INTERNATIONAL RESCUE COMMITTEE

USAID
FROM THE AMERICAN PEOPLE

SAFE AT HOME

MODULE 3: WOMEN AND CHILDREN WITH DISABILITIES AND OLDER PERSONS SAFE AT HOME

Part 6: Guidelines for Integrating an Older-Age Lens Into Existing Case Management

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DISCLAIMER

The content and conclusions in the *Guidelines for Integrating an Older-Age Lens in Existing Case Management* are those of the authors and do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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MODULE 3

INCLUSIVE PARENTING

Part 6: Guidelines for Integrating an Older-Age Lens Into Existing Case Management

1. Introduction

By 2050, 19.2% of people living in fragile countries will be aged 50 and over.[1] Globally, women will continue to form the majority of older persons. In 2015, women accounted for 54% of the global population aged 60 years or more and 61% of the global population aged 80 years or more.[2] Population aging is happening in all regions and in countries at various levels of development. It is progressing fastest in countries of the global majority, including in those that also have a large population of young people. More than 46% of older persons – aged 60 years and over – have disabilities, and more than 250 million older people experience moderate to severe disability.[3] Globally, one in two people are ageist against older people.[4] As the world's population ages at an increasing rate, it is essential to understand and address the abuse that older persons face. Population aging presents social, economic, and cultural challenges to individuals, families, societies, and the global community.

In humanitarian crises, older persons face particular risks and additional obstacles. They often face difficulties fleeing and may be left behind by family and community members and tasked with looking after property. As families are separated and community structures break down, older persons may become isolated, or required to take on new roles as heads of household, with care for children and other dependent family members. Older men are less likely to receive monetary and emotional support from family members while older women more often become primary caregivers of other family members.[5] When in displacement settings, humanitarian agencies often fail to appropriately understand and respond to the needs of older adults, let along the differing needs of older men and women. Older adults surveyed in displacement reported critical unmet basic needs, including 64% not having enough to eat, 20% with no access to shelter, and 36% reporting that neglect, isolation, and denial of resources or services were risks for older people.[6]

WORLD HEALTH RGANIZATION QUICK FACTS ON ABUSE OF OLDER PERSONS

- 90% of all abusers are family members.
- Most abusers are adult children, spouses, and partners.
- Only 4% of abuse of older persons is reported.
- Older people with dementia are at special risk. As many as 2 out of 3 people with dementia have been abused.

Risks, such as neglect, exploitation, emotional abuse, and lack of control over assets and decision-making are often exacerbated in emergency situations, as older persons are separated from community support and familiar service structures, while at the same time their role in the family and the community may be undermined or may be shifted.[7] With these shifts, the compounding effects of discrimination result in drastically different realities for both older men and older women. Gender relations structure the entire life course,[8] influencing access to resources and opportunities, with an impact that is both ongoing and cumulative. Older men, particularly after retirement, may become vulnerable due to their weaker social

1 McGiven, V. & Bluestone, K. (2020). *If not now, when? Keeping promises to older people affected by humanitarian crises.* HelpAge International. https://bit.ly/3v9lKNm

2 UN DESA Population Division. (2015). *World population ageing 2015 (ST/ESA/SER.A/390)*. United Nations. Source figure on older persons refugees. https://bit.ly/3E65ouj

3 UN Department of Economic and Social Affairs. (n.d.). *Ageing and disability.* https://bit.ly/3LU8AM4

4 World Health Organization. (2021). *Global report on ageism.* Download at https://bit.ly/37EYOPg

5 UNFPA & HelpAge International. (2012). *Ageing in the twenty-first century: A celebration and a challenge.* https://bit.ly/37F0KHk

6 McGiven, V. & Bluestone, K. (2020). *If not now, when? Keeping promises to older people affected by humanitarian crises.* HelpAge International. https://bit.ly/3v9lKNm

7 Lange, Kristin. (2019). *Expert Group Meeting on Older Persons in Emergency Crisis.* OLDER PERSONS IN FORCED DISPLACEMENT—INTERSECTING RISKS: Analytical paper for Session III: Lessons learnt, gaps and challenges. United Nations High Commissioner for Refugees (UNHCR). UNHCR-Expert-Group-meeting-on-aging_Lange.pdf

8 HelpAge International. (2017). *Violence against older women.* violence-against-older-women-.pdf (helpage.org)

support networks and can be subject to abuse.[9] Older women are more likely than older men to live alone, have no access to healthcare, food, or income. When living with others, they are also more likely to be caregivers for members of their household.[10] Older women also feel the impact of both age and lifelong gender discrimination, resulting in increased vulnerability in old age and greater risk for violence and abuse.[11]

According to the World Health Organization (WHO),[12] around one in six people 60 years and older experienced some form of abuse during the past year. Despite the clear prevalence of elder abuse, only 4% of abuse is reported. Often, older people do not have access to help. Limited systems to address the abuse of older adults, coupled with fears of retaliation, dependency on the abuser, feelings of shame and, for some, being mentally incapable of reporting the abuse, result in significant underreporting.[13] Despite a clear need for focused, intentional programming and inclusion efforts for older adults, humanitarian services remain out of reach for many older adults and data on older adults remains critically inadequate. Humanitarian agencies continue to fail to appropriately understand older people and their needs and rely on assumptions to inform programming.[14] Older people are also neglected in funding allocated for humanitarian responses.[15]

Abuse of older persons is a complex issue that shares risk factors with other types of violence, while also having unique characteristics. The recognition of and response to the abuse of older persons is still nascent worldwide, and even more so in humanitarian crises. As a result, there is a lack of standardization when it comes to definitions and interventions. Therefore, these guidelines aim to identify the most suitable response modality for humanitarian contexts.

HOW TO USE THESE GUIDELINES

These guidelines focus on addressing abuse of older persons occurring in the home as this is the most frequent situation that caseworkers might encounter in the settings in which they work. As such, protection actors, can use these guidelines to integrate a response to the abuse of older persons into existing/ established case management models. This guidance can also be used to increase the ability of teams to understand and recognize potential abuse of older adults and make appropriate referrals. The guidelines assume the following:

- There is **an existing team of caseworkers** trained in rights-based, social work case management.
- **Solid reporting and identification channels** and service delivery is in place.
- **A robust documentation system** to support the provision of case management services is in place.
- **A system for supervision** and staff support is in place.

Throughout the guidelines you will find a range of pictograms and hyperlinks so that you can quickly navigate through the document and find the information you need.

9 Crockett, C., McCleary-Sills, J., Cooper, B., & Brown, B. (2016). *Violence against women and girls resource guide: Brief on violence against older women.* United Nations. Final GBV Toolkit - Health Sector .docx (un.org)

10 McGiven, V. & Bluestone, K. (2020). See above for full citation.

11 UNFPA & HelpAge International. (2012). Ageing in the twenty-first century: A celebration and a challenge. https://bit.ly/37F0KHk

12 WHO. (2016). Elder abuse: The health sector role in prevention and response. https://www.who.int/ageing/media/infographics/EA_infographic_EN_Jun_18_web.pdf?ua=1:

13 *Ibid.*

14 McGiven, V. & Bluestone, K. (2020). *If not now, when? Keeping promises to older people affected by humanitarian crises.* HelpAge International. https://bit.ly/3v9IKNm

15 Shami, H. & Skinner, M. (2016). *End the neglect: A study of humanitarian financing for older people.* HelpAge International. Accessible at End the neglect - a study of humanitarian financing for older people.pdf (reliefweb.int)

SCOPE OF THE GUIDELINES

These guidelines are an important step toward developing and standardizing a global case management approach for identifying and addressing the abuse of older persons in humanitarian crises. While much more research needs to be done to fully understand the causal links of abuse of older persons and effective interventions for addressing it, **these guidelines seek to support protection case management service providers in the inclusion of older persons into their existing services**. While the guidance does not include specific training materials for caseworkers, it does include and highlight specific needs, concerns, and issues facing older men and women. Program managers should select the most relevant sections and topics in this guidance for their staff and build training and capacity into continued learning plans.

SECTION 1:

KEY CONCEPTS

FOUNDATIONAL TERMS

Elder or Older Person/Adult?

In the past, information on the abuse of older persons frequently used the terms "elder" and "elderly." However, this same term is used to designate an individual, often male, in a position of authority. To avoid replicating the gendered nature of the term, and in alignment with United Nations language,[16] these guidelines instead use the following terms throughout the guidance:

- Older women and men with and without disabilities[17]
- Older adults
- Older persons
- Abuse of older persons

Age

There is a lack of international consensus regarding the age range for older adults and in general the idea of "old age" can be understood as a social construct.[18] In the global north, it has been used to mark the age when an individual retires, which may not be applicable in lower income countries with lower life expectancies and no social services safety net for older people not working. Thus, some countries designate old age as starting at age 50 or 55, while others reference 70 years of age as the start of old age. **In these guidelines, older persons will be considered individuals 60 years or older.**[19] However, practitioners should use the most relevant age definition and guidance for their context. If definitions specific to the context are not easily available, use the definition of old age in these guidelines.

Accessibility

"To enable persons with disabilities to live independently and participate fully in all aspects of life [...] to ensure persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information, and communications."[20]

16 The United Nations Universal Instrument on Principles for Older Persons (1991) uses the term 'Older Persons' to refer to persons above 60 years old. The World Health Organization's Global Report on Ageism (2021) also problematizes the use of the term elder or elderly.

17 Older men and women with and without disabilities is used as a term to reflect the intersection and impact of both age and disability on persons, particularly with the discrimination they experience and their access to services.

18 Wallace, R. B. & Crabb V. L. (2017). Toward definitions of elder mistreatment. In X. Q. Dong (Ed.), *Elder abuse: Research, practice, and policy.* (pp. 3-20). Springer.

19 Older age is defined by the United Nations and the World Health Organization as age 60 and above.

20 UN General Assembly. Convention on the Rights of Persons with Disabilities (A/RES/61/106). *Article 9—Accessibility.* https://bit.ly/3LWUCcj

Ageism

The World Health Organization defines ageism as the "stereotypes (how we think), prejudice (how we feel), and discrimination (how we act) towards others or oneself based on age."[21]

Ageism happens when:

- Positive or negative assumptions are made about older people as a group and they are stereotyped rather than treated as individuals (e.g., assuming an older person is forgetful, has a cognitive impairment, or cannot understand things).
- Older people face discrimination (e.g., refusing medical services based on age or firing someone from a job because of their age).
- Negative and prejudicial attitudes to aging or older people are expressed in harmful, dismissive, or disrespectful behavior (e.g., directing comments about an older person to a younger person or child present rather than the older person directly).
- Policies, laws, and public opinion are biased against older people and uninformed by knowledge and evidence.

If someone **believes** that older adults are all frail, that is a **stereotype**. If someone **assumes** an individual has been injured solely as the result of being "old and frail," that is **prejudice**. If someone **refuses** to believe a person when they say that a family member has abused them because of their age, that person may be engaging in **discrimination** and contributing to ongoing violence, abuse, and neglect.

Ageism contributes to the violence, abuse, and neglect of older persons through a variety of ways, including:

- Stereotypes that contribute to societal acceptance of violence against older people.
- Caseworkers being more likely to detect and report abuse against younger people.
- Justice and law enforcement bodies tending to take the abuse of older persons less seriously.
- Systemic discrimination that results in not providing adequate or quality services when needed.

Caregiver of an Older Person

This guidance uses the term "caregiver of an older person" to refer to the person who provides the majority of caretaking activities for the older person who needs assistance due to physical, cognitive, or other barriers. This term is often shortened to "caregiver" except in the child protection specific guidance. In the child protection guidance, "caregiver of an older person" is used to maintain clarity between the caregiver of an older person and the caregiver of children.

Cognitive Impairment[22]

Cognitive impairment occurs when "a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life."[23] In some contexts, the term cognitive decline may also be used. Cognitive impairment is a very complex issue and, at the same time, represents a significant risk factor for abuse of older persons. Several sources of cognitive impairment, including dementia, strokes, neurological diseases like Parkinson's, cerebral palsy, and mental health conditions can all cause cognitive decline. Some forms of cognitive impairment can be improved with medication, therapeutic interventions, or both. Other forms of cognitive impairment are irreversible and will continue to cause deterioration in the older person.

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21 WHO. Frequently asked questions: Ageism. https://www.who.int/ageing/features/faq-ageism/en/

22 Wallace, R. B. & Crabb V. L. (2017). Toward definitions of elder mistreatment. In X. Q. Dong (Ed.), *Elder abuse: Research, practice, and policy.* (pp. 3-20). Springer.

23 Center for Disease Control. (2009). *Cognitive impairment: A call for action now.* https://bit.ly/3uy6VWQ.

Dementia

Dementia is defined as "a syndrome in which there is deterioration in memory, thinking, behavior, and the ability to perform everyday activities."[24] It is one of the most common forms of cognitive impairment[25] and is considered by advocates as a significant risk factor for abuse of older persons.[26] Dementia impacts memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. In addition to cognitive impairment, dementia is often preceded by deterioration in emotional control, social behavior, and motivation. Older adults with dementia often become aggressive and one of the most common drivers of this aggressiveness is unaddressed pain.[27] Their increasing aggressiveness can result in abuse and neglect from their family members or contribute to the worsening of abuse or neglect that was already occurring. Furthermore, situations in which a partner with cognitive decline may become aggressive toward their partner or other family members may be evaluated within this context.

Intersectionality

A feminist framework used to illustrate and understand interlocking systems of oppression and the resulting impacts on groups of people and individuals. An intersectional lens understands that experiences of inequality and oppression vary based on the layered identities of a person or group (e.g., race, class, gender identity, religion, sex, sexual orientation, etc.) and cannot be fully understood or addressed separately.[28]

Inclusion

A process of improving and enabling the ways in which people from diverse backgrounds can participate in community and access needed services, support, and resources. This process must be collective, include shared decision making, take proactive steps to address barriers and heightened risk, and work to intentionally create and uphold both belonging and uniqueness of individuals. When a process of inclusion is properly executed, individuals are supported to realize their rights.[29]

Mainstreaming

"The process of incorporating protection principles and promoting meaningful access, safety, and dignity in humanitarian aid." (Humanitarian Inclusion Standards). Mainstreaming is an important part of ensuring access to services for older adults. Caseworkers can contribute to mainstreaming efforts through their work to identify services and assess the services' safety and relevance for older persons.[30]

Older Person with a Disability

People face a decline in their ability to function in older age (for example, reduced mobility, vision, or hearing) which means they are susceptible to disability as part of the aging process. At the same time, persons with pre-existing disabilities will age and become older persons. As such, there are similarities with disability in terms of the need to address accessibility requirements, including the availability and use of

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24 World Health Organization. (2021). *Dementia: Key facts.* https://www.who.int/news-room/fact-sheets/detail/dementia.

25 Due to challenges in defining dementia across cultures and a lack of reporting, there is limited consensus on how prevalent dementia is among survivors of abuse in older age—estimates range from 5.4% to 62.3% of survivors. From Dong, X. Q., Chen, R. & Simon, M. A. (2014). Elder abuse and dementia: A review of the research and health policy. *Health Affairs.* 33(4), 642–649.

26 Lachs, M. S. & Pillemer, K. A. (2015). Elder abuse. *New England Journal of Medicine.* 373, 1947–1956.

27 Cravello, L., Di Santo, S., Varrassi, G., Benincasa, D., Marchettini, P., de Tommaso, M., Shofany, J., Assogna, F., Perotta, D., Palmer, K., Paladini, A., di Iulio, F. & Caltagirone, C. (2019). Chronic pain in the elderly with cognitive decline: A narrative review. *Pain and Therapy.* 8, 53–65. https://doi.org/10.1007/s40122-019-0111-7

28 Adapted from the International Rescue Committee's *Diversity, Equality, and Inclusion Strategy,* April 2021.

29 *Ibid.*

30 Inter-Agency Standing Committee. (2019). *Guidelines on the inclusion of persons with disabilities in humanitarian action.*

assistive products. There is also the concern that functional limitations will be more severe for older people with disability, which can increase the levels of risk individuals experience over time.

Reasonable Accommodation

The process of making needed and appropriate modifications, adjustments, or changes to ways of working or delivery of services in order to ensure that persons with disabilities, older persons, and others can access needed services and support and exercise their full human rights.[31]

DEFINING ABUSE OF OLDER PERSONS

The abuse of older persons is defined as "A single, or repeated act, or lack of appropriate action, occurring within any relationship, where there is an expectation of trust, which causes harm or distress to an older person."[32] Abuse of older adults **relates to both acts of commission and omission**, meaning committing an abusive act or not acting, either intentionally or unintentionally as appropriate to meet the needs of an older person.

In general, abuse of older persons is applied to relationships of trust or situations in which an individual has a responsibility to care for an older person. While the term "relationship of trust" is not well defined, it broadly refers to familial and caregiving relationships where dependency is involved.[33] Thus, abuse of older adults can occur in the home by a family member, spouse, intimate partner, or other individual sharing the living space (domestic abuse) or by caregivers in hospitals, care homes for older persons or other institutional settings (organizational abuse). At the same time, it is important to clarify that an older person does not have to be faced with disabilities or be dependent on another member in the household to experience abuse or neglect, although these dynamics place them at greater risk.

Abuse of older persons can be broken down into five different categories:[34] financial abuse and exploitation, psychological or emotional abuse, physical abuse, sexual abuse, and neglect and abandonment. However, incidents of abuse may fall into more than one category and are often cross-cutting.

Financial Abuse and Exploitation includes fraud and the misuse, theft, or exploitation of an older person's money, property, social benefits, possessions, or other assets.

