OLDER PEOPLE IN EMERGENCIES: CONSIDERATIONS FOR ACTION AND POLICY DEVELOPMENT

David Hutton

World Health Organization

Cover photo: Vidarshi de S Wijayeratna/HelpAge International; photo opposite left: WHO/Bower; photo opposite right: WHO

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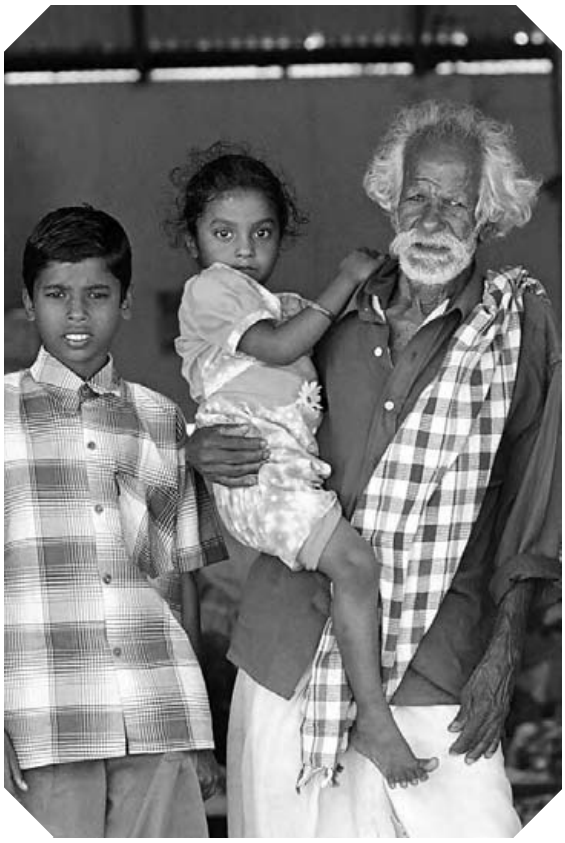

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INTRODUCTION

Older people[1] have often been overlooked in disasters and conflicts, and their concerns have rarely been addressed by emergency programmes or planners. This analysis seeks to: (1) highlight factors that particularly affect older people in emergencies, especially health-related concerns; (2) propose a strategy to raise awareness about older people in emergencies; and (3) recommend policies and practices to address these considerations.

Until recently, older people's needs in disasters and conflicts were addressed only by broader adult health and humanitarian programmes. This has changed as several recent emergencies highlighted this population's vulnerabilities. Of the 14 800 deaths in France during the 2003 heat wave, 70% were of people over 75 years ***(1)***. Of the estimated 1330 people who died in the wake of Hurricane Katrina, most were older persons. In Louisiana, 71% of those who died were older than 60 years; 47% of this group were over 77 years old ***(2)***. Worldwide, the United Nations High Commissioner for Refugees (UNHCR) has estimated that older persons make up 8.5% of the overall refugee population, and in some cases comprise more than 30% of caseloads ***(3)***. In 2005, approximately 2.7 million people over the age of 60 were living as refugees or internally displaced persons ***(4)***.

Globally, the proportion of older people is growing faster than any other age group. In 2000 one in ten, or about 600 million, people were 60 years or older. By 2025, this figure is expected to reach 1.2 billion people, and in 2050 around 1.9 billion. In developing countries, where 80% of older people live, the proportion of those over 60 years old in 2025 will increase from 7% to 12%. Moreover, life expectancy at birth has increased globally from 48 years in 1955 to 65 in 1995, and is projected to reach 73 in 2025 ***(5)***. By 2050, people over 80 years old are expected to account for 4% of world's population, up from 1% today ***(6, 7; Wells, 2005)***.

1. In developing countries, chronological age is often less relevant to older people's concerns than in developed countries, as life expectancy in the former may be as short as 50 years (e.g., Cambodia and the Lao People's Democratic Republic) and people may be seen as "old" in their 40s as a consequence of physical labour and health problems. Other countries define old age as beginning when a person is eligible to retire and receive a pension (e.g., 55 years in Malaysia). The United Nations defines older people as those over 60 years of age, and the oldest old as those aged over 80 years.

Box 1. Lesson from France: the 2003 heat wave

The 2003 heat wave in Europe killed more than 30 000 people.[a] In France, where temperatures reached 40 °C and higher, thousands of older people died of heat-related causes in rest homes and care facilities. Although the country had one of the world's most sophisticated health systems, it did not plan for extreme heat and had "a lack of preparation, [a] shortage of cooling equipment in nursing homes and hospital facilities, and [a] lack of any clearly defined roles for agencies involved".[b] This was compounded by funding and personnel shortages in many rest homes, which prevented adequate monitoring and care of residents. As for the elderly who died in their own residences, many lived alone on top floors of buildings, where rents are cheapest and temperatures were hottest. Authorities failed to identify which of these non-institutionalized elderly persons were at risk, and to communicate about or provide life-saving interventions like bottled water, ice packs and cooling equipment.

France has since taken steps to protect older people from similar situations, such as funding air conditioning for retirement homes and seeking to ensure adequate staffing during the traditional holiday month of August. District councils were instructed to establish registries of people at risk, and response guidelines for hospitals and aid workers were implemented.[b,c]

a. Kosastsky T (2003). The 2003 heat waves. *Euro Surveillance*, 10 (7), 148-149.

b. Michelon T (2004). *Lessons learned from the 2003 heat-wave in France and actions taken to limit the effects of future heat-waves in extreme weather and climatic events and public health responses.* Geneva: World Health Organization.

c. Bosch X (2004). France makes heat wave plans to protect elderly people. *Lancet*, 363 (9422), 1708.

The increasing population of older people has drawn attention to the need to revise humanitarian policies to adequately serve this group's basic living and health requirements. In 1999, the UNHCR announced the International Year of Older Persons with the observation that "older refugees have been invisible for too long" ***(3)***. In a multi-country study of older people in emergencies,[2] HelpAge International ***(10)*** concluded that "if invisibility, exclusion and powerlessness are common themes emerging from the experience of older people, then consultation, inclusion and empowerment through partnership have emerged as the primary indicators for best practice."

From a health perspective, it is important to recognize the needs of older persons and to develop appropriate policies to promote emergency health care. Yet it is equally critical to assess and prepare for demographic and health trends that determine the shape of future emergencies. By 2050, the prevalence of disability in some developing countries is projected to rise by 400% as the population ages ***(11)***. An epidemiological transition also is shifting the burden of disease from communicable to noncommunicable diseases. In 1996, deaths in developing countries attributable to communicable and noncommunicable diseases were 41.5% and 49.8%, respectively; yet this is expected to shift to 11.7% and 76.8% by 2020 ***(12,13)***. Health planners must make allowances for the years of disability that accompany many noncommunicable diseases (e.g. loss of mobility after a stroke). In developing countries, the old-age dependency ratio in 2020 is expected to reach 11 (ratio of persons 65 and over to persons aged 15–64), up from 7.6 in 1998 ***(5)***.

Emergency health policy and programming will also need to take into account probable shifts in health care strategies. Modernization and urbanization, as well as shifting values regarding family care for older people, has contributed to a marked breakdown of community and intergenerational support mechanisms ***(14)***. As increasing numbers of frail older people become both dependent and isolated, there is mounting pressure in some countries towards their institutionalization ***(13)***. Emerging care and support models may take various forms, including community-based care and health maintenance approaches, but all will require strategies to protect older people during emergencies.[3]

2. *The Ageing World and Humanitarian Crisis: Guidelines for Best Practice* examined older people in disasters in Bangladesh, Dominican Republic, Rwanda and Bosnia and Herzegovina. Commissioned by UNHCR and the European Community Humanitarian Office, the study drew upon 21 different emergencies, including refugee situations and natural and human-induced disasters.

3. Two-thirds of the deaths of older people in France during the 2003 heat wave occurred in hospitals, private health care institutes and retirement homes (*2*).

At the same time, it is important to observe that the older population as a whole is neither helpless nor dependent. Most older people are capable of coping and adapting, despite increasing poor health and frailty as they age. Older people contribute immeasurably to their families and communities in various roles, and commonly sacrifice their well being to help their children and grandchildren. In Africa, the HIV/AIDS epidemic has seen older persons assume responsibility for raising many thousands of orphaned grandchildren and other children in need. Finally, older people contribute to their communities their decades of accumulated experience, knowledge and understanding. This insight makes them an essential resource and potential partner in developing emergency preparedness and response programmes.

