

# **Strong and fragile: Learning from older people in emergencies**

November 2007

‘You are the first people in the history of this camp to ever come and talk to older people and to ask about the circumstances and needs of the elderly’

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**Funded by**



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# 1. Introduction

This report was prepared at the request of the Inter-Agency Standing Committee (IASC) Working Group. It explores the humanitarian community's current policies and practice in responding to the needs of older people affected by disaster. It identifies ways by which older people can be seen as an asset in such circumstances as much as an underserved group with a particular set of unmet needs. A summary of this report was presented, along with the recommendations contained in this Executive Summary, to the 69<sup>th</sup> Working Group meeting of the IASC, which met in Rome on November 5<sup>th</sup> 2007.

The overall finding of this report is that there are several aspects of current humanitarian practice that do not adequately meet the needs of vulnerable older people. The report makes a number of practical recommendations that are intended to help those assessing, designing, implementing and funding relief programmes to better understand the needs of affected populations and therefore to meet their particular needs. Although the humanitarian community does include older people in its current definition of vulnerability, it is often as an afterthought '.....and the elderly' - always at the end of the sentence, and almost always at the end of the list of priorities.

The context section below outlines in some detail the demographic and other trends that underpin this report. It is worth highlighting that none of these trends respect national borders, and their likely consequences are relevant for developed and developing countries alike. Examples in Europe and the US indicate that even where more developed and sophisticated civil response and health structures are in place, older people have felt the impact of recent natural disasters disproportionately, and these events have highlighted weaknesses in national and local responses.

Several of the observations we make about current practice, and some of the recommendations that result, are likely to have an impact much more widely than just on older people. This is inevitable. Whilst we have focused on the needs of a particular group, this report does not intend to make a case for responding in ways that only meet the needs of older people, other than when their particular age related needs would require it. As we discovered in both of the countries we visited, organisations with narrow mandates, narrowly applied, can unwittingly encourage exclusion. Older people are people first, and old second, and several of the recommendations we make would benefit the whole population. However, given the particular vulnerabilities and needs of the target group, it is hoped that these changes would lead to disproportionate benefit for vulnerable older people and the oldest old in particular.

The terms of reference required that we look at whether the UN Cluster System provides a mechanism where cross cutting issues such as age might be dealt with adequately. Perhaps unsurprisingly, we received a wide range of views about the effectiveness of the Cluster System, which covered more than just its impact on older people. There are clearly ways in which the whole system needs to evolve to ensure that it meets the needs of entire populations rather than just sub-sets, and we tried not to get drawn into too detailed an assessment of the Cluster approach as a whole. We are aware that other studies are underway, and our recommendations for improvement are intended to focus on the reasons why a cross cutting issue such as old age is not being dealt with as well as it might. Overall, it was clear that the system has the potential to deliver better co-ordinated and more thoughtful responses to this group.

It is important to note what we do not recommend as the way forward in better meeting the needs of older people affected by disasters:

- We do not recommend the creation of specialist new NGOs or UN institutions to respond to this growing demographic challenge
- We do not see the need for the establishment of additional Clusters to respond better to the needs of this (or any other) vulnerable group
- We do not consider 'old folks homes' or other forms of institutionalisation as a sustainable solution to the growing number of destitute older people likely to be left in need of assistance as a consequence of disasters

We feel a better way forward is to ensure that the needs of older people are built into the initial analysis, planning and implementation of relief responses, rather than have them ignored at that stage, and responded to retrospectively as part of an ever broadening 'vulnerable' group. 'Mainstreaming' is an over used word, but does reflect the most desirable outcome.

It is also important to note that by no means all of the recommendations that we make need cost more money. One of the more consistent conclusions we came to was that although there are certainly some 'technical' improvements that can be made in the way in which we currently operate, much can be achieved by better understanding the nature and consequences of the physical and other needs caused by ageing, and incorporating them into everyday practice.

We consider that, given the scale of the challenge, much of the solution lies in actively promoting a better understanding of the role and responsibilities of communities towards their own older people. We were assured by many of the people we met that traditional community and family support mechanisms were still strong, and saw some examples of this. However, at the same time we more often heard that for a variety of reasons, this is weakening. Some of this is an inevitable consequence of a number of global trends, not least the move from a subsistence- to a cash economy – a less social- and a more market- based society - but its impact is apparent. Given the growth in the numbers of older people who will both live longer and at the same time be less likely to be cared for by their families, this will oblige governments and the humanitarian community to factor it into both development and disaster response thinking.

We feel at the very least that we should be adopting a 'Do No Harm' approach towards older people affected by the relief programmes that we deliver. In order to achieve this, we will need to better understand the needs of this group. By doing so we feel that the many positive benefits of working more closely with this group will become clearer.

Although we did not set out to endorse HelpAge International's experience over recent years, many of the things we heard, and the issues that were raised with us, suggest that much of HelpAge International's analysis accurately reflects the reality on the ground. Whilst not proposing them as the definitive approach, we have attached as annexes a sample of HelpAge International guidelines in areas where we feel there is useful and relevant experience that could help organisations adapt their practice.

## **2. Background**

### **HelpAge International**

HelpAge International, established in 1983, is the only global network of not-for-profit organisations with a mission to work with, and for, disadvantaged older people worldwide to achieve a sustainable improvement in the quality of their lives. HelpAge International works to this end by supporting practical programmes; giving a voice to older people; and influencing policy at local, national and international levels.

### **Context**

An older person is defined by the United Nations as someone over 60 years of age. The 'oldest-old' refers to those over 80. Concepts of old age differ from region to region depending on culture and context. For example, becoming a grandparent or a widow; having grey hair; or enjoying the status of a community 'elder' can all be benchmarks of age. In poor countries, a lifetime's exposure to health problems means that people can seem 'old' in their 40s and 50s, in particular women after years of hard physical work and many pregnancies.

We are living in an era of rapid global ageing. By 2050 the numbers of people aged over 60 is expected to triple to 1.9 billion. Most of the increase in the older population is taking place in low-income countries where average income is less than \$2 per day. The over 80s are the fastest growing old-age group, expanding at a rate of 3.8% a year, compared to 2% per year for the 60-79 group. Work on chronic poverty is identifying older people as amongst the most socially excluded and chronically poor. Therefore, whilst increased life expectancy is one of humanity's major achievements, it also presents significant challenges in particular in crisis and disaster settings where traditional means of coping are often disrupted to the detriment of older people. Older people have many abilities and talents that are insufficiently recognized by humanitarian actors, and make a vital contribution to the care and support of children and families, in particular those affected the HIV/AIDS pandemic.

### **Process**

The HelpAge International research team visited the head offices of IASC member agencies (UNICEF, WFP, UNHCR, UNFPA, WHO, UNDP, FAO and OCHA) as well as of Oxfam GB and CARE USA, the ICRC and the IFRC in Geneva, and the British Red Cross Society in London.

The research team presented the background issues and global trends that underpin this review, and in particular raised awareness of the profile and scale of global ageing and the predicted growth in the number and impact of natural disasters. The presentations met with very little scepticism and comments received confirmed that agencies were already witnessing the first stages of these trends, and recognised them as relevant.

