVID-treating hospital (9.6% knew about the nearest testing station, 21.2% - about the COVID-19 hotline). In contrast to SW, who indicated that they were informed on that. This reflects that the level of general awareness was not satisfactory enough.

The following are more detailed results for the three categories of caregivers.

**Socio-demographic characteristics of the respondents**

The main socio-demographic characteristics of the carers were described in the methodology; in addition, detailed information is provided in Figure 3.

Figure 3. Distribution of the carers by socio-demographic characteristics

![Socio-demographic characteristics](image)

Regarding the older persons they provide care to – their age and disability status are distributed quite equally between the type of carer; even with the informal carers having the higher presence of care receivers with the most severe disabilities (group I), the difference between the groups on mean age and disability status is not significant (Table 3, Figure 4).
Table 3. The age of the person being cared about by the type of carer

<table>
<thead>
<tr>
<th>Type of Carer</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Maximum</th>
<th>Minimum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal Carers</td>
<td>77.5</td>
<td>7.8</td>
<td>92.0</td>
<td>65.0</td>
</tr>
<tr>
<td>District Social Workers</td>
<td>78.0</td>
<td>7.1</td>
<td>93.0</td>
<td>68.0</td>
</tr>
<tr>
<td>Care Providers from Shanyrak</td>
<td>75.1</td>
<td>9.6</td>
<td>93.0</td>
<td>59.0</td>
</tr>
</tbody>
</table>

Figure 4. Distribution on the carers by disability group of their care recipients

Figure 5 indicates that 51.9% of informal carers are providing care at their own home. For the social workers, this question is irrelevant, as the place of care provision is determined by the type of care – at the care recipient’s home or in the institution. 5.8% of district social workers indicated that they are the main carers, though providing care weekly. Interestingly, that from those, who indicated that they are not the main care providers, 77.6% stated that the main care provider is lacking, and 22.4% mentioned paid carer. In Almaty, two options of paid care are available: private organizations, for example, the commercial organization "Silver Age", which provides nurses on a paid basis for the entire day or on-demand and informal nurses, for example, in case of necessity respondents pay to neighbours or relatives to bring medicines, etc. All the informal carers provide care daily; 65.4% consider themselves the main carers, being siblings, children, other relatives, or paid carers.
Figure 5. The place of care provision and whether the respondent is the main carer

Figure 6. Type and duration of care

Figure 6 shows that 53.8% of the district social workers provided care for less than a year, 40.4% at the Shanyrak. It might be due to high staff turnover, associated partly with insufficient salary and moral exhaustion or professional burnout. On the other hand, most informal caregivers provided care for more than five years because it was mainly relatives of the care recipients. Regarding the type of care, the informal carers indicated the greater variety of care provided, but the majority still focus on socio-welfare care.
Changes in everyday life and care provision because of COVID-19 and containment measures

Figure 7. Changes in the ability to provide care and work schedule since the COVID-19 outbreak

As shown in Figure 7, all district social workers and 94.2% of care providers from Shanyrak indicated changes in work schedule since the COVID-19 pandemic outbreak; all of them indicated the change in the ability to provide care. The informal workers seem to be affected less severely – 32.7% indicated no change in working schedule and 38.5% - same ability to provide care. The overall workload (work scope and schedule for paid work and unpaid work at home and family members together, not in the Figure) changed for 63.5% of the IC and all the formal careers.

Figure 8. Financial constraints since the COVID-19 outbreak

Figure 8 shows that 73.1% of caregivers at Shanyrak indicated no financial constraint, whereas 67.3% of informal caregivers indicated difficulties. According to the Law, the main caregivers to the people with disability Group I are paid 41 578 tenge (=100 USD) per month while those caring for other older persons do not receive a payment. (As indicated in Figure 4, 34.6% of IC cared for persons with disabilities in Group I). Amongst the Shanyrak SW, the proportion of those indicating financial constraints was the lowest among the three groups - 26.9%. The underlying reason could be that meals were provided for free during the
lockdown; moreover, there were no transport expenses, and the PPE was also provided from the Shanyrak. On the other hand, informal caregivers noted to the interviewers that they had to spend extra money on PPE; some medicines were more expensive than before the lockdown.

The affordability of PPE (Figure 9) can also be regarded as a proxy for financial constraints. Here, the results are worrying – only 32.7% of the informal carers and 42.3% of care providers indicated such possibility. However, from the accessibility perspective, the situation is a bit more optimistic – only 42.3% of social workers indicated the lack of access, other categories of carers indicated the access was guaranteed.

Figure 9. Affordability and accessibility of PPE for carers

Even though all the carers indicated that they did not experience difficulties with access to food, drinking water, the diet changed during the lockdown for all the informal carers, care providers in Shanyrak and 57.7% of the district social workers (Figure 10).

Figure 10. COVID-19 related changes in the diet
Support from the local authorities and information channels

As shown in Figure 11, 61.5% of informal caregivers indicated that they had received financial or humanitarian help from the local authorities. The humanitarian help was provided in the form of 2 weeks' food supply, one package of masks one time for one address during the whole lockdown period. According to the decision of Almaty local authorities, some housing and communal services were paid for by the government. The payment was made on request by making a call to akimat’s hotline. However, during the survey, only 21.2% indicated awareness of the hotline. The same pattern appeared to be typical for the dissemination of the information about testing facilities and medical institutions – informal carers appeared to be totally left out of the information dissemination channel. In general, the survey reflects that while provision of social services was mainly based on application, the information dissemination was not organized on a required level. Hence, only proactive people could receive governmental help.

Figure 11. Support from the local authorities

Figure 12. Awareness about COVID-19 related institutions and services
Local authorities such as akimat were the main informational resource on COVID-19 for social workers and Shanyrak caregivers (Figure 13). Among the informal caregivers, the main information resource was either mass media or neighbours. Thus, it seems that akimat information resources are not covering the target group to a satisfactory level.

**Mental well-being**

The pandemic and the containment measures have a significant effect on the mental well-being of the respondents – all of them indicated changes in mental health, and all but 48.1% of IC indicated feeling tension after the outbreak. As noted earlier, despite the objective need and the request for psychological assistance, such measures were not provided. This is especially troubling regarding the acknowledgement of the cases of violence against older people, all the care providers in Shanyrak, 36.5% of social workers and 78.8% of informal carers, stated that they heard of such cases (Table 4). The high percentage among Shanyrak respondents can be the consequence of high staff turnover and rapid emotional burnout of employees due to the peculiarities of working conditions.

Table 4. The need for psychological support of carers

<table>
<thead>
<tr>
<th>Do you feel changes in mental health since the start of the pandemic?</th>
<th>Informal carers</th>
<th>District social workers</th>
<th>Care providers from Shanyrak</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Have you felt the tension after the COVID-19 outbreak?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>51.9%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>no</td>
<td>48.1%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Have you heard about psychological support for you?</td>
<td>no</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Is there social support for you?</td>
<td>no</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Do you need support?

<table>
<thead>
<tr>
<th></th>
<th>yes</th>
<th>100.0%</th>
<th>100.0%</th>
<th>100.0%</th>
</tr>
</thead>
</table>

Have you heard about cases of violence among carers?

<table>
<thead>
<tr>
<th></th>
<th>yes</th>
<th>78.8%</th>
<th>36.5%</th>
<th>100.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>no</td>
<td>21.2%</td>
<td>63.5%</td>
<td>0.0%</td>
<td></td>
</tr>
</tbody>
</table>

**Impact of COVID-19 on care recipients**

All the respondents indicated the negative influence of pandemic and the decrease of the mental well-being of the care recipients (e.g., all respondents from institutional care providers indicated aggression from the care recipients, some indicated that care recipient demonstrated memory impairment, suspicion, physical health problems associated with being locked in the rooms). The change in older person’s need for carer's time and effort was indicated by all formal carers and by 59.6% of informal carers. All the respondents indicated the change in the recipient’s diet, although no lack of access to food and drinking water, in general, was mentioned.