EXAMPLES:

- Stealing the money or possessions of an older person
- Selling or transferring property without the informed consent of the property owner
- Forging an older person's signature or forcing or deceiving an older person into signing a legal document or agreement
- Misuse of power of attorney, guardianship or other legal role designated to represent the interests and care of an older person

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31 UN General Assembly. *Convention on the Rights of Persons with Disabilities* (A/RES/61/106), Article 2: Definitions. https://bit.ly/3jteS9d

32 This definition was developed by the NGO Action on Elder Abuse in the United Kingdom.

33 Wallace, R. B. & Crabb V. L. (2017). Toward definitions of elder mistreatment. In X. Q. Dong (Ed.), *Elder abuse: Research, practice, and policy.* (pp. 3-20). Springer.

34 Categories are defined by the World Health Organization. https://bit.ly/37GbHlx

Psychological or Emotional Abuse is an intentional verbal or nonverbal act causing emotional pain, distress, or injury or diminished self-esteem and dignity. It includes threatening or coercive actions that create a power imbalance between the individual of trust and the older adult.

EXAMPLES:

- Verbally assaulting, insulting, disrespecting, or humiliating an older person
- Using threats, intimidation, or coercion
- Infantilizing an older person
- Disregarding an older person's knowledge, experience, and intelligence because of age.
- Excluding an older adult from making her or his own choices or decisions even though they are capable.
- Overprotection: limiting freedom of movement, decision making, etc., in the name of keeping the older person safe or to reduce the perceived burden of caretaking duties for the caregiver.
- Isolating an older person from family, friends, regular activities, or services.

Physical Abuse is any act causing physical pain or injury to an older adult.

EXAMPLES:

- Hitting, slapping, kicking, pushing, or any such similar action
- Misusing medication/s
- Enacting any type of physical punishment

Sexual Abuse is any kind of sexual contact to which the older person did not consent, was unable to consent, or was forced to consent. It includes non-consensual sexual interactions and any conduct based on sex or of a sexual nature.

EXAMPLES:

- Sexual harassment
- Sexual assault, including rape and unwanted touching
- Forced nudity
- The taking of sexually explicit photos

Neglect and Abandonment are the intentional or unintentional failure to provide for an older adult's basic needs such as food, water, clothing, hygiene, shelter, social interaction, and essential medical care.

Within the broader category of neglect, advocates often distinguish between active, passive, and self-neglect.

Active neglect describes an intentional failure to provide care.

Passive neglect involves the unintentional failure to provide care, which can be due to lack of knowledge or awareness, poor caregiving skills, illness, or other causes.

EXAMPLES:

- Failure to provide needed aids such as eyeglasses, hearing aids, or other items
- Poor hygiene of older person, for example, difficulty treating incontinence issues
- Insufficient supervision or safety measures
- Withholding medical treatment or services

- Abandonment: When a person has assumed a formal caretaking role for an older person but fails to provide that care through the act of deserting the older person, at a facility like a hospital or by leaving them behind when moving, etc.[35]
- Caregiver is unable to adjust to changing abilities of older person in their care.
- Caregiver presents with life stressors that prevent them from being able to care for older person.

HELPFUL TO KNOW

Self-Neglect, which is not a form of abuse of older persons, refers to situations in which an older adult is unable to provide for their own basic needs and protect themselves from harm. In some cases of self-neglect, the older person may not want to accept assistance from others in meeting these needs. Self-neglect can be due to illness, disability, cognitive impairment, or other causes. It is important in these cases to find a balance between concerns about the older person's safety and respecting their autonomy. It can often be very difficult to differentiate between neglect of older persons and self-neglect when they share a home with others. Examples of self-neglect include residing in unsanitary conditions relative to conditions typical for the context in which the person is living or not maintaining basic hygiene.[36]

CO-OCCURRING VIOLENCE IN THE HOME[37]

Co-occurring violence is the presence of violence against more than one family member within the same household. Broadly, this could include intergenerational violence, such as one woman's experience of abuse in her childhood and her own child's experience of abuse, but for the purposes of case management, we focus on co-occurrence over the same length of time (for example, within the span of a year, or while multiple people have been residing in the same home).

While more research needs to be done regarding co-occurring violence in multi-generational households, there is evidence to show that in many incidents of abuse of older persons, other members in the household may also be experiencing abuse at the hands of the perpetrator. For example, results of a Canadian program to address abuse of older persons showed that in about 30% of cases, the older person was one of several people in the household abused by the perpetrator.[38] Co-occurring violence in the home may manifest in different ways.

FOR EXAMPLE:

- In multi-generational households, a male head of household may commit physical and psychological abuse against a spouse and their children as well as an older parent living in the home.
- In multi-generational households experiencing poverty and multiple stressors, those dependent on care from the head/s of the household, such as children and older adults with disabilities, may experience neglect.
- In multi-generational households, a male head of household may exert control over the finances of his spouse as well as an older parent, particularly a mother or mother-in-law, against their will due to gender norms and ageism.

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35 FindLaw. *Elder abandonment.* https://www.findlaw.com/elder/elder-abuse/elder-abandonment.html

36 National Academy of Science

37 From IRC. *Safe at home: Response guidance for co-occurring intimate partner violence & child maltreatment.*

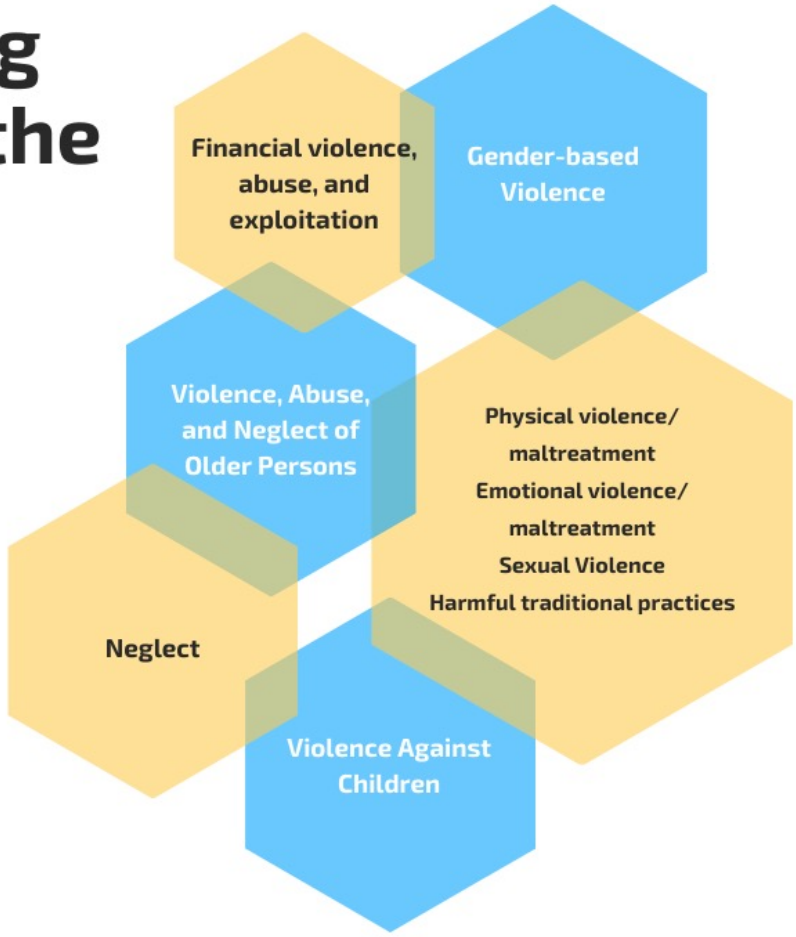
38 Storey, J. E. & Perka, M. R. (2018). Reaching out for help: Recommendations for practice based on an in-depth analysis of an elder abuse intervention programme. *Br. J. Soc. Work.* 48, 1052–1070.

- In certain cultural settings, older widows in such situations may be more vulnerable to accusations of witchcraft. Older men, older persons with disabilities, and those with significant physical differences may also be more vulnerable to accusations of witchcraft. Sometimes, these can be targeted accusations with the aim of taking over the land and resources of these older persons.
- An older woman could be experiencing intimate partner violence but also experiencing financial abuse from another family member.

The visual below maps out types of abuse that occur within other protection fields that may intersect with abuse of older persons.

Co-Occurring Violence in the Home

This chart aims to illustrate the ways that co-occurring violence overlaps across categories of violence. While different language may be used across programming, some types of violence will occur across all ages and genders. It is important to recognize that gender and age dynamics will result in different manifestations of the same types or categories of violence.



SECTION 2:

CONSIDERATIONS FOR INTEGRATING CASE MANAGEMENT SERVICES FOR OLDER PERSONS EXPERIENCING ABUSE

This section includes information relevant for GBV, protection and child protection service providers to consider how they can recognize and respond appropriately and safely to the needs of older persons experiencing abuse, either through direct case management support (GBV and general protection programs) or through referrals.

A. MULTI-SECTORAL RESPONSE

Older persons at risk for or experiencing abuse may need a variety of different services. As is the case with other forms of violence, this is called a multi-sectoral or multi-disciplinary response in which multiple actors are involved in providing a holistic response to the older person's needs.

Older adults experiencing abuse or neglect may need:

- **Medical treatment and healthcare:** Older persons may need medication, medical treatment for ongoing or emerging health problems, or even surgery. They may also need healthcare supplies such as undergarments for incontinence.
- **Caregiving support:** If families are experiencing multiple stressors, they may struggle in providing care to an older member of the family. They may need support from the community to stay with the older person at home or to assist them with activities of daily living, such as eating, getting around the house, getting dressed, toileting and so on. Careful vetting must be done to ensure the older person feels comfortable with the person providing the care and the type of assistance they will be providing.
- **Psychosocial care and support:** Where possible, older adults may benefit from a referral to a mental health provider for individualized psychological care in addition to the psychosocial support provided in the course of case management provision.

In some contexts, older adults also benefit from social support groups with their peers to form social connections and reduce isolation. Avoiding the stigma of overt mental health services, **groups with a social purpose provide valuable places for older persons to share experiences and support one another.** Such groups can also be important entry points for case management for older persons experiencing abuse as participants build trust and connection and may share personal stories. Participants may share the emotional, psychological, and social effects of displacement and/or abuse or neglect they may be experiencing in their household. This can help caseworkers identify ways the older person and/or their household needs support. Workers must of course keep in mind issues of confidentiality in addressing such a situation. These groups may also empower older persons to organize together to provide support to other older adults or

Peer-to-peer contact support may be an adaptation for older adults to maintain peer support. In order for peer-to-peer contact support to be successful, budget considerations, including the potential of phone cards or top-up availability and a firm understanding of older persons' access to technology is necessary.

the community in general following their displacement, thus regaining a valuable sense of purpose and belonging.

- **Assistive devices:** Humanitarian settings can offer challenges for those with disabilities, which often includes older persons. They may need items like eyeglasses, hearing aids, mobility aids (assistive canes or walkers) or access to large print or braille materials.
- **Livelihoods:** Many older persons want to retain a sense of purpose and contribute to the household. Finding ways to contribute can also be preventative in addressing abuse and neglect by giving older persons a way to contribute to the household and reduce financial stressors. This can include referrals for existing livelihood programs and targeted economic support that can reduce risk of abuse and promote empowerment of older persons, including unconditional and conditional cash transfers.
- **Other protection services, including durable solutions for displaced populations:** Older persons are at higher risk of separation from their families during humanitarian crisis and may need assistance with locating family members or loved ones. Resettlement application process is also a service which should be explored for older persons willing to live in a third country. Finally, return conditions in case of repatriation process and especially linkages with stakeholders in the origin country should also be mapped according to your context. If the caseworker or the agency employing the caseworker does not assist with these services, appropriate referrals should be made.
- **Legal support:** Few countries offer good legal frameworks for addressing abuse of older persons, so providing such options in many cases will not always be possible and caseworkers should pursue caution in offering legal options that are not available. However, older adults may benefit from support obtaining civil documentation and proof of property rights.
- **Options for safety and protection:** In cases of high risk or perpetration of abuse, survivors may wish for protection. This may include shelters, police or community security, or relocation. Such options may be difficult to identify for older adults and thus it is important to identify potential options during resource mapping from the start.

Protection programs that have existing case management services responding to violence and abuse are well-placed to serve as entry and referral points for services, coordinate service delivery, make referrals, and in some cases, provide direct support for older persons experiencing abuse. For example, GBV programs are well-placed to provide case management services to older women experiencing GBV which would include the provision of psychosocial support and the referral to and coordination of other services. More general protection programs are well-placed to provide case management services to a wide range of older persons. Child protection programs, while they will not provide direct services to older persons, will interface with families and older persons and are well-placed to recognize potential signs of abuse of older persons to make appropriate and timely referrals.

B. BARRIERS TO CARE[39]

Before adapting services to address the needs of older persons experiencing abuse, it is important to understand barriers to services.

Attitudinal Barriers:

- **Shame:** Older persons may feel ashamed of the abuse they have experienced by those they trusted, including family members, and may be hesitant to disclose what happened. This may be particularly true regarding issues of family honor.
- **Stigma about accepting help:** Older persons may be coping with emerging or existing disabilities, feel like a burden to others, or experience shame about not being able to participate more fully in their family or community. There may be unspoken, or openly stated beliefs in the family, community, or larger society about what it means to ask for help that may contribute to stigma around being helped.
- **Familial attitudes:** Power dynamics within the family may present particular barriers for the older person—consider if the family prevents or assists the older person to access money or make decisions regarding their health care, living situation, or assets. Family attitudes may prevent the older person from fully interacting in the world, making decisions for themselves, or operating within their full capacity.

Environmental Barriers:

- **Physical barriers:** Family members may or may not take steps to address accessibility concerns for the older person in their home. They may be limited by regulations, finances, and environment. But they may also choose not to make adjustments even when able. Consider if the older person is able to move in and out of the home, within particular areas of the home, etc.
- **Lack of privacy:** Relying on community members to support older persons can have a very positive effect on reducing isolation and easing stress in families, but at the same time it may lead to some decrease in perceived or actual privacy and confidentiality for the older person. Caseworkers should take care to communicate in line with the older person's wishes and maintain confidentiality, even from caregivers when possible. Caseworkers should work to mitigate or remove challenges to privacy and confidentiality as much as possible and take care to not default to communicating with a caregiver over the older person.
- **Communication:** If the older person has communication difficulties, family members, friends, service providers, and decision makers may take varying degrees of action to overcome these communication concerns.
- **Family or community pressure:** Family members or others in the community may pressure older persons to not report the abuse.
- **Family or community repercussions for disclosing violence:** In some instances, reporting violence in the home places the survivor at even greater risk for abuse and neglect and they may have received threats about what will happen to them if they share instances of violence with others. Threats may take many forms, including physical violence, denial of resources, greater isolation or withholding of needed medical care or medications.
- **Ageism:** Service providers may speak to older persons or approach them in a way that makes older persons feel disrespected or not supported.

[39] Adapted from IASC guidelines.

- **Cultural pressures:** Older persons may feel the need to subsume individual needs to those of the family, and to not dishonor the family by sharing problems openly in the community may make older persons reluctant to share abuse or neglect.
- **Gender inequality:** Gender inequality is experienced by all women and girls. However, older women face the compounding effects of a lifetime of gender inequality and discrimination that is compounded with age-related discrimination. The intersecting confluence of ageism and gender inequality result in specific barriers to care only faced by older women.

Institutional Barriers:

- **Communication and literacy standards:** Standards of literacy or communication in a service provision context may be monolingual or rely on a dominant language. Older persons are more likely to have lower literacy rates and fluency and/or literacy in diverse languages other than the national language being used. Therefore, when service provision and community activities are not offered in diverse languages, older persons are left out from critical access to information and opportunities for participation.
- **Poorly planned or executed physical environments:** Humanitarian settings can be particularly difficult for older persons who may have difficulty navigating uneven ground, walking long distances, or going up or down elevated areas. Some older persons may be confined to the home and unable to leave. Lack of sidewalks, paved roads, wheelchair-accessible services, etc., result in limited mobility or further restrictions on the ability to leave the home and access services; the physical environment is not set up to enable divergent mobility.
- **Lack of available and appropriate communication materials:** Older persons with vision impairments may need large print or materials with symbols in order to be able to read informational materials and know their rights. Older persons may also have difficulty hearing and need to receive services in a quiet location where they can hear well, but also in a location that protects their confidentiality if they need to speak loudly. Communication barriers like deafness and difficulty hearing may also be paired with low literacy levels and/or unfamiliarity with sign language, resulting in compounding barriers to care.
- **Administrative barriers:** Older persons may not have the required forms of civil documentation, and they may have physical or other barriers that prevent them from being able to obtain that documentation or attend required meetings with local or national agencies.
- **Services not provided to foreign nationals or people not from the local area:** Caseworkers must be clear on what they can provide and seek to identify referrals and options for support to those who are ineligible, taking into consideration issues such as disabilities or medical conditions that may prevent older persons from being able to access services in another location.
- **Confidentiality of services:** The need to coordinate among a variety of different organizations and support individuals can create challenges to confidentiality, particularly with the added complexity of needs older persons may have. Services may also be provided in settings that lack privacy, including in homes (in some instances and types of service provision) for older persons who face mobility issues and difficulty traveling to services. Caseworkers should be aware of these challenges and how various barriers and issues an older person is facing may impact confidentiality concerns.
- **Services are not available or friendly to certain groups of people (e.g., LGBTI persons, minority groups):** Older persons may face overlapping discrimination based on ethnicity/race, gender, disability, gender identity and expression, sexual orientation, and age. Care must be taken to ensure that caseworkers and others implement an inclusive approach to providing services while at the same time respecting the rights of older persons to retain their privacy and make their own decision about what they choose to reveal about themselves and to whom.