In addition to head offices, the research team visited two relief programmes with displaced and returning populations in Uganda and Pakistan, and met with a range of humanitarian agencies. These two countries were chosen for the contrasts they present - they are geographically, culturally and economically different; populations in Uganda have been displaced by conflict, in Muzaffarabad by an earthquake; in

Uganda the return process had started and in Pakistan this was being planned. In both places logistical and security challenges for agencies and government were significant.

The research team spent up to a fortnight in each place, meeting with stakeholders recommended by local OCHA and NGO partners to ensure those agencies most directly involved in programme design and implementation were consulted. These in-country conversations involved local and international NGOs, district regional and national government, and the UN system. Many of the issues and concerns identified reflected HelpAge International's previous experience and analysis.

The purpose of these missions was to look at health and protection issues in particular. A health specialist accompanied the team in Uganda, and a protection specialist in Pakistan.

Importantly, the research team met with as many older people as possible, including groups, individuals, displaced, returned, with families or on their own. The research team also gathered an informal reference group of representatives from IASC and NGO participating agencies to review and comment on the draft recommendations before submission to the IASC-WG to ensure that they were clear, practical and actionable.



**60-year-old Antoinette from Uganda is looking after seven of her grandchildren (Kate Holt/ HelpAge International Feb 2007)**

## 3. Findings

### 3.1 General

It was striking how quickly the implications of an ageing global population on the roles of organisations and individuals were recognised by the people interviewed for this report. Global ageing and increased natural disasters do not respect national borders, and their likely consequences were recognised as relevant for developed and developing countries alike.

Despite this, there are very few international or local non-governmental organisations working to raise the profile of the ageing and the needs of older people. On several occasions the research team was told they were the first visitors ever to have discussed the needs of older people, despite awareness of their vulnerability. This reality is in sharp contrast to the advocacy on behalf of other vulnerable groups.

The 'invisibility' of the older part of the population was also very striking in the two countries the team visited. In both Pakistan and Uganda, the presence of older people as a significantly vulnerable element in the displaced population was only properly exposed by the return of the bulk of those displaced. When brought together by displacement (as opposed to being distributed more manageably amongst their communities) they present a significant social and humanitarian challenge. The research team saw some particularly grim examples in Uganda, where thousands of older people face a very uncertain future in decaying displaced camps where food and medical support has been reduced or been removed by the humanitarian community to encourage return.

Illiteracy, physical weakness and limited language abilities amongst the older generation all contribute to this 'invisibility', as it makes it more difficult to communicate with them, and for them to participate and make themselves heard.

District government and camp administrations in both Pakistan and Uganda acknowledged that the 'oldest old' (80+) were amongst the most vulnerable in their populations. At the same time, at the national level, the needs of older people did not appear to be a domestic political priority. Whilst women, children and young people are catered for in their own right, older people are either not seen as a problem, or as being relatively unimportant. However, the sheer scale of the growth in numbers of older people means that it is essential for government and communities to be better able to provide support before, during and after emergencies.

Although this might be the reality on the ground, older people are included in the definitions of vulnerability in both countries visited in this study. In Pakistan the government's earthquake reconstruction agency had clearly identified older people as a key category of vulnerability, and was keen to establish programmes to support them. In Uganda, the Ministry for Gender is currently putting 'age friendly' legislation in place, but similarly acknowledges that there is little experience or tradition in understanding and responding to older people's needs. Government officials at all levels, those managing camp and displaced populations and particularly older people themselves, said that our visits were long overdue as it was high time the issue got attention.



**Kashmir Earthquake survivors (HelpAge India Dec 2005)**

There is some perception that older people should be supported and respected, but the appropriate role perceived for them (and by some older people themselves) is largely passive. It is assumed that after 60, older people 'can't work' and 'just sit'. This is exacerbated in a disaster, particularly where systems and processes exclude older people's participation in community and camp life.

Family relationships endure additional stresses as a result of economic hardship and poverty arising directly from disasters. Financial pressure is a critical ingredient in care of the old, as it puts an additional strain on family support mechanisms. Those left behind when people are displaced, or who are unable to return to their homes can quickly become destitute. The oldest old and vulnerable older people struggle to survive by manual labour.

Despite rhetoric to the contrary, the research team became aware in Pakistan and Uganda of an erosion of traditional community and family support mechanisms. These support systems tend to be further weakened by displacement, thus undermining a vital asset to facilitate support and return processes at a time when they are most needed. This trend is leading to a greater level of destitution on the part of older people, and a reduction in their ability to cope with the upheavals caused by disaster and displacement.

In both countries, but in Pakistan in particular, we heard consistent and strong expressions of cultural commitment to the care for their older people by families and communities, and witnessed plenty of practical and moving evidence to confirm this. However, we also met and heard of examples on both visits of older people made destitute both by abandonment and by the death of their children. We also received a strong sense from at least some of the interviewees of an increasing social trend in both countries that traditional respect for, and support of, older people by their families has either been lost or is being eroded. In Uganda this appears to have been

hastened by displacement and the chaotic events of the past years. It was encapsulated by the old lady in Alur camp in Uganda who said that there had been ‘.....a loss of culture – our children have become big headed....’. One old lady in Panjkot in Kashmir told us ‘.....only Allah is with (looking after) the old....’.

We witnessed the considerable anger and frustration felt by some older people:

*‘I have worked all of my life for the State, and I have been abandoned’ complained a retired man in Gulu. A displaced older woman in Olwal camp said ‘Our livelihoods have been removed by the army and by the LRA’ and demanded ‘who do we sue? Our animals were stolen by the army and the LRA. Who do we sue? Our children and families have been killed by the army and the LRA. Who should we sue? Who will compensate us?’*

All humanitarian interventions have the power to reinforce or undermine traditional values and practices, and relatively simple and no- or low- cost adaptation of existing processes and approaches can play a significant role in ensuring better access to services for older people.

### **3.2 Health**

The special health and welfare requirements of older people are not being adequately addressed. The appropriate knowledge and skills required are in very short supply when compared to the assistance available for children and pregnant women. The situation is particularly poor at the district level, where, without international assistance, technical skills in health and social care for the old are virtually non-existent.

Chronic medical conditions are not being addressed. This situation partly reflects the failure of a primary health care services to take an holistic approach to people’s medical, psychological and social needs, (an approach that is particularly pertinent to older people where health and social care issues become increasingly blurred and do not fit neatly into vertical models of provision).

The research looked at health issues in some depth in Uganda, but many of the findings were similar in Pakistan, if not always illustrated in the same extremes. As outlined in the methodology section, the team concentrated on the north of Uganda and the displaced populations living in camps<sup>1</sup>. Not surprisingly, a lack of food was cited by most as their main health issue. This was particularly so in Lira District where general food rations stopped at the end of 2006 and were reduced to 60% for Extremely Vulnerable Individuals. The lack of adequate food supplies was compounded by:

- Lack of physical energy to collect firewood and water and cook the food provided - more potatoes, rice, bananas, beans and peas in their diet would help, but they had never been asked;
- Problems with poor gums and lack of teeth; some had had teeth extracted by the LRA. There was no dental help available;
- In some households food was being withheld from older people.

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<sup>1</sup> Many of the findings corresponded with a government report looking at older people’s health issues more generally - The Republic of Uganda, Ministry of Gender, Labour and Social Development, ‘Health Needs of Older Persons: an assessment report on Kamuli and Wasiko Districts’. Department of Disability and Elderly. May 2002.

