COVID-19 AND SOCIAL WORK:
A COLLECTION OF COUNTRY REPORTS

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**Contributors are members of the
COVID-19 Social Work Research Forum
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Disclaimer

This compilation of *Country Reports* of the COVID-19 pandemic provides a snapshot of the situation in particular countries at a moment in time. It has not been peer reviewed, although it was edited several times to clarify the usage of the English language which is not the first language of a number of the authors, and to ensure uniformity of style and referencing. The authors of each *Country Report* are wholly responsible for the content and accuracy of the data and views expressed therein. Thus, neither IASSW nor the editors, individually or collectively are accountable for their work. The editors and IASSW are simply facilitating access to people's country narratives.

Sharing Information

This document should be easy to use and provide comparable information which we trust will be useful for research purposes in social work around the world. The contributors to this first edition of the collection are members of the COVID-19 Social Work Research Forum. However, not all members of the Forum have contributed to it in the short timeframe we had available. We would urge those who would like to contribute their country report to contact Lena Dominelli at lena.dominelli@stir.ac.uk and she will facilitate access to the contributions already on the IASSW website.

Future intention

There is an intention to turn this collection into a book at some point in the near future, but we felt it was important to record the positions of various countries now, briefly and quickly. This collection represents but a moment in the COVID-19 history of some countries.

The Editors
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INTRODUCTION:
COVID-19: A NEW CHALLENGE FOR SOCIAL WORK

Joseph Mooney, Timo Harrikari and Lena Dominelli

Human civilization has experienced many significant global health emergencies in recent history. From the Influenza Pandemic of 1918 to the Ebola virus, and from SARS and H1N1 to our current coronavirus one. Each has challenged and tested our governments, communities, families and individuals alike. Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), commonly referred to as 'COVID-19', came to the world's attention in December 2019 when a cluster of individuals, presenting with unusual pneumonia-like symptoms, were identified. At the time, the aetiology of these symptoms was unidentified. This cluster was linked to a live fish and animal market in Wuhan City, Hubei Province in China. Following the closure of this market on 1 January 2020 and subsequent testing, traces of what became known as COVID-19 were confirmed across the planet (European Centre for Disease Control 2020). Since then, global agencies and national governments across the world have grappled to monitor the spread of the coronavirus and implement protective measures.

By 5 July 2020, the virus had exacted an enormous human toll with 10,410,447 cases confirmed globally and 534,164 COVID-19 related deaths (World Health Organisation, 2020). Some countries and regions have been particularly hard hit. This is influenced by many variables including when the first cases emerged and the state of knowledge at the time, government responses, available resources, and community adherence to implemented restrictions and safety measures, to name a few. The pandemic and our local and global responses to it have significantly impacted our way of life, how we interact with each other and our environment, and how we help and care for those most vulnerable on the margins of our societies. In many countries, workplaces, schools, and universities have closed and mass gatherings have been postponed or cancelled. Alongside such measures, public health advice has placed significant emphasis on hand hygiene, cough-etiquette, physical distancing, and self-isolation when necessary, to stop or slow the spread of the coronavirus. Many countries have experienced high rates of unemployment in combination with shifts to remote, home-based and digitalized forms of work and governance. Varying degrees of state, legal and police enforcement of regulations have been implemented ranging from emergency powers of legislation in some jurisdictions to a reliance on individual social responsibility in others.

At the time of this writing at the beginning of July 2020, different parts of the world have been living with the COVID-19 crisis for varying periods of time. The viral pandemic that started quickly in December 2019, spread worldwide and shook the whole world. At this point, it seems that the first wave of the pandemic has weakened in Western Europe and parts of Asia, especially in South Korea and Taiwan. In Western Europe, the number of coronavirus deaths in the United Kingdom and Sweden, have continued to be sources of concern. The highest relative mortality rates are found in Belgium, Sweden, the United Kingdom and France. Moreover, the countries with the highest mortality rates in the early stages of the pandemic, Spain and Italy, have subsequently evidenced a sharp decline in mortality rates. In recent weeks, European nation-states have begun to loosen the strict regulations associated with the 'lockdown' intended to protect their populations and health services from the ravages of COVID-19. Additionally, the advent of substantial

numbers of new infections has shifted to other continents. From the end of June 2020, the number of deaths from infections and deaths caused by the coronavirus has risen in such countries as the United States, Brazil, Russia, India, Iran and Mexico. In China, which experienced the first impact of the pandemic, only a few new infections have been detected, and no new deaths have been reported recently.

Complexity theory defines the concept of the 'black swan' as a series of unpredictable events that have the potential for a wide-ranging impact and far-reaching implications (Taleb 2010). Some argue that the coronavirus pandemic seems like a 'black swan', possessing emergent powers and powerful bio-physiologic-psychological mechanisms that cause wide-ranging societal crises. We may speak of a drastic breakdown of social systems, in which both the operative principles of the systems and the ways in which people meet and interact have been fundamentally undermined. The socio-ecological 'fabric' considers local and regional factors such as age, structure, population density, economic structure and settings of the interactions between people to see how they enable and restrain the effects of a pandemic.

However, it remains to be seen how fundamentally the pandemic will change *the socio-ecological fabric of human communities and societies* in the longer run. This is particularly crucial to how societies organise themselves; how social institutions work and how people behave and act in everyday settings (see Putnam 2000); and how they interact with each other globally (Dominelli, 2020). The pandemic period has been characterised by an interesting tension between social systems. The pandemic has reminded us that although we live in a globalised world society that disregards national borders, the nation-state has emerged and shown its power in innovative ways for the first time in many decades. The *Country Reports* indicate that it is rather paradoxical, in these times of hypermodernity, that citizens' geographical mobility has been disrupted and that they have been suddenly forced not to move, in a way that is more characteristic of the premodern era.

Social work is a global, practice-based profession and an academic discipline that promotes social change and development, social cohesion and the empowerment and liberation of people. Together with health care, social welfare and social work form the core structure of the service system that maintains the well-being of a population. The *Country Reports* reveal that social work and social services have recently faced new challenges. The frontline social workers and social welfare institutions have had to adapt to the new circumstances and respond to challenges caused by a powerful biological phenomenon that is invisible in everyday activities but has a fundamental impact on the daily functioning of society. Face-to-face interactions, touch and compassion are at the heart of social work, and so we must ask how a pandemic changes people's daily lives and the functions of social work institutions and share experiences across borders to learn from each other. The principles of social work are constantly being tested, and pressures to deviate from them can intensify in exceptional situations.

While social welfare provides systemic-level support to the entire population in a society, one specific role of social work is to work with, support and take care of the most vulnerable sections of the population. The *Country Reports* support the presumption that the demographically richest and economically poorest areas around the globe are all vulnerable as hypothesised by Therborn (2013), albeit differentially (Dominelli, 2012). Some *Country Reports* illustrate how quickly the socio-ecological fabric in some Western countries has been organised in new ways as a result of the pandemic. These initiatives have been referred to as the 'new normal' by several governments in speeches on the

coronavirus. It is likely that there will be definitions of a 'new deviance', leading to new kinds of stigmatisation following a variety of responses to COVID-19.

Social control and repressive governance towards deviant and vulnerable groups of people tend to increase and harshen during a crisis. Depending on specific contexts, this may occur both during and after the current coronavirus pandemic. When criteria are set for a 'new normal', a 'new abnormal' is also defined. This results in the labelling of abnormal behaviour and leads to the stigmatisation of so-called deviant groups. Thus, one of the main tasks of social work is to adhere to and implement the national and international standards meant to protect the most vulnerable groups of people and to promote the fundamental rights of these groups in the face of social pressure, stigmatisation and scapegoating in communities.

More generally, the protection of marginalised and vulnerable groups and the promotion of their agency, especially in matters concerning themselves and their reintegration into society, are counted among the core tasks of social work. In a more abstract way, the core tasks of social work are listed in the globally recognised ethical principles of social work developed jointly by the International Association of Schools of Social Work (IASSW) and the International Federation of Social Workers (IFSW) (IFSW 2018). These principles include, among others, recognition of the inherent dignity of humanity, the promotion of human rights, social justice and the right to self-determination and participation, as spelt out in the Global Agenda which is also shared by both of these organisations.

The structure of this compilation

Social work is a profession at the frontline of this pandemic. How we live through and learn from this unprecedented lifetime experience will shape and determine how we respond to subsequent waves of the coronavirus and future public health emergencies that may face us globally and locally. Across countries and continents, there have been some common themes relating to the impact of the pandemic on those who access social work services. Concerns have been expressed in relation to the rates of domestic violence and violence against children with visibility and face-to-face contact with social workers and other caring professionals being dramatically reduced. The impact on the homeless population has presented its own specific issues relating to an inability to self-isolate or receive appropriate services. Those in specific residential settings such as older persons, people with disabilities, children's residential services and asylum seeker's accommodation also face particular risks due to limited accommodation, lack of personal protective equipment and an inability to adequately self-isolate. The challenges posed by COVID-19 speaks to the heart of social work as a profession. The need for collective responsibility, respect for human dignity and human rights, ethical behaviour and the empowerment of those who are marginalized, or risk being further hidden during periods of 'lockdown' or restriction, are challenges that social workers are, somewhat uniquely, qualified to face. While the emphasis is, rightly in many ways, to turn to the voice of medicine and public health to find ways forward, it is critical that the voices of social workers are also heard, and their knowledge and skills added to the ensuing solutions.

What follows is a series of *Country Reports*, each charting a national response to the COVID-19 pandemic with a particular focus on the role of social work and social welfare in this respect. They are arranged in alphabetical order. This collection of *Reports* is the product of an international network of social work academics with a specific interest in how social work practice, policy and education can learn from, and adapt to, our shared

experiences of this global health emergency. The network was convened by Professor Timo Harrikari (University of Lapland) to examine 'pandemic' and 'post-pandemic' social work. After a number of online discussions, an initial action taken by network members was to gather information among themselves to develop an overarching view of how the pandemic has impacted social work and those populations that the profession serves in each specific country. The following sixteen *Country Reports* cover different nation-states and are written by network members to chart this phenomenon and its impact on social work and service users. The countries represented span a number of countries, and include key insights from Albania, Australia, Bangladesh, Estonia, Finland, India, Iran, the Republic of Ireland, Italy, Japan, Latvia, Slovenia, Spain, Sri Lanka, Sweden and the United Kingdom. We are conscious of various gaps in coverage including China, Southeast Asia, Latin America, North America, Africa and indigenous people globally. We welcome these additional contributions. We hope that others will submit further country reports to add to this collection, as this one is but a modest start.

The reports follow a similar structure and focus on the key facts and figures from each jurisdiction, the impact of the pandemic on social work practice, vulnerable and marginalized populations, and local and national governmental responses to the pandemic. What we see is a common trend of periods of 'lockdown', closure of schools, businesses, universities and other places of work, recreation, and social gatherings. Emphasis has been placed on personal responsibility, hygiene, and physical distancing. However, many countries have experienced a dearth of personal protective equipment, and, in some cases, even for frontline and emergency response professionals. There are also differences with regards to coverage of particular policies and the vulnerabilities of different groups, particularly those who are marginalised.

Many countries covered within this compilation of reports present examples of government and state economic stimulus packages or measures aimed at securing the continued existence of businesses, employees, and key state services. This is, however, starkly contrasted with overwhelming reports of those on the margins, those with pre-existing vulnerabilities and of older populations being left most at risk. But there are others. For example, we learn that in Bangladesh, minority groups such as indigenous populations, the transgender community, sex workers, people with disability, returnee migrant workers, tea garden workers, and Rohingya refugees did not receive any special support from the government. While in countries such as India issues of food security have been dramatically impacted due to poor lines of transportation, increased unemployment, and lower wages.

The impact of the pandemic upon children, young people and families is also a common theme among our country reports. Issues such as school closure, prohibition of socialising in many countries, and reports of a rise in family violence have led to increased risks for children and other vulnerable groups, including black and minority ethnic groups in Western countries like the USA, the UK. These risks may go undetected and unabated due to restrictions on contact with social services, a lack of home visiting and an absence of extra layers of support offered by sporting, recreational and community clubs which have closed. The closures of schools have also meant the absence of school meals for children, often a lifeline for the most vulnerable ones in many communities. Family visits for children in state or residential care have all but stopped in many countries, with some jurisdictions closing such facilities and returning children to their families of origin. Many countries have also experienced an escalation in domestic and gender-based violence with police services within countries such as Ireland making efforts to reconnect with previous victims to ensure their welfare. A recent study highlighted in the Finnish report

shows that 75% of social workers believe that their clients/service users now have fewer opportunities to receive help for their needs than before the crisis.

The most damaging effects of the pandemic resulting from various state responses to it have impacted most on children and vulnerable families. At the other end of the life course, older people in all communities have been particularly hard hit by the virus itself. Many countries report a majority of COVID-19 confirmed cases and deaths within their older populations. That said, many jurisdictions do not have access to clear data on this area of impact, and many governments are not providing a clear breakdown of the settings in which deaths and clusters have occurred. It is clear however, from media coverage referenced in many of the reports that care homes for older people and residential settings have been the most severely affected. The Slovenian report refers to the most deaths having occurred in their older people's care settings, with Spain reporting a stark 86% of deaths being among those over the age of 70. Japan, currently experiencing a 'super-aged' society also highlights specific concerns and experiences in this respect.

The global death toll has now exceeded half a million people, highlighting the significant issue of bereavement within families. Many countries introduced measures to prohibit mass gatherings and socialisation in groups. This has had the effect of prohibiting many family, extended family, and community members from attending funeral ceremonies of friends and loved ones or, in some circumstances, being with loved ones when they were dying. In Sri Lanka, the Health Ministry decreed that cremations were compulsory for coronavirus victims, thereby ignoring traditional practices among the country's Muslim and Christian populations who worry that this rule goes against their traditional practices. The long-term impacts of such phenomena have yet to become clear.

The global social work profession has adapted and 'bent with the flood' of the COVID-19 pandemic. The *Country Reports* that follow present examples of innovative engagement with digital technology, a return to practical help and support in the form of food parcels and vouchers for vulnerable families and children, more expeditious exchanges of information and a reduction in bureaucracy between state departments and service provision; in essence a reliance on one another, and the willingness of others to assist. Our Italian colleagues mention that the thoughts of restrictions, fear of death, and uncertainty about tomorrow conjure memories of wartime for many older generations. Such memories, however, will also stir notions of collective action, joint responses and strong community spirit. A global pandemic acts like a control in a scientific experiment, it is an enemy that exerts an impact on everyone and serves to expose the stark inequalities and vulnerabilities within our countries and communities. In doing so however, it also exposes our equal worth, our interdependence. What becomes more apparent as we move through the pandemic, towards a 'new normal' in terms of governance, socialisation, economy and community, is that we must position 'care' as political and ethical posturing in our efforts to reopen and rebuild (Meagher and Parton 2004). Social work is uniquely placed and ready to help with this task.

In flood time you can see how some trees bend, and because they bend, even
their twigs are safe, while stubborn trees are torn up, roots and all.
Sophocles, Antigone

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ALBANIA

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Country context: Key facts and figures

Albania was already responding to an earthquake when COVID-19 struck, thus posing a compounded emergency for the population, its service infrastructure and government officials to address alongside COVID-19. Its specific country position is identified below.

Population and population density

The population of Albania on 1 January 2020 was 2,845,955 inhabitants (1). The population density in Albania is 105 per km^2 (272 people per mi^2) (2).

Current COVID-19 situation

In November 2019, Albania was hit by a high-magnitude earthquake, which took a toll on physical infrastructure and economic activities, leaving a burden on the budget prior to COVID-19 (3). Although the lockdown has ended, the Albanian government monitors COVID-19 and holds daily press conferences on the outbreak. In these daily updates. The Ministry of Health provides the number of cases as well as details including statistics on patients in remission, number of new cases, deaths and the total number of positive tests for COVID-19 (4). According to the latest updates (week 27/2020) in Albania, they are:

- 26,292 people tested for COVID-19. Approximately 0.92% of the population has been tested thus far for COVID-19.
- 2,402 individuals had confirmed coronavirus infection (5).
- 963 active cases.
- 55 patient deaths from COVID-19, distributed as follows: Qarku Tiranë 31, Durrës 9, Fier 5, Vlorë 2, Shkodër 6, Kukës 1, Elbasan 1. The 55 patients died in hospital while they were under intensive care for COVID-19.
- 1,384 recovered patients (6).
- Number of positive cases by region: Durrës (176), Lushnjë (33), Elbasan (34), Fier (78), Rrogozhinë (6), Kavajë (13), Korçë (39), Vlorë (92), Kukës, (1), Shkodër (291), Lezhë (32), Berat (20), Has (16), Krujë (293), Tropojë (9), Pukë (44), Mirditë (9), Kukës (35), Mallakastër (3), Kurbin (51), Mat (10), Kamëz (42), Librazhd (2), Ura Vajgurore (1), Gjirokastër (6), Sarandë (7), Pogradec (9), Përmet (1), Delvinë (11), Tepelenë (1), Vau i Dejës (1), Divjakë (6), Fushë-Arrëz (1), Selenicë (1), Belsh (1) and Tiranë (1028) (7)
- Number of active cases by region: Tiranë (371), Durrës (181), Shkodër (162), Vlorë (103), Fier (48), Lezhë (33), Korçë (26), Kukës (15), Elbasan (12), Gjirokastër (7) and Berat (5) (8).

Two main hospitals are in service for coronavirus patients in Tirana as 'COVID 1' and 'COVID 2'. According to the Albanian Ministry of Health, they had around 310 hospital beds at their disposal for the hospitalisation of patients with coronavirus. At the beginning of June, another hospital, named 'COVID 3', was adapted to prepare for a possible new wave of infections (9).

Societal measures addressing the social consequences of Covid-19

The extent of isolation

On 24 March 2020, a 'state of natural disaster' was declared across the country for a period of 30 days, which was later extended by two more months to 23 June. The following closings, isolations and restrictive practices were established:

- Borders are closed except in specific conditions and flights, ferries and cars are restricted to operating only transportation of basic needs, such as food and medicine.
- All public and non-public educational institutions were closed, including nurseries, kindergartens and schools, Schooling was resumed only for high school graduates taking university admission exams. Teaching will resume for universities during the summer, but with fewer students per class.
- Bars, restaurants, fast food, hotels, swimming pools, gyms, theatres, cinemas, nightclubs and indoor playgrounds were closed.
- Public and non-public activities, mass gatherings in closed or open places, wedding ceremonies, scientific activities, public hearings and gatherings of all kinds were banned.
- Planned surgical interventions in all public and non-public hospitals were postponed (10).
- All people coming from Italy were required to self-isolate. Violators could be fined up to 5 million lek (or 40,316 Euros).
- Television stations were not allowed to have more than two people on the same stage. A fine of 1 million lek (8,063 Euros) would apply to violations.
- Private hospitals that refuse to operate at full capacity were to be fined up to 5 million lek (40,316 Euros).
- Any trade in food or medicine that did not comply with the specified government safety regulations to combat infections risked a fine of up to 10 million lek (EUR 80,632 Euros).
- The legislation, called a 'normative act', is an emergency law taking effect without prior approval by the Parliament (11).

State measures to address social problems and needs.

Real GDP growth is expected to decline in Albania by 5% in 2020 from the estimated 2.2% growth in 2019. According to the Ministry of Finance and Economy, the first phase of lockdown will cost the economy 16 million Euros in tax revenues. The most affected sectors will be tourism, transport and trade. Fifty thousand jobs have already been lost due to the crisis.

As of May 2020, the government put a deconfinement process in place to open the economy step by step, including the reopening of tourist activities under health and safety protocols and completely removing the curfew. On 1 June, Albania opened land borders with all neighbouring countries. On 15 June, air borders with Greece opened. From 9 June, the number of new cases started rising, putting the deconfinement process in question. As the situation continued, on 19 June, the government announced increased monitoring of the measures including keeping a physical distance, wearing masks and a zero-tolerance policy towards those who fail to comply (12). The latest proceedings are as follows:

- On 29 March, the Ministry of Europe and Foreign Affairs, in cooperation with the Diplomatic Representations of the Republic of Albania throughout the world, started repatriation operations for Albanian citizens. This is also a measure to cope with the health emergency.
- On 3 April, Albania received eight tons of personal protective equipment (PPE) for medical staff, reaching a total of 23 tons of new equipment including masks, special clothing, goggles, protective helmets and other items enabling increased safety for doctors and nurses dealing with COVID-19. An export ban has been placed on drugs and medical devices unless a special authorisation is given by the Minister of Health.
- On 1 June, Albania opened land borders with all neighbouring countries, and the national curfew was lifted.
- From 10 June, beaches are open for all tourists. Albania has drafted a protocol for the summer season including measures such as thorough temperature checks for all beachgoers, an anti-COVID-19 coordinator overseeing hygiene measures and obligatory masks and gloves for staff. These items must also be available for all tourists and more. A licensing authority will check to make sure all beach areas fulfil the required conditions.
- On 22 June, Tirana International Airport was permitted to start operations of regular international flights. Maritime transport was resumed for all international passenger transport lines (13).

The Ministry of Education issued an order requiring all elementary schools, high schools and universities to deliver online lessons. All families and individuals who receive economic assistance will benefit from the payment of economic assistance without the need to apply to receive this benefit in person, as it will be online.

The social administrators of the administrative units are responsible for facilitating applications for economic assistance, enabling them to make electronic or telephone contact to assist all applicants applying for these benefits. Applications for economic assistance will be accepted by the social administrators of the administrative units in electronic form or through the postal service.

About 64,000 families will benefit from the doubling of economic aid payments throughout the COVID-19 disaster period. The pandemic was deemed a 'natural' disaster. For people with disabilities, payments will continue without interruption, and the re-commissioning of people with disabilities will take place after the state of 'natural' disaster has passed (14).

Government financial plans

On 19 March 2020, the government publicly announced the financial plan in response to the economic impact caused by the COVID-19 pandemic. Some of the measures presented below entered into force with Normative Act No. 6, dated 21 March 2020, 'On Some Amendments and Additions to Law No. 88/2019, on the Budget of 2020'.

The government has allocated a total of ALL (Albanian Lek, the national currency) 45 billion (2.8% of GDP) through two support packages for the population and the private sector affected by the COVID-19 pandemic, which includes budget spending, sovereign guarantees and tax deferrals. In addition:

- A total of USD 65 million was made available for the immediate needs of the most disadvantaged segments of the population, small businesses and potential unemployment due to the virus.
- USD 10 million was made available as a reserve fund to the Council of Ministers for any unforeseen emergencies.
- ALL 2.5 billion would be allocated to the Ministry of Health for the purpose of providing medical equipment and supporting medical staff (15).
- A sovereign fund of ALL 10 billion was guaranteed for the entities who cannot pay the salaries of their employees.
- ALL 2 billion was made available to the Ministry of Defence for their humanitarian operations.
- Late-payment interest, with a financial impact of up to ALL 15 billion, would be forgiven for active debtors (family or small business) of energy consumption.
- As of the second half of 2020, income taxes for businesses with an annual turnover of ALL 2–14 million will be rescheduled.
- The deadline for the submission of online or physical balance sheets to the National Business Centre (NBC) by the respective businesses was postponed until 1 June 2020 (16).

The Albanian government presented a second financial package of USD 20 million on 13 April 2020 to attempt to help the economy. The second financial package consists of:

- USD 150 million as a sovereign guarantee for clothing factories, manufacturers and companies operating in tourism.
- USD 70 million in financial aid as a one-time direct payment (ALL 40,000 per employee) for the following categories:
  - 100,000 employees in small businesses that were not included in the first financial package.
  - 66,000 employees of large businesses that have temporarily ceased activity.
  - 10,000 employees in tourism (17).

The overall set of changes in measures and/or changes of measures taken by government until the 1 June and from that date onwards are:

Until the 1 June 2020:

- In the red zones (Tirana, Durres, Shkoder, Kruja and Kurbin), citizens may move freely without permits between the hours of 5 a.m. and 9 p.m. Monday–Friday. In green zones, citizens may move freely without permission and without a curfew Monday–

Friday. Vehicle movements are not permitted over the weekend. Circulation in and out of red zones is not permitted.

- All schools have been closed and students finished the 2019–2020 academic year via online education. Online classes at government schools continued until 29 May 2020. Exams for fifth-year and ninth-year students were cancelled, including graduation exams for ninth-year students.
- High school graduation exams (State Matura Exams) took place from 8 June to 18 June 2020.
- High schools will reopen from 18 May to 5 June 2020 for graduating students. Lessons will take place under strict social-distancing protocols, with no more than 15 students allowed in a classroom.

From 1 June 2020:

- Preschools and kindergartens were reopened on 1 June 2020.
- All sporting events have resumed, but no spectators are permitted to attend.
- Malls and shops are open, with strict social-distancing measures in place.
- Hairdressers and dentists are open, with strict social-distancing measures in place.
- Restaurants and cafés with outdoor seating are reopened.
- All gyms, sports centres, swimming pools, internet cafes, cultural centres, entertainment centres and indoor activity centres for children reopened.
- Outdoor exercise is permitted.
- Libraries and museums are reopened.
- All public transportation is restricted indefinitely.
- Directed government offices will provide services for the public via online platforms, including the e-Albania platform.
- All land, maritime and air borders have reopened (18).

Entry and exit requirements

Land borders with neighbouring countries have been closed, and all flights in and out of Albania suspended. In mid-June 2020, the borders are gradually reopened and air services have started. Albania has increased the number of medical personnel at all ports of entry. Enhanced screening and quarantine measures are being implemented. Travellers should be prepared for travel restrictions to be put into effect with little or no advance notice (19). The list is not an exhaustive one, but it serves as general information on measures taken by the government.

Social services responses

The mode of operation of social services

There are data showing an increase in domestic violence, but little effort has been undertaken to investigate this further.

Unemployment measures

Included in the first economic package, unemployment benefits were doubled during the pandemic. As of 20 April, from the expanded economic package, 176,000 families will receive ALL 40,000 during the COVID-19 pandemic. That includes 100,000 employees from small businesses affected by the situation, 66,000 employees from large businesses and 10,000 employees from the tourism sector.

Support for vulnerable groups

Persons receiving social assistance will receive double the amount during the pandemic. The payment of rent will be postponed for the months of April and May for small businesses, families that have stopped working due to the COVID-19 situation, and students who moved back home during the pandemic (20).

Social work responses

Most affected groups defined by social workers

The groups most affected are older people, old people, people with disabilities, unemployed people, people working on the black market, children living in remote areas lacking access to the Internet and hence unable to do school work at home, families suffering domestic violence, and people living in remote areas lacking access to transport, work, health and other services. Further information is not currently available as non-governmental organisations (NGOs) are in lockdown due to the government's measures. The impact of this needs to be confirmed in the future.

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AUSTRALIA

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Country context: Key facts and figures

Population and population density

Australia's population is 25,483,610 and population density is 3 per square kilometre. Australia is an island located in Oceania and has no land border with any other country which might be a factor that helped Australia to have good control over the spread of the coronavirus. Even though Australia has the sixth largest land area in the world, the major part of its land area is not arable and most of its population lives along its coastline of 35,821 km making its population density higher than if it were scattered across the whole country.

The first COVID-19 case in Australia was reported on 22 January 2020. The number of new cases reported rapidly increased and peaked in March 2020. Since mid-April, the number of new cases reported daily has remained low. In mid-June 2020, all the states of Australia except New South Wales and Victoria had reported zero new cases for the previous two weeks. The highest rate of disease is among those in the 60–69 years age group followed closely by the 70–79 years age group. Children make up a small proportion of cases nationally. To date, over 1 million tests have been conducted nationwide. Of those tests, less than 1% were confirmed positive for COVID-19.

Number of infectious cases and time period

At the time of writing (2 July 2020), the total number of cases reached 7,920, of which 7,063 cases have recovered. Melbourne has had an incident of community transmission and this resulted in 77 new cases of COVID-19 and the Victoria State Government has ordered a lockdown in 10 postcodes of Melbourne. Among these new cases, nine cases are linked to existing outbreaks, 19 new cases have been identified through routine testing and 42 cases are under investigation (Victoria State Government, 2020).

Number of deaths

As of 2 July 2020, there were 104 reported deaths of which the majority were men aged 70 to 89 years.

Number of deaths in specific settings, such as care homes for older people and residential care for children

Twenty-two of the people who died due to COVID-19 were passengers on the Ruby Princes cruise ship which docked in Perth and Sydney. Passengers were permitted to

disembark without health precautions being carried out. A criminal investigation about this incident is currently in progress. The remaining fatalities of COVID-19 involved residents living in older people's care homes.

Societal measures addressing the social consequences of COVID-19

The extent of isolation

Australia went under total shutdown on 23 March 2020 and published a three-stage plan to ease it on 8 May 2020. Pubs, clubs, gyms, cinemas and places of worship were shut down, and restaurants and cafes shifted to takeaway only. Many businesses were shut except supermarkets, petrol stations, pharmacies and home delivery services, which continued to operate. The Australian Government requested schools to continue to teach, but parents were able to keep their children at home if they wanted to do so. Schools provided online lessons. Some Australian States and Territories closed all the schools. Penalties for breach of COVID-19 shut down, and social distancing rules were heavy, with on-the-spot fines of (Australian dollars) AUD 1,334-50 for individuals and AUD 6,672-50 for corporations. The unemployment rate in Australia was 6.2% in April 2020, and the Australian Treasury estimates this unemployment rate will peak at 10% in the coming months. The Australian Bureau of Statistics estimated that around 2.7 million people, or one in every five persons, was unemployed due to the COVID-19 the ensuing shutdown. The underemployment rate also increased by 4.9 points to 13.7%, and the job participation rate decreased by 2.4 points to 63.5% as Australians left the labour market. More women dropped out of employment than men, and young people's unemployment rate jumped to 13.8% (Murphy 2020).

State measures to address social problems and needs

On 30 March 2020, the Australian and its States and Territory Governments launched an unprecedented economic stimulus package which was on a wartime basis. The economic stimulus totalled AUD 213.6 billion direct, on-budget spending from the Federal Government, AUD 12.8 billion from the States and AUD 105 billion in lending from the Reserve Bank of Australia and the Federal Government (Karp 2020). In order to keep people employed, the Australian Federal Government launched the JobKeeper Payment Scheme through which the Government will pay AUD 1,500 per fortnight to eligible employers to pay the wages of their eligible employees for a maximum of 6 months (Karp 2020). Not-for-profit and self-employed individuals were also eligible to apply to this scheme. The Australian Federal Government also launched the JobSeeker Programme which covered all Australian citizens who were unemployed and looking for a job. Under this scheme, the individual is paid AUD 550 per fortnight in addition to the other payments that the individual is eligible for, e.g., Youth Allowance.

As soon as the total shutdown was announced, all States and Territories imposed a six months restriction on landlords evicting tenants who were financially disadvantaged by COVID-19. This legislation insisted that the tenants and landlords renegotiated a rent reduction or rent withholding for a specified period. All major Australian banks announced that they would put mortgage payments on hold for the landlords, for a specified period of time, if the landlord is in financial difficulty due to COVID-19.

Status of social welfare services, authorities and professionals in media

The Australian Council of Social Services (ACOSS) appreciated the financial stimulus packages offered by the Australian Federal and State Governments. Prior to COVID-19, the Australian Government had a scheme which paid AUD 40 per day for people who were unemployed or in other forms of financial hardship. For many years ACOSS has argued that AUD 40 a day is not sufficient for a family. ACOSS appreciated that the Australian Government launched the scheme to pay the more reasonable rate of AUD 1,500 per fortnight and urged the Government to continue this payment even after the JobKeeper Scheme finishes in August 2020. ACOSS also stated, 'We will continue to urge the Government to expand income support, JobKeeper Payment and Medicare to those who still do not have access to any kind of income support, including asylum seekers, international students and temporary migrants'. The Government has also ensured that there is 'adequate support for people with disability, carers and First Nations communities, as well as ensuring everybody has safe, secure housing' (Australian Council for Social Services 2020).

The Regional Australia Institute (2020) states that in at least 20 of regional Australian locations the JobKeeper and JobSeeker Schemes are close to the median incomes and the Schemes are timely relief that will also maintain consumer spending to safeguard the rural Australian economy. There are many small and medium enterprises which have reacted to say that their employees have been left out because they are not eligible for the JobKeeper Scheme. A leading accounting firm, KPMG (2020) states:

> 'there may still be a number of service entities that do not qualify for the JobKeeper Scheme because their circumstances do not meet the requirements. We will continue to raise these issues with the Government where opportunities arise'.

The Australian Government clearly stated that international students who study at Australian educational institutions and who hold temporary visas are not included in the JobKeeper or JobSeeker Schemes. The Prime Minister of Australia suggested that they should return to their home countries if they were not able to support themselves in Australia. Unfortunately, it was too late because countries around the world had closed their borders forcing the residents of Australia who were on an international student visa and temporary resident visas and lacked any option other than to remain in Australia with no government support, which made them vulnerable to poverty and homelessness (Xiao, Zhou, and Zhao 2020).

Social services responses

The mode of operation of social services

Social service organisations in Australia continued to provide their valuable services to the community even when the unprecedented COVID-19 situation limited their mobility. For example, the Salvation Army continued to deliver its services wherever possible by phone and video calls. Where they had to be present to provide physical and emotional support, they continued to serve the community while maintaining safe social distancing. They continued their services for vulnerable people such as the homeless, people with addictions, youth and victims of family and domestic violence. Especially for the homeless, the Salvation Army worked closely with hotels to provide safe accommodation.

Community meals for poor and vulnerable people were continued as takeaway meals. Financial counselling services continued throughout the COVID-19 pandemic (Salvation Army, 2020). Another leading social service provider in Australia is the St Vincent de Paul Society, which continued to provide its service through telephone and video. It kept its premises open and continued to offer services to vulnerable members of society by keeping social distancing (St Vincent de Paul Society 2020).

Guidelines for social services from responsible authorities

The Department for Child Protection continued its services during COVID-19. It developed resources specifically for parents and children on how to educate children about COVID-19. While maintaining social distancing, its employees continued their work during a difficult situation (Department for Child Protection, 2020). The Department of Social Services in the Australian Government continued to offer its services through its funded organisations such as Financial Crisis and Material Aid, National Debt Helpline, MoneySmart Advisers, 1-800-RESPECT, MensLine Australia, Men's Referral Services, Lifeline, a 24 hours crisis counselling service, Good Shepherd Microfinance and others. Predominantly, these services used telephone and video counselling services and face-to-face services while maintaining social distancing (Department of Social Services, 2020).

The Australian Government acknowledges that COVID-19 is changing the way we live, work and communicate. The COVID-19 pandemic and associated responses, such as restrictions on social gatherings, will have significant impacts for Australians and may cause people stress, anxiety and concern. In response to this situation, the Australian Government has created mental health support for Australians through dedicated COVID-19 digital resources and a 24/7 phone counselling service led by the non-profit organisation Beyond Blue, funded by the Australian Government. The Department of Health has created a dedicated mental health and wellbeing program for frontline health workers to provide online and phone services, giving frontline workers support when and where they need it (Department of Health 2020). The Community Visitors Scheme has been expanded, with funding for extra staff and volunteers to ensure older people receiving aged care support, stay connected online and by phone even though they may be physically separated from others (Australian Government 2020).

