



Neglect of Older People in Humanitarian Response

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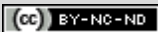
Abstract

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In times of humanitarian crises and complex emergencies, our TV screens and mailboxes fill up with funding appeals. Charities raising funds to respond to emergencies tend to rely on images of malnourished babies and winsome children to raise funds. There is something about threats to the very young that awakens the protector in all of us.

This focus on the very young is perhaps a natural reflex, yet we mustn't allow it to blind us to the needs of older people. As a doctor and a humanitarian worker, I want to challenge our sense that when emergencies arise, we should always focus first on the needs of the very young.

At the heart of humanitarianism are the principles of humanity and impartiality—the belief that all human beings deserve a life of dignity, and that all have equal value. It would run counter to these principles to exclude someone on the grounds of nationality, religion, politics or gender. I believe it is time we add to this list, asserting that it also violates the humanitarian ethos, to exclude people on the grounds of age. We have an ethical imperative to respond to the needs of older people on the same principled basis as we respond to those of children and younger adults.

Why does it Matter?

There are practical reasons why humanitarian actors such as Doctors Without Borders/Médecins Sans Frontières (MSF) must ensure that older people's needs are addressed in a humanitarian response. Older people make up a significant and growing number of those affected by humanitarian crises, and yet they are not sought out, much less prioritized, within the humanitarian response.

Yet older people play a key role in household livelihoods, both with their labor and with financial and material contributions. They usually remain economically productive for as long as they are physically and mentally able, and for as long as household requirements demand their contribution. In addition, the contributions of older people to family and household duties enable other household members to find employment and income for the household.²

Perhaps the most vital role that older people play in household economies is in caring for other vulnerable people, especially children. This is particularly the case in areas where the parent generation is missing because of AIDS, economic migration, or conflict.

In the case of AIDS, limited data makes it difficult to quantify the prevalence of such “skipped generation” households, but HIV prevalence, the mortality rates of the middle

generation, the number of orphans and the role of extended family structures all suggest that many older people are caring for children in sub-Saharan Africa.³

Similarly, high rates of migration to cities or even other countries in search of work often mean that children are left in the care of grandparents. There are reasons to believe that a child who has a grandmother has a better chance of surviving and thriving; studies show that care by a maternal grandmother improves the child's nutritional status and increases chances of survival.^{4,5}

Last but not least, older people contribute their accumulated experience, knowledge and understanding. This insight not only makes them a valuable resource for their communities, but also makes them important potential partners in designing and implementing humanitarian programs.

In order to be principled, practical and relevant, humanitarian agencies must ensure that they are able to provide the assistance that older people need, and to which they are entitled.

What is “Old”?

There is no general agreement on the age at which a person becomes old. In developed countries, the threshold tends to be 65 years. For the UN, the agreed cut-off is at 60 years, but in developing countries, where the majority of humanitarian crises take place, we see that 50 or 55 years is perhaps more appropriate.⁶

The use of a calendar age to define old age assumes equivalence with biological age, and the two are not necessarily synonymous. It is more accurate to understand old age as a relative category, construed in different ways according to a person's role and status in the community.⁷ In areas of the world where people do physically taxing labor, do not have adequate healthcare and have a low life expectancy, chronological age is less significant than physical condition as a marker of aging. A lifetime's exposure to health problems, environmental pollutants such as cooking smoke, and physical labor means that women, in particular, may be seen as old in their forties or fifties.

Unnoticed but not Unimportant

Effective humanitarian assistance is based on assessment and surveillance data on the affected population and the vulnerable groups within it, and on meeting the needs of those most in need. Almost all guidance – whether targeting general audiences (such as the Sphere Handbook⁸) or sectorial- or agency-specific audiences (such as agency handbooks, sectorial standards or emergency-specific guidelines) – requires collection of sex- and age-disaggregated data (SADD). In practice, however, most needs assessment and surveillance data combine data for all adults. This renders invisible the particular needs of older people.^{9 10} Yet health and nutrition needs of age groups differ, so it is crucial to disaggregate data to understand the profile and needs of people of various ages.

Approaches to measuring disease burden and health impact can also be discriminatory. The disability-adjusted life year (DALY) method (which is endorsed by the World Health Organization and is in common usage) ascribes a value to each year of life according to age, with years lived as a young adult being valued more highly than years spent as a young child or older

adult. Claiming that life years given to older people are objectively less valuable reflects a concern with receiving a return on investment rather than responding impartially and equitably to needs.¹¹ Such age weighting and discounting undermines the principles of humanitarianism.

Funding

Institutional donors do not regard humanitarian assistance for older people as a priority. Two studies by HelpAge International analyzed the amount of humanitarian funding targeted at older people through the UN Consolidated Appeals Process (CAP) and Flash Appeals in the past five years.^{12 13} They found that just 0.3% of projects funded included any activity that specifically targeted the needs of older people, who constitute 12.5% of the world's population. In 21 countries, there had been no projects at all in the previous two years with activities tailored for older people. (Those countries included Chad, Central African Republic, South Sudan, Yemen, Zimbabwe, and 16 countries making up West Africa.)