Teams should seek to understand the overall context and cultural concerns for older adults by completing formative situational analysis BEFORE beginning services. Annex 1: Older Person Situational Analysis, Annex 2 : Older Persons FGDs, Annex 3: Services Inclusivity Assessment, and Annex 4: Accessibility and Safety Checklist for Older Adults can be used for this.

Service Mapping[40]

If your case management program is going to be inclusive of older persons it is important to have a good understanding of what services and support networks exist in your setting or location in order to avoid duplication of services, to know service referrals you can make, and to understand the capacities and limitations of these services. Older adults need many of the same services as others in the community that your program may be already serving. During service mapping, caseworkers and others on the team should seek to assess the services likely needed for older persons experiencing abuse—looking at safety and accessibility. Where available, service providers providing specific support to older adults are also helpful. If certain agencies are identified in service mapping, caseworkers can seek to work with these agencies to strengthen their service provision to older adults.

C. DISCLOSURE OF POTENTIAL ABUSE AND NEGLECT

In the context of violence and abuse, **disclosure** refers to the way in which a non-offending person learns of abuse taking place. Disclosure of abuse against older persons can happen in different ways and disclosure is often a process rather than a single or specific event. Disclosure about the abuse of older persons can be directly or indirectly communicated. A **direct disclosure** would be that the older person themselves explicitly shares their experience of abuse – in this case to a caseworker. An **indirect disclosure** could happen in several ways: the older person makes implicit statements about the abuse; someone else – a family member, a caregiver of an older person, or a witness – discloses the abuse, and they do so either with the knowledge of the older person (voluntary) or without their knowledge (involuntary).

To facilitate disclosures of both abuse and neglect of older persons, casework staff in all protection sub-sectors should be aware of signs that abuse and neglect of older persons is happening. Signs of potential abuse and neglect may be observed by or shared with the caseworker[41] and can indicate an indirect disclosure or potentially facilitate a direct disclosure. Some examples of signs of abuse or neglect:

- A caregiver or family member has prevented the older person from obtaining food, clothes, medication, glasses, hearing aids, or medical care and/or has prevented the older person from spending time with other people.
- A caregiver or family member has spoken to the older person in a way that put them down or made them feel ashamed, disrespected, or threatened. Or, the older person reports that they don't feel people want them around at home.
- Someone took things that belonged to the older person without their permission or forced them to purchase items, spend their money, or sign documents against their will.
- They feel afraid.
- They have been touched by someone in ways they did not want.
- They have been physically hurt.

[40] Information on service mapping draws on guidelines provided in GBV IMS Steering Committee. (2017). *Inter-agency gender-based violence case management guidelines: Providing care and case management services to gender-based violence survivors in humanitarian settings.*

[41] Points below adapted from the *Elder Abuse Suspicion Index* (EASI) and the *Vulnerability to Abuse Screening Scale* (VASS) screening tools.

- They have a lack of privacy at home.
- They demonstrate feelings of sadness and loneliness and/or have the appearance of being withdrawn or not maintaining eye contact.
- A caregiver has deliberately damaged or is withholding assistive devices.
- There is the appearance of malnourishment or hygiene issues or inappropriate clothing.
- They have marks, such as cuts or bruises. (This may be difficult to assess and require involvement of a medical provider).

Caregivers may also demonstrate problematic behaviors or attitudes that indicate risk of or instances of abuse or neglect in the home and point to the need for further assessment of the caregiver's overall functioning. Power dynamics and attitudinal barriers of the caregivers can lead to neglect, especially with older persons with disabilities. It is important to note that neglect, in particular, may result from caregiver burnout and not necessarily be intentional on the part of the caregiver. In most settings, caregivers are more likely to be women who are already trying to manage and cope with other household responsibilities. Caring for an older person without adequate support may result in burnout and lead to eventual neglect. Teams can assess burnout by discussing the following with caregivers:

- They feel too tired to meet the needs of the older person.
- They feel they sometimes need to yell or raise their voice at the older person (not due to hearing issues, but to get them to listen and comply with demands).
- Sometimes they feel they need to reject or ignore the older person.
- They don't feel like they can do what is really necessary or should be done for the older person.

Lastly, signs of abuse or neglect may present themselves upon observation or analysis of what is happening in the household environment. These signs may include but are not limited to:

- Incidents of violence in the home
- A family member or caregiver who is abusing substances
- A family member or caregiver with a mental health condition
- Problematic power dynamics in the home
- A caregiver feeling overwhelmed with caregiving role
- A high level of economic stress in the home
- A caregiver who is dependent on older person for shelter, finances, and other basic needs
- High level of dependency of older person on caregivers or family members
- Low accessibility for an older person with a disability in the home

HELPFUL TIP: ASSESS ACCESSIBILITY TO BETTER UNDERSTAND THE ENVIRONMENT

You may want to modify and use Annex 4: Accessibility and Safety Checklist for Older Adults to help when considering ways the home environment may point to risk factors for neglect or abuse of older persons.

Teams may refer to Annex 5: Signs and Symptoms of Abuse of Older Persons which can indicate that referral to an appropriate service provider or further assessment is necessary to determine whether or not abuse and neglect are taking place.

The guidance provided below will help caseworkers understand the basics of how to respond to different types of disclosures.

D. RESPONDING TO DISCLOSURES

Direct disclosures of abuse or neglect

If an older person discloses incidents of abuse and neglect you should validate their experience, thank them for sharing this with you and ask them if they would be willing to follow up with an assessment to speak more about their situation and what services may be of help to them at this time. For protection and GBV teams, this can mean doing an assessment directly or referring to an appropriate provider depending on the details of the reported incident. For child protection teams, this will always mean a referral for an assessment and services if the older person wishes.

Alternatively, a caregiver or family member may report that they are struggling to adequately provide for the needs of an older person and/or are overly stressed in their role. The caseworker should offer an assessment or referral to an appropriate service provider to better understand the situation and asses the needs of the caregiver and older person. Assess the safety of the situation and determine best options for engaging the older person in services.

If there are mandatory reporting requirements, you must inform the person that you will need to report the situation and engage in safety planning with them around this situation. Such cases should always be discussed with a supervisor.

Indirect disclosures of abuse or neglect

In other instances, caseworkers may learn of potential abuse in a less clear or more indirect way.

In the case of a report of abuse/neglect by a family member, friend, member of the community or other individual: You may receive information from someone who is concerned about the older person and wants to address their situation. It is not recommended to approach the older person with questions about whether they are experiencing abuse because such reports as this may put them at risk or alienate them with questions that they may not be ready to answer yet. Instead, a protection or GBV caseworker may reach out to the older person as part of more general outreach to older persons in the community to foster a relationship with them that will allow opportunities for them to share their experiences. Options for this may include:

Responding if an older person is hesitant in speaking about their situation: *"I think my question may have made you feel uncomfortable. Do I have that right? Would you be able to let me know how it affected you? I know these questions can stir up different feelings and I want to be sensitive to this. Talking it through can help me better understand how I can be most helpful to you."*

- ☑ Invite them to join social activity group for older persons.
- ☑ As part of the support your program offers to the community, you may conduct a general assessment of their overall needs in a private setting that allows them space to speak about their situation. It is important that the family not feel singled out or targeted by such an intervention as this may make the older person more vulnerable to abuse.
- ☑ Ask the person who informed you of this situation to speak to any other providers with whom the older person is already engaged, such as medical services, so that they may also do an assessment of the person's situation in a confidential setting.
- ☑ Provide information about services your program offers to address abuse of older persons and encourage the concerned individual to share this with the older person and provide information on how they may contact you should they like to learn more or receive support.

In the case that an older person or a caregiver of the older person reports problems in their family, but it is not a clear case of abuse or neglect: The caseworker may ask clarifying questions to identify the presence of abuse or neglect. When asking questions or observing elements that relate to abuse, you must always keep in mind ways you may be putting someone at risk. It is best to speak to the older person or caregiver alone. Also, keep in mind that asking questions about difficult topics, while important, can also stir up feelings of shame, anxiety, or mixed feelings about answering. Note a sense of discomfort and hesitation an older person may have in sharing information about their situation and allow them to talk about these feelings.

Do not pressure someone to answer a question if they do not wish to; rather, explore their hesitation as this may provide important information about their situation. Once you have identified reasons behind this hesitancy, you may better identify appropriate ways of following up with them to continue establishing a relationship and further assess the situation. Or, if the caregiver's answer raises concern about issues of power and control, this may be an indication that the situation must be assessed more carefully.

E. COMMUNICATION WITH OLDER PERSONS

Older persons seeking and needing case management services in humanitarian settings face many barriers to receiving appropriate and meaningful services. This can often be mitigated in the initial introduction and engagement of the case management process. Working with older persons requires particular attention to physical, information, and attitudinal barriers that older persons with and without disabilities experience.[42] It is important to foster an environment that is accessible and respects the dignity and strengths of older persons and to be aware of ways that ageism may impact your assumptions about older persons. Teams need to be aware that older adults may speak diverse languages, particularly older women, and that they may be persons with disabilities. In addition, older persons may have lower literacy rates than the general population, and again, this may be more acute for older women. When working with older persons, teams should make sure to adjust communication methods as necessary, including sourcing interpreters of diverse languages, allocating extra time to read through forms with older persons, and using easy-to-read forms and images.

GBV, protection and child protection actors should be trained on the unique needs of older persons and the ways of communicating to address these needs. Teams may also find Annex 6: Inclusive Communication Tip Sheet and Annex 7: Removing Communication Barriers useful.

F. CAPACITY TO CONSENT

A key issue for all protection actors when working with older adults (including older adults with disabilities) is consent. Barriers to obtaining informed consent may arise in the engagement phase of case management services for any older adult. If a caseworker is uncertain of an older person's capacity to provide informed consent, it may be due to concerns around overall cognitive capacity (i.e., if the person has dementia), their mental health, or severe disabilities. Caseworkers need to ensure they obtain the consent of the older adult by removing communication barriers (see Communications Tips above). You should **always assume the older person (including an older person with disabilities) has the capacity to provide informed consent independently, no matter what their situation may be.** A person cannot lose their legal capacity to provide informed consent because they face a barrier in understanding or communicating.[43] In addition to communication barriers, be sure to assess for other reasonable accommodation needs to ensure

[42] Reference the IASC guidelines on Inclusion of Persons with Disabilities in Humanitarian Action (2019)

[43] UNHCR. (2018). *Guidance on the protection of personal data of persons of concern to UNHCR.*

understanding and ability to provide informed consent. This may be as simple as allotting more time for discussion and questions. Reasonable accommodation may also include the use of interpreters, easy-to-read forms, among other actions and processes.

WORKING WITH THE CAREGIVER OF AN OLDER PERSON AND/OR FAMILY MEMBERS TO OBTAIN INFORMED CONSENT

The caregiver of an older person might be a trusted person to obtain informed consent or a reasonable accommodation for older persons with disabilities. However, if you suspect the caregiver may be involved in or contributing to abuse of the older person, they are not an appropriate person to facilitate informed consent and another individual should be identified for this role. If you are uncertain whether the caregiver or family member is abusing the client, it is better to remain on the side of caution and identify another person to assist with informed consent.

As a general principle, caseworkers may include non-offending family members/caregivers of the older person in the informed consent process if necessary. However, following the standard guidelines, caseworkers should not involve a family member/caregiver if:

- The caregiver of the older person is the suspected/actual abuser.
- The older person does not want the caregiver included in the interview.
- The caseworker feels that the older person cannot or will not speak freely.

Please see tool: Annex 8: Principles of Capacity Flowchart. You can also refer to Annex 9: Applying a Survivor-Centered Approach with Older Survivors on how to navigate working with those who have caregivers in the context of confidentiality, security and protecting the rights of the older person.

SECTION 3:

GUIDANCE FOR GENDER-BASED VIOLENCE SERVICE PROVIDERS

This section of the guidelines is designed for GBV responders seeking to increase their understanding of abuse and neglect experienced by older women.

Violence against women is a systemic, widespread, and pervasive human rights violation, experienced by women because of gendered power differentials and inequality between men and women. Violence against women is used to maintain and reinforce these power differentials at the individual, community, and systemic levels.[44] As such, it disproportionately affects women and girls of all ages. Older women, however, can be subjected to violence, abuse, and neglect based on their age and their gender. Older women face age discrimination as well as the cumulative effects of a lifetime of gender discrimination. Therefore, they experience aging with significant differences to older men. Older women face less access to health services, lower earning capacity, uncertain land ownership rights, and their experiences of oppression from the intersections of gender and age increase their risks of experiencing abuse and violence.[45]

HelpAge's recent study into the prevalence of gender- based violence among older women and men living in protracted displacement found that 32% of women over 49 experienced intimate partner violence (17% in the past year), while 37% experienced non-intimate partner domestic violence (14% in the past year).

AAAS. (2017). *Age is no protection: Prevalence of gender-based violence among men and women over 49 years of age in five situations of protracted displacement.*

Deeply rooted prejudices and de-humanizing stereotypes about older people fuel ageism and perpetuate prevailing social norms that tolerate or even condone violence, abuse, and neglect in older age. Older women report that different intersecting characteristics put them at heightened risk of violence. This includes living with disabilities, being a migrant or a refugee, living in rural areas, having low literacy levels, being single or widowed, or receiving care and support for independent living.[46] Overall, within humanitarian responses, there is a failure to consider the relationship between age, gender, and violence. Definitions of abuse of older women often fail to acknowledge gender dimensions of violence and, on the other hand, policies and programs addressing violence against women and girls lack understanding of how such violence is experienced and manifested in older age. There is a prevailing perception that violence is typically experienced by women under the age of 50 and much research and programming regarding GBV fails to consider older women.[47]

More work needs to be done to understand the impact of violence against older women. Women over the age 49 (reproductive age) are often left out of research efforts and little data is collected on their experience of abuse despite the fact that they account for nearly a quarter of the global female population.[48] In fact, women experience violence across the life course and are at risk for abuse, violence, and neglect from an intersecting set of risk factors, including age, sex, impairment, place of origin, marital status, class, or sexual orientation. Women are also rendered more vulnerable to abuse by structural and system discrimination in

44 UN General Assembly. (2014). *Report of the Special Rapporteur on violence against women, its causes and consequences, Rashida Manjoo.* Human Rights Council 26th session.

45 UNFPA & HelpAge International. (2012). *Ageing in the twenty-first century: A celebration and a challenge.* https://bit.ly/37F0KHk

46 HelpAge International. (2017). *Entitled to the same rights.*

47 Women's Aid. (2007). *Older women and domestic violence: An overview.*

48 HelpAge International. (2017). Violence against older women (helpage.org).

areas such as land inheritance laws or lack of autonomy in institutional care situations and are also greatly harmed by such practices as witchcraft accusations.[49] Further, older people living in displacement are more likely to have experienced conflict and conflict-related displacement multiple times, compounding rates of mental distress like depression and PTSD. These mental health conditions, along with cumulative effects of trauma and stress throughout life have been linked to significantly higher rates of intimate partner violence.[50] The lack of research and, consequently, the lack of policy and programs to address the abuse of older women renders their experience invisible and thus more vulnerable to abuse.

While it is known that intimate partner violence (IPV) extends into older age, much research and programming regarding IPV fails to consider older women. Existing data on physical and sexual violence against women over the age of 49 shows it does continue in later life,[51] although estimates of IPV among cases of abuse among older women can vary widely due to the lack of data. Some research has shown, however, that intimate partners are more likely to perpetrate physical and emotional abuse against older women compared to other groups, such as adult children.[52] It is also important to note the role that the onset of dementia in male partner can play in older women's experiences of IPV. Some older women may be experiencing IPV that has been ongoing for years. They may find that this abuse is becoming more physically violent as their partner progresses with dementia. Others may be experiencing IPV that has started as their partner has aged and begun experiencing signs and symptoms of dementia.

The most comprehensive data comes from an EU- funded study in five European countries which found that 28% of older women experienced violence and abuse in their own home in the last 12 months, including: emotional abuse (24%), financial abuse (9%), violation of rights (6%), neglect (5%), sexual abuse (3%) and physical violence (2%).

Luoma, M. et al. (2011). *Prevalence study of abuse and violence against older women: Results of a multi-cultural survey in Austria, Belgium, Finland, Lithuania, and Portugal.* (European report of the AVOW project)

See Annex 11: Questions To Add to GBV Emergency Assessment Tools for ways to make situational assessments of GBV in the context better able to gather information about older survivors.

CONSIDERATIONS FOR OLDER WOMEN IN THE CASE MANAGEMENT PROCESS

Certain adjustments are critical to tailoring case management responses to older women experiencing abuse in humanitarian settings. This section is designed to meet the needs of GBV caseworkers and supervisors by providing the necessary information regarding GBV case management activities relevant to addressing abuse of older women. While covered in more detail in each case management phase description below, we highlight key over-arching issues to keep in mind regarding support to older women here:

- ☑ Older women are often viewed through the medical model lens, which focuses on frailty and lack of capacity to complete activities of daily living and thus can fail to address abuse through the lens of gender and power.[53] It also fails to recognize the interaction between older women's impairment and the barriers in the environment that prevent their full and effective participation in society and to exercise their rights on an equal basis with others.

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49 HelpAge International. (2017). Violence against older women (helpage.org).

50 American Association for the Advancement of Science (AAAS). (2017). *Age is no protection: Prevalence of gender-based violence among men and women over 49 years of age in five situations of protracted displacement.*

51 See for example the Fundamental Rights Agency's *Violence against women: an EU-wide survey Main results,* 2014; and International Violence Against Women Survey's (IVAWS) findings for Italy, Singapore, and Australia.

52 World Health Organization. (2011). *European report on preventing elder maltreatment.*

53 Kilbane, T. & Spira, M. K. (2010). Domestic violence or elder abuse? Why it matters for older women. *Families in Society: The Journal of Contemporary Social Services,* 91(2), 165–170.

