STUDY

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Intersectional evaluation of the impact of the COVID-19 pandemic on different groups

Gender, generational differences and vulnerable groups

Policy Department for Economic, Scientific and Quality of Life Policies
Directorate-General for Internal Policies
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Intersectional evaluation of the impact of the COVID-19 pandemic on different groups

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Abstract

This study examines the intersections between COVID-19, mental health and socioeconomic stressors in the lives of adolescents and young people, the impact of COVID-19 measures, including lockdowns, on children and vulnerable people, and efforts to tackle violence against women and domestic violence in Europe during the COVID-19 pandemic.

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LIST OF ABBREVIATIONS

CERV	Citizens, Equality, Rights and Values Programme
COVI	European Parliament Special Committee on the COVID-19 pandemic: lessons learned and recommendations for the future
EAPN	European Anti-Poverty Network
EDF	European Disability Forum
EIGE	European Institute for Gender Equality
EPHA	European Public Health Alliance
EP	European Parliament
EU	European Union
EWL	European Women's Lobby
FRA	European Union Agency for Fundamental Rights
GREVIO	Council of Europe Group of Experts on Action against Violence against Women and Domestic Violence
ILC	International Longevity Centre
Istanbul Convention	Council of Europe Convention on preventing and combating violence against women and domestic violence
PICUM	Platform for International Cooperation on Undocumented Migrants
UN	United Nations
VAW	Violence against women
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

Three years after the most severe contagious pandemic known to hit Europe since the 1918 flu pandemic, the medium- and long-term health and social repercussions of the COVID-19 pandemic in Europe are still being assessed and refined. This study aims to provide an overview of the impact of the COVID-19 pandemic, as well as lessons learned for potential future crises. It presents key findings of the **intersectional evaluation of the COVID-19 pandemic's impact on chosen populations of Europeans**, selected based on their particular socioeconomic position and vulnerability.

Aim and method

This study pursues a **threefold objective**:

- Identify and analyse the intersections between COVID-19, mental health and socioeconomic stressors in the lives of adolescents and young people;
- Examine the impact of COVID-19 measures, including lockdowns, on children and vulnerable people (older people, people with disabilities, migrants and refugees and poor communities);
- Look into the COVID-19 shadow pandemic: violence against women and domestic violence in Europe (data collection of the last two years; the EU and Member States´ challenges; and the added value of the Istanbul Convention).

An extensive **literature review**, **data analysis,** and **consultations** (interviews with EU key stakeholders and focus group discussions), complemented by **five illustrative case studies** have helped define the impacts of the COVID-19 pandemic.

Key findings

Between 2020 and 2022, the pandemic profoundly impacted the lives and **mental well-being** of **adolescents and young people**. Adolescents and young people are sensitive populations, who already faced intersecting mental health and socioeconomic stressors prior to the COVID-19 pandemic. The most visible impact of the pandemic on student populations, i.e. closures of education establishments, not only limited access to human and social capital, but also deteriorated adolescents' and young people's mental well-being. In addition, closures limited the identification and care of psychological disorders. The transition to 'emergency remote teaching' was largely unprepared, although successful in universities, and highlighted socioeconomic inequalities.

Overall, the **socioeconomic situation of young people** also suffered. Young people were hit harder by redundancies and confronted with difficulties in accessing employment as entrants to the labour market. The less favourable employment conditions of young people and their overrepresentation in economic sectors affected by closures can in part explain the redundancies. From a mental health perspective, unemployment of young people has been associated with higher psychological distress and the feeling of exclusion from society. Young people's expected income, financial stability, and housing security were also affected, underlined by the large proportion of students and young workers returning to their family households.

During the COVID-19 pandemic, **young people's mental health deteriorated** more intensely than that of other age groups as a result of mostly non-pharmaceutical measures (i.e. restrictions of activities and physical contacts). Especially, the prevalence of mental distress (anxiety, depression), rose particularly sharply among young people. Despite a rapid recovery of the mental well-being of young people in 2022 compared to other age groups, indicators remain below pre-pandemic levels. Several

factors have modulated adolescents' and young people's mental well-being during the pandemic. Most notably, gender, lower level of education, and lower socioeconomic position were associated with lower levels of mental health.

Access to mental health support is essential but was heavily disrupted during the pandemic. Online psychological resources and support provided a much-needed second-best for young people but did not appear sufficient nor suitable for all situations.

Children's mental health was an issue already before the pandemic. The closure of schools, childcare and sports facilities, as well as movement restrictions and confinement, created feelings of isolation, fear, anxiety, and, in some cases, depression in children. In this context, the home environment was crucial for the development of children. Parental stress due to employment status and the economic situation, as well as the uncertainty and fear of being exposed to the virus, often led to tensions among family members and cases of child abuse and domestic violence. On another note, home schooling increased educational and social inequalities, whereas the extensive use of the internet often led to internet and gaming addictions among children, and also amplified cyber-bullying and online sexual exploitation.

Older people - one of the most vulnerable groups affected by COVID-19 – encountered problems in meeting their healthcare needs, as a result of the restrictive measures imposed. The 'no visitor policy' implemented in many European countries, meaning prolonged isolation from family and friends, and prohibition of contact with people living in the same facilities, caused emotional stress, mental decline and cases of depression. For the ones living in long-term care facilities, their close proximity to others and the institutions' initial lack of readiness to protect them properly during the first COVID-19 wave increased the risk of infection. The lack of knowledge or physical ability to use digital tools, along with the lack of necessary devices for economic reasons or having connectivity issues contributed to the feeling of isolation, whereas 'information overload' was reported from older users of digital tools.

People with disabilities faced increased levels of discrimination and stigmatisation, along with social exclusion and low-quality or inaccessible healthcare services. Due to movement restrictions and confinement, people with disabilities were often at risk of physical or sexual violence.

Migrants and refugees – suffered higher mortality rates compared to native-born people, due to the poor housing conditions and having jobs that turned out to be some of the riskiest during the pandemic. Asylum seekers and unauthorised immigrants with irregular immigration status faced additional barriers with limited access to health services and vaccination processes.

Poor communities - people without a home, sleeping on the street, or in temporary accommodation - have been under continuous risk of infection of COVID-19 either due to difficulties in accessing healthcare and public health information or due to their living conditions, i.e. often overcrowded or unsanitary housing. Among ethnic minorities, Roma experienced additional barriers in accessing public health and healthcare services, due to their long-standing lack of trust between patient and care providers, making them particularly vulnerable to chronic diseases and conditions. In addition to the feeling of stress and lack of motivation as a result of lockdown measures, people belonging to poor communities continued to face systematic social stigmatisation and discrimination during the pandemic.

The COVID-19 pandemic resulted in a **shadow pandemic** of violence against women. Evidence shows that there was a direct increase in the incidence and prevalence of **violence against women**. Numerous factors contributed to the rise in prevalence and intensity of violence, including financial and mental stress, health issues, the responsibility of caring for children during school closures, difficulty in accessing services due to pandemic restrictions, and an increased time spent being stuck at home together with the perpetrator because of lockdown measures.

Given the reliance on and widespread use of digital tools at the time of the COVID-19 epidemic, women were at an increased risk of experiencing **cyberviolence**. Women affected by overlapping or multiple forms of discrimination, such as older women, migrant women and women with disabilities, were more vulnerable and disproportionally affected by the negative impacts of COVID-19.

The COVID-19 pandemic exacerbated **challenges in data collection** on violence against women and domestic violence, such as lack of data, issues of comparability and completeness and issues of statistical reliability, and added new ones. Even if in practice violence against women increased, in some cases a **decrease in reporting** was noticed. This was due to several factors such as difficulties in reaching a vulnerable population during the pandemic, increased coercive control by perpetrators and lack of mental space for the victims necessary to understand the gravity of the situation they were undergoing.

The rise in the prevalence and intensity of violence against women was aggravated by the **challenges experienced by service providers** as a result of pandemic mitigation measures, such as an increase in demand, staff shortages and prohibition of in person contact. These challenges contracted the sector and aggravated the situation for victims whose access to the services was reduced.

The ratification of the **Istanbul Convention** triggered amendments to the existing legislation and/or the adoption of new measures to support and protect women from violence and abuse. However, difficulties were encountered in implementing these actions, with **resources diverted from violence against women to immediate COVID-19 relief**.

The added value of the Istanbul Convention lies in its **comprehensiveness** and several stakeholders advocate for a ratification of the Convention at the European level.

No specific EU-level legal instrument exists yet to address violence against women and domestic violence. The adoption of **a new Directive on combating violence against women and domestic violence** could be greatly beneficial.

1. INTERSECTIONS BETWEEN COVID-19, MENTAL HEALTH, AND SOCIOECONOMIC STRESSORS IN THE LIVES OF ADOLESCENTS AND YOUNG PEOPLE

KEY FINDINGS

The life of adolescents and young people is one of **key changes, transitions and challenges**. This sensitive population already faced intersecting mental health and socioeconomic stressors in their lives prior to the COVID-19 pandemic. Between 2020 and 2022, the pandemic strongly impacted their developmental pathways, personal lives, living conditions, education and training, and access to employment.

The **closure of education establishments** not only limited access to human capital (knowledge, skills) and social capital (relationships) but also worsened young people's mental well-being, in particular in years with more academic pressure or professional training implications. Closures also made more difficult the identification of psychological disorders and the provision of direct support. The transition to 'emergency remote teaching' was largely unprepared, although considered generally successful in universities, and this shift exacerbated the persistence of socioeconomic inequalities (access to equipment, digital divide).

Some positive trends observed in young people's socioeconomic situations since the rebound from the 2008 financial crisis have been reversed by the pandemic. In particular, young people were hit harder by **redundancies** and generally confronted with **difficulties in accessing employment**. This can be explained by the employment conditions in which young people are generally hired, and by their overrepresentation in economic sectors affected by closures. From a mental health perspective, unemployment has been associated with psychological distress and a stronger feeling of exclusion from society compared to students or active youth.

Moreover, the economic restrictions have affected young people's **expected income, financial stability, and housing security**. The proportion of young people at risk of poverty increased by 1.5 percentage points in 2020. In the meantime, a large number of young people requesting support from the state, for various reasons, have not received it. Between July 2020 and March 2021, 75 % of students and 42 % of young workers were found to live with their parents, protecting them to a certain extent against economic hardship.

Most **non-pharmaceutical interventions** (i.e. restrictions of activities and physical contacts) adopted by governments to protect populations against the spread of SARS-CoV-2 deteriorated young people's mental well-being more intensely compared to other age groups.

The **prevalence of mental distress** rose among young people during the pandemic, in particular anxiety and depression, in higher proportions compared to older age groups. Despite a faster recovery in 2022 compared to other age groups, the mental well-being of young people remains below pre-pandemic levels. The long-term effects on adolescents and young people's mental health will require significant research and investments.

Studies reviewed highlight several **factors modulating adolescents and young people's mental well-being** during the pandemic. Most notably, female gender, lower level of education attainment, and lower socioeconomic position are associated with lower levels of mental well-being.

Access to mental health support is essential for adolescents and young people but was heavily disrupted during the pandemic, in particular due to school closures. The provision of online mental health support provided a much-needed alternative for young people but does not appear sufficient nor suitable to all situations.

The life of adolescents and young adults is marked by key **changes and transitions.** Their choices of tertiary education and career path, their entry into the workforce, their intense social and romantic lives, and the unprecedented changes in their living conditions are just some of the significant **challenges** that define their lives (Shanahan et al., 2022). These transitory characteristics are associated with both **adolescence**, as the period between childhood and adulthood (between the ages of 10 and 19, according to the World Health Organization (WHO)), and **young adulthood** (typically between the ages of 18 and 24 years, although some research and policy documents extend it to include the 25-29 age group).

Adolescents and young people **were already facing intersecting mental health and socioeconomic stressors** in their lives before the COVID-19 pandemic (Elgar et al., 2015; Reiss, 2013; Reiss et al., 2019; Vukojević, 2017). This chapter examines the intersections between the socioeconomic and mental health impacts of COVID-19 on adolescents and young people in order to better understand how the **additional challenges arising from the pandemic** increased their vulnerabilities and mental health risks.

1.1. Impact of the COVID-19 pandemic on the mental and emotional development of adolescents and young people

1.1.1. Non-pharmaceutical interventions impacting the lives of adolescents and young people

The COVID-19 pandemic and related restrictions adopted by governments in Europe and globally had a significant impact on young people's **developmental pathways, personal lives, living conditions, education, training and access to employment**. In parallel, their **mental well-being also suffered** (Kauhanen et al., 2022). The quality of an individual's daily experiences, the satisfaction of needs, the potential to accumulate human capital, and relationships with peers and other members of society all have an impact on mental health (Eurofound interview) – all of these factors deteriorated during the pandemic.

In most Member States, during the most severe COVID-19 outbreaks, adolescents and young people, like other citizens, were **obliged to stay at home** (lockdowns, curfews and quarantines), while their **educational establishments remained closed** (for varying lengths of time and with diverse modalities). Governments imposed additional and/or subsequent **'social distancing' requirements** (or recommendations) that limited adolescents' and young adults' interactions with their peers and with adults outside their households.

Non-pharmaceutical interventions[1] designed to prevent the COVID-19 virus from spreading **had a significant impact on the lives of adolescents and young people**:

- Containment and closure
    - stay-at-home requirements
    - intra-country movement restrictions
    - international travel restrictions
    - private gathering restrictions
    - cancellation of public events

[1] Non-pharmaceutical interventions are actions other than getting vaccinated and taking medicine that people and communities can take to slow the spread of illnesses. Classification based on Toffolutti et al. (2022).

  - school closures, workplace closures
  - public transport closures
- Health
  - testing policies
  - contact tracing
  - mandatory face covering

The decline in mental health is more attributable to these interventions than the fear of contracting the COVID-19 (Eurofound Interview). Research on the effect of various interventions on mental well-being found that restrictions on international travel and private gatherings, and contact tracing had the greatest effects on the general population (in order of importance), with important differences in the significance of each intervention in time and within sub-populations (women/men; residing with children or not; geographical differences within the European Union (EU)). Some research has suggested that certain non-pharmaceutical interventions pushed individuals below the depression-risk threshold (Toffolutti et al., 2022).

1.1.2. Adolescent and young adult development during the COVID-19 pandemic

Adolescence is a crucial developmental stage that is characterised by a rise in **social sensitivity and importance of peers**. Peers help to 'guide behaviours, shape self-concept, and gauge self-worth' (Magson et al, 2021). Adolescents heavily rely on their peer connections for emotional support (Magson et al., 2021) and **interaction with peers is considered a 'vital aspect of development'** (Orben et al., 2020).

Not being able to meet **their friends during COVID-19 lockdowns** was the greatest concern for adolescents, followed by the risks to other people´s health. However, they expressed **little concern about the pandemic's effects on their own health**. By contrast, among adults, family members contracting COVID-19 was the biggest worry (Magson et al., 2021, survey of Australian adolescents).

Government restrictions on social gatherings and cultural events **limited adolescents' social lives and social development**. The opportunities to develop social networks and build their social capital shrank dramatically (Eurofound, 2021a). Some research found that adolescents between the ages of 13 and 15 showed higher **depressive symptoms** during lockdowns than children between the ages of six and 12, possibly due to their **increased need for social contact and interpersonal relationships** (Panchal et al., 2021).

Young adults' **pre-pandemic emotional distress** was the **strongest predictive factor of emotional distress during the pandemic**, followed by during-pandemic economic and psychosocial stressors and pre-pandemic social stressors (e.g. bullying victimisation, feelings of social exclusion, or stressful life events (Shanahan et al., 2022)).

The requirement to stay at home also **hindered adolescents' efforts towards gaining independence from their parents.** In particular, lesbian, gay, bisexual, transgender and queer (LGBTQ+) adolescents and young people showed consistent declines in mental well-being (Fish et al., 2020) because they were sometimes isolated with unsupportive families and lacked opportunities to socialise in person with their peers or receive support. This took place in the context of existing pre-pandemic disparities in the health and mental health of this group (Fish et al., 2021).

Prosocial experiences (e.g. providing support, sharing, giving) were a meaningful developmental characteristic of adolescents and young adults during the pandemic. A study evaluating the emotional support provided by Dutch adolescents to family, friends and unknown others highlighted strong

support for pandemic targets (doctors, patients, at-risk persons). The beneficiaries of **prosocial behaviours with friends and family differed by age:** adolescents (15-17) were focused on their outward social circles, i.e. friends, whereas young adults (18-25) targeted their inward social circles, i.e. family members (European Commission, 2022a; Sweijen et al, 2022). However, other research suggested that engaging in COVID-19 prosocial behaviour was associated with anxiety symptoms and feelings of burdensomeness, although it is not certain whether these feelings are the cause (prosocial behaviour as a coping mechanism) or the consequence (Alvis et al., 2022).