Use of digital tools in working with clients and teamwork among staff

The Australian Government has enthusiastically embraced digital tools for use in a big way to reach members of society in need of services. For example, it launched the COVIDSafe App, which can be downloaded by members of the community. This App helps state and territory officials to quickly contact people who may have been exposed to COVID-19. This App speeds up the current manual process of finding people who have been in close contact with someone with COVID-19. This means that people will be contacted more quickly if they are at risk of the symptoms. This also reduces the chances of people passing on the coronavirus to other members of the community (Australian Government, 2020a).

Australia digitised its health services through the My Health Record, which assists the primary health care professionals to digitally access the crucial health information of their patients before treating them. The Australian Digital Health Agency (2020) reports that My Health Record assisted the Australian Government to continue to offer its primary health care services to Australians during COVID-19. Members of the community

could seek the professional assistance from their General Practitioner through Telehealth which helped the doctors and the patients to maintain social distancing.

Main concerns expressed by social services

Family violence was a significant concern in Australia when violent partners were forced to stay home, threatening the safety of women and children. Based on a survey of 80 domestic violence front line workers, Women's Safety NSW reported an increase of 40% in client/service user numbers since social isolation commenced (Duncan 2020). The Australian Federal Government acknowledged the likely increase in family violence as a result of COVID-19 and allocated an extra AUD 150 million to domestic violence support services nationwide (Carlton, 2020). Similarly, there was a sharp increase in disputes between parents providing safety to children due to the COVID-19 pandemic. The Family Court of Australia reported a rise of 39% in disputes forcing the Court to create extra resources to deal exclusively with urgent parenting-related disputes that have arisen due to COVID-19. (Family Court of Australia 2020). The Foundation for Alcohol Research and Education (FARE) conducted a national poll, which revealed that 20% of Australians purchased more alcohol and 70% of them were drinking more alcohol than usual, with one-third now using alcohol daily. This poll also found that almost one-third of people who purchased more alcohol were concerned about their drinking or someone in their household's drinking, and 28% reported that they were drinking alcohol to cope with anxiety and stress (FARE 2020).

Vulnerable populations such as Indigenous communities, which already had a high rate of domestic and family violence, were prone to see more family violence during the period of social and physical distancing measures due to COVID-19. For example, the risk of family violence was predicted to increase following the Parliament of New South Wales passing the COVID-19 Legislation Amendment (Emergency Measures) Bill granting the Commissioner of Corrective Services the power to release low-risk prisoners on parole to prevent overcrowding in prison and extending the Apprehended Domestic Violence Orders from 28 days to 6 months. Both of these Bills significantly extended the time offenders and perpetrators of domestic violence remain at home together. Both of these Orders were also anticipated to have significant implications for the safety of Indigenous households because of the high representation of Aboriginal men in the prison population (Klower 2020).

Another indication of COVID-19 having a significant effect on Australian society is an increase in the number of calls received by the 24-hour telephone counselling service, Lifeline. Lifeline received an average 2,900 calls per day during the summer prior to COVID-19 when Australia was affected by bushfires causing considerable loss of homes and other property. However, during the last two weeks of April, the number of calls received increased to an average of 3,200 per day, which was a 20% increase in call volume. This suggested that around 1 in 4 calls were about the coronavirus (Medhora 2020).

Comments

The people with unstable and/or no housing were left exposed to the coronavirus with no place for self-isolation. The Australian Housing and Urban Research Institute (2020) reports that the homeless population and visitors such as stranded backpackers had no accommodation to self-isolate. Crisis accommodation was inappropriate due to the risk

of overcrowding and lack of space for social distancing. This population also had a lack of access to proper sanitation such as hand wash, disinfectant, food and medical supplies. Couch surfers were another population who had no stable housing, the COVID-19 situation might have made them homeless due to social distancing requirements.

Just before Australia was affected by COVID-19, more than 200 not-for-profit organisations jointly prepared a major report as part of the Universal Periodic Review of the United Nations Human Rights Council. This Report was prepared at a crucial time when Australia was about to be affected by the COVID-19 pandemic, and it highlights Australia's inequalities and human rights challenges. It argues that the Australian healthcare and education were under enormous strain and structural economic inequalities severely disadvantaged vulnerable communities. Australia was not facing the COVID-19 pandemics with a strong human rights track record (Human Rights Law Centre 2020). This Report reminds Australian policymakers to show extra sensitivity to the needs of vulnerable people while planning the recovery from COVID-19.

Friel and Demaio (2020) observe that COVID-19 saw no difference between class, race or gender, and its effect has multiple implications for people who were already poor, had employment problems, high levels of existing debts, homelessness, issues with accessing health and social services and people with disabilities will be further marginalised. While the Government cannot assist everyone in the community and especially members of these marginalised segments of the society, the alternative option is the philanthropy sector which itself is undergoing extreme financial strain. Philanthropy Australia (2020) reports that the economic challenges posed by COVID-19 threatened the very existence of not-for-profit organisations and charities. This sector, which was the hope to reduce the social inequalities, had come under increasing pressure due to a sharp increase in demand for their services and at the same time, limited resources.

Social work responses

Innovative and/or alternative approaches to communities, clients/service users and their needs

The Australian Association of Social Workers (AASW) expressed its support for the Australian Government's COVID-19 financial stimulus including AUD 1.1 billion for packages to support mental health and family violence initiatives. The bulk of this money, was the AUD 669 million allocated for Medicare and subsidised Telehealth services and AUD 150 million assigned to family violence support activities (AASW 2020). The AASW is working closely with its social work members to use innovation in implementing the Government's new measures to respond to the mental health concerns raised during the COVID-19 crisis. Social workers in Australia have the important task of helping Australia in its recovery path after COVID-19. The AASW has highlighted the importance of using Telehealth and other digital technologies in delivering their services widely to the Australian community.

Social workers in Australia have kept themselves busy exploring alternative approaches to reach members of the community in need. For example, the Australian Centre for Social Innovation claims that it is exploring a new service model called the Family by Family Model which prepares families in communities to provide support to those families with a particular risk of domestic violence or substance misuse during the

long period of extreme social isolation due to COVID-19 (The Australian Centre for Social Innovation 2020).

Main obstacles to approach and support communities and clients.

Australia is in the recovery phase from once in a lifetime pandemic which the country has never experienced before. After 29 years of continuous economic growth, the Australian economy is in recession, and the economists are predicting that the worst part of the economic problems are yet to come. While unemployment is an obvious phenomenon, a high rate of underemployment is also predicted for the near future. In addition to the economic turbulence, COVID-19 has affected many other segments of the population which had never been affected before. At the forefront of this affected segment of the population are the frontline health workers such as doctors and nurses who went through a once in a lifetime challenge of serving their country with the constant worry of becoming infected by COVID-19 while lacking access to a vaccine or cure, although these have yet to be discovered. The other population groups likely to be impacted by the pandemic are the police force, employees who were made unemployed/underemployed by the pandemic who were given a short period of notice, and women and children who experienced domestic violence because they had no choice but to stay in the same household as abusive family members due to the lockdown. The Australian Government predicts a surge in mental health problems among the general population as a result of the pandemic. Australian social workers and other helping professionals are expected to deal with this situation, which can be very challenging.

Australia has large rural and remote areas and with sparsely distributed populations. The COVID-19 pandemic has severely affected these population groups, and they are in need of social work services. The social work profession faces the challenge of delivering their services to the rural and remote populations of Australia.

The economic stimulus schemes such as JobKeeper and JobSeeker will only last six months and end in August 2020. There is a prediction that Australian households will experience a wide range of psychosocial problems when their financial safety is threatened following the end of government assistance. The social work profession will have the enormous task of supporting Australian communities through this challenging time by reaching people in need on-time.

The role of national associations of social workers in supporting practitioners during Covid-19

Australia's only registered national association of social workers, the Australian Association of Social Workers (AASW) has been proactively responding to the challenges posed by COVID-19. AASW has been releasing a range of policy statements addressing the unique needs of different segments of Australian society. AASW has also created an online professional resource package for social workers who are serving the COVID-19 patients in the communities and also for social workers who are working along with other frontline health workers in hospital settings. In addition, AASW has been offering a range of Continuous Professional Development (CPD) programmes for professional social workers. For example, there have been programmes orienting social workers in ways of using technology to offer effective tele-social work interventions.

Consequently, social workers have played a number of roles during the pandemic. The National President of AASW Christine Craik summarised the impact of Covid-19 on the profession and the roles that practitioners have played in a speech delivered on 30 March 2020 by saying:

'Social workers know only too well that emergency circumstances such as these lead to a surge in the incidence of mental health issues and family violence. The population has been directed to stay at home largely, which means that, not only are perpetrators likely to feel a sense of a loss of control over many aspects of their life at present, they will also have greater access to those who they feel entitled to abuse and control. Those living with family violence and abuse will also have a sense of fewer choices being available to them in terms of alternative living arrangements. Social work is in the frontline service category, with social workers still providing support and services under these circumstances. A lot has been said about our heroic health services workers and social workers are an integral part of that team'.

She also added that:

'AASW also welcomes government support for residential tenancies and we cannot allow homelessness to dramatically increase during a time when there is a surge in family violence cases and increased unemployment as a direct result of Covid-19' (AASW, 2020).

With these words, Craik also highlighted some of the hardships that service users have had to cope with and the importance of the profession's contribution to the struggle against COVID-19.

Concluding Comments

The social work profession in Australia has a long history of working with natural disasters such as drought and bushfires. Prior to COVID-19, Australia was recovering from large scale bushfires. Specifically, the bushfire of 2019-2020 was severe, and it affected a large part of rural and remote Australia. It can offer lessons for disaster work. Australian social work has much more to learn to assist the Australian population in its recovery from COVID-19 effectively.

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BANGLADESH

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Country context: Key facts and figures

Population and population density

Bangladesh is a highly over-populated country. The total population of the country was estimated to be 162.7 million in 2017, and the area is 147,570 sq. km (BBS 2018). The government recently claimed that the total population is 165.6 million, and the density of population as 1,116 persons per sq. km (BBS 2020), among the highest in the world. In 2020, the total population is expected to reach 170 million, and by 2030 it could rise to 186 million (UN, 2019).

Infection, death and time period

First confirmed case of COVID-19 in Bangladesh was detected on 7 March 2020. From then onwards, the spread of COVID-19 increased significantly over time (Ramachandran, 2020). The present trend clearly shows that the worst of the infection is yet to come (Table 1; Figure 1; Figure 3). Although the rate of infection was low throughout March, it started to rise sharply until the end of April. The total confirmed case of COVID-19 was 51, and the number of deaths was only 5 in March 2020. There were 1,602 people tested up to March, among these, 5 had died and 25 had recovered (Health Bulletin, 2020a).

Table 1. Statistics on COVID-19 pandemic infections in Bangladesh (Source: Self-created)

Month/2020	Tested	Confirmed	Recovered	Deaths
March	1,602	51	25	5
April	64,666	7,667	160	168
May	308,930	47,153	9,781	650
up to 10 June	441,470	74,865	15,900	1,012

On 5 April 2020, a further 18 new cases were reported. This was a 26% increase over that of the preceding day. The death toll to 5 April was 9. Bangladesh witnessed 127 confirmed cases on the very next day - 6 April and then faced a steep rise as the figure went up to 1,012 on 14 April 2020. On 6 April the total number of deaths was 12, which increased to 46 on 14 April (Health Bulletin 2020b). The number of confirmed cases surged to 3,772, and the death toll reached 120 on 22 April (*The Financial Express*, 22 April 2020). On 30 April, the number of confirmed cases was 7,667, and the death toll was 168, as shown in Figures 1 and 2 below. A total of 64,666 people had been tested, and among all COVID-19 positive patients, 160 people had recovered by 30 April 2020 (Health Bulletin, 2020c). On 6 May 2020, the total number of confirmed cases was 11,719 and the death toll had

reached 186 (Tithila, 2020). The total number of infected cases was announced as 18,863 and the death toll as 280 on 14 May 2020 (Health Bulletin, 2020d).

Figure 1. Trend of Infection of COVID-19 in Bangladesh (Source: Self-created)
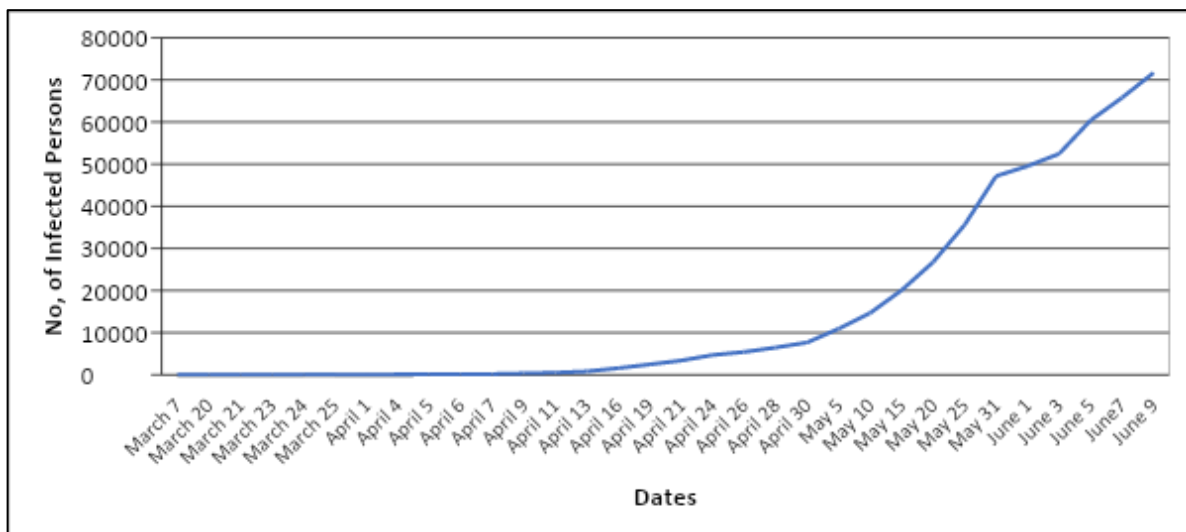
Figure 2. Trend of Death due to COVID-19 in Bangladesh (Source: Self-created)
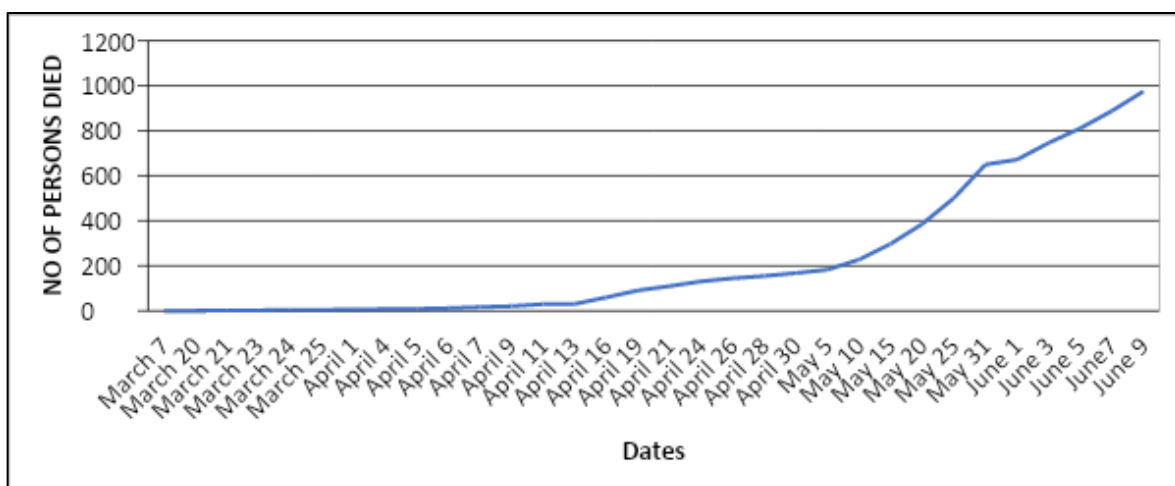
Bangladesh confirmed the total cases of COVID-19 as 30,205 and the death toll as 432 on 22 May (Health Bulletin, 2020e). By 26 May, the confirmed cases stood at 36,751, and the death toll reached 522 (Health Bulletin, 2020f). As of 31May, the number of infected cases was 47,153 and the death was 650 (Health Bulletin, 2020g). And, by 10 June 2020, the confirmed cases rose to 74,865 and the total deaths rose to 1,012 (IEDCR, 2020).

Figure 3. Trend of COVID-19 Infection and Death in Bangladesh (Source: Self-created)
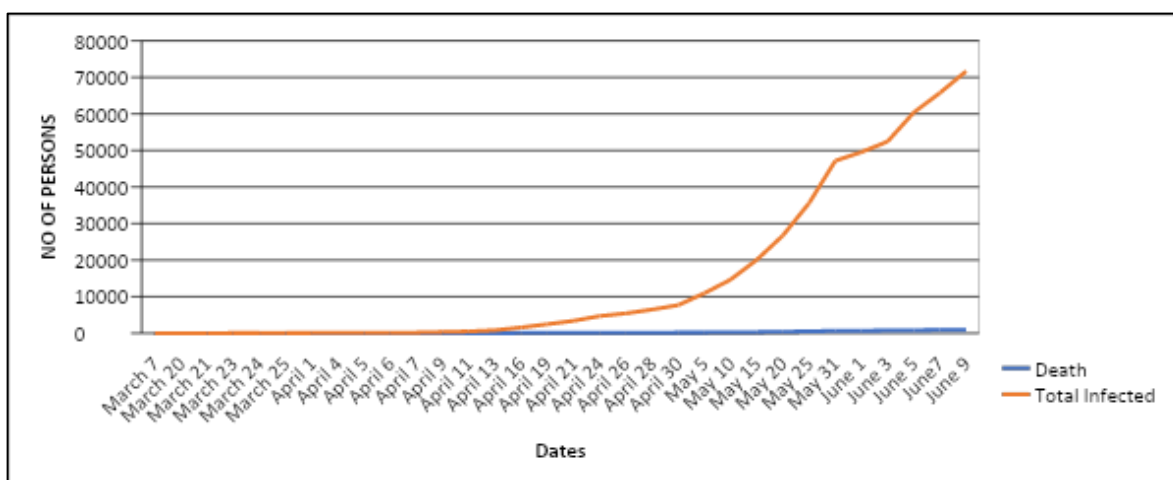
Age, gender and region-wide confirmed coronavirus and death cases

In Bangladesh, the younger population has tended to become infected by COVID-19, which is different when compared to Europe and America, where the older people are more likely to be infected by COVID-19. In Bangladesh, studies show that 72% of those infected are below 50 years of age, 62% belong to the 21-50 age group, while 15% belong to the age group 51 to 60, and 13% are above 60 years of age (Maswood 2020). Other statistics show that 71% of the total infected are men, with 29% of women infected by COVID-19. Of the total number of dead, 9% were 41-50 years of age; 27% were aged 51 to 60, and the highest proportion - 42% were above 60 years of age. Men, compared to women, are much more prone to have had the coronavirus and die due to COVID-19. Approximately 75% of the deaths from COVID-19 are men (Dhaka Tribune 2020).

Regionally, Dhaka city has been most affected, at the time of writing (June 2020), there are 21,143 confirmed cases, followed by Chattogram with 3,115 confirmed cases, and Narayanganj with 2,753 confirmed cases. District-wise, Dhaka (excluding the city) has the most confirmed cases with 1,569 of them, followed by Cumilla and Munshigonj confirming 1,208 and 1,200 cases respectively up to 10 June (IEDCR 2020). Infection and recovery rates among the total of confirmed cases is 1.4% and 21.2% respectively (Corona Tracker 2020). Though Dhaka and its adjacent districts have been affected most, all 64 of Bangladesh's districts have confirmed COVID-19 cases.

Societal measures undertaken related to COVID-19

The Bangladesh Government quickly brought back more than 300 Bangladeshi people from Wuhan, China in early February because Wuhan was badly hit by COVID-19. Screening devices were installed at all international airports as well as at land ports. Substantial numbers of people were screened at the airports, and many people suspected of having COVID-19 were immediately quarantined. As soon as the first case was detected, the government shut down all educational institutions across the country and declared a public holiday from 26 March to 4 April. The public holiday was later extended

in different phases until 30 May. International flights from Europe, America, and many other regions were suspended to thwart the spread of COVID-19. The Government initiated a rigorous awareness campaign to the population at-large through public and private mobile phone networks. Telephone hotlines have been opened for people to utilise and find help if needed (World Economic Forum 13 April 2020). The authorities declared a shutdown of all ancillary business and services. Different organizations were asked to continue their activities with workers working online from home if possible. People were requested to stay in their residence while their employment was retained by their employers. All types of transport such as trains, buses, boats, and small vehicles with the exception of transportation hauling goods, were prohibited from use on the streets or in waterways.

The Government initially did not use the word 'lockdown' instead they used 'public holiday' or 'shutdown'. The strategy was to try not to cause panic among people, rather than make people aware of the highly contagious nature of the coronavirus, so that people could follow the health guidelines to remain safe. Later on, many districts, sub-districts, cities, and even some villages had been declared as under 'lockdown', due to rapid infection rates in particular areas. Police and civil administration were asked to discourage and restrict people from wandering on the streets. In some cases, the civil administration also imposed penalties on those going onto the streets without any valid reasons. Once 'lockdown' had been declared in an area, people were strictly prohibited from coming out of home from 6 pm to 6 am. Following the health guidelines of WHO (World Health Organisation), the Government required people to wear facemasks when going out in the event of an emergency. Everyone had been advised to maintain social distance and frequently wash hands for at least 20 seconds to avoid COVID-19 infection. Mass gatherings, political, social, cultural, religious or any other sorts of rallies, and congregations have been banned throughout the country. However, in some cases, the Government could not fully implement the ban order on huge congregations or general gatherings of people. It is difficult to follow the WHO guidelines such as social or physical distancing to combat COVID-19 in a country like Bangladesh (Anwar, Nasrullah and Hosen 2020; Kamal 2020; Majee 2020).

Economic package and peoples' suffering

Prime Minister Sheikh Hasina announced a stimulus package worth USD 600 million to deal with the situation created by COVID-19 for the export-oriented industries on 25 March. This fund has been proposed for use to ensure the salaries and wages of the affected employees and workers mostly in the readymade garment industries in Bangladesh. The second stimulus package was announced on 5 April by the Prime Minister, substantially increasing the total amount to USD 8.5 billion (2.5% of GDP). The stimulus package plan is to be executed in four phases as immediate, short and long term through four programmes: increasing public expenditure, formulating stimulus packages, widening social safety net coverage and increasing monetary supply. On 13 April, the Prime Minister announced cash assistance of approximately USD 91 million for the workers involved in the informal sector. A considerable amount of money was also declared as health insurance for frontline workers such as the doctors, nurses, other health workers, and bankers. Both formal and informal sectors were badly hit by COVID-19, resulting in a loss of livelihood for the workers, especially those involved in the informal economy, and also the uncertainty that prevailed among those working in formal sectors such as those in the manufacturing industries. There are more than 50

million people dependent on the informal sector for their livelihoods who have now become completely jobless.

The Government has initiated food aid programmes like the Vulnerable Group Feeding (VGF) and Vulnerable Group Development (VGD) under a social safety net coverage for six months. Although it is a well thought out initiative for the poorest of the poor people who are attached to the informal sector, their suffering is most likely to be longer than six months (World Economic Forum, 2020). There are allegations from different groups for not receiving any form of help from the government. Protests and looting food relief provided by the government has been observed. Day labourers, rickshaw pullers, small traders, hotel workers, maid servants and garment workers in Bangladesh are worst hit by COVID-19. Around 4.1 million workers, of which 70% are women, work in 4,500 garment factories located in big cities including the capital Dhaka. Though some of the garment factories have opened, most of them are still shut down. Many of the workers have already lost jobs and some have yet to receive their backdated pay. The Government claims that around 5 million people would receive food free of cost, and others would enjoy relief under the Open Market Sale (OMS) of rice and wheat which the government subsidised so that it could be purchased at a very low price. Thus, 2.1 million metric tons of food grains will be procured to ensure food security for the people and help the farmers obtain fair prices for their crops (Sakib 2020). The Government has also helped around 5 million low income families severely affected by COVID-19 with direct cash transfers worth BDT 2,500 (Bangladeshi Taka) or USD 30 to each family through mobile banking (UNB 14 May 2020).

Social welfare services being offered

Government, non-government and international organizations have introduced different types of social welfare services for affected people and also for their regular clients/service users who have been hit by COVID-19 one way or another. These welfare services are delivered both outdoors and online. Many of the organizations are directly involved in distributing relief materials among the most affected people. A few of them provide services like counselling, motivation, guidance, and training to their clients/service users online. But most organizations have postponed their regular outdoor welfare services. It is to be noted that non-government organizations (NGOs) have been playing an effective role in providing welfare services to the needy in Bangladesh since 1980. Even now many of the NGOs are engaged in massive awareness campaigns for COVID-19 by deploying their health workers at the community level across the country (BRAC 2020). Some of the voluntary organizations along with the International Committee of the Red Cross (ICRC) and the government authorities have come forward to take care of the dead bodies which have been left by relatives. In some cases, the bodies were COVID-19 positive. NGOs like Al-Markazul Islami and Quantum Foundation have been permitted by the Government to take appropriate measures in order to bury the dead bodies infected with COVID-19 (ICRC 2020).

NGOs and their beneficiaries face difficulties

COVID-19 has posed a serious threat to the existence of many small NGOs working across the country, as donor organizations could cut off or stop the flow of funding without warning. A considerable number of NGO workers may be fired without notice if there is a funding crunch. Welfare projects undertaken by the NGOs are going to be severely

hampered, causing enormous sufferings for those heavily dependent on their services. Many of the NGO workers expressed their apprehension in the face of the pandemic during personal conversations with them. Although government social welfare services are well-covered by most of the media, different sorts of services provided by volunteers, individuals and small NGOs are not highlighted to the same extent by the leading media during the pandemic in Bangladesh. Social work services and services akin to social work undertaken by government and NGOs in the time of COVID-19 need to be considered valuable. But the government does not seem to be keen to work with NGOs in a coordinated way while fighting COVID-19 (Ahmad, 2020).

Domestic violence, child abuse and stress increase

Domestic violence, especially violence against women is rampant in Bangladesh (Das et al., 2016). It has been reported that the incidence of rape and violence against women have increased during COVID-19. Since people are mostly confined at home and the men have started spending longer periods of time with family members, intimate partner violence has been increasing. Adults are stressed as they have no work, no office to go to, and in many cases no income. This results in frustration for them and leads to violence against wives and children. Many of the families are now living in overcrowded housing as members once living outside the family for earning purposes have come back, and in a few cases, distant relatives have flocked together in the same household. Consequently, the possibility of child abuse by family members and relatives has increased during this time of crisis. However, child abuse is rarely reported or discussed openly in Bangladesh. Most importantly, it has become difficult for abused women to receive help and support from the social welfare agencies which have postponed their outreach activities due to COCID-19. Still many abused women have lodged complaints with the police against men and are holding them responsible for battering women in the time of COVID-19 (Anwar, Nasrullah and Hosen 2020; Hossan 2020; Jahid 2020; Mizan 2020).

Social work responses

Social work is not professionally recognized in Bangladesh. Apart from social work graduates, others are involved in social work services offered to individuals, groups and communities through NGO activities and government initiatives (Das 2018). COVID-19 has forced all social work or social welfare agencies either to postpone or limit their regular activities. Most of the organizations have postponed field-based services and activities as people have been asked to stay indoors during the COVID-19 crisis. Thus, it is a difficult time for those who use social work services from NGOs and government organizations to access them. Though the government has taken elaborate measures to support the most vulnerable people, there are many groups that remain beyond the coverage of government initiatives. Around 52% of the people including the indigenous population, transgender community, sex workers, people with disabilities, returnee migrant workers, tea garden workers, and Rohingya refugees, have not received any special support from the government. Many other groups like daily wage-earners, rickshaw and van pullers, construction labourers, agricultural workers, people involved in poultry and farm businesses, hotel and restaurant workers, transport workers, street vendors, maid servants, and cleaners who have already lost a job, remain deprived of relief or allowances offered by the government (NAWGB 2020; UNWomen 2020). Around 63% of the ultra-poor families living in the coastal belt feel forced to take a loan from the

traditional money lenders as they fail to access the OMS food at subsidized rates and cannot receive an allowance under the safety net programme of the government (UNB 14 May 2020).

Concluding comments

Bangladesh does not have any recognized national social work association. Yet, associations of different organizations have been supporting COVID-19 affected people in many ways. Quite a few volunteer organizations and groups, student unions, and self-motivated individuals are actively engaged with different programs designed to reach out and help those who have suddenly become unemployed due to COVID-19 (Bakhtiar 2020).

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ESTONIA

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Country Context: Key facts and figures

Population and population density

According to revised data from Statistics Estonia, 1,328,976 persons lived in the Republic of Estonia on 1 January 2020. The population density in Estonia is 31 per km² (Estonian Statistics 2020).

Number of infectious cases and time period

The first case of confirmed novel coronavirus (COVID-19) in Estonia was found on 26 February 2020. It was a single case. The first case of death related to COVID-19 was reported one month later. According to the data from the morning of 14 May, more than 95,000 first-time tests have been carried out in Estonia, of which 1,973 (2.1%) have been confirmed positive for the SARS-CoV-2 virus. Most of those affected by it were persons between 49 and 59 years of age. A total 69 persons have died related to COVID-19.

Comments

Official information about COVID-19 in Estonia can be found on the website of the Health Board. During the pandemic, collecting and publishing updated, detailed statistics has been problematic, as well as providing data to scientists who can model the outbreak of the virus. For example, the Health Board does not have information about how many persons have died because of the SARS-CoV-2 virus pneumonia and how many died because of comorbidities. At the end of March 2020, a Scientific Committee was formed to give advice to the government, and the scientists had the opportunity to obtain the data. Although access to the data was given to the scientists, these data are neither reliable nor detailed. Nevertheless, it is possible to form a hypothesis that most deaths are connected to nursing homes, according the number of outbreaks of the infection in nursing homes and media coverage of this phenomenon. Mainly, the deceased are 80

years old or older, and nursing home clients/service users are dying in both hospitals and nursing homes.

Information and surveys about the consequences of the pandemic have not been published, and the main sources for observing and analysing the situation are on the official website of the Health Board, Statistics Estonia, articles published in media and in the journal *Sotsiaaltöö* (*Social Work*).

E-school, e-health and teleworking have been the main changes that have been fully tested in practice after the restrictions were implemented. For example, the Estonian educational system has become digitalised; social services are offered online; and the unemployment office offers online consultations.

Societal measures addressing the social consequences of COVID-19

The extent of isolation

On 12 March 2020, the government of Estonia declared an emergency situation until 1 May. The government announced nationwide restrictions, closing all sports halls, sports clubs, gyms, spas, saunas, swimming pools, water centres, day centres and children's playrooms, including those operated by hotels and other accommodation providers. Additional controls were introduced at all of Estonia's borders, and a webpage with crisis information, [www.kriis.ee,](www.kriis.ee) was launched.

At the same time, additional restrictions were placed by the government on care homes, since older people and people with chronic illnesses are some of the most at-risk groups threatened by COVID-19. Venues that remained open were: grocery stores, pharmacies, telecommunications outlets, bank offices, parcel vending machines and shops selling or renting aids and medical devices based on an aid or medical device card. Gradually, all restaurants, bars and other entertainment facilities were closed, and by 27 March only takeaway food sales were allowed. Many Apps to order food from shops and restaurants were overloaded and this created problems.

The settlement of Saaremaa in the western corner of Estonia (2.5% of the country's population) has become the epicentre of Estonia's coronavirus outbreak. Saaremaa has a population of 33,000, and 551 cases have been diagnosed there. Access to Estonia's western islands was closed to everyone except those registered as permanent residents on the islands from 14 March until 2 May. Non-residents were given the chance to leave, but islanders have been told they must stay put.

The emergency situation, lasting until 18 May was prolonged. In comparison with other European countries, restrictions in Estonia were not as strict, and following the rule of '2+2' (two persons and two metres apart), it was possible to move around freely, and being outside was encouraged for staying healthy.

At the end of April 2020, Saaremaa organised a strike against the restrictions on moving freely between the mainland and Saaremaa. Before Good Friday, churches were required to remove restrictions about not having ceremonies in churches. At the beginning of May, the government decided to alleviate the restrictions, and step by step, in the middle of May, society was opened again to all activities. Meanwhile, some nursing homes had a difficult time, struggling with a high number of positive coronavirus cases and a stigmatising attitude from the community.

As of 15 May 2020, the governments of Estonia, Latvia and Lithuania opened their internal borders and allowed free movement for their citizens and residents, creating a

zone dubbed the 'Baltic bubble' or 'travel bubble' (BNS, 2020). Finnish Foreign Minister Haavisto, criticised the Baltic prime ministers' decision, stating that, 'Ministers from all three countries had gathered in Riga and said they could sit there together. It was a small demonstration of how well the Baltics are doing compared to others' (Lind 2020). The 'Baltic bubble' was opened for two weeks, but, according to Rutt Kalda on the University of Tartu (homepage on 3 June 2020), the number of cases has not risen, and research shows that the opening-up measures have been justified.

To conclude, only SARS-CoV-2 virus-positive persons were in isolation, controlled by the police and counselled by the Health Board. The slogan, 'Conscience is the best coercive measure' was effective, and only a few cases of non-compliance with the obligation to stay at home and a penalty payment of 2,000 Euros, was imposed on each infraction. After the emergency situation had ended, it was analysed, and in the ensuing discussion, the Health Board's effectiveness in dealing with the situation came under attack. The conclusion was that the Health Board was not able to perform its tasks. The Health Board proposed new positions to perform these tasks in the future.

State measures to address social problems and needs

The unemployment rate rose from 5.3% in December 2019 to 7.8% by the end of May. Right after the announcement of the emergency situation, based on the proposal of the Estonian Unemployment Insurance Fund, the government directed an additional 147.9 million Euros to compensate employees for the reduction in their wages during the crisis. The Estonian Unemployment Insurance Fund will compensate 70% of the average wages from the last 12 months but will pay no more than 1,000 Euros per claim. This has been a temporary measure in force from March to May. According to Unemployment Insurance Fund statistics, a total of 135,912 persons benefited from this measure by mid-June 2020.

Additional resources were allocated to compensate for the increased use of sick and care leave due to the COVID-19 virus, including for the first three days of sick leave, from the time the emergency was imposed until the end of May 2020. People had the opportunity to request sick leave or care leave in the patient portal themselves.

The closure of educational establishments places an even greater burden on parents with children with special needs who require further monitoring and support in both study and self-care activities at home. Therefore, the government has made available a temporary special allowance to provide replacement income for the parent who, due to the need to care for a child with special needs, is temporarily forced to be absent from work. The allowance is granted for parents who are raising a child with a severe or profound disability, a child who has weakened immunity or a child with certain special educational needs, when the parent had registered for unpaid leave.

Status of social welfare services, authorities and professionals in the media

During the crisis, the professions of home care and nursing home workers received the most attention. There were several articles reviewing difficulties in home care work and the situation in nursing homes, such as the shortages of staff and personal protection equipment (PPE). In Saaremaa County, soon after the outbreak of the virus was reported, many articles were published regarding nursing home clients' lives during the COVID-19 pandemic. One critical reflection about what was going on in hospitals (and indirectly, also nursing homes) was done by a blog and a book, *Life at the Forefront: Corona Battle at Kuressaare Hospital*, by Elo Selirand, a director and screenwriter. Also, volunteering by

students and other volunteers in nursing homes and hospitals was analysed very much, and many articles were published about their courage and self-sacrifice.