- ☑ Older women may not seek services or be unable to seek services because the physical spaces these services are offered in are inaccessible (through distance from the home, lack of ramps, etc.) or because the service providers' attitudes present a barrier (disregard for older women or a belief that they do not need the services), or because of institutional barriers (a lack of funding for services designed for and targeted to older women).

- ☑ Older women may not seek services from GBV programs as they do not receive information about such programs, or receive information that is not accessible, or information is solely reflective of younger women, resulting in older women not recognizing these services as available or targeted to them. Further, following the pervasive views in society which tend to follow the medical model, they may not see their situation as relevant to such services.

- ☑ When older women do access GBV programs, they often feel out of place and do not "see themselves" in the program's services, including shelters, as most others in the program are younger and programs are often not equipped to address or accommodate needs and health problems older women may be facing.

- ☑ Violence by an intimate partner may be mislabeled as "caregiver stress" rather than abuse given the common frame of most programs addressing abuse of older persons, which often looks for drivers of abuse in the stress and strain of providing care rather than power dynamics in the home. Programs need to be aware of this issue in facilitating referrals to programs to ensure the proper lens.

- ☑ Older women may be primary caregivers for a partner with whom they have experienced a long history of violence and abuse based on a power and control dynamic that has placed women in positions of ongoing hypervigilance, isolation, and anxiety. Male spouses continue patterns of abuse in the relationship although these patterns may change and shift over time. Older survivors themselves are aging and finding it hard to manage the care needs of their spouse and the cumulative history of abuse may have had a negative impact of their health as well. Older women in such situations may be hesitant to ask for help due to shame about their situation, sense of obligation to care for their spouse as well as threats to their safety based on the abuse.

When working to better integrate older women into case management services and more appropriately meet their needs, GBV programs will need to look at all aspects of programming, not just case management. Linking older women with group psychosocial activities that are geared for their age range can help facilitate access to case management, as well as reduce social isolation. However, transportation assistance to these services will be critical for many older women because of mobility issues, injury, impact of abuse, and awareness of these services. Ensure that caseworkers are a wide variety of ages - some women might enjoy younger caseworkers, others will feel more comfortable speaking to someone closer in age. Evaluate any remote services in place as the technologies used may be inaccessible for many older women.

Types of Older Abuse Cases GBV Programs May Address

GBV caseworkers are likely to see the following types of abuse of older women:

- ☑ An older woman facing long-term violence in the relationship with their partner. They may seek assistance as some aspect of their overall functioning or life situation has changed, such as a deterioration in their health, which render them less able to cope with the violence.

- ☑ An older woman with a partner whose cognitive impairment/dementia progression results in her experiencing IPV for the first time.

- ☑ An older woman experiencing abuse by their adult child. Most common forms of abuse by adult children are financial and emotional abuse, but of course may vary case by case.

- ☑ A GBV survivor who is the sole caregiver for her older parent/s and is experiencing difficulties in adequately providing for their needs, and reports a situation of neglect. For example, the survivor may be struggling to cope with her own traumatic experiences or facing financial stressors to a degree that make it challenging for her to care for her older parent/s and children without support.

- ☑ A GBV survivor who is also a caregiver for an older person. She may be experiencing violence or may have experienced violence in the home that is also affecting the older person for whom she is caring.

- ☑ An adult female family member who is seeking support to address challenges their family is facing in caring for an older female family member, particularly related to hygiene issues and medical needs, which meets criteria for neglect.

- ☑ An older woman initially referred for services and support with her caregivers. Through assessment, she discloses experiencing emotional abuse from her caregivers.

PROGRAM ADJUSTMENTS THROUGHOUT THE GBV CASE MANAGEMENT CYCLE:

STEP 1:

INTRODUCTION AND ENGAGEMENT

The introduction and engagement step are instrumental in building a relationship with the survivor over time and entails a number of tasks for you to complete according to accepted standards of case management services. It is important to foster an environment that respects the dignity and strengths of older women and to be aware of ways that ageism may impact your assumptions of older women. **Educating yourself ahead of time on ways to provide reasonable accommodation to an older woman with disabilities is important in successfully engaging older women in GBV case management.**

Annex 7: Removing Communication Barriers and Annex 9: Applying a Survivor-Centered Approach with Older Survivors can be useful.

Concerns related to consent may be particularly acute for older women survivors of GBV. Case managers should be aware of concerns around capacity to consent that may be further hampered by the perpetrators, their abuse and coercion, and other factors that may result in an older survivor's unwillingness or inability to communicate openly. Because older women may experience abuse that impacts their self-determination and further face discrimination and oppression as both an older person and a woman in a patriarchal culture, case managers need to take extra care to ensure empowerment and self-determination exist from the beginning of the case management relationship.

Case managers can follow these key actions to support decision-making and preserve the self-determination of survivors during the assessment phase and beyond:

- Adjust your communication using a range of methods to convey information in a way that the survivor can understand; take time to explain the case management process and key concepts.[54] For example, the case manager may want to use easy-to-read case management forms to facilitate understanding of aspects of the case management process. These forms are located in Annex 14: Easy Read GBV Consent Form, Annex 15: Easy Read GBV Safety Plan and Annex 16: Easy Read GBV Client Feedback Form.
- Let the older woman include any person/s they wish who can support their understanding and communication in the informed consent process. As part of a reasonable accommodation process ensure she outlines her needed accommodations to be able to take part in your case management services including by involving a trusted person to remove barriers to the services.
- Consider informed assent. You can look for the *expressed willingness* of the survivor to participate in services if they face barriers communicating or providing consent. You can use pictures, hand gestures or symbols to ask if someone is willing to participate in an activity, access a service, or share their story. Also watch for signs of agitation, anger, or distress that may indicate that the survivor is not happy with something being discussed or an activity that is being undertaken.

Refer to Annex 8: Capacity to Consent and Best Interest Determination Flowchart.

HELPFUL TIP(S): CONCLUDE SESSION TACTFULLY IF COERCION IS SUSPECTED

If you are meeting together with the survivor and family member or caregiver and suspect that the survivor may be facing coercion or is not comfortable with the other person you should conclude the session. It is not advisable to state clearly that you do not feel the family member or caregiver is an appropriate individual to assist the older person. Instead, you may simply state that you are unable to complete the session at the present time and will need to reschedule. You can state you need to clarify policies for having an additional person participate. You can review situation with your supervisor to identify other ways of engaging the survivor in a safe way to better understand their relationship and assess level of risk in involving the caregiver or family member.

What To Do If You Cannot Obtain Informed Consent: If, after exhausting all options in trying to facilitate communication, you are unable to do so with the survivor, such as may arise in cases of severe cognitive impairment, you may need to identify someone who is able to make decisions on the survivor's behalf. Such situations raise difficult ethical questions for a caseworker, especially in situations where there is a need to navigate the balance between autonomy and safety.

Cases in which cognitive capacity is in question should always be addressed in supervision and can also include consultation with medical and mental health professionals trained in assessing capacity if they are available. The latter may be particularly important if addressing the survivor's situation may require legal intervention. There are particular tests and methods for assessing cognitive capacity and it is best to have a trained professional conduct an assessment if the person's care may involve the legal system.

Remember, capacity to consent is not static. Case managers may encounter situations in which a survivor becomes incapable of consenting and needs a person designated to make decisions in her best interest. Case managers may also work with older survivors who regain capacity to consent after a period of time

[54] *Light for the World.* (2017). Disability Inclusion Resource Book.

when they did not have it, and a person was designated to make decisions in their best interest. Once the survivor regains capacity, their decisions at this point take precedence over any other prior decision/s made on their behalf. Both situations illustrate the importance of recognizing the fluid and changing nature of capacity in older survivors as well as the need to continually reassess capacity.

Issues to Consider Regarding Fluctuations in Capacity:[55]

- ☑ A person's cognitive impairment can be due to medical problems or issues of pain and can improve once these conditions are addressed.
- ☑ Cognitive capacity can fluctuate based on various factors and is not a set condition. An older person's capacity may be different at another time of the day or when they are calmer, if upset.
- ☑ An individual may have cognitive capacity for certain types of situations, but not others. For example, they may have the capacity for sexual consent but not for complex financial decisions.

In the introduction and engagement phase, if cognitive concerns are present, the case manager should work with the survivor to address these to obtain informed consent for services. The case manager should also make note to reassess the cognitive capacity of the survivor periodically throughout the case management relationship. Depending on the factors contributing to the survivor's impaired cognitive capacity, reassessment of capacity may need to be done more or less frequently throughout the case management process.

This section highlights key issues to consider in assessments of older women survivors regarding abuse and neglect. You may choose how best to integrate these elements into your current assessment template either by adapting questions you currently use or adding those developed in the abuse of older persons assessment form referenced in the various sections below.

1. Nature of the Abuse:

Caseworkers must gain an understanding of the abuse the older woman has faced. As a caseworker, you may have already identified some first signs of abuse. The needs assessment will ensure you can gather more detailed information to be able to plan with the survivor regarding ways of addressing the abuse she is experiencing. Keep in mind that if the abuser is a family member, a child or a spouse, the survivor may have had a long-term relationship with this person with many changes over time and therefore their experience of the abuse may be complex and nuanced.

Note that identifying physical marks of abuse may be more difficult in cases of older women because they may experience falls and bruising due to the aging process. Many times, abusers seek to explain marks due to these causes as well. Case managers should engage medical providers to assist in identifying, where possible and appropriate, marks from physical abuse. Medical providers may need to seek guidance on making this determination if they are not experienced in such cases.[56]

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[55] Wallace, R. B. & Crabb V. L. (2017). Toward definitions of elder mistreatment. In X. Q. Dong (Ed.), *Elder abuse: Research, practice, and policy.* (pp. 3-20). Springer.

[56] A helpful reference table on this topic is provided in the following article which is available online here: Lachs, M. S. & Pillemer, K. A. (2015). Elder abuse. *New England Journal of Medicine,* 373, 1947–1956.

STEP 2:

KEY ASSESSMENT CONSIDERATIONS FOR OLDER WOMEN

When using the GBV Inter-Agency Case Management Guidelines and the supporting tools, the assessment focuses on four main areas of need. To align with that needs assessment, key considerations are grouped under these assessment categories: safety needs and strategies, health needs and support, psychological needs and support and legal needs and support. Through the assessment, the caseworker should gain a clear understanding of both the areas in which an older survivor needs support and the level of support they need. This can help to identify both areas in which they may be at risk for abuse or neglect and also what types of support they may need if they decide to leave the abusive situation. Additional key areas to assess include activities of daily living, managing finances, accessing social networks, and addressing health issues.

See Annex 10: Assessment of Daily Living Activities

1. Safety Needs and Strategies

When assessing safety needs of an older survivor, it is important to always prioritize the pre-assessment activities. Always ask about their immediate safety and address any urgent medical needs. When an older woman is experiencing IPV, sexual abuse or exploitation, or severe neglect, they may be facing imminent threats to life. Addressing these, just like with any survivor, takes precedence over additional detail or understanding of any incidents of violence.

Older women experiencing IPV may have more limited social networks and support than younger women, further limiting their options for leaving an abusive situation, even temporarily. Because social isolation often increases with age, older women may not be able to identify others who could offer support, shelter, or safety. This, coupled with potential physical disabilities or limitations, can severely restrict her movement from the home. It is important to note in the assessment, if physical disabilities or mobility issues are present, if these were the result of abuse, normal aging, or both.

Because an older woman may have multiple intersecting needs based on her age and gender, it is important to understand what other service providers she may have already seen or accessed services from. Once these immediate activities have been addressed, caseworkers can continue assessing additional safety needs. An important piece of this work is also to understand what services the older woman feels she needs and whether she has been unable to access any of those services. The inaccessibility of key services impacts and further exacerbates safety concerns the older woman may have. Working with the older woman to remove barriers to services she has prioritized may be a key piece of addressing safety needs and key actions within a safety plan. Caseworkers can have a conversation with older women about the services she wants to access and what steps can be taken to address the barriers she has identified.

With older women, caseworkers should remember that her closeness with the perpetrator(s) and the abuse may result in unwillingness or inability to disclose details about the nature of the abuse and who the perpetrator is. Further, because older women may be reporting for the first time but may have experienced multiple and/or chronic incidents of violence over their lifespan, understanding when abuse took place may not be easily distilled into a specific time frame or single incident.

When assessing for the survivor's sense of safety in the home, is also important to assess who depends on the survivor for what types of assistance (financial, housing, childcare etc.) and **explore the nature of these relationships to identify any abusive patterns on the part of family members, whether they are caregivers to the older person or someone the older person trusts**. Assess for any substance use or mental health problems on the part of caregivers or dependent persons of trust as these can be risk factors for abuse. Any key risks of abuse should be addressed though the collaborative development of a safety

plan. Key issues to consider in safety planning with older survivors are issues of disability, mobility, and reliance on the abuser for support with activities of daily living or other areas, as well as the older woman's dependence on caregivers for access to and use of her assistive devices like glasses, hearing aids, canes, or walkers.

OUR RECOMMENDATION

A GBV safety plan should be modified for working with older women. It is recommended that you consult with your supervisor to determine what should be added for older women survivors. Teams may find it useful to add specific accessibility questions for older survivors.

2. Health Needs and Support

Caseworkers must not assume that older women do not experience sexual violence. Older women survive experiences of rape, sexual assault, and sexual exploitation that may have health implications.

Even when working with a survivor who has not experienced sexual violence, be sure to obtain a full picture of the older survivor's health and any key medications, medical treatment, and ongoing health problems they may be facing. Critical areas to ask about including any physical or sensory disabilities or cognitive impairment the older person may be dealing with as well as any assistive devices (hearing aids, glasses) they may utilize or lack currently.[57] Given that older women report a lack of access to healthcare at higher rates than older men. Therefore, caseworkers must assess what health needs a survivor may have, the immediacy of those needs, and the potential barriers to be addressed in seeking those services with older women.

3. Psychological Needs and Support

Older women experience aging in distinctly different ways from older men. While some aspects of aging and gender offer protective factors for older women, others result in significant risk for older women. Older women are more likely to have stronger support networks than older men, though they still face higher rates of isolation than younger women.[58] While they may have stronger support networks, they are also more likely to be caregivers of others in their households.[59] Older women with disabilities, particularly if unable to assist in caregiving or household work, may be even more isolated and seen as a burden by their families.[60] Assessing an older woman's support network, her current caregiving roles, and the impact those roles may be having on her levels of stress is important in determining potential psychosocial support needed.

Caseworkers should take care to assess an older woman's access to basic services, including shelter, food, livelihoods, and others, as all of these can be significant sources of stress for older persons. Older women report higher rates of limited or no access to these services than older men. They also report higher rates of inability to cope with these issues.[61] Further, because older women have faced a lifetime of discrimination, including access to education, many are unable to access the information needed to obtain these services,[62] compounding stress and psychological impact.

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57 McGiven, V. & Bluestone, K. (2020). *If not now, when? Keeping promises to older people affected by humanitarian crises.* HelpAge International. https://bit.ly/3v9lKNm

58 UNFPA & HelpAge International. (2012). *Ageing in the twenty-first century: A celebration and a challenge.* https://bit.ly/37F0KHk

59 *Ibid.*

60 Falb, K., Asghar, K., Pardo, N. M., Hategekimana, J. D., Kakay, H., Roth, D., & O'Connor, M. (2022). Developing an Inclusive Conceptual Model for Preventing Violence in the Home in Humanitarian Settings: Qualitative Findings From Myanmar and the Democratic Republic of Congo. Journal of interpersonal violence, 37(3-4), 1076–1105. https://bit.ly/3vhlv4a

61 McGiven, V. & Bluestone, K. (2020). If not now, when? Keeping promises to older people affected by humanitarian crises. HelpAge International. https://bit.ly/3v9lKNm

62 UNFPA & HelpAge International. (2012). Ageing in the twenty-first century: A celebration and a challenge. https://bit.ly/37F0KHk

Older women who are widows may face additional psychological stress from the accompanying loss of status. In many cultures, women's status is directly linked to the status of their husband.[63] If providing services to a survivor who is newly widowed, a widow who lives alone, or who has not remarried, the caseworker should assess the impact and potential risks of both poverty and social isolation and exclusion.

Risk of Self Harm or Self Neglect: It is also critical to assess for any ways the older survivor may be a danger to themselves, such as through self-neglect or through thoughts or plans about committing self-harm. Each program must have clear guidelines on which staff member/s is/are qualified to conduct a suicide assessment. **Such assessments should only be carried out by trained, qualified staff.** If such staff are not available in the program, the case should be referred to another actor providing such services. Contrary to prevailing thought, older persons can be at high risk for suicide, and this should be assessed with each older person.

See Annex 12: Suicide and Self-Harm in Older Adults for further discussion of suicide rates among older persons.

4. Legal Needs and Support

Older survivors may need support obtaining needed civil documentation or addressing a lack of legal status. Lack of these legal foundations may render them more vulnerable to abuse or less able to address the abuse they are experiencing. As with other populations, **older women may need legal counseling and/or assistance or seek representation to address abuse through the legal system.** Both should be explored with the survivor. The decision whether to pursue justice is an important one, and survivors need to have access to full information when making this decision. It is important for you to understand whether the incidents of abuse are considered a crime within the legal framework of your setting, and, if so, whether the older survivor wants to take legal action. It is also important to know whether there is a legal framework for abuse of older persons at the local and national levels.

You may refer to Annex 13: Legal Framework Analysis for further discussion of protecting the legal rights of older persons.