Figure 14. Financial difficulties of care recipient and change in care needs during the pandemic

50% of informal carers indicated that the person they cared for experienced difficulties with receiving pensions or disability benefits during the COVID-19 outbreak. The close results are reported for Shanyrak. The highest proportion was among people receiving care at home, probably related to the low level of digital literacy and inability to use external help.

In general, low unmet need for medical care (here, the question related not to regular medical services received as part of special social services, but ordinary medical help) and medicine were reported (Figure 15). Interestingly, only informal carers indicated the inability to receive medical care, while no interruptions with medication were acknowledged. The situation was the opposite for the older persons receiving care at home; despite no unmet medical care needs, 44.2% of district social workers reported no access to the required medicine.
Regarding the access to regular social and medical service, the major interruptions in their provision were indicated: 73.1% of informal carers, 51.9% of district social workers and all care providers from Shanyrak. Still, the regular social and medical service was insured, at least for the formal care recipients. Both district social workers and institutional care providers did not mention that problem. At the same time, 67.3% of informal carers pointed out that the older people they cared for did not regularly receive regular special services. But the interruptions still affected all the categories of older people (Figure 16).
Social participation

Figure 17. Social activity of the care recipients before COVID-19 pandemic

The pre-COVID-19 social activity of older persons reported by carers was low to moderate (Figure 17). The institutionalized population demonstrated the highest results, as Shanyrak organized their social life – 57.7% participated in social events and almost 60% - in religious services. One-fifth of home-care service recipients communicated with family, friends, and relatives, and only 1.9% participated in religious events. At the same time, 28.8% of informal carers reported the care recipients’ communication with close relatives and friends (probably regarded as a wider family outside of the household), no one participated in religious services, and 19.2% indicated social events.

The COVID-19 pandemic greatly influenced the older persons' social activity: only 3.8% of the informal carers indicated no change, the other groups were unanimous. Still, most older people receiving informal care (73.1%) and formal care at home (63.5%), and all the institutionalized older persons continued to have a social life in some forms (Figure 18).

Figure 18. The influence of COVID-19 on the social activity of the care recipients
Component 2. Care recipients, survey results

The total number of survey respondents N=300 people. As stated in the methodology, one hundred respondents are older people living alone and in need of LTC. One hundred respondents live at Veterans Home “Shanyrak”, and 100 people come to the Active Ageing Centre.

Socio-demographic characteristics of the respondents

Figure 19. Age distribution of the respondents

The mean age in the respondent group of older people living alone and in need of LTC is 82.4 (n=100, SD=5.6), the average age at Shanyrak 81.2, (n=100, SD= 5.6), Active Ageing Centre visitors - 81.9 (n=100, SED=5.3). There was no statistically significant difference amongst the groups, which aligns with the study design to involve approximately the same age people for better data comparability (see Figure 19 for age distribution).

Figure 20. Gender distribution of the respondents
The sample reveals a gender disproportion (Figure 20): more women than men in all three groups, with the lowest number of men present among AAC visitors. As stated earlier, in Kazakhstan, the life expectancy of women is longer than that of men, and their social participation may be higher.

Among the respondents, only single people or people in widowhood are represented. Slightly more than half of all the respondents have children (Figure 21).

Figure 21. Family status of the respondents

![Family status](image)

The social workers provide most of the care (all the respondents due to the sample frame need LTC) for home-based population and medical workers – in Shanyrak, the children are in the second place, with the indicator to be higher for AAC visitors, as for them there is no “living alone or not being provided care by the children” requirement. The request for care is similar among all the three groups – many older people need help with household tasks, body hygiene is ranking the second and psychological help being chosen by 12-15% of the respondents. For the majority, help is required daily, with Shanyrak’s residents surprisingly showing slightly lower results.

Out of 100 people living at Shanyrak, 31% have the I group of disability, and 23% have the II group of disability. Similarly, amongst those living alone, 31% have the I group of disability, 22% have the II group of disability. Still, most respondents can walk independently, with Shanyrak residents showing almost the same results as visitors of the AAC. At the same time, older people living alone and in need of LTC have a higher proportion of those who cannot walk independently, which can be linked with the lack of enabling environment in the private housing (Figure 23).
More than half of the surveyed older people require help buying groceries (Figure 24); social workers and neighbours or relatives provide such help. For the institutionalized population, the role of social workers is expectedly higher. At the same time, older people living alone and visitors of the AAC show a close pattern with about 55-57% doing shopping on their own, 23-26% relying on social workers and 19-20% being helped by neighbours.
Changes in everyday life and services provision because of COVID-19 and containment measures

In general, the care needs and requirements changed for half of all care recipients because of the pandemic; the differences between the groups are statistically insignificant. The same picture is observed regarding general notions of challenges – 58% of institutionalized older adults, 49% of those living alone and 50% of Active Ageing Centre visitors stated they experienced challenges or difficulties during the quarantine (Figure 25). The influence of lockdown on physical health was stated by 49% of Shanyrak residents, 51% of living alone older people and 60% of the AAC visitors, as the last group is the most active and capable of visiting the Centre.
Older people reported difficulties obtaining pensions/benefits during the lockdown: 49% of the respondents who live alone indicated that they struggled with getting their pensions during the lockdown. For the Active Ageing Centre, the situation was the same: 48% indicated problems. The probable reason behind challenges with receiving might be that most people older than 80 prefer using offline retirement accounts instead of online banking; besides, according to our survey, only 26.7% of care recipients know how to use applications. On the other hand, institutionalized older people at Shanyrak did not have such problems in 76% of cases. This is because the mechanism of pension provision (30% left after deduction for institutional care) is settled and did not undergo changes because of the pandemic. According to the Law, the disability allowance is not paid to people who live at special social services facilities as they are considered on public provision.

The results for the survey of the care recipients slightly differ from Component 1, where 53% of the residential care providers and 75% of the district social workers indicated that care recipients experienced difficulties with receiving pensions and benefits during the pandemic.

Most people indicated that they do not have extra funds for getting PPE, 84% and 71% for the residents of Shanyrak (See Figure 26). For AAC visitors, the indicator is much lower – 37%. Some indicated that it was difficult to go outside, as there were no masks available. At Shanyrak, the residents were tested on PCR for COVID-19 infection, as well, as they were supplied with PPE. The other two groups had to spend money on PCR and PPE from their budget. Due to expert interviews, the community SW did not wear masks while providing care, potentially contributing to the spread of infection, while the survey’s results indicate 100% usage.

About half of the population indicated that the local authorities provided assistance and humanitarian or financial help.

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36 People with disabilities group I and II get monthly paid 65, 860 tenge (≈160$) - 1,92 subsistence minimum; people with disabilities of Group II are paid 52 483 tenge, (=126) - 1,53 subsistence minimum.
The provision of medical services was interrupted: 21% of institutionalized respondents and 34% of older people living alone or visiting the AAC indicated the unmet need for medical care during the quarantine. The estimations are much higher than those given by carers (district social workers and Shanyrak care providers reported no situations where the needed medical care could not be obtained). Still, the higher accessibility of medical services in Shanyrak can be explained by the availability of its medical unit with GP, cardiologist, surgeon, and geriatrician. Moreover, the nurse practitioner provided primary care at the Shanyrak. Many residents indicated not having bedsores as they used to have a massage, regular showering, and other hygienic procedures. The delivery of medicine for home-based recipients was organized either via social workers or by paid delivery.