Joint- and mobility- problems were also of high concern. Joint pain, especially hips and knees, and back pain were a widespread problem. We were told that 'when very painful older people soaked their joints in hot water'. It was reported that the staff at the camp clinics and general hospitals were totally uninterested in such 'ageing' issues and never offered analgesia or other help, such as mobility aids. Various analgesic gels were found in the private drug shops in villages but few people had enough money to buy them.

Reduced mobility affects survival. As the camps close the older people we talked to all needed to work on farms or in gardens to feed themselves and survive. At this level no one gets a pension. Older people weed gardens on their hands and knees to earn enough to feed themselves and their grandchildren. When they can no longer do this they know they, and possibly those in their care, will die.

Nearly all those interviewed had problems with their eyes, predominantly presbyopia (long-sightedness incident to old age), cataracts, chronic infections and post infection and trachoma scarring. Excellent ophthalmology facilities are available in nearby towns, but very few of the older people we met in the camps and villages knew about the services available or had the capacity to access them

**Symptoms and health conditions observed and reported included<sup>2</sup>:**

Under-nutrition and malnutrition; wasting  
Respiratory tract infections  
Eye complaints – poor eyesight; cataract; ectropion; sore eyes; eye infections  
Joint problems – joint pain; painful legs, hips and knees; swollen knees and ankles; backache  
Mobility problems – unable to walk due to pain or paralysis; post-stroke complications; need for mobility aids such as walking sticks, strollers and wheelchairs  
Headaches  
Poor teeth and gums  
Skin disorders – oedema; ulcers; rashes; discolouration; irritation  
Insomnia  
Stress and anxiety; loss of senses  
Swellings – non-toxic goitre; hernia  
Hearing loss  
Malaria  
Abdominal pain

Despite the obvious health needs of older people, there was difficulty accessing services. The camp clinics are seen as providing services for children and pregnant women and the facilities, skills and drugs available supported this view. 'We never see a health worker in the village unless they are attending to immunise children' was a widespread viewpoint.

The older people we talked to felt that the attitude of staff at the hospitals and clinics was neither respectful nor helpful. They were treated as 'worthless' and told that their problems were 'just because of age' and that 'nothing could be done...'. This

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<sup>2</sup> Medical notes were not available and kept and physical examination was not undertaken. The conditions reported here were observed by the team or reported by members of the interview groups. It is worth noting that conditions such as mental health problems and urinary incontinence were hardly mentioned and it was impossible to assess the level of cardiovascular disease, malignancy etc in the communities we visited.

perception has been reported by a number of authors<sup>3 4</sup>. During our visits there was a glaring lack of any health worker with a remit for the care and welfare of older people. We came across no homecare or outreach schemes.

The direct health issues we were told about were exacerbated by a range of factors, including the burden of caring for orphans, which was made even more difficult by the lack of school places for children and the expense associated with sending them to school.

In Olwal camp we visited two very old people, one a blind and severely arthritic man, unable to leave his hut, and looked after by his wife who also cared for seven grandchildren. The other was a very frail, blind woman who was unable to stand. She could crawl to the entrance of her hut but was essentially 'marooned' and looking after five grandchildren who came back to the hut to sleep at night but who otherwise ran wild in the camp, scavenging for food or being fed by neighbours.

Access to clean water, shelter, bedding, transport, financial loans and credit were also cited as problems impacting on health, often compounded by family abuse. We did not examine the people we met and basic health records were not available. It was therefore impossible to comment on conditions such as high blood pressure, heart disease, intestinal infestation and malignancies, for example. Certain conditions, such as urinary disorders and uterine prolapse, were not mentioned, almost certainly due to the large numbers and mixed nature of the groups we talked to.

### Psycho Social

A striking finding was the level of psychosocial needs encountered in both Pakistan and Uganda. Depression, loneliness, despair, a reduced sense of self worth, isolation, role change; all were in evidence. Given the circumstances in which people find themselves this is hardly a surprise; however, older people tend to be disproportionately affected.

As stated above, agencies unwittingly contribute to the problem by employing young or middle aged local staff thus further marginalising older people. As a consequence, decisions are taken, and processes established, that often do not reflect the particular interests of this group, further exacerbating their sense of disconnection and irrelevance.

Mental health issues still tend to be somewhat taboo and local service provision weak or non-existent in many developing countries. Trauma and other related mental health consequences of disasters tend to go unrecognised and certainly untreated.

### **3.3 Displacement, separation and return**

As stated above, the research team was struck by the 'invisibility' of older people and their needs in camp settings in both Uganda and Pakistan, and conversely, by their sudden emergence as the majority of those unable to return home when camps are closed. In both Lira (80%) and Muzaffarabad a high proportion of those left behind were there primarily for age related reasons.

<sup>3</sup> Ahenkora K. The Contribution of Older People to Development: The Ghana Study. London, HelpAge International 1999 (unpublished).

<sup>4</sup> Troisi, J. Training to provide for healthy rural aging. Journal of Rural Health, 2001, 17:4, 336-40.

Physical infrastructure, such as latrines, can be made more accessible for older users (and for other vulnerable groups) with relatively little effort. Oxfam GB's recent experience in Sindh Province of Pakistan during the August 2007 floods highlighted the beneficial impact of such relatively modest changes on access for older people.

The humanitarian community tends to recruit and employ young people, ideally multi lingual, to help administer camps and design and deliver services. Whilst it is clear why this occurs, older people feel excluded, ignored, and under-recognised. This leads to an increased sense of isolation and worthlessness; contributes to the despair that many feel; and undermines any authority or position that they might have had in their home setting. If older people's views and interests are ignored in the process of establishing and administering displaced camps, then feelings of uselessness and worthlessness may be exacerbated, and the design of procedures and the delivery of services may well be inappropriate for their needs.

In a similar vein, child friendly spaces in camps have tended to exclude grandparents (perhaps the original "child friendly space"). Where grandparents have been actively engaged (as they were in some camps in Pakistan) it has worked to everyone's benefit.

### Displacement and separation

Very few older people were separated from their families in Pakistan as a consequence of displacement. Most of the separations resulted from the transporting of the injured for medical care in other parts of the country. Families in the affected areas were able to decide for themselves whether to move or not, and if they did so, tended to do so as family units with their older relations. Those that stayed did so to protect their property, and because stored food and crops were available locally. Families who chose to stay in or around their damaged homes seemed to feel that they had fared better than those who had moved.

In contrast, the conflict in Uganda scattered families widely and the research team heard of many examples of older people who had become lost and separated from their families. People were often not given the choice to stay or leave – that decision was often forced upon them by the parties to the conflict. Once separated, older people were often abandoned by their families, or remained unaccompanied in displaced camps and settlements.

### Return

Governments and donors are keen to see an early end to the relief phase of any emergency. There is often a political incentive as well as a humanitarian one to get people home. These two interests can be uneasy bedfellows if the timetable driving return is quicker than is practically appropriate.

The process of returning home following displacement (even if relatively short term) raises significant issues for older people, and should be considered as a potentially serious future problem as their numbers inevitably grow. Older people left behind, or unable to return to their homes, can quickly become destitute.

It is clear that a proportion of the older displaced, particularly those without family support, will not be able to return home without significant assistance. In an under-resourced return programme they and any dependent grandchildren, risk being left destitute in decaying IDP camps.