[63] UNFPA & HelpAge International. (2012). Ageing in the twenty-first century: A celebration and a challenge. https://bit.ly/37F0KHk

STEP 3:

ACTION PLANNING

As in regular GBV programming, based on the case management assessment, the caseworker develops an action plan with the survivor and/or caregiver to address their most pressing needs. This may include plans to provide key psychosocial services in addition to linking with other services. **It may also include plans to address the level of support needed by the older survivor to access services, depending on the barriers they experience because of a disability and on the breadth of services available for older persons in the community.**

Caseworkers may find that they need more meetings to complete the action planning adequately in some cases, particularly those with older survivors requiring an array of services and who may need to process information at a slower pace. Similarly, case management services to older survivors may require more regular and intensive follow-up for several reasons: older women may face mobility-related barriers or other difficulties and require greater reasonable accommodation getting to meetings with other providers; caseworkers may find a limited number of services available for older women and may need to spend more time advocating for other actors to provide the support needed; and cases of abuse in later life often require a variety of services and coordination among the various providers to ensure referrals are followed up on and coordinated with others as necessary.

If programs are engaging the caregiver in services as well, action planning may need to be broken up into two parts: meetings with the older survivor and another joint session with the older survivor and the caregiver/family. Two examples of the latter situation include:

- In cases where two caseworkers are involved (such as when they have approached programs to address issues of neglect) and it is agreed that joint interventions would be beneficial to support the older survivor and their family or caregiver, collaborative action planning would be necessary. A separate session can be scheduled with both caseworkers, the older survivor, and their family member/caregiver to develop an action plan for joint interventions.
- If one caseworker will be supporting both the older survivor and the caregiver/family member, they may also decide to hold a separate action planning session for the survivor and then one together with their caregiver to discuss a plan for those interventions that will be provided jointly.

KEY ADJUSTMENT

Using your existing case plan form, be sure to modify it to add categories, interventions and referrals as needed. Given the fact that cases involving abuse of older survivors are often complex and involve interventions from different categories, the case plan form may need to have additional categories, actions, and referrals noted. Case conferencing may also be a useful additional action to include in the case plan form

Key services and activities considered in action planning include:

- **Action Planning for Safety:** Review key safety risks identified in the assessment and plans for following up on each of them. For each safety-issue that you review:
    - List the safety plans developed and have copies included in the action plan.
    - Identify how you will use these tools to assess for safety (e.g., review in each follow-up visit) and for accessibility. For example, if a safety plan was developed around abuse the survivor is experiencing, discuss how often you will review this plan, and schedule the next follow up visit to assess how the safety plan is working and any needed modifications, and any referrals necessary as part of the safety plan. Include specific planning and steps to ensure the survivor can access the center to review or attend follow-up visits.
    - Set up the date and location of the next follow-up meeting to assess safety.
    - Identify any referrals needed to address safety concerns. Facilitate critical referrals for health needs immediately.
- **Health Services:** The health services needed by a survivor may be a complex set of services that address consequences of violence and ongoing health issues associated with aging. Working to remove barriers to health services may be a key component of the action plan, given that in one assessment, 56% of older women reported no access to healthcare.[64] Addressing ongoing health issues may increase the options a survivor feels she has to recover from violence by increasing mobility and overall health.
- **Counseling and Emotional Support:** These services would address the needs of older women regarding the abuse and/or neglect they have experienced. Key issues to consider are that older women may have experienced abuse over the course of many years of their relationship, the types of abuse may have shifted over time and with the aging process. Older women may also have more complex needs for addressing health and mobility issues which may make them more reliant on their partners or family members and thus make leaving the abusive situation more difficult.
    - **Family Members or Caregivers:** If presented with a case from a caregiver seeking to address a situation of neglect without physical, emotional, financial, or sexual violence in the home, part of the action plan may be to provide psychoeducation on the aging process, particularly issues of cognitive decline, facing the older person. Providing a non-judgmental place for the caregiver to talk through challenges they are facing in their role and how to improve the situation can help shift behaviors and attitudes of the caregiver.
- **Support Groups:** Older women who are survivors of GBV can be integrated into women's only safe spaces to help them establish connections with others, increase coping skills and improve their self-esteem and sense of self-efficacy. It is important to ensure that older women are made welcome in these groups, that the meetings are held in locations that are accessible for those with limited mobility, and that the spaces offer conditions that enable those with low vision or difficulty hearing to participate, conditions such as adequate lighting, low noise etc. In addition, it is important to remove barriers for them to participate in any activities and to engage with materials distributed. Ensuring that older women are represented among facilitators can also be important to making safe places inclusive. Consider referrals to group services or activities taking place in organizations that serve older persons with and without disabilities.
- **Community-Based Interventions:** In many cases, community interventions may be helpful in reducing the risk of abuse of older women. General community education efforts to promote greater awareness of the negative impact of ageism and foster positive images of older women can be helpful in promoting a better environment for older women. Providing information about abuse (types, signs, and symptoms)

[64] McGiven, V. & Bluestone, K. (2020). *If not now, when? Keeping promises to older people affected by humanitarian crises.* HelpAge International. https://bit.ly/3v9lKNm

and psychoeducation about cognitive impairment and common challenges in aging can also improve greater understanding of old age and improve support for older women. Community education efforts can also ensure that older women know about GBV and the services available to help them cope with violence in the home.

- **Livelihoods:** While it may not be intuitive to ask an older survivor about livelihoods, it can be an important consideration. If the assessment identifies the overall income level of the survivor and the financial stressors they or their family may be facing, addressing those should be included in the action planning. For many survivors, the issue of their livelihood and that of their household can be interwoven in the experience of abuse and neglect. If the caseworker offers them support in gaining access to livelihood programs, they must ensure that this will not contribute or play into dynamics of financial abuse the survivor may be facing. For example, if the survivor's child is intimidating them into providing financial support, then finding another source of livelihood without addressing the financial abuse will only serve to worsen the situation.

  The action plan should indicate what steps are necessary to support any livelihood concerns expressed by the survivor. Given the limited options available to older persons, this may be a challenging section of the action plan; the caseworker may have to engage in advocacy efforts to enroll the survivor into relevant livelihood programs.

HELPFUL TIP: COORDINATION WITH LIVELIHOOD STAKEHOLDERS

Coordinate with livelihood providers to find appropriate ways to involve older women in their activities. It is not a good idea to have programs that specifically target older women who have experienced abuse, as these could become stigmatizing. Ideally, there would be accessible, safe, confidential ways to make referrals to existing programs that can incorporate survivors without disclosing what happened to them or creating a perception that survivors of abuse get special treatment.

- **Material Assistance:** One fundamental element to bear in mind is the difference between material assistance provision linked to case management services versus the material assistance provided by basic services stakeholders. **The outcome of any material assistance provided under case management relates to a survivor's action plan and prioritized needs. They do not aim to cover all the basic needs of survivors.**

OUR RECOMMENDATION

For basic needs coverage refer the survivor to the adequate available services such as food security, basic assistance, shelter, WASH stakeholders.

Key Areas in Which Older Women May Need Assistance:

- ☑ **Access to Information and Accessible Communication Channels:** The inability to access information or the inappropriate and ineffective ways in which information is communicated to older adults both creates and exacerbates barriers to other needed services. Addressing the ways in which you and other service providers communicate with older women can help improve access to critical services and help survivors better prioritize and address their needs.
- ☑ **Access to Assistive Devices:** You can decide that under your case management services older women might be eligible for support in accessing assistive devices such as crutches, wheelchairs, toilet chairs, eyeglasses, hearing aids, etc. This type of support might contribute to the mitigation of exposure to abuse for the survivor by increasing daily independence, for example.
- ☑ **Adequate Hygiene and Dignity Items for Older Survivors:** Hygiene issues might contribute to a certain range of neglect instances among older women. Hygiene kits specifically addressing needs of older women are rarely distributed by Non-Food Item stakeholders. Constitute the list of items you would like to include according to the needs in your context; items might include soap, buckets, adult diapers, towels, bedsheets, plastic cover for mattresses, pressure mattresses, or warm clothing.
- ☑ **Transportation Costs To Access Basic Services:** Lack of transport needed to access basic services, such as health services, could increase protection risks for older women, particularly if they need to pay for transportation. Because survivors often have critical health needs resulting from the abuse they have experienced, and as older women, are less likely to have access to financial resources, it can be important to include coverage of transportation costs to ensure that survivors can effectively and meaningfully access services.
- ☑ **Uncovered Fees To Access Health:** Some health care costs may not be covered by the State and/or the humanitarian system, putting older survivors and their family at risk of using negative coping mechanisms to be able to cover those costs. To mitigate those risks, it may be important to anticipate coverage of such sudden costs for some survivors based on clear eligibility criterion.

HELPFUL TIP(S)

Ensure advocacy towards basic assistance stakeholders in favor of better inclusion of older persons in their services and mainstreaming protection principles such as meaningful access, safety, and dignity.

CASH MODALITY

There is a growing body of evidence that cash assistance as part of protection case management has the potential to contribute to protection outcomes. Cash is recognized as an empowering tool. However, it is essential that the caseworker and the client understand if there are associated risks and how to mitigate them. Cash provision can be a source of financial abuse for older persons, which needs to be mitigated. If you want to include cash as a tool within case management services, be sure to develop a standard operating procedure for how to identify, assess, deliver, monitor, and evaluate the provision of cash safely and equitably.

STEP 4:

CASE PLAN IMPLEMENTATION AND FOLLOW-UP

Caseworkers should arrange follow-up visits with older survivors as they would with other populations during case management. A few issues may need to be considered in the context of follow-up visits with older women:

1. Following Up on Referrals:

Caseworkers are responsible for following up on referrals to make sure services are provided in a timely and accessible manner. Cases of abuse or neglect of older women may have many different referrals that need to be followed up on and coordinated. In addition, it is critical to confirm that services are adequately meeting the needs of older survivors and facilitate additional referrals if gaps in service provision arise.

2. Case Conference:

Caseworkers may need to organize a meeting with the main actors and service providers that are involved in the case plan, to discuss the action plan and find short-term and/or long-term solutions. This procedure is best reserved for complex cases and often when a survivor's needs are not being met in a timely or appropriate way and when a joint response is critical. Note that this process may need to be used more often with older survivors because of the complexity of their cases. These meetings provide opportunity to review activities, establish progress and barriers, map roles and responsibilities, look for solutions and adjust current service plans as needed.

OUR RECOMMENDATION

Caseworkers looking to improve their case management services to older women should review their service mapping to identify potential additional services that meet the complex and inter-connected needs of those cases. Programs can use their service mapping to indicate the level of accessibility of these services to ensure older women with disabilities can access them. Programs should consider fostering the development of multi-disciplinary teams whenever possible to coordinate services to older survivors given the complex and inter-connected needs of these cases.

3. Re-Assessing Changes in an Older Woman's Situation:

An older woman's situation can be quite fluid and change quickly over time, particularly if there are medical issues involved. Caseworkers may need to hold more frequent follow-up sessions in complex or high-risk cases to assess their physical and emotional well-being and safety issues.

Safety: Any survivor's risk of harm might increase once abuse has been disclosed. Older women who are part of caregiving relationships may not be able to speak openly about their safety in front of family members/caregivers. It may be necessary to ask older survivors questions about safety in private.

Health: An older woman's health and functioning may fluctuate frequently, even more so than other survivors. The caseworker may need to see an older woman more often to monitor their situation. Because older women's health and functioning may fluctuate as a natural part of their recovery from abuse, but also because of physical health problems associated with aging, caseworkers should follow more closely those older survivors with more severe physical health concerns compared to those with less fluctuation in their situation. If an older woman is experiencing fluctuations in physical health, accessibility barriers to health services may be exacerbated. If she does not know what her physical abilities will be consistently, this can

further impact her ability to seek out and receive needed health services that do not have appropriate accessibility measures.

Mental Health and Psychosocial Support: Just like physical health, an older survivor's mental health may fluctuate frequently. Older survivors may be more isolated than younger survivors, as older adults are often more isolated than younger adults. For older survivors, it may be helpful to reassess psychosocial state on a weekly basis or more. If, over time, an older survivor's well-being is not improving or seems to be deteriorating (e.g., they are not caring for themselves and/or are further isolating themselves) caseworkers should work to determine if a physical health referral, or more specialized psychosocial or mental health care (if available), or referrals to both physical and mental health care should be considered. Supervisors should be consulted in such cases to determine whether to make such a referral.

Psychosocial support can provide the survivor with the skills they will need to manage some of the symptoms they may be experiencing. Psychosocial support groups may also be important for older survivors in combatting isolation, by helping them make social connections with their contemporaries and gain skills they have not had the opportunity to learn earlier in life. All of these can be important to regaining and building a sense of empowerment for the older survivor. In addition to referring survivors to group psychosocial support activities and higher-level mental health care services, caseworkers may directly provide psychosocial support, such as:

- ☑ **Relaxation Training:** Teaching survivors skills for managing anxiety can help them feel more in control of their bodies and calm their minds, but some types of relaxation exercises may be contraindicated for older persons. Be sure to assess for any medical issues that may make breathing exercises challenging for older survivors.

- ☑ **Teaching Coping Skills:** Older survivors may have negative feelings after abuse, and this may be even more pronounced if they have internalized blame for many years in a long-term abuse relationship. They may attribute the abusive behavior on the part of their partner or spouse to the stress of caregiving, to addressing their deteriorating health condition, or to other challenges they are facing. They may feel that they are a burden to their family. Developing a coping plan can support the survivor in managing their emotions by helping them recognize their feelings, positive and negative, and increasing their capacity to cope with difficult emotions. *Note: Teaching coping skills requires training and practice.*

STEP 5:

CASE CLOSURE AND EVALUATION

Following standard guidelines for case closure, a case is closed at the request of a survivor. It is important to note conditions of an older survivor may change quickly if new health issues arise or cognitive functioning declines. In that case, another assessment of support may be needed.

When working with older survivors, caseworkers should be prepared for their death while still engaged in the case management process. Because health situations can change rapidly in old age, a sudden or unexpected death of a survivor may occur that is not related to or resulting from ongoing abuse. In these circumstances, the case will be closed, but support for the family should be considered where appropriate. In cases of an older survivor's death, the caseworker should debrief this with their supervisor as part of ongoing supervision.

SECTION 4:

GUIDANCE FOR PROTECTION SERVICE PROVIDERS

This section of the guidelines is designed for protection responders seeking to increase their understanding of rights violations experienced by older persons, which includes abuse and neglect.

These guidelines intend to give you guidance on how to respond to these complex cases involving older persons while adhering to the Protection Case Management Approach. Older persons in humanitarian crisis face difficulties both due to pre-existing conditions as well as the particular conditions of the crisis itself. Because protection teams focus on identifying and addressing the concerns of persons at heightened risk of rights violations, they must understand how age can increase risk of rights violations.

An older person may have more risks, including social stigmas based on age, disability, and increased barriers to services, which are associated with common difficulties in functioning due to new impairments related to age and barriers in the environment. Older men and women with disabilities may have increased risk factors across all three risk categories assessed by protection teams. In addition, as we age, protective factors like social connections, skills and abilities, and resources to plan ahead can all decrease or cease to exist. It is important for protection actors to take into consideration ways in which a crisis situation may exacerbate the effects of pre-existing conditions and lead to more long-term harm to an older person's well-being and resilience.[65]

FIGURE 2
Recognising Risk & Protective Factors

Figure is taken from the "Your Guide to Protection Case Management Guidelines."

When protection actors engage in a case management process with older adults, and potentially their families or caregivers, they must work to recognize how the interaction of the older person's aspects of identity are interacting with threats and barriers in the wider environment and how age may be diminishing the protective factors they can access. This recognition is important to ensure the protective factors that an older person does have and can access are utilized appropriately and for the most impact.

Given the broad scope of clients and multiple rights violations that protection caseworkers might be addressing, the table below has been developed to provide guidance on the key risk factors to take into consideration to determine the level of risk of older persons' abuse cases.

[65] HelpAge International. (2013). *Protection interventions for older people in emergencies.*

This table does not aim at being comprehensive but is rather to orient your discussion at country-level to identify the most at-risk cases.

High Risk	Medium Risk	Low Risk
The identified older person's life is in danger (suicidal behaviors, health urgent needs, physical safety concerns). There is a lack of community/family support systems. There is use of negative coping mechanisms.	*The identified older person has already received partial support which need to be strengthened. There is fragile community/ family support system. There is willingness from the caregiver to improve the older person's situation. There is use of negative coping mechanisms without immediate risk for dignity and life.*	*The older person already receives support, and no additional assistance is required. There are solid support systems in place at family and community level. There is no use of negative coping mechanisms. The existing needs are related to improving the overall situation of the older persons.*
CONTRIBUTING RISK FACTORS		
Individual Risk Factors for Caregivers and Older Persons		
• Mental health condition • Substance use • Low education level • Poverty • Minority language speaker • Being female • History of trauma		
Relational Risk Factors		
• History of abuse and/or conflict over the course of the relationship • Caregiver has insufficient training or support for their role • Poor connection to social networks • Physical, mental, and/or social isolation • Shared living situation – and living with a larger number of household individuals besides a spouse increases the risk[66] • High degree of dependency in the relationship – especially situations in which the caregiver is dependent on older person		
Community Risk Factors		
• Poor community supports for older persons and particularly those experiencing abuse • Low capacity for or sense of shared responsibility for welfare of community members (this can be due to crisis event or conflict which impacts community cohesion and functioning) • High levels of poverty within the community • Accessibility to and availability of services may be more limited in rural settings • Environmental and structural changes that disrupt social networks of older persons (i.e., humanitarian crisis, conflict, or natural disaster that takes down buildings/locations where older persons met) • Member of a minority community • Targeted violence during conflicts		

[66] Lachs, M. S. & Pillemer, K. A. (2015). Elder abuse. *New England Journal of Medicine.* 373, 1947–1956.