Box 2. Learning from older people: the Kobe earthquake

The earthquake that struck the Japanese city of Kobe and surrounding Hyogo Prefecture on 17 January 1995 left 6533 people dead, 43 792 injured and 510 000 homes damaged or destroyed. Although proportionately more older people died in the disaster than any other population group, older people are the volunteers who share their stories of survival and resilience at a Disaster Reduction Museum. Watanabe[a] reported in 2006:

"Eight years after the [quake], elderly people in the Nagata district, which was badly affected by the disaster, started conducting storytelling for groups of students on school trips. Elementary and junior high students have no experience of [this event] or, if they did experience it, it was when they were very young and they have no memory of [it]. … Through these storytelling activities, children who have not experienced major earthquakes learn how powerful they can be, and are motivated to think about the necessity of preparing for disaster and ways of coping if one occurs."

a. Watanabe, T (2006). *Older persons in emergency situations: a case study of the Great Hanshin-Awaji Earthquake*. Research Institute of Nursing Care for People and Community, University of Hyogo. Unpublished paper prepared for the World Health Organization.

The elderly are one of several population groups historically more vulnerable in emergency situations. Children, disabled people and those with chronic diseases also share health and safety issues with their elders. An integrated health strategy for older people will need to address cross-cutting issues involving these other groups.

Similarly, older people's safety in emergencies depends on more and larger factors than health services. Economic and social marginalization, protection from abuse and exploitation, social welfare and intergenerational support are chronic issues vital to older people's well being. Some agencies even resist identifying older people as a particularly vulnerable group requiring special attention, instead advocating that planning efforts should focus on the needs of affected populations in general.

Yet there is an emerging consensus towards addressing the needs of older people in disasters and conflicts ***(15)***. This does not necessarily mean that numerous special services should be established for older people. HelpAge International calls for "integrating older people into mainstream services and ensuring equity of service provision across all sectors of a community." This includes provision of the necessities required for basic living needs and protection/advocacy services as well as medical and mental health care. Similarly, UNHCR in 1999 concluded ***(16)***:

> *While the elderly clearly have special problems there is little to be gained from establishing yet another separate refugee category with [a] distinct set of guidelines and interventions such as those devised for refugee women and children. What is clearly required, however, is a more targeted inclusion of the elderly in all aspects of programme of planning and implementation, with the aim of helping young elderly to be more self-supporting and promoting better community care initiatives for the very old.*

Health is defined not only by an absence of disease or infirmity, but also by a capacity to cope with life challenges and to maintain one's physical, mental and social well being ***(17)***. While planners must ensure that older people have access to basic health services during emergencies, their capacity to maintain their heath will reflect their ability to re-establish their relationship networks and their self-sufficiency whenever possible. It is therefore relevant to recognize the overlap between health and broader socioeconomic conditions that influence people's capacity to survive and recover after disasters.

Pakistan, WHO/Bower

John Cobb/HelpAge International

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VULNERABILITY AND HEALTH IN EMERGENCIES

While older people vary greatly in their health status and ability to adapt, the risks to this population in emergencies remain significant. By one definition, ageing refers to a progressive loss of adaptability so that the individual becomes increasingly less capable of coping with life challenges *(18)*. In developed countries, studies have shown that up to 40% of persons over 65 suffer from a chronic illness or disability that limits their daily activities. Of those 75 and over, less than one third experience good health; over one third of those 80 and over cannot walk outside their homes without assistance *(19,20,13)*.

Worldwide, it is estimated that more than 80% of the disabled population lives in developing countries, where the prevalence of disability is approximately 20%. That rate is expected to increase dramatically as populations age *(21)*. By 2050 in India, the incidence of disability is expected to jump by 120%, in China by 70% and in sub-Saharan Africa by 257% *(11)*.

Emergency planners must consider these trends, because poor health and reduced mobility increase the risk of serious injury and illness in disasters. Older persons have sustained more injuries in disasters than other groups because of functional limitations such as poor balance, muscle weakness and exhaustion *(2)*. Older persons have higher rates of coronary heart disease, diabetes, stroke, cancer, respiratory diseases and rheumatism *(17)*. A study in China found that 74% of those over 80 years old had chronic diseases, 1.5% were physically disabled or handicapped, and 3.46% had Alzheimer disease *(22)*. In Iraq, more than half of 340 older people surveyed by HelpAge International *(23)* had chronic joint and bone problems, hypertension, heart problems, diabetes and reduced eyesight and hearing. In West Darfur, Sudan, 34% of surveyed refugees 50 and over were disabled, 27% could not move without help and 19% had severely impaired vision; while 61% reported chronic diseases that required specialized treatment and/or medicines that were not available *(24)*.

In Africa particularly, HIV/AIDS must be taken into consideration. Although commonly associated with the younger or middle generation, unexpectedly high rates have been found among older persons. In 2005, UNAIDS/WHO *(25)* reported that 21% of people 50 years and older tested in Botswana were HIV-positive, along with 25% of 15–49 year olds. In Uganda, 7% of men aged 50–59 were found to be HIV-positive, the same as the national adult rate.

Even normal physical changes associated with aging that may not greatly impair daily functioning, such as reduced mobility and failing eyesight, can become significant handicaps during an emergency. A WHO report noted that "An older person with arthritic knees and diminished vision, living alone in a high-rise apartment with no family members or friends nearby, can become incapable of getting food or water or of fleeing danger, and may be overlooked by neighbours" *(26)*. For some older people, the loss of eyeglasses and walking canes can increase their dependency on others for sustenance and security. Older people's susceptibility to dehydration, hypothermia and hyperthermia can endanger them during flight, evacuation or other circumstances which place them in unfamiliar living conditions *(2)*.

Box 3. The Kobe earthquake: after the shock

Of 6533 Kobe earthquake fatalities, 53% were over 60 years old. Of 930 people who died of the quake's secondary effects within six months, 90% were over 60; the average age of these later fatalities was 69.2 years. After the earthquake, many older people's health suffered from harsh living conditions and loss of caregivers. For those with medical conditions and disabilities, prolonged residence in emergency shelters was damaging. Inadequate heating and poor nutrition contributed to high rates of dehydration, diarrhoea, muscle and joint-related symptoms, hypertension, pneumonia and other ailments. Many who had been receiving health support within their homes were without caregivers, necessary treatments and means for self-care. Those taken to hospitals were frequently returned to the temporary shelters because of inpatient bed shortages.

The Health Advisors System was formed after the Kobe earthquake. This was part of the broader nursing care system in Hyogo Prefecture but targets older persons and others with special needs. This programme included outreach services to these groups to ensure continuity of health care and social welfare support, as well as community activities to reduce isolation. Resident social meetings, health consultations and other events helped older people re-establish support networks and enhanced their quality of life and sense of community.[a]

a. Watanabe T (2006). *Older persons in emergency situations: a case study of the Great Hanshin-Awaji Earthquake.* Research Institute of Nursing Care for People and Community, University of Hyogo. Unpublished paper prepared for the World Health Organization.

Vision, hearing and other sensory deficits and cognitive/neurological deterioration may make it more difficult for some older people to understand emergency warnings and directions. They may be unable to evacuate or seek safety, or become disoriented and confused in unfamiliar surroundings. In the United States of America (USA), it is estimated that 15% of men and 11% of women aged 65 and older have either moderate or severe memory impairment. At age 85, one third of people experience memory impairment *(27)*. Although data are not as reliable for older persons in developing countries, it is estimated that Alzheimer disease occurs in about 3% of all adults aged 67–74. Those over 85 years have a 25% probability of developing Alzheimer disease *(17)*.