The same pattern is seen in special social service availability, while social workers and care providers reported that care recipients could get regular social or medical services during the pandemic, 47% of institutionalized older adults, 40% of older people living alone and 46% of AAC visitors indicated that services
were unavailable for them. In addition, half of all the respondents indicated that the quality was also affected (Figure 29).

Figure 29. Availability of medical and social services

Regarding the ambulance, 76% of those living alone required an ambulance during the lockdown, whereas at Shanyrak, 41% indicated such need, and among visitors of AAC, there were 51 requests. The numbers at Shanyrak may be lower because of the regular medical assistance, medical examinations, and ensured medicines' availability. The frequency of the ambulance arrival varies significantly between the respondents' groups: if in Shanyrak the ambulance came in 73% cases, to people living alone – only in 66% cases. Visitors of the AAC reported that the ambulance came in 100% cases and was on time. The timing was also met for the institutionalized population. At the same time, the living alone people indicated that the ambulance was not late (subjective judgment) in 38% of the cases it came, which is a low value (Figure 30). The reason behind this was that the ambulance was overloaded with COVID-19 patients.

Figure 30. Ambulance call and timing
Most respondents indicated changes in their nutrition, respectively 95%, 83%, and 86% of those living alone, in Shanyrak and visiting Active Ageing Centre (Figure 31). It was challenging for them to get products because of physical restrictions to get to the shops, as only grocery shops larger than 500 m² were open and entrance queues. Moreover, public transport was not available; only taxis were working. The prices for the taxi were overcharged. Later, paid delivery was introduced by many cafés and restaurants, grocery shops, pharmacies. The residents of Shanyrak indicated that they were unable to purchase food during the lockdown; still, in general, at Shanyrak, no major nutrition changes were expected as social centres are totally on public provision, but the regulations on the safety measures for food delivery could influence the menu. Many residents also noted that they felt abandoned when the usual meals were not in the cafeteria as usual, but in their rooms; food was sometimes cold because of the delivery procedure. People living alone were affected the least.

Figure 31. Nutrition changes

Awareness and information sources

As shown in Figure 32, the general awareness of COVID-19 self-protection was the lowest among those living alone; in particular, 46% indicated no awareness of COVID-19 protection. Only 18% and 13% indicated no awareness of COVID-19 self-protection in the Shanyrak and Active Ageing Centre. Still, the usage of PPE was indicated by 89% of all care recipients with no significant differences between the groups. Less than half of all the older people were aware of the closest testing facilities, living alone older people showing the lowest results. The information on the hotline appeared to be more widespread – 50.7% of the respondents indicated they have an idea of its existence. Still, the value is extremely low since humanitarian assistance was provided among others on a declarative basis during the pandemic via the hotline. The main source of information (Figure 33) for older people remained the media (from 65% for Shanyrak residents to 82% for older people living alone), with neighbours and friends ranking second.

The general IT literacy and digital skills are low (Figure 34): amongst those living alone and those living at Shanyrak, only 18% and 7% indicated an ability to use web-based applications. The expert indicated that they do not have smartphones and mobile Internet as these are additional expenses. Only 3% of respondents from Shanyrak indicated some digital courses organized for them (which is 1% of the surveyed respondents). The usage of phone and video calls is relatively high – 51.7% of older people indicated the usage of the mobile phone and even higher – 55.3% for the video calls with no statistically significant differences between...
the groups. However, the question does not specify whether older people were using the video calls on their own or with the assistance of carers. The values indicate the total lack of readiness for digitalization of daily services – a considerable part of older adults is left behind, widening the digital divide and the associated inequality.

Figure 32. Awareness of COVID-19 protection measures and resources

Figure 33. Source of informational awareness about COVID-19
Social participation

The self-evaluation of social participation shows quite low connectedness of older people to the community (Figure 35): 17.3% of all the respondents regularly communicated with a relative before the pandemic outbreak, 24% - with neighbours, with no statistically significant difference between the groups. The participation in religious services also does not differ much between respondents – on average, 42.7% indicated such experience. The significant difference is in the participation in social events – with values ranging from 18% for the living alone older people and 31% of Shanyrak residents to 58% of the AAC visitors. In general, the self-evaluation of social participation of older people living at home is higher than the estimates from carers, especially for social events participation and religious services. At the same time, the estimation for the institutionalized population is lower by self-evaluation.

The COVID-19 pandemic profoundly influenced the older persons' social activity, yet the evaluation of the magnitude by older people themselves is more restrained. If social workers were largely unanimous in their
negative assessment of influence, among older people themselves, 44.7% noted changes in social life and 54% in the activity, with the highest results expectedly affecting the visitors of the AAC (Figure 36).

**Figure 36. COVID-19 influence on social participation**

![COVID-19 influence on social participation](image)

**Mental well-being**

Regarding the psychological impact and well-being, 50.7% of all respondents indicated feeling pressure during the pandemic, with no significant differences between the groups (Figure 37). The main reasons were the fear of being infected, with the lack of attention from the social worker occupying the second place. The more detailed information on mental well-being indicators is available in table 5, with the differences between the groups being statistically insignificant except for the increased irritability. AAC visitors used to have psychological classes and occupational therapy and indicated that they started to feel memory impairments, suspicion, suicidal thoughts more often because of the pandemic. Additionally, 45% of the older respondents indicated that they know about violence cases among friends of their age with no difference between the groups.

**Table 5. Mental well-being detailed statistics**

<table>
<thead>
<tr>
<th></th>
<th>VH Shanyrak</th>
<th>Older people with LTC-need</th>
<th>Active Ageing Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased anxiety</td>
<td>59.0%</td>
<td>60.0%</td>
<td>55.0%</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>60.0%</td>
<td>60.0%</td>
<td>58.0%</td>
</tr>
<tr>
<td>Increased irritability and moral stress</td>
<td>49.0%</td>
<td>79.0%</td>
<td>74.0%</td>
</tr>
<tr>
<td>Sense of hopelessness</td>
<td>73.0%</td>
<td>64.0%</td>
<td>63.0%</td>
</tr>
<tr>
<td>Increased general level of stress</td>
<td>52.0%</td>
<td>52.0%</td>
<td>51.0%</td>
</tr>
</tbody>
</table>
To summarise, it can be said that at Shanyrak, there was more medical and social assistance, better informational support, and living conditions were affected less. On the other hand, no COVID-19 associated psychological and moral support was provided, neither for the residents nor the staff. The respondents reported dramatic changes in mental well-being and the quality of care provided.

According to the survey results, the older people living alone met considerable challenges, as community SW visited them only once a week, which affected their lives. There were dietary, financial constraints. This respondent group experiences more disruptions in medical and social services, and the arrival of an ambulance was the lowest, and the timing was the longest. The older people living alone were also the least knowledgeable about COVID-19 protection measures. Still, in the case of social participation, their lives have not changed much, which reveals the difficulty of their pre-pandemic situation.

Group III, which present the AAC visitors who live alone, appeared by the survey results to be more vulnerable on many indicators, as there was no support from local authorities. In addition, the medical assistance was not available on the required level; the financial constraints were caused by additional PPE expenses and increased food and medicine prices, and the regular social activities were discontinued.