Some articles posed questions about a rise in child abuse or domestic violence cases, arguing how much a crisis can affect domestic violence or alcohol abuse. Suicides among teenagers were discussed briefly in connection with mental health issues.

Comments

Although social work as an activity was visible from the first days of the crisis, the central role during the crisis was dominated by health care and the economy. Mental health issues, people's psychosocial needs and social model in dealing with a complex situation were left in the background. Even the Estonian Science Agency's call for project grants pointed out the need for new solutions in diagnostics for the novel corona virus or a broader analysis of the macroeconomic consequences of the pandemic.

The Minister of Social Affairs emphasised the important role of social work in a crisis situation on a daily basis, but mainly called on residents to contact a social worker if the need arose.

Social services responses

The mode of operation of social services

The Social Insurance Board of Estonia, the organisation responsible for organising and offering state-based social services, offered services with limited possibilities for access mainly because of the restrictions on movement. Local governments have the right to organise local social services according to the circumstances. The latest news about the organisation of social services locally was published in the journal *Sotsiaaltöö* (*Social Work*) at the end of May 2020.

Sirlis Sõmer-Kull (2020), the Head of the Estonian Social Work Association, stated that all local governments have tried to find quick solutions or have reorganised social services in cooperation with local community and volunteers. Volunteers helped older people or other persons who could not access shops or pharmacies, but they also helped families to support children at home. Most problematic, according to many specialists (Sõmer-Kull 2020; Tõru 2020), was finding replacements for workers who were ill. Most field social workers in local government used e-counselling, and all field social workers were obliged to adapt to the special character of e-counselling (Laanemann 2020).

Very positive feedback achieved effective cooperation between the Ministry of Science and Education, the Unemployment Office and vocational schools to establish an e-learning course for care workers (Sõmer-Kull 2020). Support to avoid burnout for field social workers was mentioned by many specialists (Mitendorf 2020; Sõmer-Kull 2020).

A main conclusion drawn from lessons learned during the crisis was that field social workers have not been recognised, and the question remains of how to make social work more visible, to improve awareness and understanding of this much-needed profession (Sõmer-Kull 2020).

Guidelines for social services from responsible authorities

Many guidelines were sent directly to social service management authorities, such as home care, nursing homes, child protection, victim support and children with special

needs, and also guidelines for families experiencing divorce. The guidelines usually assumed that service delivery was in progress, specifying special conditions like restrictions on visiting relatives in nursing homes and personal protection guidelines.

Like other countries, Estonia has taken additional steps to guarantee support for victims of gender-based and domestic violence, as well as for specialists in shelters. There are customised guidelines for women's support centres, working in emergency situations and providing help and shelter for women in need of help. These guidelines also include guidance for workers in women's support centres (as well as shelters) who are in a risk group because of their health condition or age, such as recommendations and instructions to work from home and with telecommunication and online options. Additionally, the guidelines include references to relevant general guidelines, and recommendations from the Health Board. Local governments have approached local communities publishing special magazines to inform people about various concerns including service delivery, helplines.

Use of digital tools in working with clients and teamwork among staff.

The local government workers offered e-counselling using telephone, Facebook and Skype. All digital solutions to combat the COVID-19 crisis were published in a special issue describing digital solutions in different sectors (1). Some examples of digital communication with clients include the following:

- The Social Insurance Board organised tablet computers *for care homes* in Saaremaa, the epicentre of Estonia's COVID-19 outbreak, to facilitate contact between residents and family members that had not been possible due to physical distancing requirements.
- Women's support centres held regular web briefings for women's support centres all over Estonia to share good practices and solutions, coordinated at the state level. In addition, encouraging *messages were sent through the media about help services* available to them, e.g., victim support, a 24/7 crisis helpline, women's support centres and shelters. Some women's support centres have been practising and communicating about *web-based solutions and chat options,* especially through social media as ways to get help when making a phone call was not possible.
- Multi-Agency Risk Assessment Conference (MARAC) Meetings continued to operate. Multi-agency teams have had virtual meetings to share information about survivors of domestic abuse and who have been assessed to be at risk of serious harm or homicide. These virtual meetings ensure continuing co-ordination at the highest level of support to keep the safety nets in place.

Social work responses

Most affected groups defined by social workers

Until now, no research has been done in the field to identify the groups most affected by COVID-19 in Estonia. According to interviews published in the media, the most vulnerable have been older persons in nursing homes. According to the first analysis of free-form diaries (2), the greatest needs were in ensuring food-supplies and home-care work. Because older persons stayed at home, care workers were over occupied due to the

isolation. Loneliness of older people versus the effectiveness of restriction was under discussion in the public media.

Innovative and/or alternative approaches to communities, clients/service users and their needs

Alternative approaches were mainly in the field of community work, and web pages and Apps were developed to mediate contacts between helpers and those in need. In addition to the approaches described in a previous section on cooperation with different ministries, a new data and information exchange system was launched. This will make it faster for people in need, and especially children, to get help and support. Through the new system, the police can immediately send information about people at risk and in need of help to the local government, and information about victims of intimate-partner violence would go to the victim-support worker of the Social Insurance Board.

Main obstacles to approaching and supporting communities and clients/service users

At the beginning of the crisis, the most problematic issue for the social welfare sector was a lack of personal protection equipment (PPE). The frontline work of the welfare sector was underestimated and undervalued compared to the medical sector. Also problematic was isolation and coping with childcare at home, especially for the parents of children with mental health problems. All-day care facilities for children, adults and older persons were closed, and people were isolated in their homes without any information. Immediately after announcing the emergency situation, a special online resource, the Help 1247 service was opened. Its creation relieved a lot of pent-up tension about service availability.

Critical evaluation of state measures

Speaking of the situation in Estonia, well-known Estonian virologist Merits (2020) summarised the situation by saying that:

> 'I think we have, surprisingly, done everything more or less right. We haven't panicked, we haven't made too much fuss. We have, in my opinion, disseminated quite enough information. And also, we have not introduced preventive methods that would not work' (Merits cited in Vahtla, 2020).

The role of national associations of social workers in supporting practitioners during the coronavirus crisis.

In Estonia, 40% of social workers do not have social work education, nor is there a licencing system for social workers. All higher-education institutions established curricula according to the National Qualification Standard for social work, and it is usually a generalist type of education. It is obligatory for child-protection workers and care workers to have a qualification in social work or care work.

The Estonian Social Work Association offered help during the pandemic and reported that local governments were very quick and innovative in offering services in the new situation. Estonians are very prone to digitalise work, and the pandemic provided an

excellent opportunity to do so. The overload of information and regulations was mentioned by many social workers during the pandemic.

Concluding Comments

During the process of writing this document, Estonia has had only one or two cases of infected persons per day. Everyday life has returned, and yet the country prepares for a 'second wave' of the pandemic. Nevertheless, it is still not clear how much knowledge has been gained and how much society can protect the most vulnerable persons in the community. Research in the field of social work during the pandemic is not supported by the government, and researchers are looking for opportunities to gain insight into this unique set of challenges.

Notes:

1. *Fact sheet.* On https://e-estonia.com/wp-content/uploads/factsheet-covid19-solutions-200402.pdf
2. This refers to parallel and comparative diary data collection initiated in several COVID-19 SWRF countries in the spring of 2020.

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FINLAND

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Country context: Key facts and figures

Finland is a country in Northern Europe. It is classified, along with Sweden, Norway, Denmark and Iceland, as one of the Nordic countries with a Nordic welfare state. The population of Finland is 5,528,390, and the population density is 18 inhabitants per km^2 (Statistics Finland, 2020). From a European perspective, Finland is a very sparsely populated country, which has, historically speaking, prevented the spread of epidemics.

   With regards to the COVID-19 pandemic, the number of infections in Finland is 7,100 and the number of deaths from the disease caused by the virus stands at 328. In relation to the Finnish population, the total incidence is 128 cases per 100,000 inhabitants. The median age for all coronavirus-related deaths is 84 years, and 45% of deaths have taken place in older people care homes. Of those who have perished from COVID-19, the majority, or 52%, have been women (National Institute for Health and Welfare 2020).

Figure 1. Confirmed COVID-19 infections, daily new cases and cumulative deaths, Finland 2020
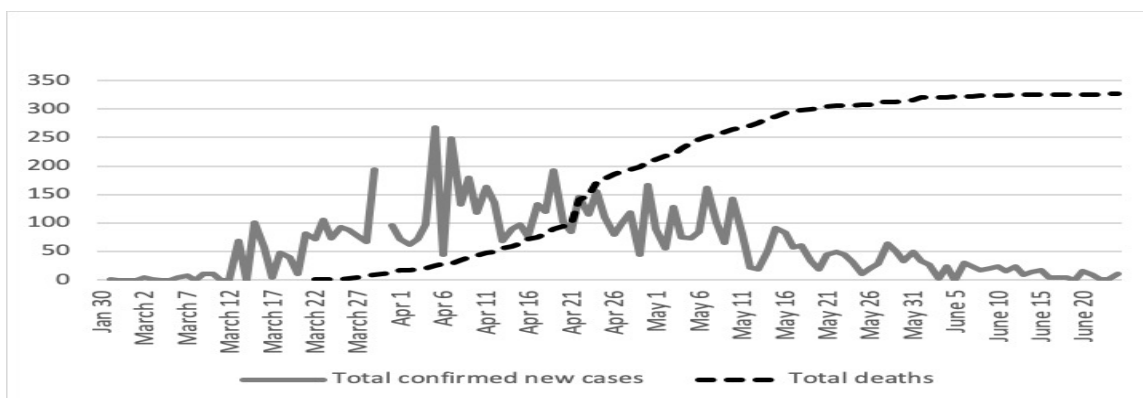
Source: World Health Organisation (WHO), COVID-19 situation reports.

Thus, in Finland, the number of deaths caused by the pandemic has remained quite low. In June 2020, the number of new infections appears to be declining. Recently, there have been days with no new cases of infection. There has been a public debate about a new wave of virus infection possibly coming in the autumn, but no reliable prognoses have been presented thus far.

Societal measures addressing the social consequences of COVID-19

The extent of isolation

The Finnish government has closely monitored the spread of the pandemic, and it has reported the changing situation on a daily basis. The media briefings have been attended by representatives of the National Institute for Health and Welfare, who have spoken about changes in the pandemic situation. In providing regulations related to the pandemic, the principle of proportionality has been applied: the measures directed at controlling a specific phenomenon have to be in proportion to its amount and quality. As a consequence, the government has sought moderate and impose gradual restrictions on citizens. There has not been any general policy on penalties for breaking the rules, and these have been mainly observed by people with few exceptions.

Partly for this reason, an absolute shutdown has not been instituted in Finland. On 18 March, the Finnish Parliament decided to apply the Emergency Powers Act, for the first time during peacetime and also since World War II. This Act permitted the Government to use many types of restrictions. Most restrictions took place from March to May 2020. The borders of Finland were closed and reopened for work-based and essential travel from the EU-Schengen area from mid-May onwards. People who have returned to Finland from abroad were expected to stay at home for two weeks and keep a social distance from other people.

The government's emergency measures targeted a few groups of people and geographical locations. With regards to geographical areas, the Uusimaa District which includes the capital area was isolated from the other parts of the country from 28 March to 19 April 2020. Those who crossed the border without permission were fined. Moreover, the governmental instructions suggested that people aged 70 or above were expected to stay at home in quarantine-like conditions. Visits to older people's care homes and other social care institutions or care homes were restricted for relatives and outsiders. Other than that, people have been able to go out freely. The government has recommended that people work from home offices, keep physical distancing while meeting other people and avoid travelling. In the public sector, the Finnish government has recommended that employers order their employees to work from home. In the private sector, the employer had to assess whether it was necessary to go to the workplace and take their employees' health into consideration.

With regards to public meetings and attendances, the government provided guidelines as well. The elementary schools were closed, and the students were moved to home-school arrangements for two months. Higher education institutions, such as high schools and universities, continued operating and provided teaching online until the summer of 2020. It seems that many previous restrictions have been loosened from the beginning of June onwards due to the low number of new coronavirus infections. Since March, restaurants have been allowed to sell takeaway meals only, but in June they were allowed

to open with specific safety regulations. Other public buildings, such as museums, theatres and cinemas, were re-opened, and public events involving up to 50 people were permitted. Finland has no official recommendations for the use of face masks in public areas.

State measures to address social problems and needs

Kansaneläkelaitos (KELA 2020) is the government agency in charge of settling benefits under Finnish social security programmes. In general, KELA has provided temporary financial assistance to citizens due to the pandemic outbreak. Some changes were made to unemployment benefits, especially concerning self-employed persons and entrepreneurs who lost work and income due to the COVID-19 pandemic, and to regulations addressing the pandemic. The government has also distributed direct financial support to companies based on their applications. Temporary financial assistance on the basis of childcare responsibilities for guardians taking unpaid leave from work due to the epidemic outbreak was available between 16 March and 13 May 2020. Based on media polls, most Finnish people are content with the way the government has handled policy and restrictions during the coronavirus (Hiilamo 2020).

Social services response

The mode of operation of social services

The work of social service workers and institutions has continued almost as usual, except with more distant and digital meetings with clients. Some social services not regarded as necessary in the emergency situation were temporarily closed or operated through online/distance contact only during the peak of the coronavirus. Shelters intended for homeless people, as well as food donation services immediately faced a crisis of service provision: they were either closed or forced to change their operational tactics. The most vulnerable people have had severe problems in finding information on the changes in services, since face-to-face contact services had been closed or reduced. Many social services based in the voluntary sector, for example, daily groups for older people, peer support groups for people with mental health problems, have either been cancelled or to operate only on an online basis.

In Finland, the Ministry of Health and Social Affairs is responsible for providing guidelines and instructions for social welfare institutions and social work. The Ministry has delivered guidelines, as exemplified for social services and professional work with clients/service users in need of immediate intervention, e.g., child protection, violence, and mental health services. According to the precept of the Ministry of Social Affairs and Health, all workers working at care homes and in client's/service users' homes were to use a face mask (MSH 2020).

Use of digital tools in working with clients/service users and teamwork among staff

Based on the trade union Talentia's survey (Ahonen et al. 2020), 58% of social welfare workers (n = 1,558) experienced that work during the pandemic has been implemented using online tools or phone calls. Of the workers, 30% answered that the coronavirus had no effect on how they work with clients. However, there was a wide variety of guidelines concerning working from home offices and using 'distant tools' for client/service user

contacts. Some of the social welfare workers felt unequally treated compared to their workmates, as organisations and workplaces varied. According to some, lack of electronic equipment and tools had prevented working from an office at home. Some of the informants reported that they believed they had experienced the greatest digital leap in their history (Ahonen et al. 2020).

Main concerns expressed by social services

Social workers recognise that the effects of the pandemic will will arise in social services following a delay. The clients/service users will need more help after the pandemic. Based on the Talentia survey (Ahonen et al. 2020), 76% of social workers were worried about their clients'/service users' survival. Among social workers, 51% feel that the coronavirus has had a negative effect on the how individuals' needs can be evaluated by the social services. Forty-one percent responded that their clients/service users do not have technical equipment or other appropriate resources for using digitalised services, and 75% responded that their clients/service users now have weaker opportunities to get help for their needs than before the crisis (Ahonen et al. 2020). Voluntary neighbourhood aid has occurred, but it is not organised by social services.

Social work responses

Most affected groups as defined by social workers

Social workers are worried about older people in general and those in care homes in particular. They are also concerned about the coping capacity of the relatives who take care of older people at home. The daily groups for older people and other daily services have been closed, and consequently, the relatives caring for them have no opportunities to rest and/or take time off.

Social workers are also worried about children in vulnerable situations and families with mental health or substance abuse problems. Families have been obliged to stay at home more, and that has had an impact on them. In some, the situation has shifted in a better direction, but in some other families, it has become much worse (Ahonen et al. 2020). The number of mandatory child welfare notifications has decreased in many cities in Finland (Yle 2020a). At the same time, the number of police visits to people's homes has increased due to domestic violence cases (Police of Finland 2020).

It is also evident that homeless people have been forced to stay on the streets more, given that shelters and other public places have been closed. Their options to handle hygiene needs have also become worse because of the closure of these services. People on the streets have experienced more hunger and inadequate nutrition due to closed food donation and food sharing services (Yle 2020b).

Main obstacles to approaching and supporting communities and clients/service users

Many clients/service users have lost contact with basic services such as schools, school nurses, mental health services, homeless shelters. These clients/service users do not get their usual help from other services. These other services have become important partners in social work by providing all the help needed by some clients/service users. These partners also contact social services if they worry about a person's well-being. The

closure of services complicates the information flow to social services about the people in need of help and also information regarding the needs of clients/service users.

The role of national associations of social workers in supporting practitioners during the coronavirus crisis.

The Talentia Union of Professional Social Workers has supported practitioners by collecting experiences about working conditions and sharing information about working regulations and workers' rights during the coronavirus pandemic. Based on their survey, most social workers have received enough information from their employers about the coronavirus prevention and working arrangements (Ahonen et al. 2020).

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INDIA

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Country Contexts: Key facts and figures

Population and population density

India is a large sub-continent in Asia. The population of India is 1,352,617,328. The population density was reported at 455 sq.km in 2018 (World Bank 2020).

Number of infectious cases and time period

There were 106,737 active cases, 6,075 deaths and 104,106 cured or discharged cases, and 1 case that had migrated. By 16 June, these had risen to 153,178 active cases, 9,900 deaths, 180,012 discharged cases and 1 case that had migrated (MOHFW 2020).

Number of deaths

More than 70% of the cases were due to comorbidities as stated by the Ministry of Health and Family Welfare, Government of India (GoI) (MOHFW 2020). There are four major states which show 70% of the COVID-19 cases are concentrated. These are Maharashtra, Tamil Nadu, Delhi and Gujarat. But there has also been an increase in recent weeks of cases from Madhya Pradesh, Uttar Pradesh, Rajasthan, Bihar and Karnataka. A noticeable increase in deaths was also seen in Madhya Pradesh, Uttar Pradesh and Tamil Nadu (Radhakrishnan, Sen, and Singaravelu 2020). Case fatality rates have been going down and now stand at 2.79% and recovery rates have also shown an increase and are now at 48% (1). On 12 June, the central government warned of increased confirmation rates from 4.87 % to 5.7% within 46 districts across 13 states reporting confirmation rates of 10% in the three states of Maharashtra, Delhi and Telnagana and in other locations. Confirmation rates were more than 20% in both urban and rural areas. Medical facilities, like ventilators and ICU (intensive care unit) beds in these states, are expected to reach full capacity in the near future. Sixty-nine districts across 13 states in the country have a fatality rate of more than 5%. Of these fatalities, 51 are concentrated in four states (numbers in brackets): Madhya Pradesh (21), Uttar Pradesh (11), Maharashtra (10) and Gujarat (9) (Ray 2020). Six states, Maharashtra, Tamil Nadu, Delhi, Gujarat, Rajasthan, West Bengal, contributed 76% of all COVID-19 positive cases. Moreover, 82% of total deaths came from five states: Maharashtra, Delhi, West Bengal, Gujarat and Madhya Pradesh. This is despite the national rate doubling (16.9 days as against 14.1 days two weeks earlier) and stable CFR (number of fatalities per 100 detected cases) at around 2.9% compared to 2.96% a fortnight before that (Ghose 2020).

Comments

States which have shown good progress in terms of recovery and zero deaths, are now showing a spike, especially after the return of people from abroad and within India was facilitated by the Government of India through their Vande Bharat Mission and Shramik Special Trains for the movement of migrant labour, respectively. Most of the north-eastern states showed no cases but with the return of their residents, cases have shown a spike. The recent government tally of the COVID-19 situation emphasised the spread of the coronavirus to the eastern and rural parts of India. The most densely populated urban settlements, and congested markets for food supplies, including grains, fresh vegetables, and fish constitute serious points of concern for the spread of the coronavirus.

Disaggregated data is not yet accessible. Though a recent article speaks of the burden of confirmed cases being higher in men (66%) compared to women (34%) and with CFR (case fatality rates) among men and women being 2.9% and 3.3% respectively according to crowd-sourced data (Joe et al 2020).

Also, positive test rates remain constant. This means that with increased testing, more cases are being found, even discounting the effects of the lockdown conditions with physical distancing to prevent the spread of COVID-19 (Mukhopadhyay 2020).

The serological survey by the Indian Council of Medical Research (ICMR) in 69 districts of 21 states also hints at a large number of cases, at least twenty times higher than that of what is officially stated, and estimates in early May claim that cases would have reached 700,000 (Koshy 2020).

The situation is changing very fast and with community spread being feared now. The case of other disasters like the cyclonic storms of *Amphan* in West Bengal and *Nisarga* in Maharashtra have only added to the COVID-19 problems. Thus, some parts of India are facing compound disasters.

Data transparency in collection and sharing the disaggregated data is required if social workers are to respond professionally. Otherwise, we end up with planning for interventions that grossly mismatch realities on the ground. Fatalities have also occurred during the humanitarian crisis of migrant movement back to their original villages, and these are not reflected in government data, but these are estimated at 884 persons.

Societal measures addressing the social consequences of COVID-19

Imposing lockdown conditions

Lockdown conditions were first announced on 24 March with the first phase running from 25 March to 14 April. The second phase ran from 15 April to 3 May. The third phase went from 4 May to 17 May, the fourth phase from 18 May to 31 May; and the fifth phase from 1 June to 30 June. This created containment zones with relaxations put in place as deemed fit by state governments. Each lockdown period saw the central government and the state governments imposing strict conditions with relaxations or restrictions imposed on new activities depending on the local conditions of spread. The interstate movement of migrants was stopped when they wanted to go back home from large metropolitan areas back to their villages. But, this condition was relaxed towards the end of April, by which time many thousands had already begun walking back to their villages. State governments also extended these lockdown conditions from time to time. Some areas which did not find cases were declared as green zones and economic activities and social activities permitted with physical distancing and other COVID-19 guidelines. The guidelines announced on 1 June called for the phased relaxation of lockdown conditions

from 8 June by allowing for the opening of temples, malls, shopping complexes and hotels with strict physical distancing norms to be followed.

Disaster Management Act 2005 and Epidemic Diseases Act 1897 (2)

These two Acts were used by the state to carry out the control of the public and mete out punishments related to any transgression of these restrictions. Under the Disaster Management Act 2005, the central government declared COVID-19 a 'notifiable' disaster and a 'critical medical condition' or 'pandemic situation'. Even though health is a state subject, the invoking of the Disaster Management Act means that central government had taken control with the three-week lockdown it issued under Sections 6 and 10 of this Act. Also, this Act authorises the National Disaster Management Authority (NDMA) to use powers to prepare national level plans for disaster management and carry out their implementation through the disaster management authorities of the states. Thus, the NDMA is now the nodal agency in charge of containing the pandemic, coordinating with the states, and providing them with relief funds.

The penalties imposed come from enforcing lockdown restrictions to prevent the spread of disease. These are imposed under Section 144 of the Criminal Procedure Code (Cr. Pc.), to prevent a gathering of more than 5 persons. It also forbids the public's movement among all establishments like schools, colleges, offices, public transport, and except for emergency and essential services, these have been completely shut down. Violating Section 144 of the Cr. Pc. is punishable under Section 188 of the Indian Penal Code (IPC). This was imposed in a majority of the states across India under the NDMA Act. The penal provisions are listed in Sections 51 to 60 of the Disaster Management Act 2005. Punishments for violating the lockdown conditions can lead to imprisonment and fines and include actions such as obstruction or non-compliance with a public order which will lead to punishment of 1 year in jail or a fine or both. If violating lockdown conditions leads to a loss of life, then 2 years imprisonment is given. Making false claims (Section 52) will lead to 2 years in jail and a fine. Misusing relief money or materials will also lead to 2 years in jail and a fine. Disobeying a public servants' order will lead to one year's imprisonment with a fine of INR (Indian rupees) 1000. Failure of officers to perform their duties will be punished with one-year jail and fine. People violating the quarantine rules will be punished under Section 188 of the Indian Penal Code. Under Section 3 of the Epidemic Diseases Act of 1897, punishment for disobeying the law, causing annoyance, obstruction or injury to persons lawfully employed, carries a jail term of one month and a fine of INR 200. If the disobedient act endangers human life, health or safety, the punishment will be imprisonment for 6 months or a fine of INR 6,000 or both. Section 4 of the same Act gives protection to officials and or persons acting under the law.

Restrictions on economic activities and relaxation of some activities

Restrictions on all economic activities except for essential services such as those involved in the production and distribution of medicines-medical equipment, food, postal, financial services, security services including the police and defence services. These norms first came up on 25 March with guidelines issued by the Ministry of Home Affairs of the Government of India. These were subsequently being lifted in different parts of the country depending on the coronavirus caseloads and containment zones.

<u>All public activity was banned</u> and the complete closure of places of work excepting for the essential goods and services meant that schools, colleges, religious places, shopping malls, cinema houses, hotels, and hospitality industry were closed down. Sports activities, marriage celebrations, and public gatherings were all banned. Public movement was completely restricted, and air, rail, and bus transport were stopped completely. From 1 June, there was an easing of lockdown conditions with strict guidelines for maintaining hand hygiene and physical distancing measures. Shopping malls, religious places, hotels were being opened from 8 June 2020. State governments were given the freedom to impose or relax restrictions according to their reading of the situation in their specific state.

<u>Entry banned to those from other countries</u>. Travel to and from other countries was banned by air, land, and sea routes. Many people stuck overseas could not come back because of suspended flight operations. Special flights were organised by the Indian State to bring them back through the *Vande Bharat Mission,* from 7 May onwards.

<u>COVID-19 related guidelines for care, protection and prevention measures</u>. Special guidelines were announced from time to time to protect the COVID-19 front line workers, like the medical, sanitation, police and administrative personnel. Some states announced insurance measures. Some others ordered punishment for those disrespecting or discriminating against frontline workers. Public encouragement measures, such as 'clapping hands', 'lighting lamps', 'showering petals' from the air were also undertaken to show appreciation for such workers.

Front line workers faced discrimination in some quarters where people in residential areas avoided them or insulted or assaulted them by-blaming them for being carriers of the coronavirus and potential sources of infection. In many other cases these negative stories were offset by the positive stories of strength and support they received from their families, friends and communities who gave them due respect.

Those who were returning home from the major cities where infection rates were high, were similarly treated negatively and seen as potential carriers of COVID-19 infection. Yet, in many cases, the quarantine conditions were of poor quality and physical distancing standards could not be met properly. At many villages, the elected Head of the Village Administrative Unit (Gram Panchayat) was given the responsibility of meeting the needs of the quarantine with low or inadequate resources.

The finances of the state governments were affected, and this also placed tremendous pressures on governments to face the disease burden in acute cases. PPEs (personal protective equipment), ventilators, and testing kits were in short supply. The situation has since improved somewhat. But the recent 12 June projections from central government speak of the states running out of ventilators and ICU beds.

State measures to address social problems and needs

Understanding the social and economic context in India is essential in examining how the state is offering support. A number of social welfare services try to address the needs of poor people by providing food rations, nutritional and educational services, health services and housing support. These services have been in operation since independence and with modifications to eligibility conditions over time have facilitated greater access.

<u>The affected groups</u> are listed below:

- Daily wage workers residing in the cities.
- Home-based workers, particularly women.
- Homeless people.
- Workers in various informal and formal sectors of the economy lost jobs and wages due to lockdown conditions, spanning across major sectors of the economy. These are the following (Kotwal 2020):
  - agriculture and allied activities, these included farmers, agricultural labour, fishers, nomadic and pastoral communities which work mostly in the informal sector and form a minority of workers in the formal economy.
  - manufacturing and industrial companies including people working in or owning factories, industrial establishments, special economic zone industrial activity and mining.
  - service sector enterprises including owners and workers involved in i) trade, hotels, and restaurants; ii) transport, storage, and communication; iii) financing, insurance, real estate, and business services; and iv) community, social, and personal services, including health and educational services belonging to the formal as well as informal sector.
- Self-employed people in various sectors of the economy are also affected severely. Within the trade sector, the Micro-, Small and Medium Enterprises (MSME) were also affected by lockdown conditions.
- Workers, especially migrants who wanted to return to their villages.
- Rural and urban poor families.
- Differently abled people.
- Stranded students in other cities or states within India and abroad.
- Stranded visitors from abroad.

Lockdown effects on poor and vulnerable people: Impacts on food supply.

Food supplies depend on the supply chains being continuous, and this chain got broken or stalled due to lockdown restrictions imposed on working conditions with physical distancing (social distancing is the government word), and shortages of labour as workers returned to their villages (Narayanan 2020).

Interstate movement of vegetables and other foodstuffs was affected, due to a lack of labour for loading and unloading, and so perishable products suffered. Many farmers could not take their products to market because of lockdown conditions. Hence, they had to feed them to animals or leave them in their fields. This included exotic fruits like strawberries or common fruits like watermelons. Farmers in the perishable goods sector suffered labour shortages, even if there was access to *mandis* (local term for markets).

India is a vast country and each state had its own way of dealing with the crisis. Some markets operated with physical distancing and others not. The latter led to an increase in cases. Supply chains were assured through permissions for markets to operate with physical distancing. Local grocery shops and food retailers were permitted to function within limited timeframes to ensure food security.

Food security was drastically impacted by questions of availability and access to food. Lack of wages for daily wage earners and their inability to buy food grains, became a major issue across the country. School closures have also impacted on the mid-day meal for children. The Integrated Child Development Services Programme ensured nutrition on a daily basis for school-going and children going to preschool respectively in both

urban and rural areas. The lockdown also had a severe impact on homeless people and those who depended on alms in the streets, particularly at religious places.

Lockdown conditions and the misery of migrants

Circular migration has been a poverty coping mechanism followed by poor people in rural areas as they migrated to cities for shorter or longer periods to participate in construction projects, highways construction, hotel industries, travel and tourism, trade, sanitation, health and education services. Large scale migration with estimates of 100 to 139 million people from poorer areas in the states of Jharkhand, Bihar, Chattisgarh, Odisha, Rajasthan, Madhya Pradesh, and West Bengal went to urban areas in Delhi, Mumbai, Ahmedabad, Suat, Bangalore and to various other cities in the states of Karnataka, Maharashtra, Kerala, and Gujarat. Migration for agricultural work to the Punjab and Haryana takes place on a regular basis. Lockdown has impacted severely all these workers who lost work and were not paid wages or have run out of food rations and their savings in surviving and paying their rents. This compelled them to move back to their villages, in what is described as a mass movement of people reminiscing the exodus of people during the partition of India. Street vendors in major cities and towns involved in varieties of trade also got affected drastically.

The vulnerable groups

The Adivasi or original inhabitants known officially as 'Tribals', are recognised in the Constitution of India as 'Scheduled Tribes'. These groups have been impoverished by being displaced from their habitats due to various development projects. Poor rural people have always used migration as a coping strategy to survive, by seeking work elsewhere which can be anywhere in the country. Most of the migrants belong to the 'asset poor' people among scheduled castes and scheduled tribes.

Facilitated by the rail and road network this migration has been taking place among 'foot loose' labourers who have settled in metropolitan regions and built a city's infrastructure with their labour. They reside in the poorer regions of the city in what are known as 'slums' with very poor health, sanitation, drinking water, and housing infrastructures. The health infrastructure in these tribal belts had already been poor and health indicators have also been poor. The wellbeing of women and children and other vulnerable groups with poor health and nutrition status are badly affected by these conditions.

Certain occupational groups will similarly be seriously impacted because of their precarious livelihoods. These include artisanal groups, those in primary sector occupations like farmers, agricultural labourers, fishers, forest dwellers, and pastoralists. The impact is also much stronger among occupational groups which are low waged, pay daily wages, casual earners, contract labourers, artisanal groups and those in petty trade and small enterprises.

Government policies related to demonetisation in 2016 sought to curtail the predominantly cash economy (98%) and affected livelihoods in the informal and formal sector too. The banking infrastructure is geared to support the formal sector and there is an attempt to formalise informal economic transactions. However, this is beset with banking reforms that focus on cost cutting banking operations through mergers and reducing their infrastructural presence. Digital transactions are also beset with uncertainty in online support systems.

Loss of jobs and wages

Lockdown had severely affected all vulnerable groups across the varying geographic regions of the country as economic activities were stopped and supply chains were affected. Since there was no income for many during the last four months, demand for products has also not been there. With demand being low, spending has been low and has already been noted in economic surveys conducted by various institutions, prior to the budget presentation in February this year. The unemployment rate rose to 23% post lockdown conditions in May compared to 8% in March, before lockdown was announced. In June, the unemployment rate reduced to 17.6% due to the resumption of economic activities (CMIE 2020).

The vast majority of women in the informal sector who are home based workers have also suffered this loss of work and what little support they had to maintain their families has now been lost. It is estimated that nearly 400 million workers in the informal sector have lost wages and/or jobs due to the lockdown conditions (Countercurrents Collective 2020).

Reforms for an economic push during the COVID-19 crisis

The Government was pushing for law reforms that would facilitate the revival of the economy, such as changes to labour laws that are anti-worker by removing the right of workers to organise into trade unions, increasing working hours to 12 hours per day, removing penalties on employers if they do not provide safety and security at the workplace including removing welfare provisions for workers; reform of the agricultural sector (Yadav 2020) that facilitates large scale privatisation by transferring land from individual farmers to corporate firms, reforms in the environmental impact assessment when granting project clearances for mega projects, corporatisation of the fishing industry with an imminent threat to large number of small fishers.

Education has suffered a severe setback with schools and colleges being closed. Online educational teaching-learning processes are being encouraged, but there has been a very serious lack of infrastructure, in terms of digital connectivity and students cannot access these facilities. It is often that in remote areas in the northeast region of India, people have to go to another village or a site 20 to 30 kms away just to access the internet or secure a telephone connection. This makes education through digital modes very difficult.

Mental health issues have risen with loneliness and the increased debt burden caused by lack of wages due to lockdown. The failure to pay people monies due have made people take the extreme step of committing suicide. Being tested positive for COVID-19, has made it seem that it is the end of the world. Thus, the pandemic has brought new fears as people who tested positive feared their end to be near and committed suicide. Mental health issues are on the rise due to a lack of human contact and families being separated from each other as family members became stranded in other places. Mental health issues of students, older people, single person households, and women headed households have only increased. The burden on women has increased due to the pandemic as they have to cope with the increased domestic demands of hygiene and sanitation, collection of fuel and wood, and fetching drinking water in rural areas due to their carrying the disproportionate share of household responsibilities.

Rise in agrarian distress. The debt burden in India is high with 52% of rural households indebted. In some states, this reaches 92% (MOSPI 2014). This also places farmers at risk of committing suicide due to prevailing agrarian conditions that give low value to agricultural work. In this situation, the coping strategy of poor people is to migrate to places where work is available. but this has been stalled by lockdown conditions. A press release of a survey reporting on how the debt burden has increased in rural areas has pointed out that 30% of the households surveyed have had to borrow from their kin or money lenders. For such families, schooling becomes a costly choice which they would like to abandon. Farming communities are also staring at the fearful prospect of not having enough seeds for farming as their money supplies have become exhausted during the lockdown period. Reliance on remittances from migrants for agricultural operations has also been strongly affected (Vikas Anwesh Foundation 2020).