Feeling socially connected was a protective factor for mental health during the pandemic, preserving individuals from anxiety, depressive symptoms, and lower levels of life satisfaction (Magson et al., 2021). As schools closed and out-of-school physical gatherings were prohibited or restricted, adolescents and young people turned to **digital means to maintain contact** with their friends and peers. There were fears that this could have **long-term negative consequences for mental health** (Organisation for Economic Co-operation and Development (OECD), 2021a) and lead to **smartphone and internet addictions**. However, preliminary evidence suggested that digital communication limited the mental health consequences of physical distancing, facilitating communication and social support, while retaining key components and qualities of face-to-face interactions. **Online socialisation with friends should be distinguished from other uses of devices and the internet**, considering that passive use (consumption of online content) was not linked to positive mental health outcomes (Orben et al., 2020).

1.2. Impact of the COVID-19 pandemic on the socioeconomic situation of adolescents and young people, and mental health implications

This subsection reviews the impact of the pandemic on adolescents' and young people's socioeconomic situation and the related mental health consequences, focusing particularly on **access to education and skills**, **employment and activity,** and **financial and housing situation**.

1.2.1. Disrupted access to education and skills

Education establishments play multiple roles and are not only places where students acquire knowledge and skills (human capital), but also where they develop peer socialisation and belonging (social capital), practice physical activity, receive social and emotional support from adults beyond their household circle (teachers, professors, education personnel), and adhere to a daily routine. Significantly, schools are often **primary points of identification and referral for psychological disorders** (OECD, 2021a; OECD, 2022a). When educational establishments were closed during the pandemic, their role as a development driver and protector of students' mental health was significantly constricted.

A considerable proportion of tertiary education, courses and lectures moved to online or blended/hybrid education. For most of 2020 and 2021, there was serious disruption to the regular ways students in high school/university and young professionals acquired knowledge and professional experience. Many Member States chose to prioritise the presence of younger pupils and students in education establishments over students who were considered more independent in their learning and more familiar with digital tools. In addition, students were evaluated via online exams, and certain education establishments abandoned final exams or substituted them for assessments by teachers and professors, which had an impact on university placements (Eurofound, 2021b). A study on young Spanish people during the pandemic found that teenagers in years with more academic pressure

(exams for university entry) or in professional training (traineeships) showed more anxiety and depression (Pizarro-Ruiz and Ordóñez-Camblor, 2021).

Education systems were **not prepared to provide quality online education and training**. Key challenges were the choice of the most appropriate technologies and methodologies, and the absence of prior training (European Commission, 2022b). Indeed, an important distinction must be made between 'emergency remote teaching', as experienced during the pandemic, and planned and organised 'online learning', where the materials and methods are specifically developed and suited. Nevertheless, it appears that **most higher education institutions successfully transitioned** to remote teaching (European Commission, 2022b). Almost half of students believed that their academic performance worsened (European Commission, 2022b), while only 40% of students in the Member States were satisfied with the quality of remote teaching during the pandemic as of July 2020 (Eurofound, 2021b). Student satisfaction does not reflect the quality of teaching alone, as these new forms of learning presented new challenges and potentially created their own stressors, such as technical problems, limited understanding of learning materials, inability to ask questions, limited motivation, boredom, anxiety, frustration and anger (European Commission, 2022b).

As of July 2020, 21% of students did **not have sufficient equipment to study online** at home, with higher proportions among students having difficulties making ends meet (26%) and those living with their parents (23%) (Eurofound, 2021b). School closures and distance learning exacerbated pre-pandemic **educational inequalities** (European Commission, 2022b). Such inequalities were confirmed in OECD countries, with 20% of students in disadvantaged schools not having access to a computer and more than 10% lacking the quiet study space necessary for online schoolwork (OECD, 2020a). Studying online requires appropriate equipment (in particular, a personal computer, and reliable internet access), as well as a dedicated study space (Eurofound, 2021b), when university libraries were not accessible. These difficulties may have been reinforced by the absence of a supportive family environment (for many reasons), in a context where in-person exchanges with education personnel were not possible (Eurofound, 2021b). Surveys among students highlighted the significance of person-to-person interaction and synchronous interactions (European Commission, 2022b).

For young adults in transition from education to the labour market, 'training pathways' and 'work-based learning', in the form of **traineeships, apprenticeships, or first employment opportunities, were heavily disrupted by the pandemic** (European Parliament, 2021). More generally, the pandemic created difficulties for newly graduated young people to access the labour market.

1.2.2. Prospects, access to, and maintenance in employment

Following the recovery from the 2008 financial crisis, the COVID-19 pandemic **reversed the positive trends observed in many indicators of young people's socioeconomic situations**. To better understand the impact of the pandemic on young people's employment situation and prospects, it is important to understand the situation as it existed before the onset of the pandemic: young people often worked in lower quality jobs, on temporary contracts, and with low revenues (Eurofound, 2021b). The OECD figures showed that 35% of young people (15-29) were employed in low-paid and insecure positions on average in 2019, compared to 15-16% for older age groups (OECD, 2020a).

The restrictions on economic activities and preservation of employment via subsidisation, as well as considerable uncertainty about the course of the pandemic, **limited companies' willingness to hire new employees or trainees**. In addition, young workers in the context of their studies or training, or those already in employment, were hit hardest by **redundancies**. This is explained by the prevalence

of more precarious employment conditions (part-time, temporary contracts), lack of seniority in companies, and the principle of 'last in, first out' (Eurofound, 2021b).

In the spring of 2021, one year after the pandemic began, young adults aged 18 to 29 were the population **most likely to have become unemployed** as a result of the pandemic (17% unemployed, compared to 9% for older working age groups) (Eurofound, 2021a). The rise of unemployment between 2019 and 2020 was strongest among 15-29-year-olds compared to older populations, increasing by 1.4 percentage points (p.p.) (Eurofound, 2021b). In parallel, Eurostat estimated that the youth employment rate (same age range) fell by 2.3 p.p. in the same period. A significant rebound was observed in 2021, but the employment rate remained 0.7 p.p. below pre-pandemic levels (2019). There were significant differences across Member States and the extent of the recovery varied: higher youth employment rates in 2021 (compared to 2019) were observed in the Netherlands, France, Ireland, Germany and Denmark, while they remained below pre-pandemic levels in most of the Member States (Eurostat, 2022a).

Job vacancy rates between 2019 and 2020 suggest that the **high proportion of young people working in economic sectors heavily impacted by non-pharmaceutical interventions** may help to explain the pandemic's harsher effects on youth employment (15-29). Compared to adults over 30, the employment of young people was higher in accommodation and food services, wholesale and retail (depending on the region), arts and entertainment, and health and social work in 2019. Accommodation and food service was the first sector impacted by the decrease in the job vacancy rate between 2019 and 2020 (-1.2 p.p.). Wholesale and retail experienced a smaller decrease, on average. Nevertheless, a more nuanced analysis reflected Member States' economic profiles and level of stringency of responses during the pandemic (Eurofound, 2021b, based on EU Labour Force Survey (EU-LFS) 2019).

When looking at the employment conditions in these sectors, retail, accommodation and food service have high rates of **temporary contracts** (36% of 15-29-year-olds in 2019, compared to 15% for the whole population) and **part-time jobs**. Temporary contracts may be linked to **job insecurity**: there was a 3 p.p. drop in temporary contracts in 2020, hinting at a reduction in jobs for young adults and for the general population. In 2019, young people worked more in part-time employment compared to other age groups (22%, compared to 18% for the whole population) and this figure remained stable throughout the pandemic. Interestingly, in 2019, almost half of students with part-time contracts (47%) took those contracts as a result of their education, i.e. to finance their studies and/or costs of living. Similar numbers were recorded in 2020, while a further one-quarter (27% in 2019 and 24% in 2020) took part-time contracts because they could not find full-time work. Part-time work is linked to greater financial difficulties (Eurofound, 2021b).

Recent graduates had **difficulties finding jobs** during the pandemic: the percentage of young people in employment within three years of leaving school decreased across all levels of education from 75.7% to 73% between 2019 and 2020, with notable differences between Member States (baseline and dips). Due to the economic uncertainty facing businesses and pandemic-related health and safety restrictions, the path between education and employment through apprenticeships and traineeships was more difficult for those enrolled in vocational training (OECD, 2021b). Highly skilled young people may have had to take jobs below their qualification levels to enter the employment market (Eurofound, 2021b).

Unemployment is associated with poorer mental health (Gedikli et al, 2022; Picchio and Ubaldi, 2022) **and depressive symptoms** (Amiri, 2022). Unemployment was found to be associated with greater psychological distress among Israeli young people during the pandemic (Achdut and Refaeli,

2020). While employment and its corresponding revenue enable access to goods and services, from the perspective of mental health, employment serves to facilitate socialisation with peers and define workers' sense of their role in society (e.g. perception by others, sense of purpose). Unemployment or inactivity of young adults dramatically increased their risk of depression and feeling excluded from society, compared to students and young workers (Eurofound, 2021a). The OECD acknowledges the important role of (meaningful) employment, education and social protection as protective factors in promoting good mental health (OECD, 2022a).

From a broader perspective, adverse economic conditions change **young people's outlook on their future careers and socioeconomic status**. Eurofound data show that young people's levels of optimism about the future exceed those of older adults. Looking at specific factors, personal financial difficulties and job insecurity are strongly negatively correlated with young people (aged 18-29) feeling optimistic about their future (Eurofound, 2021b). This uncertainty seems to be clearly perceived by young workers and reflected in their appraisal of employment prospects: during the pandemic, the highest levels of feelings of job insecurity were identified among young people, reaching 32% (Eurofound, 2021b).

1.2.3. Financial and housing situation

Some young people were under considerable **financial stress** as a result of being unemployed/inactive, being unable to find employment, or involuntary poor working conditions (low-paid jobs, part-time), which can lead to in-work poverty. The proportion of young people (15-29) at risk of poverty increased by 1.5 p.p. between 2019 and 2020, from 25.1% to 26.6% (Eurofound, 2021b). The risk of poverty is higher for young people losing employment, given their lower capacity of having accumulated savings (OECD, 2020a).

Students who relied on part-time employment to fund their studies and cover living expenses may have experienced serious financial difficulties or been forced to give up their studies (permanently or temporarily). In July 2020, 47% of young people in **unemployment or inactivity** experienced financial difficulties (50% had no savings), while 23% experienced housing insecurity (Eurofound, 2021b). Economic hardship was limited for some, with a large proportion of young people, students or unemployed people **living with their parents**. At the end of 2022, households' financial difficulties remained significant, particularly in view of the strong inflation wave in Europe (Eurofound, 2022a).

Young people in **precarious financial situations** had **higher risks of mental health issues**. A significantly higher proportion of these young people were at risk of depression, compared to those who did not report financial difficulties during the pandemic. This confirms the pre-pandemic association of lower income with increased risks of poor mental health (OECD, 2022a).

Young Europeans' financial difficulties, housing instability, and feelings of exclusion from society appeared to be greatly reduced by receiving **financial support from social security systems**. However, Eurofound survey data show that 11% of those who requested support from their State in any form (one-third of young people aged 18-29) had not received it by spring 2021 (Eurofound, 2021b). Undoubtedly, a wide range of individual factors and circumstances contributed to this outcome and governments should consider whether and how young people are more likely to fall through the gaps in the safety nets of social security systems. A cohesive system of unemployment benefits, furlough, and non-contribution-based social security for adolescents and young adults would constitute valuable protection in times of crisis.

A significant number of young adults enrolled in higher education **returned to live with their families** due to their difficult financial situations or the lack of (affordable) student housing in many universities. Young people generally have more precarious housing situations, as they are less likely to be homeowners or are more likely to have a more recent mortgage (Eurofound, 2021b; OECD, 2022b). Between July 2020 and March 2021, the number of **young people (18-29) living with their parents increased** by 10 p.p., representing 75% of students, and, more strikingly, 42% of young people who were employed at the time of the Eurofound survey in March 2021. Other students did not have family households or other spaces to move to for their studies, potentially increasing the risk of becoming homeless.

Returning to live with their parents may have limited young people's freedom and autonomy, **slowing down the 'path to adulthood'** (Eurofound, 2021b) represented by financial autonomy and independent living. However, young people who lived with their parents gained some financial and housing security and reduced their financial strain. It also protected those who were unemployed or inactive from feeling socially excluded, although students felt more socially included if they lived away from their parents (Eurofound, 2021b).

Living alone was found to be a risk factor for increased anxiety and depression during the COVID-19 pandemic in Belgium (Sciensano, 2021) and for social exclusion (Eurofound, 2021b). Spending time with a cohabitating family member served as a protective factor against depression (and loneliness) for Canadian adolescents, as social support represents a buffer against risk factors (Ellis et al., 2020). Social isolation and loneliness are predictors of poor mental health for children, adolescents and young adults, in particular depression, which may develop several years later (Loades et al., 2020), suggesting a need for sufficient mental health supports for young people in the medium-term aftermath of the pandemic. However, some adolescents were unwilling to spend more time with their household family members, which may have negatively impacted 'family well-being'. By contrast, additional time with household family members put adolescent victims of abuse in greater danger (Green et al., 2021).

1.3. Quantification of the impact of the COVID-19 pandemic on adolescents' and young people's mental well-being

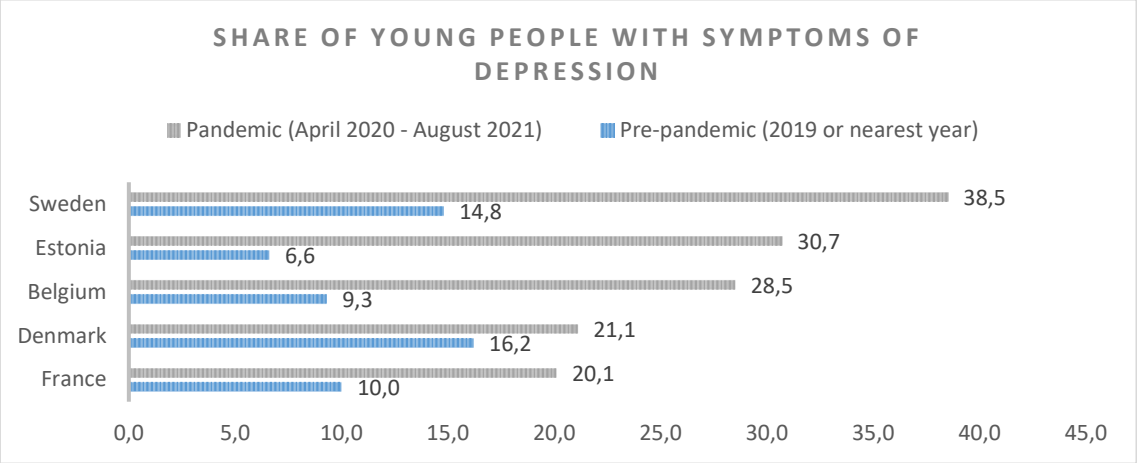
Mental illnesses and mental ill-health are difficult to measure, particularly among young people. Mental illnesses can be identified either through **external behaviours** (e.g. aggressivity, oppositional stance), but are often **internalised** and thus more difficult to identify (European Commission, 2022a). The range of symptoms identified during the COVID-19 pandemic included **anxiety and depression**, but also **loneliness, psychological distress, anger, irritability, boredom, fear, stress, self-harm, and eating disorders** (Nearchou et al., 2020; Oliveira et al., 2022; Panchal et al., 2021; Panda, 2021; OECD, 2022a; INSERM interview).

Prior to the COVID-19 pandemic, in 2019, more than one in six young people (15-29) in the EU (more than 14 million) had a mental health issue (OECD, 2022a), but young people generally had higher mental well-being than other age groups (European Quality of Life Survey (EQLS), 2016; Eurofound, 2018). However, the first results of surveys assessing the levels of young people's mental health during the COVID-19 pandemic surprised researchers by showing that **the pre-pandemic situation had reversed** (OECD, 2022a; Eurofound interview).

Symptoms of depression among young people multiplied two- and threefold during the pandemic, according to available national longitudinal statistics. In some Member States, at certain times, the share of these young people reached twice the share of all adults. Similar trends are observed for **symptoms of anxiety** (OECD, 2022a). According to Eurofound's 'Living, working and COVID-19'

survey, in spring 2020, summer 2020 and spring 2021, **more young people (18-34) reported feeling tense, lonely or depressed than older people. On average, young women had more negative feelings than young men** (Eurofound, 2021a). The **life satisfaction of young people dropped** from 7.4 (out of 10) in 2016 (Eurofound, 2018), to 6.3 in spring 2021, with lower averages among unemployed young adults and differences across EU country groups (Eurofound, 2021b).

Figure 1: Pre-pandemic and during-pandemic share of young people with symptoms of depression, selected Member States



Source: OECD (2022a), Health at a Glance: Europe, 'Symptoms of depression amongst young people more than doubled in several European countries' (based on data from public health institutes and Eurostat).