All three groups indicated physical health impairment due to movement restrictions. Regarding mental well-being, most respondents report increased anxiety, sleep disturbance, irritability, and general stress levels. The general affordability of PPE costs appeared to be low; the assistance provided by the local government reached only half of the respondents. The COVID-19 influenced older persons' social participation and activity, which was low to moderate (for institutionalized population) even before the pandemic. The general level of information distribution and digital accessibility, and affordability is low. Thus, the digitalization of key services may increase the digital divide gap - it is necessary to make sure that information reaches the older persons via traditional media channels.
III. Almaty qualitative study results

*General measures*

The health care providers report a considerable increase in the number of beds for patients with infectious diseases, organization of the quarantine hospitals, the strengthening of the work of PHC (298 mobile teams in 74 polyclinics), an establishment of a telemedicine centre and the creation of the stabilization fund for pharmaceuticals and medical devices worth 10 billion tenge with the necessary stocks of medicines for 68 titles. PPE supply for health workers was ensured, and measures to reduce prices for PCR-testing and PPE for the general population were taken. The health care department introduced an electronic application, "Saqbol", that anonymously traced the person’s recent contacts with the COVID-infection. During the state of emergency and quarantine, the social well-being department provided vulnerable categories of the population with food and household kits (first to the older persons living alone and later to other categories of the population who have applied through call centres).

*Health care responses*

It was announced that medical workers could receive financial compensation. In reality, the measure was limited to medical workers working at the medical centres for infectious diseases and was paid only once. For general medical workers, in case of positive PCR-testing, two weeks leave without pay was granted for having home-based treatment. To motivate the doctors, the salary was raised, round 450 000 tenge (1000 USD), compared to the community GP, round 150 000 (350 USD). In addition, the families of the doctors who died from COVID-19 were paid 2 000 000 tenge (4,700 USD). But those payments were made only for the medical workers who were working at the medical centres for infectious diseases. The medical personnel working at the polyclinics, or any other hospitals were not paid any additional surcharge, which created the staff drain.

One of the respondents stated that there was no direct financial support for medical staff. Still, the hospital administration provided all required PPE, medicines, and free transport for the doctors: "in the beginning, we had to pay for PCR ourselves, which was too expensive, around 18 000 (42 USD); many medical workers refused to come to work, as it was too expensive for the community doctors, nurses and other medical workers. Upon that, the administration made the PCR testing free for all the staff".

The respondents note the enormous workload due to the staff shortage (sick leaves, refusals to work, lockdown of the city) and a rising number of COVID-19 cases: "During the day, we worked with the patients; at night, we were busy with paperwork, database, and tracing of contacts of the patients who were found to be COVID-19 positive". "The staff was morally exhausted due to the team's overworking; some clinical cases were extremely hard; we faced many deaths, which was morally upsetting. Moreover, wearing protective costumes was also physically hard, especially in the summertime. Besides, it was hard to hear and talk to patients; we did not sleep properly". Still, no psychological support was provided for medical workers.

Due to the staff shortage, the institutions recruited final-year medical students from medical universities, colleges, and volunteers, but as "those students were not educated properly", "many mistakes were made". Due to the staff shortage, the patients were treated by non-profile specialists; for example, the COVID-positive patients were treated by gynaecologists or psychiatrists. On the other hand, it should be noted that the patients who were planned to have routine surgery underwent the planned surgery. However, the rehabilitation was problematic as there were movement restrictions, and many hospitals were shut for quarantine.
The situation in the LTC

The LTC institution work was guided by the Chief Sanitary Doctor decree for the special social establishments. According to the decree, the residents and the staff were obliged to have PCR—testing twice a month, once in 2 weeks. All staff members were provided with protective coats, masks, gloves, PPE, sanitisers. Sanitary Epidemiological Representatives and city polyclinics specialists were invited to train the staff of LTC institutions, who in turn educated their residents. The family visits were banned; the communication was managed via gadgets, video, and telephone calls. As there was a considerable lack of devices among care recipients, the staff members helped organize video calls through their own devices. One institution reported that there was no internet/Wi-Fi connection at the establishment, only at the administration department.

Because of the city's lockdown, the employees had to stay in the institutions, although it was difficult to provide adequate living conditions such as meals and rooms for sleeping in the beginning. One of the institutions reported using warehouses to provide sleeping accommodation. As there was no additional budget for meals, the institution had to ask sponsors to help with PPE, meals, and medicines.

Care institutions did not report any problems with medical assistance or with medication. Still, the nutrition changes were unavoidable - the city was closed. Moreover, it was impossible to get some products (food suppliers were obliged to present PCR which was expensive and performed only in several laboratories initially, some products have strict storage regulations etc.). Thus, the residents complained both about the menu changes and that they were served in the rooms and sometimes the food was cold when it finally arrived: "The residents complained that due to isolation, they had to have meals in their rooms, and that was done to get rid of them".

Separately, the situation of people with dementia should be noted: no significant changes in dietary habits or medical treatment for people with dementia were reported, but physical health impairments were significant. It applied to most residents, as they almost all were "tied" to their rooms. They could not have walks, perform proper physical exercising, labour therapy sessions, which significantly affected their physical health. People with dementia became more aggressive and stressed. Despite being under the control of a psychiatrist and the regular nurse 24/7, there were cases when the social workers and nurses were attacked. But it was hard to define the borderline between the COVID-associated aggression and the clinical features of dementia.

Social workers reported extremely harsh working conditions, work overload, and burnout due to staff reductions and additional pressure caused by COVID-19 (both in long-term care facilities and social welfare departments). The lack of moral and psychological support at all levels also made a negative contribution. The same as for medical workers, only unpaid leave in case of illness was provided. At the beginning of the pandemic, because of the lockdown, there was a staff shortage. As reported, in 10-15 days, the staff was morally exhausted due to physical exhaustion, fears and aggression from the residents. The intensity of care was also decreased: "We focused on those who require LTC, the disabled and those who cannot walk due to advanced age. We developed a schedule by which the nurses prioritized those who stay in the palliative care department. Whereas those who could walk, provide self-service, and cook themselves were persuaded to "understand the situation" and assist, so to say, to the staff". There were problems with regular care, e.g., massage, reported: people who lie in bed often suffer from bedsores, the staff tried to provide the washing and massage at least two times a week: "Due to the staff shortage, we could not provide the care as before the COVID, but we managed to provide the service at least twice a week".
The social welfare department also reports the challenges that arose from the absence of a single database of citizens in need of LTC; there were no exact addresses or phone numbers where humanitarian aid could be delivered. As a result, a huge amount of time was spent surfing the Internet looking for addresses and contact details. Another reported problem relates to the low digital skills level - many recipients did not have online banking, and the cash payments had to be taken to their homes.

**Lessons learnt**

The COVID-19 revealed many problems in healthcare, such as a general shortage of medical staff and social workers, a deficit of medical beds, low salaries and high turnover, lack of specialists in geriatrics and palliative care and general underfinancing of the sector. After the COVID-19 outbreak, several important measures were introduced. For example, there were changes for the staff composition in the institutions to provide a better staff-clients ratio, salary for the staff was raised to provide motivation, the ethics, and educational sessions for the staff on geropsychology were included in the programme. The polyclinics increased the number of regular doctors. Akimat allocated funds for Wi-Fi coverage and installing call buttons to every room in the residential institutions surveyed (regardless of the resident's physical health status).

Akimat also introduced the Centre of Telemedicine both for medical specialists and patients. The doctors are provided with professional consultations, online courses for the doctors were introduced. Online pharmacies were actively introduced into practice. Many laboratories and infectious diseases treatment centres were opened.

The database on older persons in need of long-term care, living alone, older persons with disabilities was updated, indicating a positive shift from the declarative principle towards prevention and targeting.