Older people's health may also be compromised by poor diet and nutrition. A study in central Ethiopia found that 67% of older people were malnourished; a third of these were severely malnourished ***(28)***. Malnutrition's causes may include poverty, responsibility for supporting grandchildren, living alone or age-related disabilities such as immobility, blindness and/or loss of teeth ***(29)***. During emergencies, older people's vulnerability to hunger is often heightened by inaccessible food distribution points, difficult-to-digest foods, inability to prepare foods and many older people's tendency share scarce food rations with family members ***(29,30)***. In Bosnia-Herzegovina, Vespa and Watson ***(31)*** found that older people were at the greatest risk for undernutrition:

> *The poor nutritional status of elderly people in Bosnia-Herzegovina can be attributed to a number of physiological and psychosocial factors. Dietary energy requirements were probably increased by cold temperatures and lack of heating during the winter months and by the physical exertion required for collecting fuel, water, and food rations. Elderly people may be particularly disadvantaged because of impaired mechanisms for conserving body heat. Despite higher than average quantities of household food stocks, age-related disabilities which cause problems with vision and manual dexterity may have affected their ability to prepare and cook meals. Violence, separation from families, isolation, and breakdown of formal and informal support systems may have triggered depressive illness, which is known to be accompanied by weight loss and ill health.*

From a mental health perspective, older people have been found to be more resilient than younger people, in part because they have greater life experience to rely on ***(32,33)***. Yet there is a growing awareness of disasters' and conflicts' magnified effects on older persons, as losses, displacement, poor health and social exclusion may act as cumulative and interactive stressors that can lead to trauma-related syndromes, anxiety, depression and other illnesses ***(34,35,36)***. Older people may have stronger ties to their homes and communities than younger people, and be less willing to evacuate or uproot; they may also experience greater adjustment difficulties ***(37)***. Older people in crises experience dramatic changes in their lifestyles and community standing; this too may affect their well-being.

> *The wider effects of a disaster or crisis may see older people lose their roles or status within a community, and they may find it more difficult to adapt to new and unfamiliar situations, such as living in camps. In Darfur, sheikhs who once led their communities have lost much of their traditional authority as conflict has disrupted and displaced their communities, and their roles have largely been taken over by camp managers, local government officials and international agencies. A resulting lack of motivation and confidence can lead to depression, reducing intellectual capacity and cognitive function.* ***(6)***

Older people may encounter invisibility, exclusion and abuse in crises. Because more frail and elderly persons may be housebound, they can be overlooked in assessments and relief operations. Thus their health care needs may also be underserved, in terms of outreach and accessibility but also in making available medications and other resources for chronic health and disability problems ***(38)***. In Pakistan, for example, older people remained largely invisible during initial humanitarian health assessments and operations because organizations did not have direct policies or procedures relating to them ***(39)***. As a consequence, the health needs of older people were overlooked in terms of chronic diseases and their treatment.

Relief agencies also have commonly failed to recognize the dietary needs of older people in emergencies, and excluded them in supplementary feeding programmes even when they were caring for younger children. In West Darfur camps, HelpAge International (2005) found that 29% of older people caring for orphaned children had not been targeted for extra food aid, and that more 60% of those surveyed reported having difficulty collecting food due to mobility problems ***(29)***. In a rapid nutrition survey conducted in May 2006, 40% of older people in Darfur were found to be at risk of malnutrition ***(40)***.

There is considerable evidence that the marginality experienced by older people places them at risk for abuse and exploitation. In rural India, research has shown that 24% of people aged 70 and over may be either physically abused or neglected; in South Africa, 32% of older people surveyed have been ill-treated by either family members or caregivers ***(41)***. In a single month in Mozambique, HelpAge International identified 142 acts of abuse against older people in the communities in which the agency's partners worked ***(42)***. Although such abuse is less reliably documented in emergencies, there have been reports of emotional and psychological abuse, theft of rations and supplies, and physical violence. In West Darfur, older women have been raped while collecting wood outside of camps ***(43,6)***.

Box 4. Addressing older people's needs in West Darfur

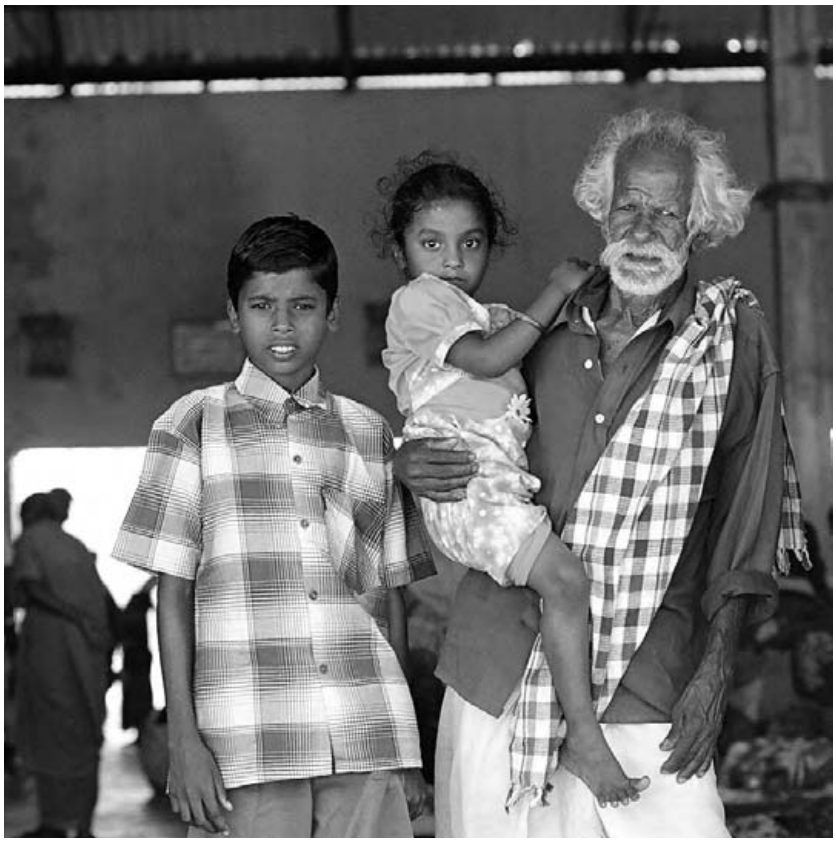
Since the Darfur conflict began in 2003, over 2 million people have been displaced and almost 300 000 have died from disease and starvation. It has been estimated that about 8% of those living in camps are older people, half of whom live alone. A 2004 assessment carried out by the HelpAge International[a] found that 45% of these displaced people lacked adequate shelter and 61% had untreated chronic diseases.

In response to the crisis, HelpAge International has addressed these problems in seven camps. These activities have reduced older people's suffering and raised their social standing in their communities.

- Committees of elders represent this group's needs and rights, deal with humanitarian organizations and coordinate outreach services to vulnerable people.
- A network of community health workers in each camp provides outreach and basic care to older people.
- A system of donkey-cart ambulances transports older people to medical appointments.
- In partnership with the World Food Programme, supplementary food baskets are distributed to older people at risk of malnutrition or caring for dependents.
- In one camp, a social nutrition centre provides cooked meals to vulnerable older people three times weekly.
- Social activity centres allow older people to gather, share news and stories, and make handicrafts to rebuild their sense of community.
- A shoe-making cooperative, a bakery, livestock regeneration, distributed seeds and garden tool kits help older people maintain their self-sufficiency.

a. HelpAge International (2005). *Rebuilding lives in longer-term emergencies: older people's experience in Darfur.* London, HelpAge International.

Exploitation of older people reflects their socioeconomic marginalization and diminished capacity to protect themselves from abuse. In emergencies, with the breakdown of normal mechanisms for support and protection, these risks are heightened. Particularly in developing countries that lack subsidized health care and social pension schemes, older people may experience both worsening health and destitution, increasing their risks in crises and individual misfortunes as they lose their self-sufficiency. As older people's community standing often diminishes with age, so too does their visibility in emergencies and their ability to advocate on behalf of themselves in shaping assistance and programming.



WHO/Bower

Gina Bramucci/HelpAge International

3

ECONOMIC MARGINALIZATION

Research in developing countries has shown that older people consistently experience disproportionately high levels of poverty ***(44)***. It is estimated that 80% of older people in these countries have no regular income and 100 million live on less than US$ 1 a day ***(45)***. More than 10% of people living on less than US$ 1 per day are over 60 years old (*29*). In Malaysia, older people comprise only 5.9% of the population but 37% of the poor ***(46)***.

Because older people are viewed as less productive and a poor investment, they are often forced to create their own work or accept low-paying, denigrating jobs in the informal sector that younger people have rejected ***(29,47)***. Research among older Iraqis and their families ***(23)*** found that more than half of the 340 households studied were living below the poverty line of US$ 3 a day. A study in Haiti showed that 80% of older men and 75% of older women went hungry on a regular basis because of inadequate income ***(48)***.

The economic marginalization of older people has multiple health effects and spiralling consequences. Poor diet and nutrition have been linked to a wide range of later-life illnesses including heart disease, hypertension, diabetes, osteoporosis, stroke and different forms of cancer ***(49,50,51)***. Poverty also deprives older people of social protection and health care, including basic treatment and medicines for chronic diseases. This is especially the case in rural areas, because hospitals and clinics tend to be concentrated in urban centres and because poor rural-dwellers often cannot afford either transport costs or medical fees ***(48,52)***.