The impact of the pandemic on mental well-being was stronger in spring 2021 than spring 2020, after the beneficial effect of the lower incidence of the pandemic during summer 2020 had faded (Eurofound, PPT). Peaks of the COVID-19 pandemic were associated with a degradation in the population's mental health (anxiety and depression) in France and Belgium (OECD, 2022a). In spring 2021, two-thirds (64%) of EU survey respondents aged 18-34 were **at risk of depression** (Eurofound, 2021a).

Suicide is one of the leading causes of death among young people. Recent studies reported contrasting results, although a meta-analysis of October 2022 reported an overall annual increasing trend between 2019 and 2020 among young people under 19 years old, in particular of suicides among young people psychiatric settings (Bersia et al., 2022). Preliminary evidence from the Member States also suggests an increase in the incidence during or in the aftermath of the pandemic (e.g. Belgium). Consolidated Eurostat data on the prevalence of suicide among European adolescents and young people (TPS00202) are not yet available for 2020-2022. However, figures are available on the striking increase in **suicidal thoughts**, with a fivefold increase observed in Belgium and France. According to the OECD, this represented one in four young Belgians and French respectively in March 2021 and September 2022 (Sciensano and Santé Publique France via OECD, 2022a). Data from France and the Netherlands showed that the number of emergency visits for suicidal ideation of young people remained much higher than pre-pandemic (OECD, 2022a).

Unfortunately, the **psychological disorders** prompted or worsened by the pandemic were **not resolved as quickly as desired**. The lifting of restrictions did not lead to a recovery of mental health to pre-COVID-19 levels. The population's mental well-being may suffer long-term repercussions from so-called stress proliferation. According to the most recent estimates, the risk of depression (WHO-5 score) remained very high in spring 2022 for the whole population but in particular for younger adults (49% of the 60+ population, compared to 58% for 18-29-year-olds). However, despite a greater

propensity for reduced mental health during the pandemic, spring 2022 data showed that **young adults 18-29 recovered their mental health more quickly than older age groups**. Nevertheless, this age group continues to experience more negative emotions and depression (Eurofound, 2022a): in early 2022, anxiety and depression symptoms were still double the pre-pandemic levels (Eurofound, 2022a; OECD, 2022a).

1.4. Mitigating the impact of the COVID-19 pandemic on mental health

The vast **majority of mental health disorders start in adolescence** (Solmi et al., 2022), meaning that adolescents and young people may be a particularly **vulnerable** population group and it is **essential to protect their mental health**. According to a large-scale study in the United States (US), 75% of adults who say they've ever had a mental health condition say their first symptoms appeared during adolescence (Kessler et al., 2012).

Notwithstanding the specific mental health characteristics described above, a general improvement of employment and financial security is the most powerful tool to improve the socioeconomic situation of young people, including in times of crisis. Such improvements can also help to maintain their mental health to levels comparable to those of the whole adult population.

1.4.1. Factors impacting the response to socioeconomic stressors of adolescents and young people

The literature reviewed allows for several preliminary observations in respect of the risk factors for developing psychological distress during the pandemic:

- **Gender**: generally, female adolescents and young women are more affected by mental health issues, and this was clearly confirmed during the pandemic (Magson, 2021; Mansfield, 2022; Ozamiz-Etxebarriat, 2022; Panchal, 2021; Pizarro-Ruiz, 2021; Theberath, 2022 (meta-analysis); Thorisdottir, 2021).
- **Media exposure to COVID-19 news**: being highly exposed to media reports about COVID-19 was significantly associated with increases in anxiety and depression and declines in mental health in young people (Panchal et al., 2021; Wang et al., 2020; Strasser, 2022). Other researchers did not find any association between media exposure and anxiety, quality of life, or depressive symptoms (Magson et al., 2021).
- **Use of social media**: increased social media use was associated with increased adolescent depression and anxiety (Ellis et al., 2020; Lee et al., 2022). Further results showed that, although most studies reported a positive association between poor well-being and social media use, and poor well-being and media addiction, not all types of digital media use had adverse consequences for adolescent mental health. In particular, one-to-one communication, self-disclosure in the context of mutual online friendship, and positive and funny online experiences mitigated feelings of loneliness and stress (Marciano et al., 2022).
- **Socioeconomic status and education level**: education is positively associated with well-being, with lower anxiety and depression reported in people with higher education (Sciensano, 2021). Socioeconomic disadvantage is associated with higher levels of social stress (financial strain) and is directly associated with mental distress (Schoon and Henseke, 2022). Adolescents in higher socioeconomic positions showed a greater difference in life satisfaction between the control group and the COVID-19 group (Mansfield, 2022). Indirectly, young people from lower social classes were more affected by the loss of employment (OECD, 2021c).

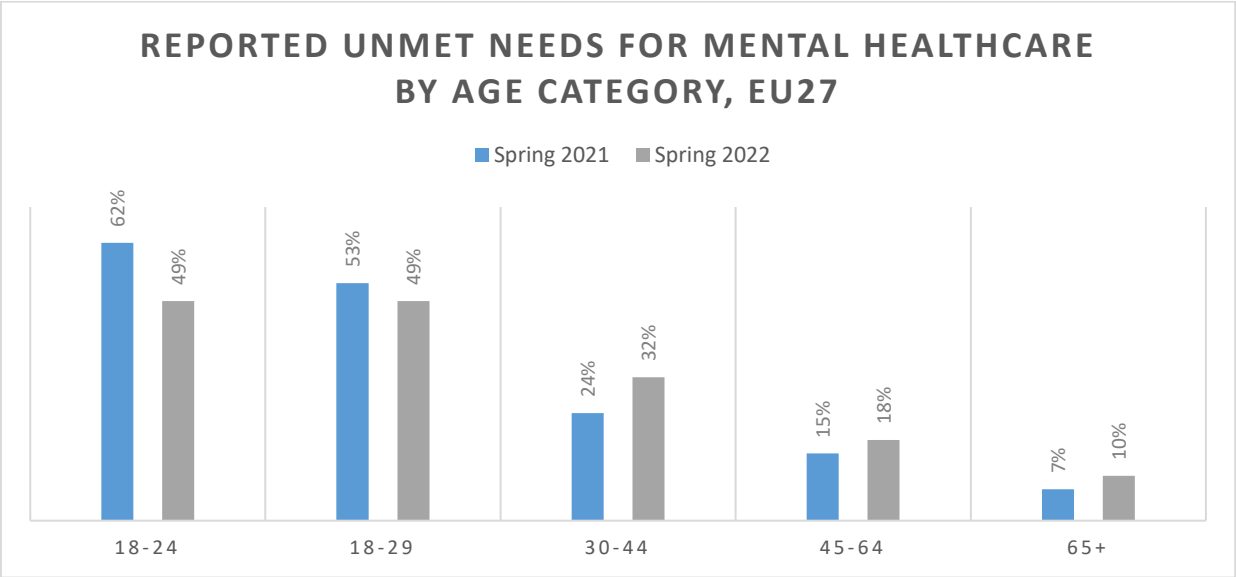
Psychological resources, resilience factors, and coping strategies helped adolescents and young people endure the pandemic. Psychological resource factors such as hope, self-efficacy, resilience and optimism have a significant role in protecting mental health during socioeconomic adversity (Schoon and Henseke, 2022). Reduced psychological distress was associated with:

- **Maintaining a daily routine**: this protective factor of mental health was particularly disrupted by the closures of educational establishments at all levels (OECD, 2022c; Panchal et al., 2021).
- **Physical activity**: reduced levels of physical activity were reported during the pandemic, with corresponding increases in screen time (Kornbeck et al., 2022), despite the fact that sport acknowledged to have a positive effect on mood (Marconcin et al., 2022). For adolescents and young people, participation in physical activities (within/outside education establishments) were considerably disrupted.
- **Pre-existing psychological resources**: perceived trust, optimism and a sense of mastery counter psychological distress (Achdut and Refaeli, 2020). These psychosocial resource factors can help to mitigate vulnerability to psychological distress, in particular among disadvantaged young people (Schoon and Henseke, 2022).
- **Positive coping strategies** (Theberath et al., 2022), such as positive reappraisal/reframing of the situation (Shanahan et al., 2022) and capacity for resilience also had an effect.

1.4.2. Access to mental health support

Access to mental health support was **heavily disrupted** during the pandemic. A systematic review of the recourse to psychiatric services in high-income countries globally found a considerable decrease in access to such support among children and young people during the first year of the pandemic (Wan Mohd Yunus et al., 2022). This issue particularly affected adolescents and young people with pre-existing mental health problems. The main gateways for the identification of psychological distress and delivery of support and mental health resources are schools, universities and workplaces, which were closed, sometimes for long periods. Despite the growing need for mental health support, **the number of referrals in schools fell during the pandemic**. In spring 2021 and 2022, the highest share of unmet mental healthcare needs was identified in young people aged 18-24, reaching 62% in 2022 and remaining at 49% in 2022 (Eurofound, 2022a). According to the same e-survey, unmet mental healthcare continued to rise across all age groups in the EU between spring 2021 and spring 2022 (from 20% to 23%), with limited access to mental healthcare affecting more women than men.

Figure 2: Reported unmet needs for mental healthcare, by age EU-27



Source: Eurofound (2022b), Fifth round of the 'Living, working and COVID-19' survey: Living in a new era of uncertainty.

Growing mental healthcare needs may lead to insufficient capacity in the Member States. For example, figures from the Finnish Institute for Health and Welfare shows a sixfold increase in the share of children and young people waiting more than 90 days for non-urgent specialised mental healthcare (OECD, 2022a). Young people are more familiar with information and communication technology (ICT) tools and could resort to **online mental health support** (teleconsultations, online platforms and apps, telephone hotlines, or physical centres offering online consultations), although not all young people were satisfied with this method of delivery (OECD, 2021a). Facilitating access to mental health support, possibly via telemedicine and telepsychology should consider its limitations, particularly the recognised digital divide and difficulties in accessing a private space (Pierce, 2021).

Box 1: Case study – Santé Psy Etudiant (France)

France adopted an interesting approach to providing mental health support to students facing particular isolation and psychological distress during the pandemic. Managed by the Ministry of Higher Education and Research, '**Santé Psy Etudiant**' is a psychological programme providing free-of-charge access to eight sessions with a psychologist. Students are first asked to visit a general practitioner or the education establishment's health service, which then directs them to a psychologist. The programme initially ran between March 2021 and 31 December 2022 and has been extended for 2023. According to data provided by the French authorities, use of the programme peaked between April and July 2021, in the first half of 2022, and again at the end of 2022.

The French government provides a list of the 1 180+ voluntary and certified practitioners on a dedicated website (https://santepsy.etudiant.gouv.fr/). Data provided by the French government show that almost **40 000 students** engaged in more than **180 000 sessions** (an average of four and a half sessions per student).

A comprehensive **evaluation of the effectiveness** of the measure is not possible as it was adopted too quickly to build in evaluation procedures (e.g. baseline evaluations of patients' mental health, changes after the sessions). The proportion of sessions organised in teleconsultation is not publicly available, although the French authorities recommend a maximum of 25%. According to qualitative information received from a prevention service for students via the INSERM, a number of young adults had serious psychiatric disorders and resorted to this type of consultation due to other service

closures or overload. According to the 2022 annual report of France's Court of Auditors, the measure **did not initially match the scale of mental ill-health and healthcare needs** in the youth and student population, particularly those at risk of depression.

Limitations of this measure include the cost: reimbursement for practitioners amounts to EUR 30 per session, which is low compared to revenue generated in private practice. The Court of Auditors also highlighted that deployment of the measure was limited by the administrative and financial burdens it represented for universities and not all universities implemented the measure.

Pre-existing and additional measures were also adopted to support students' mental health. For example, access to the university psychological support office, where psychiatrists and psychologists can provide sessions, and the 'Nightline' service, a hotline where student volunteers provide listening support to other students.

For non-student populations, '*MonParcoursPsy*' (formerly '*Mon Psy*') has been deployed since April 2022 for anyone older than three years, in slightly less favourable conditions. These sessions must be paid for by the patient and are then later reimbursed by the social security system. This mechanism includes the possibility of conducting sessions remotely.

The programme is continuing after the pandemic and has sparked discussions on the need for better coverage of mental health under the statutory health insurance system, as well as on the status and role of psychologists in the healthcare system. Nevertheless, retrospective and prospective research on outcomes is lacking.

Sources: Dedicated website; interview with a senior researcher at the French National Institute of Health and Medical Research; OECD, (2022), Consultation with a counsellor at the Ministry of Higher Education and Research as reported by the INSERM during the interview; Court of Auditors, (2022), Annual report.

Whether and how often adolescents and young people with mental health problems use a mental health service depends on factors such as the **territorial availability of resources, ways of accessing services, stigma and social barriers, lack of detection of problems, and erroneous/mistaken referrals**. Different **professionals** working in health or related fields (psychologists, teachers, primary care doctors and other specialties, nurses, social workers, etc.) **should be able to detect psychological problems** among young people they work with (in order to be able to provide them with better guidance). The OECD supports embedding mental health support in educational and workplace settings, public employment services and in the social protection system (OECD, 2021a). This is particularly important in view of young people's longer working hours, reduced work autonomy and lower job security.

Stigma has a **small to moderate negative effect on help-seeking** (Clement et al., 2015; Coleman et al., 2017; Ran et al., 2022). Internalised stigma towards mental health problems thus likely presented a barrier to adolescents and young people seeking help during and after the COVID-19 pandemic. In addition, **COVID-19** and **mental health issues** may interact via **common risk factors** (differential exposure according to jobs, the prevalence of chronic disease, income inequality, and limited access to healthcare). COVID-19 stigma particularly affects visible minorities, healthcare workers and younger individuals (Ran et al., 2022). Strong results were seen for support to young people to fight self-stigma and discrimination (Mulfinger, 2018) and promote resilience (Jones, 2021) in particular within schools (Dray et al, 2015).

Finally, young people were insufficiently involved in the design of government responses to youth-specific challenges. **Only 15% of youth organisations** surveyed by the OECD **believed that their government considered young people's views when adopting lockdown and confinement measures** (OECD, 2022c).

2. IMPACT OF COVID-19 MEASURES, INCLUDING LOCKDOWNS, ON CHILDREN AND VULNERABLE PEOPLE

KEY FINDINGS

The COVID-19 pandemic **severely affected the well-being of children** and, compared to adults, may continue to have more often **long-term consequences** for them, including cases of **post-traumatic stress**.

The **home environment**, as well as **parental stress**, played a crucial role in children's well-being during the pandemic, with tensions among family members and cases of child abuse and domestic violence.

Home schooling highlighted **educational and social inequalities**, and the **extensive use of the internet**, as a result of distance learning and for entertainment, increased internet and gaming addiction among children, as well as cases of cyber-bullying and online sexual exploitation.

As a vulnerable population group, **people with disabilities** faced **increased levels of discrimination and stigmatisation**, which were exacerbated during and after the pandemic. Low-quality or inaccessible healthcare services, as well as social exclusion, significantly contributed to **feelings of loneliness, stress, and a higher risk of depression**. Movement restrictions and confinement also **increased the risks of physical or sexual violence against people with disabilities**.

Although **older people** were one of the most vulnerable groups affected by COVID-19, their frequent **exclusion from surveys and studies** was a major impediment in analysing the effects of the pandemic.

Older people living alone typically ran a higher risk of isolation due to the closure of several networks they have come to rely on and the distance from their families, whereas **older people living in long-term care facilities** were more likely to experience negative outcomes, e.g., getting infected by the virus, due to their close proximity to others, communal living arrangements, and underlying comorbidities, along with the institutions' initial lack of readiness to protect them properly during the first Covid-19 wave, in particular.

The **lack of digitalisation among older people** – due to lack of knowledge or the physical ability to use digital tools or the lack of devices for economic reasons – also contributed to their feelings of loneliness and vulnerability. On the other hand, **older internet users** often suffered from **'information overload'** about the dangers of the virus from scientific and media articles.

Lockdown measures exacerbated the risk of older people experiencing **violence, abuse, and neglect** from family members and/or caregivers.

Mortality rates among **migrants and refugees** were between two and five times higher than those of native-born people, particularly among those living in poor housing conditions and working in high-risk jobs.

Due to the **irregular immigration status**, asylum seekers and unauthorised immigrants frequently had access only to emergency care and encountered substantial barriers in accessing health services. Some avoided seeking healthcare or providing information on their health status due to distrust of authorities and fear of deportation, detention, or penalties as a consequence of declaring their irregular status. This affected the **vaccination process** for this population group.

Linguistic and sociocultural barriers might have prevented migrants from accessing or benefitting from healthcare.

Even before the outbreak of COVID-19, **people belonging to poor communities** often faced **difficulties in accessing healthcare and public health information**.

Homeless people frequently experienced **social stigmatisation and discrimination**. Their **living conditions**, whether on the streets or in homeless shelters, significantly affected both their physical and mental health. Together with restrictions on social interactions in public spaces, the closure of shops and restaurants affected **panhandling**, which is among the main sources of income for homeless people.