Societal Risk Factors
• Ageism • Tolerance for violence within the community • Migration and/or social change, which impact family cohesion and intergenerational caregiving expectations • Significant gender, social, and economic inequalities • Expectation that family members should care for older persons without support from others • Harmful traditional beliefs (i.e., witchcraft accusations primarily targeting older women) • Poor rule of law • No or limited legal framework for addressing abuse in later life • Policies of inheritance and land rights which impact ways power and material goods are allocated within families

Older people may be struggling to cope with a variety of challenges and risks linked to their age, gender, sexual orientation, gender identity, gender expression, sex characteristics, ethnic identity, religious identity, disability, etc., which can place them at heightened risk for rights violations. The interaction between physical health conditions and barriers to services could lead to inability to access basic goods and services (i.e., food and healthcare) presenting a risk to their survival. At the same time, the older persons may have weaker or fewer social connections, which results in not being cared for by their family or community or being excluded as a result of stigma and discrimination. This can be particularly true for older people with diverse sexual orientations and gender identity/expressions who have been cut off or distanced from families. If they live alone, they could face risk of increasing marginalization as their independence level decreases because of barriers along with a lack of willingness, time, or capacity of other family members or caregivers to provide support. Older persons also face threats to safety that may not be as easily apparent because of their age. Chronic health conditions, such as diabetes or high blood pressure, can present threats to safety as they may require consistent and frequent access to healthcare services. Older persons run the risk of having severe complications if these conditions are not treated. Health problems arising due to an emergency, even a seemingly minor issue such as seasonal flu, can lead to a significant deterioration in an older person's health with severe consequences. Older persons with disabilities may be at heightened risk when dependent on others following a crisis, as their typical family and community support structures are unavailable, and they face a dramatic change in their surroundings. While not exhaustive, these are examples of issues that can limit older persons' access to goods and services.[67]

[67] HelpAge International. (2013). *Protection interventions for older people in emergencies.*

RIGHTS VIOLATIONS FACED BY OLDER PERSONS IN EMERGENCIES[68]

At the Level of State Armed Groups and International Actors	At the Level of the Individual, Family, and Community
Safety and Security: Physical risk or harm as a result of natural disasters or conflicts. Older people's reduced regenerative capacity and mobility challenges place them at greater risk of injury and make them at heightened risk of longer-term impacts resulting from an injury. They are also more likely to be left behind if unable to flee or flee quickly.	**Violence:** The act or threat of physical, sexual, or psychological abuse. Cycles of dependency, discrimination, and isolation may place older people at risk of abuse within the family. Within the community older people may become victims of attack as a result of perceived vulnerability.
HLP Rights: Interference or discrimination regarding the right to enjoy one's house, land and other property, and possessions. Older people who have lost or never possessed ownership documents, and older women and widows who are not always recognized in inheritance law, face challenges in proving ownership of land or homes. They may also be at high risk of forced eviction.	**Neglect and Deprivation:** Older people may be prevented from accessing the goods and services they need. This can be unintended or may be the result of deliberate discrimination.
Documentation: Loss or destruction of personal documentation (such as ID, birth certificate, or marriage certificate) and difficulty replacing it. In some cases, older people may have never been issued with relevant, up-to-date documentation.	**Isolation and Dependency:** Lack of access to support and social relationships compounds the isolation felt by older people, as does the high level of help required in daily activities.
Freedom of Movement: Restriction on the rights to travel, reside in, or work in any part of the state, as well as to leave that state and return at any time.	**Family Structures and Family Separation:** Family structures, for example older-people-headed households, female-headed or widow-headed households, and households with large numbers of dependent children create specific protection risks for older people and their families. Involuntary family separation affecting older people increases their levels of isolation and reduces levels of support, making it harder for older people to access the goods and services they require.
Meaningful Access: Humanitarian assistance is not provided according to need and without discrimination. The failure to ensure access and accessibility of services for older people poses a major violation of their rights.	

[68] *Ibid.* Table 1: Protection issues faced by older persons in emergencies. (p. 12).

CONSIDERATIONS FOR OLDER PERSONS IN THE CASE MANAGEMENT PROCESS

Situations Case Managers May Encounter

Household Facing Strained Resources: While research shows that the main predictor of abuse of older persons is dependency of the caregiver on the older person and unhealthy power dynamics, these underlying drivers of abuse can be exacerbated by stress caregivers face in supporting an older family member. For example, an older person may report that financial stressors of the caregiver or household play a key role in their experiences of mistreatment, particularly financial abuse. They may wish to engage the caregiver or family as a whole in the treatment to explore ways of expanding their livelihood options and connecting the family or caregiver with support systems within the community to better provide for the older person.

Community-Related Issues: In many humanitarian settings, the community may be very tightly knit with all the pluses and minuses this entails. In these situations, abuse may be perpetrated by a community member or group of members due to ageism, ableism, and traditions such as witchcraft, that may place blame for community hardships on older members, particularly women. In such situations, it may be necessary to engage the community through community education and other efforts to address such problems.

Family with History of Poor Interpersonal Relationships: In some cases, families may present with histories of discord and poor interpersonal relationships, including histories of parenting practices that may have been abusive. Adult children may feel resentful of older parents and less willing to help them cope with the challenges of old age. The appointed caregiver may take a more commanding tone and approach rather than a collaborative one that respects the older person's rights. Ageism may add another layer to these interpersonal dynamics.

In such situations, adult children may exclude older parents from participation in decision-making regarding the family and treat them like children. They may take over financial management of the older parent's finances and use the older parent's money for personal needs rather than meeting the needs of the parent. The older person may suffer from medical neglect and lack items such as walking aides or hygiene items.

History of Gender-Based Violence: Older women may be experiencing IPV or other forms of GBV, have a history of experiencing GBV, or both. Older women may be hesitant to speak about experiences of GBV for a variety of reasons and constraints based on gender and age factors. If protection case managers suspect an older woman is experiencing GBV or an older woman discloses incidents of GBV to the protection case manager, the case manager should offer a referral to appropriate and relevant GBV services. If the client prefers to stay with the protection caseworker, that person should seek support from a GBV specialist.

Family or Caregiver Unable to Provide Appropriate Support: A family or caregiver may be strained with inadequate emotional and financial resources to care for the older person, which can result in situations of neglect. The caregiver may be juggling many other challenges and responsibilities. They may be a teen or young adult who has been asked to take on the role of caregiver for which they are unprepared. Generations may have different expectations about caring for older family members which may cause tension. Many times, this role falls to women who already face many barriers to full inclusion in society. The family as a whole may be struggling to meet basic needs let alone resources to provide the necessary medical, assistive technology, or hygiene items for their older family member. The assessment may reveal any of these themes and the older person may wish some support for their caregiver or family.

Because protection caseworkers often have large caseloads, a context-specific protection analysis can help inform prioritization of cases. Teams can use the Protection Case Management Tool: Annex 3 Key Questions for Prioritization Reference to help determine cases with highest priority. For more information on how to use this tool, see the Protection Case Management Guidelines.

In protection case management, prioritization focuses on assessing risk and protective factors of individuals within a dynamic and changing context. Therefore, it does not use pre-defined categories of persons with specific needs to determine prioritization. Older persons would not immediately be prioritized solely because of their age. Below is an excerpt of the form applied to examples of older adults in need.

FINANCIAL ABUSE AND EXPLOITATION		
Type of Violation(s) Financial abuse and exploitation Examples: • Confiscating money earned by the older person • Controlling access to finances, services • Illegal or duplicitous property transfer from older persons, particularly older women. • Theft of assets, including cash, valuables, and personal property	**Definition** When a person of trust misuses or takes assets of a vulnerable adult for their own personal benefit, without the knowledge or consent of the adult. It includes any deprivation of critical financial resources through: • Deception • False pretenses • Coercion • Harassment • Duress or • Threats	
FOR ADAPTATION: Examples of Risk Factors and Protective Factors in Your Context Based On Your Protection Analysis		
Examples of environmental risk factors, causal agents, and root causes	Examples of individual age, gender, and diversity factors which due to the context can increase individual risk	Examples of protective factors which reduce or mitigate the risk
• Negative social attitudes toward older persons • Poor legal protection for older persons • Absence of dedicated services for older persons • Poor mainstreaming within existing services	• Recent change in abilities or impairments. • Dementia • Other cognitive impairment • Living in a remote area • Landholder	• Able to travel to services • Positive relationship with caregiver • Employed in neighborhood • Attends services of agency specifically focused on older adults.
Examples of Risk Level To Determine Prioritization - Adapt for your context.		
Low: Probability of a serious risk to individual safety is low, however an intervention to respond to individual specific needs can be required to reduce vulnerability.	**Medium:** Probability of a serious risk to individual safety requiring intervention within a week. Bi-weekly follow-up required by phone and visit. The number of follow-ups will decrease according to the individuals' needs.	**High:** Serious and imminent risk to individual safety requiring immediate action in a maximum of 48 hours. Depending on situation, weekly follow-up is required by phone and visit. The number of follow-ups will decrease according to the individuals' needs.
Example: The individual is already receiving services from another organization. No disclosure of support required, observed, or communicated. There is an existing solid community and/or family support network. There is no obvious use or risk of negative coping strategies. There may be an existing additional need for another type of support not directly related to the protection incident.	**Example:** The individual was already identified by a partner and has received some form of support, but this needs to be reinforced. There is fragile existing family and/or community support. There is risk of and/or use of negative coping strategies as a result of the protection incident and/or due to risk of the protection incident. There is no immediate threat to life.	**Example:** Threat to life is identified; there are suicidal behaviors or health consequences endangering the life of the individual and/or family member(s). There is a physical safety risk. There is absence or a very low level of family and/or community support. The person may live alone. There is visible risk of and/or use of resorting to negative coping strategies. There are multiple protection risk(s) correlated and/or as a consequence.

PROGRAM ADJUSTMENTS THROUGHOUT THE PROTECTION CASE MANAGEMENT CYCLE:

STEP 1:

INTRODUCTION AND ENGAGEMENT

When working with older persons, challenges to obtaining informed consent may arise. Protection teams can use the Annex 6: Inclusive Communication Tip Sheet and the Annex 8: Capacity to consent and best interest determination to try to address these concerns.

What To Do If You Cannot Obtain Informed Consent: If, after exhausting all options try to facilitate communication, you are unable to do so with the older person, such as may arise in cases of severe cognitive impairment, you may need to identify someone who is able to make decisions on the older person's behalf. Such situations raise difficult ethical questions for a caseworker, especially in situations where you are trying to navigate the balance between autonomy and safety.

Cases in which cognitive capacity is in question should always be addressed in supervision and can also include consultation with medical and mental health professionals trained in assessing capacity if they are available. The latter may be particularly important if addressing the older person's situation may require legal intervention. There are particular tests and methods for assessing cognitive capacity and it is best to have a trained professional conduct an assessment if the person's care may involve the legal system.

HELPFUL TIP(S)

Even if cognitive concerns or capacity issues are not present, caseworkers may be meeting with both an older person and a family member or caregiver. If you are meeting together with an older person and family member or caregiver and suspect that the older person may be facing coercion or is not comfortable with the other person, you should conclude the session. It is not advisable to state clearly that you do not feel the family member or caregiver is an appropriate individual to assist the older person. Instead, you may simply state that you are unable to complete the session at the present time and will need to reschedule. You can state you need to clarify policies for having an additional person participate. You can review the situation with your supervisor to identify other ways of engaging the survivor in a safe way in order to better understand their relationship and assess level of risk in involving the caregiver or family member.

STEP 2:

ASSESSMENT

The protection assessment will focus on working with the older person to identify their protective strengths, capacities, and sources of resilience in addition to the various factors placing them at heightened risk for rights violations. As protective factors are identified, the caseworker can also identify areas of concern pertaining to the abuse and how that abuse may be compounding, resulting in the older person experiencing multiple rights violations. In addressing both protective factors as well as risk factors, the caseworker and older person can identify how protective factors may be able to mitigate some risk factors and address identified barriers. Older persons may have protective factors that include supportive family members, prior work experience or financial literacy, and life experiences that have contributed to particular skills of the older person.

1. Nature of the Abuse

Caseworkers must gain an understanding of the abuse the older person has faced. As a caseworker, you may have already identified some first signs of abuse. The needs assessment will ensure you can gather more detailed information to be able to plan with your client regarding ways of addressing the abuse they are experiencing. Keep in mind that if the abuse is with a family member or spouse, the person may have had a long-term relationship with this person with many changes over time.

Note that identifying physical marks of abuse may be more difficult in cases of older persons due to the fact that they may experience falls and bruising due to the aging process. Many times, abusers seek to explain marks due to these causes as well. Medical providers should be engaged to assist in identifying, where possible, marks from physical abuse. Medical providers may need to seek guidance on making this determination if they are not experienced in such cases.[69]

2. Safety

Risk of Abuse: It is important to assess who depends on the older person for what types of assistance (financial, housing, childcare etc.) and **explore the nature of these relationships to identify any abusive patterns**. Assess for any substance use or mental health problems on the part of a family member or caregiver who depends on the older person as these can be risk factors for abuse. Any key risks of abuse should be addressed though the collaborative development of a safety plan. If there are immediate safety concerns to address, these should be prioritized and addressed before continuing with an assessment. If there are not immediate safety concerns, the assessment should be completed before creating the safety plan with the older person.

Risk of Self Harm or Self Neglect: It is also critical to assess for any ways the older persons may be a danger to themselves, such as through self-neglect or thoughts about or a plan to commit self-harm. Each program must have clear guidelines on what staff member is qualified to conduct a suicide assessment. **Such assessments should only be carried out by trained, qualitied staff.** If such staff are not available on the program, the case should be referred to another actor providing such services. Contrary to prevailing thought, older persons can be at high risk for suicide, and this should be assessed with each older person.

3. Health Situation

Be sure to obtain a full picture of the older person's health and any key medications, medical treatment, and ongoing health problems they may be facing. Critical areas to ask about include any physical or sensory condition or cognitive impairment the older person may be dealing with and the interaction between these impairments and the older person's environment. Ask about any assistive devices (hearing aids, glasses) they may utilize or lack currently.

4. Dependence on Others for Support

Gain a clear understanding of both the areas in which an older person needs support and the level of support they need. This can help you identify both areas in which they may be at risk for abuse or neglect and also what types of support they may need if they decided to leave the abusive situation. Key areas to assess include activities of daily living, managing finances, accessing social networks, and addressing health issues.

See Annex 10: Activities of Daily Living Assessment

[69] A helpful reference table on this topic is provided in Lachs, M. S. & Pillemer, K. A. (2015). Elder abuse. *New England Journal of Medicine.* 373, 1947–1956. https://bit.ly/38fuB9q

5. Current Economic Situation

While it may not be intuitive to ask an older person about livelihood it can be an important consideration. Assess for the overall income level of the client and any financial stressors they or their family may be facing. For many clients, the issue of their livelihood and that of their household can be interwoven in the experience of abuse and neglect. You may want to offer the older person support in gaining access to livelihood programs but ensure that this will not contribute or play into dynamics of financial abuse the older person may be facing. For example, if the older person's child is intimidating the older person into providing them with financial support, then finding another source of livelihood without addressing the financial abuse will only serve to worsen the abuse.

HELPFUL TIP: COORDINATION WITH LIVELIHOOD STAKEHOLDERS

Coordinate with livelihood providers to find appropriate ways to involve older adults in their activities. It is usually not a good idea to have programs that specifically target older clients who have experienced abuse, as these could become stigmatizing. Ideally, there would be accessible safe, confidential ways to make referrals to existing programs that can incorporate clients without disclosing what happened to them or creating a perception that survivors of abuse get special treatment.

6. Legal Needs

Older persons may need support with obtaining needed civil documentation or addressing a lack of legal status. Lack of these legal foundations may render them more vulnerable to abuse or less able to address the abuse they are experiencing. As with other populations, **older persons may need legal counseling and/or assistance or seek representation to address abuse through the legal system**. Both should be explored with the client as well as any institutional barriers impacting the legal system, for example, laws that disproportionately favor younger adults. The decision whether to pursue justice is an important one, and clients need to have access to full information when making this decision. It is important for you to understand whether or not the incidents of abuse are considered a crime within the legal framework of your setting, and, if so, whether the older person wants to take legal action. It is also important to know whether or not there is a legal framework for abuse of older persons at the local and national levels.

You may refer to Annex 13: Legal Framework Analysis for further discussion of protecting the legal rights of older persons

Making a Decision about Engaging the Family Member or Caregiver

Engagement with the family member or caregiver must be done thoughtfully and carefully. Several issues need to be assessed in making the the decision. The table below provides some key principles that can help you in assessing if it is safe to engage the caregiver and how best to do so.

Area to be Assessed	Consider Engaging the Caregiver	
	YES	NO
Wishes of the Caregiver	The client wishes to preserve relationship with caregiver and can identify ways it would feel safe to engage them.	The client does not want to preserve the relationship.
Attitude of the Caregiver Toward the Older Person and the Reported Abuse/Neglect	The caregiver acknowledges problematic aspects of their behavior and expresses an interest in the well-being of the older person.	The caregiver does not express concern for the well-being of the older person and does not see their behavior as problematic.
Safety Concerns	There are no critical safety issues present, or safety issues do not present imminent threat to client's well-being. The caseworker feels adequate safety measures are in place for their own protection.	The assessment reveals severe, ongoing violence or threats to the physical, emotional, and financial well-being of the older person on the part of the family member. The caseworker does not feel adequate safety measures are in place for their own protection.
Availability of Referrals Suitable To Address the Type of Risk Factor Presented by Caregiver	There are adequate referrals or program resources available to address the caregiver's condition or situation, such as mental health or substance abuse treatment, livelihood assistance, medical care etc.	Referrals available are not appropriate to address the caregiver's condition or situation. Advocacy efforts may be needed to create such services. Referring caregiver to existing services may do more harm than good.
Caregiver Exposure to Abuse	The caregiver has also been a target of violence by the abuser in their role as caretaker of the older family member. The older person would like them to get some help, too.	The caregiver has also been a target of violence by the abuser in their role as caretaker of the older family member. However, the older person feels it would be too risky to involve them or does not want to reveal that they are accessing help.