Many of the older people consulted for this report were faced with intractable choices. Should they return home to face the uncertainties of reduced access to food, clean water, health care and importantly education for their dependent grandchildren, or should they stay where these have been provided? The lack of any educational provision in return areas was regularly stated as a major disincentive for older people who were reluctant to take dependent grandchildren out of school.

Return programmes are traditionally under- resourced. Health and nutritional status often dip as people struggle to rebuild their lives and livelihoods with inadequate means to do so. The phasing out of food distributions and the provision of 'take home' rations rarely fills the gap until the next harvest, and older people, and particularly those without family support, find this process very difficult. This situation would appear to be the case in both Uganda and Pakistan, and the consequent deterioration in nutritional status in both should come as no surprise.

Attention must be given at an earlier stage to identifying long term solutions to the needs of vulnerable groups. Community and family support mechanisms must be strengthened and underpinned to prevent this group being left behind and posing intractable social care problems.

Whilst social care institutions may be attractive from a political viewpoint as a means of 'tidying away' the last remaining displaced people, they should be seen as a last resort. Every effort should be made from as early in the emergency response as possible, to ensure that vulnerable individuals are recognised by those with protection responsibilities, families and communities.

### Shelter and land

Access to land following displacement emerged as one of the most important issues in both country examples studied. The longer the period of displacement, the more difficult and intractable land tenure and ownership issues become when return is possible. The research team expects to see this issue become increasingly important in the years ahead, not least because the rapid population increases in a number of developing countries will place ever greater pressure on usable land.

Following displacement from rural areas, families have traditionally returned with seeds and tools and some basic food to enable them to plant and grow sufficient food. For older people, this assumes that they either have family support to help them clear and rehabilitate their fields, or that they possess the physical strength to do so themselves. The research team met large numbers of older people who had neither, and were effectively stranded in displaced centres.

Shelter, or the lack of it, poses one of the greatest obstacles to older people's return after displacement. In Uganda, after years away from home, people faced the daunting prospect of starting from scratch, with roads, water sources and fields overgrown or non-functioning. Many older people, especially the oldest old, said they were physically unable to rebuild their houses. However, if some way were found to build them, then they would prefer to return to their villages and attempt to restart their lives. In Pakistan, the issue of shelter is also fundamental. Return has been complicated by the unstable nature of the soil, which has led to warnings that some of the areas to which people are returning are geo-morphologically dangerous.

Establishing ownership of disputed land is stretching Uganda's traditional conflict resolution mechanisms. Disputes can be taken to the formal official judicial system. However, the research team heard from older people of their fear that if that happens, the rich will always win, and put the older poor at a disadvantage. Lack of

documentation proving ownership following a disaster has been a significant protection issue. Although it affected all older people, the research team heard several times that access to land and to adequate shelter was an issue that affected older women in particular.

### Migration

Migration is one of several global trends having a potentially detrimental impact on the lives of older people. In Pakistan immediately following the earthquake, there was movement of people in two directions. Those living in the affected areas chose whether to stay or leave to seek assistance. At the same time, a large number of men who had been living away from their families as migrant labour were returning in an attempt to discover whether their families had survived. The population actually hit by the earthquake was disproportionately composed of older people, women and children.

Given the predicted increase of large scale, global economic migration by men of working age, the humanitarian community should expect to see rural areas, and particularly remote ones, with a population composed of a disproportionate number of older people, women and children. Some of that movement may be temporary, but the continuing growth of cities and urban economies, and the impact of climate change on agriculture are leading to significant and permanent shifts. The humanitarian community should therefore expect future disasters in remote areas to have an immediate impact on a disproportionately vulnerable population.

### **3.4 Role, capabilities and livelihoods**



**73-year-old John Riukaanya cares for more than 20 orphans in Uganda (Kate Holt/ HelpAge International Feb 2007)**

The role of older people in families and societies is often significant, and as often overlooked. Many older people are intimately involved in childcare, for example. This becomes particularly noticeable in societies heavily affected by HIV and AIDS where

grandparents become primary carers. Estimates are that over half the children in the north of Uganda are now being cared for by a grandparent. Data from sub-Saharan Africa has found that up to 60% of orphans live in grandparent-headed households, in particular those headed by older women.

#### **Child Friendly Spaces in Pakistan**

Child friendly spaces have become a standard intervention especially of UNICEF since the refugee situation in Albania in 1999. They are intended as a means of addressing the psychosocial needs of children through activities and play. Following the advocacy of HelpAge in Pakistan, UNICEF and its implementing partner agreed to pilot an intergenerational approach. This involved inviting older people to attend the child friendly spaces for half an hour once a week.

This proved to be very popular with both older people and the children. The older people began to attend every day for the full time telling stories, organising activities and taking responsibility for equipment etc. This gave older people a sense of value and respect.

In addition to playing an important role in the extended family, older people are the repository of traditional knowledge and survival strategies of benefit to others, for example collection, preservation and preparation of wild foods. Studies in Africa have shown that the presence of a grandmother in the household reduces infant mortality and improves nutritional status and child development. Older people can pass on professional or artisanal skills to children; contribute to the income and food security of their families; and possess knowledge of traditional or complementary medicine. Finally, they are often the preservers of cultural and social identity through oral history, story telling and songs and can help solve problems and advise younger people.

#### Livelihoods

Financial pressure resulting from disasters places an additional strain on all family relationships, and is a critical ingredient in care of the old. In the absence of any form of statutory welfare support, increasing numbers of older people will be in need of an income however modest, to be able to maintain themselves and any dependents.

The need to develop appropriate livelihoods for older people was a consistent theme both of older people themselves as well as other interviewees. After health, it was identified as their greatest challenge. Traditional food or cash for work programmes tend to exclude older people, who are unable to undertake heavy labour, and there are limited alternatives available through existing livelihoods programmes. There was a clear sense of the need to develop more innovative and flexible economic opportunities which recognise the physical limitations of older people. The research team met numerous older and most vulnerable people struggling to survive on a pittance by daily labour.

The research team heard from older people in both Pakistan and Uganda – and in particular from those who were responsible for bringing up small children- that they faced real economic pressure. The team encountered pitiful examples in Uganda of people in their 70s and 80s struggling to raise tiny sums by daily labour in an attempt to pay school fees or buy food for children in their care. In Pakistan as well, older people in the displaced camps around Muzaffarabad expressed concern that they were not able to earn an income.

## HIV and AIDS

The HIV pandemic has distorted the nature, roles and responsibilities of the crisis-affected populations, with a particular impact on the older population. With rising rates of HIV infection globally (not entirely unrelated to migration), we should expect to see an increase in grandparent-headed families.

Whilst a natural disaster may cause many deaths and injuries, the particular impact that HIV and AIDS has on the productive age-group (15-45) leaves in its wake a population of old and young often with mutual caring responsibilities. This has significant implications both for immediate responses and the management of support for populations affected. As is to be expected, the direct impact was most apparent in Uganda, with over half the children in the north now being cared for by a grandparent.

### **3.5 Humanitarian reforms**

The overall finding of the research team was that the Cluster system is potentially an excellent way of ensuring that cross cutting issues such as the needs of older people are adequately understood and responded to. However, in both field visits the research team heard suggestions that there had been some shortcomings in practice. These included:

- Actual or perceived conflicts of interest on the part of the Cluster Lead Agency.
- Some significant weaknesses in the actual management and chairing of Cluster meetings.
- Cluster Lead agencies being allocated or taking on too many Lead roles, to the detriment of the service provided.
- A combination of poor individual and member agency understanding of protection or a consequence of organisational mandates resulting in too narrow a focus on child protection.