Increasing Population Numbers

Demographics suggest that populations facing disasters will include an increasing proportion of older people. About 12.5% of the world's population is aged 60 or over; 17% are 55 or older; more than 22% are 50 or older.¹⁴ Moreover, with demographic change (declining fertility rates combined with increasing life expectancy), elderly populations in developing countries are growing faster than in developed countries.¹⁵ By 2050, the number of people over 60 is projected to almost triple, from 865 million in 2010 to 2.4 billion, to constitute 21% of the world's population. By then, more than 80% of older people will live in developing countries – where disasters are more likely to occur and their effects to be greater – compared with 60% today.¹⁶

Where a generation is missing because of high HIV prevalence, conflict or economic migration, communities have higher proportions of older people. This is particularly common in remote rural areas.¹⁷

Older people often make up a high proportion of people who choose not to flee in times of conflict.¹⁸ Hardship associated with a long trip and problems that get worse with age such as poor eyesight and limited mobility make it less likely that the elderly will get out of danger and seek help. Moreover, their reluctance to leave homes, land, livestock or orphaned children under their care makes them less likely to receive any assistance.¹⁹

A Commitment to Non-Discrimination?

Old age today is grounds for exclusion from humanitarian assistance. This was indeed the case in the Somali capital city in 2011. During the height of the nutritional crisis, nearly all of the screening and therapeutic programmes were directed towards children and their mothers. I observed that a large number of malnourished older people were living in makeshift tents all across the city, yet almost all the people being assessed for malnutrition were children. Far too often, older people, invisible to aid providers, are too frail or self-abnegating to seek assistance even when it is being provided a few meters away. This is unacceptable.

Among the 100,000 people displaced from Sudan's Blue Nile state in July 2012, an MSF team found that the 50-and-above group, constituting 10.5% of the population, were dying at over five times the rate of those aged 5 to 49 years (3.45 vs. 0.61 per 10,000 per day, respectively) and at over twice the rate of those under the age of 5 (1.26 per 10,000 children per day).²⁰ We now know that three out of four killed by the 2005 Hurricane Katrina in Louisiana, were over the age of 60 even though they constituted only 11% of the population.^{21 22} Similarly, one of three casualties in the 2011 Tohoku earthquake and Tsunami were over the age of 60 despite comprising just one fourth of the population.²³ Those above age 60, constituting 9% of the Nepalese population, are considered to be among the most vulnerable victims of the 2015 Nepal Earthquake.²⁴ Even allowing for the obvious fact that people naturally die at higher rates when they get older, these are unacceptably high figures and should not be ignored.

Why are older people invisible to humanitarian agencies? Hutton suggests that, "We do not assess older people's needs, nor do we address their needs through our assistance."²⁵ Maybe we see more inherent value in the life of a child than that of an older person; perhaps utilitarian considerations of the longer-term future of a society come into play; or maybe we simply go with the flow of current aid practice without questioning it. For whatever reason, humanitarian actors do not consider older people a priority, even though they are generally recognized to be a vulnerable group.

Age and Vulnerability

Health Needs

Age has an important impact on health. Older people have limited regenerative abilities and have health risks and needs that differ from younger people's. The prevalence of chronic and non-communicable diseases increases significantly in old age; global aging is recognized as a major driver of non-communicable disease predominance in developing countries.²⁶

Older people in low- and middle-income countries are at especially high risk of cardiovascular disease, strokes, diabetes and dementia. They may require palliative care and end-of-life pain management. Evidence from conflicts and natural disasters shows that much excess morbidity and mortality results from the exacerbation of existing non-infectious diseases such as hypertension, diabetes and cancer.²⁷

This was exemplified in a recent survey of some of the estimated 10 million Syrians who have been displaced from home since the start of the civil war in March 2011 (7.8 million internally displaced and 2.8 million in neighboring countries such as Lebanon, Turkey, Jordan, and Iraq).²⁸ The survey conducted by HelpAge International and Handicap International in Lebanon and Jordan showed that 54% of older Syrian refugees have a chronic ailment while 65% present signs of psychological distress.²⁹

Yet the management of non-communicable chronic disease is a rarity humanitarian responses, and there are virtually no guidelines for management of chronic medical conditions after disasters.³⁰ The latest revision of the Sphere Handbook, however, does recognize the increasing evidence of acute complications from chronic diseases in disasters and supports and encourages their treatment.³¹

Older people may also be at increased risk from communicable diseases. Infectious diseases have a specific presentation in older people. This is most obvious with respect to HIV and TB, but it also applies to infections such as diarrhea, pneumonia, and neglected tropical diseases.³³ There are also reports of higher parasite loads, and in cases of malaria, a higher proportion of severe forms and an increase in fatal disease amongst older people.