STEP 3:

ACTION PLANNING

Implementation steps for abuse of older persons follow the same principles as for other programs. Caseworkers develop a case action plan with the older person and his/her caregivers (where relevant) based on the main needs that emerge during the assessment. **A key difference for action planning for older persons may be the complexity of the response that will need to be organized as well as the level of support needed by the older person taking into account disability, barriers to access, and breadth of services available for older persons in the community.**

Caseworkers may find that they need more meetings to complete the action planning adequately in some cases, particularly those with older persons requiring an array of services and who may need to process information at a slower pace. Similarly, case management services to older persons may require more regular and intensive follow-up for several reasons: older persons may have functional difficulties and require greater assistance participating in meetings with other providers; caseworkers may find a limited number of services available for older persons and may need to spend more time advocating to ensure that other actors provide accessibility and needed support; and cases of older abuse often require a variety of services and coordination among the various providers to ensure referrals are being follow up on and coordinated with others as necessary.

If programs are engaging the caregiver in services as well, action planning may need to be broken up into two parts: meetings with the older person and another joint session with the older person and the caregiver/family. Two examples of the latter situation include:

- In cases where a caseworker for the older adult and a caseworker for a caregiver are involved and it is agreed that joint interventions would be beneficial to support the older person and their family or caregiver, collaborative action planning would be necessary. A separate session can be scheduled with both caseworkers, the older person, and their family member/caregiver to develop an action plan for joint interventions.
- If one caseworker will be supporting both the older person and the caregiver/family member, they may also decide to hold a separate action planning session for the older person and then one together with their caregiver to discuss a plan for those interventions that will be provided jointly.

STEP 4:

CASE PLAN IMPLEMENTATION AND FOLLOW-UP

Caseworkers should arrange follow up visits with older persons as they would with other populations during case management. A few issues may need to be considered in the context of follow up visits with older women:

- **Following Up on Referrals:** Caseworkers are responsible for following up on referrals to make sure services are provided in a timely and accessible manner. Cases of abuse or neglect of older persons may have many different referrals that need to be followed up on and coordinated. In addition, it is critical to confirm that services are adequate to meet the needs of older survivors and facilitate additional referrals if gaps in service provision arise.
- **Case Conference:** Caseworkers may need to organize a meeting with the main actors and service providers that are involved in the case plan, to discuss the action plan and find short-term and/or long-term solutions. This procedure is best reserved for complex cases, often when an older person's needs are not being met in a timely or appropriate way and when a joint response is critical. Note that this process may need to be used more often with older persons because of the complexity of their cases. These meetings provide opportunity to review activities, establish progress, identify barriers, map roles/responsibilities, look for solutions, and adjust current service plans as needed.

OUR RECOMMENDATION

Caseworkers looking to improve their case management services to older persons should review their service mapping to identify potential additional services that meet the complex and inter-connected needs of those cases. Programs can use their service mapping to indicate the level of accessibility of these services to ensure older women with disabilities can access them. Programs should consider fostering the development of multi-disciplinary teams whenever possible to coordinate services to older persons given the complex and inter-connected needs of these cases.

- **Re-Assessing Changes in an Older Person's Situation:** An older person's situation can be quite fluid and change quickly over time, particularly if there are medical issues involved. Caseworkers may need to hold more frequent follow up sessions in complex or high-risk cases to assess their physical and emotional well-being and safety issues.
- **Safety:** Any older person's risk of harm might increase once abuse has been disclosed. Older persons who are part of caregiving relationships may not be able to speak openly about their safety in front of family members/caregivers. It may be necessary to ask older persons questions about safety in private.
- **Health:** An older person's health and functioning may fluctuate frequently, even more so than other people who experience abuse. The caseworker may need to see an older person more often to monitor their situation. Because older persons' health and functioning may fluctuate as a natural part of their recovery from abuse, and also because of physical health problems associated with aging, caseworkers should follow more closely those older persons with more severe physical health concerns compared to those with less fluctuation in their situation. If an older person is experiencing fluctuations in physical health, accessibility barriers to health services may be exacerbated. If an older person does not know what her physical abilities will be consistently, this can further impact her ability to seek out and receive needed health services that do not have appropriate accessibility measures.
- **Mental Health and Psychosocial Support:** Just like physical health, an older person's mental health may fluctuate frequently. Older persons may be more isolated than younger survivors as older adults are often more isolated than younger adults. For older persons, it may be helpful to reassess psychosocial state on a weekly basis or more. If, over time, an older person's well-being is not improving or seems to be deteriorating (e.g., they are not caring for themselves or further isolating themselves), caseworkers should work to determine if referral to physical health care or referral to more specialized psychosocial or mental health care (if available), or referrals to both physical and mental health care should be considered. Supervisors should be consulted in such cases to determine whether to make such a referral.

  Psychosocial support can provide the older person with the skills they will need to manage some of the symptoms they may be experiencing. Psychosocial support groups may also be important for older survivors in combatting isolation, by helping them make social connections with their contemporaries and gain skills they have not had the opportunity to learn earlier in life. All of these can be important to regaining and building a sense of empowerment for the older person. In addition to referrals made to group psychosocial support activities and higher-level mental health care services, caseworkers may directly provide psychosocial support, such as:

  ☑ **Relaxation Training:** Teaching survivors skills for managing anxiety can help them feel more in control of their bodies and calm their minds, but some types of relaxation exercises may be contraindicated for older persons. Be sure to assess for any medical issues that may make breathing exercises challenging for older survivors.

  ☑ **Teaching Coping Skills:** Older survivors may have negative feelings after abuse, and this may be even more pronounced if they have internalized blame for many years in a long-term abuse relationship. They may attribute the abusive behavior on the part of their partner or spouse to the stress of caregiving, to addressing their deteriorating health condition, or to other challenges they are facing.

They may feel that they are a burden to their family. Developing a coping plan can support the survivor in managing their emotions by helping them recognize their feelings, positive and negative, and increasing their capacity to cope with difficult emotions. Note: Teaching coping skills requires training and practice.

STEP 5:

CASE CLOSURE AND EVALUATION

Following standard guidelines for case closure, a case is closed at the request of a survivor. It is important to note conditions of an older survivor may change quickly if new health issues arise or cognitive functioning declines. In that case, another assessment of support may be needed.

When working with older survivors, caseworkers should be prepared for their death while still engaged in the case management process. Because health situations can change rapidly in old age, a sudden or unexpected death of a survivor may occur that is not related to or resulting from ongoing abuse. In these circumstances, the case will be closed, but support for the family should be considered where appropriate. In cases of an older survivor's death, the caseworker should debrief this with their supervisor as part of ongoing supervision.

SECTION 5:

GUIDANCE FOR CHILD PROTECTION SERVICE PROVIDERS

This section of the guidelines is designed for child protection (CP) responders seeking to increase their understanding of abuse and neglect experienced by older persons.

Child protection actors' interactions with older adults will be entirely different from Protection and GBV actors mainly because child protection services focus on the child as the direct recipient of services. However, this may be different in situations where older adults are the primary caregivers of children or cases where children are caring for older persons. In many humanitarian settings, older persons often assume the role of caretaker for dependents whose parents are missing. In some cases, older persons may have already been taking care of children prior to the humanitarian crisis and end up caring for an even greater number of children afterward.[70] It is very important the CP programs identify older persons in caretaking roles and consult with them regarding key needs and challenges in caring for children post crisis – both in terms of their needs and that of the children.[71] Further, when children are caregivers for older adults, they are at risk for physical health and mental health issues due to the burden of care.[72]

Child protection actors should be prepared for the potential of identifying older adults experiencing abuse while working with children experiencing violence in the home. While more research needs to be done regarding co-occurring violence in multi-generational households, there is evidence to show that in some incidents of abuse of older persons, other members in the household may also be experiencing abuse at the hands of the perpetrator. For example, results of a Canadian program to address abuse of older persons showed that in about 30% of cases, the older person was one of several people in the household experiencing abuse.[73]

Because of the unique role CP actors have in working with older adults, this guidance focuses solely on these three aspects: working with older adults as primary caregivers of children, working with children who are caregivers for older adults, and identifying and referring older adults at risk of or who are experiencing abuse and neglect.

CAREGIVING ACROSS THE LIFESPAN

The guidance in this section focuses on aspects that may not be easily recognized to address and accommodate older adult caregivers. Key considerations for older adult caregivers of vulnerable or marginalized children include:

- Communicating with older adults
- Addressing barriers to caregiving and accessible service provision
- Assessing the older person's ability to continue being primary caregiver

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70 HelpAge International. (2012). *Older people in emergencies – Identifying and reducing risks.*

71 *Ibid.*

72 Conway, K. (2019). The experience of adult children caregiving for aging parents. *Home Health Care Management & Practice,* 31(2), 92–98. doi:10.1177/1084822318803559

73 Storey, J. E. & Perka, M. R. (2018). *Reaching out for help: Recommendations for practice based on an in-depth analysis of an elder abuse intervention programme.* British Journal of Social Work. 48, 1052–1070.

Caregivers, for both children and older adults, will have different needs for support depending on many factors, including their age, gender, sex, ethnicity, etc. CP case managers often work with older persons who are primary caregivers of children. Caseworkers should be aware that older adults are caregiving at a particular point in their lifespan when they may also often need caretaking. Just as always, caseworkers should work with older adult caregivers to identify any assistance the person may need to meet the needs of the children in her or his care. Caseworkers should be careful not to assume that an older adult caregiver cannot provide a stable, caring, and safe environment for children just because they are older. Identifying and addressing barriers the older adult is facing can impact their ability to care for the child and help ensure consistency of caregivers where appropriate.

COMMUNICATING WITH OLDER ADULTS

When working with older adult caregivers, child protection teams should take specific steps and measures to ensure the communication needs of these older adults are met. Communication challenges are not a reason for removing a child from an older caregiver or determining that an older caregiver can no longer meet the needs of the child. It is the responsibility of the case management team to meet and address any communication barriers.

Potential communication barriers for older adult caregivers include literacy, deafness and hearing impairments, and translation and interpretation. Easy to read information about child rights, available services and case management may help older caregivers to understand key aspects of service provision if literacy is a concern. They may also need translation as older persons are more likely to speak diverse languages rather than the official language of a country or region. With any intake, assessment, or follow up involving an older adult caregiver, with or without disabilities, caseworkers should allot more time for explanation, questions, and addressing barriers to understanding. Ensure that necessary interpretation is available in advance of any meetings involving the older adult caregiver. This may include interpretation for deaf caregivers.

Recognize that older adults with disabilities may also be caregivers of children and have additional communication barriers. If failing vision is a concern, easy to read forms can help. Braille forms may also be useful. If hearing is a concern, make sure to review appropriate communication methods with older adults in Annex 6: Inclusive Communication Tip Sheet. Just speaking louder or shouting is not an appropriate method of communication for older adults with hearing issues. Older adults who are deaf may also have literacy challenges. The ability to address these overlapping challenges before any meetings or sessions with the caregiver will strengthen the relationship with the caregiver, increase the potential to address key challenges and barriers to caregiving, and offer appropriate support to both the child and the caregiver. Communication challenges and barriers with older caregivers must be addressed early in the relationship to ensure that older caregivers and the children they care for are aware of available services and know how to access those services.

Communication barriers can also include a lack of awareness of services because the information is not targeted or accessible to older adults. CP caseworkers may identify cases where the older person caring for children isn't able to access information about child protection

RECOMMENDATIONS FOR COMMUNICATING WITH OLDER ADULT CAREGIVERS

- Early on, assess how best to communicate with an older adult caregiver; do not make assumptions about hearing, eyesight, or cognitive decline before engaging directly with the older adult caregiver.
- Offer child protection information in diverse languages and accessible formats such as easy-to-read and braille.
- Provide interpretation (including sign language interpretation, if necessary) during case management sessions involving an older adult caregiver.
- When involving an older adult caregiver in a case management process, ask them how they would like to communicate.

because of information barriers (format used, location advertised, information is targeted at adults of reproductive age). In many contexts, because information is adult oriented, children will not know if the adult in their life isn't aware. Therefore, child protection teams can also review their information dissemination and awareness strategies to ensure that older adults are targeted in addition to children and adults of reproductive age.

If caseworkers are unclear about how best to communicate with an older caregiver, the simple and most straightforward solution is simply to ask them. Caseworkers should avoid making assumptions about what the older adult needs and instead engage them in dialogue.

ADDRESSING BARRIERS TO CAREGIVING AND ACCESSIBLE SERVICE INFORMATION

Older adult caregivers may also face physical barriers in accessing available and needed services. The inability to access needed services for themselves may impact their ability to appropriately care for children in their home. They may also be unable or have challenges in ensuring the children in their care access needed services because of physical limitations or disabilities. For example, older persons may not be able to walk the same distance to services as adults of reproductive age or may not have accessible transportation available to reach services. CP caseworkers may also work with older caregivers of children who self-isolate because of perceived stigma, shame, or fear of leaving the home as their abilities change with aging. Because of this, CP caseworkers may need to assess the physical challenges and barriers a caregiver is facing. Some of these challenges may be able to be addressed within the work of child protection; however, many of them may require referrals to other services.

RECOMMENDATIONS FOR ADDRESSING BARRIERS TO CAREGIVING

- Assess and determine barriers related to mobility and accessibility.
- Determine which barriers can be addressed by CP in working to support the child and determine which will need to be addressed through referrals to other services.
- Map available services to enable appropriate referrals.

Child protection caseworkers should map the available and accessible services for adults, including any older-age-specific services and services tailored to individuals with disabilities (although not limited to older-age-specific targeting). When connecting with service providers, caseworkers should explore how accessible/older-age-friendly the service provision may be. Examples of referrals may include to health services, older-adult-specific case management services, women and girls' safe spaces (for older women), and support groups and peer groups for older adults. Transportation services, if available, and livelihood referrals can provide both significant psychological relief and stress reduction and also access to needed services and resources for both the caregiver and child. Older adults report high levels of stress and isolation, and when they are caregivers, they report that this is further exacerbated because of insufficient financial resources.[74] Because financial stress may limit the ability to pay for transportation to needed services, buy adequate amounts of food (even when already receiving food rations), and keep children clothed and fed, among other needs, livelihood referrals or cash transfers may be particularly important for older adult caregivers. SOPs should look into considerations for older persons to access cash if this is an approach used. Cash SOPs might assume older persons have access to ID, phone, bank accounts, etc., which they might or might not have; if they do not have these, they may not be able to access the service intended to assist them.

Ensuring an older adult has the resources to meet their needs and can access appropriate services themselves will help facilitate their ability to be caregivers for longer as they age.

74 Rural Health Information Hub. (2018). Older adult populations serving as caregivers. https://bit.ly/3L8gMbH

ASSESSING ABILITY TO CONTINUE BEING PRIMARY CAREGIVER

Child protection teams must recognize that caregivers needs are not static, especially older caregivers. Their needs will change as they age and can change rapidly in cases of illness, newly diagnosed chronic or terminal health conditions, and increased stress. Sometimes a decline in physical or mental health can be reversed or slowed. Other times, this decline will increase. Conditions like dementia and other forms of cognitive impairment are often irreversible. There may be support and services that can help slow this decline or it could be quite rapid. Further, physical decline is associated with old age and for many older adults, continues with limited ability to slow or reverse. Because of this, there may come a time when an older adult is no longer able to care for a child or children in their home. Child protection caseworkers must be aware of this possibility and be able to work with caregivers to assess and determine their own ability to care for these children. Ideally, an older caregiver can continue caring for a child for as long as possible. Separation from a caregiver can be traumatic for children, particularly if done against the wishes of both the child and caregiver. Caseworkers' focus should be on ensuring the continued caregiving arrangement for as long as possible. This is done by removing as many barriers as able and ensuring access to needed services. If a caregiver has reached a point where they are no longer able to care for a child, caseworkers should endeavor to make plans and alternative arrangements for caregiving, to the extent possible, with both the older adult caregiver and the child/children.

RECOMMENDATIONS FOR ASSESSING ABILITY TO CONTINUE BEING PRIMARY CAREGIVER

- Determine health conditions that may impact ability to be primary caregiver.
- Respect the child's wishes around staying with a caregiver to the extent possible and safe.
- Address barriers to caregiving to ensure stability in the child's life and maintain caregiving situations to the extent possible.
- Work with child and caregiver make plans for when the older person can no longer continue being a caregiver.
- Work with the child and caregiver to find alternative arrangements if necessary.

Children Who Are Caregivers

While caseworkers may work with children and their older adult caregivers, the opposite is also true. Children become caregivers for older adults as well. Being a caregiver for an older adult puts the children who are caregivers at additional risks similar to those faced by children who are caring for other children. Children who are caregivers are at risk of higher rates of depression and anxiety, isolation and ostracization from other children on account of being different, and potential self-esteem and image concerns.[75] [76] However, they can also have a stronger sense of their skills and abilities, improved self-image, and feelings of accomplishment and satisfaction that originate in their abilities to care for the older adult.[77] Whether the child's experience of caregiving is primarily positive or primarily negative, the child should be supported through child protection services and CP actors should seek to ensure the older adult is supported through appropriate, available services.