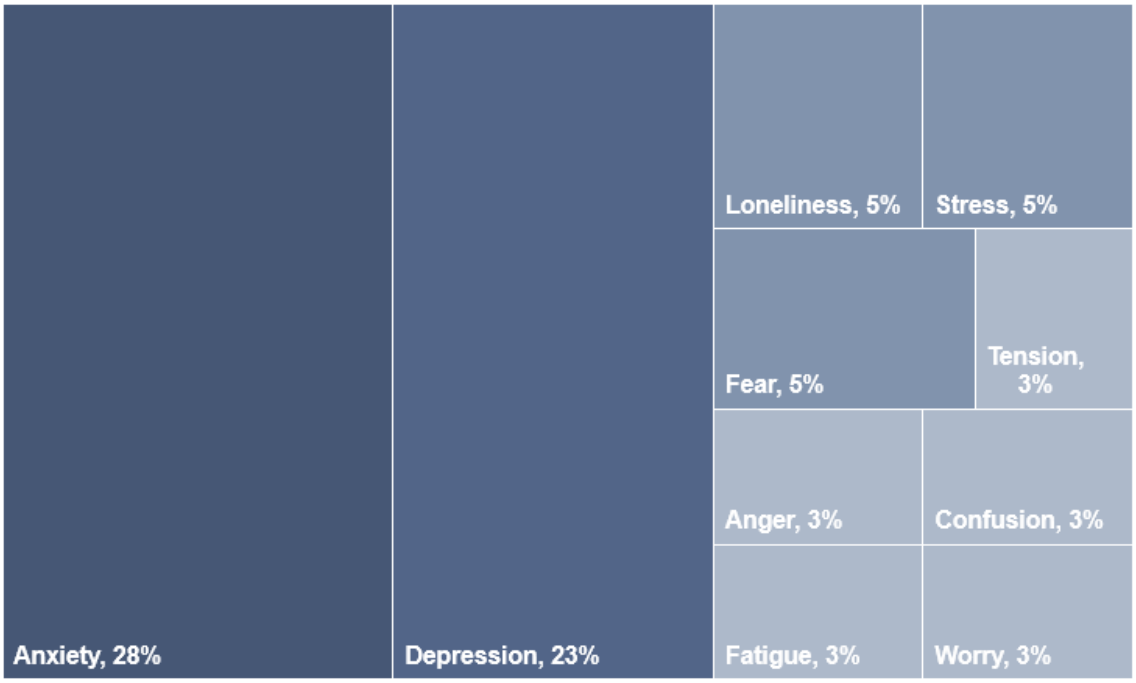
2.1. Impact of COVID-19 measures on children

Research found that the COVID-19 pandemic **severely affected children's mental and physical health**, and, compared to adults, may continue to have long-term consequences for them (Singh et al., 2020). Even before the COVID-19 outbreak, children's mental health was an issue of concern: the 2017 Mental Health of Children and Young People (MHCYP) survey in England identified that one in nine children likely had a mental health disorder, with a 49% increase in emotional disorders compared to the previous survey in 2004 (Creswell, 2022). The outbreak of COVID-19 and the adoption of government measures to combat the virus had a notable effect on the mental health of children.

The **closure of schools, childcare and sports facilities**, as well as **movement restrictions** and **confinement**, were some of the main measures adopted to tackle the spread of COVID-19. School closures were implemented for several months across different countries and affected an estimated half of the global student population (Nearchou et al., 2020). In fact, a prediction model by German researchers predicts that school closures impacted children's non-cognitive skills and thus their wages in the longer term (Fuchs-Schündeln et al., 2021). While the duration and the severity of the measures imposed varied between countries, the adoption of these measures often dramatically changed children's daily routines. The closure of schools, for example, had an important **effect on children's everyday well-being**, including their sense of routine, community and escape from family issues (European Commission, 2022a).

The measures imposed created **feelings of isolation, fear, anxiety, and, in some cases, depression in children**. The lack of socialisation, illness or bereavement of family members, and parental fatigue and stress also severely affected children's mental health. Emotional, psychological and behavioural stress were linked to the imposition of COVID-19 measures (Kauhanen et al., 2022), with research from previous pandemics showing that **children who experienced enforced isolation or quarantine were five times more likely to require mental health service input and to have experienced high levels of post-traumatic stress** (Loades et al., 2020). Although it is expected that anxiety, irritability, sadness and changes in biorhythms linked to stressful situations lessen when restrictions are eased, some children to developed more serious mental health issues (Ajanovic et al., 2021).

Figure 3: Reported effects of COVID-19, respondents aged 4-19 years



Source: Theberath et al. (2022).

Significant high rates **of hyperactivity, inattention and abnormal emotions** were reported in eight and nine-year-olds between April and May 2020 (Université Paris-Saclay, 2022). A particular increase in difficulties was noted for **primary school-aged boys**, notably in hyperactivity and inattention (Creswell, 2022). According to the results of a 2021 study, comparisons of children's emotional status and behaviours before and during the pandemic revealed that **children were more introverted, nervous, pessimistic, and unruly, and less extroverted, compliant, optimistic, social, calm, and active during the pandemic** (Kamaşak et al., 2022). The fact that pre-existing situations of mental discomfort were exacerbated by the confinement measures should not be overlooked (Council of Europe, 2021).

The **home environment played a crucial role** in children's mental health. The measures imposed, especially confinement, meant that members of the family spent most of their time in the same space. In that context, elements such as parental situation (including employment status, remote or essential worker status), availability, and ability to support children affected the everyday life of the children (European Commission, 2022c). **Parental stress** due to employment status and economic situation, as well as the uncertainty and fear of being exposed to the virus, resulted in **tensions among family members and cases of child abuse and domestic violence** (Kauhanen et al., 2022; Brown et al., 2020). Children living in violent families were at particular risk during the lockdowns, especially because social workers could not engage in their normal preventive work (INSERM focus group on 19 January 2023). Parental stress is a risk factor for adverse child outcomes, including the development of **aggression, behavioural problems and anxiety**, **compromised emotional coping, impaired social cognition, and diminished treatment response** (Crum Moreland, 2017). The limited operation or closure of social care services made it more difficult to access services, especially for children (OECD, 2020b). It is worth noting that an **increase in family violence against children, particularly girls,** was also reported during the pandemic (Bhatia et al., 2021; European Institute for Gender Equality (EIGE), 2022a; INSERM focus group on 19 January 2023).

Children's learning environments were chiefly affected by parental involvement in education matters, such as children´s schooling, as well as housing conditions, including space, sound, and comfort (European Commission, 2022c). **Home schooling** became the norm following the closure of schools, but this was not straightforward for all families. In many cases, **parents struggled** to support their children's learning, especially if they themselves had a low level of education, and depending on their employment status (e.g. working from home) (Eurochild, 2020). In fact, home schooling **increased educational and social inequalities** (Scarpellini et al., 2021). Neither students nor teachers were ready for this sudden shift: **low levels of digitalisation**, including both availability of and access to digital solutions for online and blended education, and the digital skills of teachers and students, were the main obstacles to the learning system (European Commission, 2022c). The concept of home schooling was even more **challenging for families experiencing poverty and social exclusion** (see section 2.5) (Eurochild, 2020), as well as **for children with disabilities** (see section 2.2) (Scarpellini et al., 2021).

Parent mental health is closely linked to children's mental health. Parental mental health conditions, such as stress, affect a child even before they are born (Singh et al., 2020). In general, parents' encouragement of child development and emotional expression are protective factors in children's mental health (Save the Children Europe, 2020). According to a 2021 study, one in 14 children had a caregiver (father, mother or another caregiver in a parenting role) with poor mental health. Those children, who had a male caregiver with poor mental health, were more likely to have poor general health, including mental health (CDC, 2022).

Extensive use of the internet by children was another phenomenon during the pandemic. Apart from the use of the internet for **distance learning**, children usually considered the internet **their only escape**, especially during periods of lockdown. During the pandemic, the use of smartphones, tablets and computers increased and often contributed to **internet and gaming addictions among children** (Kamaşak, 2021). It also revealed that the increase in unsupervised internet use had amplified **cyber-bullying and online sexual exploitation** (OECD, 2020b).

Toddlers seemed to spend **more time on screens during lockdown** than before (Bergmann, 2022) and the lack of sports and outdoor activities in favour of screentime could be a damaging trade-off for children (Ajanovic et al., 2021). The extent of screen time among children was also related to the duration and the severity of the lockdowns introduced nationally (UNICEF, 2020).

Measures to tackle COVID-19 also affected children's **physical health**. The closure of schools, childcare and sports facilities, as well as movement restrictions, resulted in **very limited or even a total lack of activity** for the population in general, including children. Evidence has found that **physical and sports activities decreased significantly** during the lockdown, with children **adopting less favourable diets** and parents frequently reporting that their children had experienced **weight increases** (Ajanovic et al., 2021; Nearchou et al., 2020). A **loss of cardiorespiratory fitness** was also observed (Nearchou et al., 2020).

The **strong link between physical activity and mental health** should not be overlooked. Research showed that children who had an outdoor space at home (e.g. a garden or terrace) during the lockdown experienced fewer psychological and behavioural issues. **Sleep disturbances** were associated with engaging in less sport than before, which was usually the case during the lockdown (Ajanovic et al., 2021). Accounting for pandemic stressors, **more physical activity and less screen time were associated with better mental health for children** (Tandon et al., 2021). As noted in a survey in Spain in 2020, children who could go outside during COVID-19 restrictions, as well as children whose parents were less stressed, were more likely to experience less psychosocial difficulty. **Similarly, anxiety and depression symptoms and other negative outcomes were more likely in children**

whose parents reported higher levels of stress and depression or who were unemployed (Ajanovic et al., 2021). **Introducing therapeutic interventions and strategies** (Theberath et al., 2022), including training in positive coping strategies, providing support to families, and additional social supports through schools, social media, healthcare, and government could all be useful ways to mitigate the impact of COVID-19 measures on children.

Box 2: Case study – Cyprus

In May 2020, an **ad hoc working group** including representatives of youth organisations was established by the Youth Board of Cyprus (the government body responsible for youth issues). The main objective of the working group was to make recommendations on how to best address the impact of the COVID-19 pandemic on young people.

The ad hoc working group was divided into **four sub-groups**, each focusing on a different topic:

1. Mapping the situation of young people and youth organisations due to the pandemic;
2. Reporting good practices from governments and civil society in Cyprus and abroad;
3. Reporting good practices among young people to support society;
4. Reporting on digital tools and other practices to assist youth work.

Overall, **33 people participated in the four sub-groups**, exchanging views, expressing their concerns, and making suggestions on how to address the emerging challenges.

The results of the four sub-groups were presented in July 2020. They found that psychosocial and economic issues were the **main challenges** for young people, while technological problems also represented a major challenge. The sub-groups **suggested a number of initiatives to combat these challenges**. For example, the sub-group focusing on psychosocial issues suggested online psychological support and youth empowerment, focusing on the benefits of sports for physical and mental health, and dealing with harassment. Other key recommendations included financial support from the State, as well as free workshops in all regions (including the most remote) on new technologies and digitisation, and the creation of a 'live' online platform where young people interested in a specific issue can organise themselves, exchange ideas, offer their specialised services, and formulate and implement actions for social change.

Source: Youth Board of Cyprus (2021a); Youth Board of Cyprus (2021b); Youth Board of Cyprus (2020)

Box 3: Case study – Spain

Spain was among the Member States that imposed **the strictest confinement measures** in Europe to tackle the spread of COVID-19. From 14 March to 26 April 2020, citizens of Spain were not allowed to leave their homes, except for exceptional reasons. This meant that children, like other vulnerable groups, were not allowed to leave their homes for **more than 40 days**. Starting from 26 April 2020, minors were allowed to go out for one hour to walk, run, cycle, scooter or play within a one-kilometre radius of their home between the hours of 9am and 9 pm, accompanied by a parent, guardian or older sibling.

Studies in Spain showed that COVID-19 measures, including the strict confinement rules, gradually cultivated feelings of anxiety, helplessness and loneliness. These were accompanied by coexistence problems, as families had to reorganise their everyday lives and spend most of their time together. A feeling of cumulative stress from the restrictive measures, as well as parental stress, significantly affected children's **mental health**.

As early as May 2020, Save the Children, a leading non-governmental organisation (NGO), warned that social isolation measures could cause permanent **psychological disorders** in children, including prolonged stress and depression. Research also showed that bonding problems, as well as fear, attention problems and continuous inquiry, were more likely to be observed in children as an impact of the COVID-19 measures.

The **physical health** of children suffered significantly during the pandemic. Even before 2020, Spain was among the countries with the highest predominance of childhood weight issues and obesity in the EU. During the pandemic, changes in nutrition habits were reported across the Spanish regions, along with increases in obesity percentages in children. Evidence shows that stressful situations can also affect the physical health of the children in other ways, for example weakening the immune system (Pizarro-Ruiz and Ordóñez-Camblor, 2021).

Source: Ajanovic et al. (2022); Matalí-Costa and Camprodon-Rosanas (2022); WHO (2022); Dawes et al. (2021); Ramos Álvarez et al. (2021); Pizarro-Ruiz and Ordóñez-Camblor (2021); Save the Children (2020); El Pais, Society (2020).

2.2. Impact of COVID-19 measures on people with disabilities

An estimated 1.3 billion people – or one in six people worldwide – have a significant disability[2] (WHO, 2022). In general, people with disabilities tend to have a shorter life expectancy, have poorer health, and experience more daily limitations, such as accessibility to healthcare facilities (WHO, 2022). **People with disabilities are thus considered more vulnerable**, with poor quality or inaccessible healthcare services impacting their health to a greater extent than that of other groups (United Nations (UN), n.d.). Disability is also a factor in **intersectional discrimination**: people with disabilities experience underestimation, exclusion and social marginalisation, which violate their human rights (Peredo, 2016). There is considerable **stigmatisation** towards people with disabilities across family, school, work and social contexts, which **was exacerbated during and after the pandemic**. Tackling stigma and prejudice against people with disabilities in society at a fundamental level can help to alleviate the structural factors that contribute to the inequities that affect people with disabilities within and outside crises (Jesus et al., 2021).

COVID-19 measures significantly affected the health and well-being of people with disabilities. According to a Eurofound survey in spring 2021, one in four respondents with disabilities **could not access mental healthcare when they needed it**. Limited access to healthcare, together with social exclusion, significantly contributed to pre-existing **feelings of loneliness** and a **higher risk of depression** (Eurofound, 2022b). For instance, restrictions on leaving institutional care facilities or having visitors to those facilities, as well as social distancing measures within such settings, **isolated** people with disabilities from their families and friends. In addition, restrictions on accessing non-essential health services severely affected their health by **limiting their access to occupational therapy, physiotherapy or mental health supports** (European Commission, 2021a). In the absence of these services, people with disabilities experienced **anxiety and stress** (European Commission, 2021a). As the link between physical activity for people with disabilities and their mental health is being recognised (Theis et al., 2021), the adoption of contingency plans for exceptional circumstances (e.g. lockdowns) could ensure their continued access to health and support services (Jesus et al., 2021).

[2] The UN Convention on the Rights of Persons with Disabilities defines persons with disabilities as 'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.'

Introducing societal changes through health and social policy, for example, could help to safeguard the well-being of people with disabilities beyond the pandemic (Jesus et al., 2021).

Movement restrictions and confinement **increased the risks of physical or sexual violence against people with disabilities** (Shakespeare et al., 2021). Evidence has shown that **women with disabilities** were more likely to experience domestic violence, emotional and sexual abuse than women without disabilities (Meyer et al., 2022).

The pandemic had a larger impact on perceived physical and mental health, as expressed through **changes in eating habits and tobacco use** among people with disabilities, compared to people without disabilities (Tuakli-Wosornu et al., 2022). For people with physical disabilities, various impacts on daily functioning and a decrease in access to healthcare were observed during the pandemic, as were **changes in social and lifestyle habits, mood changes, and decreased levels of physical activity** (Lebrasseur et al., 2021).

Jesus et al. (2021) set out **10 impacts of the pandemic on people with a disability**:

- Disrupted access to healthcare (other than for COVID-19);
- Reduced physical activity, leading to health and functional decline;
- From physical distance and inactivity to social isolation and loneliness;
- Disruption of personal assistance and community support networks;
- Children with disabilities disproportionally affected by school closures;
- Psychological consequences of disrupted routines, activities, and support;
- Family and informal caregiver burden and stress;
- Risks of maltreatment, violence, and self-harm;
- Reduced employment and/or income exacerbating disparities;
- Digital divide in access to health, education, and support services.