Cluster agendas appear to be more reactive than proactive, preferring to look at what is easily measurable and achievable in the short term (e.g. number sharing and relief delivery allocation), without necessarily properly understanding underlying issues and longer-term solutions and impact. This may be inevitable given the emergency nature of the Cluster System, but it does minimise the time that can be spent on longer term planning and on developing an appropriate awareness of cross cutting issues such as the needs of older people.

The recent 2007 cluster evaluation recognizes that cross-cutting issues (including HIV, the environment, age and gender) can be neglected and that the cluster system may have unwittingly further marginalized these issues. In particular it makes reference to weak inter-cluster co-ordination; inadequate information management; and lack of standardised data collection systems (for example, disaggregated data by age and sex) that could help draw attention to specific groups.

Discussions held at both head offices and in the two field locations reflected a desire to see the clusters work for the benefit of all those who are vulnerable, including older people, and in particular the present opportunity to ensure that considerations of ageing are integrated into the wealth of new guidelines and tools being developed at the global level. This view seems to be supported by the cluster evaluation which questions the value of creating new lengthy guidelines on cross-cutting issues which can be of 'limited assistance in the midst of a crisis response'.

## 4. Conclusions and recommendations

### 4.1 Conclusions

- Older people have not been a focus for humanitarian response agencies. With changing global demographics and a greater degree of sophistication in humanitarian response the 'invisibility' of older people will no longer be tolerable or excusable. The sheer scale of growth of the ageing population demands that governments and communities themselves are better able to provide support before, during and after emergencies.
- As a consequence of large scale and increasing economic migration by men of working age, we should expect to see rural areas, and particularly remote ones, with a population disproportionately composed of older people, women and children. Some of that movement may be temporary, but the continuing growth of cities and urban economies, and the impact of climate change on agriculture is leading to significant and permanent shifts.
- The erosion of traditional family and community support mechanisms is leading to greater destitution in the older population, and older people's reduced capacity to cope with the upheavals caused by disaster and displacement. With rising rates of HIV and AIDS infection globally (not entirely unrelated to migration), we should expect to see an increase in grandparent headed families.
- In the absence of any form of statutory welfare support, increasing numbers of older people will need to earn an income, however modest, to be able to maintain themselves and any dependents. This has important implications for the design of any food or cash for work schemes, and return programme design. If older people are able to earn an income (however modest) it might reinforce and encourage traditional support.
- These trends combined will demand that humanitarian agencies respond in a more focused way to the needs of older people, and especially the oldest old and the most vulnerable. Older people have special needs, in terms of health, mobility and their productive economic capacity.
- Older people are a great resource for the community, from childcare to leadership. A more sophisticated understanding of older people's needs and capacities will lead to innovative humanitarian programming. This is an imperative for the humanitarian community as we seek to improve provision of care and ensure equal rights for all in emergencies.

### 4.2 Recommendations

The following recommendations arising from the review were put to, and fully endorsed by, the IASC Working Group at their meeting in Rome in November 2007.

1. Increase awareness amongst policy makers, donors and practitioners of:
  - the global growth in the numbers of old and very old;
  - its impact on disaster affected populations, and

- the need to incorporate this understanding into all aspects of contingency and preparedness planning, relief responses and return processes.
2. Strengthen the Cluster system's response to the cross cutting issue of age, by:
    - Developing a training and induction module for all Humanitarian Coordinators and Cluster Chairs on the special needs and opportunities that accompany an ageing population, covering both the scale and implications of this trend.
    - Ensuring that considerations of age are integrated into the guidelines and technical resources that are currently being developed to ensure that relief responses reflect the fact that older people have special requirements but also represent a social asset.
  3. Introduce more effective data collection processes to ensure that registration, needs assessment, morbidity and mortality figures are collected and disaggregated by age and sex to allow for better understanding of, and response to, the needs of older people.
  4. Relief agencies should consult with, and actively engage, older people in decision making and programme design and delivery, to improve the appropriateness of service delivery. Programmes must be inclusive and accessible by all, and inter generational approaches and the use of older people's committees are both techniques that can assist in achieving this.
  5. Health services should better reflect the particular health needs of older people. Treatment should be given for those chronic conditions that reduce older people's active participation in the life of the community.
  6. Acknowledge the need for many older people to earn an income. Many older people care for children as a result of displacement, conflict, the HIV pandemic or all three. All livelihood and income generating interventions should be designed to include them, capitalise on their skills and be realistic about their capabilities.
  7. Return, repatriation and reintegration programmes should reflect the special requirements of older people. The challenge and needs of the 'unaccompanied old' should be addressed as energetically as those of unaccompanied children, with priority placed on strengthening reunification and family and community-based solutions.
  8. Recognise the physical changes in food needs that accompany ageing, and reflect these in any food support being considered.
  9. Population registration processes need to better record and disaggregate data on affected populations. Whilst individual organisations will follow their own procedures, HelpAge International's recommended registration guidelines are attached as annex 3. As a minimum, it proposes recording age and gender in categories of 60-80, and 80 and above

## 5. Annexes

### 5.1 Annex 1: IASC project proposal and Terms of Reference

#### Project Proposal

#### **Older people in crisis and disaster settings: addressing their talents and vulnerabilities**

##### Introduction:

HelpAge International, established in 1983, is the only global network of not-for-profit organisations with a mission to work with, and for, disadvantaged older people worldwide to achieve a sustainable improvement in the quality of their lives. HelpAge International works to this end by supporting practical programmes; giving a voice to older people; and influencing policy at local, national and international levels.

In July 2006 HelpAge International was invited to present the protection and assistance needs and contributions of older people in emergencies to the Inter Agency Standing Committee -Working Group. As a result the IASC Working Group decided that HelpAge International, with OCHA's help, should facilitate an inter-agency review of IASC members' policy and practice in relation to addressing the situation of older people in humanitarian settings. This proposal is concerned with taking this work forward and represents a significant opportunity to make progress on the promotion and protection of older people's rights and well-being in the context of humanitarian action.

##### Context:

An older person is defined by the United Nations as someone over 60 years of age. The 'oldest-old' refers to those over 80. Concepts of old age differ from region to region depending on culture and context. For example, becoming a grandparent or widow, having grey hair, or a change of status such as becoming an 'elder' can all be benchmarks of age. In poor countries, a lifetime's exposure to health problems means that people can seem 'old' in their 40s and 50s, in particular women after years of hard physical work and many pregnancies.

We are living in an era of rapid global ageing. By 2050 the numbers of people aged over 60 is expected to triple to 1.9 billion. Most of the increase in the older population is taking place in low-income countries where average income is less than \$2 per day. The over 80s are the fastest growing old-age group, expanding at a rate of 3.8% a year, compared to 2% per year for the 60-79 group. Work on chronic poverty is identifying older people as amongst the most socially excluded and chronically poor. Therefore, whilst increased life expectancy is one of humanity's major achievements, it also presents significant challenges in particular in crisis and disaster settings where traditional means of coping are often disrupted to the detriment of older people.