State response with regard to the food supply of affected groups. The government had adequate stocks of food grains of 77 million tonnes in its warehouses under the Food Corporation of India. The Government announced measures to supply food grains at subsidised prices through the Public Distribution System (PDS). The government announced an extra food grain ration of 5kg rice or wheat and 1kg of pulses under the PDS system for 3 months from April to June 2020 for poor people. However, the lack of proof of identity to access these, e.g., ration cards, or other identity documents, has been hindered and compounded by the slow processing of many applications for this Scheme. A large number of people, around 100 million, could not access these free or subsidised rations (Mukherjee 2020) because central government insisted on using the 2011 census figures to fix the PDS quota for each state. A number of people who had ration cards at their places of residence in the villages could not access the Scheme if they were migrants living in cities. The government also announced that civil society organisations which were mostly voluntary organisations registered under various Acts of Government to provide voluntary services were asked to distribute food grains from warehouses at subsidised cost.

Migrant workers. The Government announced that workers would have to stay in the cities and that their rent could not be collected by house-owners. Also, it passed orders that MSME sector employees were to be paid for the months of April and May. The Supreme Court of India has directed the central Government and the states not to take coercive action, including not initiating penal actions on employers for not paying wages. Rail transport was allowed by special trains (SHRAMIK trains) to take migrants back to their home states. Six million migrants used 4,450 such trains to reach their home states from 1 May to15 June (Dutta 2020).

Stimulus package to revive the economy. During the first half of May, the Government announced financial packages to various sectors of the economy and announced that all ration cards will have national portability. Support has been provided to the economy through a financial package. However, this was less than one percent of GDP and grossly inadequate as most of the packages focused on borrowings from public sector banks to tide firms over the economic crisis.

Stimulus for poor people. The state announced a slew of measures from time to time to put cash in the hands of 344 million Jan Dhan Account holders. Women account holders

under this measure received two instalments of INR 500 each in the months of April and May. This covered 200 million accounts.

<u>Stimulus to the farmers</u>. The Government's PM-KISAN (Pradhan Mantri Kisan Samman Nidhi Yojana) Scheme enables small and marginal farmers to receive to INR 6,000 yearly paid into bank accounts in 3 installments. It had been put in place before the COVID-19 crisis to provide for 125 million such farmers, but it has acquired greater importance now.

Comments

The states' responses have been deemed class biased because lockdown was announced which left just four hours for the people living away from home, especially the working poor people to return home which was located hundreds of kilometres away. There seems to be a lack of planning in the entire exercise of whether it is getting lockdown conditions ready, transport to take migrants back to their places of residence, preparing hospitals, testing protocols, and standard operating procedures for various eventualities. Since public transport such as train services have been suspended, a large number of people in Mumbai who use the suburban train services, and who provide essential services in health, sanitation, fire stations, and police departments have been unable to travel to their workplaces. Some of the Mumbai hospitals are operating with less staff than needed due to the lack of public transport. Transport services are under the control of the central government, who fear infections will rise if public transport is restored. This changed on 15 June and suburban train services have been restarted in Mumbai.

Public health spending has been low for decades and the public health infrastructure is not in a shape to meet the demands of the pandemic. India is spending less than 1.3% GDP on health and has low wages for frontline workers in the health sector like the Accredited Social and Health Activist (ASHA—acronym within Indian languages meaning hope) and the Anganwadi workers in the Integrated Child Services Scheme ensure nutritional supplements for pregnant and lactating mothers and young children below 6yrs of age.

The stimulus packages announced by the government are nothing other than putting banks at the forefront to increase lending and rehash previously budgeted programmes as COVID-19 packages. The state needs to focus on the triple strategy of survival, revival and recovery, where first is ensuring the survival of those who lost jobs and wages. The second is reviving production capacities in the non-essential sectors, with an estimated additional fiscal support of 2 trillion Indian rupees to fund this support for a period of 3 months. (Sen 2020). Such a package would have a better chance of leading to recovery.

Social services responses

The social welfare services are curtailed due to the pandemic, and particularly affected are the health and nutritional services. In the Health Service, most of the government hospitals are being converted into COVID-hospitals, with curtailed services to the other communicable and non-communicable diseases, including cancer. All surgeries and elective operations have been postponed indefinitely.

Educational institutions are closed affecting the schooling of 330 million children, with an impact on their nutrition as they cannot now access meals served during school hours, under the Mid-day Meal Programme. The processing of applications for pensions under

disability, old age and widow assistance by Welfare Services are delayed due to lockdown conditions. The processing of disability certificates is also being delayed because the certification is done by doctors who are all now occupied with responding to COVID-19 cases. Yet, these certificates form the basis for accessing disability pensions.

Job schemes, like the employment guarantee ones, have seen a manifold increase in employment seekers in the rural areas. This requires a scheme to be flush with funds. However, employment dues for the past few months have not been paid to the states. The recent budget in February 2020 has seen a 19% decline in schemes that support children to be healthy, such as the Mid-Day Meal Scheme, National Health Mission (NHM), Food Subsidy Scheme, Mahatma Gandhi National Rural Employment Guarantee Scheme, National Rural Drinking Water Mission, and others (Pant and Ambost 2020).

There are also issues related to conditionalities imposed on states with performance linked budget allocations under NHM grants from the central Government. This actually ends up penalising the weaker states because they fail to meet the conditionalities and creates a very serious problem in meeting demands made of the health infrastructure. Heightened demand for services inhibits their making an effective response to the COVID-19 pandemic (Pant 2019). Insurance coverage for frontline hospital workers has been announced by various state governments and in case of death almost one crore (10 million Indian rupees) is being made available for bereaved families.

Community support was used for contact tracing of cases following the Tablighi Jamaat meeting in Delhi from 1 to 21 March. This had people from various states in India participating, and those who caught COVID-19 subsequently spread the infection to their home states on their return.

Many of the civil society groups have focused on relief distribution during the pandemic. Their endeavours were accentuated during the two natural disasters attending Cyclone Amphan and Cyclone Nisarg in the east and west coasts of the country. Their impact on the states of West Bengal and Maharashtra respectively, has occurred alongside the pandemic.

The media has played its part in highlighting the guidelines to be followed. However, the coronavirus pandemic is also seen as one big continuous live story, without actually raising serious questions about the way testing and contact tracing protocols are being followed. These cover the justice questions regarding access to resources and the inadequate and flip-flop responses of state governments and the central Government in meeting the livelihood and health needs of the population.

Social work responses

The most affected groups defined by social workers are:

- Those suffering food insecurity, homelessness, daily wage labourers, unskilled labourers, auto-rickshaw drivers, drivers of electric rickshaws, rickshaw pullers such as those working in transport, construction and manufacturing industries, street vendors and hawkers.
- Homeless people and those seeking alms.
- Migrants who want to go back home.
- Workers who have been laid off.
- Patients with other illnesses stranded in towns and cities.
- Students who became stranded.
- Quarantined people.

- Differently abled people who wanted to go back to their villages.
- Differently abled people in the pandemic situation seeking access to support services including e passes but experiencing difficulties in doing so.
- Patients with cancer or other terminal illnesses unable to access facilities when existing hospitals have converted their service areas into COVID-19 specific wards.
- Persons in quarantine in rural areas.

Innovative and/or alternative approaches to communities, clients/service users and their needs: Responses from Civil Society

A large number of registered and unregistered organisations, groups, and individuals assisted in filling the service gaps. Cooked food and dry rations were supplied across the country in large urban settlements and the places where circular migrants returning to their villages were stuck or were in transit, walking or cycling hundreds of kilometres. These provided:

- Stories of using voice recording to help migrants to return.
- Stories of community quarantine being made effective by harnessing religious institutions in a spirit of togetherness, e.g., Madrasas and temples being used for migrants in the village to stay during quarantine periods.
- Extraordinary stories of people helping other people through 'people to people' help
- Stories of frontline health workers (ASHA) working with communities to instil social distancing measures during cremations.

Main obstacles to approach and support communities and clients/service users

The pandemic has brought to light many social fissures and stereotypes to the fore. This has affected the health workers, when they faced discrimination as 'carriers of the virus' and were denied housing facilities or were abused during their community contact tracing efforts. These negative stories were offset by the generally positive way in which health workers were respected. Frontline health workers and their families have also suffered due to their prolonged periods away from family members. Children were especially hard hit when parents were involved in frontline duties.

These highlighted the major concerns for supporting communities as:

- Attitudes of the different classes in understanding the plight of less privileged people.
- Attitudes of discrimination and the type casting of people as 'carriers of illness', which were particularly onerous for certain minorities like Muslims, and frontline health workers.
- The treatment of the COVID-19 pandemic as a law and order situation.
- Heightened fear regarding the coronavirus.
- Governance structures assuming highly centralised directions.
- Bureaucratic procedures and hurdles, slowing down processing times which should have been speeded up considering the vulnerabilities that people experienced.

Critical evaluation of state measures

These would be the following*:*

- Inadequate and ill-timed responses.
- Undertaking law reforms that promoted the ease of doing business more than ensuring ease in living for the masses of people.
- Lack of transparency in data about the pandemic – number of cases, COVID-19's distribution across various social categories, impact on various sectors of the economy.
- The inability to accept the realities on the ground and the ensuing challenges, the lack of disaggregated authentic data and opting instead for 'image building exercises' of having controlled the pandemic.
- Ignoring the migrant workers' needs when announcing the lockdown conditions.
- Ignoring the 'workers' in public spaces while announcing lockdown conditions.
- Issuing guidelines hurriedly, then retracting them and changing the goal posts.
- Not using the epidemiologists' insights when announcing measures.
- Treating the pandemic as a strictly 'law and order' issue rather than a health one.
- Ignoring the demands being made of the health infrastructures being required to deal with the pandemic and not including remedying this in the announcements of fiscal packages.
- Ignoring issues related to the availability of drinking water and water generally.
- The curtailing of democratic rights by carrying out arrests of civil rights activists without due process.
- Not announcing the free supply of food to all affected and relying on identity cards and ration cards which may not be updated or conducted with due process, and thereby excluding almost 100 million people.

The role of national associations of social workers in supporting practitioners during the coronavirus crisis.

Professional social work organisations have responded to the crisis, by organising donation drives, distribution of relief materials, conducting surveys, blood donation camps, organising online skill training programmes and webinars. The names of these are the: Kerala Association of Professional Social Workers, National Association of Professional Social Workers in India (NAPSWI), Indian Society of Professional Social Workers, and other associations in New Delhi and at the state level. These also include the Indian Society of Professional Social Work, Karnataka Association of Professional Social Workers, Professional Social Workers' Association, Bombay Association of trained Social Workers. All of these associations are affiliated to the India Network of Professional Social Workers' Associations. Other associations that are playing a significant role are the Association of Professional Social Workers and Development Practitioners (based in Chandigarh) and the All India Association of Medical Social Work Professionals (IAMSWP). These associations are also involved in journal publications, like NAPSWI which supports *Social Work Research and Action*, IAMSWP has recently launched the *Indian Journal of Health Social Work*.

There are organisations in the development sector which have conducted surveys and produced reports that provide an analytic understanding of the crisis. Relief activities were also being undertaken by a number of organisations like the National Fish Workers Federation, The National Hawkers Federation, National Alliance of People's Movements and Apna Ghar. These have risen to the challenge and filled the gap to serve people who are in need.

Concluding comments.

There has been a significant amount of people-to-people support provided in a much more sensitive and empathetic response than that given by the Government. Nevertheless, the Government through its administrative machinery has a large reach compared to that of civil society organisations. Suddenly, there is a crisis which has been looming due to the poor health infrastructure, with over 160 million not having access to drinking water and over 255 districts identified as water stressed in the country. This pandemic will severely strain water resources further. The existing inequalities in access to health services have worsened because there is overwhelming reliance on the private sector due to poor public provision. Nearly 400 million people have been pushed into poverty through loss of wages and jobs, and there will be uneven impacts coinciding with class, caste, and gender inequalities (Countercurrents Collective 2020). The social determinants of health in India are unfavourable to the health and nutrition status of women and this impacts their resistance to infections in general and COVID-19 in particular. As families get pushed into poverty, there is a fear that a number of children will be forced into child labour. With the pandemic, India's poverty rate will rise to 46.3% more than twice the levels prevailing in 2011-2012. The total count of poor people is predicted to rise to 623 million in a population of 1.37 billion (Saini 2020).

The 'rights' of workers, Adivasis, women, and minorities are constantly under threat, and in the name of controlling the pandemic, democratic processes are being dashed. Measures for doing so include taking the ordinance route to changes in labour laws, diluting the provisions of the Right to Information Act, and the suspension of civic rights. These all form major challenges for social work practice.

Implications for social work professionals

Critical challenges for social workers include:

Food security. There is an increased focus on poverty alleviation work to be initiated and continued at least for another six months both in urban and rural areas. To this end social work professionals need to work with other civil society groups to ensure that direct cash transfers are lobbied for those who lost wages and jobs in the informal sector.

Health sector work. Safety and wellbeing measures for frontline workers must be implemented strictly just as lockdown was. More advocacy, research, and policy are required to change the Government's action for ensuring the safety and wellbeing of every individual. Increased spending on the health infrastructure to deal with the pandemic is also necessary. Social workers could join frontline health workers in assisting and taking care of back-end operations so that the gaps in health services could be covered somewhat. Community level mental health services need to be initiated following the lines of barefoot psychiatry. Resident Welfare Associations could be trained by social workers to take care of those in quarantine. Social work schools and students could be associated with village or urban cluster quarantine centres for dealing with the pandemic.

Ensuring workers' wages are paid and rights ensured

Social work professionals could engage with employers for the payment of wages during the lockdown period. It must be ensured that the Government's cash transfers enter the bank accounts of workers. Social work professional bodies need to connect with other organisations in the non-governmental and non-profit realm to build alliances and networks for effective changes to be initiated. The labour laws are being changed by the state governments through special ordinances. Their passage has been protested by trade unions and led to their subsequent withdrawal. However, advocacy for more protective measures, especially for wages and cash transfers is needed.

Social work education and training

Dealing with the pandemic also calls for the restructuring of educational experiences to facilitate the teaching–learning process. This requires allowing students to pursue their fieldwork in the specific areas that they are located within, to take account of the rise in the number of coronavirus cases and further delays in restoring public transport. India is a vast country with social work teaching taking place in well over 400 institutions.

There is a need for professional social work bodies to come together. First, a common agenda focusing on 'education and training' has to be established. Second, the need to engage in authentic research practice is a must, because this enables advocacy for greater transparency and increased welfare spending.

The curriculum has to be grounded in the realities of India and this requires the 'moving of classroom teaching and learning' to the field. This also requires intense engagement by both the social work educators and the trainees. Specific semester objectives for the next six months focusing on mitigating the effect of the pandemic and lockdown need to be put in place. These focus areas could be on ensuring the survival and dignity of people, initiating and enhancing local economic activities, ensuring adequate nutrition to all (particularly among vulnerable groups), initiating community education activities, promoting mental health among vulnerable people, ensuring responsive and accountable governance mechanisms, and focusing on the inclusion of particularly vulnerable groups. These suggestions can be followed by schools of social work collectively or individually in their own context, given that this context varies from region to region. Social work schools need to network with the administration and elected bodies at the local level for effective practice. Alliance building and networking can thus be seen as another area of major focus.

Social work research

It is possible that schools of social work would research the above areas for at least another two years, whether it be student dissertations or MPhil or doctoral research. A substantial research agenda could focus on social work education, models and practices during the pandemic, during lockdown and after. Research can be conducted on how social work schools have reworked their curriculum, their design and practice in the fieldwork practicum. Research can also cover responses and relationship-building with affected communities, the evaluation of the fieldwork while incorporating inputs from the communities. Research can also be used to assess the preparation of and training in skills needed to work in such difficult times, the transformations in supervisory roles and responsibilities and preparations related to these, and the conceptual and theoretical frameworks and models associated with the fieldwork practicum. Research can also underpin international collaborations and networks for research, global collective

concerns, ideas and practices, and how these can influence the local research agenda, practice, and skills training.

Research would also be needed with regards to the following topics:

- Vulnerable groups and their coping and resilience strategies.
- New organisational forms, and governance mechanisms.
- Social communication and social relationships during and after the pandemic.
- Local knowledge in and conceptualisations of dealing with the pandemic.
- Community health and mental health approaches and practices in dealing with the pandemic.
- Renewal strategies for the local economy.
- Alliance building and networking among social work and development and health professionals.
- Human rights practice.
- Social policy practices with reference to pandemic.

Notes:

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IRAN

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Country context: Key facts and figures

Iran was one of the countries that was hit by Covid-19, early on in the pandemic. As of 3 June 2020, the World Health Organization (WHO) home page lists total cases, new cases, deaths and new deaths in Iran, as shown in Figure 1 below.

Figure 1. Confirmed Cases, 15 February–3 June (Cumulative)
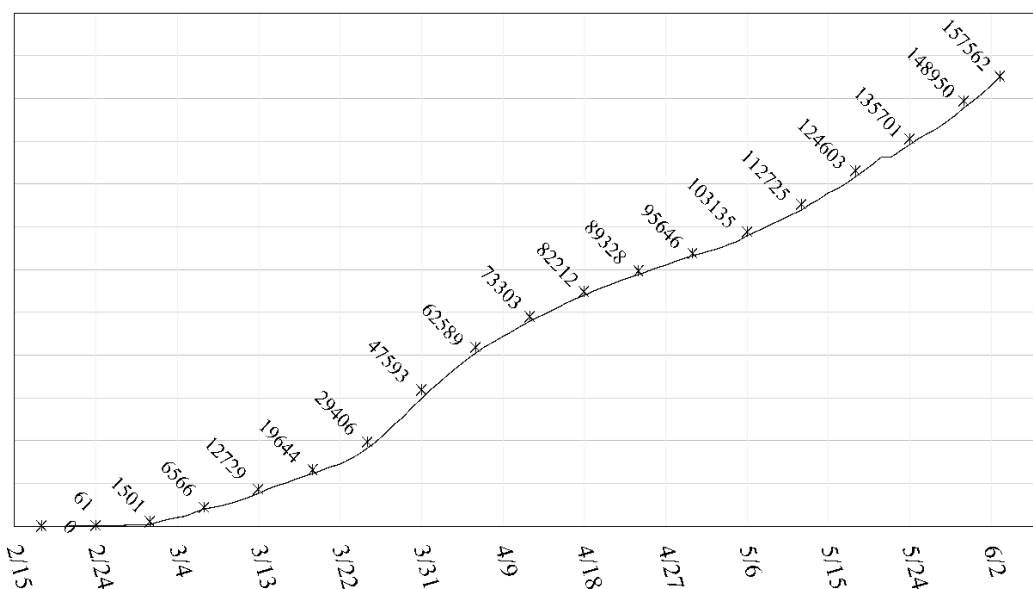
Source: World Health Organisation statistical tables

Comments

The figures given by the Ministry of Health and Medical Education have been disputed both inside and outside Iran, including by members of the Iranian Parliament (med Rxiv, 24 February 2020; Aljazeera, 25 February 2020). Michael Ryan, Chief of the WHO Health Emergencies Programme, told the press that the mortality rate in Iran indicated its outbreak might be more widespread than realised (BBC 2020a).

According to WHO Regional Emergency Director Rick Brennan, the number of cases reported in Iran may represent only about a fifth of the real numbers because testing, as is the case even in some wealthy European countries, was restricted to severe cases (Reuters, 17 March 2020). Some outside estimates of the numbers of COVID-19 deaths are much higher than those from government sources (Reuters 29 February 2020; France 24, 1 March 2020).

The Government has also been accused of cover-ups, censorship and mismanagement (Radio Farda, 5 March 2020; *The Times of India*, 5 March 2020). However, as of 2 March 2020, the CNBC home page reported the WHO as saying that it has not seen problems with Iran's reported figures (CNBC 2020).

Societal measures addressing the social consequences of COVID-19

Some sources report that Iran's leaders have resisted imposing lockdowns despite it being one of the world's worst-hit countries. They have insisted that all necessary measures are being taken. Hassan Rouhani, the President of Iran, said that there were no plans to quarantine areas affected by the outbreak, and only individuals would be quarantined (BBC 2020b). Some measures that were taken are as follows:

- Around 70,000 prisoners were temporarily released to limit the further spread of the disease within prisons.
- To prevent the spread of the coronavirus, the government has cancelled public events including Friday prayers, closed schools, universities, shopping centres, bazaars and holy shrines and banned festival celebrations (Aljazeera, 10 March 2020).
- The Ministry of Sports and Youth took steps to cancel sporting events, including football matches.
- The Ministry of Islamic Culture and Guidance announced the cancellation of all concerts and other cultural events for one week (Radio Farda 2020).
- All parks and public gardens in Iran were closed by the order of officials, and police would deny entrance (IRNA, 25 March 2020).
- As confirmed cases mounted, Iran's health minister announced that checkpoints would be placed between cities to limit travel (BBC 2020c). The government indicated that it might use force to limit travel between cities (*The Guardian*, 6 March 2020).
- The Administrative and Recruitment Affairs Organisation ruled that telecommuting would be permissible for government employees (Asr Iran, 3 March 2020).
- Rouhani announced that half of all government employees would work remotely from home (Reuters, 24 March 2020).
- Iran allowed some businesses in Tehran and nearby towns to re-open, with a third of government office employees still working from home. Restaurants, malls and grand bazaar remained closed, and school study from home has yet to be made available (France24, 18 April 2020).

Social services responses

Economic measures were announced to address financial problems of families and businesses. The *Financial Times* home page published measures that included guaranteeing bank credit of IRR (Iranian rials) 10 million (USD 61 million) to 23 million families with a 4% interest rate. This measure covered most of the country's population. It also offered low-interest-rate loans of up to IRR 20 million to lower income households as care packages.

As of 6 April 2020, the BBC Farsi home page reported that Rouhani requested the withdrawal of USD 1 billion from the National Development Fund, a move approved by the Supreme Leader of Iran (BBC Farsi 2020). Twenty percent of the country's annual

budget was to be allocated to addressing the pandemic (Tasnim News Agency, 28 March 2020).

Social work responses

The most affected groups, as defined by social workers, are the following:

- Older people.
- Women.
- Children.
- Patients with severe and chronic diseases.

Innovative and/or alternative approaches to communities, clients/service users and their needs

The Social Work Bureau of the Ministry of Health and Medical Education, with the cooperation of the State Welfare Organization, Iranian Red Crescent Society, Imam Khomeini Relief Foundation, Municipality of Tehran and University of Social Welfare and Rehabilitation Sciences, have designed Guidelines for the Psychosocial Support of Survivors and Families of the Victims of COVID-19 (Efat Bahari and Arezoo Soltani, WhatsApp message to author, 25 May 2020).

The Deputy of Treatment (Social Work Bureau) and the Deputy of Health of the Ministry of Health and Medical Education have designed guidelines for social workers, psychologists and psychiatrists for psychosocial support in care centres for COVID-19 patients (Efat Bahari and Arezoo Soltani, WhatsApp message to author, 25 May 2020).

The Social Work Bureau of the Ministry of Health and Medical Education has designed a Psychosocial Intervention Protocol Against the Coronavirus for hospital social workers (Efat Bahari and Arezoo Soltani, WhatsApp message to author, 25 May 2020).

Critical evaluation of state measures

Public trust in the authorities' capacity to deal with the virus had been undermined by the Government's initial response to the outbreak. The Government initially rejected plans to quarantine entire cities and areas, and heavy traffic between cities continued ahead of the celebration of Nowruz (the Iranian or Persian New Year), despite the Government's intention to limit travel. The Government later announced a ban on travel between cities following an increase in the number of new cases. Also, a shortage of masks and disinfectant gels, even in hospitals, has been widely reported.

The role of national associations of social workers in supporting practitioners during the coronavirus crisis.

Social workers have undertaken various roles to support practitioners during the pandemic.

- The volunteers of the Iranian Scientific Association of Social Work have designed 12 children's books for the time of quarantine for three age categories: under 6; 6 to 10; and 10 to 15 years old. The books are available to the public on this Association's website.

- A booklet on older people's care during the outbreak of an infectious disease has been designed by the Iranian Scientific Association of Social Work.
- The Iranian Scientific Association of Social Work provided an intervention programme for psychosocial support in cooperation with professional social workers, entitled *Remote Psychosocial Support*.
- Educational programmes are held online through the Instagram page of the Scientific Association of Social Work of Iran.
- The Iranian Association of Social Workers has released the contact numbers of some experienced experts (social workers or related specialists) to provide expert and supervisory advice and technical assistance in various fields across the country, if needed. These individuals work voluntarily, free of charge, to help experts in the context of the coronavirus crisis.

The situation is an evolving one, but social workers in Iran have risen to the challenges posed by COVID-19.

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IRELAND

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Country context: Key facts and figures

Population and population density

The Republic of Ireland (hereinafter 'Ireland') is located in the North Atlantic and shares a land border via Northern Ireland, with the United Kingdom. The total population of Ireland is 4,921,500 (Central Statistics' Office estimate as of April 2019) and it has a population density of approximately 70 people per km². Ireland is a largely rural country with larger urban pockets surrounding its major cities of Dublin, Cork, Galway and Limerick. The density average in 2016 was 2,008 people per km² in urban areas and 27 people per km² in rural areas (Central Statistics Office 2020).

Number of infectious cases and time period

Table 1 below depict the situation regarding the spread of COVID 19 according to setting.

**Table 1. Notified number of clusters/outbreaks COVID-19 by location and
HSE to 4 June 2020**

Outbreaks of COVID-19

Table 6: Number of clusters/outbreaks COVID-19 by location and HSE area notified to midnight 04/06/2020

Outbreak Location	E	M	MW	NE	NW	S	SE	W	Total
Other*	21	14	51	26	9	81	31	33	266
Nursing home	123	16	13	38	5	10	16	36	257
Residential institution	112	12	6	16	4	19	10	5	184
Hospital	60	3	2	14	2	12	3	6	102
Workplace	8	5	5	14	1	8	3	3	47
Comm. Hosp/Long-stay unit	4	4	2		4	6	5	4	29
Total	328	54	79	108	25	136	68	87	885

*Other outbreak location includes all outbreaks locations other than residential facilities, acute hospitals and workplaces. This includes community, extended family, hotel, private house, public house, retail outlet, travel related and all other locations.

Source: National Public Health Emergency Team, 6 June. On https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casesinireland/epidemiologyofcovid-19inireland/COVID-19_Daily_epidemiology_report_(NPHET)_06062020_final_website.pdf

Ireland's first case of COVID-19 was diagnosed on 29 February 29. This was a single case. At time of writing (8 June) there have been 25,159 diagnosed cases. Of these, 57% are women and 43% are men, the median age of confirmed cases is 48 years with a mean of 51 years (Range 0-106 years). Of confirmed cases of COVID-19, there have been 3,319 cases (13%) that have been hospitalised and 410 have been admitted to Intensive Care Units (ICU), and Ireland has experienced 1,417 COVID-related deaths. Dublin, Ireland's largest urban centre accounts for almost half (48.2%) of all confirmed cases. Community transmission of the virus accounts for 39% of all cases with close contacts and travel abroad accounting for 59% and 2% respectively. Clusters are defined as being linked to the same space and time and outbreaks are linked to a common source. Ireland has recorded 885 COVID-19 clusters or outbreaks across several settings:

Number of deaths (on 8 June 2020).

Since Ireland's first case on 29 February, there have been 1,679 COVID-related deaths, 1,417 of these are confirmed as being related to COVID-19 with a further 160 'possible' and 'probable' COVID-19 deaths. There are no reliable statistics detailing confirmed COVID-19 related deaths across settings.

Comments

At time of writing, the death rate in Ireland has slowed and in recent weeks the State has been reporting deaths in single digits. Daily confirmed cases have also fallen alongside ICU (Intensive Care Unit) bed admission and hospitalisation. This has led to an acceleration in Ireland's phased 're-opening' plan. While there are no reliable statistics in respect of a breakdown of the death rate across settings, it is possible to hypothesise from the outbreak/cluster Table 1 above and media coverage in Ireland, over the past two months, that nursing home settings have accounted for a large proportion of deaths. Specific concerns are also being voiced for those in other residential and secure accommodation such as residential childcare settings, emergency homeless accommodation, and direct provision, e.g., asylum seeker accommodation.

The Irish independent Health Information and Quality Authority (HIQA) has recently reported that they have received 280 complaints regarding nursing home facilities in the first two months of lockdown. While many of these reports are redacted and not available to the public, the *Irish Times* (8 June2020) has reported that 48 complaints related to poor infection control, 43 to poor communication and 23 regarding inadequate physical distancing within nursing homes. There have also been concerns expressed regarding the redeployment of nursing home staff to other 'frontline' duties such as contact tracing, leading to an absence of experienced and familiar staff attending to residents.

Societal measures addressing social consequences of COVID-19

The extent of isolation

The first case of COVID-19 was confirmed in Ireland on 29 February, and this was a single case. On 12 March, the Irish Government closed schools and childcare settings, tertiary level colleges and universities and public buildings such as libraries, museums and

offices. Mass gatherings were also restricted at this time including music concerts and sporting events. This resulted in significant loss of employment with some sectors, such as early years childcare and the hospitality sector, was particularly hard hit.

Movement was restricted to within a 2km radius from your home. Movement within this radius was for individual physical exercise individually or within family groups, to attend essential appointments or to get essential food and supplies. Physical distancing of 2 metres was also imposed at this time with strong recommendations and guidance regarding cough hygiene, handwashing and use of sanitisers. Personal movement was initially restricted to within 2km except for the use of essential services. On 28 March, the Government of Ireland published a list of essential services including the following:

1. Agriculture and Fishing.
2. Manufacturing.
3. Repair and installation of Machinery and Equipment.
4. Electricity, Gas and Water.
5. Construction.
6. Wholesale and Retail Trade.
7. Transport Storage and Communication.
8. Accommodation and Food Services.
9. Information and Communications.
10. Financial and legal activities.
11. Professional, Scientific and Technical activities.
12. Rental and Leasing Activities.
13. Administrative and Support Services.
14. Public Administration and Defence.
15. Human Health and Social Work Activities.**
16. Community and/or Voluntary Service.

**Social work and social care activities, defined as 'essential services', included disability services, mental health, child protection and welfare, domestic, sexual and gender-based violence, medical settings and homeless services including outreach ones (Government of Ireland 2020).

State measures to address social problems and needs

Immediately following the introduction of restriction measures in response to COVID-19, on 15 March, the Irish government introduced the COVID-19 Unemployment Benefit, also known as the 'Pandemic Unemployment Payment' (PUP). This is a social welfare payment originally introduced at a rate of 203 Euros per week, which was increased to 350 Euros per week on 24 March. Any employee or self-employed person who lost their job due to the COVID-19 public health emergency is eligible to apply for the payment and it remains in place at the time of writing. Illness Benefits for COVID-19 related absences were also increased to 350 Euros per week and an existing six-day waiting period was abolished (Beirne et al. 2020). This was not a means-tested benefit and individuals could apply for this payment on-line. This measure is due for review on the 8 June 2020. The Government also introduced the COVID-19 Wage Subsidy Scheme for businesses and/or employers to supplement or fund the wages of employees.

At the start of May 2020, over 598,000 people were receiving the COVID-19 Unemployment Benefit. Together with the numbers of people already unemployed at the

start of the pandemic, on the 1 May 2020, there were 1.23 million people relying on the state for part or all of their income (Wall 5 May 2020).

The Department of Justice and Equality launched a public awareness campaign on domestic violence during the COVID-19 pandemic on 10 April 2020. This campaign involved collaborative work between the state and voluntary sector services, newly created TV and radio advertisements and additional funding provided for services that were working with victims. Initiatives included, for example, the provision of additional practical support by Tusla (the Child and Family Agency), prioritising of domestic violence cases by the Gardai (national police service), the Legal Aid Board and the Courts and the provision of additional funding for advice lines for women and men. A dedicated website was also launched with provided practical information on domestic violence and links to specified domestic violence responses services and information (see www.stillhere.ie).

Status of social welfare services, authorities and professionals in media

In general, the media focus on social work in Ireland is confined to children and family services and more specifically on child abuse cases. Journalists, such as Mary Raftery, have played a key role in unveiling child abuse in residential care in Ireland and some journalists provide nuanced coverage of social work issues in the country (Gaughan and Garrett 2011). More recently, media coverage of the 'Grace Case' in Ireland led to a watershed moment in the public and private sphere in Ireland (Hughes and Houston 2019). The Grace case involved a woman born in 1978, who, as a child and vulnerable adult, was subjected to a long period of severe abuse by her state appointed foster carers, even though concerns had been raised throughout Grace's placement. In an analysis of 40 newspaper articles published about the Grace case in the period February 2016 to October 2017, Hughes and Houston (2019) found that social workers were not given the opportunity to shape much of the discourses surrounding the abuse of Grace and had little involvement in contributing any insights into social work specific roles and responsibilities (Hughes and Houston 2019). Interestingly, although some articles in the Hughes and Houston (2019) study referred to the public service role of the social work 'whistle-blowers' whose actions lead to the inquiry into the Grace case, politicians were in the ascendance in the management of the narrative about Grace as the shocked moral arbiters questioned both the length of time it had taken to identify those involved and the system of child protection and child care.

Comments

The above is just one example of the representation and status of social workers in the Irish media. In addition to this, at the time of writing, the Irish Government is in a state of transition, with an outgoing Government currently in a 'caretaker' role as Government formation talks continue. As part of these negotiations, the Irish Department of Children and Youth Affairs, which oversees a budget which encompasses child welfare and protection services, sexual and gender based violence services, youth and family support resources and primary and early years and educational welfare, is in line to be merged with the Department of Education. This move risks a further silencing of the social work voice.

Social services responses

Children and Family Services

On the 1 January 2014, Tusla, the Child and Family agency, under the Child and Family Agency Act 2013 became an independent legal entity, distinct and separate from the Health Service Executive (HSE), the national public health service provider. Tusla is the dedicated state agency responsible for improving outcomes and wellbeing for children. This national statutory agency includes Children and Family Services, the Family Support Agency and the National Educational Welfare Board as well as incorporating some psychological services and a range of services responding to domestic, sexual and gender-based violence. The Family Support Agency, now part of Tusla, assists 107 Family Resource Centres throughout Ireland to provide counselling services for those experiencing marriage or relationship difficulties or bereavement, and for children experiencing bereavement or parental separation.
The Health Service Executive (HSE) is the state agency that is required to provide services to adults and children needing health and social care, specifically, the Medical Care, Social Welfare, Adult Mental Health and Child and Adolescent Mental Health services. Social workers are employed in different roles in the children, family and health services in Ireland and all were affected by the spread of Covid-19.

The mode of operation of social services in times of coronavirus measures

Tusla, the National Child and Family Agency in Ireland, continues to provide key services across core areas that support children and families at risk during COVID-19 including: child protection and welfare services; services for children in care, and domestic, sexual and gender based violence services, together with voluntary and statutory partners and funded agencies. Social workers and other Tulsa practitioners have also been working with local partners and organisations to develop creative solutions to help children and families during the pandemic. Emergency child protection assessment and intervention work has continued throughout this period (www.tusla.ie/about/covid-19-update/).

   Staff members in Tusla have also been involved in various local initiatives around the country. For example, in the west of Ireland, Tusla co-funds the provision of homelessness, senior support and domestic violence services which continued to operate throughout the pandemic, while operating with COVID-19 prevention, control and social distancing measures in place and the requirement for people who need to access their services to first use the contact phone numbers for these services (www.copegalway.ie). Tusla also provided additional funding for domestic violence response services such as Women's Aid, the Rape Crisis Network and the Men's Development Network. When a domestic violence service lost staff due to restrictions following the COVID-19 pandemic, the Government committed to providing funding so that the service could employ temporary staff to replace the staff member unable to attend work (see www.stillhere.ie).