Uncertainty or fear about COVID-19 also impacted the mental health of people with disabilities. Research has found that people suffering from mental illness can find isolation and fear particularly devastating (Shakespeare et al., 2021). Measures such as the **use of facemasks** and **social distancing** created an **additional burden** for people with hearing loss (preventing lipreading) or people with visual impairments (Shakespeare et al., 2021; European Disability Forum (EDF), 2021). In those cases, people with disabilities were also **often stigmatised** (Shakespeare et al., 2021). People suffering from visual impairment experienced additional difficulties due to the lack of tailored information about disinfection and the need for in-person assistance from others in performing basic daily activities such as crossing the street (Senjam, 2020).

Living conditions for people with disabilities were particularly challenging in institutions. Numerous **deaths** took place in relevant facilities and institutions during the pandemic: for example, as of January 2021, people with disabilities accounted for 38% of the total recorded deaths from COVID-19 in Croatia; in Slovenia, 51% of deaths from COVID-19 were people in long-stay institutional care for older people or people with disabilities; in France, figures published by the French Ministry of Health on 21 January 2021 reported a total of 71 342 deaths as a result of COVID-19, of which 30 395 (43%) were residents in care homes (European Commission, 2021a).

Children **with disabilities** usually need to be further supported to adjust to the measures and to understand how to keep themselves safe. Children with disabilities **were further disadvantaged in their education, as since distance learning was not always adaptable to their specific needs**. In general**, learning loss** during school breaks could be **higher for children with disabilities** (OECD, 2020b). Many children with disabilities receive therapeutic support to develop communication and social-emotional skills, but those activities were suspended during periods of confinement, with many families lacking guidance and information on the services and assistance available (OECD, 2020b). In most cases, **community support centres were closed and parents of children with disabilities had to bear the care burden alone**. On the other hand, **children** who remained in institutions were frequently **isolated and could not be visited by family and friends** (Eurochild, 2020).

2.3. Impact of COVID-19 measures on older people

The lack of data capturing the lived realities and human rights of older people risks making **inequalities faced by older people invisible** (UN, 2020a). The exclusion of older people from surveys and studies was increasingly evident during the COVID-19 pandemic (UN, 2020a). Several sources stated that **older people were deeply affected** by the risks and negative consequences of the pandemic.

In April 2020, three Commissioners of the EU (Kyriakides, Dalli and Schmit) wrote an open letter describing older people as '**one of the most vulnerable groups affected by COVID-19**' (European Commission, 2020a). They were at highest risk of severe illness and death from the pandemic due to their potential health frailty and existence of comorbidities that influenced and magnified the impact of COVID-19 (AGE, 2020). People aged 65+ encountered **problems in meeting their healthcare needs** as a result of restrictive measures, with issues in accessing medical services, unaffordability, fear of infection and waiting lists (Eurofound, 2022c).

The **living conditions** of older people in long-term care facilities or living alone could increase the risks related to the pandemic (European Commission, 2020a). Those in **long-term care facilities** were more likely to be infected and to experience negative outcomes, given their close proximity to others, communal living arrangements, and underlying comorbidities (AGE, 2020; Global Alliance International Longevity Centre (ILC), 2022; Council of Europe, 2020a). Other factors related to pandemic management in these facilities also significantly impacted older people, such as **the lack of readiness in long-term care institutions**, including persistent staffing shortages, lack of personal protective equipment (PPE) among care staff, insufficient epidemiological surveillance, ineffective infection prevention and control procedures, and inadequate coordination between these institutions and hospitals (Council of Europe, 2020a; Eurofound, AGE focus group on 19 January 2023). As a result, this group experienced the highest fatality rate during the massive increase in death rates at the start of the pandemic in 2020-2021 (AGE interview; European Centre for Disease Prevention and Control (ECDC), 2020). Harsh isolation measures were imposed on this group, which harmed their mental health and well-being (Council of Europe, 2020a). The **'no visitor policy'** implemented in many European countries, the consequent prolonged isolation from family and friends, and the prohibition of contact with people living in the same facilities caused emotional stress, mental decline and cases of depression (ILC, 2022; AGE, 2020; AGE focus group on 19 January 2023; AGE interview). To address these challenges, it has been suggested that long-term care should shift from large facilities to smaller, community-based and home care that is more decentralised and provides better chances for social integration, while reducing risk exposure (AGE interview; European Care Strategy).

Similar negative impacts on mental well-being were also detected in the **older population living alone** (European Commission, 2020a; ILC, 2022). In addition to the high risk of isolation due to the closure of several networks (such as clubs and charities) and distance from their families, older people living alone risked not having access to necessary services and not receiving help for everyday tasks (AGE, 2020). For example, older people may have been unable or afraid to go to the shop to buy food without the support of family and friends, placing them at risk of malnutrition (AGE, 2020). Greater attention needs to be paid to the loneliness of older people during any possible future periods of confinement, in addition to taking into account the associated depression symptomatology and measures to strengthen social support networks in these circumstances.

Another factor that negatively impacted older people is their lack of **digitalisation**. The pandemic's increased reliance on technology and the internet for services could exclude older people who are less connected or able to use technology (ILC, 2022). Digitalised pandemic-related services that may have been more difficult for older people to access included test and vaccination appointments, teleconsultation with doctors, and QR codes to prove vaccination/recovery/negative COVID status (AGE interview). In general, older people **lack the knowledge or physical ability to use digital tools** (such as computers, tablets, or smartphones), or **lack the necessary devices for economic reasons, or have connectivity issues** (Webb and Chen, 2022; AGE interview). While online services largely replaced in-person visits, it was necessary to maintain appropriate access to health services where remote consultation was not possible or was not equally effective (AGE, 2020; Webb and Chen, 2022). The disconnection from family and friends – which exacerbated the **feeling of loneliness and vulnerability among older people – was more keenly felt by those who were digitally excluded** (AGE, 2020; Webb and Chen, 2022). By contrast, older internet users were at risk of 'information overload' about the dangers of the virus from scientific and media articles, possibly becoming '**overwhelmed, paranoid, or distrustful**' (Webb and Chen, 2022). While greater attention has been paid to digitalisation since the pandemic, this has not always reached older persons, as the focus is often on providing digital skills to those of labour-market age. It is thus unclear whether and how far older workers or jobseekers have benefitted (AGE interview). Several suggestions were identified to **tackle the digital divide**: putting in place community projects providing support; organising training on digital resources for people unfamiliar with information technologies (IT); promoting interventions through online technologies to establish social networks and a sense of community (e.g. more frequent telephone contact with significant others, close relatives and friends, voluntary organisations, or health professionals); closing the geographical gaps between urban and rural areas by bringing broadband internet via cable or mobile (Armitage and Nellums, 2020, Banerjee and Rai, 2020; Brooke and Jackson, 2020, Eghtesadi, 2020; Jones and Keynes, 2020; AGE focus group on 19 January 2023 and interview).

Older people were more likely to experience **mental health** issues. Their social networks were further restricted by the pandemic, increasing their sense of isolation and loneliness, which is associated with anger, anxiety and emotional instability (Webb and Chen, 2022; AGE, 2020; Eurofound, 2022c). **Social isolation and loneliness** are serious public health risks that affect a significant portion of the older adult population. The pandemic had an increasingly negative effect on the number of older adults who were socially isolated and at high risk from for both COVID-19 and loneliness (Rodney et al., 2021). Loneliness was one of the main risk factors for depression and anxiety in older adults during the pandemic (Palgi et al., 2020; Shrira et al., 2020). Older adults of different ages or living arrangements experienced varying levels of loneliness. According to Beadle et al. (2022), those at the highest risk for loneliness were adults aged 80 years and older, older adults living alone, or those living in a long-term care facility.

Loneliness activates the sympathetic nervous system, which leads to **hypertension, elevated stress hormone levels, and inflammation** (Webb and Chen, 2022). For older people experiencing cognitive decline, such as dementia, the situation was even worse: the disruption of their daily routine, lack of stimulation and memory training, and lack of regular contact with their loved ones, friends and social care team, all presented risks for further cognitive decline and increases in feelings of irritation, stress, anger and anxiety (AGE, 2020).

Several national surveys highlighted the **importance 'of the quality and type of social engagement, rather than just the quantity of it'**. This suggests that older people who lived in care homes (where there was at least minimal social interaction) but could not receive visits from their loved ones were also severely impacted by the mental health consequences of the restrictive measures (Eurofound, 2022c). This also negatively impacted older people placed in end-of-life care facilities and their 'quality of dying' (AGE focus group on 19 January 2023; AGE interview). Bereavement was a key trigger of mental health issues during the pandemic (Santini and Koyanagi, 2021). Experiencing the death of someone close was more common among older people and restrictions made it more difficult to deal with grief normally (Eurofound, 2022c).

Even before the pandemic, only a limited number of older people with a mental disorder used a service for support (Volkert et al., 2017). This may reflect an **internalised stigma** among older people, leading them to avoid seeking professional help (González-Domínguez et al., 2018). The potential stigma among primary healthcare professionals towards mental disorders in older people should also be considered (Holm et al., 2014). This situation may lead to **under-detection** and, consequently, **under-treatment** of mental disorders in older people. In addition, the stigma associated with age (ageism) should also be added. A practical example of stigmatising attitudes towards older people with a mental disorder is that of depression, which is usually seen as a natural consequence of ageing and physical illness, and thus may not be appropriately diagnosed or treated. Older adults reported experiencing **more ageism** during the COVID-19 pandemic, including hostile and benevolent ageism from their families (Barth et al., 2021; AGE interview). 'Ageist' discourse may exert a negative influence on older adults' lives, causing severe social and psychological impacts (Silva et al., 2021). The WHO and the World Psychiatric Association (WPA) suggest organising effective education programmes for professionals promoting non-stigmatising assessment and treatment of older people with a mental disorder (WHO and WPA, 2003). The World Report on Ageism recently noted that three strategies should be developed to reduce ageism: policy and legislation, educational activities, and intergenerational contact interventions (WHO, 2021c).

Older people were **more likely to experience violence, abuse, and neglect** from family members and/or caregivers during lockdowns (AGE, 2020; ILC, 2022; UN, 2021). The WHO defines the abuse of older people ('elder abuse') as 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person'. This can include psychological abuse, physical abuse, financial abuse, neglect, and sexual abuse: (WHO, 2021a). There is little data on elder abuse, partly because it is considered taboo in many communities and is generally regarded as a private concern (ILC, 2022), and partly because surveys and studies tend to exclude the older part of the population, rendering them 'invisible' (UN, 2020a; AGE, 2020). Although there is little information and evidence on elder abuse, previous tragic events have demonstrated that interpersonal violence escalates and intensifies in times of crisis (ILC, 2022). Measures implemented during the pandemic ran the risk of further isolating victims, hindering their access to assistance and support services, and making it more challenging for them to ask for assistance and support or to report abuse (AGE, 2020; AGE interview).

The **COVID-19 pandemic disrupted intergenerational exchanges and contacts** (Drury, 2022). Exchanges with young people within the family was significantly reduced, while intergenerational contact outside the family context was almost non-existent. A traditional common space of intergenerational exchange outside the family is the workplace, but teleworking measures substantially decreased contact between generations (AGE interview). This had negative consequences for both older people – who often derive stimulation and a sense of purpose and helpfulness out of meaningful intergenerational exchanges – and young people, who saw their social capital – particularly important at the beginning of their working life – reduced (AGE interview; AGE focus group on 19 January 2023). Given their positive outcomes, intergenerational exchanges should be fostered and supported by governments (AGE Interview; AGE focus group on 19 January 2023; Drury, 2022).

Older women suffered more than men from the negative impacts of the COVID-19 pandemic (Eurofound, 2022c). First of all, women comprise the majority of older people and residents in care homes (UN, 2021) and are more likely to experience health issues because – although having an higher life expectancy than men – they have less healthy life years during their lives (AGE interview). In addition to demographic reasons, older women are more likely to live in poverty, experience social exclusion, and have minimal or lower pensions (AGE, 2020). All these factors had the potential to exacerbate the negative impact of the virus by worsening older women's access to protective items, food, water, information and health services (AGE, 2020; UN, 2021). Older women also often provide care for older relatives, increasing their risk of infection (ILC, 2022). Finally, they were sometimes reluctant to seek assistance from formal or informal care services because of societal and cultural expectations that they will themselves care for relatives and family members with disabilities (UN, 2021).

The closure of schools and care services meant that a lot of informal care was provided by older people (AGE interview). This had certain positive outcomes, strengthening links within families and relieving the additional burden of care on parents. However, in some cases, it meant that older people had to provide care without having chosen to do so (AGE interview). This had the potential to impact older women of working age, in particular, possibly prompting them to leave the labour market earlier in order to provide care to their families during the pandemic (AGE interview). Finally, older women are less exposed to new technologies and develop fewer of the skills needed to use electronic and digital tools. This digital gender divide made it more difficult for older women to be independent, socially included, and able to access assistance (UN, 2021; AGE interview).

2.4. Impact of COVID-19 measures on migrants and refugees

Infection and serious disease risk was disproportionately high in migrants and refugees during the pandemic, and their **mortality rates were two to five times higher** than those of native-born people (Slootjes, 2021; OECD, 2022d; Crouzet et al., 2022). The effects and repercussions of the health crisis are perceived differently depending on socioeconomic status: those who are less advantaged – migrants included – were **more severely affected**. **Social inequalities grew** during the COVID-19 pandemic, exacerbating the differential rates of disease or mortality (Crouzet et al., 2022; Platform for International Cooperation on Undocumented Migrants (PICUM), 2021). In this context, **health disparities were intensified**. There were several reasons why migrants and refugees were more likely to be impacted by COVID-19.

Poor housing conditions with higher incidences of overcrowding can increase the risk of contracting diseases, including COVID-19 (OECD, 2022d; Crouzet et al., 2022; UN, 2020b; Council of Europe, 2020b; Slootjes, 2021; Kluge et al., 2020). In a 2020 interview, the Special Representative of the

Secretary-General on Migration and Refugees of the Council of Europe, Drahoslav Štefánek, stated that even before the COVID-19 crisis the situation in refugee camps and/or shelters was critical, being 'totally overcrowded with not enough sanitation facilities' (Council of Europe, 2020b). Major issues included a lack of clean and running water and soap, insufficient medical staff, and poor access to reliable health information (Kluge et al., 2020). Consequently, they were unsuitable for the proper implementation of public health measures, such as social distancing, proper hand hygiene, and self-isolation (Kluge et al., 2020; Crouzet et al., 2022). The lack of medical facilities and medicine shortages frequently made it difficult for people living in humanitarian settings to obtain essential healthcare treatment during the pandemic (Kluge et al., 2020).

Migrants were overrepresented in the jobs that turned out to be the riskiest during the pandemic (Bossavie et al., 2020; OECD, 2022d; Slootjes, 2021). More specifically, they faced challenges in respecting the social distancing rule, often being employed in jobs deemed to be essential and characterised by proximity to other people, such as low-skilled delivery jobs and cleaning services (Slootjes, 2021; Bossavie et al., 2020). Interestingly, 'not only the immigrant workers were more exposed to the economic and health-related shocks of the pandemic, but they also served as a protective shield to the native workers' (Bossavie et al., 2020). By taking over certain jobs pre-pandemic that then turned out to be higher risk occupations post-pandemic, migrants 'pushed' native workers to specialise in and move to occupations that were more 'teleworkable', could be performed from the house in safety, and that in any case required less direct contact with clients and co-workers (Bossavie et al., 2020).

Irregular immigration status contributed to worsening COVID-19 impacts. Even though access to healthcare is a fundamental human right under European and international law, asylum seekers and unauthorised immigrants frequently **only have access to emergency care and encounter barriers in accessing health services** (Slootjes, 2021; UN, 2020b). Irregular migrants may avoid seeking healthcare or providing information on their health status due to distrust of authorities and fear of deportation, detention, or penalties as a consequence of declaring their irregular status (UN, 2020b; Slootjes, 2021). This circumstance can worsen their health problems, leading to longer-lasting diseases and higher costs for them to bear (Slootjes, 2021). The **vaccination campaign** is one such example. PICUM attempted to compile a map giving an overview of access to vaccines for migrants, and considered two factors: the **existence of administrative barriers** (i.e. whether undocumented migrants can access vaccinations without having to present proof of residency, identity, or other documentation – such as a social security number); and **protection from immigration control** (i.e. whether there are guarantees that protect migrants from checks or arrests during the vaccination procedures). The map painted a very varied picture of access to vaccinations for undocumented irregular migrants in the EU, with some countries guaranteeing good access to vaccination (e.g. Belgium, France, Portugal), others not giving access (e.g. Hungary, Poland), and still others varying by region (e.g. Italy, Spain) (PICUM, 2021). In September 2022, the OECD noted the scarcity data on vaccine take-up by migrants and refugees but reported that the **vaccination rates seemed lower** for this population group (OECD, 2022d).