In its work in crisis settings, HelpAge International has learnt that older people have particular vulnerabilities in times of conflict or disasters associated with natural hazards. For example, lack of mobility, poor eyesight or blindness, arthritis or rheumatism can make access to support difficult and aid services often do not take these issues into consideration. HelpAge International's experience indicates that in times of displacement older people are often reluctant to leave and are therefore often the last to flee from danger. In Darfur older people expressed the view "This is

my land. I will not leave it. I will die on it".<sup>5</sup> Once displaced, older people suffer great upheaval and often become both socially isolated and physically separated from their families on arrival in new places. The on-going crisis in Darfur also challenges the established view that older people are not victims of rape and sexual violence. Older people in Darfur are often responsible for tasks such as foraging for wild foods and collecting firewood outside the relative safety of the camps, in order to protect younger members of their communities from rape, despite putting themselves at risk. In other areas where older women have been obliged to live in close proximity with men due to a crisis, there have been instances of their rape, for example in Bangladesh flood shelters.

Elder abuse, such as physical, sexual, psychological and financial abuse, neglect and abandonment is under reported and tends to take place when resources are stretched and older people are perceived to be a strain on household incomes. Older people in rural areas may be especially vulnerable to the effects of natural disaster or conflict. Approximately 60% of the world's older people live in rural areas. Migration of the young to cities means that fewer people are available to care for and support older family members often leaving them isolated. It is the poor that always suffer the most enduring damage and older people are consistently among the poorest and most vulnerable parts of society.

It is important to recognise that older people have vital contributions and capacities that are rarely recognised and built upon, particularly in crisis contexts. For example, they contribute significantly to the care and support of children. Population flight or death of middle-aged population groups in conflict, place a particular burden of care upon them. The HIV pandemic has changed the role of older people, as grandparents struggle to look after their elder off-spring and orphans. Data from sub-Saharan Africa found that up to 60% of orphans live in grandparent headed households, in particular those headed by older women. Already poor families can be driven into absolute poverty through the sale of assets to pay for medicines or loss of income. This in turn increases vulnerability during times of stress with fewer resources available to them to withstand the shocks of a crisis. Older people maintain traditional knowledge and survival strategies of benefit to others, for example collection, preservation and preparation of wild foods. Studies in Africa have shown that the presence of a grandmother in the household reduces infant mortality and improves nutritional status and child development. Older people can pass on professional or artisanal skills to children, and contribute to the income and food security of their families and possess knowledge of traditional or complementary medicine. Finally, they are often the preservers of cultural and social identity through oral history, story telling and songs and can help solve problems and advise younger people.

#### Problem Statement:

There is limited awareness of the rights, needs, and contributions of older people in crisis settings. There is an urgent need to raise their profile amongst humanitarian decision-makers and practitioners. Analysis of who are the most vulnerable has tended to focus on children and women (for example, pregnant and lactating women). As a result, older people are routinely neglected in humanitarian planning and programming. The invisibility of older people is reflected in the failure of needs assessments to illustrate the situation of older people. Agencies (usually INGOs) tend to undertake rapid assessments tailored to their own skills and institutional mandates and based on the resources available or anticipated. Comprehensive

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<sup>5</sup> "Rebuilding lives in longer-term emergencies", HelpAge International, page 9. Quotation from field work shared during an interview with an OCHA Field Officer, Geneina

assessments that provide a total picture of needs are extremely unusual. Data is rarely disaggregated by sex and age, and when it is, this is usually limited to women and children, contributing to older people's invisibility and exclusion in all subsequent response. This applies even in contexts where there are substantial resources, such as the Asian Tsunami. Although age (not 'ageing') has been identified as a cross-cutting issue, the current humanitarian reform agenda has yet to agree a strategy to support comprehensive and coherent action on ageing in crisis-settings. Whilst general aid services that are intended to support all of the affected population (for example water and sanitation, shelter, camp management) require the integration of age sensitive programming, there are also some sectors where urgent consideration of older people's specific needs are essential (health, protection) and technical resources to support this are lacking.

#### Overall Goal:

To improve the attitudes and activities of the humanitarian community in relation to older people in crisis and disaster settings, in order to address their capabilities and vulnerabilities in an appropriate manner.

#### Proposed actions:

Objective 1 To raise awareness and engage a cross-section of IASC agencies and cluster leads on issues relating to older people and emergencies, including a review on their own policy and practice.

Some research undertaken by HelpAge International in 2005 relating to the policy and practice of some UN agencies and the Disasters Emergency Committee NGOs in the UK reflected numerous misconceptions about older people in crises. For example, many agencies stated that they felt that specialist agencies were working on this issue, (despite the fact that there is no formal institutional home within the UN for the issue of ageing); that older people are passive beneficiaries rather than resourceful and that older people were covered through existing programmes and that their families and communities are caring for them. A shift in attitudes on ageing is required to end inadvertent discrimination. The best starting point for this is to work with some key UN agencies and operational INGOs who can reflect upon and change their own internal policy and practice, as well as promote discussion of the issue more broadly in the sector.

It is proposed that a consultant spend a maximum of 3 days each with selected agencies to review the way in which older people's protection and assistance needs are addressed in policy and programming frameworks, reviewing what is currently being done; identifying where opportunities exist to do more and what changes and modifications are needed in terms of tools and methodologies to enhance action in relation to older people in disaster and crisis settings. This exercise will work with a cross-section of humanitarian entities, including UN and INGOs and will also look at how older people are addressed in the context of cluster planning and programming, meeting with key personnel and departments. Agencies who have expressed an initial interest in participating in this exercise include the International Federation of the Red Cross and Red Crescent Societies, UNICEF, UNHCR, Medecins Sans Frontieres and Concern Worldwide. This exercise will be carried out through workshops and meetings with senior members of participating agencies.

Objective 2 To examine needs assessments tools and identify measures so that assessments and analysis identify the concerns of older people.

Whilst the internal literature of many humanitarian organisations today include older people amongst their list of 'vulnerable' groups, as does the Sphere Minimum Standards, in reality they are rarely identified in needs assessments. Population data is not disaggregated by age and sex (Sphere Standards estimate that older people comprise 7% of disaster affected populations, though in refugee situations this can be as high as 30%) and physical evidence of older people's situation on the ground is rarely gathered. The result of which is that older people are often not even considered in initial planning of response, raising serious questions about the humanitarian principle of impartiality to which most organisations also subscribe i.e. that aid priorities are calculated on the basis of need alone. Indeed, funding to directly support older people represents a tiny proportion of the overall sums channeled through the UN or NGOs – usually 1% or less of a donor response in a given country, and significantly short of the 7% benchmark recommended by Sphere. One of the reasons given for this is the lack of independent needs assessments and reliance on implementing partners who have expertise in other areas of response.

To fulfil this objective the aforementioned consultant will link in to on-going work on enhancing needs assessments and existing 'Needs Analysis Frameworks', tools and methodologies to help identify revisions that are required to make them more objective. This will require discussions with senior-level staff from UN-OCHA (CAP, HRSU, HICs) and INGOs in the field in two pilot cluster locations through workshops and meetings.

Objective 3 To identify current policy and practice in the health and protection clusters in relation to older people, make proposals to enhance tools and methodologies as deemed appropriate and develop a policy briefing paper outlining the key issues.