Social work responses

Most affected groups as defined by social workers

In Ireland, almost half of all deaths due to COVID-19 have taken place outside hospitals but in residential nursing homes, without access to social work palliative care or

bereavement support (Casey 2020). Child protection and welfare social workers have raised concerns about the lack of in-person parental visits, difficulties monitoring children and a withdrawal of traditional supports such as schools and sports clubs during the COVID-19 pandemic in Ireland (Kenny 2020). While social workers are deemed essential workers by the Government, the in-person services they provide have been scaled back, due to social distancing. Tusla also said there has been a 25-33% reduction in the number of referrals since the start of the COVID-19 outbreak, which leaves many people worrying that children in need are not being heard. There are concerns that the network of teachers, coaches, and extended family members, who may have referred cases to Tusla, now have less contact with families than before the COVID-19 pandemic.

One of the first issues for children in care was the question of access or contact visits between birth families and children in care. With the Government advising that people should not leave their homes, such visits became an insurmountable challenge with a lot of frightened foster carers with underlying health conditions fearing that they could contract COVID-19 as a child returned to their care after a contact visit with their parents. It is reported that some foster placements have also broken down, due to the extra stress that foster parents and children are under (Kenny 2020).

Innovative and/or alternative approaches to communities, clients/service users and their needs

Social workers are trained to provide that safe space where families and service users can express their difficulties and frustrations and solve problems to address issues within the constraints of life during the pandemic. In this situation, this therapeutic space can be provided over the phone or social media platforms while social workers also assess the crisis level and the needs for the service user and/or their family (McGuirk 2020).

Amanda Casey, a member of the Irish Association of Social Workers and Head of Medical Social Work at a major voluntary hospital in Dublin reports that social workers have brought relatives to car parks to wave through windows, supported communication via technology (and provided emotional support after the call ended) and printed out family photographs for bedside lockers. Social workers have asked families how they would like staff to care for their much-loved relative at the point of death, when a heartbroken family could be physically present and have helped to return sentimental possessions to the newly bereaved in a sensitive way. Social workers have also organised death certificates and worked with undertakers when a distressed relative needed support with planning a funeral. This is the help dying and bereaved people request, and this is the person and family centred care that the dying and bereaved in all settings deserve to access.

In relation to the rights of children in care to have contact with their families of origin, social workers report that video calling has provided a way to resolve the challenges presented by family contact in a time of COVID-19, and they believe that this will continue in the post-COVID era (Kenny 2020). A child protection and welfare social worker describes the measures adopted which include:

'A social worker can meet the parent, ring the child, and then they can talk. The child can show their parents their bedroom, the dog that they are always telling them about…this never happened before as parents never visit foster homes'.

This innovation can be more difficult when the child is an infant, but social workers have reported that new access centres have been set up, which are cleaned after each visit, and there is not the multitude of staff using the venue as there was before. Other innovations reported by social workers include garden visits or allowing older children to walk around outdoors with their parents while maintaining two metres distance (Kenny, 2020).

Social workers around the country adopted a range of innovative practices in response to client/service user needs during the COVID-19 pandemic. Some of these were shared with up to 700 social workers who logged on to a webinar hosted by social work academics and practitioners through the University College Cork on the 3 June 2020. A padlet resource was created enabling the easy sharing of tools and information among social workers and clients/service users (Burns and Ó'Súilleabháin 2020). Mental health social workers and psychotherapists adopted online platforms such as WhatsApp to provide support and counselling sessions for clients/service users (Healy 2020). Social workers and other practitioners provided parenting support programmes to parents/carers or to adolescents through social media platforms such as Zoom or WhatsApp (Sharry 2020). Some social workers and other practitioners provided a structured intervention such as the Non-Violent Resistance Model for child to parent violence and abuse through telephone or social media platforms (Harrington 2020). Other social workers used social media platforms and blogs to engage in social work activism and information/resource sharing (Cuskelly 2020; Mooney 2020). Some social workers and other practitioners developed guidelines for the facilitation of online or telephone support for parents and/or carers living with violence at home through the use of, for example, the Non-Violent Resistance Model (Coogan and Lauster 2020; Coogan et al 2020).

Main obstacles to approach and support communities and clients/service users
-
The children, families and adults usually served by social workers have been impacted by the closing of Day Services, Social Clubs and Residential Respite Services where vulnerable persons and their families received significant support in dealing with their already substantial life challenges. For example, some of the services that have been closed include day services for persons with physical, intellectual, and sensory disabilities; group support and treatments for persons with mental health conditions; day services and community support for older persons living alone. These examples do not include the considerable individual and family support that social workers provide to the users of services run by the state and voluntary sector that have been impacted by measures taken in response to COVID-19 (McGuirk 2020).

Key obstacles to providing social work support and services to clients/service users and communities during the COVID-19 pandemic included the lack of access to reliable WIFI or broadband coverage in some areas, the lack of access to laptops, computers or phones, in some cases due to poverty, and the different policies in some organisations regarding the use of some social media platforms (Sharry 2020; Healy 2020).

Critical evaluation of state measures

During the initial stage of lockdown public support for the Government's decision was strong and by and large the Irish people adhered to physical distancing, restricted movement, and travel for essential services only. While it is too early to say, definitively,

how effective these measures have been, it is clear from the daily statistics that the death rate, hospitalisation, use of ICU beds and community transmission are all reducing.

The role of national associations of social workers in supporting practitioners during the coronavirus crisis

In Ireland, social workers work under the Social Work Registration Board (SWRB) at CORU, the multi-profession health regulator. 'Social work' is a protected title in Ireland and no one can work as a social worker unless she/he is registered with the SWRB. Established in 1971, the Irish Association of Social Workers is a professional association representative of social workers in Ireland with a membership of over 1,300 individuals (see www.iasw.ie). Its aims include increasing access to information and support for social workers, facilitating social workers in meeting the SWRB requirements of continual professional development activities and enhancing the public profile and perception of social workers. The Irish Association of Social Workers (IASW) is an active member of the International Federation of Social Workers. The IASW is also an active member of the Children's Rights Alliance which unites over 100 organisations and individuals committed to changing the lives of children in Ireland by making sure children's rights are respected and protected in Irish laws, policies and services (www.childrensrights.ie/alliance-members). On 27 March 2020, the Children's Rights Alliance called on the Irish Government to provide targeted resources for families and children at risk during the time of COVID-19, particularly for children living in families where there is domestic violence or problems with addiction, families living in direct provision centres and children who would usually obtain free school meals (Ward 2020).

   The Irish Association of Social Workers has supported social workers throughout the crisis through the development of a dedicated webpage (https://iasw.ie/page/568) with links to resources developed by members on, for example, the role of social workers medical social workers during the crisis, providing on-line support for parents and/or families, and the procedures for using video and audio conferencing. The same IASW website also provides links to resources relevant to social work practice from sources such as the International Federation of Social Workers and from the British Association of Social Workers. The IASW provided regular chat-room sessions where social workers could log in and join in a facilitated conversation about the impact of COVID-19 on their work. With funding from the Department of Children and Youth Affairs, the IASW launched a national survey on the impact of COVID-19 on social work practice and the support, if any, made available by employers to social workers working from home. The IASW has also advocated with the Government, the Health Service Executive and with Tusla, the National Child and Family Agency, with examples of advocacy letters and service needs during the COVID-19 pandemic. These are outlined at https://iasw.ie/page/568

Concluding comments

The toll of COVID-19 on individuals, communities, nations, and the globe has yet to be established. Scientific evidence tells us that we should expect a resurgence or 'second wave' of the pandemic in times to come. Our learning from and experiences of this initial wave is essential, so that we are best prepared for what the future holds. Social work, an essential frontline service, is at the forefront of this pandemic and is uniquely positioned to offer support and innovation across all our socio-ecological layers, from micro to

macro levels. The toll, while not yet counted, will most likely see: an escalation in mental health issues; a backlog of child protection and child welfare concerns; a fall out from a noted rise in domestic violence (whose extent is yet unknown); impacts related to the inability of families to attend funerals; fathers unable to attend maternity wards; and children at developmentally and educationally sensitive stages absent from school. As communities and families turn to one another for support and solace, it is imperative that governments and state services position 'care' as a core aspect of our re-opening and re-building.

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ITALY

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Country context: Key facts and figures

Italy has a population of 60,359,546 inhabitants and a density of 199.82 per km^2 (official data, 2018). The confirmed number of cases of coronavirus on 25 May 2020 were 230,158. The number of deceased persons is 32,877 (14,3%). The latest data analysis, on a sample of 31,096 deceased persons, indicates that the average age of the deceased person is 80 years; the highest number is concentrated in the 80-89 age group. Only 1.1% of deaths are under 50 years of age. Most of the deaths (50.4%) occurred in Lombardy, the biggest region in northern Italy, which is the most affected by the coronavirus (Istituto Superiore di Sanità 2020). According to a survey conducted in the period February to April 2020, care homes for older people accounted for 40.2% of deaths attributed to the coronavirus. Pending official data on the proportion of deaths in homes for older people, several newspapers have published estimates at the European level: more than 50% of deaths occurred in homes for older people.

Italy is one of the European countries most affected by the coronavirus. However, there are great differences in the national territory: the northern regions of Lombardy, Piedmont, Emilia-Romagna and Veneto in particular, are the most affected. In southern Italy the number of infections has been much lower; today (end of May) in several regions there are no more new infections. The health service, which in Italy is organized by the regions, has many difficulties and there are differences in emergency strategies.

Societal measures addressing social consequences of COVID-19

For about 2 months (14 March to 17 May 2020) in Italy there was a very strict lockdown. It was only possible to go out for health, work and urgent needs such as buying food, short walks near home to get air. The workplaces remained closed. Only hospitals, industries of food and other strategic sectors, food retail and essential services such as the public bus services were open. The penalties for breaking the rules were administrative sanctions from a minimum of 400 Euros to a maximum of 3000 Euros. As of 18 May there has been a progressive loosening of the lockdown. Today, people are allowed to move around their whole region, but moving between regions is not yet permitted. If a distance of at least one metre is not possible, a mask is mandatory. The Italian Government has provided for emergency measures to support people forced to interrupt their work, with a bonus of 600 Euros per month. The Government has also provided for the possibility of low-interest loans and the suspension of certain taxes. Aid from the European Union is being defined. Civil Protection (a government organisation) and local volunteers have provided primary aid for the most disadvantaged people. The Government has also established that social services support the national health service: 600 social workers,

will be hired in specific care continuity units to carry out multidimensional assessment activities. The media have always appreciated the importance of health and social professionals. Representatives of these professionals, among them the President of the National Association of Social Work, claim the need for stable support for those professionals (Gazzi 2020).

So, in order to deal with the emergency, two types of intervention have been activated: measures to impose social distancing, and economic interventions. Some categories of workers, such as shopkeepers, barmen, hairdressers and barbers, have complained that the lockdown was too long. My opinion is that not all the population has understood the seriousness of the situation and the importance of putting health protection before economic gain. It should be pointed out, however, that the vast majority of citizens have behaved responsibly. The whole population consider as heroes those doctors and nurses who have treated so many people. Sometimes these professionals sacrificed their lives in the course of their duty. The number of cases of coronavirus infection among healthcare workers in Italy reached almost 28,000; the number of doctors who died is more than 150.

Social services and social work responses

Due to the coronavirus, the social professions have been facing unpredictable situations for the past two months. The older people, the most fragile and vulnerable in these terrible days, told us that they feel like they did at another time: the years of the last World War, when they were little more than children. Restrictions, fear of death, uncertainty about tomorrow, are some of the memories that emerge. The image of the war is very strong, perhaps too strong for some of us, but it is still useful for us to understand and reflect upon these insights.

A recent article that argues that the American coronavirus pandemic is more difficult than that in Europe, calls for an immediate social work response to the situation (Walter-McCabe 2020). Their daily working life indicates that many professionals working in the social services system are putting themselves at risk. They are facing the difficulties encountered during these weeks, each with their own skills, with their own commitment, and each with their own spirit of initiative. As a social worker, I feel like reporting the voice of many colleagues, thinking about one of the fundamental imperatives of this moment in this country. That is, to take into account the rules to which all citizens must adhere for the collective good and the right to health of all (including avoiding travelling away from the home as much as possible); and to combine these with what I can do to carry on, at least partly, in my work.

What I have observed is that, in coping with the emergency, colleagues have reacted by developing strategies that, on the one hand, guarantee essential performance and, on the other, strengthen internal cohesion. In times of emergency for social workers, as for all helping professionals, it is important not to get stuck on the procedures usually used in providing services. We need flexibility, enterprise and creativity to think about how we can usefully be using the limited tools available in the moment.

We were equipped, in a very short time, with smart working, which alternates with face-to-face work which was reduced to a minimum. Smart working is now being used by many professionals. Day after day, they are reinventing work tools, experimenting with new practices, new channels of communication. Telematic tools, personal computers and/or smartphones are being used. Through these, listening to others is possible, relationships can be maintained with people being followed up, discussions with

colleagues and inter-professional work between the different service providers is being carried out. Even at a distance, it is possible to make comparisons and work with others in solidarity. Managers and colleagues of social services workers report that some collaborations have increased. For example, with voluntary workers and civil protection, new initiatives have been implemented in order to respond to the needs of the moment and the organization of the same services has been done with systematic comparisons that have allowed a precise assignment of tasks, so as to avoid overlapping provisions.

The use of telematic tools has also resulted in some resistance and scepticism which is being overcome and is having positive evaluations from those operating these. It is considered constructive and is allowing new opportunities to be taken and for unexplored paths to be followed.

There is no lack of problems, such as concerns about openness to the public, for the correct receipt of the necessary documentation so as not to interrupt the necessary administrative procedures. One can perceive from the confrontation with colleagues and also from the positions taken by the entire professional community, that the importance of helping to spread correct information is felt very much. The social secretariat, sometimes a little 'forgotten', finds in these difficult days a vital and indispensable space.

At the centre, in these days of quarantine that can drive away or in any case make help more difficult to obtain, there is the concern for weaker people, such as lonely people, those at risk of domestic violence, those who have physical and mental health problems including mandatory health treatments for psychiatric patients, for example, increased during lockdown. Then there are the individual pathways of care that risk being interrupted or in any case to suffer unexpected and difficult 'diversions'. I think, for example, of the consequences of the meetings suspended in a neutral place between parents and children, of territorial education for minors, and services for disabled people.

Drawing inspiration from the operational areas of which I have more direct knowledge, it is inevitable to ask, 'What happens to the socio-rehabilitative pathways?' In the field of criminal justice, suspension is a probable scenario, sometimes for objective reasons, such as not being able to go to work, which can underpin alternatives to prison, such as probation. Social workers must face problems like this. The relationship between social work and support, prefigures the foreshadowing with the person, resumption of the interrupted path, and redefinition of a project. Today, responding to these issues requires that social workers consider perspectives and approaches that are different from those of yesterday.

Then there are the primary networks of people. Think of the relatives of prisoners, for whom visitation in the jail with relatives have been suspended. Here too, information and support, in fundamental collaboration with the educators of the penitentiary system, assume a crucial role. For example, these can give the prisoners whose face to face interviews with relatives were interrupted and replaced by intensified telephone calls, messages about what is being done to deal with the emergency. Doing so is necessary so as not to interrupt paths aimed at reintegration into the socio-family context. Organizations have sought formal ways to speed up some procedures through decrees and circulars, for example, to allow those who are at the end of their sentences to be released from prison (another place of emergency now) to access home detention.

Among the many services that work in difficult situations, unthinkable until a few weeks ago, I can mention services for drug addictions. They have reduced routine interventions in order to guarantee those interventions that cannot be postponed, saving hours for the team (doctors, nurses, social workers and educators) who will have to go and replace quarantined staff in the hospital. For example, social workers and educators

will be able to take care of those aspects of triage that are not strictly medical. Also, here we need flexibility, in a reality in which hierarchical roles seem to be 'suspended' and in which we rediscover a solidarity that, in desperation, is extraordinary.

In this emergency, more than ever, we are focused on the 'here and now' and putting aside everything that can be postponed. Yet, it is important to think about the post-coronavirus period. There will be an overall problem of the system's resilience. Today, we cannot predict the damage and consequences for future scenarios, whether economic, social or health. We will certainly have to face up to a situation of difficulties and serious shortcomings. It can be assumed, for example, that people can count on special funds to the end of the emergency phase, when (and if) it will be possible to reopen and return services to a normal situation.

Returning to the initial image, that of war, sooner or later it will be necessary to think about reconstruction. The history of social services indicates a lot about this. Perhaps proactive reactions and attitudes to what is happening may be useful. It will be necessary to stop and think about the profession, recovering also the 'human' dimension of time. Perhaps facing the emergency is rediscovering those values and professional action that bureaucratic 'sclerotization' and frenetic work have often overshadowed. Perhaps this critical period will open our eyes and make us 'see' resources that have often been overshadowed. Moreover, for services and the social work profession, today's experience can be an opportunity to be better prepared for future emergencies.

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JAPAN

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Country context: Key facts and figures

Population and population density

Japan consists of four main islands, Hokkaido, Honshu, Shikoku, and Kyushu, and nearly 6,800 smaller islands (1). The total land area of Japan is approximately 378,000 square kilometres (2). The largest island, Honshu, is approximately 228,000 square kilometres and is the seventh largest island in the world.

The population of Japan is estimated at 126,144,000 as of 1 December 2019. Japan has 47 prefectures, and each prefecture is governed by a local administration. The population density of the country is 340.8 persons per square kilometre. However, urban areas like Tokyo, Osaka, Aichi, Fukuoka, Kanagawa, Saitama, and Chiba prefectures, have a much higher density of more than 1,000 persons per square kilometre.

Table 1. The population by age and sex, as of December 1, 2019, Final estimates

	Both	Male	Female
Total Population	126,144,000	61,401,000	64743,000
Percentage distribution of age groups (%)			
Under the age of 15	12.0%	12.7%	11.4%
Age of 15-64	59.5%	61.9%	57.2%
65 and over	28.5%	25.4%	31.4%
75 and over	14.7%	11.9%	17.3%
85 and over	4.7%	3.0%	6.3%

Source: Statistics Bureau of Japan, Ministry of Internal Affairs and Communications

The number of COVID-19 infections and the time period.

On 16 January 2020, the first COVID-19 case was confirmed in Japan. This was followed by a large number of infections aboard the Diamond Princess cruise ship. In its report, the Ministry of Health, Labour and Welfare (MHLW) released the information that there were 21 COVID-19 positives, including six Japanese aboard the ship. As of 12 February, out of 492 people that were PCR (polymerise chain reaction) tested, 174 tested positive. On the same day, the MHLW released information that among 16 people, a Japanese person tested positive for COVID-19.

The first death in Japan was reported on 14 February. In February, infections spread rapidly in mainland Japan, with the number of symptomatic COVID-19 positive individuals rising to over 200 by the end of the month. The current report shows the number of COVID-19 positives in Japan as 16,884 people.

Table 2. COVID-19 infections in Japan calculated by MHLW as of 31 May 2020

	PCR tests 1*	COVID-19 Positives	Hospitalization		Dispatches	Mortality	Monitoring
				Severe cases			
Cases 2**	246,100	16679	1436	115	14333	892	22
Quarantine at the airports	45,640	190	36	0	154	0	0
Returners by chartered vessels	829	15	0	0	15	0	0
Total	292,569	16,884	1472	115	14,502	892	22

 *1 Several local authorities have counted cases differently when releasing the number of cases.
**2 Source: Local authorities' press-releases.

Number of deaths in specific settings

There are no official reports on the number of COVID-19 deaths in care homes for older people, nor child residential services in Japan. However, the MHLW released reports on 31 March of 'clusters' in medical institutes and social work service institutes for older people, disabled people, and children. The 'clusters' refer to places where a COVID-19 positive individual came in contact with more than five people around the same time. The MHLW reported that fourteen clusters occurred in eight prefectures: Hyogo, Ibaraki, Gunma, Kanagawa, Chiba Tokyo, Aichi, and Oita.

Comments

Japan is currently deemed a 'super-aged' society. In the light of reports that senior citizens are the high-risk group with regards to COVID-19 (Ausubel 2020), the MHLW and local authorities have repeatedly alerted social work service providers on the importance

of raising awareness on hygiene since February. Fourteen clusters appeared, and the data indicate that Japan had nearly faced the collapse of the healthcare system. The facts suggest that Japan is in a period of lull just before the second severe wave of COVID-19.

During the first wave, the number of people identified as COVID-19 positive, and who were forced to wait for hospitalisation increased by more than three hundred in April. Some quarantine measures have been taken to contain the spread of COVID-19. Additionally, there have been some reports of infection with no apparent routes of transmission. Figure 1 in Appendix One below shows the transition of COVID-19 cases testing positive in hospital. The number of new COVID-19 cases testing positive were reported over 1,000 in April, and it may be that the peak of the 'first wave' had been reached at the end of April 2020 (see Figure 2 in Appendix One).The Japanese government has begun to respond to the serious allegations that it has conducted fewer tests for the virus than other countries. Japan has lost 892 people due to COVID-19, as of 31 May 2020.

Societal measures addressing the social consequences of COVID-19

31 January. In response to the WHO's Public Health Emergency of International Concern (PHEIC), the government announces that it would take the necessary measures (Ministry of Health, Labour and Welfare, 2020).
1 February. Notification for the establishment of a consultation centre for returnees and contact persons. Individuals with respiratory symptoms or fever of 37.5°C or higher and a history of travel to Hubei province, including Wuhan, within the preceding two weeks, to be classified as suspected cases of infection.
2 March. Paid subsidies (up to 8,330 Yen per day) for workers who take temporary leaves of absence from elementary schools, etc., until the end of March.
6 March. Request various organisations to retain employees (Ministry of Health, Labour and Welfare), and special measures to provide subsidies for employment adjustment.
26 March. A governmental task force was established.
7 April. The Head of the Government Task Force declared a state of emergency under Article 32(1) of the Act. The period for implementation of emergency measures is 29 days, from 7 April to 6 May, applicable in 7 prefectures, Saitama, Chiba, Tokyo, Kanagawa, Osaka, Hyogo, and Fukuoka. On 16 April, 6 additional prefectures: Hokkaido, Ibaraki, Ishikawa, Gifu, Aichi, and Kyoto, were included in this list because of the spread of the infection. The remaining prefectures were added to the list in view of minimising the movement of people. The period for implementation of emergency measures in these areas was from 16 April to 6 May, which was subsequently extended until 31 May.
20 April. Special fixed benefit payments of 100,000 Yen per person became available.
23 May. It was decided that, 'Emergency measures need not be implemented in all prefectures'. In the past, clusters were identified in indoor facilities such as restaurants, live houses, bars, gyms, and athletic classes. However, outbreaks have now been observed in medical and welfare facilities as well.

General policy for dealing with the new coronavirus infections by the government

After the state of emergency is lifted, the level of socio-economic activity will be raised gradually, while easing requests for voluntary restraint on going outside, restrictions on the use of facilities among others., by setting a certain period of transition. These moves

will take into account the situation regarding the infection in the region, the status of securing medical care provisions, and health systems, on the assumption that a 'new lifestyle' to prevent the spread of infection will take root. At that time, the prefectural governors need to make appropriate decisions because infection status would show region-wide variations. In addition to establishing a 'new way of life' to prevent the spread of infection, the government will encourage businesses to implement guidelines for the prevention of the spread of infection that are formulated for each industry.

As the further spread of COVID-19 remains a possibility, the status of infection will be continuously monitored by establishing a surveillance system and providing and sharing appropriate information. In addition to making all possible preparations to maintain the healthcare system in case of an outbreak of infection, the government will work to improve inspection measures, strengthen the healthcare system, and undertake measures to contain the spread in the clusters. Through appropriate measures, it will be possible to achieve both the prevention of the spread of infection and the maintenance of socio-economic activities on a sustainable basis. If the spread of infection is detected again, strong measures will be taken to contain the spread as soon as possible.

The following items are of particular importance for the government's implementation of the new coronavirus infection control:

- <u>A call to avoid discrimination</u>. Discrimination is based on misunderstandings and prejudices against infected persons and persons in close contact with them, as well as medical institutions, medical personnel, and others involved in countermeasures.
- <u>Avoid eating with people other than family members</u>. This time, the government will make it known that it would not implement measures such as 'lockdowns' (urban blockades), and called for a calm response from the public such as voluntary restraint of movement across prefectures, non-essential return trips and travel, avoiding crowding at public places and preventing hoarding.
- <u>Seek cooperation from citizens in refraining from leaving their houses.</u> Specific prefectures should continue to encourage people from leaving their homes in accordance with the government guidelines, to 'reduce contact opportunities by at least 70% and as much as 80%'. Encouraging residents to avoid movement between prefectures, as much as possible, for example, when returning home or travelling for non-essential reasons. In addition, people of all ages are urged to refrain from going out to restaurants in downtown areas, where clusters have been reported to date.
- <u>Restrictions on organising events</u>. Specific prefectures shall request voluntary refraining from holding events and functions or large gatherings that may cause clusters, in accordance with the law.
- <u>Restrictions on the use of facilities</u>. The first step is to make a request for cooperation under the law, and if the request is not complied with, without justifiable reasons, the second step shall be to make a request under the law, followed by a directive under paragraph 3 of the same article of law, and to publish these requests and directives.
- <u>Attendance at work</u>. Specific prefectures should encourage business operators to take the following measures: Strongly promote telecommuting and rotating work even in workplaces where attendance is required to reduce chances of contact, including the aim of reducing the number of attendees by 70%.
- <u>Handling of schools</u>. The Ministry of Education, Culture, Sports, Science and Technology (MEXT), in light of the 'new way of life', will disseminate the code of conduct for schools and specific measures to prevent infectious diseases, as indicated

in the 'Manual for the Hygiene Management of New Coronavirus Infections in Schools' and other documents.

- <u>Reduction of childcare and temporary closures of childcare centres and after-school children's clubs.</u> The Ministry of Health, Labour and Welfare (MHLW) announced its policy on reducing childcare places by temporarily closing childcare centres and clubs. In this regard, the MHLW will demonstrate the concept of scaling back the provision of childcare, such as asking parents who can afford it to refrain from visiting the preschool, and taking temporary breaks while reserving childcare for the medical professionals, who need to continue working to ensure that society remains functional, and children of single parents who have difficulty taking time off from work.
- <u>Lifting emergency measures</u>. After the declaration of the state of emergency, prefectures will take measures to lift the coronavirus threat. Until the 'new way of life' takes root in the entire society and economy, a certain period of transition will be set aside, and a gradual easing of requests for self-restraint from going out, restrictions on events, restrictions on the use of facilities will be made while the situation is assessed for the risk of spread of infection approximately every three weeks.

Other government-initiated measures point out that social workers will be involved in implementing are:

- Consideration for human rights, and response to various social issues.
- The transmission of the new coronavirus infection can occur to anyone, so it is crucial to ensure that information about the status of infection does not create a negative image for a particular individual or community. In particular, there have been cases where the human rights of patients, infected persons, their families, and people involved in treatment and countermeasures have been violated. The government will take appropriate measures to prevent such situations from recurring.
- The Government shall implement necessary measures such as support for schools to accept children who have temporarily returned home from overseas and the prevention of bullying. Implementing these measures will involve social workers.
- In implementing various measures, the government and related organisations shall minimise the restrictions on the freedoms and rights of the people and shall give due consideration to the impact on women and persons with disabilities.
- The Government will implement the necessary measures such as spreading awareness to the public, so that medical personnel engaged in countermeasures against the new coronavirus infections will not be affected by rumours.
- The Government distributes two masks to each household.
- The Government, in cooperation with local administrations, will provide appropriate support to address the social issues that arise as the measures will be protracted.

    o The impact on mental health due to prolonged abstinence from going outside the house, spousal violence, and child abuse.
    o Consideration for information disclosure and cooperation with human rights.
    o Bankruptcy, unemployment, and suicide, due to the suspension of business activities.
    o Life of older people living alone who tend to be socially isolated, single parent families on leave and others.

- Maintenance of health and care services for older people under voluntary restraint of going out.

Comments

The media reports daily on the harsh working conditions and discrimination of medical professionals. However, topics related to nursing care and social welfare are seldom mentioned. Many medical professionals have commented on coronavirus-related coverage, while social work and care-related professionals are rarely asked to comment.

Social services responses

Income compensation for individuals and households.

The Japanese government began providing a special fixed benefit of 100,000 Yen per person to all the citizens in the Basic Resident Register with 27 April as the base date. This was additional to the temporary special benefits to households that had been receiving the child allowance (Ministry of Health, Labour and Welfare, 2020a). However, due to concerns about the leakage of personal information and the general public's aversion for centralised number management by the national government, personal numbers have not been fully integrated into digitalised identity cards. This has caused delays in sending out the benefit application forms for those living in urban areas with a large population.

Benefits and loans to business owners.

The national government has decided to provide sustainable benefit to business owners who have difficulty in resuming their business. In addition, to retaining their employees' services, a subsidy was provided to compensate for the employees' leave allowances. Moreover, some states and municipalities provided additional benefits. However, in these cases, it is complicated to fill out the documents to apply and submit the tax-related materials necessary for submitting the application. Moreover, small business owners have been struggling to receive these benefits.

Support for low-income individuals

In April, when the national government declared a state of emergency, the number of people applying for public assistance increased. In urban municipalities in Tokyo, the number of applications increased by more than 40% in April (Asahi Newspaper Digital, 2020). The national government decided to allow exceptional ownership of property such as cars and stores so that recipients can rebuild their lives smoothly when they eventually receive their incomes. In addition, telephonic interviews are also permitted to reduce infection for those originally required to undertake home visit assessments (Ministry of Health, Labour and Welfare, 2020b). Besides public assistance, the Tokyo Metropolitan Government has taken measures to allow homeless people to stay free of charge at business hotels, a move that has benefited more than 500 people. Furthermore, the Council of Social Welfare, which is involved in supporting needy people, has instituted a loan programme for daily living costs and a temporary rent subsidy for those who might lose their housing.

Responding to older people and persons with disabilities who need nursing care

The MHLW regulates various forms of services such as inpatient and outpatient services for older people and persons with disabilities who require nursing care, in accordance with laws such as the Long-Term Care Insurance Act. The Ministry has announced that flexible service delivery can be offered in urgent and unavoidable situations on the condition that the safety of the user is ensured (Ministry of Health, Labour and Welfare, 2020c). Through this announcement, service agencies could provide services with fewer staff, and day care staff can provide services at the user's residence to avoid infection among staff. However, most service agencies and institutions are social welfare corporations whose care staff are not well educated or trained to prevent infections properly. Furthermore, the staff faced an enormous challenge in providing care due to lack of masks, protective clothing, and disinfectants when the infected person could not be hospitalised due to the shortage of hospital beds.

In addition, older people and people with disabilities were forced to stay confined at home due to the suspension of salon activities being carried out in the community. Therefore, isolation from the community and functional decline due to lack of exercise were exacerbated, and the burden of family care has been increasing. The staff of the Local Older People's Care Management Centre and local certified community welfare volunteers have checked on the safety of people and also provide consultations over the telephone.

Women and children

As schools are closed, child abuse at home and violence against women has increased. Children's welfare centres and women's counselling centres provide telephone consultations on a daily basis, but as family members stayed home all day, telephone consultations have become difficult in some cases. In addition, home visits to prevent abuses were denied by the suspected abusers on the pretext of preventing infection, and there was no possibility of confirming the safety of children. The Cabinet Office enlarged the 24-hour telephone and SNS counselling system for women (Cabinet Office, 2020). It has made special arrangements so that women who had fled to escape their spouse's violence and lived outside, were permitted to obtain support money when not in their place of residence. In addition, the Labour Department of MHLW requested special consideration for pregnant women in the workplace so that they can work safely.

Mental health

Mental health centres provide telephone counselling on a daily basis, and since April, consultations regarding stress and anxiety have greatly increased. According to the MHLW, the number of consultations at mental health and welfare centres nationwide increased from 1,739 during February and March, to 4,946 in April alone (3). Some non-profit organisations (NPOs) also provide consultation services through e-mail and social networking sites (SNS), and their number has increased. However, it is likely that mostly young people will use these digital tools. NPOs that provide telephone counselling for suicide prevention need to limit their services to reduce the risk of infection at work.

Students

According to an internet survey conducted by 'FREE for Higher Education Project', about 20% of students said that they were considering leaving school due to the decrease of income from their parents and themselves as of 29 April (4). According to the research conducted by the Jiji Communication Company, more than 100 universities have provided emergency benefits to their students to prepare for online education. It has also been pointed out that students in social work, medicine, and nursing may not be able to take on-site training and lose the opportunity to receive the necessary education. On 29 May, the national government decided to pay 100,000 to 200,000 Yen to students whose income had dropped significantly. Furthermore, an emergency special interest-free loan type scholarship as well as an emergency tuition reduction scheme were introduced.

Discrimination

Discrimination and prejudices were directed not only towards persons infected by the coronavirus and their families, but also the medical staff who treated them. Moreover, some parents found that their children were sometimes rejected from nursery schools, and thus denied an educational opportunity.

In summary, the Japanese government provided emergency assistance in various areas and allowed flexible responses. However, it was difficult to attend to everyone's needs due to the complexity of the administrative procedures. In addition, social welfare corporations that offer services to people such as older people and people with disabilities have been receiving less support from the government compared to medical institutions, and both staff and users have been facing great challenges in dealing with the risk of infection, care burdens, and financial difficulties.

Social work responses

Vulnerable people

Many vulnerable people with whom social work is usually involved, such as low-income people, women, children, the older people, people with disabilities, students, and people with mental challenges, have been significantly impacted by the spread of COVID-19. In addition, social welfare corporations and their employees, who regularly provide services to these people, are obliged to carry out their duties with limited resources and less support. In that sense, they are also included among the vulnerable populations.

Ethical dilemmas of social workers

According to a survey conducted by Japanese Federation of Social Workers (JFSW), many social workers have experienced ethical dilemmas in the field (JFSW 2020). For example, it is not possible to conduct general assessments and hold care conferences due to the spread of the infection. Therefore, the needs of clients and their families are not fully assessed, and necessary services cannot be coordinated. Furthermore, due to social distancing measures and lack of resources, it is difficult adequately to provide services to clients/service users whose emotions become unstable in a time of isolation and anxiety.

Recognition and support for social workers and social welfare corporations

On 18 May, the Japanese Association of Certified Social Workers submitted a request to the national government. As indicated earlier, there was no clear policy on service management on the spread of COVID-19. Small agencies terminated their services while others kept operating to maintain their clients'/service users' wellbeing without proper infection control equipment and guidelines. At the end of May, the national government announced that it would offer additional financial benefits to the staff who work at social welfare corporations as well as provide educational support for them. As for social work education, the Japanese Association for Social Work Education conducted a survey on member universities regarding on-site training. The national government has indicated that students can take online practicum training in place of an on-site one. Universities have been figuring out how to offer proper and meaningful online practicum training. Anyhow, these professional organisations need to monitor the needs of members, make requests to the government, and find breakthrough measures.

Concluding comments.