One of the respondents shared an opinion that older adults (over 65 years old) became more active and more united; in addition, age discrimination issues were voiced at the level of the city Akim. Programmes for older persons and older people with disabilities were developed and introduced into the city budget.

The medical profession's prestige increased, there stated to be a re-evaluation of life values, people become more patient with each other.

One of the institutions built a greenhouse to provide vegetable and grocery products without relying on suppliers. The institutionalized older people are reported to become more proactive: outdoor activities such as physical exercise and walking become more popular. The disabled residents also showed interest in having "fresh-air" sessions. The new forms of social activities are also mentioned in the interview: "The residents started to write letters to communicate with their friends, so we developed a post, so to say. On the other hand, hand-writing was an effective way not only to communicate but also to deal with stress". Some people also engaged in window-seal gardening, and some (not numerous) residents who have smartphones could benefit from e-learning.

The Akimat also attempted to strengthen the dissemination of information and control negative publications to ensure reliability and equal access to the essential information.

Volunteer movements have developed to a certain extent. An operational volunteer headquarters was established in Almaty with the support of the Akimat. Resident students, interns, and 1–3-year students received and supervised patients with suspected COVID-19 and carried out information work with patients on preventive measures. Resident students provided full-fledged medical assistance, and those with initial
courses provided assistance that did not require higher qualifications, for example, transporting medicines for older people.

By October 2020, the youth wing of the non-governmental organization "Jas Otan" developed and presented the "Almaty Volunteers" platform, where volunteering was divided into seven areas, for example, medicine, ecology, science, sports, and charity. Various NGOs got involved. There were more attempts to systematize the work of volunteers; for example, many non-governmental organizations were united at the Almaty Volunteers platform http://almaty-volunteers.kz/.

The volunteers note that they have learned a lot, communication skills, some practical skills, in general, the problems of practical healthcare have become more understandable for them. Unfortunately, with the development of the situation, there was a drop in interest and involvement in volunteering. At the very beginning, many people wished to be volunteers; by the second wave, the enthusiasm diminished, only intern doctors and retired doctors remained. The respondent explains that it was only possible to go outside with permission during the first wave, so there were more people. During the second wave, no strict regulations were applied.
Part IV. Nur-Sultan pilot survey results

Along with a survey in Almaty, a similar study was carried out in the capital of Kazakhstan, the city of Nur-Sultan. As part of the survey, a sample of 150 social service recipients was interviewed: 100 of them living alone received services at home, and 50 were based in the Sharapat social service centre (residential home). For the study's purposes, only respondents 60 years old and older were selected for the analysis – the final sample was constituted of 38 institutional care recipients and 96 home-based recipients. In addition, a survey of carers was conducted, both informal and formal (7 social work specialists, two psychologists, 41 informal careers). Unfortunately, due to the characteristics of the questionnaire and the conditions of the survey, it is not possible to divide these categories. Furthermore, the sample was compiled through the database of one public association, so it may be biased compared to the general population, as some older people who are not covered by the support of such associations could be in a more vulnerable position.

A part of the survey, including institutionalised older people, due to the quarantine measures was carried out by filling out the questionnaires by the respondents themselves in the presence of a social worker. For those older people who, due to health reasons, cannot fill out a questionnaire (read, write, etc.) on their own, the survey was conducted jointly with social workers. The questionnaire was not adapted to the needs of the target group. As a result, the data contains a substantial number of omissions, which is important to keep in mind, while interpreting the results obtained. On the other hand, qualitative questions allow us to penetrate deeper into the nature of the phenomena and assess the impact of COVID-19 on target groups from the inside perspective.

It is interesting to note how the main page of the social service centre Sharapat website conveys the orientation of the Kazakh society towards family care and profound stereotypes about institutional care, which was mentioned in Part I of the report:

"Subconsciously, we make a certain reserve for the future, raising children. But as time shows, this is not a guarantee that in your old age, you will not be left alone with your modest needs and demands. [...] People living here [in Sharapat] also once believed that they would be happy to be loved and live surrounded by their relatives - after all, some have children, grandchildren, and relatives. But life did not turn out as dreamed; of course, the caring staff of our institution do everything possible so that the older adults and the people with disabilities do not feel lonely, but nothing can replace the comfort of the family hearth".37

Qualitative research also confirmed this position. According to experts, the city primarily needs day centres and the possibility of temporary residence for older people in institutions (for example, for the period of hospital treatment or vacations of children, who usually provide care). Still, according to the dominant view, older people should mainly live with their families.

According to the expert interview, the more positive results of Nur Sultan can be partly explained by the capital status of the city "with social publicity, issues are resolved quickly in 1-2 days, as it was in the case with the price of masks and with the availability of drugs. In Nur-Sultan, difficulties with the supply of PCR tests, e.g., did not arise, everything was organised on time". In addition, in Nur-Sultan, there are permanently functioning volunteer organisations with a longer history and experience. "The pandemic brought people closer together. A lot of people were ready to provide services to those in need on a gratuitous basis. Social workers, together with relatives and volunteers, organised uninterrupted delivery of everything older people needed. All emerging needs were met with the maximum speed and accuracy".

37 https://sharapat-astana.kz/ru/
No information about the drop-offs and concerns about privacy was received from the respondents in Nur-Sultan. The expert connects this with people's confidence in the organisation on whose behalf the survey was carried out and the fact that this organisation signed a memorandum on joint work with the main political party.

The age distribution of the respondents is presented in Table 6.

**Table 6. Age distribution of the respondents in Nur-Sultan**

<table>
<thead>
<tr>
<th></th>
<th><strong>Home-based recipients</strong></th>
<th><strong>Institutional recipients</strong></th>
<th><strong>Carers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean</strong></td>
<td>79.8</td>
<td>72.4.0</td>
<td>43.1</td>
</tr>
<tr>
<td><strong>Minimum</strong></td>
<td>60.0</td>
<td>61.0</td>
<td>25.0</td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td>97.0</td>
<td>88.0</td>
<td>75.0</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>7.1</td>
<td>7.7</td>
<td>11.8</td>
</tr>
</tbody>
</table>

**Component 1. Carers**

**Socio-demographic characteristics of the respondents**

Most surveyed carers (we remind that it is impossible to distinguish formal and informal carers) are females; 82% stated they have children (and 43% of all the respondents have school-age children). The majority provided care for one to five years (54%), followed by caring for five and more years (30%). The care is usually provided weekly, which is unexpected regarding the majority of the informal carers in the sample (Figures 38 and 39).

**Figure 38. Gender distribution and parental status**
The average age of care recipients is impossible to determine, as the carers filled the questionnaire for several care recipients at once, stating the age range, e.g., 45-80 or 70-92. Still, 52% indicated that their care recipients are in the at-risk group for COVID-19.

**Changes in everyday life and care provision because of COVID-19 and containment measures**

The carers indicated moderate changes in life because of the COVID-19 pandemic and containment measures: 34% indicated that their work schedule was affected (56% noted no change), the overall workload (work scope and schedule for paid work and unpaid work at home and family members together) increased (54% noted an increase, 30% noted a decrease, and 16% noted no change).

Was the work schedule affected? 56.0% noted an increase, 34.0% noted no change, and 10.0% noted a decrease.

Have the overall workload changed? 72.0% noted an increase, 12.0% noted a decrease, 10.0% noted no change, and 6.0% noted an increase in workload that was not expected.

Has the ability to provide long-term care changed? 62.0% noted an increase, 6.0% noted a decrease, 22.0% noted no change, and 10.0% noted a decrease in ability.