In countries affected by HIV/AIDS, older people's vulnerability is heightened by the financial and social burdens they face. A World Bank study ***(53)*** found that one-fifth of orphaned children in 22 of 28 countries in Africa and Latin America were living with their grandparents. A study in Zimbabwe (*54*) found that over 70% of caregivers for people with HIV-related illnesses were over 60 years of age. In sub-Saharan Africa, as many as 90% of AIDS orphans are cared for by extended family, usually grandparents ***(55)***.

Box 5. Surviving AIDS and poverty in Swaziland

In 2003, the Umchumanisi Link Action Research Network researched the situations of older people in Swaziland, where more than 38% of the population was HIV-positive. Although the burden of caring for the ill and orphaned had fallen mainly to the elderly, the researchers concluded[a] that "an overview of the programmes designed to assist the elderly shows that support tends to be sporadic, inadequate and reaches very few of the destitute elderly." Only about 54% of over 2000 older people surveyed were aware of programmes set up to assist them. Of these, only 29% had not experienced problems in attaining assistance: 30% faced transportation problems, 13% complained about eligibility criteria, 11% had not received information on where or how assistance is provided and 4% reported harassment by welfare officials. One elderly man described the abject poverty in which he lived: "As we gathered here we slept without taking food, and from here I will go home and eat cow dung and sleep."

a. Umchumanisi Link Action Research Network (2003). *Social protection of the elderly in Swaziland*. Research report submitted to the Coordinating Assembly of NGOs (CANGO).

Kate Holt/HelpAge International

Research in Africa and Asia has highlighted a range of problems experienced by older care-providers ***(56,29,54)***. Many are forced to use their savings or sell land and other assets to support those in their care. Already poor, they typically fall into destitution as they struggle to find money to pay for home-based care, medical bills, extra food and water, and school fees and clothing for adopted children. Other problems include exhaustion, grief and emotional upheaval, conflicts with family members, social stigma and discrimination.

From a health emergency management perspective, the economics of ageing have several implications. On one hand, the retention of livelihood and self-sufficiency among older people allow them to better maintain their health and contribute to the well-being of their households and families. On the other hand, poverty increases strains on their health and heightens susceptibility to illness. It also reduces older people's capacity to cope with hardships imposed by a disaster or conflict in terms of having assets to survive and re-establish livelihoods. Finally, as older people experience increasing destitution, this can further reduce their ability to afford and access health care, increasing morbidity and disability.

SOCIAL DISINTEGRATION AND MARGINALIZATION

Older people in developing countries have traditionally maintained reciprocal relationships with their adult children, receiving support in exchange for work in the home or on the land. Yet in many countries rapid industrialization, urban migration, unstable employment and low wages increasingly erode intergenerational dependencies ***(14)***.

In Africa, this has been compounded by the HIV/AIDS epidemic, which has both reduced intergenerational support and increased financial and care burdens for older people ***(56,57)***. Changes in familial and community values in some counties mean that older people are no longer afforded the respect, authority and care they were accorded in the past; these changes increase their risk of financial, physical and psychological abuse ***(58)***.

The social marginalization and isolation of older people can be expectedly heightened by disasters and conflict. Crises such as wars, famine, forced migration and the HIV/AIDS epidemic not only disrupt and fragmentize the social fabric, but often result in the death or dislocation of younger adults on whom older people rely for support. Older persons may be reluctant to leave their lifetime homes or lack the physical capacity to evacuate or flee ***(59,60).*** In studying the assistance to older refugees during the Croatian crises, the UNHCR ***(61)*** observed:

> *When the Croatian military stormed the UN Protected Zones on 4 August 1995, most of the population fled instantly, leaving behind several thousand elderly persons who were 'in all aspects dysfunctional'; scattered in villages over a wide area[,] they were 'in poor, even critical health condition, in destroyed homes and in communities with no transportation, services or food supply'.*

Even in less desperate conditions older people may be left to cope and survive on their own, often with increasing exclusion and deprivation. Unlike younger people, older refugees and displacees may be physically unable to work for food or travel to secure food rations. A study in Sudan, for example, found that 21% of older refugees had not registered for food rations; 20% were surviving on one meal a day. Of those caring for orphaned children, 29% had not been targeted for supplementary food aid ***(29)***.

Box 6. The aftermath of the 2004 Indian Ocean tsunami

Banda Aceh was the area most damaged by the December 2004 tsunami: nearly 170 000 people died and more than 500 000 were displaced. Despite programmes implemented by the United Nations (UN) and Non-Governmental Organizations (NGOs), research conducted by HelpAge International[a] showed that older survivors' needs were largely overlooked:

- Rations were neither easily digestible nor easy-to-cook foods.
- Temporary shelters were rarely suitable for older adults, having steep staircases, poor lighting and no handrails.
- Some shelters lacked mattresses for older people to sleep on.
- Washroom facilities were difficult to use, especially at night due to distance and poor lighting.
- Medical staff lacked knowledge about age-related ailments, and facilities were not equipped to treat chronic illnesses suffered by older people.
- Arrangements were not made for housebound elderly to seek medical care. Other older people were not able to seek treatment at health centres because of transportation costs.

a. HelpAge International (2006). *Indonesia – Aceh Province: disaster responses and recovery phrases.* Unpublished paper prepared for the World Health Organization.

There is evidence that older people's vulnerability reflects inadequate emergency planning. Socially marginalized within their own communities, older people may be invisible to humanitarian agencies as well. HelpAge International (2005) has observed that humanitarian organizations often assume that older people's needs will be met by their families or the community; this leads to health and nutritional problems as they are overlooked during assessments and relief operations. To this point, interagency guidelines on estimating food and nutritional needs during emergences noted:

> *Theoretically, a well-planned general ration is usually adequate for older persons. However, in practice, a number of other factors often results in the general ration not actually meeting the nutritional needs of the older persons. Some of these factors include: poor physical access to the ration as a result of marginalization or isolation; poor digestibility, especially of whole-grain cereals; lack of motivation or inability to prepare foods; and poorer access to opportunities for supplementing the ration (30).*

In terms of planning and programming, it is important to recognize the underlying determinants increasing older people's vulnerability in disasters and conflicts. While frailty and poor health increase risk in emergencies, economic and social marginalization often have a greater impact on older people's capacity to cope and recover. This may be particularly pronounced in countries without social protection or subsidized health care programmes to protect them in crises. It is important that these programmes are planned and implemented to take into account the diversity of older people, as older women may be marginalized by their lower economic and social standing as well as by their age.

John Cobb/HelpAge International

John Cobb/HelpAge International

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THE ISSUE OF GENDER

Of the 9.2 million refugees around the world in 2004, 75–80% were women and children. Of the 4.7 million refugees under the protection of the UNHCR, approximately 50% were women and girls *(62)*. Women's vulnerability in conflict zones and emergencies in general is well documented in terms of physical, sexual and psychological abuse, exploitation and trafficking. Women are also made vulnerable by unequal power relationships and social inequities; they are frequently socially and culturally subservient, have less access to education and means of production, and hold lower status and less power and influence than males *(63)*.

In part because of their longevity, typically more older women than men are exposed to the impacts of disasters and conflicts. In developing countries there are 100 women for every 91 men; this is expected to widen in 2030 to 100 to 86, respectively *(48)*. Because the proportion of women among the elderly increases with age, they also comprise a larger share of the oldest old. Today, there are 67 million more women aged 60 and over than men, and twice as many women aged over 80. By 2050, 55% of people over 65 will be women *(6)*.

Older women are made vulnerable in several ways. Ageing women are subject to some disabilities and diseases more than men, although men are more prone to other illnesses. Whereas the prevalence of heart disease and stroke is higher for men, women of similar age are more likely to experience dementia, cataracts, breast cancers, osteoporosis and rheumatoid arthritis *(64)*. Because women live longer than men they experience a greater proportion of their life with poor health and disability. In Cambodia, the proportion of life expectancy lost to ill health and disability among women is 16.8 years, in comparison to 14.7 for men. In Viet Nam, the respective figures are 15.9 and 12.7 years; in the Philippines, 14.3 and 11.9 years *(65)*.