In this emergency situation, the requirements of social distancing, and reducing the risk of infection greatly constrained vulnerable people and social workers. In addition, those not accustomed to digital environments such as SNS are at risk of further social isolation. To alleviate this situation, new methods such as online counselling, online visits to facility residents, online case meetings, and robotic care should be encouraged and instituted. Social workers and social welfare corporations must play a major role in teaching and disseminating new technologies to clients/service users, families, and workers. In addition, further research is required to investigate the needs of both clients and workers, and to create necessary measures to better respond to the upcoming second outbreak of COVID-19.

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Appendix One: Japan

Figure 1. Transition of COVID-19 positive cases in the hospital (April-May 2020)
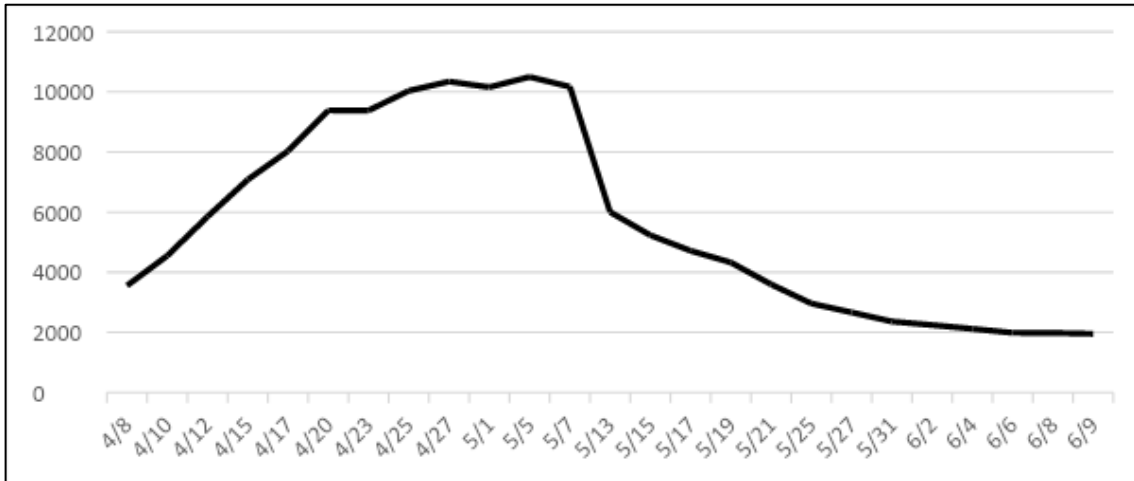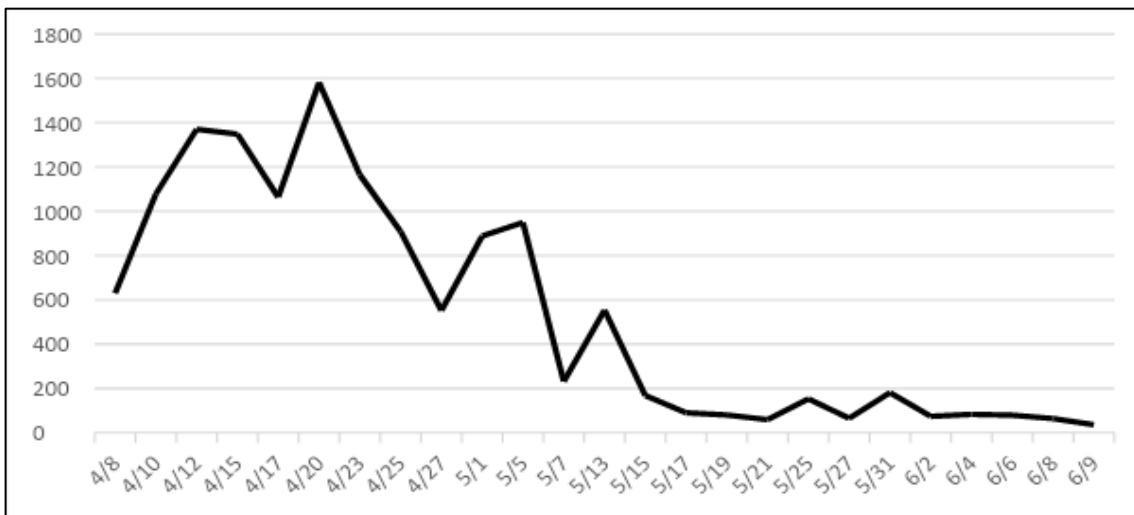

Figure 2. COVID-19 new positive cases (April-June)

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Community context: Key facts and figures

Population and population density

The current population of Latvia is 1,907,675 based on the data provided by the Central Statistical Bureau of Latvia (CSB). The density of population is 30.32 per km². One third of the population is concentrated in the capital city Riga where 32.9% of all residents live (CSB, 2020). The population growth rate is -1.08% (negative). The density of population is 30.32 per km² (total land area of 62,200 km). About 15% of children are aged under 14 and about 20% of the population is older people (CSB. "Latvia Demographics Profile 2019" n.d.).

Number of infectious cases and time period

Starting from the beginning of the pandemic until 2 June 2020, the total number of cases in Latvia reached 1,079. Of these, 24 had died, and 760 had fully recovered during this period. The first two cases were identified on 8 March 2020. The maximum number of cases in Latvia had reached 48 a day (Worldometer 2020). Most of the cases (n = 556) were identified in Riga, the capital of Latvia which is also the place with the highest population density. There were 112,965 tests performed during this period (SPKC, 2020). The state carried out most of the tests in social care institutions and shelters, therefore, most COVID-19 cases were found there. Medical staff, TV reporters, police workers, military personnel, food supply and veterinary workers were tested free of charge. Other individuals would have to have COVID symptoms and a physician's referral to have a test free of charge.

Number of deaths.

According to official statistics, the number of deaths from COVID-19 on 21 April 2020 was a maximum of four. By 2 June 2020, the total number of deaths reached 24 (Worldometer 2020). Most were in the 70-75 age group as identified by the Latvian Centre of Disease

Prevention and Control. Unfortunately, there are no further official data on the characteristics of the cases that died.

Number of deaths in specific settings

By 25 May 2020, COVID-19 had been identified in 12 social care institutions and 7 of them were care institutions (LSM, n.d.). However, this information is commonly available and taken from newspapers, not from official websites.

Comments

Although the number of tests per million of population in Latvia is relatively high (59,845 per million), the tests are not free of charge for the whole population. Therefore, the number of COVID-19 cases is likely to be underestimated. However, a low population density and the mental health cautions characteristic of Latvians (reserved, distrusting) can be helpful in controlling the spread of the virus.

Societal measures addressing social consequences of COVID-19

On 12 March 2020 exactly a day after WHO (World Health Organisation) declared a pandemic, a state of emergency was declared in Latvia for a period of four weeks ('Par ārkārtējās situācijas izsludināšanu' n.d.). The state of emergency stipulates that all state and regional authorities must consider reducing face to face activities. Teaching should be performed remotely for all age groups ranging from primary schools to universities. However, pre-school educational institutions (like kindergartens) are required to provide services for those children whose parents have to work during this period. A two-meter social distancing rule was declared. The exception is two persons from the same household that are permitted to be together in public (the so called 2*2 rule). A penalty for breaking this rule is from 300 Euros. However, a real punishment has seldom been applied. All shopping centres and shops excluding groceries and pharmacies were closed for the first four weeks. Face masks were not mandatory in public places. Group sport activities were not permitted both indoors and outdoors, but people were encouraged to exercise and strengthen their immune system outdoors without breaking the distancing rule (activities like walking and visiting parks were strongly recommended). A stay-at-home order was not stipulated but was strongly recommended ('Par ārkārtējās situācijas izsludināšanu' n.d.). Self-isolation was mandatory only for persons with clear signs of the coronavirus disease and for those that had returned to Latvia from other countries. The only strong penalty (up to 2000 Euros) was adopted for breaking this isolation. However, the penalty was used only on a few occasions. Social support measures that were provided included: 1) a work stoppage benefit due to the crises (from 180 to 300 Euros per person); 2) for unemployed persons (extended benefit payment period); 3) additional child benefit for each child under age 18 (50 Euros per month); 4) additional benefit for young family members aged 18-24 if their survivors have lost income from work. All benefits are paid during the crisis and an extension is dependent on the epidemiological situation (Labklājības ministrija, A n.d). The Latvian response to the COVID-19 crisis has been praised as successful. There have been relatively few confirmed cases and very few deaths (Rasnaca 2020).

Comments

The Latvian government's response to the crisis was timely and successful. The problems were linked to working conditions and the possibilities of teleworking. Telework was never imposed. However, many companies used it as a solution anyway.

Social services responses

The Ministry of Welfare, in cooperation with social work professionals, has issued Guidelines for Social Work Organizations in Municipalities. The aim of the Guidelines was to blunt the effect of possible negative consequences of the COVID-19 pandemic on vulnerable families with children (Labklājības ministrija, n.d.). These Guidelines include:

- Information about the new challenges resulting from the emergency situation faced by social workers working with families with children.
- Recommended immediate actions to be taken and decisions to be made.
- Information on what support is necessary for social workers and other professionals that work with families with children during the emergency situation and their after-effects in order to ensure necessary cooperation and child protection.

The experience and recommendations from international social work and child protection organisations in this emergency situation were taken into account when preparing these Guidelines. The Guidelines included appendices with additional useful information for social work.

Social work with families with children

All inhabitants in Latvia have been living in an emergency situation since 12 March 2020. Everyone is concerned about the health of their relatives and family members as well as those around them, but the reactions and level of concern have differed. Various groups have had similar responses to the emergency situation and the associated crisis but may also have very different ways of coping with it. The responses are significantly affected by the resources available.

The situation created by COVID-19 is unpredictable and may quickly change family circumstances in which children reside. The results of measures taken to curb the spread of the virus, for example, remote learning, restrictions on movements, unemployment, income loss, restricted access to different services including social services, the loss of regular social contacts and daily routines have a direct impact on every family. Parents might have to look for alternative childcare options or to give up paid employment.

Social workers and other specialists involved in family and child protection have stated in mass media outlets that the incidence of domestic violence have increased (up to 20-30% as a preliminary assumption) including violence against children. In these circumstances of a tightened physical space and reduced social interactions, both the emotional and economic pressure increase. Latvia's national professional organisation, the NASW (National Association of Social Workers) compares the position of social workers in emergency situations with that of doctors. NASW argues that further support and security measures are necessary to ensure that social workers including child protection workers and other social support workers could adequately attend to their clients/service users (1).

In emergency situations, the families with children most at risk are those which even before the crisis situation did not have enough emotional, material and social resources and did not have the ability to have a balance in various elements of social functioning – carrying out everyday tasks, growth, work, and child rearing. These are the families that already needed a multifaceted support system. The disruptions to support systems for these families can create long-term consequences for them. These included: a worsening of existing problems, an increase in the occurrences of emotional, psychological and physical abuse against children, increases in risk factors, relapses for parents with addiction issues, binge drinking, difficulties for parents with weak skills in everyday tasks and other areas and parents with mental health issues.

Some additional suggestions concern child protection, social services and state police cooperation. These are:

- A continuation of the provision of social services regarding security and child safety in families, including maximum support to ensure that children stay in the family.
- Continued cooperation with family support centres (AG) in order for the parents to be able to visit their children, with adequate social distancing or remote meeting options in place. Providing support to parents to be able to have their rights respected covered items such as ensuring access to the internet and online meetings with their children if no other options are available.
- House visits could be carried out by a mobile brigade or the numbers of visits could be reduced, e.g., by having one visitor collect the information needed for a different agency or colleague at the same time.

Comments

State institutions (Ministry of Welfare), non-governmental organizations as well as professional social work organizations focus attention on families with children. This was prioritised and some other vulnerable groups, e.g., homeless persons, older age social care receivers and ex-offenders, clients/service users with mental health problems, were partly neglected. This was especially important for those without internet connections and digital skills.

Social work responses

Challenges

During the last couple of months, the daily tasks of social workers have been full of challenges. Some of these were:

- The professional boundaries within social work have become blurred. This has been the case for work tasks, relationships with clients/service users and with colleagues. For some workers, their work has entered their private sphere in a very direct manner. Both private and professional lives need to be maintained within the same physical space. At the same time, maintaining professional boundaries has always been a prevalent theme within social work and maintaining these invisible boundaries may come easier for social workers in comparison to other professions.

- It is difficult for social workers to play the role of advisors because the emergency crisis has given rise to situations where they have to admit a lack of knowledge of the changes that have followed from emergency decisions.
- Confidentiality has also become a challenge. Can we be certain it can be maintained using online communication (Barsky, 2020)? Does the distanced consultation occur only between the client/service user and the social worker or are any family members present in the background or in the next room? How can accelerations of conflict within the families of clients/service users be discussed in such circumstances?

Challenges in everyday practice were characterized in interviews with social workers. Below are a couple of quotes from them:

> 'I work both face-to-face and remotely. I have remedies. Negotiations, consultations, provision of information take place mostly. If it is necessary to provide services, then I prepare documents. Unfortunately, there is no placement of clients in care institutions. They have to wait in line' (Pliot study interview).

> 'The main challenges are working with clients with mental health problems. Unfortunately, some addicted clients also do not understand the seriousness of the situation' (Pilot study interview).

Successful survival shows up within points where the strengths of the social worker's abilities and the challenges and difficulties created by emergency situations are balanced (Ungar 2013). This point exists within the context of a particular environment.

A proportion of workers continue carrying out their tasks meeting clients/service users face to face and visit them in their homes but some workers working from home have to create a new workspace, usually allocating a corner of a room that may also need to be shared with other family members sometimes. Furthermore, a work environment is not just the physical space. It is usually also the space where communication between colleagues, traditions, emotional and intellectual opinion exchanges occur. For a large proportion of workers, space with these resources has disappeared.

It is also a task for social workers to notice what is happening within their surrounding environment and society. Both international and Latvian mass media have pointed out the vulnerability of marginalised groups while social distancing is in place, paying attention not only to the effects of possible infections but also other risks associated with social distancing, for instance, domestic violence (*The Guardian* 2020). WHO has pointed out that there is an increase in people's loneliness, anxiety, depression, insomnia, substance abuse, suicidal tendencies during quarantine and social distancing (WHO 2020). Within the social media in Latvia, the problems associated with unemployment and financial troubles are more likely to be highlighted. Social isolation has certainly helped to curb the spread of the virus, but it cannot be denied that it has a variety of other consequences – a financial crisis, risk of violence, and the worsening of people's mental health (Kumar 2020). Furthermore, different attitudes towards the measures taken have created fractions within society. Social workers need to find solutions to problems within this social environment while maintaining their professional resilience.

Concluding comments

The state of emergency in Latvia started on 12 March and was extended until 12 May. It is intended to end on 9 June. The government banned all private arrangements, other than the holding of funeral ceremonies outdoors provided that the distance of two meters between persons and other epidemiological safety measures were respected.

The registered unemployment numbers rose by 25% during the COVID-19 crisis (Nodarbinātības Valsta aģentūra, n.d.). As a result, social spending has been increased and previously affluent families and persons were also affected. The tensions within families were fuelled by the long period of staying at home. That is the reason why the Ministry of Welfare drew attention to families with children. Other vulnerable groups affected by the crisis mentioned by the social workers that I interviewed are people in need of social care, people with mental health problems, homeless persons and those with addictions.

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SLOVENIA

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Country context: Key facts and figures

Population and population density

On 1 January 2020, Slovenia had a population of 2,095,861 and the population density was 103.4 per km².

Number of infectious cases, deaths and time period

The first coronavirus case in Slovenia was confirmed on 4 March 2020. Between 4 March and 29 May, 1,473 people were infected of which 650 were men and 823 were women. This period comprises the timeframe for this Report. The number of people tested during this time was 79,897.The total number infected by COVID-19 in care homes for older people was 460. Of these, 323 occurred among residents, the rest occurred among staff (Government of the Republic of Slovenia, 2020; NIJZ, 2020).

Table 1. Number of deaths by gender and age. Data from 12 March to 29 May

Number of deaths by gender	108	Age groups	Number of deaths
Men	**44**	85+	14
		75-84	17
		65-74	10
		55-64	2
		45-54	1
		Total	**44**
Women	**64**	85+	47
		75-84	11
		65-74	5
		55-64	0
		45-54	1
		Total	**64**

Slovenia is divided into 12 statistical regions and COVID-19 deaths were recorded in 8 of them. These were distributed as follows:

- Osrednjeslovenska had 24 deaths in the municipalities of Brezovica 3, Domžale 2, Horjul 6, Ljubljana 11 and Škofljica 1, Litija 1.
- Gorenjska had 4 deaths in the municipalities of Jesenice 1, Kranj 1, Naklo 1 and Žirovnica 1.
- Pomurska had 20 deaths, all in one municipality, Ljutomer, occurring in a care home for older people.
- Podravska had 2 deaths in one municipality, Maribor.
- Koroška had 1 death in the municipality of Ribnica na Pohorju.
- Obalno-kraška had 1 death in the municipality of Piran.
- Jugovzhodna had 18 deaths in the municipalities of Metlika, 17 of which were in a care home for older people, and Trebnje 1.
- Savinjska had 38 deaths in just one municipality, Šmarje pri Jelšah, all in a care home for older people.

Number of deaths in specific settings

All residential care facilities for children and young people were closed down and children were sent home to their families. Most deaths happened in care homes for older people. Data on the number of deaths in care homes by the National institute of Public Health (NIJZ) were published once, that is on 4 May (Rajšek, and Javornik 2020). They accounted for 78 out of 100 deaths. The second information on deaths in care homes was published in a daily newspaper on 24 May. Out of 108 overall deaths, 86 were in care homes for older people (Kovač 2020). Deaths among older people in long-term care constituted more than 80% of them. A majority of deaths were in three residential homes in the cities of Ljutomer, Metlika and Šmarje pri Jelšah.

Societal measures addressing social consequences of COVID-19

The extent of isolation

All data below are taken from the Governmental web page on the COVID-19 disease (Government of the Republic of Slovenia 2020a). The measures and the timeline are identified below:

On 6 March, the first measures were adopted. These included were a prohibition of visits in hospitals and residential homes for older people. Visits were again allowed with the limitations of no body contact and a distance of 2 meters on 11 May. Personal contact like holding hands was allowed from 25 May.

On 7 March, the Minister of Health signed an Order imposing a ban on gatherings at events in public places. On 9 March, all preventive programmes in hospitals were suspended and all non-urgent specialist examinations were cancelled until further notice to be rescheduled at a later date. Only acute illnesses and conditions that could lead to a deterioration of health were addressed. The Order prohibiting indoor public gatherings was amended to reduce the upper limit from 500 to 100 people. The timeframe that developed was as follows:

On 12 March, the Government *declared an epidemic*. All kindergartens, schools and universities were closed, starting on 16 March. Educational institutions for adolescents with emotional and behavioural disorders referred thereto by a court are excepted from this measure. The Government adopted the proposal for the Act on the Intervention Measure of Partial Wage Compensation. Parents who stay at home to care for their children are entitled to 50% wage compensation. Healthcare professionals are banned from entering infected areas or areas at immediate risk of coronavirus outbreaks, i.e., the countries with identified coronavirus cases. This Order lays down the duty of healthcare professionals and associates to perform their activities under specific circumstances, such as the ban or restriction on taking annual leave and the restriction of the right to strike and to training.

On 14 March, the Government announced social distancing and isolation. Public transport was banned on 16 March when the Government issued the Ordinance to temporarily ban the provision and sale of goods and services directly to consumers in the territory of the Republic of Slovenia. These included accommodation, catering, wellness, sports and recreational outlets, cinematographic and cultural facilities, hairdressing, cosmetics and pedicure services, gaming and other similar activities with some exceptions like stores selling food and pharmacies.

On 19 March, the Government issued the Ordinance on the temporary prohibition of public gatherings at public meetings and public events, and other events in public places. Individuals were allowed to move in, access and stay in a public place while keeping a safe distance from other persons for the purposes of: getting to work, including agricultural work; accessing emergency and necessary services in food stores, pharmacies, drugstores, gas stations, post offices, municipal utility services; providing care services and assistance to persons in need of support; accessing services for persons with special needs; and accessing public parks and other areas for walking. These exceptions may be defined in detail by a mayor through a decision that is made public for an individual local community depending on the specific needs within that community.

On 30 March, a law on the temporary release of prisoners with less than 6 months of sentence still to serve came into effect. This law was adopted after the first case of coronavirus among prisoners that was diagnosed on 16 March and the second case on 29 March.

On 16 April, the government started to ease restrictions. It allowed some stores to open from 1 May. These were mainly stores selling mostly construction and installation materials, technical goods or furniture, specialised shops for selling motor vehicles and bicycles, dry cleaners and repair shops, the personal collection of goods or food at pick-up points ensuring minimum contact with consumers, hair and beauty salons, certain sports and recreational services, pet grooming salons also following distancing measures.

On 29 April, the Government further lifted the prohibition of movement outside the municipality of permanent or temporary residence.

On 15 May, the Government adopted the Ordinance announcing *the end to the SARS-CoV-2 (COVID-19) epidemic,* which was initially declared on 12 March. Since the risk of

spreading COVID-19 still persists, the general and specific measures will continue to apply until 31 May. After this date, any measures would be decided on the basis of the epidemiological situation in Slovenia and abroad.

All shops, restaurants and services were opened from 1 June. Most of the economy started operating, but there were substantial problems in some branches like the car industry, trucking industry, construction, and tourism. There are still limitations in kindergartens, but all pupils in primary school from grades 1-9 are back at school. Secondary school pupils will not return to school in this school year. They will finish this year's studies via computers. Universities are still closed, although staff are allowed into the premises, but there is yet no information on when they will be opened.

State measures to address social problems and needs

The state issued three packages of measures to address needs of the economy and of individuals. They were as follows:

The first package of measures included mostly measures for covering the costs of salaries and lost income. These were limited incentives for individuals, and not for the economy and employment. These measures meant that:

- Aid was provided to all full-time students residing in the Republic of Slovenia in the form of a one-off crisis allowance amounting to 150 Euros, which was paid by 30 April 2020.
- For large families with three children, the Act proposed an allowance of 100 Euros, and for families with four or more children an allowance of 200 Euros, in addition to the allowances that they already receive.
- Pensioners will be entitled to a one-off solidarity allowance in order to ensure better social security for the most vulnerable pensioners whose pensions are less than 700 Euros. The allowance will be paid as three different amounts depending on the amount of an existing pension: 300 Euros for pensions up to 500 Euros, 230 Euros for pensions ranging from 501 to 600 Euros, and 130 Euros for pensions ranging from 601 to 700 Euros.
- Recipients of financial social assistance and income support are also eligible to receive a one-off allowance amounting to 150 Euros.

The second package addressed the economy and employment. The measures it contained aimed to help the economy and preserve jobs, which also included self-employed people. The Government will cover part of salaries (compulsorily insurance) and compensate for lost income for those that stayed at home due to the closure of a workplace or taking care of children due to closure of schools and kindergartens and introduced a basic income for self-employed persons. There were no measures for other social groups in need.

The third package also covered the economy and employment as a significant increase in registered unemployment was observed by the end of April compared to March. Subsidised short-time work replaces subsidised temporary lay-off until 31 December. To assist tourism, the government will grant a voucher to each Slovene citizen to the value of 200 Euros, and for minors, a voucher to the value 50 Euros. These vouchers can be redeemed until 31 December 2020 (Government of the Republic of Slovenia 2020a).

Status of social welfare services, authorities and professionals in media

The media reported mostly on the situation in care homes for older people, on violence against women and children, on the problem of isolation in relation to homeless people and on food poverty. The articles about care homes for older people were raising issues of the large number of infected older people, on their access to health care and admission to hospitals that only accepted the most serious cases. Issues like whether care homes for older people are health or social welfare institutions were problematised. The lack of doctors and nurses in care homes and the quality of life and the human rights of residents were raised. Most deaths happened in just 3 care homes. The extent of isolation rose when care homes were totally closed to outside visitors for 2 months. This included relatives who were not allowed to visit, even when a relative was dying, and the lack of consistent information on what was happening in care homes. These points were most intriguing for journalists and a number of NGOs working in this field.

The issue of violence against women and children was the second issue that was raised by NGOs and commented upon by the media. Here, the question of the social services response to the violence was problematic, especially in respect of child protection, and the lack of consistent information. The results of the survey undertaken by the Institute of Criminology by the Faculty of Law at the University of Ljubljana was presented as a report on criminal acts in the time of the coronavirus crisis (Plesničar, Drobnjak and Filipčič 2020). They found out that although the number of all criminal acts declined during the coronavirus crises, the number of domestic violence cases rose. They revealed that mandatory isolation actually maximises the risk of violence and maltreatment within families occurring and minimises access to help and support.

The issue of poverty, especially food poverty was raised after the closure of schools and the food delivery programmes. In Slovenia, pupils have food including a hot lunch provided by the schools. When the schools were closed, no food was provided. The Red Cross and Caritas programmes of food delivery were also closed for direct services. Here some good practices were presented in the media where local communities and various NGOs, e.g., for homeless people, drug-users, older people and children, responded to this problem by establishing meals-on-wheels services or delivered food in the community.

No media reports can be found on any other issues like the lack of participation of social welfare professionals in governmental planning of measures against the coronavirus crisis. It is obvious that health professionals and economists are deemed the most competent in this field and social welfare which includes social workers is somehow not considered as having any of the required expertise.

The most prominent concerns expressed in the media covered schooling and isolation. There have been broad debates on whether on-line schooling offers the same quality of teaching, and how pupils be prepared for final exams and the 'matura' (1). Also, the organisation of family life was an important topic in the media, especially the support given to children's schooling. Here, it was recognised that home-schooling can be a source of deepening social inequalities.

Comments

On the 4 May, Slovenia began to be governed by a new right-wing government after the previous one stepped down. Since then there have been massive public protests against some of the measures introduced by the new government. The protests are known as 'Cycling Fridays' (Novak 2020) and are organised because of government attempts to use

the COVID-19 situation to limit freedom and the rights of people. Protests are taking place every Friday and people are cycling around the Parliament and government buildings. Part of the protests are also highlighting the situation in care homes for older people.

Social services responses

The mode of operation of social services

There is a lack of information to give a consistent and correct overview of the mode of operation of social services. What is known is that they responded differently. Some closed their doors and workers stayed at home waiting to be called to duty. Some of them organised in shifts, so that the service was not closed but access became restricted and a reduced number of workers were at work. Some of them worked from home via telephones and computers. Social services have a central web page (Association for Centres of Social Work 2020) with basic information for users and they also have a central office where no additional information is available. They have asked service users to come to the centre only in emergencies, advising them to use telephone or email instead. If they are claiming social benefits, they should submit an online form or leave it in the post-box at their local centre. Many NGOs also worked from home via telephone and computers. Day centres for homeless people and people with mental health problems were closed. No admissions to care homes were possible. It is not known yet how shelter for victims of violence or crisis centres for children and young people have operated. Were they available or did they also close their doors? We assume that practices differed across Slovenia, but that has yet to be explored. Children with learning difficulties that had close relatives, were sent home from residential homes. In Slovenia, these are called group homes. Only young people with learning difficulties who did not have anyone to go to were allowed to remain in them.

Guidelines for social services from responsible authorities

Slovenian social services are state funded and there are 63 of them around the country. Social services are authorised to provide services for families and individuals in need of support and protection. This includes those experiencing problems either between family members or when they are deprived of financial, housing or other resources. But they also are authorised to protect children in cases of violence and maltreatments as well as other victims of violence. Social services have departments for family affairs, adoption and foster care, children and youth work, for people with mental health problems and for people with disabilities. The network of centres of social work as they are called in Slovenia, is complemented by the network of supporting programmes offered by NGOs and private providers in very different fields and services. These cover homelessness, violence against children and women, youth work, programmes for older people, counselling and therapy among many others. The second network of services are care homes for older people and the third one covers special care homes for people with disabilities and mental health problems. These also provide financial social assistance.

All measures issued by the National Institute of Public Health (NIJZ) which is responsible for coordinating health care measures for the overall population also apply to social services. Apart from these measures which are listed below, there were some instructions specifically for social services issued by the Government on 13 March 2020 (Government of the Republic of Slovenia 2020b):

- No visitors in care homes for older people and hospitals, not even in the case of a dying relative.
- In other residential settings there were strict distancing measures as no personal contact was allowed and a distance of 1.5 metres was obligatory.
- Centres of Social Work (Social Services) were advised to restrict contacts with clients/service users to emergencies mainly, and instead to have contact via telephone or computer. Home visits were restricted to emergency situations.
- The committees for the assessment of needs of persons with disability to receive personal assistance were off duty, so no new personal assistants could be nominated.

On 18 March 2020, the Ministry of Labour, Family, Social Affairs and Equal Opportunities issued new guideline for the protection of users and staff members and volunteers in the field of social protection (Government of the Republic of Slovenia 2020c). These measures included:

- A restriction of personal contacts in Centres of Social Work. Exceptions were emergency situations (child protection is determined by the Family Act, Family Violence) where the protection of persons is needed. Otherwise, social services are advised to work with the use of digital tools (email, computer, telephone).
- Admission to crisis centres and supervised contacts between parents and children (in situations of restrictions in contacts between a parent and a child). Crisis centres are not closed but have to comply with rules issued by the NIJZ. In cases of new admissions, they also have to operate according to the rules, and what primarily applies is a 14-day quarantine. Supervised contacts are not advised, as physical contacts are restricted for people not living in the same unit.
- Residential homes and day-care facilities for children and adults with learning disabilities were closed except for cases where no other care could be provided.
- Day centres for a variety of groups: older people, people with mental health problems, children and young people, were closed down, but staff have to be available for emergency situations, so that users can call them or can send them emails.
- The same applies to counselling and therapy services and programmes.
- Residential programmes (groups or community homes where people reside) stay open until the first case of infection by the coronavirus. They have to respect NIJZ instructions and when newly admitted, they have to respect the rules on quarantine.
- Day centres for homeless people have been closed down. Instead, street work for the supply of food to homeless people is encouraged.
- All other social programmes have been cancelled and practitioners have started working on-line or via the telephone.

At the end of May, the Government in Slovenia declared the end of the epidemic and all programmes started operating but with some strict rules to be observed (Association for Centres of Social Work 2020). This included physical distancing and users having to telephone first to make appointments. Users are not allowed to stay in premises longer than needed, have to wear masks and respect other measures set by the NIJZ. In addition, visitors are allowed into care homes for older people if they uphold the same instructions listed above for the Centres of Social Work.

Use of digital tools in working with clients and teamwork among staff

As we (the authors) have already stated, the majority of contacts between social workers and service users have been reduced to telephone, email or to make appointments for face-to-face contact. There is no report yet on how this approach has been working, what it was possible to do online and how this affects people in need of services and social workers. There is no information on how staff members have communicated between themselves, either.

Main concerns expressed by social services

Not much can be found about the response of social services. Mostly there are reports from care homes for older people that expressed many concerns due to the lack of help they received from the authorities. They felt left alone with very serious situations to address. They felt their work has not been appreciated because they were 'attacked' by public opinion claiming that they are not doing enough to prevent the coronavirus from spreading, and also that the restriction of contacts especially for people with dementia or those who were terminally ill, has been inhuman. Such opinion affected staff that actually worked very hard and were exposed to infection to a much greater extent than the general population due to the lack of masks and other medical protection equipment. They felt as having been 'sacrificed' somehow and marginalised in these difficult times. This provided a reason for a protest organised by the Association of Care Homes for Older People (RTV Slovenia 2020). On 24 April, they stopped working in all care homes throughout Slovenia, and went out of the buildings for 15 minutes. Their basic claim was that governmental measures to protect older people were insufficient and to a great extent wrong.

Apart from what was going on with the older people, some associations for homeless people pointed to the many problems that related to the specific situation of homelessness. For example, the paradox of isolation, that it is only possible if one has a place to isolate in. There were also reports from these associations that outreach is extremely difficult due to lack of human resources. They also made the point that the most deprived homeless people will make do without the service. They accepted donations in money and in-kind to at least cover the basic needs of homeless persons (Kings of the Streets 2020).

Comments

We, the authors, need much more information to comment on developments as we would like. The lack of knowledge is also a result of modest media reports on social services and on measures that were applied in this arena. We have raised some issues we consider important in points 2 and 3 in this *Country Report*. Further research is needed.

Social work responses

Most affected groups defined by social workers

The main source for this Report is the web page of the Association of Social Workers Slovenia (DSDDS) and some diaries written by social workers for a research project undertaken by the authors of this *Report*. Groups that social workers highlight as being most affected are single parent families that experience many problems due to closure of

the primary and secondary schools and who need support in helping children around schoolwork and also around the coordination of work and family obligations. They are also writing about lonely older people in the community, people with mental health problems and others that live alone and have a weak social support network. Also, families with low educational attainment experienced problems in helping schoolchildren in distance learning and homework. Major problems that are frequently highlighted by social workers relate to violence and neglect, mostly against women and children. Isolation has 'fuelled' violent behaviour since there has been no mechanism of approaching families and it has been very hard for the victims to report violence because they were trapped in the same space as the perpetrator. More in-depth insight into affected groups requires more information to be obtained.

Main obstacles to approaching and supporting communities and clients/service users

Restriction of personal contact and the use of digital tools were also problematised. Digital tools are not to be blamed as they offer some contact, but users of services that are experiencing poverty, deprivation or/and social exclusion do not have access to computers and do not know how to use on-line programmes and tools. The most common source of communication is the telephone which has many limitations because there is no eye to eye contact which remains a very important means of communication for social workers.

Critical evaluation of state measures.

We, the authors, do not have enough information to elaborate on these measures. The DSDDS published a letter on their web page (Association of Social Workers, Slovenia 2020) that is critical of governmental measures. The main criticism relates to the absence of social workers among the other professionals in the groups that designed the measures regarding COVID-19. The letter also pointed to the invisibility of social workers and social services in the media.

Another problem is a lack of information on the social services web pages. Information was available only on its central webpage and most of the users of services were not aware of. it The Association of Social Workers also pointed out that social workers are too silent, not visible enough and almost passive during these times of crisis.

They are also pointing to the many good practices that were developed as a sign of solidarity among people. People organised on a local level and helped with food delivery, offering transportation with their own cars to people that needed it as all public transport had been stopped.

The role of national associations of social workers in supporting practitioners during the coronavirus crisis

The National Association of Social Workers in Slovenia supported practitioners mostly by publishing letters that pointed to problems in relation to the closure of social services (as discussed above). They also encouraged social workers to be proactive and start working in the communities. They published and translated the note from IFSW (International Federation of Social Workers) on the response of social workers to the COVID-19 disease. They helped researchers extend invitations to social workers to participate in three research projects that were initiated by different research groups.

Concluding comments

The lack of information about the response and the role of social workers is visible and clearly points to the lack of activities in the public arena on their part.

<u>Notes</u>:

1. 'Matura' is the final exam after finishing secondary schooling and is a condition for enrolling in a university

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Country context: Key facts and figures

Population and population density

Spain has a population that reached 47,100,395 million inhabitants in 2019, observing an increase in the population since 2018 when it had reached 46.7 million inhabitants. It has a population density of 92.7 km². The growth of recent years is due to migrations, which resulted in those with overseas origins forming 9.8% of the population in 2018. (National Institute of Statistics 2019). Spain is territorially divided into 17 regions (Comunidades Autónomas, in Spanish) and two autonomous cities located on the north coast of Africa, Ceuta and Melilla.