Finally, **linguistic and sociocultural barriers** may prevent migrants from accessing or benefitting from healthcare (OECD, 2022d; Slootjes, 2021; Crouzet et al., 2022; UN, 2020b; Kluge et al., 2020). The lack of proficiency in the host country's language may cause misunderstandings about the functioning of the healthcare system and create communication problems (OECD, 2022d). For example, people may struggle to express their symptoms adequately or comprehend the diagnosis and available treatments and – conversely – doctors may not understand their needs and prescribe a treatment that does not fully meet their needs (Slootjes, 2021). This may happen more frequently in the case of older migrants, especially older women migrants (AGE interview). The pandemic showed the **importance of correct**

translations and effective communication strategies, highlighting the crucial need to translate health information in minority languages to guarantee the same level of health protection to everyone (Slootjes, 2021). In this context, introducing culturally appropriate validated tools to detect mental health problems in refugees, along with national training programmes to provide technical assistance, support culturally relevant behaviours, attitudes, and policies in clinical practice, and help to address mental health stigma, could be of significant use (Brink et al., 2016; Pottie et al., 2011). Additionally, the introduction of a comprehensive biopsychosocial assessment and meaningful interventions, over time, with trusting, supportive therapeutic relationships, and with specialised mental healthcare teams should also be considered (Pottie et al., 2011).

These factors contributed to a negative impact on the physical health of migrants and refugees, as well as on their **mental health** (Spiritus-Beerden et al., 2021; Crouzet et al., 2022). Numerous studies conducted for earlier epidemics and pandemics (e.g. Ebola, HIV) identified a variety of **detrimental effects of viruses and diseases on patients' and families' mental health** (Tucci et al., 2017; Remien et al., 2019; Kamara et al., 2017). COVID-19 caused the same detrimental effects on mental health as its predecessors. One 2021 study found that migrant respondents who reported having more trouble getting the medical care they needed during the COVID-19 pandemic also reported having more problems with their mental health, experiencing feelings of anxiety and depression (Spiritus-Beerden et al., 2021). Individual perceptions of certain preventive measures also contributed to worsening mental health. Lockdowns caused fears of illness, stress and lack of motivation, but these effects were worse for migrants and refugees, who had already experienced a type of lockdown in relation to violent or traumatic circumstances, such as war or periods of mourning (Crouzet et al., 2022). The inequalities stemming from language barriers led to unequal access to health information, increasing anxiety and stress related to the pandemic (Yen-Hao Chu et al., 2020; Crouzet et al., 2022).

It can thus be concluded that the COVID-19 pandemic disproportionally impacted migrants and refugees.

2.5. Impact of COVID-19 measures on poor communities

Even before the outbreak of the COVID-19 pandemic, people without a home, sleeping on the street, or in temporary accommodation often suffered from multiple health issues, including **tri-morbidity**, i.e. the **co-existence of physical and mental health issues together with addiction problems** (European Public Health Alliance (EPHA), 2020). Additionally, they typically faced **difficulties accessing healthcare and public health information** (EPHA, 2020). According to a survey conducted by the European Anti-Poverty Network (EAPN) in 2020, the healthcare systems of more than half of the Member States already faced challenges in providing quality health services to people in need, especially people belonging to poor communities, before the pandemic (EAPN, 2020). In addition, the prohibition of social interaction in public places, together with the closing of businesses like restaurants and shops, may have had an **impact on the income** of homeless people, which is primarily derived from **panhandling** (Crouzet et al., 2022; Perri et al., 2020).

People belonging to poor communities often experience **social inequalities** (e.g. social exclusion) and health inequalities (e.g. lack of physical and mental support services) (Mezzina et al., 2022). Their **rights and access to social and health opportunities are greatly reduced** (Mezzina et al., 2022). Young people in **precarious financial circumstances**, young women, and young people at **risk of exclusion** (due to sexual orientation, migration status and race/ethnicity) were at heightened risk of mental health issues over the course of the pandemic (OECD, 2022a). Among ethnic minorities, **Roma** experience more barriers in accessing public health and healthcare services, given their historic **lack of trust between patient and care providers,** making them particularly vulnerable to chronic diseases

and conditions (AGE interview; Hanssens et al., 2016). **Poor quality housing** and **social exclusion** constitute additional vulnerability factors affecting older Roma, together with higher barriers in accessing information, testing and vaccination procedures, and devastating mental health effects due to the confinement measures (AGE interview). Training programmes for professional groups engaged in direct care behaviours could be of considerable benefit (Complutense University of Madrid (UCM) Chair - Group 5 Against Stigma, 2022).

Homeless people have been **systematically stigmatised and discriminated** against over time, and **homeless women are one of the most stigmatised groups in society**. They often suffer from low self-esteem due to daily manifestations of stigma and labels, such as 'bad mothers' or 'prostitutes', which makes them feel alone and demotivated (European Federation of National Organisations Working with the Homeless (FEANTSA), n.d.). In addition to societal stigmatisation, homeless women and women who experience housing instability are disproportionately **more likely to use emergency departments** and are **at greater risk of violence** (Kushel, 2022). In many cases, domestic violence was a crucial factor in women becoming homeless (FEANTSA, 2021). In this context, launching social campaigns against stigma, raising awareness among the general public, and promoting the use of less stigmatising language and information in the media could help to reduce discrimination. It is also important to promote the active participation of people experiencing these stigmatised conditions in the design and implementation of anti-stigma actions at all levels, and to facilitate social mechanisms to encourage disclosure of information regarding their experiences (UCM Chair - Group 5 Against Stigma, 2022).

The COVID-19 pandemic highlighted the importance of housing as a social determinant of health (Perri et al., 2020). Pandemic measures significantly affected the lives of poor communities, including homeless people. For instance, people without a home had nowhere to stay when feeling ill, and the implementation of social distancing rules was quite challenging for those residing in homeless shelters (Markkula Center for Applied Ethics, 2021). **Homeless shelters are the ideal environment for the transmission of contagious diseases** due to the shared and usually crowded living spaces and high population turnover (Perri et al., 2020). It could be useful to promote Housing First programmes in responding to challenges beyond the COVID-19 pandemic (Mejia-Lancheros et al., 2022).

In addition to the high risk of contracting a contagious disease, **living in overcrowded or unsanitary housing** can affect people's mental and physical health (European Union Agency for Fundamental Rights (FRA), 2020). Facilities such as shelters, churches and community centres that routinely provided food, water, hygienic needs, and shelter at night were mainly closed during the pandemic (Markkula Center for Applied Ethics, 2021), which not only affected the physical health of homeless people but also created feelings of isolation due to the disruption of social interactions and movement restrictions (Perri et al., 2020). Lockdown measures also appeared to affect the mental health of homeless people by engendering **feelings of stress and lack of motivation, as well as the fear of illness** (Crouzet et al., 2022). In general, being homeless or at risk of homelessness is closely linked to mental health problems (EPHA, 2020; Mezzina et al., 2022). Corey et al. (2022) reported that the pandemic had numerous health impacts on homeless people, including infection, morbidity, mortality, hospitalisation, fear of infection, access to housing, hygiene, food, as well as mental health issues, substance use, other health-related outcomes and treatment services.

3. THE COVID-19 SHADOW PANDEMIC: VIOLENCE AGAINST WOMEN AND DOMESTIC VIOLENCE IN EUROPE

KEY FINDINGS

The COVID-19 pandemic resulted in a **shadow pandemic** of violence against women – evidence shows that there is a **direct increase in the incidence of violence against women during pandemics and natural disasters.**

The COVID-19 pandemic increased the risk of women suffering from **cyber violence**.

Women affected by an overlapping of multiple forms of discrimination, such as **migrant women and girls and older women, were more vulnerable and disproportionally affected** by the negative impacts of COVID-19.

Several challenges are evident in measuring the incidence of violence against women and domestic violence (**lack of data, issues of comparability and completeness and issues of statistical reliability).** The COVID-19 pandemic exacerbated these challenges and added new issues, such as difficulties in reaching a vulnerable population during the pandemic and increased coercive control by perpetrators. In some cases, **there was a decrease in official reporting**.

Service providers encountered several challenges during the pandemic measures, which contracted the sector and aggravated the situation for victims whose **access to these services was reduced**.

Ratification of the Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention) triggered amendments to the existing legislation and/or the adoption of new measures to support and protect women from violence and abuse. However, difficulties were encountered in implementing these actions, with **resources diverted from violence against women to immediate COVID-19 relief.**

Addressing violence against women should be a **priority for the European Commission and the European Parliament.** The EU signed the **Istanbul Convention** in 2017, but **negotiations to ratify it are ongoing.**

The adoption of a **new Directive on combating violence against women and domestic violence** could be significantly beneficial, as **no specific legal instrument addresses violence against women and domestic violence at EU level.**

3.1. Data collection on violence against women and domestic violence during the COVID-19 pandemic

3.1.1. COVID-19 and violence against women and domestic violence: what the data say

Data on previous pandemics and natural disasters show that gender-based violence, especially sexual and domestic violence, is **more prevalent and severe during times of crisis** (EIGE, 2021; WHO, 2021b). The COVID-19 pandemic was no different, with the UN labelling the increase in such violence the '**shadow pandemic**' (UN, 2021). **Multiple factors** that create tensions and strain were exacerbated by the restricted lockdown living conditions, such as exposure to economic and psychological stressors, health concerns, and an increased burden of providing care and educational support during school closures, **increasing the risk of domestic violence** (UN, 2020c; WHO, 2021b; Fraser, 2020; Gulati and

Kelly, 2020; EIGE focus group on 19 January 2023; Council of Europe Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO) interview; European Women's Lobby (EWL) interview).

Several sources indicate that the COVID-19 pandemic led to a **direct increase in the incidence of violence against women** (Meurens et al., 2020; UN Women, 2021; EIGE, 2022a; EIGE interview; GREVIO interview). These conclusions are underpinned by qualitative assessments from a smaller number of respondents. The **lack of quantitative data** reflects issues of comparability, completeness and statistical reliability (see Annex 1), as well as additional difficulties in reaching a vulnerable population during the pandemic (data collection efforts were interrupted generally). These **difficulties in reporting are amplified where intersectionality is concerned**, i.e. data collection on disadvantaged women, such as migrants or members of the Roma community (GREVIO interview).

Qualitative estimates are a useful source of information. However, while they show that the COVID-19 pandemic raised levels of violence against women, they do **not allow for an assessment of the volume of that increase.**

The findings of qualitative investigations were supported by **quantitative exercises**. Carried out in 13 countries[3], the UN Women survey found that **45% of respondents had either experienced violence themselves since the COVID-19 pandemic outbreak or knew of another woman who had** (UN Women, 2021).

The Flash Eurobarometer commissioned by the European Parliament to mark International Women's Day 2022 is the most prominent data source in the EU on the impact of the COVID-19 pandemic on violence against women and domestic violence (European Parliament, 2022a). That **2022 Eurobarometer survey** found that **77% of women in the EU believe that the COVID-19 pandemic led to an increase in physical and emotional violence in their country**, ranging from 93% in Greece to 47% in Hungary[4] (see Figure 4). When 'Don't know' responses are excluded, more than 75% of women believe that there was an increase in all but three countries[5].

While it does not contain time series and thus does not allow for a comparison over time, the survey included several questions directly relating to women's experience of violence during the pandemic, as well as whether the respondents knew women in their family or circle of friends who had experienced different forms of violence: online harassment or cyber violence (16%); street harassment (16%); domestic violence or abuse (14%); economic violence (14%); and harassment at work (11%).

[3] Albania, Bangladesh, Cameroon, Colombia, Côte d'Ivoire, Jordan, Kenya, Kyrgyzstan, Morocco, Nigeria, Paraguay, Thailand and Ukraine.

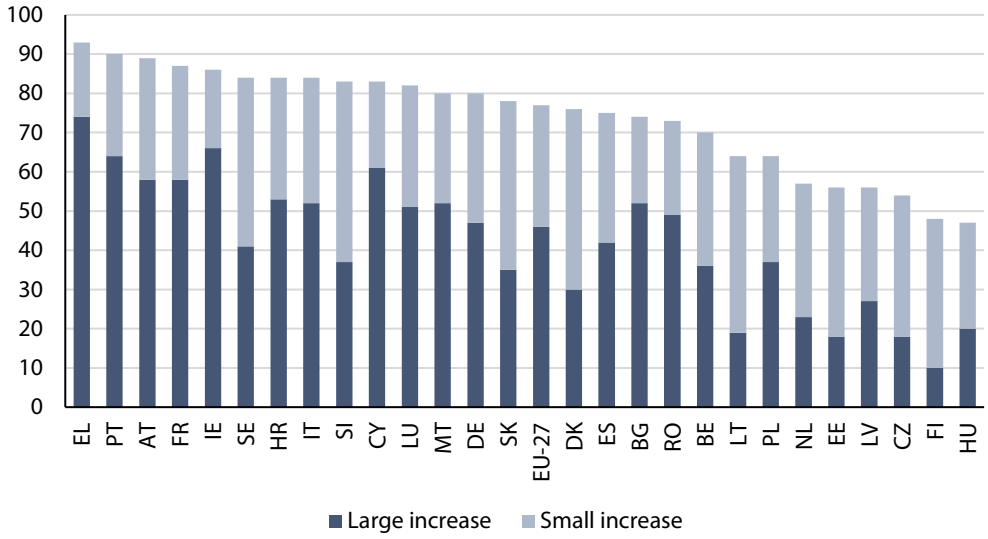
[4] Results for individual countries are shown in Figure 5 and in Annex 1; several countries recorded a high proportion of 'Don't know' responses, in Annex 1.

[5] The proportion of women expressing this opinion after the 'Don't know' option is excluded is shown in Annex 1.

Figure 4: 2022 Eurobarometer on violence against women during the COVID-19 pandemic

Source: European Parliament, (2022a).

Figure 5: Proportion of women who believe there was an increase in violence against women in their country since the start of the pandemic, EU-27, 2022



Source: European Parliament, (2022a).

The most common forms of violence differed significantly between Member States: in Greece, Ireland, Malta and Luxembourg, street harassment was the most common form of violence that women were aware of that it had been experienced by women in their family or circle or friends. By contrast, economic violence was the most common form in Bulgaria and Cyprus. Domestic violence or abuse had the highest levels in Romania, Greece, Croatia and Cyprus, at around one-quarter of respondents (European Parliament, 2022a).

The **2014 FRA survey** provided robust data on several facets of violence against women[6]. The survey found that **one in three women in the EU was a victim of physical and sexual violence by a partner, non-partner, or both**, with country-level estimates varying from 19% to 52% (FRA, 2014). As the FRA survey has not been repeated, it is difficult to establish differences in the level of violence against

[6] The FRA survey investigates: the prevalence of physical and sexual violence; emotional, psychological and physical consequences; psychological partner violence; stalking; sexual harassment; experiences of violence in childhood; fear of victimisation; and attitudes and awareness of the issues.

women over time. Several other data sources exist but vary in their coverage of Member States and the timeliness of estimates[7]. This gap will be somewhat filled by the Eurostat-managed **EU survey on gender-based violence against women and other forms of interpersonal violence (EU-GBV)**, which was launched in response to the data collection requirements of the Istanbul Convention and carried out its first round of data collection in 2020-2023. EU-wide results are due for publication in 2023 (the rationale and process for data collection of the EU-GBV are laid out in Eurostat, 2021). At the time of writing, however, 2021 data are available for only seven Member States: Austria, Bulgaria, France, Latvia, Lithuania, the Netherlands and Slovenia (Eurostat, 2022b).

3.1.2. Lack of official reporting during the COVID-19 pandemic

Paradoxically, even if violence against women increased in reality, a **decrease in reporting** was noted in some cases (Senior experts on gender and gender-based violence focus group; GREVIO interview; EWL interview). For example, shelters in Italy reported a 50% drop in reports, while *Telefono Rosa*, an Italian anti-violence NGO, reported a decrease of 55.1% in calls in the first two weeks of March 2020 compared to the same period the previous year (EWL, 2020a). Several factors may have influenced that decrease in reporting. For instance, in order to report violence **a victim must recognise themselves as such**; however, when a person lives in a violent context, they may not identify themselves as a victim because **violence gets 'normalised'** and – consequently – is not reported (Senior experts on gender and gender-based violence focus group on 19 January 2023). This can happen more frequently during a pandemic because the **stress factors** may not allow victims the mental space to understand the gravity of the situation (Senior experts on gender and gender-based violence focus group; EWL interview). During COVID-19 lockdowns, **perpetrators were able to exert even more coercive control over their victims**, making it difficult for victims to identify or report their situation (GREVIO interview; EWL interview).

Some women preferred to approach NGOs for help during the pandemic rather than official services. This may be the result of several factors, including a tendency to distrust government services, the absence of an obligation to recognise themselves as victims in the strict manner required by official services, and perceptions of NGOs as bridges to official services (EWL focus group on 19 January 2023 and interview) It has thus been suggested **to improve the interrelation between NGOs and State services** (EWL focus group on 19 January 2023).