Preliminary results from a study of data from MSF cholera treatment centers in Haiti indicate that people over 60 years old are more likely to present with severe dehydration as opposed to mild dehydration when compared with younger adults. In addition, after controlling for other factors, people aged 80 years or older have 11 times the mortality of younger adults in cholera treatment centers.³⁴ Preliminary analyses of age-disaggregated fatality rates of the recent outbreak of Ebola Virus Disease (EVD) in West Africa also suggest poor survival rates among older people when compared with young adults.³⁵ Yet older people are rarely if ever identified as an at-risk group for communicable diseases, and infection control programs do not usually consider approaches geared specifically to the elderly population.

There is evidence even from settings such as the UK's National Health Service that an inverse care law operates: older people generally have higher healthcare needs than other demographic groups, and yet they have a lower provision of and access to medical care.³⁶

Nutrition Needs

Few nutrition surveys are carried out among people aged 60 years and above, and, as we have seen, survey data collected in humanitarian crises are rarely disaggregated to show the situation of older age groups. It is generally accepted that measuring the malnutrition of children under five years provides an indicator of whether a nutrition intervention is needed in the general population, but this does not provide humanitarian agencies with enough information on other age groups to inform targeted interventions.

In October 2011, HelpAge conducted a nutrition survey of older people in the refugee camps of Dadaab, Kenya.³⁷ It showed that older people were also vulnerable to malnutrition, although they were not recognized as such in the other surveys that had been done, and they were not included in supplementary and therapeutic nutrition programs. HelpAge International recommends the use of MUAC (mid-upper arm circumference) for assessing the nutritional status of older people and recommends that older people be systematically screened and included in nutrition surveys.³⁸

Food rations also need to be adapted for older age groups. Although total recommended energy intake declines with age, requirements for many nutrients increase in order to maintain organ systems with declining functionality. Inadequacies of micronutrients – such as vitamins B6, B12, C and E, folate and calcium – are common amongst older people and are linked to the risk of chronic disease. Adequate protein is also critical for maintaining functional status with age. At the same time, older people may require smaller amounts of iron and vitamin A, nutrients emphasized for maternal and child nutrition.³⁹ As is often the case with older people, however, research on their nutritional requirements is inconclusive.

Access and Capacity

Many older people are not able to travel to health and registration facilities, stand in queues for food distributions, carry heavy packages of food or containers of water, or compete with younger people for relief supplies. In Lebanon, one out of every four older refugee was not

registered, compared to one out of eight children. Strength, mobility, eyesight, and hearing decline with age, all of which affect people's ability to access humanitarian assistance. As a result, older people often depend on support from their families and communities to access care and assistance.

WHAT NEEDS TO BE DONE?

There is a need for academic, research, and practice communities to work towards ensuring that vulnerable groups are not excluded and their needs are met by humanitarian aid. I outline a set of priority areas for humanitarian response, to be incorporated into practice, research, and policy:

PRACTICE

Collect age-disaggregated data on who is accessing humanitarian assistance to ensure that older people are not being excluded.

Ensure that all surveillance, needs, and vulnerability assessment data are disaggregated for older age groups.

Systematically screen older people in nutrition surveys using MUAC.

Provide adequate care in emergencies for chronic diseases and conditions, including palliative care and pain relief.

Ensure that infection-control programs take into account the differing presentation and needs of older people.

RESEARCH

Research the optimum nutritional support for older people in emergency settings.

Conduct operational research into the best way to ensure that older people's health needs are comprehensively met in humanitarian programs.

Conduct operational research to determine how best to improve older people's access to humanitarian assistance both in open settings and in camps.

POLICY

Ensure that institutional funding bodies include the needs of older people in project proposals where appropriate, and fund them adequately.

There is a widespread assumption amongst aid agencies that older people are always cared for within their families. However, in many situations, particularly in crises and disasters, this is a myth. For example, following the 2010 floods in Pakistan, the Ministry for Social Welfare estimated the number of older people living without family support at 10% of the older population. Similarly, 9% of older people in the Occupied Palestinian Territories live alone. In camps for internally displaced people (IDPs) in Darfur, half of all the older people live alone. Special attention needs to be given by humanitarian agencies to facilitate older people's access to care and assistance and ensure that they are not excluded.

Conclusion

As the numbers of older people affected by humanitarian crises and disasters increase, policy and practice must be adapted to ensure that older people's needs are consistently considered. Being old should no longer mean being ignored.



AAGE President Iveris Martinez (FIU) and Dr. Unni Karunakara at the Association for Anthropology and Gerontology Conference on "Health Disparities in Aging," held February 5-7, 2015. (Photo courtesy of Iveris Martinez)

NOTES

1. An earlier version of this paper titled "Humanitarian assistance for older people: does it matter?" (June 2012) was presented to Doctors Without Borders for discussion, and later published in PLoS Medicine (December 2012; 9(12):e1001357) as "Ending Neglect of Older People in the Response to Humanitarian Emergencies."
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