It has been noted by HelpAge International, for example in Darfur, that older people are normally cared for by their children or relatives and that they are respected for their wisdom and experience in the family or community. However, in a conflict situation the social structure collapses. When coping strategies are stretched to their limits during a crisis, perceptions of older people can quickly alter. Where once they were considered central to family life, older people may suddenly become socially isolated. Older women in particular (there are almost twice as many women as men in their over 80's) can be vulnerable, as they are likely to be widows and less likely to re-marry, leaving them alone and often reliant on the goodwill of relatives or neighbours with increased likelihood of health problems associated with old age. Furthermore, in humanitarian crises older people, especially women are likely to provide care to grandchildren or orphans. In war as in peacetime the most vulnerable members of society suffer disproportionately from sexual assault.

Health consistently ranks alongside material security as the primary concern for older people in humanitarian crisis. For many older people, physical health is their single most important asset and is bound up with the ability to work and to function independently. Nonetheless, older people continue to face discrimination in accessing essential services that directly affect their health and when they do go to clinics can be told that there is nothing to be done, they merely have a disease called 'old age'. Many older people have problems with mobility - a third of older people surveyed by HelpAge International in West Darfur were disabled in some way. The establishment of community-based Health Workers who could go to these older people, rather than expect them to make the journey to a clinic, a functioning referral system and 'old-age' clinic times are simple measures that can make an enormous difference to the lives of older people.

WHO has shown that as low income countries age, there is a corresponding shift in disease patterns with chronic illness such as heart disease and cancer becoming the leading causes of death and disability among older people in developing countries. Hypertension, strokes, diabetes, arthritis, osteoporosis and mental health condition such as dementia and depression also affect older people, reduce the quality of life and threaten their independence. Yet, older people's specific health needs are not met or addressed in emergency settings. Reasons for this include the priority health providers' accord to children and women, lack of qualified staff trained in geriatric medicine and geriatric drugs, and the tendency to justify programme priorities on the basis of traditional perspectives that do not take account of the specific concerns of older people.

The consultant will:

Analyze existing relevant tools relating to health and protection, consulting with key agencies, cluster leads such as WHO as the cluster lead for health, UNHCR and UNICEF, OHCHR as the leads for protection, and other relevant service providers.

Identify gaps in existing tools and make detailed recommendations as to whether revisions are required or the production of new technical guidance material.

Travel to 2 pilot cluster field locations with a health specialist to look at health and protection issues in practice. In particular the consultant will attend co-ordination meetings, set up individual meetings with those agencies mandated to provide protection and involved in the provision of health services, and coordinate work shops and interactions at the country level to examine these issues.

Produce a policy briefing paper on health and ageing in crisis and disaster settings; protection and ageing in crisis and disaster settings which will provide an overview of the key pertinent issues and actions that should be taken to address them.

Having completed all three objectives of the project, HelpAge International will report back to the IASC-WG making clear recommendations about where there is a need to focus on the development of improving existing tools to support older people and next steps.

HelpAge International will also continue to offer further support to humanitarian agencies and monitoring of these issues beyond the life of the project. Indeed, HelpAge International aims to build on this project with further funding by developing this area of work over several years through strengthening the evidence base for humanitarian action by improving international and southern agencies' capacity to appropriately assess the humanitarian and protection needs of vulnerable, especially older, people. The long-term goal of this work would therefore be that the needs of vulnerable groups affected by humanitarian crises, especially older people, are more effectively met by the international system.

Time-frame:

The project will run from April – November 2007 (approximately 8 months) with an expected budget of approx. GBP 78,000.

March 2007	Consultant and funding secured
April-May	Work with agencies at head offices
June	Field work and preliminary feedback to the IASC-WG
July and August	Field work and development of guidance materials
November	Final report back to the IASC-WG meeting

## 5.2 Annex 2: HelpAge International data collection and disaggregation guidelines

*Older people tend to be invisible....because they tend not to be counted*

### Introduction

At HelpAge International, a key external advocacy message is that we, and other organisations, disaggregate beneficiary population data by age and sex, and by doing so increase the visibility of older people as a vulnerable group. This message is increasingly being spread through our partners, other NGOs and INGOs, various UN agencies, and other interested parties including government ministries worldwide.

### Background

The definition of what constitutes old age is a key issue for HelpAge International. *At the moment, there is no UN standard numerical criterion, but the UN agreed cut off is 60+ years to refer to the older population*<sup>6</sup>. At HelpAge International, we follow this UN definition. However, many of our beneficiaries are younger, falling into the 50-60 year old age cohort. We know that older people suffer from poverty but access to detailed, disaggregated data would enable us to more fully present the multi-faceted situation of older people globally and across the whole chronological spectrum of older age.

Data about all age groups is important; we should know the chronological age of our target population to aid effective programming and ensure appropriate allocation of resources. The needs and capabilities of a 60 year old can be starkly different to those of an 80 year old. However, data is rarely disaggregated by sex and age, and when it is, it is usually limited to male and female and adult and child, contributing to older people's invisibility and exclusion in both development and humanitarian response activities. This has been seen to apply even in contexts where substantial resources exist, such as the Asian Tsunami.

In the developed world, chronological age plays a paramount role in determining the cultural onset of *old age*. The age of 60 or 65, the retirement age in most western and northern countries, is often said to mark the beginning of old age<sup>7</sup>. In comparison, in developing countries, the definition of what constitutes as an older person can be very different. Chronological time may have *little or no importance*<sup>8</sup>, deferring to other factors of cultural importance such as: transformations of social status (such as change in work status, becoming a 'elder' or a grandparent) or physical changes (such as menopause or greying of the hair).

Who is vulnerable and disadvantaged varies between societies but generally includes women, children, older persons and those with disabilities. However, there are a large number of other groups that have other vulnerability factors which need to be acknowledged; this may include factors such as caste or HIV status. For example, HIV and AIDS prevalence data is generally only collected to age 49. This approach continues to convey an ambiguous and discriminatory message to programme implementers and policy makers. Thus in HIV projects data should be disaggregated beyond the age of 50.

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<sup>6</sup> WHO, Definition of an older or elder person, <http://andandwww.who.intandhealthinfoandsurveyandageingdefnolderandenandindex.html>

<sup>7</sup> Gorman M, 1999, The Ageing and Development Report, pp7

<sup>8</sup> Gorman M, 1999, The Ageing and Development Report, pp7

At a sub-Saharan African international meeting of experts (facilitated by WHO and HelpAge International) on what minimum data sets (MDS) on ageing should be collected, it was agreed that:

50 years of age should be used for the MDS Project as the lower threshold for data collection related to ageing and older persons. It was felt that this age (instead of the previously agreed on age of 60 years) was a more realistic reflection of ageing for many people in Africa and, furthermore, will help provide data that will indicate emerging trends that might affect policy and planning<sup>9</sup>.

And, with much of HelpAge International's work is in sub-Saharan Africa, this shared recommendation should be reflected within data disaggregation policy recommendations.

Experience has shown that much of this data is available in the field at village level. For example, many village level committees in the tsunami programme collect the ages of their participants at a weekly level. If this disaggregated data is consistently collected at the needs assessment stage, it will help to identify from the start the most vulnerable older people and ensure that they, and their household members, are actively included in projects directly affecting them, and enable future programming needs to be better targeted and disaster risk reduction methods initialised.