3.1.3. Challenges for violence against women service provision during the COVID-19 pandemic

The rise in the prevalence and intensity of violence against women was aggravated by the **challenges experienced by service providers as a result of pandemic mitigation measures**. Generally, helplines and shelter accommodation reported a considerable increase in demand (EIGE, 2021; Van Ness, 2021; Meurens et al., 2020; GREVIO interview). However, these facilities experienced staff shortages due to an increase in workers going on sick leave because of contracting COVID-19, self-isolation due to symptoms, and volunteers and workers needing time off or reduced working hours in order to take care of dependents (e.g. children during school closures, older family members) (Meurens et al., 2020; EIGE, 2021; GREVIO interview). These two elements caused a contraction of the sector and aggravated the situation for victims of domestic violence, whose **access to these services was reduced** (EIGE, 2021; Gulati and Kelly, 2020).

[7] Annex 1 presents a non-exhaustive list of datasets on violence against women, and comments on their relevance for this study.

Service providers encountered **difficulties in reaching victims**. Movement restrictions meant greater contact between victims and perpetrators, increasing their control and hindering victims efforts to escape the abusive relationship (WHO, 2021b; Meurens et al., 2020; EIGE interview; GREVIO; interview; EWL interview). Women encountered complications in contacting support services by phone or online, as they were at home for most of the day with a perpetrator who also had control of these technologies (Meurens et al., 2020). There was a push to find new ways of providing support to victims through a remote service delivery model, but confidentiality and technology issues presented a problem (EIGE, 2021; GREVIO interview). The services providers themselves found it difficult to provide support without face-to-face contact (EIGE focus group on 19 January 2023; GREVIO interview). During the consultation activities, it was suggested that the institutional response to violence in times of crisis should be strengthened in order to better identify the risk of violence for victims and improve efforts to combat strain among service providers (EIGE focus group on 19 January 2023).

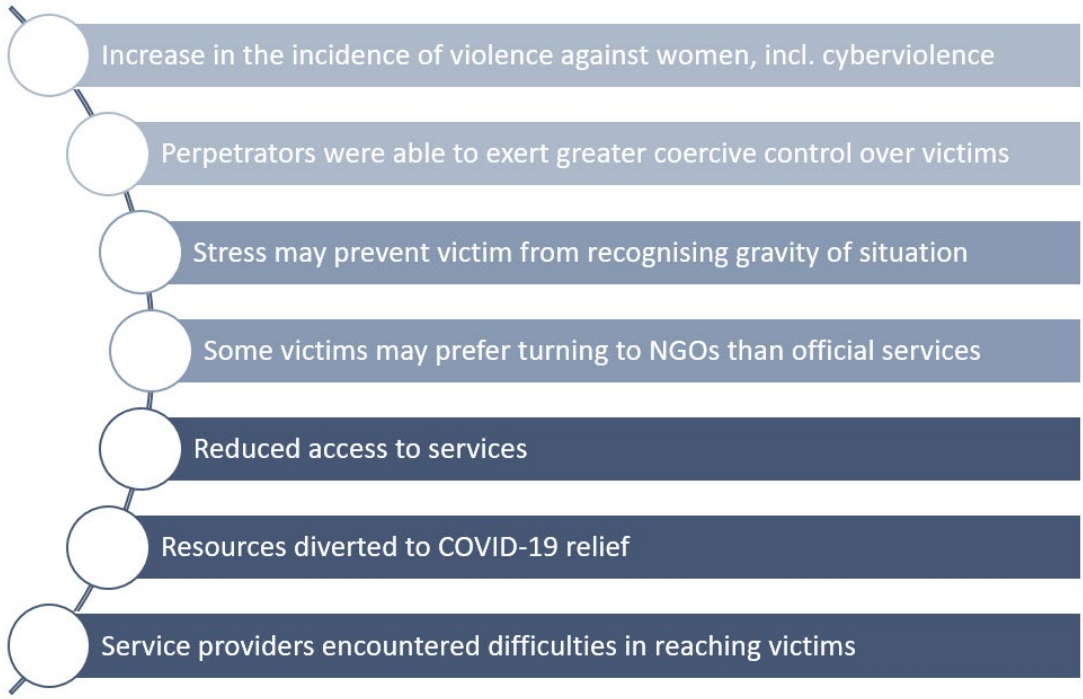
3.1.4. Cyber violence during the COVID-19 pandemic

The digital dimension of violence also needs to be considered. The COVID-19 pandemic increased **reliance on digital tools,** particularly during lockdown measures, and internet connection was widely regarded as a need and indeed almost a fundamental right (EIGE, 2022b). Even though the digital dimension helped to ensure services during the COVID-19 pandemic, cyberspace is not always a safe space (EIGE, 2022b; EIGE focus group on 19 January 2023). Technology, especially as employed in online and digital spaces, amplifies and facilitates gender-based violence. The perpetration of violence against women online or with the help of technology is seen as a continuity of the different forms of such violence (GREVIO, 2021; GREVIO interview; EIGE, 2022b; EWL, 2020b). **Women and girls are highly exposed and more prone to suffering the consequences of cyber violence** (EIGE, 2022b). Digitalisation can therefore be considered another factor that exacerbated the impact of COVID-19 on women by opening another area of possible abuse for abusers.

3.1.5. Intersectionality and the COVID-19 pandemic

Although violence against women affects all women, **certain groups of women were more vulnerable and disproportionally affected** by the negative impacts of COVID-19, where intersectionality meant that some women were exposed to multiple forms of discrimination and violence (EWL, 2020b; GREVIO interview). For instance, there were concerns about the risk of an increase in violence against **migrant women and girls** because of the inevitable escalation of fear and tensions in refugee camps (as locations already suffering from high densities of population and poor provision of water and sanitation) (Fraser, 2020; UN, 2020b; EWL, 2020b). Similarly, **older women's** economic insecurity, challenges in access to quality and affordable health and care services, and limited autonomy and independence put them at a greater risk of violence, abuse and neglect (UN, 2021; AGE interview).

Figure 6: COVID-19 pandemic and violence against women and domestic violence



Source: Authors' own elaboration.

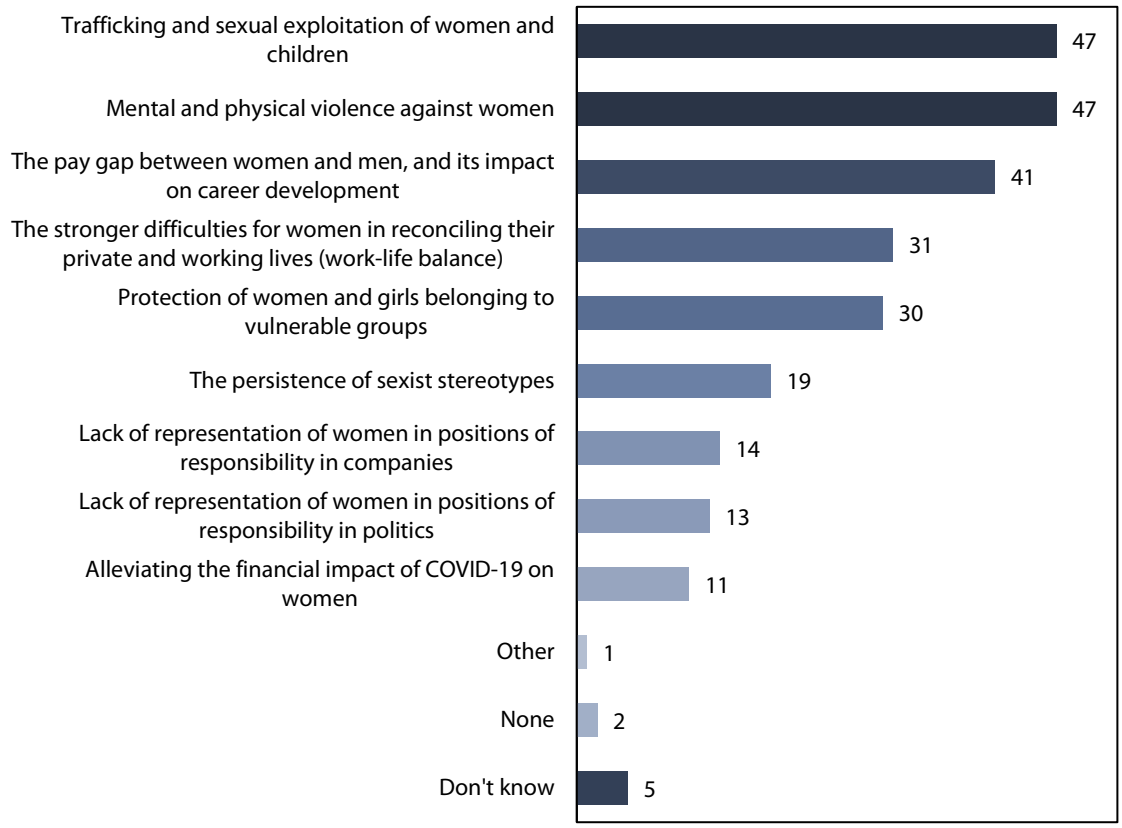
3.2. Actions to tackle violence against women and domestic violence during the COVID-19 pandemic

At EU level, the **Gender Equality Strategy 2020-2025** sets 'Ending gender-based violence' as its objective, stating that '[T]he EU will do all it can to prevent and combat gender-based violence, support and protect victims of such crimes, and hold perpetrators accountable for their abusive behaviour' (European Commission, 2020b). That commitment to proposing new rules to put an end to gender-based violence against women is reaffirmed in the **European Pillar of Social Rights Action Plan** (European Commission, 2021b). Although violence against women and domestic violence are **not specifically addressed by any EU laws**, in March 2022, the Commission adopted a **proposal for a Directive on combating violence against women and domestic violence**.

The European Commission provides **funding for organisations to undertake projects on gender-based violence** through the Daphne pillar of the Citizens, Equality, Rights and Values (CERV) Programme. At the end of November 2022, the European Commission announced an **EU-wide harmonised number for helplines for victims of violence against women** (116 016), allowing women victims of violence to call the same number, irrespective of where in the EU they are, in order to get advice and support (European Commission, 2022d).

The 2022 Eurobarometer on violence against women during the pandemic showed that many women believe that **addressing violence against women should be a priority for the European Parliament** (European Parliament, 2022a). 'Mental and physical violence against women' was seen as the most important gender-related issue, together with 'trafficking and sexual exploitation of women and children', each selected by 47% of women as priority areas for the European Parliament (see Figure 7).

Figure 7: With a view to the role of the European Parliament, which of the following gender-related issues would you like the Members of Parliament to tackle as a priority? (%)



Source: European Parliament, (2022a). Multiple answers allowed.

During the pandemic, Member States took various actions to implement changes or establish **new measures to support and protect women against violence and abuse**. In effect, the pandemic put violence against women under the spotlight and urged governments to act quickly (GREVIO interview). However, difficulties were encountered in implementing these actions, as **resources were diverted from violence against women to immediate COVID-19 relief** (EIGE, 2021; Fraser, 2020; Meurens et al., 2020; GREVIO interview). The Council of Europe established a webpage that presents these measures and practices (Council of Europe, n.d.a.). A small number of Member States put in place national policies or action plans rather than simply ad hoc measures (EIGE interview). In Spain, for example, a contingency plan specifically addressed intimate partner violence in the context of COVID-19 (EIGE, 2021).

Some Member States put in place **legislative or judicial interventions** (AT, BE, CY, IE, FI, FR, NL, SK) that implemented measures such as keeping courts and prosecution services open for cases of domestic violence, speedy processing, enhancing the use of videoconferencing, and supplying PPE to staff and court attendees (Meurens et al., 2020). The governments in Italy and Spain declared that survivors of violence who sought assistance would not be subject to severe curfews and orders to stay at home (WHO, 2021b). In Belgium, support services for women victims of violence were considered essential services (Meurens et al., 2020).

To expand victims' access to communication and support resources during COVID-19, governments **maintained and/or expanded helpline** availability for survivors, increasing the numbers of volunteers, boosting helpline hours, and creating new lines or new communication options (e.g. WhatsApp chats, SMSs) (WHO, 2021b; EIGE, 2021; EWL, 2020b). Governments and/or NGOs also developed **new apps or other online methods** to provide survivors with psychological and legal support through online platforms or facilitate access to other support services related to violence and abuse (Meurens et al., 2020; EWL, 2020b). In Cyprus, the NGO One Women At A Time conducted Zoom-based webinars on 'How to legally "shut out" your COVID-19 abuser', providing legal advice to women (WHO, 2021b). In Czechia, the ROSA Centre initiated the Bright Sky mobile app to provide support and information to victims and witnesses of abusive relationships (Meurens et al., 2020).

Awareness-raising campaigns encouraged victims to access support services and shared service contact details (Meurens et al., 2020; WHO, 2021b; EIGE, 2021; EWL, 2020b). EIGE stressed the importance of campaigns for witnesses: campaigns can avoid situations where the witness does not intervene because they do not recognise the situation as violence. They can also explain to witnesses how to contribute to preventing violence in practice (EIGE, 2020). Some campaigns encouraged witnesses to respond. For instance, in Slovenia, the police (in cooperation with NGOs and the Association of Social Work Centres) shared an appeal with the wider public to report violence, particularly given the limited access by NGOs and Social Work Centres. Similarly, in Croatia, the 'Behind the Door' campaign aimed to act preventively to protect victims of domestic violence during the pandemic by appealing to personal responsibility and civic courage to ensure timely notification of violence cases (Council of Europe, n.d.a.).

The **maintenance of shelters** was a key priority for governments during the COVID-19 pandemic (WHO, 2021b). Temporary accommodation was provided to counterbalance the overcrowding in shelters (EIGE, 2021; EWL, 2020b), with hotels and educational institutions also used to welcome victims (EIGE, 2021). In Germany and France, for example, unoccupied hotels rooms and holiday accommodation were repurposed to provide short-term rental solutions for victims (Meurens et al., 2020; Council of Europe, n.d.a).

3.3. Case studies (Belgium and Sweden)

Box 4: Case study – Belgium

Belgium was outstanding in its adoption of promising measures and best practices to tackle the issue of violence against women and domestic violence during the COVID-19 pandemic. The United Nations Development Programme (UNDP) and UN Women COVID-19 Global Gender Response Tracker (which monitors government responses to the pandemic and highlights those that integrated a gender lens) reiterated their praise for Belgium's commitment.

In April 2020, all competent ministers of the federal level and federal states met in an **Inter-ministerial Conference** on 'Violence against Women and Quarantine Measures'. The aim was to discuss the government measures in place to deal with violence against women, improve existing actions, and agree on new actions. Given the increased risk of violence as a result of the containment measures to combat COVID-19, the Brussels-Capital Region, the Walloon government and the Brussels French Community (Cocof) established a Task Force on conjugal and intra-family violence, which consulted with local actors on the sector's needs, and then acted accordingly.

Support services for victims of domestic and sexual assault remained open, but in-person support was substituted by phone service and internet chats. The initial start-up expenses in shifting to online services were partially covered by funding from regional governments. Existing phone

helplines hired more staff to increase capacity and opening hours. In addition, the reception system for victims of domestic violence was strengthened: existing shelters remained open and operational, with new temporary shelters also provided. In order to ensure they could respond quickly to demand, helplines and support chats were reinforced and continuously checked. To ensure discreet access for victims to support services, the code 'Mask 19' was introduced as a communication tool for victims to use in pharmacies to flag their need for support. Adopted from the Canary Islands, this measure was implemented in Belgium, accompanied by budget reserve funds and awareness-raising campaigns.

Awareness-raising campaigns included the Flanders campaign, 'Afraid to stay home?' (*Bang om in uw kot te blijven?*), which was funded by the Flemish regional government and promoted by the local telephone helpline through social media (1712). Similarly, the campaign 'Nothing justifies domestic violence' (*Rien ne justifie la violence conjugale*) was implemented in Wallonia and made available to hearing impaired and deaf people.

Source: EIGE (2021); Council of Europe (n.d.a); Meurens (2020); UNDP and UN Women tracker.

Box 5: Case study – Sweden

In Sweden, the results of a study to gather data on **women's violence experiences** were published at the end of 2022. Around 15 000 women aged between 18 and 84 years old were asked to answer questions about their experiences of men's violence since their 15th birthday, including during the last two years of the pandemic (2021-2022). The study response rate was 44.4%. Questions covered threats, physical violence and sexual violence (defined and counted as violence), as well as economical violence, sexual harassment and digital violence (not included in the core definition of violence). The questions covered several relationships: a) non-sexual relationships, b) men with whom the woman had had a sexual relationship but had not cohabited with ('boyfriends'), c) former cohabitees and former spouses, d) current cohabitees and spouses, and e) relatives.

Overall, 55% of the women reported **experiences of violence** from at least one man since her 15th birthday. During 2021-2022, 15% of all women reported experiences of violence. These rates were **significantly higher among younger women**: 39% of women aged 18-24 years of age reported having experiences of violence during this period, most commonly threats.