Women also are made vulnerable by the myriad social, economic and health disadvantages they experience throughout their lifetimes and which contribute to higher rates of illness and disability in later life ***(66)***. Bonita ***(67)*** has observed that years of childbearing and feeding children at their own nutritional expense mean that many older women suffer anaemia and osteoporosis. The World Assembly on Ageing reported: "For women, a life course approach to well-being in old age is particularly important, as they face obstacles throughout life with a cumulative effect on their social, economic, physical and psychological well-being in their later years" ***(68)***. Women also face a greater likelihood than men of widowhood and worse survivorship affecting their health and well-being ***(69,70)***.

> *To begin with, women's longer life spans, combined with the fact that men tend to marry women younger than themselves and that widowed men remarry more often than widowed women, mean that there are vastly more widows in the world than there are widowers. Given that women in many countries rely on their husbands for the provision of economic resources and social status, this means that a large percentage of older women are at risk of dependency, isolation, and/or dire poverty and neglect.*

The vulnerabilities of older women are inevitably heightened during disasters and conflicts. In West Darfur, older women were found to outnumber men by 40% in some camps ***(71)***. Older female refugees may face greater responsibilities as heads of households even though they are isolated and destitute. Unless specifically targeted, older women risk of being overlooked during distribution if they are too frail or weak to wait in lines or are otherwise less visible to humanitarian organizations. This can be especially the case in cultures where women are forbidden to interact with males other than family members. This situation not only creates difficulties in accessing relief assistance from male relief workers, but heightens women's risk of abuse and exploitation ***(71)***. Moreover, because women often live in narrow social networks due to social and cultural norms, they may also have limited opportunities to re-establish relationships for support and mutual aid ***(72)***.

Box 7. The tsunami's impact on women

The 2004 Indian Ocean tsunami killed more than 220 000 people in twelve countries. Despite the disaster's physical magnitude, its impacts were shaped by social and cultural factors. In many coastal villages, the ratio of women to men killed was more than three to one. Women were more vulnerable because they worked in their homes rather than elsewhere. Many did not evacuate, but stayed back to look after children and other family members, or were searching for their children when the second wave struck. Others were unable to swim or climb trees, often because traditional clothing limited their mobility.

Even after the tsunami, women suffered disproportionately, experiencing verbal, physical and sexual abuse in resettlement sites, particularly around toilets. Many were pressured into early marriages, while loss of income and of self-sufficiency raised the risk of sexual exploitation and dependency. Because widows were not allotted separate shelters, many have been forced to live with relatives whose main interest was compensation.

In its programme in Banda Aceh, Oxfam[a] began to address these issues through the following:

- Ensuring full consultation and participation of women in all livelihood and cash-for-work activities.
- Building women's shelters in areas where they felt secure.
- Providing equal pay for women and men in cash-for-work programmes.
- Assessing the different needs of women and men in all programmes.

a. Oxfam International (2005). *The tsunami's impact on women*. (www.oxfam.org/en/files_ bn050326_ tsunami-women/download)

The differences between older men's and women's lives highlight the need to recognize gender implications across the lifespan. Although considerable attention has focused on women in disasters and conflicts, this has tended to focus on younger generations, with particular attention given to education of girls, maternal health and sexual violence. Older women have remained a peripheral concern, despite the facts that they are more likely to be widowed, to experience chronic health problems and to face exclusion. Planners and emergency workers must consider these issues among older female refugees and survivors.

Pakistan 2001, WHO

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CAPACITY AND CONSULTATION

Along with recognizing older people's vulnerabilities, it is important to recognize their capacities and the contributions they make to families and communities. In sub-Saharan Africa, it has been estimated that 30% of households are headed by a person over 55 years old, with two thirds of these households having one or more children under age 15 ***(73)***. In labour participation studies in over 20 African countries in the early 1990s, the International Labour Organization found that between 74% and 91% of people over 65 years continued to work ***(38)***. UNCHR (2003) has observed:

> *While the plight of older refugees can be severe, they should not be seen only as passive, dependent recipients of assistance… Older refugees serve as formal and informal leaders of communities; they are valuable resources for guidance and advice, and transmitters of culture, skills and crafts that are important in preserving the traditions of the dispossessed and displaced. Older refugees can and do make an active contribution to the well-being of their next-of-kin, and only become totally dependent in the final stages of frailty, disability and illness. Older persons have taken the lead in return to countries as far afield as Croatia and Liberia. Older persons can also contribute to peace and reconciliation measures. Good programming requires these roles are utilized.*

While acknowledging older people's contributions in their daily lives and in coping with disasters and conflicts, it is more critical to recognize the need to integrate older people in planning and programming. Older people's low visibility can have significant bearing on their access to available health and humanitarian assistance. In the aftermath of the Indian Ocean tsunami in Sri Lanka, it was reported that over 9000 older people had been missed by humanitarian organizations.

Box 8. Building local capacity after floods in Mozambique

In 2000, Cyclone Eline and heavy rains struck Mozambique. Flooding began in early February and continued until March, covering 140 000 hectares of arable land. Over 45 000 people were rescued from rooftops, trees and other isolated areas, 700 people died and 500 000 were displaced.

After the flood, HelpAge International of Mozambique worked with a local non-governmental organization to help poor and vulnerable older people. Comprised of retired people, this group carried out home visits to identify problems faced by older people and ensure they received essentials such as food, blankets and clothing. The programme also worked with communities to raise awareness of older people's participation in the rebuilding of their communities. Oxfam[a] reported that:

- Councils representing older people were organized in each village and worked with community groups to identify vulnerable older people and coordinate reconstruction of their homes.
- Older people were included in planning and implementation of all community recovery activities, including animal distribution, access to agricultural seeds and tools, and credit for income-generating activities.

a. Oxfam International (2005). The tsunami's impact on women. (www.oxfam.org/en/files_ bn050326_ tsunami-women/download)

Lack of consultation with older people also may lead to mistaken assumptions about the assistance they need or want. A HelpAge International survey of international NGOs across four countries *(74)* showed that the most common activities implemented as well as the most common problems that NGO staff members believed older people faced differed from the problems identified by refugees. Whereas older refugees identified income, access to health services and shelter as their top three priorities, the top NGO activities related to health, food and nutrition, and water and sanitation. Neither shelter nor skill training was an NGO priority, although the latter addressed the refugees' top concern, income.

From a health perspective, recognizing the capacities of older refugees can have multiple benefits. Consultation and a participatory approach ensure that older people's health and social welfare needs are integrated into assessments, programming and delivery of health care and humanitarian assistance. Channelling appropriate resources to older persons can enable more self-sufficiency, autonomy and independence, all of which are important to physical and psychological health. Yet older people's health and social needs cannot be addressed in isolation, as intergenerational support, advocacy and abuse issues are almost always intertwined within a broader family and community context. These require community-based strategies involving multiple stakeholders.

Jean-Marc Giboux/WHO, Afghanistan, 2002

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POLICY AND PROGRAMME IMPLICATIONS

Despite a clear need to develop integrated and comprehensive approaches towards the care of older persons in emergencies, this task is hampered by several conditions. First, research on which to base policy and programme recommendations is lacking, especially when compared to the attention given to groups like women and children. Although older persons are made more vulnerable by their declining health as well as their social and economic marginalization, they are also affected by issues common to other ages, such as lack of protection and inadequate health services.

It is important to note that research assessing relief shortcomings to older people usually do not have disaggregated data to permit an analysis across all age groups as well as other vulnerable groups like the disabled. There remains a question as to how the reported assistance gaps also reflect general coordination and distribution issues. While significant numbers of older people in developing countries do not have access to health care and social welfare schemes, limited infrastructure capacity also means a large proportion of the general population also lacks such services. Comparative analyses across age, gender and disability would distinguish issues specific to older people from those indicating broader deficiencies.

Yet the lack of research and policy regarding older people in emergencies reflects the low level of attention this group has received. For example, UNHCR noted in 1999:

> *Outside eastern Europe where the elderly have attracted more interest, the social assistance policies adopted by UNHCR and its implementing partners are often focused primarily on children and women of child-bearing age for whom elaborate strategies are being devised. Rarely have training programmes, income-generation schemes, micro-loan projects or even community development projects been designed so as to deliberately include older refugees, tap their potential and ensure their voices are heard.*

The existing gaps in services and programming for older people cannot be effectively addressed without drawing more attention to their needs. In many developing countries, institutional and attitudinal barriers have limited the integration of age-related priorities into health policy and services, which in turn creates both direct and indirect barriers to care. A 2006 HelpAge International study in Kenya found that 54% of older people seeking treatment at a local hospital had waited to be seen for between two and five hours, and 70% reported that staff had expressed negative attitudes towards them. Over 10% could not afford the medications prescribed and 86% of those admitted had shared a bed with another person.