The carers indicated moderate changes in life because of the COVID-19 pandemic and containment measures: 34% indicated that their work schedule was affected (56% noted no change), the overall workload (work scope and schedule for paid work and unpaid work at home and family members together) increased...
for 12% of the respondents, decreased for 10% and remained unchanged for 72%. The ability of care provision was also not harmed – 62% indicated the usual situation, and 22% stated their ability increased, with only 6% pointing to the drop (Figure 40). The lockdown in Nur-Sultan was held in strict compliance with all sanitary standards, with the announcement of the restrictions on leaving and entering the city. Social workers lived in Sharapat during the lockdown. Still, due to the expert's opinion, this did not cause major problems, as they could be housed in the premises of the paid department, which was not completely filled. The issue of food and the organisation of its financing was resolved at the expense of a non-working day centre, usually providing food for the older visitors.

Difficulties in providing long-term care that the individuals acknowledged include lack of bus service (the bus connection was discontinued), difficulties to provide services remotely and inability to receive medical services in person. According to a qualitative expert interview, older people were not incredibly happy about remote services, and therefore the services were provided in the mixed mode whenever possible. Considering the possibilities of older adults and that some find it difficult to perceive information online, social workers tried to keep distance services in the minority. Part of the older people used mobile smartphones with the help of social workers.

Regarding the income, the situation appears to be more challenging – 42% carers reported the experienced loss of income. Still, the affordability of PPE remained quite high – only 6% of respondents were unable to afford the extra expenses on PPE (Figure 41).

Figure 41. COVID-19 effects on income and affordability of PPE

The diet changes are stated for only 6% of the respondents, difficulties with access to food, drinking water and staple goods – just for 2% - the social workers and family carers seem to be basically not affected.
Information sources

The distribution of the information sources is much more varied than in the Almaty data: 56% receive information on protecting themselves and care recipients from COVID-19 from the local authorities, 48% indicated mass media, 36% government. Other options involved social service centres, friends, and neighbours (Figure 43).

Figure 43. Sources of information about COVID-19

The awareness about COVID-19 among carers is rather high – about 12% of the respondents are unaware of the COVID-19 hotline, testing facilities and nearest treating hospital (Figure 44). 64% acknowledge that they are aware of all three options.
Mental well-being

Despite a moderate influence on the workload, the psychological tension due to the pandemic was stated by 44% of the respondents (Figure 45). The main reasons for it were being anxious about the impact of the pandemic and fears connected to being infected.

Figure 45. Mental well-being

The question about mental health changes (Figure 46) gives somewhat expected lower results. Mental health issues are associated with certain stigmatisation in society – only 12% of the respondent indicated feeling some changes. Unlike Almaty, psychological support was available for 40% of the respondents, and 84% indicated they do not need support. Psychological assistance for social workers of Sharapat was provided by the institution (staff of 2 psychologists); for social district social workers and informal careers, it can be
provided by public organisations, which can be contacted directly or via social service organisations and public associations.

The mentioning of violence cases is much rarer than reported for Almaty – 80% of carers stated that they have not heard about violence cases among cares. According to the expert’s opinion about institutionalised population, "good practices for preventing violence against older adults in Nur-Sultan include conscientiousness, correctness, openness and transparency on the side of the staff. It will be pertinent to note that the telephone numbers of the hotline, responsible specialists and employees are available for all categories of people living in Sharapat. Furthermore, in each block of Sharapat, access to the Internet is ensured; if necessary, social workers assist in the accessibility of the Internet for those who have difficulties working with the Internet". Outside of the institutions, the cases of abuse are reported only to relatives and friends (rarely because of the cultural norms) or indirectly assessed by social workers while contacting older persons. The launch of a psychological hotline dedicated to all older people experiencing neglect or abuse can be recommended.

Figure 46. Mental health and support for carers

Impact on the care recipients

The impact on care recipients (from the perspective of carers) was mainly in the form of the increased need for services (which strangely did not transfer in the equal increase of workload for social workers) – 42% of the carers indicated this option. 30% evaluate the care need as usual, and 18% even spoke about the decrease (Figure 47). The decrease could partly be explained by reducing or limiting contacts due to containment measures and a personal decision about the possibility of infecting oneself or a care recipient (e.g., decreasing the frequency of sanitary/hygiene & cleaning services, avoiding visiting doctors, or having physiotherapy at home, etc.). The regular access to medical and social services was disrupted – 38% noted that the regular services available before the pandemic became less accessible (Figure 48). Commenting on the partial decrease in the workload, the expert noted that "a feeling of fear gripped people when a wave of information about people affected and died from COVID-19 spread in the media. Especially after the spread of information about the progressive number of dying people. People were ready to isolate and refuse any contact. A terrible time that we managed to survive with great difficulty. Due to quarantine measures, visits by narrow specialists were not fully provided, and services were provided online".
The difficulties with older persons receiving pension payments were noted by 20% of the carers (Figure 47) and probably related to the rapid switch to online banking, which was inaccessible for some older adults due to a lack of digital skills or devices. On the other hand, the medical care (here, the question related not to regular medical services received as part of special social services but ordinary medical help) remained accessible. From 60% of the respondents who stated such a need, only 3% stated they could not receive it. Thus, only 2% of the whole sample experienced unmet medical needs. The close situation is with the medicines – 84% were taking medication, and 90% did not report any difficulties (Figure 49). The diet of older persons remained without major changes – 84% stated no disturbance in that area (Figure 48).

Figure 47. Difficulties in obtaining pensions and change in needs for social services.

Figure 48. Diet change and access to regular medical and social services.
The mental health of the care recipients (by evaluation of the carers) remained mostly unchanged (78%); for 12%, it even got better, and only 4% of the carers report a decline in it (Figure 50).

**Figure 50. Mental health of the care recipient**

*Social participation*

The regular social contacts before the pandemic were maintained by at least 60% of the care recipients, 54% participated in social events and 26% in religious services. Despite the stated effect of COVID-19 on social activity (56%), 78% of older persons continue to maintain social connections outside the family. Phone (fixed or mobile) and video calls were not used just by 6% of the sample (Figure 51).
Component 2. Care recipients

Socio-demographic characteristics of the respondents

Gender distribution of home-based and institutional care recipients differs significantly – the higher prevalence of women among home-based recipients can be explained by the older age of the sub-sample and the higher probability of older women living alone. 55.2% of home-based recipients and 26.3% of the institutionalised recipients indicated that they have children who, for some reason, were unable to provide needed care to the parents (Figure 52).

Figure 52. Gender distribution and parental status

Usually, the required care is provided by social workers for 96.9% of home-based recipients and 84.2% of Sharapat residents (Figure 53). Still, home-based recipients also indicated help from siblings (6.3%) and quite a frequent occurrence of voluntary help (20.8%), which was not stated so frequently in the Almaty survey (in this question, multiply answers were possible). According to the expert interview, "the volunteer movement has been actively developed in the city since the Soviet period. During the pandemic, there were
plenty of volunteer teams, and they worked harmoniously and, it should be noted, responsibly. The delivery of food and medicines was carried out contactless: delivery to the door, then video call. After establishing contact with the recipients, the delivered package was left at the door”.

The majority of home-based recipients noted the need for household help (88.5%), home cleaning (64.6%), as well as medical (57.3%) and psychological (56.3%) help. The request for psychological help and body hygiene was relatively lower for institutionalised older people (23.7% and 15.8%).

Figure 53. LTC provision

Like in Almaty, where most respondents stated the need for daily or weekly help, 85.4% of home-based respondents stated that the help is required weekly in Nur-Sultan. In Sharapat, the preference for daily provision (57.9%) is clearly in line with the institutional living settings (Figure 54).