The overall figures showed that **sexual violence** from men with whom the women are no longer living was substantially higher than violence from men with whom they were still living: 23% of women stated that a former cohabitee/spouse had violated her sexually, compared to 5.5% in current relationships. The same pattern was evident in relation to physical violence, as already shown in an earlier similar national prevalence study on violence against women (Captured Queen). **Significant difficulties exist for women to report violence as violence in an ongoing relationship,** likely due to the **process of normalisation** that happens when women's boundaries are constantly pushed and they eventually develop a notion of being partly responsible for the violence.

The pandemic made it **particularly difficult for women to report violence**, chiefly due to the potential consequences of such a report. A woman experiencing violence by her spouse/cohabitee may feel that reporting the situation will worsen things. In addition, the **limited operation of many societal services** made the process of divorcing or moving appear more difficult. Studies on victimisation may show even **lower reporting** when conducted during a pandemic situation.

The overall figures of the Swedish study on violence against women, as well as pre-pandemic studies at national and European level, show that violence against women is a **widespread phenomenon across different countries**. Support services provided by the State, including financial support to women's shelters and municipal-level initiatives, can be of considerable help in such circumstances.

Source: FRA, (2014), Violence against women: an EU-wide survey; Lundgren, (2012); Lundgren et al., (2001a); Lundgren et al., (2001b); Westerstrand et al., (2022).

3.4. Importance of the Istanbul Convention in the wake of the COVID-19 pandemic

The Istanbul Convention is a landmark treaty of the Council of Europe that opens the path to **creating a pan-European legal framework to protect women against all forms of violence, and to prevent, prosecute and eliminate violence against women and domestic violence**. This instrument was negotiated by the 47 Member States of the Council of Europe and adopted on 7 April 2011 by its Committee of Ministers. The Istanbul Convention has been ratified by 34 of the Council of Europe's Member States, which must now take action to uphold their commitment to preventing and combating violence against women and domestic violence (Council of Europe, n.d.b.).

To date, the Istanbul Convention has been **signed by all EU Member States and ratified by 21.** The following Member States have signed but not yet ratified the Convention: Bulgaria, Czechia, Hungary, Latvia, Lithuania, and Slovakia. However, in July 2020, the Polish government announced its intention to withdraw from the Istanbul Convention. At the end of March 2021, the Polish parliament voted to send a bill called 'Yes to Family, No to Gender' to parliamentary committees for examination, which calls on the country to withdraw from the Istanbul Convention (Amiel, 2021). As yet, however, the withdrawal has not taken place.

The **EU signed the Istanbul Convention in 2017, but the negotiations to ratify it are ongoing** and it is not yet a legally binding text for the EU. In the Roadmap published in 2015, the European Commission affirmed that ratification would contribute to the EU commitment to gender equality, improve the health and lives of victims, bring savings to the EU economy by reducing gender-based violence, promote cooperation among Member States to combat violence against women, allow for the coordination of policies across EU institutions, allow for closer cooperation with the Council of Europe, and increase global visibility of the EU's commitment to the elimination of violence against women (European Commission, 2015).

The Convention is seen as a much-needed comprehensive framework to comprehensively tackle the issue of violence against women (De Vido, 2017). In fact, that comprehensiveness was noted during the consultation activities as the most important feature of the Istanbul Convention, with several stakeholders advocating for EU ratification of the Convention (Senior experts on gender and gender-based violence focus group on 19 January 2023). In the Gender Equality Strategy 2020-2025, the European Commission affirmed that 'concluding the **EU's accession is a key priority for the Commission**' and added that it intends to propose appropriate measures to accomplish the same goals as the Istanbul Convention, should EU ratification remain blocked (European Commission, 2020b). The next step for formal EU accession requires the adoption of a Council decision following the consent of the European Parliament; however, **discussions are ongoing** in the Council's working party on Fundamental Rights, Citizens' Rights, and Free Movement of Persons (European Parliament, 2022b).

The Istanbul Convention's obligations cover four categories of action – the four Ps – which aim to tackle violence holistically: preventing violence against women, protecting victims, prosecuting perpetrators, and implementing related comprehensive and coordinated policies. The Convention also establishes

a specific monitoring mechanism (GREVIO) to ensure the effective implementation of its provisions by the Parties. GREVIO draws up and publishes reports evaluating legislative and other measures taken by the Parties to give effect to the provisions of the Convention.

Recent studies and the stakeholder consultation for this study recognised the **added value of the Istanbul Convention** (Meurens et al., 2020; EWL, 2020b; GREVIO interview; EWL interview; EIGE interview). For instance, all countries that ratified it (except Cyprus) have adopted new legislation and – in general – the **adoption triggered amendments to existing legislation** (Meurens et al., 2020; EWL, 2020b). Some ratifying Member States created criminal offences for actions such as stalking and forced marriage that were previously classified under various broader offences (Meurens et al., 2020). The Istanbul Convention is the first instrument to explicitly include the requirement of due diligence, which is intended as a tool for victims 'to hold States accountable, providing an assessment framework for what constitutes effective fulfilment of a State's obligations, and for analysing its actions or omissions' (United Nations General Assembly (UNGA), 2013). Finally, the existence of a monitoring mechanism formed by an independent body of experts (GREVIO) and a political body (the Committee of the Parties) is considered a strength of the Istanbul Convention: the fact that States have to report to the Committee on their implementation of GREVIO's recommendations ensures their accountability (Meurens et al., 2020; EIGE interview; GREVIO interview; EWL interview).

The ratification of the Istanbul Convention appeared to **indirectly trigger governments to react quickly to the pandemic**. By contrast, actions in countries that had not ratified the Istanbul Convention were largely initiated by NGOs and there was limited coordinated action at government level (except Lithuania) (Meurens et al, 2020; EWL, 2020b). The Convention's mandate to establish a variety of support services is one of its strengths and proved extremely important during the COVID-19 pandemic. For example, in Germany, Italy and Spain, new women's shelters were opened and existing shelters offered new services, while in France, the authorities set up a platform for reporting gender-based and sexual violence in 2018 (Meurens et al., 2020; EWL, 2020b). In September 2020, the Committee of the Parties published a declaration on the implementation of the Convention during the COVID-19 pandemic and provided examples of how governments could react to the rise in cases of violence against women (Committee of the Parties to the Istanbul Convention, 2020). The importance of the application of the Convention during the pandemic was stressed by Marceline Naudi, chair of GREVIO, who affirmed that the Convention should apply in 'sickness and in health' – like in a marriage' (Council of Europe, n.d.c.).

Notwithstanding its added value, **the Istanbul Convention may not be enough to effectively tackle the issue of violence against women**, at least in the short term (EIGE interview). Some Member States are very reluctant to ratify the Istanbul Convention (e.g. Hungary) and others resist it even after ratification (e.g. France, where proposed legislation on same-sex marriage and adoption was criticised; or Italy and Slovenia, where the introduction of sexuality education in schools was heavily discussed) (Meurens et al., 2020). Several factors affect the implementation of the Istanbul Convention: victim-blaming attitudes; gaps in data collection, which can compound the implications of violence against women and prevent funding for essential preventive services; lack of gender-sensitivity training for first responders, such as police and judicial service; persistent gender stereotypes that justify men's control of their households; and failure to accept that violence against women is a gendered phenomenon (EWL, 2020b; GREVIO interview; EWL interview; EIGE interview).

As a result of these persistent challenges in implementing the Istanbul Convention, **no specific EU-level legal instrument yet exists to address violence against women and domestic violence**. The adoption of the **new Directive on combating violence against women and domestic violence** (European Commission, 2022e) proposed in March 2022 **could be greatly beneficial** (EIGE interview;

EWL interview; Senior experts on gender and gender-based violence focus group on 19 January 2023). The proposed Directive aims to ensure a minimum level of protection against such violence, across the EU, whether it takes place online or offline. It sets out targeted rules for the protection of this group of crime victims to strengthen the actions taken by Member States. The proposed Directive criminalises cyber violence and emphasises the need for harmonised definitions and better data collection, which is viewed as an important improvement given the 'push' towards digitalisation during the COVID-19 pandemic (EIGE, 2022b). The hope is that the adoption of such a Directive, although not as ambitious as it could be, will push the Member States to establish minimum support services and measures and ensure their accountability (EIGE interview, EWL interview). This is even more important in the context of growing anti-gender movements in some Member States (e.g. Bulgaria, Hungary, Poland), which make it increasingly difficult to advocate for victims of gender-based violence there (EIGE interview; Meurens et al., 2020).

According to stakeholders, the best-case scenario is a combination of the ratification of the Istanbul Convention at EU level and the adoption of the new Directive on combating violence against women and domestic violence (Senior experts on gender and gender-based violence focus group on 19 January 2023).

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ANNEX 1: METHODOLOGY AND DATA COLLECTION

Methods

This study relied primarily on existing **scientific publications and grey literature,** complemented by **interviews with key EU stakeholders** and five illustrative **case studies**. It also entailed an updated overview of data from the last two years on efforts to tackle violence against women and domestic violence in Europe. This IDA also benefited from a **focus group meeting** with key stakeholders, where the preliminary findings were presented and discussed. Each method is detailed below.

Literature review

The literature review comprised the **identification, collection, review and analysis** of the most relevant written sources in English.

Several **research questions** for each chapter guided the literature review:

Box 6: Research questions for Chapter 1

Intersections between COVID-19, mental health, and socioeconomic stressors in the lives of adolescents and young people

- How has the COVID-19 pandemic affected the lives of adolescents and young people, in particular in terms of education, socialisation, or mental, physical and socio-emotional development?
- How has the COVID-19 pandemic affected the socioeconomic situation of adolescents and young people? To what extent? In comparison to other age groups?
    - Employment: restricted employment opportunities or job losses, both for students, e.g. in hotel, retail and catering (HORECA), and young professionals
    - Education and training: restricted capacity to build skills and gather human capital; the impact of online education
    - Financial strain
- What are the main mental health problems reported in the wake of the COVID-19 pandemic?
- What is the relationship between mental health and the presence of socioeconomic stressors? How do socioeconomic stressors impact adolescents' and young people's mental health? To what extent did the COVID-19 pandemic increase this relationship? What typology of short-term and long-term consequences (in particular, mental health disorders) were observed and are expected?
- What are the risk and protective factors for developing mental disorders?

Box 7: Research questions for Chapter 2

Impact of COVID-19 measures, including lockdowns, on children and vulnerable people

- How have the COVID-19 restrictions adopted by governments affected the lives of children, in particular in terms of education, socialisation, or mental, physical and socio-emotional development?
- What were the immediate effects of life in lockdown on children and vulnerable people?

- What is the impact of measures adopted in the response to the COVID-19 pandemic on children's, young people's and other vulnerable groups' health and well-being?
- How was the well-being and mental health of children, adolescents, young people and other vulnerable populations (aged, women, people with disabilities, migrants and refugees, people living in extreme poverty) affected by COVID-19 measures adopted in the response to the COVID-19 pandemic and economic instability in the wake of the pandemic?
- To what extent have COVID-19 measures aggravated educational inequalities?
- Have COVID-19 restrictions had a disproportionate impact on people with disabilities?
- To what extent did social distancing put migrants and refugees and poor communities at higher risk in comparison to other groups?

Box 8: Research questions for Chapter 3

Tackling violence against women and domestic violence in Europe during the COVID-19 pandemic

- What impact has the COVID-19 pandemic had on the prevalence and intensity of violence against women and domestic violence?
- What are the latest developments in data collection on violence against women and domestic violence at both European and national level?
- What are the key actions at EU level to tackle violence against women and domestic violence in Europe? Have there been new developments during the last two years?
- What is the added value of the Istanbul Convention? Have there been additional initiatives introduced during the last two years, e.g. support services, to which the Convention has contributed?
- What are the latest developments on the possibility of the EU acceding to the Istanbul Convention?
- What are the remaining challenges in implementing the Istanbul Convention?

Once the research questions were finalised, the researchers developed appropriate **search terms**. These were used in combination to ensure that only relevant sources were identified.

The researchers identified a **list of databases** covering academic and scientific literature, as well as policy documents. Each of the databases was searched using all agreed search terms and strings.

Targeted interviews with EU stakeholders

To complement the literature review, the study team carried out **semi-structured interviews with key stakeholders** covering the three main topics of the IDA. The interviews took place in December 2022 and January 2023. This was intended to validate the findings from the literature, cover perceived gaps (e.g. elements mentioned in the literature but not covered in sufficient depth, or research not yet finalised), and obtain additional information. The **questionnaire** was tailored to each stakeholder, based on their specific knowledge and experience (e.g. questions to EIGE focused on violence against women and domestic violence).

The table below presents the European (and national) stakeholders interviewed in the context of this study.

Table 1: List of stakeholders interviewed

Stakeholders	Date of the interview	Inputs for
AGE Platform Europe	20/02/2023 (Video conferencing)	Chapter 2
European Foundation for the Improvement of Living and Working Conditions (Eurofound)	13/12/2022 (Video conferencing)	Chapter 1
European Institute for Gender Equality (EIGE)	12/12/2023 (Video conferencing)	Chapter 3
European Women's Lobby	23/01/2023 (Video conferencing)	Chapter 3
French National Institute of Health and Medical Research (*Institut national de la santé et de la recherche médicale*, INSERM)	09/01/2023 (Video conferencing)	Chapter 1 and Case Study on France)
Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO)	20/01/2023 (Video conferencing)	Chapter 3
Organisation for Economic Co-operation and Development (OECD)	15/12/2022 (Video conferencing)	Chapter 1

Source: Authors' own elaboration.

Case studies

The research team carried out **five case studies** to better illustrate the findings of literature review and interviews. The case studies focus on:

- Good practices to protect vulnerable groups from the impact of restrictive measures: a psychological programme to provide mental health support to students who faced particular isolation and psychological distress during the pandemic (**France**);
- A working group on the impact of COVID-19 on young people (**Cyprus**);
- Countries that adopted very restrictive measures on children and young adults to control COVID-19 and related impacts (**Spain**);
- Good practices to tackle the issue of domestic violence and violence against women during the COVID-19 pandemic (**Belgium**);
- Data on women's experiences of violence, including during the last two years of the pandemic (2021-2022) (**Sweden**).

Focus group meeting

A **focus group meeting with key EU stakeholders was held on 19 January 2023** to present and discuss the preliminary findings of this analysis. Attendees included the Milieu Consulting study team, senior experts and representatives from the European Parliament, Eurofound, OECD, INSERM, AGE Europe, EIGE and EWL. This draft IDA reflects and incorporates the relevant feedback/comments from the focus group participants.

Methodological issues in measuring violence against women

Social indicators are generally evaluated based on a **set of criteria** that assess their robustness and accuracy. According to Atkinson et al. (2002), an indicator should:

- Identify the **essence of the problem** and have a clear and accepted interpretation and definition;
- Be **robust** and statistically validated;
- Be **responsive** to effective policy interventions but not subject to manipulation;
- Be **measurable** in a comparable way across Member States;
- Be **timely** and subject to regular revision and update; and
- Should **not impose too large a** burden on Member States in terms of data collection.

Measuring the incidence of violence against women and domestic violence encounters **challenges** on each criterion. The first barrier relates to an overall **lack of data**, which has been recognised through Article 11 of the Istanbul Convention's mandate on further data collection (Council of Europe, 2011). However, the available data – whether from surveys, administrative data, or crime statistics – also face **issues of comparability and completeness**.

While efforts have been made to clearly define key terms in relation to violence against women (e.g. through Article 3 of the Istanbul Convention; EIGE, 2017; Eurostat, 2022c), data may still struggle to capture the phenomenon in the same way in different Member States. Firstly, national legislation on what constitutes rape or sexual assault, for example, may vary, and phenomena such as economic and psychological abuse are not always registered as gender-based violence (EIGE, 2019). Where data are recorded in a gender-neutral way, it is not possible to distinguish the gendered nature of violence in the home, or the relationship between perpetrators and victims (EIGE, 2022a). Whether the data are processed before, during or after an investigation, and whether it counts individual offences or the number of persons charged, also affects levels (EIGE, 2017).

Secondly, additional **issues of statistical reliability** arise from variations in the extent to which offences are recorded and how the data are collated. Factors such as cultural norms mean that victims in some Member States are more likely to report offences, or to accept or discount certain cases of violence (whether within the family unit or unwanted advances in the workplace) (EIGE, 2017; Eurostat 2022b).

The 2014 FRA survey – the latest large-scale EU survey on the topic – concluded that because Member States' definitions differ along with reporting, prosecution and conviction rates, 'official crime statistics say more about official data collection mechanisms and the culture of reporting rape than they do about the "real" extent of rape' (FRA, 2014).

These limitations should be borne in mind when interpreting data on violence against women. Nevertheless, the issues are widely recognised and documented, and several data collection efforts have sought to fill the knowledge gap and provide accurate data.

This study examines the intersections between COVID-19, mental health and socioeconomic stressors in the lives of adolescents and young people, the impact of COVID-19 measures, including lockdowns, on children and vulnerable people, and efforts to tackle violence against women and domestic violence in Europe during the COVID-19 pandemic.

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