Even when health services are implemented, inattentiveness to age-related issues may limit their use. Research in Bolivia showed that only 32% of older people eligible for free health care were using it; the other 68% were not aware of this entitlement, could not pay for transportation to seek treatment or lacked proper documentation.

Research among humanitarian organizations also has revealed shortcomings. In a 1999 survey of humanitarian agencies, HelpAge International found only three organizations had oldest people among their highest priorities. ***(74)*** Thirty-two, or over half, gave children their highest priority; 22 accorded older people the lowest priority or none whatsoever. As recently as 2005, the Humanitarian Practice Network reported that "aid funding to directly support older people represents a tiny proportion of the overall sums channelled through the UN and NGOs – usually 1% or less of a donor response in a given country, and significantly short of the 7% benchmark recommended by SPHERE" ***(6)***. In reference to international conventions and practice related to older people, the Humanitarian Practice Network has observed:

> *While older people are covered by international laws protecting or promoting the rights of civilians, there is a general lack of explicit reference to them compared to other groups. This contributes to a lack of analysis and awareness of their situation.*

Despite the relatively low level of attention given to older people, several policy and better practice documents have been developed that may form the basis for more integrated humanitarian and health planning. The 2002 Madrid International Plan of Action on Ageing (*68*) discusses emergencies and provides recommendations aimed at: (1) ensuring equal access for all persons to food, shelter, medical care and other services that promote self-support and personal health; and (2) promoting older people's contributions towards reconstruction of their communities. In 2004, UNHCR acknowledged the importance of mainstreaming age alongside women and children, undertaking the Age, Gender and Diversity Mainstreaming Initiative in eight countries ***(62,75)***. In addition, the agency developed a *Practical guide to the systematic use of standards and indicators in UNHCR operations* ***(76)*** and an *Operations protection in camps and settlements reference guide* ***(77)***, both recognizing older people as one of four planning and programming priorities along with women, children and the environment. Similarly, the *Emergency food security assessment handbook* developed by

the World Food Programme ***(78)*** refers to young children, the ill and older people as needing specific attention. HelpAge International has published a series of documents including *Older people in disasters and humanitarian crises: guidelines for better practice* ***(10)***; *Protecting and assisting older people in emergencies* ***(6)***; *Better nutrition for older people: assessment and action* ***(79)***; and *Addressing the nutritional needs of older people in emergency situations in Africa: ideas for action* ***(80)***.

Box 9. Working with and learning from older people in Lebanon

The hostility in July and August 2006 involving Israel and Lebanon killed more than 1000 Lebanese civilians and wounded nearly 5000, while displacing nearly a million from their homes. In response to this, the Makassed Philanthropic Association began operations at ten Beirut schools to meet the health and humanitarian needs of over 3500 displaced persons. Older people played an important role in making this a success. N Kronful[a] recalled:

"At the Ali Bin Abi Taleb school in Beirut, the life of the displaced remained quite cheerful, in spite of the adversities of war. This school had welcomed about 185 displaced of all ages: infants, children, women, older people and [a] few young men. Every morning, the chores were distributed. Social workers from the Makassed Association would take the children to the courtyard and organize various activities for them: storytelling, face-painting, drawing lessons, reading. The younger women were assigned the duty of cleaning the premises on a rotating basis. The older ladies were asked to cook for the groups. All these activities would end by noontime. After a much-needed rest, the displaced would spend their afternoons together, walking around the surrounding streets, some buying needed items. The older men would sit in one of the corners discussing the political situation, with varying levels of optimism. The older ladies would rally around them children and tell them stories about life in the village in yesteryears.

"This organization and delegation of tasks in that school was soon adopted in other centers. Older people have provided a significant level of support for the displaced children and the worried younger mothers. Older people provided supervision, care and guidance."

a. Kronful N, unpublished communication, December 22, 2006

This suggests that problems associated with the health and humanitarian needs of older persons indicate a lack of awareness of the issues rather than an absence of policy guidelines, although programme and practice gaps exist. Particularly from a preparedness and response perspective, priority must be placed on increasing the visibility of issues related to older persons in broader policy, planning and programming forums, including funding policies and consolidated appeals. This approach of mainstreaming older persons into health and humanitarian programming integrates this population's needs and issues into organizational policies, providing a systemic and sustainable strategy to address the problem. Additionally, it helps to ensure that information related to older persons is integrated into humanitarian, social and health initiatives by promoting cross-sectoral consultation and partnership-building via an integrated approach, not a separate parallel effort.

At the project level, mainstreaming can foster awareness and inclusion of older people's needs in humanitarian assessments and programmes. For example, sensitivity to their physical vulnerabilities and the use of data disaggregated by age and gender can help ensure that assistance is accessible to frail and/or disabled older people. Development of training and education modules about older people's health needs, common chronic diseases and nutritional requirements can also expand workers' knowledge of obstacles that keep older people from accessing care (disability, reduced mobility, invisibility and exclusion from planning). Such protection and health issues also can be routinely addressed in field-level planning and coordination, ensuring that policy is effectively translated into service delivery and practice.

A more inclusive and participatory approach to programme design and implementation identifies and addresses issues related to specific health and service needs (e.g. ensuring access to older persons who are hidden or left behind). Wells ***(6)*** recommended:

> *It is essential that older people participate in all stages of the project cycle. Needs assessments should include older people (and not just 'elders' or those in a leadership role), and data collected should always be disaggregated by age and gender. Community groups should ensure that older people are invited to participate, and [that they be] supported when they do. Particular care and attention need to be given to identifying those who are household-bound in order to develop a true overall picture of the needs of a community; older women require specific consideration. Information campaigns should include older people, and outreach services are essential in reaching the most vulnerable. Impact assessment and evaluations should incorporate older people's views.*

From a recovery and transition perspective, broader issues determine how older people cope and adjust during emergencies. This reflects the degree to which older people's needs are integrated into emergency management; for example, ensuring that geriatric medications and disability aids are included in emergency medical stockpiles. However, older people's health will also reflect their ability and means to re-establish self-sufficiency and maintain their autonomy and independence in daily life.[4] This is likely to depend not only on support they receive from grown children or kinship networks, but also on their access to more formal infrastructural assistance, such as subsidized health and medicine plans or social pension schemes[5] that can be critical to their daily sustenance. In Africa, for example, social pensions have been found to reduce the scale of poverty among older people by 94%, and within the general population by 12.5% ***(45)***. In Brazil, research has shown that pensions can reduce the probability of a household becoming poor by 11% ***(45)***.

Box 10. Social protection in Zambia: a self-help approach

It is estimated that 47 million Africans aged 60 and over are chronically poor. In 2004, the Kalomo Social Cash Transfer scheme was piloted in Zambia with the aim of reducing extreme poverty and hunger among the poorest 10% of households in the Kalomo District. This targeted mainly households headed by older people caring for orphans. These beneficiaries were identified by community welfare committees, with advice from traditional leaders.

Each household received the equivalent of a second daily meal for a 6-person household. These transfers were made either through savings accounts at local banks or, in more remote areas, were disbursed through schools and hospitals. Beneficiaries were free to use the transfers as needed, purchasing necessities like food, soap and blankets but also investing in seed and livestock and hiring neighbours to plough fields.

The programme was instrumental in improving the living conditions of the targeted households. Proof of this improvement included a noticeable drop in the incidence of begging among the older poor as well as improved school attendance by their children. "The flexibility of the cash transfers, their regularity and reliability (unlike most other assistance reaching the villages) [were] regarded by the beneficiaries and other stakeholders as the most important features of the scheme. Also highly praised [was] the participatory targeting and approval process."[a]

a. Schubert B & J Goldberg (2004). *Scaling up – extending social cash transfers beyond the pilot area.*

4. Autonomy is the ability to control, cope with and make decisions about how one lives on a day-to-day basis according to one's needs and preferences. WHO in 2002 defined independence as the ability to perform functions of daily living and to live independently in the community with no or minimal assistance from others.

5. Social pensions are programmes providing cash income, usually for older people, including both non-contributory and contributory cash transfers. HelpAge International estimated in 2003 that only about one third of the world's aged population was covered by such plans.