#### Policy recommendations

HelpAge International calls on organisations to **include** older people by breaking down data by age and gender and ensure older people's participation in all stages of the project cycle. Following internal consultation in HelpAge International, recommendations are as follows:

As a **minimum** (for external parties, new partners or partners with limited capacity) the following categories should be collected;

- 60-79, male and female
- 80+, male and female

As a **optimum level** (for developed HelpAge International programmes, baselines of older person focused programmes, other programmes working specifically with older people, and HIV/AIDS programmes)

- 50-59, male and female
- 60-69, male and female
- 70-79, male and female
- 80+, male and female

#### Conclusion

To have a united message on the disaggregation of data adopted across HelpAge International will encourage comparison across programme countries. Trends and themes can then be easily identified and built into our programme and advocacy work. The disaggregation of data will allow older people, and their family members, to be fully integrated into programmes, counted and involved. While the level of disaggregation may vary upon programme needs and capacity, there remains a minimum level that should be achieved by all programmes.

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<sup>9</sup> Kowal, P, 2001, Indicators for the Minimum Data Set Project on Ageing: A Critical Review in sub-Saharan Africa, [http://andandwww.who.int/andhealthinfoandsurveyandageing\\_mds\\_report\\_en\\_daressalaam.pdf](http://andandwww.who.int/andhealthinfoandsurveyandageing_mds_report_en_daressalaam.pdf)

### **5.3 Annex 3: Checklist for older persons in Internally Displaced Persons camps**

This checklist has been designed in order to gain a rapid overview of the situation of older people in an IDP camp. It was submitted to the Representative of the UN Secretary-General on the Human Rights of Internally Displaced Persons Mr. Walter Kälin by Global Action on Aging and Help Age International in August 2005

#### Demographic data

Is there demographic data available disaggregated by age and gender? If not could it be included in data collection?

1. What is the number of unaccompanied older people?
2. What is the number of children being cared for by older people?
3. How many older headed households are there?
4. How many housebound older people are there?

#### Health

1. Are there special clinic days for older people?
2. Are there outreach health services for the housebound?
3. Are there drugs available to treat the common causes of morbidity amongst older people?
4. What are main disabilities of older people? Is there a record in the camp?
5. Are mobility aids available?

#### Nutrition

1. Is the ration suitable for older people?
2. Have older people been screened to enter feeding programmes?

#### Distributions

1. Are there special provisions to avoid older people queuing for long periods of time?
2. Are there special provisions to help older people carry loads back from distribution points
3. Are NFIs (Non Food Items) appropriate for older people? E.g. clothes, extra blanket etc.

#### Inclusion

1. Are older people represented on committees (e.g. health, water, women's etc)?
2. Has an older people's committee been established?
3. Are older people active participants in camp activities, e.g. literacy projects, life skills, agriculture etc?
4. Are older people represented as a vulnerable group at camp management level?

#### Social support

1. Do older people receive support from family and neighbours?

2. Who is collecting fuel and water for older people?
3. Have older people been separated from their families?

## 5.4 Annex 4: Contacts and acknowledgments

We would like to thank UNFPA (United National Population Fund) Humanitarian Response Unit for funding and supporting this piece of work. In particular we would like to thank Pamela Delargy, Chief; Dr. Henia Dakkak, Technical Adviser; and Sara Abranyos for Administrative support

### Uganda

We are extremely grateful for the support and participation of a large number of people in Kampala, Lira, Gulu and Amuru, all of whom helped to inform our visit. Thanks to staff at CARE Uganda and UN OCHA, whose time, local knowledge and logistical support allowed us to meet a wide range of individuals and organisations. Our particular thanks also to the older displaced residents of Aler, Ogur and Agweng in Lira District and of Olwal and Guru guru in Gulu District.

### Contacts

Herbert Baryayebwa	Government of Uganda	Commissioner for Disability and the Elderly
Jane Brouillette	Government of Uganda	Technical Assistance, Office of the Prime Minister
Lt Col (Retd.) Walter Ochora	Government of Uganda	Resident District Commissioner
Charles Uma – Chairman	Government of Uganda	District Disaster Management Committee
	Government of Uganda	Chief Administrative Officer (CAO), Lira
Michael Nidoi	Government of Uganda	Office of Prime Minister District Disaster Coordinator
Tim Pitt	UN OCHA	Head of Office
Andrew Martin	UN OCHA	Head of sub office
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Harry Neer	UNHCR	Head Sub Office
Michelle Berg	UNHCR	Protection Officer
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Semmy Angenyo	UNICEF	
Baw Gilbert	WFP	
Dr Olu	WHO	Head of Health Cluster
Christine Gottschalk	USAID	Northern Uganda Advisor
Gerald	DFID	Conflict Advisor
Michel Meyer	ICRC	Head of Delegation
Petter	ICRC	Emergency Coordinator
<p><b>Representatives of the following NGOs and NGO members of the Contact Group</b>            CARE Uganda, CCF, CPAR, Gulu NGO Forum, Gulu Old Age Association, IRC Uganda LADAF, Lira NGO Forum, Lira Women’s Peace Initiative, Light Force International, Norwegian Refugee Council, OXFAM, Project Heifer International, Samaritan’s Purse, Support the Elderly People Organisation, Uganda Red Cross Society, World Vision Uganda</p>		

## Pakistan

We are extremely grateful to all those we met in Pakistan, but in particular would like to thank the staff of Merlin in Islamabad and the field in AJK. Their assistance in helping us to set up our meetings and their logistical support enabled us to visit remote communities which would otherwise have been very difficult for us to access.

## Contacts

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Syed Nazr-ul-Hassan Gilani	AJK Government, Muzzafrabad	Secretary, Religious Affairs, Social Welfare & Women's Deveopment, Auqaf Zakat & Ushar
Zahid Hussain Chaudry	AJK Government, Muzzafrabad	Director Social Welfare and Women's Development
Raja Sajjad	AJK Government, Muzzafrabad	Additional Commissioner and Manager CMO
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	WFP, Muzzafrabad	
Dr Hashim Dalil El Amin	WHO, Muzzafrabad	Head of Field Office
George Cook	UNICEF, Muzzafrabad	Head of Office
Mohamad Mehdi	UNICEF, Muzzafrabad	Child Protection Specialist
Zahida Manzoor	UNICEF, Muzzafrabad	Child Protection Consultant
Raja Arshad Rashid	IOM, Muzzafrabad	Head of Sub Office
Soumana Kouyate	UN DSS, Muzzafrabad	Field Security Officer
Taskin	Merlin, Muzzafrabad	Head of Office
Dr Gulshan	Merlin, Muzzafrabad	Acting Medical Coordinator
Dr Ahrema	Merlin, Muzzafrabad	
Doctor Panjkot team,	Merlin, Muzzafrabad	
Yunus	Merlin, Muzzafrabad	Project Manager, IDPs
Murad Zeb	HelpAge International	Protection Officer
Asma Akbar	HelpAge International	Public Health Coordinator
Raja Sajjid Khan	Kashmir Development Organisation	Project Coordinator
Jean Phillippe Kiehl	ICRC	Head of Protection
Mubashir Nabi	Save the Children UK	Programme Manager
Dr. Maleek Zaeem Ulhaq	Save the Children UK	Health Coordinator, Kashmir
Sahid Minhas	International Catholic Migration Commission (ICMC)	Programme Manager
	Neelum Valley: Merlin medical teams in Sarli Sacha and Panjkot	
	Neelum Valley: Sarli Sacha Older people's Committee and Panjkot Older people's Committee	