Figure 54. Frequency of care provision
Regarding independence of movement (Figure 55), the respondents show quite similar distributions: around 55% of the respondents in both groups showed no limitations for movement. Still, the percentage of disability is slightly higher for the institutionalised older adults (26.3% against 19.8% stated).

Figure 55. Movement restrictions

For groceries shopping, more than 90% of the respondents cannot perform this daily routine by themselves. Instead, the majority is helped by social workers (100% for institutional settings and 93.8% for home-based care), with still private contacts and volunteers playing a significant role, especially for home care – more than 15% for each category (Figure 56).

Figure 56. Ability to buy groceries

Changes in everyday life and care provision because of COVID-19 and containment measures

38.5% of the home-based care recipients and 55.3% of the institutionalised older people answered that they experienced challenges during the quarantine (Figure 57). The respondents were speaking about lack of access to the city, restriction of movement and freedom, being tired of sitting at home, hypodenamia due to lack of movement, weakened blood circulation, pain, heaviness in the whole body, deterioration of health,
feelings of fear, lack of medicines in the pharmacy and lack of communication with friends and family. In most cases, the care recipients' needs remained unchanged – 70.8% of home-based recipients and 60.5% of those living in Sharapat indicated no change, 15.8% of institutionalised older people (3.1% in-home care) answered positively. Thus, it can be stated that pandemic and the following containment measures were more challenging for the institutionalised population.

Figure 57. Challenges and changes in needs and requirements during the quarantine

Only a few respondents indicated difficulties receiving pension payments and benefits during the pandemic – 8.3% of the home-based recipients and 7.9% of the institutional care, which is more than 2 times lower than the results reported by carers. Still, the affordability of PPE is on the considerably low level - 26% of the first group and 52.6% of the second group – clearly stated the inaccessibility (Figure 58).

Figure 58. Difficulties obtaining pensions and affordability of PPE

Most recipients received help from the local authorities (only 3.1% of home-based care recipients gave a negative answer) in the form of PPE, humanitarian aid, medication, and financial help (the last one almost
exclusively for the home-based recipients, as the institutionalised population is not awarded additional benefits) (Figure 59).

Figure 59. Help from local authorities

The provision of social services in Nur-Sultan remained good (Figure 60) – 60.4% of the home-based respondents indicated the usual provision schedule, 8.3% - the lower level of services and 22.9% – the higher. The results for the Sharapat are even more positive, with 50% of respondents stating the increase in availability (while 7.9% noted the decrease and 23.7% the usual level). The main comments of the respondents were related to lack of possibility of in-person access to health clinics38 and other public places (Shaparat), shortage of medicines in city pharmacies, difficulties in service accessibility from March to May (stabilised since November). Additionally, respondents spoke about services they used, like product delivery by volunteers and home delivery from the pharmacy. The same results are obtained from the direct question on the quality – only 4.2% of home-based recipients and 10.5% of the Sharapat respondents stated the changes in the quality (the direction of the change was not surveyed). The unmet need for medical help was managed to be kept at a low level – 4.2% of group 1 and 7.9% of group 2 stated they did not receive medical care, although required it; and 16.7% and 7.9% respectively received the medical services in the volume lower than required. The medicines were delivered by social workers and personal contacts or, in the Sharapat residents' case – directly by the institution.

To improve the work of social services from the point of view of respondents, social workers need to provide more communication, possess more time to be interested in the recipient's mood, be more polite, be empathetic, more attentive, do not get sick, and doing so "keep the chin up". In addition, several respondents pointed out the need to provide social workers with transport and increase their salaries.

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38 Older people living in Sharapat use the services of the polyclinic only in case of need of narrow specialists. During the pandemic, wide access to medical care was organized online for all categories of service recipients. If the circumstances were urgent, then a visit to the clinic was organized with strict precautions. Narrow specialists consulted online.
The diet remained unchanged for at least 73.1% of the respondents; the inability to buy food during the quarantine was stated for 2.1% of home-based and 28.9% of institutionalised recipients (Figure 61). The Sharapat residents noted receiving purchases via social workers and relatives (in addition to normal meals), the home-based recipients – via internet shops and social workers. The indicator of maintaining a habitual diet is significantly higher than the Almaty results. According to the expert in Sharapat, "the facts of cold food delivery have not been revealed; food delivery was organised simultaneously in all four blocks and is delivered at the right temperature to the older persons. Additionally, in each block within walking distance, including guest rooms, there is access to a microwave oven, where, if necessary, you can warm food to the required temperature". Additional investigation into maintaining the institutions’ food supply solutions could be beneficial for future containment measures.

Figure 61. Ability to maintain a habitual diet and purchase food
**Information channels**

The respondents showed a high level of COVID-19 protection measures awareness. The information was primarily received from the mass media (70.8% of the home-based recipients and 60.5% of institutionalised ones), friends and neighbours (home-based care recipients mostly) and local authorities and government (institutional care) (Figure 62).

Figure 62. Sources of information about COVID-19

The awareness of the testing facilities and COVID-19 hotline (Figure 63) is in line with Almaty findings, except for only 18.4% of the institutionalised older adults having answered positively on the hotline question, which can be explained by the availability of necessary information directly from the institution.

Figure 63. Awareness of COVID-19 facilities

The usage of the applications is higher than in Almaty settings – 14.6% of the home-based recipients and 18.4% of institutionalised ones answered positively, which can probably indicate the wider use of smartphones (Figure 64).

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Still, unfortunately, such information was not collected. The training was received by 9.4% of home-based recipients and 18.4% for Sharapat, but the timing is uncertain. Thus, it could be before-the-pandemic initiatives. The higher percentage could also be connected to higher voluntary activities or age differences of the sub-samples. No separate courses were conducted during the pandemic, according to information from the expert. Older people receive the necessary gadgets and basic skills within the family, and the need for communication encourages them to continue to use new technologies. Public associations conducted courses on the use of the Internet and devices before the pandemic, but the level of population coverage is difficult to assess.

Noteworthy, the use of telephones is considerably higher among the Sharapat residents, the use of video calls is only a bit lower. Additional investigation is needed to determine whether it is an outcome of the specifically provided measures or the consequences of the age distribution inequity (Figure 65). It should be noted that the questions about the use of a phone and video calls were combined in the questionnaire; there is a possibility that respondents could answer positively, referring only to mobile phones, while the answer was coded for both. In this case, the indicator for video calls will be overstated.

Figure 65. Usage of mobile telephone and video calls
Social participation

Before the COVID-19 pandemic, the regular social contacts were stated by 66.7% of the home-based recipients and 76.3% of the institutionalised persons (Figure 66).

Figure 66. Social contacts before COVID-19

![Bar chart showing social contacts before COVID-19](image)

The main communication partners were friends (41.7% and 44.7% respectively), relatives (33.3% and 36.8%), to a lesser extent, family (13.5% and 13.2%). The home-based older persons also noted the regular social contacts with social workers (9.4%) and neighbours (2.1%).

The participation in social and religious events is distributed according to the pattern previously revealed in Almaty – institutionalised population benefited more, as their social life is in a way preorganised by the institution. 21.9% of the home-based recipients participated in social and 12.5% in religious events, while for the institutionalised sub-sample, the results amounted to 55.3% and 34.2% (Figure 67).