This broader approach, which takes into account underlying mechanisms of survivability, requires that emergency preparedness and response enhance individual and community resilience.[6] This is particularly necessary during the recovery and transition phase, when emergency management projects can be coordinated and linked to broader health and social welfare programmes. Similarly, increased attention might be given to social and cultural norms that have traditionally provided older people with a position of respect within their communities and can afford them a continuing role through hardships and upheaval. The 2002 Madrid International Action Plan on Ageing ***(68)*** cited the need to provide sufficient minimum income, security and social protection to empower older persons:

> *…to fully and effectively participate in the economic, political, and social lives of their societies, including through [access to knowledge, education and training], income-generating and voluntary work … and the recognition of the crucial importance of families, intergenerational interdependence, solidarity and reciprocity of social development.*

The WHO Health Action in Crises cluster cannot assume responsibility for promoting resiliency among older people, as this includes a myriad of issues which are beyond its immediate mandate and capacity. However, the ability of older people to maintain their self-sufficiency and autonomy through work, intergenerational support and social pension schemes ultimately determines their capacity to cope with and recover from crises. Similarly, subsidized health care and medicines can enable older people to cope with chronic health conditions and disabilities as they age. To the extent that these conditions place older people at increased risk in emergencies, appropriate health care and social services are important steps towards mitigating the effects of disasters. As equitable access to health care and protection is a fundamental human right often denied to older people, this is a human rights issue.

Box 11. Human rights and older people

Abuse of the elderly can be physical, psychological, emotional, financial and social. In many countries the combination of gender, disability and age leads to increasing social marginalization of and discrimination against older people in their communities.

Barriers that prevent older people from claiming their rights can include:[a,b]

- Negative social attitudes
- Poverty and social exclusion
- Lack of awareness among older people and society
- Discriminatory laws and policies
- War and conflict.

Those responsible for violating older people's rights can include:

- Relatives and family members, through abandonment and abuse
- Health care and social workers, through negative attitudes and poor treatment
- Governments, through inadequate policies to protect older people
- Community and NGOs, through age-biased programming
- Education systems, through the negative depiction of aging and the exclusion of adult and lifelong learning.

a. HelpAge International (2005). *Rights and older people: facts and figures* (www.helpage.org/researchand/policy-1/background)
b. HelpAge International (2005). *Rights and older people: facts and figures* (www.helpage.org/researchand/policy-1/facts and figures)

6. Resilience can be defined as the ability of individuals, families, groups and communities to cope successfully with significant adversity or risk. This capability changes over time, is enhanced by individual and systemic protective factors and contributes to the maintenance and enhancement of health ***(82)***.

Those seeking to develop emergency preparedness, response and recovery policies that which reduce health risks facing older people can also collaborate with WHO programmes such as Health Action in Crises and Ageing and Life Course that seek to raise awareness of these issues. Cross-sectoral partnerships can increase understanding of older people's needs and capacities in broader policy forums to link older people's vulnerability in disasters with other frameworks oriented towards their livelihoods, social welfare, protection and civil rights. Among other tasks, this may include promoting the principles of active ageing,[7] encouraging policies to protect older people and to promote gender equality in programming, and recognizing the importance of intergenerational ties and social networks in maintaining personal and community resilience. Emergency preparedness and response considerations must also be taken into account as policies and programmes address the ageing population. For example, institutions caring for frail or disabled older people can develop practical evacuation and emergency care plans.

The following recommendations aim to enhance emergency health planning and programming for older people. While a number relate specifically to health management (e.g. ensuring evacuation plans address mobility issues, including geriatric medicines and disability aids in emergency medical stockpiles), others pertain to broader social and health issues that require coordination across government departments and other agencies (e.g. encouraging subsidized medical care and social protection schemes). The proposed actions within any phase (i.e. preparedness, response, recovery and transition) tend to be related and are not exclusive to one another. For example, plans developed during the preparedness phase will be implemented during the response phase. Similarly, policies developed during the recovery and transition phase may help older persons after a disaster as well as enhance preparedness by strengthening capacity to cope with crises. The recommendations, although aligned along different themes, follow three broad priority directions: (1) enhancing visibility of older people and increasing awareness of their needs and priorities in emergencies, (2) developing and implementing guidelines and practices responsive to the needs of older people during and following disasters, including participation in planning when relevant; and (3) promoting cross-sectoral collaboration to mitigate determinants of older people's vulnerabilities in disasters.

7. WHO in 2003 defined active ageing as "the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. ... Active ageing applies to both individuals and population groups. It allows people to realize their potential for physical, social, and mental well-being throughout the life course and to participate in society according to their needs, desires and capacities, while providing them adequate protection, security and care when they require assistance."

Jean-Marc Giboux/WHO, Peshawar, Pakistan, 2001

PREPAREDNESS PHASE

Preparedness refers to policies, strategies and programmes developed in collaboration with Member States and internal and external partners to minimize the adverse effects of disasters. This includes promoting the visibility of older people and awareness of their needs in emergencies; developing guidelines, tools and practices to ensure appropriate emergency health care; and facilitating their participation in humanitarian relief programmes.

OBJECTIVE 1: INCREASE VISIBILITY AND RAISE AWARENESS AMONG HEALTH AGENCIES AND HUMANITARIAN ORGANIZATIONS OF OLDER PEOPLE'S NEEDS AND PRIORITIES IN EMERGENCIES.

- Mainstream and integrate issues related to older people and emergencies into existing policies and guidelines (i.e. emergency medicine, nutrition, protection, gender-based violence, participatory assessments and programming). Include plans for older people in national policy and guideline documents.
- Highlight the need to assist and protect older people as well as their capacities and contributions in rebuilding affected communities.
- Develop inter-agency efforts to identify gaps, develop practice guidelines and provide training and education.
- Promote better practice policies and documents among all stakeholders.
- Collaborate with funders to increase humanitarian assistance to older people based on needs assessments and reflect these in funding proposal criteria.
- Involve older people in developing emergency management activities to increase their visibility and ensure their needs are taken into account, for example, in shelter plans and locations.

OBJECTIVE 2: DEVELOP ESSENTIAL MEDICAL AND HEALTH RESOURCES FOR OLDER PEOPLE IN EMERGENCY PRACTICES.

- Identify and include essential medicines for older people in emergency kits. Include medicines for chronic diseases and other illnesses common among this group.
- Develop disability aid packages with equipment such as eyeglasses and walking sticks.
- Develop education modules for health professionals on diseases common among older people, including HIV/AIDS.
- Develop and disseminate guidelines for geriatric medicine in emergencies and humanitarian crises.
- Within the health care system, ensure that conditions and needs common to older people are integrated into patient triage, clinical evaluation, treatment, the emergency medical response system and access to specialty care.
- Ensure that nutritional guidelines for food distribution suitable for older people are integrated into health planning and response plans.
- Ensure local development of guidelines for feeding older persons, using locally available foods to the extent this is possible where populations depend on external food aid.
- Implement gender-based analyses in planning and programme design to account for differences between older men and women in terms of both health needs and access issues.

OBJECTIVE 3: DEVELOP EMERGENCY MANAGEMENT POLICIES AND TOOLS TO ADDRESS OLDER PEOPLE'S HEALTH-RELATED VULNERABILITIES.

- Integrate older people's health needs and related issues into assessment tools and practices.
- Develop community-based tools using disaggregated data to identify vulnerable older people. Include formats to identify chronic health conditions, disabilities and nutritional needs.
- Develop procedures to identify hidden and stay-behind older people.
- Develop standardized tools to assess support needs of older persons, including inter-generational and community care options.
- Develop age-friendly standards and guidelines so that service and care environments are accessible to older people with disabilities.
- In collaboration with older people, their families and communities, develop personal and household preparedness kits in areas of predictable disasters.
- Collaborate with communities in identifying and implementing community-based home care and support strategies which may reduce older people's isolation and vulnerability during crises.
- Develop guidelines and evacuation plans that include mechanisms to identify and transport frail, disabled and older people with special medical conditions. Identify procedures to ensure adequate care and treatment as necessary.
- Develop guidelines to ensure safe and adequate treatment of older people in evacuation centres and refugee camps.
- Ensure that health care facilities have feasible plans to care for older people during disasters and humanitarian crises.
- Develop monitoring and evaluation tools to measure the performance of health care services and humanitarian interventions targeting older people. These measures should be integrated into existing monitoring and evaluation procedures where possible.