Number of infectious cases, deaths and timeframe

In Spain on 21 May, there were a total of 247,086 people who had been infected by the coronavirus. Of these, 124,964 have been hospitalized and 11,650 are in the Intensive Care Unit (ICU). The number of deaths according to Comunidades Autónomas is still imprecise because there have been problems in collecting this information.

 The following data was obtained from the last published report by the Ministry of Health on 24 June 2020.There are slight discrepancies in the data because in some cases, information about the sex of infected or dead people has not been provided, only the age. At the regional level, the number of people infected comes from the latest publication by the Ministry of Health. The figures have been highest in the Regions of Madrid, with 71,579 people infected, then Catalonia with 60,927 people infected and Castilla León with 19,589 people infected (Ministry of Health 2020 and Instituto de Salud Carlos III and Red Nacional de Vigilancia Epidemiológica 2020).

 If we look at the criteria of age and sex, while 135,909 women have been diagnosed, only 102,983 men have been diagnosed. The age range with the most diagnosed cases is that of those aged between 50-59 years in both men and women (Update nº 109. Coronavirus disease COVID-19. 05/18/2020. Consolidated data at 00:00 hours on 18 May 2020).

By 21 May 2020, the number of deaths in Spain totalled 28,330. This total has to be treated with caution because, according to the Comunidades Autónomas, it is imprecise as there have been problems in collecting the information required. Each autonomous community has provided data in different ways. Some have added the number of confirmed tested COVID-19 cases, while others have included cases with the symptoms of COVID-19. No post-mortem tests have been performed due to the lack of testing capacity.

Looking at the regional criteria in the distribution of deaths, the figures have been higher in the autonomous communities of Madrid, with 8,417 deaths, Catalonia with 5,666 deaths and Castilla la Mancha with 3,020 deaths (Ministry of Health 2020 and Instituto de Salud Carlos III and Red Nacional de Vigilancia Epidemiológica 2020).

Distribution of deaths by sex and age

An examination of the distribution of COVID-19 deaths according to sex and age reveals that among the 10,946 deceased men, the age group where the most deaths have been registered was that of those over 80 years of age. In the group of men aged 80-89 years, 39.9% of men infected by COVID-19 died. Among women, there were 8,240 coronavirus related deaths in this age group, of which 42.5% died (Update nº 109; Coronavirus disease COVID-19 of 18 May 2020; Consolidated data at 00:00 hours on 18 May 2020). However, this document indicates that these data may not be consistent because in some cases there is no information available by sex/gender, only by age.

Number of deaths in specific settings.

The number of infections has been especially high among health professionals and older people in care homes. The latter were the group most affected by deaths due to the coronavirus. Of the reported cases, 24% were among health professionals, and the percentage of deaths among women was higher than that among men. Among the health professionals who caught COVID-19, 76% were women (Instituto Carlos III and Red Nacional de Vigilancia Epidemiológica, 29 May 2020).

According to the latest data published in mass media, which can have problems of reliability, in Spain there are 19,169 COVID-19-related deaths among older people in approximately 5,457 residential care homes, whether public, private or in the community. The Ministry of Health has not yet published the exact data. One of the problems in collecting data has been that Comunidades Autónomas have so far been offering data in different and not always accurate ways, because some add those with symptoms compatible with COVID-19 but unconfirmed to the total number of COVID-19 deaths, while others add only confirmed cases, as clarified earlier. In Spain, the Comunidades Autónomas notify the Ministry of Health daily of the accumulated confirmed cases of COVID-19; the total number of cases, cases among health professionals, hospitalizations, ICU admissions, deaths and recovered cases.

Most deaths have occurred in Madrid, Catalonia, Castilla y León and Castilla-La Mancha. In the Community of Madrid there are 5,972 deaths with coronavirus or related symptoms. Of the more than 700 residential homes in these locations, 475 are for older people. The rest are centres that social services have authorized as residential homes that provide care for older people, people with disabilities and people with mental illness.

In the Region of Catalonia there are a total of 64,093 older people living in one of the 1,073 either public or private residential homes in this area. Those who have died from

the coronavirus in these places rose to 3,973 since 15 March. This represents 71% of the total number of deaths in the community, according to the register of regional funeral homes. The Department of Health has reported that so far there are 13,826 people diagnosed with the coronavirus in nursing homes. In Castilla y León, the places in public and private residences amount to almost 44,300 and 2,566 people have died in public and private centres according to data provided by the Regional Government of Castilla y León. Of these, 1,465 had tested positive for the coronavirus and 1,101 had compatible symptoms. In Castilla-La Mancha, the death of 2,440 users of nursing homes had been attributed to the coronavirus. Of these, 1,254 were confirmed cases and 1,186 corresponded to people suspected of being infected by COVID-19. Altogether, these comprised 82% of the total deaths registered in the region. (RTVE News 29 May 2020).

Societal measures addressing social consequences of COVID-19

The extent of isolation

On 14 March, a state of emergency was approved by Royal Decree with an initial duration of 15 days. In total, it has been renewed 6 times and the government has extended it until 21 June. The state of emergency assumes that the control of public administrations is under the direct orders of the competent authority, which in this case has been the central Government's Ministry of Health, for the protection of people, property and places.

The main restrictions of the state of emergency have been to limit movement by public roads except for:

- Purchasing food, medicine and other basic items, assistance to health centres, services and establishments.
- Travel to the workplace (under a justification issued by the company).
- Return to the place of habitual residence.
- Travel to financial and insurance entities.
- Assistance and care for the older people, minors, dependents, people with disabilities or vulnerable people.
- Walking pets.

In the educational and training field, these measures materialised in the suspension of face-to-face educational activity in all centres and stages, cycles, grades, courses and levels provided in Article 9 of the Royal Decree 463/2020, from 14 March. It means that educational centres were closed at all levels, from kindergarten to universities, and online education started from the end of the academic year on 19 June for primary and secondary school, and universities are still providing online education until the end of July.

Besides that, the Royal Decree-Law 10/2020, of 29 March, regulated a recoverable period of paid leave for employed persons who do not provide essential services, in order to reduce the mobility of the population in the context of the fight against COVID-19. This established a two-week period of recoverable paid leave for workers confined to their homes because they were unable to telework or their activity was not among those included as essential services.

From 26 April, children were permitted to move outside the home while the state of emergency stood. To do so, they had to observe certain conditions, e.g., being given a specific time slot to attend for services. From 2 May, people 14 years of age and older could carry out non-professional physical activity outdoors during the state of emergency, but also within a given timeframe.

According to the Ministry of the Interior, the proposed sanctions and arrests for infractions committed against the measures adopted in the framework of the state of emergency registered throughout Spain by all the police forces from 10 May were as follows: 7902 detained and 922,598 sanctioned.

Failure to comply with the state of emergency would be sanctioned by law. Penalties ranged from 100 to 600,000 Euros or imprisonment from three months to one year, depending on the severity of the offence. These penalties can be summarized in the points specified below:

- Violations against citizen security: 100 to 600 Euros for those who remove or move fences from the security perimeter.
- Disobedience to authority or refusal to identify yourself from 601 to 30,000 Euros.
- Public health offences: For conduct against public health or omission thereof, from 3,001 to 60,000 Euros, and if the risk were very serious, the fines would range between 60,001 and 600,000 Euros.
- Violations against the national civil protection system: Sanctions imposed on people for this infraction ranged from 30,001 to 600,000 Euros when they failed to comply with orders, prohibitions or instructions that put the safety of people or property at risk. If the risk involved danger or was significant, the penalty could increase from 1,501 to 30,000 Euros.

The Congress of the Deputies approved the state of emergency on 14 March 2020 and extended it six times. It is due to end on 21 June 2020. The entire process of ending the lockdown and returning to the 'new normal' has been carried out following three phases that are explained in Table 1 below (Ministry of Health, 29 May 2020).

Table 1. The three phases of the state of emergency

	e
	Phase 0
General terms	- Working from home. - Restaurants, bars and hotels are closed. - Public transport operating at 30% capacity. - The retailer commercial sector opens with appointments. - Online education - From 18 May, the government considered certain measures to alleviate the restrictions of 'attenuated phase 0'.

Social Services Centres	- Maintain telematics attention in programmes, devices and features (phone calls, video conferencing, voice messages). - Provide face-to-face care and follow-up meetings in emergency situations and when the social situation requires it. - Ensure that people who need it, have the possibility of contacting Primary Care Social Services, through the channels established for this purpose (telephone, internet.) and ensure its effectiveness.
	Phase 1
General terms	- Contact in small groups. - Commerce and hotels open outdoors at 30% capacity, but not in common areas. - Urban Transport at 80 to 100% capacity. - Other trains and buses at 50% capacity. - Shows indoor for 30 persons; outdoor for 200 persons. - Libraries are open. - Scientific seminars occur online. -Shows indoor for 30 persons; outdoor for 200 persons. - Scientific seminars occur online.
Social Services Centres	- Opening of the centres in established hours by appointment, booking a time slot or days for people at risk, e.g., older people, disabled, pluripathology and others. - Ensure security and protection measures, both for professionals and caregivers. - Restrict home visits to urgent and strictly necessary cases. - The distribution of spaces may be modified, where necessary, in order to ensure the interpersonal safety distance. - Group, family or community interventions will not be initiated.
	Phase 2
General terms	- Bars, restaurants, hotels open at 1/3 in common areas and indoors. - Weddings and funerals with limited numbers. - Outdoor markets. - Cinemas, theatres open at 1/3 or 50 persons indoors and 400 outdoors. - Education for 6-year old children is open for parents working outside the home. - Voluntarily, for students of secondary education who pass key stages in the Spanish baccalaureate (bachillerato) during year two and year four, before they graduate. - Other educational centres can be open. - Visits to people with disabilities living in residential centres. - Scientific seminars at 50% capacity. - Common areas in shopping centres at 40% capacity. - Disco and night bars are still closed.
Social Services Centres	- Maintain opening by using an appointment system. - Restart home visits when necessary, taking appropriate protective measures. The time spent in the homes will be strictly necessary for the fulfilment of this objective. The professional shall ensure that no person affected by COVID-19 or is under quarantine resides at that address. PPE (personal protective equipment) will be used during each visit. - In-person, group, family or community activities with a maximum number of 1/3 of the usual capacity will be launched, provided that the minimum recommended interpersonal distance is ensured.
	Phase 3

General terms	- Weddings and funerals with more assistants can be celebrated. - Scientific seminars can be attended by less than 80 persons. - Bars and restaurants can have half of their capacity indoors and outdoors. - Beaches will be open with safety distances being maintained. - Common areas in shopping centres and hotels will be open at 50% of capacity. - Public transport will be working at 100% capacity. - Protocols of re-incorporation to work will be developed and for the envisaged reduction of the spread of coronavirus in older people's residential care homes.
Social Services Centres	- Opening of the centres and activity, and a progressive return to normal, with the limitations and protections that the health authority requires. - Group activities will be maintained with 50% of participants, provided that the minimum recommended interpersonal distance is ensured, and always taking into consideration the limitations and protection set by health authorities.

State measures to address social problems and needs

The health crisis caused by COVID-19 has had very important economic implications for Spain. In the first place, the lockdown supposes the cessation of productive and commercial economic activities not considered essential, in contrast to public health and social services, food shops, agricultural and livestock activities. Productive activity is estimated to have decreased by more than 40% at the beginning of the state of emergency. It is estimated that GDP will decrease by 15% this year (2020).

Given the impact on the economy and the people, the Government of Spain has launched a series of economic and social measures to reduce the impact of the cessation of economic activity and the unemployment that this generates (Ministry of Social Rights and Agenda 2030, May 2020). The main measures are:

1. Evictions, renting and housing. For tenants and landlords, and mortgages the measures include suspension of evictions, extension of renting houses contracts, moratorium on renting debt, temporary deferment on rent payments, rent payment aid: bank guarantee, rent payment aid: loans from the state, moratorium on income for use other than of housing or with large holders, moratorium of mortgage debt.

2. Protection of workers. For workers in situations of vulnerability, the rights of labour, and agrarian sector workers, the measures included the prohibition of layoffs, enlarged unemployment protections, extraordinary allowances for domestic servants, exceptional unemployment benefits for the end of a temporary contract, artist's collective unemployment benefits, and temporary recruitment of workers in the agricultural sector. The ERTE (Expediente de Regulación Temporal de Empleo), or Temporary Employment Regulation File in English, was first approved during the state of emergency. However, on 25 June 2020 the extension of this measure was approved to remain in place until 30 September.

3. Consumers and families in a situation of vulnerability. The measure for these groups aimed at guaranteeing the supply of electricity, petroleum, gas and water, suspension of obligations arising from non-mortgage-guaranteed credit

agreements, contract resolution without penalty by consumers and users, resolution of package travel contacts (travel and accommodation), prohibiting the increase in prices of communication services during the suspension of portability, discontinuation of the product return period.

4. <u>Universities</u>, contracts for lecturers, academics, assistants, visitants and general staff; assistance for students, researchers and professors.

5. <u>Domestic violence</u>. Measures were enacted for people -women, sons and daughters who were victims of and suffered from gender violence in situations of constantly being at home with their perpetrator during the state of emergency. Funds were also provided for caring responsibilities and for children to cover outings for children and dining scholarships.

6. <u>Self-employed, small and medium-size enterprises</u>. A social bonus was introduced for self-employed workers, deferment of tax debts, moratorium on contributions and debts to social security, extraordinary benefit for cessation of activity for self-employed people, liquidity guarantees to sustain economic activity for self-employed people and companies, support for companies and freelancers in the tourism sector.

7. <u>Small and medium-size enterprises</u>. There was an extraordinary postponement of the repayment schedules for loans granted by the general secretary of industry and small and medium-size companies, calls for modification of the moment and terms for the provision of guarantees for loans granted by the SGIPYME (General Secretary of Industry and the Small and Medium sized Enterprises), and refinancing of loans granted by SGIPYME and supply flexibility.

Besides these measures, there has also been the approval of Royal Decree-Law 20/2020, of 29 May, establishing the minimum living. income. It is a benefit aimed at preventing the risk of poverty and social exclusion of people who live alone or are integrated into a coexistence unit and lack basic economic resources to cover their basic needs. It is configured as a subjective right to an economic benefit, which is part of the protective action of social security. It guarantees a minimum level of income to those who are in a situation of economic vulnerability. It seeks to guarantee a real improvement of opportunities for the social and labour-force inclusion of the beneficiaries.

Status of social welfare services, authorities and professionals in media

The status of social work as a key profession to face the social consequences of COVID-19 has not been recognized in the media since the approval of the state of emergency. The media has not echoed the importance of the role of the social workers in the pandemic. However, news of collaborations in the main national channels have increased since the President of the General Council of Social Work was interviewed on 13 May. In the ensuing newscast on the main public channel to explain the important work being carried out by their social interventions with more and more people at risk of social exclusion, the message was spread by social networks with the hashtag 'Responsible Social Work'. In addition, in some programmes that deal with current affairs in politics and foundations such as the Fundación Pilares have collaborated on social intervention in nursing homes,

talking about the Person-centred Model and calling attention to the demands for new intermediate resources for traditional residential care. The professional associations have supported the campaign on *Responsible Social Work*, thanking social workers for their commitment and their great work in these difficult times. To this awareness campaign on social networks, people and colleagues could be added further messages, photos and videos of thanks (Consejo General de Trabajo Social, 29 May 2020).

On the other hand, politicians are being criticized in the media for their management of the pandemic because political parties are using the unclear number of deaths for voting interests, as well as the management of the crisis during the first weeks of the state of emergency in relation to the provision of health equipment for professionals and the collapse of the healthcare system and the management of older people's care.

Social services responses

The mode of operation of social services in times of coronavirus measures

Municipal social services have been open, covering basic social needs as essential services in this health pandemic and have had a significant social impact. Either face-to-face or blended attention has been provided, depending on the critical moment of the pandemic with teleworking from their own family setting. Adjusting various aspects of the family environment has been necessary since all family members were at home at the same time. Meanwhile, in giving assistance and aid, NGOs such as the Red Cross, Caritas and others at the local level have also addressed the basic needs of citizens, with regards to food and support for older people or those in situations of dependency.

Social work has made the most of its resources, coordinating between professionals from different municipalities or associative entities. At the same time, responses have been given in an emergency, tools and work methodologies have been modified to adapt to new circumstances and the usual practice has been innovated.

The municipal services had to meet the need for food aimed at minors at risk of exclusion since the dining room scholarships were suspended at the closure of the schools. As for basic food, the municipal services also provided home help, catering and telecare to many older people and disabled people in a situation of dependency. Many of these cases are new and this help was in addition to other services already received.

The Public Social Services System has provided important support for families living in the shadow economy, regardless of the type of protection. Many of them are self-employed women who clean houses and care for other people. They were forced to close their businesses, but now they have been able to reopen, or they have done so with many debts and little return. In turn, social workers have had to make an added effort to be up to date on the different decrees approved, to interpret them, and provide rigorous information to citizens about how these affect them in their social realities.

Guidelines for social services have been issued from responsible authorities in relation to working with clients/service users in need of immediate intervention. Some guidelines have been published by the General Council of Social Work since 14 March. These are:

- Specific measures adopted by the government determining public social services as essential work in facing COVID-19 (28.03.2020).
- An open letter citing social work as one more profession to face COVID-19 (31 March 2020).
- Communication and social nets in a scenario of emergency (03 April 2020).

- Proposals from social workers for older people's care homes facing the health state of emergency with COVID19 (03 April 2020).
- Recommendations from General Council of Social Work for Social Services facing the situation of COVID-19 and the post-coronavirus crisis (08 April 2020).
- Proposals from Social Work in Education during the health state of emergency for COVID-19 (08 April 2020).
- Ethics and the deontology of social work during the health state of emergency with COVID-19 (08 April 2020).
- The mourning due to COVID-19 among social workers (13 April 2020).
- Social work with groups in times of a pandemic (14 April 2020).
- Social services in Spain. The commitment to subjective law and its declaration as matters of essential services and of general interest (16 April 2020).
- Communitarian social work in times of teleworking for conducting interventions with people (16 April 2020).
- People with disabilities and their families facing COVID-19 in times of a pandemic (16 April 2020).
- Recommendations from General Council of Social Work to social workers within the frame of the Transitional Plan to the 'new normality' (07 May 2020).
- Intervention from Social Work with Homeless People during the state of emergency (08 May 2020).
- Social work in gender violence situation during COVID-19 (11 May 2020).

Use of digital tools in working with clients/service users and teamwork among staff

Social services have innovated by the launching of social and emotional support telephone services, especially for people with mental health problems that have exacerbated their situation during the pandemic and the emergence of new cases. The most vulnerable people with whom social workers intervene have been contacted by phone, mail or new technologies to ask about their situation.

There have been a number of key concerns expressed by social services. In this pandemic, it has become clear to everyone that health care must be public and of high quality. Concern has also been expressed about the quality of care and the lack of resources in homes for older people. These have become areas of unrest and death, but also belong to our welfare system. Looking to the future, this aspect must be studied to prevent situations such as those experienced in the residential sphere from recurring in future.

Social work responses

Most affected groups defined by social workers

The most affected group of people from a health point of view has been older people, and especially those who live in older people's care homes. However, from a social perspective, many other groups have also suffered the consequences of coronavirus. One of them has been that of homeless people. The General Council of Social Work published *The intervention from social work with homeless people in a state of emergency* in collaboration with the GEIES (State Group of Intervention in Social Emergencies). Some

key measures have been based on doing tests to detect positive cases and the creation spaces in municipalities for homeless people during the state of emergency in collaboration with the Military Unit of Emergencies and Municipal Networks.

Another big group affected by the lockdown has been women who are victims of gender violence. It is important to incorporate the gender approach in a transversal way when analysing the impact of COVID-19. A gender perspective is essential to address the consequences of the pandemic. Thus, it is important to determine the factors that increase the impact of the socio-health crisis on women. Following the Report of the Women's Institute on 29 May 2020, we can highlight four general aspects:

- Increase in workloads and overload of socio-health work and essential services. In Spain, 66% of health professionals are women, but they reach 84% in nursing.
- Care and domestic tasks carried out by women in the period of lockdown. Women remain central to these tasks. This assumes an important and unequal mental and domestic workload which can be reduced if men take a fair share.
- Economic poverty and job insecurity. Women suffer greater economic and labour poverty derived from a situation of precariousness and chronic vulnerability. This precariousness makes it more difficult to cope with the new period of crisis, especially among young women with low educational qualifications, and migrant women.
- Increase in gender violence and of all types of violence suffered by women as women. Calls to the telephone number for the use of women victims of gender violence in Spain have increased by 46% in two months. Online consultations increased more than 650% and psychological and emotional support through WhatsApp rose by almost 130%.
- People with disabilities, especially those who are dependent and their families. The General Council of Social Work has published a document to promote the use of new technologies in this situation, and as a reflection about the need to promote more community social work in situations like the current one. It is very important to detect critical situations in the community and to create basic protocols for paying attention to local needs to facilitate access to services and the addressing of their demands.

Main obstacles to approach and support communities and clients/service users

To alleviate the situations caused by COVID-19, for the most vulnerable groups, exceptional measures are required. The most pressing demands are regarding the basic social services benefits, the protection of families and attention to child poverty, the increase in home care and services for the older people, additional support in situations of dependency that require reinforcement of the templates for the basic network of social services and residential centres for people in situations of dependency. At the same time, it is necessary to ensure the tranquillity and safety of older people in their homes, intensifying contact with them through telecare and in coordination with home help services, to detect possible situations of need and intervene quickly and efficiently. In implementing all these measures, they have claimed that they must be carried out to guarantee the safety of workers, to avoid the spread of the virus among older people, especially vulnerable ones, given the number of infections in certain residential facilities, and the demands for adequate protection among workers in this sector.

Critical evaluation of state measures

One of the main criticisms of the state measures taken is related to the limitations on the freedom of citizens due to lockdown in their homes. This has been broadcast by the media and legitimized by the health authorities. However, it has weighed in the minds of citizens throughout this time, and the security forces have had to intervene on many occasions to sanction and inform citizens. The disturbance of public order during the harshest periods of confinement have not been excessive, but they have had a strong impact from the point of view of public opinion. The media has highlighted many of these uncivil behaviours, in spite of their not being the experience of the majority of the population.

In the health sector, the lack of supply of necessary medical devices (PPE) for protection from the coronavirus among health workers and the prevention of the spread of the pandemic has been criticized strongly. An important issue in favour of the government has been the measures that became the norm so that the central government could set prices by regulating the prices of medicines and essential materials in the face of the epidemic. With respect to working conditions, the General Council of Social Work reports that since the beginning of the crisis, the health of six out of ten social workers has not been adequately protected in order to deliver the direct care they have provided.

In social services, situations of basic needs have been especially attended to. However, applications for support have been overwhelming due to the delay in the payment of aid for self-employed people whose income has been reduced even though they are entitle to receive payments under the Temporary Employment Regulation Files. The State Public Employment Service (SEPE) has managed online applications and financial benefits derived from temporary unemployment situations. The increase in requests including an overflow by professionals and the difficulties derived from the technological problems of the users, have generated problems of forms and deadlines in the collection of benefits.

The role of national associations of social workers in supporting practitioners during corona crisis

The activity of the General Council of Social Work has been intense during this pandemic and it presented amendments to the wording of the Draft Education Law on 22 May to the Commission of Education and Professional Training of the Congress of Deputies. It requested that the new wording be included in the Education Law to recognise the right to protection and well-being of students at risk, experiencing social disadvantage or vulnerability or who have unique educational needs. It has also been requested that professionals responsible for social interventions are guaranteed inclusion in the educational system. This new Law is an opportunity to guarantee the inclusion of all students in the educational system, especially those who are minors for whom it is necessary to ensure their protection with the necessary professional resources, well-being and education. The General Council of Social Work appeals to those politically responsible to guarantee this right.

The last intervention of the General Council of Social Work has been its deliberations on the Royal Decree Law on the Minimum Vital Income of 29 May. The first observation was satisfaction with the approval of the Royal Decree-Law of Minimum Living Income that will help to mitigate the socioeconomic crisis generated by COVID-19, as a good step to advance the recognition of such rights. Guaranteeing sufficient income to cover people's basic needs for goods and services, and expenses right now is crucial. At the same time, it considers that an Income Guarantee System should prioritise citizen's subjective right to goods and services, by reducing the structural indicators of poverty, inequality and vulnerability, thereby improving the quality of life of citizens.

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Royal Decree. 463/2020. 14 March. *Declaring the state of alarm for the management of the health crisis situation caused by COVID-19.*

SRI LANKA

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Country context: Key facts and figures

Population and population density

Sri Lanka is a small island in the Indian Ocean with a land area of 25,000 square miles and a population of approximately 22 million. The Sri Lankan population is equivalent to 0.27% of the total world population. Sri Lanka ranks number 58 in the list of countries (and dependencies) by population size. The population density in Sri Lanka is 341 per Km^2 or 884 people per mi^2 (Department of Census and National Statistics 2020). Sri Lanka was under different colonial masters for more than 500 years and independence was finally granted in 1948. The country remained a Dominion of the British Empire until 1972.

Since independence, all successive governments in Sri Lanka have been implementing long-term and short-term strategies and programmes to achieve sustainable economic growth with social development indicators. Though the per capita income level is low, these measures have enabled Sri Lankans to enjoy a comparatively high quality of life among the south Asian countries (Central Bank of Sri Lanka 2018).

Number of infectious cases and time period

Sri Lanka's authorities reported its first confirmed case of COVID-19 on 27 January 2020.

Table 1. Local Situation of COVID-19 in Sri Lanka as of 24 May 2020

Total Number Confirmed				1089,*
Total Number Recovered		674		
Total Number of Deaths		9		
Confirmed and hospitalized - today 10am		413**		
Suspected and hospitalized - today 10am		97#		
Details of COVID-19 diagnosed patients –Last 24H				
Number inward as at today10 am	COVID-19 Positive - last 24H	Discharged from the hospital - last 24H	Number of deaths - last 24H	Number inward as at today10 am
406	25	18	0	423

Source: COVID-19: Situation Report, 24 May 2020, 10.00am Ministry of Health and Indigenous Medical Services

The first coronavirus patient was a Chinese national who was visiting Sri Lanka. She was treated and she made a full recovery and returned to China. On 11 March, the first Sri Lankan to be confirmed within-the country was reported as a tour guide. As the number of confirmed cases began to rise, the Government declared an island-wide curfew to control the spread of the virus (Reliefweb 2020).

Number of deaths

As of 26 May 2020, the total number of deaths in the country stands at 10. Out of these, six are Muslims and others are Buddhists. It was also reported by the Health Ministry that the six persons who died of coronavirus suffered pre-medical conditions such as heart diseases, hypertension, chronic kidney diseases and diabetes. The information shows that, except for one person, all were in the over 50age bracket. Two deaths were reported from the North Central Province and the remaining cases were reported from the Western Province of the country. Persons who are diagnosed with coronavirus infection are treated at the National Institute of Infectious Diseases (IDH) and all the district hospitals and teaching hospitals in the country are equipped with considerable facilities to perform tests and treat infected persons.

It was also acknowledged by different stakeholders that the number of deaths in some districts has increased among persons with pre-medical conditions as their mobility is constrained due to lockdown and 66 days of strict police curfew imposed by the Ministry of Defence of Sri Lanka. It was also noticed that obtaining a travel pass was difficult and therefore, persons who were under medication for various ailments failed to attend regular medical clinics and dialysis. This unprecedented environment led to a worsening of the health conditions of those patients who remained unattended so that facilities could be released for Covid-19 patients.

A critical note on the cremation of the dead bodies of Muslims

The Health Ministry of Sri Lanka has announced that cremations are compulsory for coronavirus victims, ignoring traditional practices of the country's Muslim and Christian populations who worry that the rule goes against their traditional practices. Three Muslims are among the seven people who have died so far from the infectious disease in this country. Their bodies were cremated by the authorities despite protests from relatives. The Muslim Community is deeply distressed with the continued cremation of Muslims who die as a result of the coronavirus as the Government continues to cremate Muslims who die, without any regard to the objections of the family and Muslim religious leaders (Amnesty International U.K 2020). The Government was also accused by a Muslim family and Islamic Clerics, that the dead body of a 44-year-old Muslim woman who did not die from COVID-19 was cremated by the authorities without considering the grievance of the bereaved family members and their community. Two days after the cremation of the dead body the results showed that there had been an error in the initial testing of this particular victim.

Number of deaths in specific settings

No deaths of children or older persons from any residential care or institutions have been reported so far. One of the reasons behind this situation is that the reported number of

infectious cases and deaths in Sri Lanka is relatively small and has finally reached its peak, compared to its neighbouring countries including India, Pakistan and Bangladesh. It is noteworthy the Sri Lankan Government devised a viable prevention and treatment strategy to combat the outbreak of global pandemic. It has its positive elements and its flaws. The Government has faced very strong criticism of its actions to combat the coronavirus. Some of the criticisms levelled at it were:

- The Government did not take any stern action against the skyrocketing prices of food items and essential commodities. In particular, poor people suffered a lot due to the food price volatility.
- The Law and Order apparatus used violent measures to control potential infections and restrict public mobility.
- There was a perceived delay in providing relief materials and essential services from the Government's end.
- The Government did not consult social workers or leading humanitarian experts to obtain their advice before launching its intervention plan.

Comments

Most of the infected cases which are currently reported from the Health Ministry are armed personnel and foreign returnees. Therefore, the Government is reluctant to share accurate information with the public. The relevant authorities were concerned about the restraint of the Government on revealing reliable information to interested stakeholders. However, it is crucial to mention that although the number of identified infectious cases were relatively small, the Government worked proactively to mobilize its limited resources to respond effectively to the consequences of the pandemic. The immediate measures to send the infected persons to quarantine camps or actions taken by the government stakeholders to put the suspicious cases or potential carriers on self-quarantine with the support of Public Health Inspectors, Family Health Workers and medical doctors of the particular district hospitals, were commendable. These services are continuing until the time of writing without any interruption.

Societal measures addressing social consequences of COVID-19

The extent of isolation

The Ministry of Defence imposed a Police Curfew for about 66 days and it was lifted with many guidelines and restrictions on 19 May 2020. However, the curfew will remain in force until further notice in two districts namely, Gampaha and Colombo. This will continue in another 23 districts from 10.00p.m to 4.00a.m on a daily basis. The Government has announced that people who breach the curfew regulations will be placed before a Magistrate's Court and may be sentenced to six months of imprisonment and a penalty of 10,000 Sri Lankan Rupees. According to the available police statistics, from 20 March, a total of 64,387 persons have been apprehended for breaching the regulations of social distancing which is expected to be at least one meter or three feet. The police also notified that it has filed cases against 20,497 persons, and nearly 18,169 vehicles,

including motorbikes, cars and trucks which have been confiscated. Another 7,934 persons have been charged with a penalty attached (Xinhuanet 2020).

The Health Ministry and Defence Ministry have begun relaxing restrictions in a bid to restore normalcy in the country. Sri Lankan health authorities have limited the number of guests at weddings, funerals and parties at 25, as one of several guidelines to thwart the coronavirus. The authorities have recommended that all planned events and gatherings during this period are avoided or cancelled. The Health Ministry, in providing operational guidelines for workplaces, has requested that the public, government officials and event managers check the temperature of all guests entering their premises and that reception halls, parlours or venues should have adequate ventilation or should be outdoors. Guests must avoid sharing utensils and that venues, including furniture, must be disinfected before and after events. Beauty parlours, hairdressing salons and liquor bars are strictly instructed to maintain the stipulated social distancing. This is applicable to any public or private transport services, trishaws, eateries and hospitals. Any violation of maintaining social distancing will result in legal consequences.

Status of social welfare services, authorities and professionals in media

The government of Sri Lanka and its service apparatus use almost all the print and electronic media and social media to educate its citizens on the consequences of the coronavirus. The focal point of the propaganda is the medical challenges of the pandemic. However, private and non-state-owned media critically view the short-term and long-term challenges and potential strategies to bounce back from the negative impact of the global pandemic.

Social services responses

The mode of operation of social services

Government offices are functioning for limited working hours and they are allowed to work under very strict health surveillance. Fifty percent of the employees are requested to work on a roster basis and each one of them should work at least for two to three days a week. It is the responsibility of the head of the institution to make sure that the WHO guidelines or guidelines prescribed by the Government are properly communicated to staff and followed under any circumstances. Limited face to face contacts take place when selecting beneficiaries based on the instructions and guidelines stipulated by the Government of Sri Lanka and the distribution of dry rations.

Guidelines for social services from responsible authorities

Digital tools are used in a limited manner in working with clients/service users and to promote teamwork among staff members. The psychological counsellors working with the state and non-state sectors are allowed to do online counselling, to monitor the progress of their clients/service users, using mobile apps such as Viber for group meetings and information sharing and are widely used by both government and non-governmental sectors. Social workers are encouraged to participate in online workshops and experience sharing sessions. They are frequently asked to attend online training on teamwork, relaxation therapy for women affected by domestic violence and relaxation for NGO workers, and normal conference calls providing basic psychosocial knowledge.

These are some of the operational guidelines and gazette statements released by the relevant authorities after the COVID–19 outbreak:

- Operational Guidelines on Preparedness for and Responses to the COVID-19 Outbreak in work settings such as barber shops and beauty salons.
- Dialysis of kidney disease patients with COVID-19 confirmed or having a contact history with COVID-19 patients.
- Quarantine of health staff who have been exposed to COVID-19 patients.
- Hospital preparedness for the COVID-19 global pandemic.
- Release of persons who have quarantined in the Quarantine Centres.
- Management of psychiatric patients during COVID-19 outbreak.
- Screening and management of healthcare workers following exposure to a confirmed/suspected case of COVID-19 (V2 dated 01April 2020).
- Interim guidance to conduct a safe meeting in response to COVID-19.
- Coordinating psychosocial activities.
- Providing guidance through phone calls to handle with child abuse, family violence.

Main concerns expressed by social services.

The cash support and in-kind support provided by the government was insignificant and does not help the distressed communities to ease their considerable pain. The selected families were provided with (Sri Lankan Rupees) SLR 5,000. This is a one-off cash payment which is equal to USD 27. It is also vital to mention that individuals, charity minded persons and the Sri Lankan Tamil Diaspora worked hand-in-hand to provide people in need with some food, dry rations, and essential commodities. It was observable that community-based organizations such as libraries, Temple Trustee Boards, non-governmental organisations, and charities provided timely support for distressed communities to meet basic needs such as food, medicines, and agricultural inputs. This kind of collective community responsibility was witnessed for the first time in the history of Sri Lanka. Otherwise, there was a practice of expecting relief materials and services from the state and non-state sectors due to the impact of prolonged war in the country. The government also introduced a programme called *Saubhagya* (fortune) to promote home gardening among underprivileged families to ensure some additional income and promote the domestic consumption of locally produced organic vegetables among them. This programme was well received. In addition, the *Samurdhi,* a self-help group initiative to help women who belong to poor families. Beneficiaries were also provided with free food and dry rations to manage the unexpected food shortage.

Social work responses

Some social workers voluntarily worked with these stakeholders to monitor any potential overlapping of service provision and helped the stakeholders to develop proper criteria for selecting the most appropriate persons to support. However, it has been learned that some government officials and *Samurdhi* officers have abused their power, to relax the criteria, and unethically select some beneficiaries for the one-time cash relief. Some beneficiaries have also expressed their concern that they have not been shortlisted for the payment although they are entitled as per the government's criteria. Psychiatric social workers have been involved in distributing medicines to patients who were on

regular clinical observation. The family members of psychiatric patients also received supportive counselling as a part of the medication and rehabilitation of patients.