Thus, the second group felt the influence of COVID-19 containment measures on social activity to a significantly greater extent (23.7% against 8.3% for social participation and 42.1% against 19.8% for activity). Still, remarkably, almost 50% of all the respondents did not indicate the pandemic influence (Figure 68).
Mental well-being

Tension during COVID-19 was openly expressed by 44.8% of home-based recipients and 39.5% of Sharapat residents (while 31.3% and 50% respectively stated the absence of such tension).
The increased tension (Figure 69) was connected to the fear of getting infected (89.6% of home-based respondents), lack of food and medication (12.5% and 7.9%) and feeling of uselessness (5.2% for group 1 and 7.9% for group 2). Recipients of care at home also reported the lack of attention from relatives and friends (6.3%) and insufficient attention from a social worker (4.2% group 1 and 2.6% group 2).

Regarding the mental well-being and stress coping strategies, 38.5% of the home-based recipients and 31.6% of institutionalised recipients reported anxiety, 35.4% and 34.2% sleep disturbance, respectively (Figure 70).

The heightened irritability was relevant for 25% of group 1 (with additionally 8.3% experiencing it occasionally) and 39.5% of group 2. The level of general stress distribution gives close results (31.3% and 42.1% for groups 1 and 2, respectively).
To deal with stress, the respondents use the following techniques and activities: chat with friends and social workers, maintain the belief in all the best, think of good, presume calmness, walk, listen to music, and perform creative hobbies, watch television or sleep. Some respondents resorted to the help of medicines, drank soothing tea. However, the most common answer was the absence of a particular method, when respondents tried not to pay attention, bypass, and try to do something meaningful.

Some 7.3% of the home-based respondents and 13.2% institutional-based ones mentioned knowing about the violence cases (Figure 72). Several respondents reported that they know about the cases but prefer to keep silent to avoid consequences. Thus, the previously done recommendation for a special hotline gains additional support.

When asked what the pandemic taught them, respondents mentioned: to take care of your health, treat yourself more carefully, be careful; protect relatives; maintain kindness and understanding; to appreciate what we have, the value of attention and communication with colleagues and friends; maintain hygiene and distance; do not humiliate, do not panic, do not get upset, maintain patience and calmness; value freedom and relationships with people, value yourself and loved ones.
V. Main conclusions

Similar to many other countries, the LTC system in Kazakhstan was not ready for the COVID-19 pandemic and the ability to respond to the challenges at the local level varied as survey results in Almaty and Nur-Sultan indicate. The main challenges across country were the health and social care staff shortage and no reliable database on LTC needs. The realisation of staff shortage led to the database systematization of social and medical volunteers, who partially helped to replace the missing staff. The LTC in the country is mainly request/application-based; there was no systematic data on LTC need and support provided for neither care recipients nor caregivers.

The primary healthcare system and medical organizations had weak procurement; there was also a deficit of infectious diseases specialists. To address it, medical centres for infectious diseases treatment and prophylactics were established. Besides, medical education was impacted, and new "old" specialities such as infectious diseases specialities were re-introduced at bachelor and postgraduate levels. The medical staff shortage led to an improved social package for doctors and other medical workers focusing initially on those directly involved with the COVID-19 response. There was a deficit of medicines during the early period of pandemic, attributed largely to speculations of private pharmacies. The subsequent establishment of the stabilization fund helped to prevent the deficits of main medicines, PPE, masks, ventilators. This resulted in better readiness for COVID-like critical situations.

Inadequate information resulted in a distrust of the government and low public awareness of the protective measures and governmental support. There was also no single reliable data resource on main COVID-19-related statistics. Nonetheless, during the second wave, the situation improved, the media was actively recruited, citizens' voices were heard, and the dialogue between the administration and the citizens was established. Many bureaucratic procedures were simplified, and medical and social services became more accessible for people.

Introduced quarantine and sanitary measures resulted in an increase of general digital literacy amongst all age groups. At the beginning of the COVID-19 pandemic, there were problems with receiving pensions, allowance payments and humanitarian help. New realities led to the development of many online-educational programmes for all ages. Still, regarding the generally low level of digital literacy among older persons and low prevalence of smartphones and use of internet it is important to ensure equal affordability, accessibility, and digital skills among older citizens to provide them with access to new initiatives and programmes.
The summary of the recommendations is presented at Figure 73.

Figure 73. Recommendations
Further, the necessary recommendations for certain categories of the population will be considered.

**Older people living alone in need of LTC**

According to current standards, special social services include socio-welfare services for older persons living alone. Considering the age and state of health of older adults, social workers for instance, carry out routine cleaning of the living space, following the schedule and agreement, no more than two times a month, undertake more profound general cleaning, including washing windows, no more than two times a year. If desired, older adults can receive additional services on a paid basis. However, according to the results of this study, it is extremely difficult to afford paid services; therefore, an increase in the duration and frequency of socio-welfare service provision would improve the quality of services and the quality of life of older adults with special needs.

Currently, social services are provided at least two times a week (standard foresees up to three-times a week); the maximum duration is no more than 2 hours. One social worker can care for eight older adults living at home. For example, 2,500 registered older adults live alone in Almaty, and 331 social workers provide services to them. One social worker is assigned to one micro-district to optimize the time spent on the road. However, many social workers spend more time shopping for food and medicines to ensure affordable prices. In addition, paying for utility bills in banks and receiving free medicines involves long queueing, which is inconvenient for both the social worker and the service recipient. Perhaps creating an electronic portal that allows to apply for the necessary medicines and products at the best price, with subsequent delivery through a courier, could optimize the process. Thus, there would be more time for communication with and the in-person service to care recipient, which should decrease complaints on the lack of attention from social workers.

According to the Standard, the social worker provides psychological, pedagogical, educational, health-improving services for the care recipient. However, due to a shortage of qualified personnel, professional competencies do not always meet the required standards for quality service delivery. Therefore, consideration should be given to divide the tasks between several specialists, for example, gerontopsychological support service with the professional psychologists separately from social workers. In addition, the involvement of NGOs or the non-profit civil sector as a potential service provider in providing psychological, educational, pedagogical services could significantly improve the quality of service delivery and, accordingly, the quality of life of not only service recipients but also social workers.

Because of the pandemic, the provision of special social services at home during the COVID-19 was performed only for the older adults in strong need of care to ensure the safety of service recipients and the social workers themselves. Social workers regularly phoned service recipients: if the older adults did not get in touch, social workers turned to neighbours. According to our research, neighbours and the media were the main sources of information for living alone older people. Many also noted that they asked neighbours to buy them food or medicine during the first and second waves. The further systematization of "good neighbourliness" would help to level the shortage of personnel in the social and medical service.

**Medical and social institutions**

Strengthening information work not only for service recipients but also for the state. As the situation with COVID-19 showed, the basic measures for the prevention of the disease were followed. However, explanatory work with residents was not sufficient, which generated mistrust and social tension among residents. Increasing residents' autonomy through ICT training, using social networks and video calls would help avoid an information vacuum and provide citizens with relevant information. In addition, motivational
and psychological work could help reduce aggression and emotional burnout among service recipients and employees.

The participatory approach to decision making may relieve tension and ensure the transition from passive consumption of services to active participation in the life of institutions, which would improve the quality of service delivery and create the right climate. The retrospective anonymous questioning and the development of programmes considering the needs of older adults, depending on their physiological and cognitive abilities, would help motivate them and adapt to modern realities.

The Standard strictly regulates the provision of social services in medical and social institutions, therefore limits the flexibility to correspond to the needs of residents. For example, doctors working in different departments (e.g., the palliative department and other departments) physically do not have time to provide qualified medical care, so increasing the staff according to the needs or changing the Standard itself adapted to the work load would not only reduce burnout among staff but and would improve the quality of services.

According to our research, narrowly specialized medical care is provided to residents through visits to the polyclinics; laboratory tests are also carried out in the same polyclinic. Considering the epidemiological situation, institutions should have their mini laboratories with basic medical laboratory tests capacities.