Yugoslavia, WHO/UNHCR

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EMERGENCY RESPONSE AND OPERATIONS PHASE

The response phase includes those activities and procedures designed to minimize the immediate impacts of a disaster or humanitarian crisis. In some cases, a disaster or conflict may occur in a country where there has been little or no preparedness activity. Typically, the immediate foci are evacuation and shelter, treating injuries, preventing infectious diseases and providing food and water. Operational procedures developed during the emergency preparedness phase should be implemented to protect the health and safety of older people. These include identifying older people at risk, ensuring that they have access to health care resources and coordinating health and social services.

OBJECTIVE 1: ENSURE THAT OLDER PEOPLE ARE AWARE OF AND HAVE ACCESS TO ESSENTIAL EMERGENCY HEALTH CARE SERVICES.

- Use established assessment tools to identify and locate frail and disabled older people and those with chronic diseases and special medical conditions, as well as older caretakers of orphaned children.
- Ensure that assessments are participatory and target all elderly populations. Assessments should include information on health conditions, social support needs, caretaking responsibilities and available means to meet basic living needs, including access to food and health services, treatment and medicines.
- Ensure that assessments are coordinated across primary health care, rehabilitation, long-term care and social services to meet the needs of older people.
- Implement outreach services and referral mechanisms to identify and ensure care for hidden or stay-behind older people.

- Coordinate primary health care, rehabilitation, long-term care and social services to establish system referral mechanisms that older clients may require.
- Assess and organize training for health staff to ensure knowledge of geriatric nutritional, health and medical care needs.
- Establish information programmes to educate older persons, families and caregivers about nutritional needs, medical conditions and health care options.
- Use disaggregated data to assess services by age and gender.

OBJECTIVE 2: PROVIDE AGE-SENSITIVE AND APPROPRIATE HEALTH AND HUMANITARIAN SERVICES TO MAINTAIN OLDER PEOPLE'S HEALTH.

- Ensure that equitable access to shelter, clothing, food and sanitation prevent deterioration of health through integrated individual assessments and referrals to health and humanitarian agencies.
- Ensure that age-friendly practices are used to promote services to older people with disabilities.
- Provide access to appropriate health care, including medicines for chronic diseases and disability/restorative aids.
- Collaborate with communities in identifying community-based home care and support options for frail and disabled older persons.
- When appropriate and feasible, develop mobile clinics to extend health services to older people living in remote locations.
- Implement mechanisms to assess nutritional balance and ensure access to supplementary food programmes when appropriate, taking into account that many older people also care for children. Provide education on food preparation using supplementary or locally available foods.
- Ensure that protection needs of older persons are integrated into programming (e.g. social welfare or community services) to identify persons at risk and prevent abuse and exploitation.
- Undertake monitoring to assess continuing effectiveness of services to older people.
- Use disaggregated data to assess efficiency of implemented activities by age and gender.

OBJECTIVE 3: PROMOTE CROSS-SECTORAL PLANNING AND COORDINATION TO RAISE AWARENESS OF OLDER PEOPLE'S NEEDS IN CRISES AND REDUCE THEIR RISK OF MARGINALIZATION AND DETERIORATING HEALTH IN EMERGENCIES.

- Raise awareness among agencies and organizations concerning physical and health issues specific to older people and of ways to adapt basic need support to their requirements (e.g. supplementary food rations, livelihood needs and protection issues' impacts on older people's physical and psychological health).
- Where possible, include older persons in planning and programming committees to increase their visibility and ensure their needs and priorities are integrated.
- In coordination with appropriate partners, establish community self-help groups to facilitate community care for more vulnerable older people.
- Recognize self-sufficiency as key to maintaining health and encourage the inclusion of older people in training programmes, income-generation schemes, and community development projects.
- Establish older people's committees to facilitate self-advocacy and communication with authorities and ministries of health to increase access to existing services and entitlements.

Pakistan 2001, WHO

10

RECOVERY AND TRANSITION PHASE

A main focus of the recovery and transition phase is the development and implementation of mid- and longer-term post-emergency policies, methodologies and standards. This effort may be directed at the continuing health care needs of older people, but also may develop and institutionalize disaster reduction and health emergency management structures. For older persons, the recovery and transition phase presents an opportunity to begin to address broader systemic inequities that undermine their health and capacity to recover from crises.

OBJECTIVE 1: BUILD INSTITUTIONAL CAPACITY AND COMMITMENT TO ENSURING THE HEALTH AND SAFETY OF OLDER PEOPLE IN EMERGENCIES.

- Integrate cross-cutting health emergency management issues into global/regional/country strategic plans.
- Promote inter-agency and cross-sectoral consultation on cross-cutting policy and programming issues to build consensus, commitment and capacity to respond to older people's needs in disasters and humanitarian crises.
- Collaborate with ministries of health to establish mandates and legislation ensuring the provision of care to older persons; apply a human rights framework to these issues when appropriate.
- Collaborate with ministries of health to develop options to increase older people's access to affordable health care services, including the implementation of subsidized medical and medicine programmes.
- Advocate for enhanced funding and humanitarian assistance to older people in emergencies and conflicts. Encourage funding agencies to recognize older people as a priority.

- Develop frameworks to promote participatory, transparent and accountable processes to advance the needs of older persons.
- Develop sustainable mechanisms to maintain advocacy and consultation of older persons within the health care-system. Establish and involve advocacy committees in the planning, implementation and evaluation of emergency management practices when appropriate, for example regarding the design of community shelters that may be accessed by older disabled people.

OBJECTIVE 2: STRENGTHEN THE CAPACITY OF MINISTRIES OF HEALTH AND HEALTH CARE SYSTEMS TO MEET THE NEEDS OF OLDER PEOPLE IN EMERGENCIES.

- As required, integrate the medical and nutritional needs of older people into local public health and emergency preparedness and response strategies.
- Develop strategies to ensure that existing health care systems develop capacity (infrastructure and knowledge) to meet the increasing proportion of older people who will be impacted by disasters in the future, taking into account medical, disability and mental health needs including dementia and Alzheimer disease.
- Collaborate with communities in identifying community-based home care and support strategies for older people as an option to reduce older people's isolation and vulnerability to disasters.
- Collaborate with communities to develop and maintain disaster reduction committees. Assist in the implementation of strategies to strengthen community support to older people and reduce their levels of risk during disasters (e.g. development of community emergency response teams or mutual assistance groups among more vulnerable elderly).
- Integrate older people's needs into exercise designs and facilitate the dissemination of lessons learned.
- Develop performance frameworks and monitoring mechanisms to assess medical response systems and older people's access to specialty care in emergencies.

OBJECTIVE 3: DEVELOP MECHANISMS TO ENSURE CONTINUING DEVELOPMENT AND EXCHANGE OF EXPERTISE AS THESE RELATE TO OLDER PEOPLE IN EMERGENCIES.

- Develop and provide ongoing training and education to staff on the needs and priorities of older people, including responsibility to include this population in planning and policy development.
- Integrate issues related to older people in emergencies into relevant university curricula.
- Undertake comparative research to assess the health status (including access to assistance) of older persons in emergencies vis-à-vis other age groups.
- Undertake research to address demographic shifts and the increasing proportion of older people in disasters as this relates to health care and infrastructure/facility development.
- Ensure emergency preparedness and response considerations are integrated into relevant services and institutions (e.g. facilities caring for frail and disabled elderly are required to develop and practice evacuation and emergency care plans).

OBJECTIVE 4: PROMOTE ACTIVE AGEING AS A STRATEGY TO REDUCE VULNERABILITY AND DEVELOP RESILIENCY TO DISASTERS.

- Promote a wider understanding among ministries of health and humanitarian organizations of the economic and social factors contributing to the vulnerability of older people, including issues related to livelihoods, intergenerational dependence and social pension.
- Develop policies that recognize active ageing *(81)* and resiliency *(81)* as facilitating older people's capacity to prepare for, cope with and respond to the affects of disasters and conflicts.
- Include a life course perspective that recognizes health promotion and prevention of disease and disability.
- Support cross-sectoral forums and activities which link the risks of older people in emergencies to frameworks for livelihoods, protection and gender-based equality, health promotion and social pension.
- Collaborate with relevant organizations to mainstream the health needs of older people into existing humanitarian programmes addressing shelter, nutrition, livelihoods, protection and gender-based violence.
- Develop information campaigns and encourage media to highlight both the needs and capacities of older people and to increase their visibility.
- Collaborate with funding bodies to integrate active ageing as a criterion in funding proposals targeting older people.

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