Most affected groups defined by social workers

Social workers and service providers have defined the following sectors as most vulnerable due to the corona pandemic. They are: daily wage earners, women headed households, households headed by elders and underage children, poor income families, families having persons with disabilities (mental and physical), persons working in informal sectors with no legal status (proper registration or work contracts), social protection programmes, and children of poor families.

Innovative and/or alternative approaches to communities, clients/service users and their needs

Social workers have intervened, through electronic platforms, with respect to some problems such as child abuse and domestic violence. For instance, social workers opted to provide their professional services via smartphones. Some people in need were placed into groups and guided to help each other using their smartphones. The social workers guided their clients/service users to deal with husbands who abused alcohol, violent family leaders, quarrels among the children, sexual harassment of women and child sexual harassment via their smart phones. People, who were in need, connected via mobile apps such as Viber and WhatsApp, and virtual meeting platforms like Zoom and Microsoft Teams. Some social workers used these electronic platforms to conduct self-help group meetings twice a month. The non-governmental sectors are planning to have workshops and training programmes using these alternative communication strategies where the conventional methods were restricted by the Government and people are expected to maintain social distancing. This transformation can be considered as a positive aspect of the pandemic and the social workers can also think about alternative and innovative practices to support vulnerable sectors of the population. Such innovative practices also can be evolved into a new model of good practice in social work.

Main obstacles to approach and support communities and clients

Law and order imposed in the country is the main obstacle to approaching people in need. Free movement of the general public is restricted by a prolonged curfew and other legal measures. An inter-district travel ban has been imposed through-out the country and a very strict travel pass system has been imposed by the Secretariat of each district. Security personnel are authorized with limitless power to control people's movement. The Health Ministry and its apparatus warn the people of the potential outbreak of more infection. Therefore, these aspects restrict the social services apparatus and social workers in approaching and extending their support to communities and clients/service users.

The role of national associations of social workers in supporting practitioners during the coronavirus crisis.

The role of social workers to help people in combating coronavirus and supporting their clients/service users is tremendously limited due to various reasons. The social workers

or their official body were not invited by the authorities to extend their professional support in the early stages of the pandemic outbreak. The Government mainly relied on the medical apparatus, administrative sector and military personnel to perform tasks pertaining to sending suspicious infected cases to quarantine centres, hospitals or PCR testing laboratories. The lack of recognition of the social work profession in Sri Lanka makes social workers feel inferior about their professional role in the pandemic situation. The existing lockdown and police curfew also curtailed the initiatives taken by social workers to extend their support to needy people. The Sri Lanka Association of Professional Social Workers organized a webinar to educate its members and social work practitioners in general on the role of social work in the pandemic situation. However, they could not go beyond this limit to work with needy people.

Concluding comments

The Government and relevant stakeholders have urged Sri Lankans to adhere to all the health guidelines stipulated by the Health Ministry and WHO (World Health Organisation) to combat the coronavirus infection and its overwhelming consequences. The spread of the pandemic has now been brought under control to a considerable extent. However, the threat persists. The Government claimed that the pandemic is being controlled by the selfless services rendered by the medical professionals, health workers, security apparatus, volunteers and political leaders. However, extreme military intervention has created a lacuna for social work professional interventions and social workers have been kept away from the scenario for many reasons. The coronavirus victory is also used by the government media to promote its political agenda and electoral lobbying. This matter is considered the prime concern of both ruling and opposition political parties.

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Country context: Key facts and figures

Population and population density

Sweden is one of the Nordic countries. The population of the country is 10,094,444 and the population density in Sweden is 25 per Km^2 or 64 people per mi^2 (Worldometer 2020).

Number of infectious cases and time period

There were 37,814 confirmed cases of COVID-19 from 2 April to 1 June 2020.

The number of deaths.

A total of 4,403 deaths were attributed to the coronavirus. Among this figure were 1,982 women and 2,421 men. Their age distribution was as follows:

- 90 + yrs.: 1,115
- 80-89 yrs.: 1,815
- 70-79 yrs.: 967
- 60-69 yrs.: 311
- 50-59 yrs.: 132
- 40-49 yrs.: 42
- 30-39 yrs.: 12
- Unknown: 0

The number of deaths in specific settings

Older people were most affected by COVID-19. By 28 May, there were 1,946 deaths in the age group ranging from 70 to over 85 years. These deaths were known to have occurred mainly in homes for older people (National Board of Health and Welfare 2020a). In more specific numbers, they were:

- 70-74 yrs.: 117

- 75-79 yrs.: 216
- 80-84 yrs.: 394
- 85+ yrs.: 1219

Comments.

Sweden has not had any known coronavirus deaths of children in residential care. In Sweden, older people can have help in their homes, instead of going into residential care homes. Among those that stayed in the community, 583 deaths attributed to COVID-19 occurred among the 75 to the over 85 age group (National Board of Health and Welfare 2020a).

Societal measures addressing the social consequences of COVID-19

The extent of isolation

Sweden has not had an absolute lockdown. Childcare facilities and primary schools have conducted their business as usual. However, all other teaching activities have been conducted remotely from the beginning of April to the end of the semester. As an executive authority, the Public Health Authority has issued guidelines and recommendations that the population must follow. Travelling within the country has been limited to a distance corresponding to 2.5 hours of driving. Social distancing is recommended, which means 1.5 to 2 meters between people in business and similar contexts. But there is not a prohibition sanctioned by legislation about it. Individuals should work from home if possible. Older people aged over 70 should remain in isolation and not meet others at all. There is a prohibition or temporary law against visiting older people living in homes for older people. There is also a general prohibition of crowds larger than 50 persons.

State measures to address social problems and needs

The service sector has been severely affected by the pandemic and tax relief has been introduced for companies to deal with the economic crisis. It is still too early to see the consequences of these in terms of unemployment, loss of income and the increased costs that this will mean for society. Some changes have also been implemented in the health insurance system due to the infection and more extensive opportunities to stay at home with suspected infection. Increases in housing subsidies and access to unemployment insurance funds have also been made.

As a result of the coronavirus, the government has presented proposals for an extra amending budget. The amendment budget now creates an opportunity for the state subsequently to compensate municipalities and regions for the extraordinary measures and additional costs in the healthcare system linked to the coronavirus. In addition, the National Board of Health and Welfare received a grant of SEK 20 million, primarily for personnel costs, training efforts and equipment. The National Board of Health is assigned the task of disseminating information about the coronavirus to all personnel within the social services. In light of the new coronavirus that causes the disease of COVID-19, the National Board of Health and Welfare is commissioned to produce, compile and

disseminate information to all personnel within the social services' areas of activity on what measures need to be taken to protect groups at risk. This includes, among others, the care of older people and care of people with disabilities. Efforts within the social services must be of good quality. For the performance of tasks within the social services, there must be staff with appropriate training and experience.

When it comes to emergency preparedness, some social functions are more important than others. In Sweden, social services and health care are counted as socially important activities. Such activities should always be conducted at such a level that the community can function and offer the necessary services, care and security. Many people are dependent on efforts from both the social services and the health services, which places great demands on collaboration between the principal players.

Status of social welfare services, authorities and professionals in media

The welfare sector is working as usual, but health care services and older people's care services, in particular, are heavily burdened. The Public Health Authority reports daily on developments and the issues regarding COVID-19, in close collaboration with the municipalities and healthcare services, drawing lines for the continued approach.

Social services responses

The mode of operation of social services

The work of social services has continued almost as usual. There has not been any period of total lockdown. Some areas such as older people's care and those working with people with disabilities have become more concerned. In these areas, there are official directives that must be followed, such as not permitting visitors into care homes for older people. The professionals working at these places are also continually tested for COVID-19. For other activities of the social services, the general injunctions, such as social distancing, extra careful hand hygiene and working from home at the minimum signs of illness are to be followed. Many social services workplaces have divided the working days of the week in a form of a rolling schedule when part of the social work profession will have to work from home during certain days, but only if the tasks allow it. Some social workers also describe that physical meetings with service users have become fewer and that they are meeting digitally via various platforms such as Microsoft Teams and Zoom and sometimes the face-to-face-meetings have been replaced by a phone call.

Guidelines for social services from responsible authorities

The National Board of Health and Welfare has, in close cooperation with the Public Health Authority, drawn up guidelines for how the social service's social work should be conducted (The National Board of Health and Welfare 2020b). Here, a particular focus has been on the group of older people and people with disabilities. The guidelines are focusing on social distancing, focus on hand hygiene and to look after the social workers so that they would not be working if there is the slightest sign of illness [4]. The Government has banned visits to care homes for older people on account of the COVID-19 until 31 August 2020. At the same time, the Government commissioned the National Board of Health and Welfare to develop supporting directives on how to follow-up this ban (Swedish Government 2020).

Domestic violence has been recognized on the basis of certain statistics and assumptions that this problem may increase in the prevailing circumstances. With regards to children and young people, the national strategy has taken great responsibility for the welfare of the group, especially by deciding, for example, not to close childcare and primary schools, in the light of the knowledge that it can lead to greater risks for vulnerable children. This has also been an effort to ensure that the part of the labour market that can still be effective, a situation that could not be averted by the absence of childcare facilities. The State Institution Board (SiS) takes the risk of the spread of COVID-19 very seriously and limits the possibility of visits to institutions. In order to reduce the risk of transmission to those placed in an authority's youth homes and homes for drug-use-treatment as well as its employees, the possibility of visits and other external contacts is limited. Instead, contact with the young people placed in these is primarily via telephone.

When it comes to emergency preparedness, some social functions are more important than others. Social services and health care are counted as socially important activities. Authorities have pointed out that their activities should always be conducted at such a level that the community can function and offer the necessary services, care and security. Many people are dependent on efforts from both the social services and the health services, which places great demands on collaboration between these professionals.

Use of digital tools in working with clients and teamwork among staff

Digital platforms such as Zoom and Teams have increased significantly in use among professional social workers. In the past, the social services, in particular, had not used these digital tools to any great extent. The Teams platform is used to a greater extent by the social services because it has a higher degree of security than Zoom. It is still too early to say something about how these are experienced, although we (the authors) will shortly analyse our first materials on the matter. Regarding contact with clients and users, it is also premature to say something about which digital technologies are used more often.

Main concerns expressed by social services

When the social services express their concerns, they are mentioning that of older people in the first instance. Discussions have focused on how to protect this group more effectively. The problems that have been discussed are two-fold: concerns about older people; and concerns about the professionals who work with them.

Domestic violence has been discussed as an increasing problem when people are, for example, losing their jobs and incomes and confined to the same space as the perpetrator. Regarding children, the social services have said that there are concerns that they become invisible when the face-to-face-meeting is replaced by phone or video calls. Another concern is the future and the consequences of the pandemic. What will happen when a lot of people have lost their jobs and income?

Social work responses

Most affected groups defined by social workers

As indicated above, children, those experiencing domestic violence, older people are those occasioning most concern.

Innovative and/or alternative approaches to communities, clients/service users and their needs

Civil society has taken a bigger place by offering help, for example, by examining matters for older people aged over 70 years because they are a risk group. Some NGOs have also taken responsibility for homelessness and 'secured beds for the night' for people during this time, and to a greater extent than before. They have also been offering different forms of help to families living in poverty. Some local networks have also been formed to help, discuss and make social problems visible during this time.

Main obstacles to approach and support communities and clients/service users

Maybe one obstacle has been to see and recognize the groups needing support. Since Sweden has not had a total lockdown, the problems and their consequences may take some time before they become visible.

Critical evaluation of state measures

Protection measures have mainly been directed at those working in the health care sector. Social services personnel have not received the same attention. When a lot of the resources from the state are allocated to the health sector, social work and its practice become sidestepped somewhat. One consequence of this is that social problems can grow big in silence and become a bigger problem for society to take care of later. Just in the past week, discussions about this situation have appeared.

   Another risk is that the social services' activities and municipal health care may be affected in the double sense of a general spread of infection. This is because certain groups of staff may fall ill at the same time as the need for interventions from social services and the municipal health services are expected to increase. Even if all available extra personnel are called in and resources are redistributed, situations may arise that require difficult re-prioritisation to ensure that the needs that must necessarily be met have been. Such needs can be basic life-sustaining efforts for people of all ages, e.g. food, medicines, visits to the toilet and personal hygiene. It may also apply to financial assistance as well as other forms of support to various target groups who may need immediate assistance, e.g., children and young people who suffer badly, people who are subjected to abuse and people with alcohol or addiction problems. Cooperation in a situation where there is an increased need for support and very limited access to resources, collaboration is especially important to ensure that available resources are used as efficiently as possible. Municipalities and regions are key players at the local level, and they need to work closely to reduce vulnerability and increase crisis management capacity. In a widespread infection, municipalities need to plan to be able to provide support and assistance to significantly more people and to target other groups than those they normally do.

The role of national associations of social workers in supporting practitioners during the coronavirus crisis.

The National Associations of Social Workers in Sweden is also the union for social workers, and it has collected information regarding the coronavirus and COVID-19 on

their homepage. They have not been doing any more than that. The discussion concerning the social workers during this pandemic has, unfortunately, been quiet.

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Country context: Key facts and figures

The United Kingdom (UK) is made up of the four countries of England, Scotland, Wales and Northern Ireland. In 2020, the population of the UK was estimated to be about 67 million. The majority of the population, over 56 million people, live in England, with an estimated 5.5 million in Scotland, 3.2 million in Wales and 2 million in Northern Ireland. The population of the UK is spread unevenly, with the population density ranging from 5,700 people per square kilometre across London to fewer than 50 people per square kilometre in the most rural local authorities of the UK (ONS 2020).

The first coronavirus cases were confirmed in the UK in late January 2020. They were two people returning to Northern England from China. On 6 February 2020, a British businessman in Brighton was diagnosed with the virus after catching it in Singapore. Later that month, on 28 February 2020, the first person to catch coronavirus within the UK was diagnosed, a man who lived in Surrey, but who had not been abroad. This indicated that community transmission was occurring, and possibly asymptomatic people, or those who had the coronavirus but did not know it, were taking it from one place to another and passing COVID-19 to those they encountered. The system of Test and Trace to isolate those affected was aimed at controlling its spread. However, the ending of this tracking process to find who had been infected on 20 February 2020 meant that a key tool for controlling the spread of the virus had been lost.

The first death in the UK was on 3 March 2020, when a woman in her seventies was confirmed to have died from the coronavirus in Reading. At this point, 100 people in the UK had tested positive for the virus. By 8 April 2020 the rates of people who had died in hospital and had tested positive for coronavirus rose to over 1,000 per day. At the time, not all the deaths of people that could be COVID-19 related in the community or care homes were being counted. The daily death rates reported have decreased since April, and on 5 June, the daily reported death rate was 357 (HM Government 2020), although it has been dropping since, in some nations more than others. For example, Scotland and Northern Ireland have had several days with no new deaths occurring. These fluctuations are still occurring despite the overall downward trend.

As of 6 June 2020, the total number of laboratory-confirmed coronavirus cases was 284,868 and the total number deaths of people who have had a positive test result was 40,465 (HM Government 2020). The majority of deaths involving COVID-19 have been

among people aged over 65 years and almost 50% of these occurred in the over-85 age group (ONS 2020). By this time, deaths attributed to COVID-19 included those dying in both hospitals and care homes. Care homes across the UK have been devastated by COVID-19, and there has been much criticism of government policies towards residents and staff in care homes, particularly in the early stages of the pandemic. In mid-April people were being discharged from hospital to care homes without being tested for COVID-19. By mid-May, 40% of care homes had been affected, and nearly as many COVID-19 deaths were being registered each week in Britain's care homes as in its hospitals (Booth 2020).

The mortality rate for COVID-19 deaths is higher in men, in deprived areas and for people from certain Black, Asian and minority ethnic (BAME) groups. A report by Public Health England found the more deprived the area of residence, the higher the mortality rate. The report also concluded that British BAME people have about twice the incidence of mortality from COVID-19 compared to white British people. Whilst much of this excess can be attributed to deprivation, even after accounting for deprivation, there is excess mortality in the Bangladeshi community (PHE 2020).

Comment

The effects of the pandemic in the UK have been devastating, and the impact has been disproportionately felt amongst certain groups and communities, with the pandemic exacerbating existing structural inequalities. Britain's record on the numbers of people infected and dying from coronavirus is worse than in most other countries in Europe. As of 6 June 2020, Britain became the second country in the world, after the US, whose official death toll from coronavirus exceeded 40,000 (WHO, 2020), and it has one of the worst death rates according to excess mortality figures (Burn-Murdoch and Giles 2020). This situation has since changed, and as of 12 June, Brazil and India are reporting more COVID-19 cases than the UK, and the death rate is rising considerably as a consequence, with Brazil recording the second highest level of deaths from COVID-19 after the USA. As discussed below, there has been much concern about the inadequacy of the British Government's actions to mitigate the consequences of the pandemic.

Societal measures for addressing social consequences of COVID-19

Public health measures

In the weeks following the WHO (World Health Organisation) declaration of a coronavirus global health emergency in late January, the UK Government was slower than many countries in expanding their testing capacity. It abandoned that strategy in February, only to resume it to some extent on 30 May. When other countries were starting lockdowns, large sporting and cultural events continued to go ahead in the UK during the first half of March, leading to a spike in the numbers affected. Overseas travellers were not tested and traced, even though in the Liverpool-Atletico Madrid match, many fans from Spain who would have been exposed to COVID-19 in their own country which had already banned sports events from taking place, attended in significant numbers.

The UK Government imposed lockdown on 23 March 2020. This involved banning all 'non-essential' travel for British people, contact with people outside one's home, including family members and partners, and shutting almost all schools, business, venues,

facilities, amenities and places of worship. People with symptoms, and their households, were told to self-isolate, while the most vulnerable - those over 70 and those with certain illnesses, were required to shield themselves. People were made to social distance, keeping at least 2 metres apart when in public. Police were empowered to enforce the lockdown, normally through fines, and the Coronavirus Act 2020 gave the government emergency powers. Additionally, emergency field hospitals, known as 'Nightingale hospitals' were urgently built in order to increase bed capacity in the National Health Service (NHS). All non-urgent hospital treatment was postponed and health staff redeployed to fight the coronavirus. The focus on preventing hospitals from becoming overwhelmed, was achieved. However, this has meant that care homes were having to take patients with coronavirus from hospitals, but without knowing which were infected and without having adequate personal protective equipment (PPE) for staff and other residents (Booth 2020). There was considerable concern over the Government's failure to ensure sufficient PPE supplies for health and care staff, let alone others in the community requiring it, including social workers and social care workers. The lack of PPE in caring institutions allowed the infection to spread more quickly throughout hospitals and care homes.

A major concern during the period of lockdown which was exposed towards its end, was that the Prime Minister's Special Advisor, Dominic Cummings drove his wife and child from London to Durham, undertook several trips to hospital when in Durham, and then travelled to 30 miles to the village of Barnard Castle to test his eyesight, and justified it all as necessary for him to access childcare when he and his wife were falling ill to the coronavirus. The inadequate justification for this action raised the issue of why his interpretation of the rules was permissible at a time when other people could not see loved ones in hospital or care homes or attend the funerals of those loved ones who had died. Cummings' actions and the Prime Minister's defence of them, undermined trust in the Government among many members of the public.

In May, the lockdown started to be eased. On 10 May 2020, Prime Minister Johnson asked those who could not work from home to go to work, avoiding public transport if possible; and encouraged the taking of 'unlimited amounts' of outdoor exercise while allowing driving to outdoor destinations within England. Other easing measures happened during May and early June. Whilst many of the laws and regulations in relation to the pandemic covered the four countries of the UK, the devolved governments of Scotland, Wales and Northern Ireland have used their own powers to respond differently with regards to the easing of lockdown. Schools opened in England for some children in early June, but not in the other countries. However, even in England, many parents refused to send their children to school, fearing that they might become infected and then pass the disease on to other members of the family. Teachers were worried that they too could end up transmitting the coronavirus to those in their homes, given that the potential of children who may be asymptomatic to spread the disease remains unknown. There are concerns among many, including scientists that are advising the Government, that lockdown restrictions are being lifted too soon and that infection and death rates will rise again, particularly as the testing and contact tracing system is not yet fully functional, and may not be for some time. The public is demanding a public enquiry into the Government's handling of the COVID-19 crisis and one has been promised once the pandemic has ended. However, the COVID-19 Bereaved Families for Justice UK, consisting of survivors of people who have died from COVID-19, especially in care homes, insist that the enquiry is opened now to prevent avoidable deaths due to Government mistakes.

Throughout this period of time, the Government sought to offset the economic pain of the coronavirus by introducing the 'furlough' system of paying 80% of a worker's wage if the employer retained their job, providing interest-free loans for small businesses and helping key sectors of the economy to function by ensuring that the children of 'essential workers' could continue going to nurseries, school or creches. This economic strategy ensured that people on low pay could afford the basics, e.g., food. But it meant that rents and mortgages became unaffordable. Thus, the Government introduced a 'mortgage holiday' and barred evictions for those in the private rented sector. Whilst helpful in the short-term, this strategy still leaves the question of what happens when these schemes end, unanswered.

Much of the attention of the media and public in relation to professionals during the height of the pandemic and lockdown, was on doctors and nurses working in the NHS. They were portrayed as 'heroes' and for ten weeks people came out of their houses every Thursday at 8pm to clap for NHS workers and carers. Although identified as key workers, social workers have received much less attention from the media and politicians.

Comments

There continues to be much debate and questioning of the UK Government's handling of the coronavirus pandemic, which continues with the easing of the lockdown. There are calls for a public enquiry as some commentators argue that the government is putting business interests before public health. Moreover, the Government introduced a 14-day quarantine for travellers coming into the UK from 9 June 2020, which is believed to be regarded positively by the public (*The Observer* Editorial 2020). However, British Airways, Easyjet and Ryan Air are mounting a court challenge to this policy as they expect it to result in considerable loss of revenues. Additionally, there are also supporters of the easing of the lockdown and opening up of schools. The former is driven by concerns about the damage being incurred to the economy and the hardship many, especially those on low incomes, are facing during the lockdown. The latter arises due to the worry that existing inequalities and underperformance in schools will be intensified among the disadvantaged sections of the population that are not getting adequate home schooling during the lockdown.

Social services responses

Social services for children in need, child protection and children in care continue to be provided by (municipal) local authorities with some services, such as family support and advocacy provided by charities. Also, many children's homes and fostering services are provided by private companies. Adult social work services for older people, people with mental health or substance misuse problems or disabilities, and other vulnerable adults, are provided by local authorities, the National Health Service, some charities and private companies. Home care and residential care for older and disabled people are largely provided by private companies.

Social service providers had to respond very rapidly to the pandemic and lockdown. Many social workers moved to working from home and used phones, messaging and WhatsApp to keep in touch with service users. Home visits have continued for some service users, especially for emergencies and very vulnerable children and adults. Residential and home care workers have continued to offer direct care to children and adults. There has been a delay in the requirement for and provision of PPE for social

workers and care workers, with funding issues being cited as a contributing factor to its lack in residential care for older people (Milne 2020). The British Association of Social Workers (BASW), the Department for Education and the Department for Health and Social Care have all issued guidance for social workers during COVID-19, available on their websites.

There are very real fears about the dangers lying behind the closed door of the family home, beyond the professional gaze for children and adults at risk of abuse or neglect. However, there are also examples of creative ways of practicing differently happening, including providing young people with computers to use during the lockdown. Technology can in some cases aid communication, especially with young people more accustomed to its use as a mode of communication. Although there are groups of service users who are unable to use or, through poverty, have access to digital technology, both social workers and local authorities are seeking funding from the voluntary sectors and other sources to provide laptops for as many young people as possible. The family courts have moved to being conducted largely virtually with concerns expressed about the fairness of remote hearings in specific cases and circumstances where there may be communication difficulties, for example, using interpreters remotely.

Comment

The pandemic has clearly exacerbated the deep structural inequalities that already exist in British society and the hollowing out of support services following a decade of 'austerity' policies. Life during the pandemic has been extremely difficult for many millions of people across the UK, but particularly so for individuals and families on low and precarious incomes and in over-crowded sub-standard housing. The role of community-based, local mutual aid groups has been instrumental in providing basic support for vulnerable people in the community. Indeed, research by the New Local Government Network (2020) found community cohesion and trust have never been higher, with over 95% of council leaders noting that the contribution of community groups to their COVID-19 response has been very significant or significant. One of the outcomes of this pandemic, could be a reinvigorating of community-based social work, which has largely disappeared over the years in the UK, except in rare situations, e.g. the Gilesgate Project (Dominelli 2012).

Social work education

Social work education has not been spared the impact of COVID-19. All universities went online, and this raised considerable problems for social work students who were not allowed to continue with practice placements. There have been and continue to be on-going discussions with the professional regulators in the four countries of the UK regarding adapting requirements in ways that ensure that students meet professional standards but with flexibility for doing so in the current context. What to do about this remains controversial, and although many students did continue to work in agencies as volunteers and paid workers, they were not offered university support for these activities, except informally by their tutors. Some social work academics, including one of the authors (Lena Dominelli) supported social workers in the UK and internationally by establishing a support network operating through remote means to offer support and information. Much of this was provided through leaflets which social workers distributed locally, and in some courses. These can be found on the IASSW (International Association

of Schools of Social Work) and the BASW (British Association of Schools of Social Work) websites. A small group of social work academics, including one of the authors (Anna Gupta) and a practitioner established a free on-line journal during the pandemic that has issued four editions and has attracted contributions from social workers, students, academics and people with experience of social work services and is available on https://sw2020Covid19.group.shef.ac.uk

The situation for the next academic year remains uncertain, although online provision is likely to remain in force. Additionally, universities have not been immune to economic exigencies. Many are running deficits and are concerned that this will cause considerable hardship next year as student revenues are expected to fall dramatically. Overseas student numbers are anticipated to fall significantly, and large numbers of home students are planning to defer for a year. This will lead to significant job losses and closures of courses deemed 'economically non-viable'. Yet, a twitter campaign to increase the amount and number of social work bursaries across the board and letters written to relevant ministers and politicians initiated by one author (Lena Dominelli) has not produced the desired results. Thus far, the body responsible for the UK university sector – Universities UK, on which all university vice-chancellors sit, have had their request for emergency funding of about £2 billion rejected by the Government.

Concluding comments

The COVID-19 pandemic has hit the UK hard, and it has the highest number of cases and deaths in Europe. This sad state of affairs may have been avoided if the Government had acted differently, such as going into lockdown earlier. This issue will become the subject of a public enquiry in due course. Meanwhile, there is significant concern about a second wave, and the differentiated impact of the coronavirus which has hit older people, health and social care workers, BAME groups and other disadvantaged groups particularly hard.

Social workers have been adversely affected, losing much of their face-to-face contact with service users, trying to provide services with inadequate PPE. Nonetheless, they have continued to provide much needed services heroically and without appropriate PPE, and have risked their lives and those of their families to do so. Social work academics, researchers and students have also struggled with the pandemic. Some have continued to provide services to others in their communities (however defined), and all have gone to teaching and learning online, a reality which is likely to continue for some time.

These experiences among health and social care professionals, the social work communities of practice, and volunteers in the community have highlighted key lessons for restructuring society. These are hoped to continue into the post-COVID period. They include: addressing structural inequalities, especially the racism that is endemic in British society; ensuring the valuing of public services and civic duty including those offered by social services. Let us hope that together, people in their communities can influence politicians to bring about much needed social changes highlighted by the disparities exposed by Covid-19.

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CONCLUSIONS

Lena Dominelli and Timo Harrikari

COVID-19 has raised many questions for societies across the world to address. It has brought out the best in community volunteering as people came together to support each other in times of need and exposed the value of community. However, this solidarity remained local as each country focused mainly on national, not international developments. COVID-19 also highlighted weaknesses in government strategies aimed at dealing with the pandemic, and as a result some countries suffered fewer casualties than others. Most governments responded by declaring a state of emergency in which many taken-for-granted freedoms including those of consumption, movement and association were curtailed. Ensuring the survival of the general populace replaced individual freedom of choice that had been a hallmark of modern societies. Responses to these restrictions were varied, but generally, most populations followed the instructions issued by their governments.

The contributions to this compilation have highlighted key trends in policy and practice in dealing with the pandemic. However, they are limited to 16 countries, and so these concluding comments can only relate to them. The data provided within these *Country Reports* have revealed the many patterns that exist in all the stories that have been brought together. Some are shared with others. Some are different. But all are important.

Shared patterns in analysis and service delivery

A key issue that arose in all the contributions is the importance of the family – whether nuclear, extended, or blended, in enabling people to survive COVID-19. At the same time, the family was called upon to cover the gaps left by the withdrawal of state services and the demands that had to be met regardless. This also increased the household burden on women who found that in addition to cooking, cleaning and caring, they had to 'home teach', even though they may have been working from home and had to share this space with every family member. School closures and the inadequacy of online and home instruction over time has been a common trend, although there are variations in how quickly schools were reopened. In countries like Sweden, they were never closed.

Technology has been considered an ambiguous blessing by many contributing authors. Although all countries had social workers move from face-to-face interventions to online ones, these were not seen as beneficial for all the situations that social workers encounter. The inability of social workers to assess children at risk effectively if relying solely on this means was a concern for many practitioners. Among those patterns of behaviour that are similar were concerns about the increase in domestic violence and potential abuse of children and older people in families that are struggling with being confined in the same, sometimes small, spaces for a prolonged period of time. However, most highlight the paucity of data available on this topic.

Another common trend is reflecting upon the invisibility of professional social work. Despite the absence of comment upon social work in the media, in some countries, e.g., India, the contributions of social workers in relieving COVID-19 distress in both the formal and informal sectors have been substantial. In others, e.g., Slovenia, social workers have played a modest role in providing services under COVID-19, while in Sri Lanka, the

current Government has shown little enthusiasm for increasing its role during the pandemic. Additionally, in Sri Lanka, the Government has ignored cultural traditions when demanding that all COVID-19 infected bodies were cremated rather than being buried when people died. This undermined the cultural needs of Muslims and Christians, religious minorities in a predominantly Buddhist country. Cultural sensitivity, ethical behaviour and anti-oppressive practice have received both implicit and visible treatment in all contributions, but it is expressed primarily as person-centred practice.

Another common pattern that has emerged is the higher rate of deaths among older people, and the particularly shocking situation of deaths in care homes for older people. This trend is often driven by insufficient supplies of personal protective equipment (PPE) and resourcing, including of staff, and a general indifference to their well-being. In some situations, e.g., the UK, this included the transferral of older people from hospital settings to the care ones without their being tested for the coronavirus. Hence, if they were carrying it, they would be bringing it with them into the care homes where susceptible people lived. The inadequacy of support for people generally, but especially for older people, disabled people, those with substance misuse problems and homeless people also feature often in this compilation of *Country Reports*. Austerity, a feature of neoliberalism, was highlighted by many country reports for undermining capacity in health care system and social services. This prompted calls for the under-capacity in these services to be addressed, e.g., Slovenia and India.

Another common pattern was reflected in the concern of the implications of lockdown for national economies, and a potential, deep recession on the horizon in all countries. It damage is expected to be severe everywhere, but the narratives contained within these pages indicate that the challenges will be particularly harsh for those like Bangladesh and India. This outcome is feared despite the attempts in most countries to mitigate this damage through state support for businesses and jobs. There have also been discussions about whether giving priority to the economy is the way to ensure that the many inequalities exposed by COVID-19 will be overcome. This debate is likely to continue for some time. Food insecurity was another common theme. It was most poignant in India where imaginative schemes were used to ensure that those that the Government had let down when it initially introduced the lockdown, especially migrant workers, were fed.

Another feature these contributions commented upon was the lack of adequate and reliable data about what was occurring within the social system generally. These also highlighted the lack of certainty in the figures concerning how many people had succumbed to the coronavirus, how many had died from it, and where they were located. The paucity of robust data made it difficult to plan the services that would be needed, and to prioritise responses. Additionally, it subjected many people to unnecessary risk.

Different patterns in the conditions surrounding the COVID-19 emergency

Different trends were apparent in the ways that countries dealt with the pandemic, especially in terms of preparing for it, reacting to it when it arrived, and the conditions to be followed in lockdown and is duration. In Australia, the term lockdown was rejected in favour of shutdown. In Italy, practitioners highlighted the importance of interagency collaboration as key to controlling the ravages of the coronavirus. Despite this, various restrictions prevailed in all the countries covered because the fear of the coronavirus returning is widespread. So was the importance of not stretching demands on health services beyond their capacity to cope. Sweden is particularly interesting in that it introduced a limited lockdown, and future research can be used to highlight what this

meant for the everyday lives of people surrounded by uncertainty about who was infected by COVID-19 and who was not.

The testing and tracing regimes of different countries have also been varied, often due to shortages in capacity to carry them out and follow through. However, those who have carried these out systematically have had better outcomes in terms of reducing the spread of the coronavirus by having people quarantine or self-isolate if they had the coronavirus or suspected that they did. Another surprising trend was the large number of deaths among men, where in some countries, e.g., in Sweden and the UK, they were higher than those of women. In others like Spain and Finland, deaths attributed to COVID-19 were much higher among women than men. A further concern, was the disproportionate number of deaths among Black, Asian and Minority Ethnic Groups (BAME), e.g., the UK. Along with the impact being hardest on those with limited financial resources and other forms of structural disadvantages, there are urgent calls for transformational action to be taken to eliminate such disparities of outcome.

While the current coronavirus pandemic will eventually end, a recent analysis of the future of social work suggests that we may have entered a new historical era in which the profession faces an increasing number of ecological (Dominelli 2012) and biological hazards that threaten the survival of humankind (Harrikari and Rauhala 2019). In general, we know more about our environment than ever, but it has also become more unpredictable and complex and subjected to extreme levels of exploitation (Dominelli, 2012). This insight has been exposed by the COVID-19 pandemic that was first noticed in a market selling wild animals for human consumption. The growing encroachment of humans into the planet's remaining wilderness is likely to increase humanity's susceptibility to further pandemics as the human-animal barrier continues to be broken.

Nonetheless, despite the challenges facing humanity, the socio-ecological fabric of human communities has quickly turned to more networking to form alternatives in everyday existence. Consequently, social work has been increasingly surrounded by multi-directional dynamics, where social systems are complex, emergent and stratified. As the global interdependence of natural, bio-physiologic, economic, political and social systems becomes evident, new, immediate and resilient solutions will have to be developed to govern living conditions within the global village. Indeed, social work is a part of adaptive governance that promotes the adaptation of human communities and strengthens their resilience in changing circumstances (Boyd and Folke 2012). Resistance to external shocks, the ability to recover from such external shocks and the ability to adapt to new circumstances require the strengthening of the resilience of social work professionals and social welfare institutions (Rapeli et al. 2018). They also require social workers like us to make demands of the policymakers that they make available the resources that will instigate a new, hopeful era in human relations, and one that acknowledges the interdependence between people and the animal and plant kingdoms. Hopefully, this compilation of first-phase country reports can initiate long-term developmental work in social work which can offer the profession research, innovative models and new recommendations for best practices to be better prepared in future pandemics. This collective experience has also affirmed the importance of affirming international solidarity in solving complex disasters such as this health pandemic and move together as one world. If this can take place, then the negative cloud of COVID-19 may have a silver lining in bringing humanity together to solve 'wicked' social problems that affect everyone, albeit differently. Social work has an undeniable role to play in this scenario.

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