[75] D'Amen, B., Socci, M. & Santini, S. (2021). *Intergenerational caring: a systematic literature review on young and young adult caregivers of older people.* BMC Geriatr, 21, 105. https://bit.ly/3k3LDdy

[76] Austin, L. (n.d.) *Children as caregivers.* Today's Caregiver. https://caregiver.com/articles/children-as-caregivers/

[77] *Ibid.*

IDENTIFYING AND REFERRING OLDER ADULTS AT RISK OF OR EXPERIENCING ABUSE AND NEGLECT

Types of Cases CP Programs May Identify

Child protection caseworkers identifying older persons experiencing abuse should refer the older survivor to either a GBV program or general protection program based on gender considerations and the dynamics of the abuse and neglect. As a result, guidance in this section focuses on recognizing potential abuse and neglect and engagement and obtaining consent with older persons, but it does not cover the full case management protocol as this is not relevant to CP caseworkers.

Because CP caseworkers will likely only encounter older adults when there are children with specific concerns in the home, a list of potential scenarios is provided to help caseworkers be aware of potential situations of co-occurring violence in the home that may involve older adults and children:

- ☑ An older woman facing long-term violence in the relationship with her partner and who has now taken on a caretaking role for children whose parents are missing following a humanitarian crisis.
- ☑ A woman who is the sole caregiver for her older parent/s and three children and is experiencing difficulties adequately providing for the needs of her older parents and her children and reports a situation of neglect. She may be facing financial stressors to a degree that makes it challenging for her to care for her older parent/s and children without support.
- ☑ In a multi-generational household, a male head of household may commit physical and psychological abuse against a spouse and their children as well as an older parent living in the home.
- ☑ An older woman with disabilities who unexpectedly became responsible for the care of her younger grandchildren, a task that is challenging given the financial and physical constraints she faces.
- ☑ An older woman who has been a caregiver for her grandchildren but was referred to child protection for not being able to care for the children in her care. She shows signs of cognitive decline and potential inability to care for her grandchildren any longer.
- ☑ A child who reports witnessing the abuse of an older person in their home.

Making Appropriate Referrals for Older Adults Experiencing Abuse and Neglect

Child protection caseworkers can provide assistance to older adults within a family intervention aimed at addressing the needs of children in the home. However, child protection caseworkers are limited both in terms of the variety of services they can offer an older adult and in terms of the boundaries of their expertise. Older adults have distinct needs that CP caseworkers will not be able to address. Therefore, CP caseworkers need to make appropriate referrals. CP workers should be aware that the referrals for an older adult will change depending on their abilities, strengths, protective factors, and role within the family. An older person who is a caregiver for a child may need services specifically focused on assisting them in their role as caregiver. Meanwhile, an older person who is being cared for by a child may need referrals and assistance with health and transportation if the child is unable to facilitate their travel to healthcare. Older adults within a family may be experiencing abuse or neglect and need referrals to protection services. Because of the variety of services and referrals an older person may need, CP teams should consider training or ongoing learning activities to become more aware of the various services needed by older adults. These include, but are not limited to:

Health: All older adults may need referrals to health services simply to address common issues with aging. However, for older adults being cared for by children and older adults experiencing abuse or neglect, health concerns may be critical and need to be addressed immediately. CP caseworkers should be aware of this potential and able to facilitate immediate, critical referrals when necessary.

Livelihoods: Livelihoods, particularly cash assistance, can help many older adults in a variety of ways. Older adults may need transportation to health services and may have health needs that are not subsidized or that require payment. Older adults who are caregivers of children may have limited or no income and need cash support to care for these children. In extended family dynamics, cash and livelihood income can help older adults feel like valuable members of the family, potentially helping to ease tense family dynamics.

Transportation: As older adults age and face changing abilities, transportation becomes more important for many. As they age, older adults may no longer be able to walk the same distances to services. Lack of transportation access then becomes a barrier to multiple other needed services. CP workers should identify with children and the older adults in their lives whether and in what ways lack of transportation access is impeding an older adult's ability to care for the child. Referrals for transportation can be made in these situations or a referral to Protection or GBV can be made to determine the transportation needs of the older adult.

Psychosocial Support: Older adults often become more isolated as they age because of changing physical abilities, but also because of perceived shame and social stigma associated with aging and perceptions of their abilities. Psychosocial support, particularly group activities with peers can be an important source of stress mitigation and connection building. These activities may take place within women and girls' safe spaces, community centers, protection spaces or other venues. If a referral or these activities is not mapped in your referral pathway, a referral to protection or GBV to help coordinate such services may be appropriate.

Protection/GBV: If CP teams suspect abuse of an older person in the home of a child they are working with a referral to Protection or GBV service provider should be considered. Because CP teams may only have a report of abuse of an older person through a child or another family member without being able to speak to the older adult, teams can implement a standard process of referring older men to protection and older women to GBV.

Legal/Justice: Older adults may need legal and justice services unrelated to the child client. Unless the child protection team has legal staff part of their team, it would likely be most appropriate to make a referral to protection services to coordinate and support in accessing legal and justice services.

ANNEX 1:

ABUSE OF OLDER PERSONS SITUATION ANALYSIS

This tool aims at supporting you in developing your situation analysis of abuse of older persons in your context. There are seven main categories of information to explore to better understand abuse of older persons in your context. They are:

❶ Defining aging
❷ Understanding and perceptions of abuse of older persons
❸ Forms of abuse of older persons
❹ Understanding risk factors for abuse of older persons
❺ Analyzing the legal framework and practices
❻ Analyzing coping mechanisms and protective factors
❼ Analyzing the available response and gaps

The below table lays out the seven categories, suggests what you might learn from each category, where you may be able to access the data, and some of the conclusions you may be able to draw.

Purpose of Data Collection (Primary and/or Secondary)	Key Considerations	Data Source	Drawing Conclusions (With Examples)
DEFINING AGING IN YOUR CONTEXT			
• Determine the numerical component of age, as it may vary from one country to the other. Furthermore, in humanitarian settings, the numerical value that defines old age might be different according to the context and living conditions. • Understand how older persons are perceived in the context you operate in. • Understand the social role of older persons and the impact of the crisis.	**Ensure you determine the influence of gender dynamics for all those elements.** **Ensure you determine how difficulties in functioning may link to perceptions of age/aging**	**Available data collection tools:** • FGD • Washington Group Questions integrated into research, monitoring, and evaluation processes **Secondary sources of data**	**Older persons might be at risk of abuse if:** • Ageism seems prevalent in your operating context; • The crisis negatively impacted family cohesion and inter-generational caregiving expectations, including the expectation that family members should care for older persons without support from others; • There are significant gender, social, and economic inequalities in older persons' roles.
UNDERSTANDINGS AND PERCEPTIONS OF ABUSE OF OLDER PERSONS			
• Determine level of recognition of abuse of older persons and its different forms. • Determine harmful attitudes about aging and older persons. • Determine societal factors and especially cultural norms contributing to abuse of older persons. **[Refer to risk and protective factors section for more details on culture influence and examples.]**	Abuse of older persons entails a cultural component which might influence terminology and accepted categories by populations you will be working with. It is therefore important for situation analysis purpose and program design to understand population perceptions of abuse of older persons.	**Available data collection tools:** • FGD **Secondary sources of data**	**Older persons might be at risk of abuse if:** • There is a certain level of tolerance for violence against older persons within the community; • There is a low capacity for or sense of shared responsibility for welfare of community members; • Cultural norms or common attitudes disrespect older persons or center value of a person around productivity and economic contribution.

Purpose of Data Collection (Primary and/or Secondary)	Key Considerations	Data Source	Drawing Conclusions (With Examples)
FORMS OF ABUSE OF OLDER PERSONS: CATEGORIES WHICH MANIFEST IN YOUR CONTEXT			
• Understand how abuse of older persons manifests in your context. • If you have case management services which include older persons you might already be able to extract data about the type of elder abuse. • You may choose to extract data from clients above 60 years old or choose a different lower age limit in alignment with the definition of aging in your context.	Ensure your analysis is intersectional – looking at elder abuse across sex/gender, disability status, and other relevant factors.	**If case management data available:** Analyze data from clients above 60 years old: • # of older persons under case management • # of abuse cases per type **Secondary sources of data:** • Existing country assessments on older persons • Health sector data/ assessment results	**This data will help you understand:** • Type of reported abuse of older persons; • Perceptions of abuse of older persons as a whole and different types of abuse; • Risk factors to elder abuse.

Example of older person abuse manifestation:

Abuse and neglect by a daughter-in-law: In some cultural settings, the daughter-in-law is the designated caregiver of the partner's parents. Providing care creates a burden for daughters-in-law and greater stress on top of other tasks they already have to do. The daughter-in-law herself may be or have been subject to discrimination, GBV, or other stress factors that influence her interactions with her partner's parents, and ageism can also play a role in ways families set up care for older persons. In addition, transition regarding roles of younger and older generations within communities can exacerbate that situation as daughters-in-law can be caught between traditional norms that dictate taking care of older persons and current norms for younger generation that don't call for this.

Accusations of witchcraft: Older women, especially widows, are often particularly vulnerable to witchcraft accusations. In some cultural settings, individuals or the community may claim witchcraft on the part of an older person to explain circumstances such as infertility, illness, drought, poverty, or other difficulties facing the family or community. In some situations, family members may also use witchcraft allegations to assume control of property, particularly housing, belonging to an older family member, especially an older woman.

Threats of "outing" an older adult: Members of LGBTQI community may have concealed their gender identity or sexual orientation given fear of discrimination or violence. Those committing abuse against older LGBTQI adults may threaten to "out" them to their family, the community, or authorities.

Purpose of Data Collection (Primary and/or Secondary)	Key Considerations	Data Source	Drawing Conclusions (With Examples)
UNDERSTANDING RISKS FACTORS FOR ABUSE OF OLDER PERSONS AT THE INDIVIDUAL AND RELATIONSHIP LEVEL			
• Understand individual and relationship risk factors for abuse. • Understand how attitudinal barriers contribute to abuse.	It is recommended to only produce this type of analysis if you have pre-existing data from case management services. Due to the sensitivity of such information, it is recommended to do it through confidential data collection methodologies.	**From case management data or confidential surveys only:** • # of abuse survivor and/or caregiver with mental health condition; • # of abuse survivor and/or caregiver with substance use • # of abuse survivor with disability/ies that lead to significant dependency • # of abuse survivor and/or caregiver with a low education level • # of abuse survivor and/or caregiver economically vulnerable • # of abuse survivor and/or caregiver member of a minority community • % of affected women • # of abuse survivor and/or caregiver member in a shared living situation	This data will help you understand: • Qualitative information about the risk factors to elder abuse; • Contextual trends in elder abuse.

Purpose of Data Collection (Primary and/or Secondary)	Key Considerations	Data Source	Drawing Conclusions (With Examples)
ANALYZING THE LEGAL FRAMEWORK & PRACTICES IN YOUR CONTEXT			
• Understand individual and relationship risk factors for abuse. • Understand how attitudinal barriers contribute to abuse.	National frameworks on older persons' rights and abuse of older persons will differ from one context to the other. Please note that after drawing an understanding of the corpus of available laws you need to understand the level of enforcement [legal practice] of those laws and policies. Available data collection tools: Refer to the legal analysis section	**Secondary sources of data:** • Existing national legal framework analysis on older persons' rights	This data will help you understand: • Qualitative information about the risk factors to elder abuse; • Contextual trends in elder abuse. **Example of abuse of older persons manifestation:** **Threats of deportation:** For older adults who are immigrants, individuals of trust may use threats of revealing their legal status of seeking their deportation as a form of abuse
ANALYZING COPING MECHANISMS & PROTECTIVE FACTORS			
Older persons and communities have necessarily put in place certain coping mechanisms. It is important to identify them being negative or positive to either find alternatives through programming or build on the protective factors put in place.	**Please note that all risk factors can be protective factors if analysis leads to the opposite conclusion.**	**Available data collection tools:** • FGD **Secondary sources of data:** • Existing country assessments on older persons • Existing country assessments on older persons • Health sector data/ assessment results	**Include protective factors you have identified throughout the analysis.** **Older persons might be at risk of abuse if:** • There is disruption in social networks of older persons (buildings/locations where older persons met are not functioning); • There are poor community supports for older persons and particularly those experiencing older person abuse; • There is low capacity for or sense of shared responsibility for welfare of community members. (This can be due to crisis event or conflict which impacts community cohesion and functioning.)
ANALYZING THE AVAILABLE RESPONSE AND GAPS			
The level of understanding of the available service for survivor of elder abuse and gaps will be instrumental for you to design your case management services but also advocacy strategy. It is also important to note that the lack of access to services is a key risk factors to elder abuse.		**Available data collection tools:** • FGD • Individual interview • Key Informant Interview **Secondary sources of data:** • Existing country assessments on older persons • Existing country assessments on older persons • Existing service mapping	**Older persons might be at risk of abuse if:** • Accessibility to and availability of services is limited.

ANNEX 2:

OLDER PERSON AND CAREGIVER FOCUS GROUP DISCUSSION GUIDE

DIRECTIONS FOR USE:

Focus group discussions (FGDs) are an important way for you to gather information from the community about the way older person abuse manifests and how the community is addressing the issue. Depending on the needs of the team and the information being sought, FGDs can be organized for older persons and their caregivers or specific questions relating to old age can be incorporated into a more general or broader FGD about services.

When deciding which approach will best meet your informational needs, consider the following questions:

1. Have you just begun setting up programming? Is there opportunity to build in specific questions to initial FGDs and avoid duplication or participation fatigue?
2. Do you have the capability to organize age-specific FGDs?
3. Do you need to do caregiver-specific FGDs?
4. What information do you already have available from other sources (PIMS, GBVIMS, case files, previous FGDs, KIIs, Camp Coordination feedback channels, etc.)
5. What is your staffing structure? Does the team have staff available to do multiple FGDs?
6. Will staff need additional training to complete FGDs?

Once teams have determined if they will incorporate specific questions into broader FGDs or hold specific FGDs with older persons and their caregivers, key considerations and actions need to be taken to ensure successful FGDs.

Integrated FGD Questions

If teams will be integrating questions about older adults into broader FGDs, determine what key questions you would like to add to your existing FGDs. Suggestions for critical questions are below. Teams should ask all groups (no matter the age of the adult participants) the questions regarding older persons, but they should be prepared to spend more time and gather more detail in groups where older adults are participants. Consider the guidance on group composition and ensure the necessary steps are taken to have active participation from the older persons in your FGDs.

Questions to consider integrating into other FGDs:

- Who is considered an older person in your community? What makes them an older person? (Try to determine if there are differences in what determines old age for men and women.)
- What are the essential activities undertaken by older men and older women?
- Do older men/older women own property and homes? Do older men/older women control household income?
- Which decisions in the home do older men and older women typically make? Which decisions in the community do older men and older women typically make?

- What are some examples of the way older persons experience abuse?
- Do older men and older women experience the same type of violence?
- Where does older person abuse occur ? Who is committing the violence against older women? What about older men?
- Do older persons seek help when they are experiencing abuse? If not, why not? Does this vary for older men versus older women?
- What role does stigma play in influencing whether or not an older person reaches out for help? Does this vary for older men versus older women?
- Are there accessibility barriers to older people getting help? Does this vary for older men versus older women?

Note that you are unlikely to be able to integrate all of these questions into a broader FGD. If the team feels that all of these questions are critical to meet your needs, consider doing standalone FGDs specifically relating to older adults and their needs. If you do integrated groups, choose 4–5 questions at most to integrate into the FGD.

Standalone FGDs

If standalone FGDs for older persons and their caregivers will be completed, given staffing and space considerations, it would be helpful to host separate focus groups for caregivers and for older persons[1] at the same time at the venue. This can create a safe space for each group to explore their different concerns, may decrease the demands on caregivers who now would not need to come on multiple days and increase the participation of people who are not used to being separated from their caregivers. If this is not possible, you may assess feasibility of hosting the groups on separate days or at different times. You should prioritize hosting groups for older persons if you are unable to manage groups for both caregivers and older persons.

Description of Groups	Recommended Number of Participants
Female Caregiver	8–10 Participants
Male Caregiver	8–10 Participants
Male Older Persons	8–10 Participants
Female Older Persons	8–10 Participants

GROUP ACCESSIBILITY AND PARTICIPATION

Group discussions should ideally be conducted with men and women separately, or include breakout sessions, to gather in-depth information about their specific and varied needs. When conducting groups with older persons, adaptations will need to be made to ensure their ability to participate. Assess the need for easy-to-read forms, practice communication methods with older adults beforehand, and build in more time for explanation in the beginning if necessary.

Ensure enough time to explain the FGD and its purpose and to obtain consent from the participants. Refer to Annex 6: Inclusive Communication Tip Sheet, Annex 7: Removing Communication Barriers and Annex 8: Capacity to Consent Flowchart to ensure teams are taking the necessary steps to ensure understanding.

[1] Based on IRC GBV and Disability toolkit and European commission, *Gender-Age Marker toolkit.*

Teams can use existing consent forms for the FGDs; however, these may need to be modified into an easy-to-read format. Older persons with hearing or vision impairments may need additional accommodation to ensure understanding and ability to give consent (e.g., sign interpreter, verbal reading, and explanation of the consent form, etc.)

Older persons with different types of disabilities can participate in the same group discussion, according to their communication skills and preferences. No matter if separate or integrated FGDs take place, make sure the older persons with disabilities have been asked about reasonable accommodation and accessibility needs. Ensure preparation ahead of time to meet these needs, including easy-to-read forms, other adapted materials, and alternative activities to facilitate these discussions. Remember that older persons with different types of disabilities will need different adaptations to facilitate effective participation. Some examples include:

- Male or female older persons with physical disabilities
- People who are Deaf/deaf and use sign language to communicate
- Persons with intellectual disabilities who might prefer to use drawing, stories, or photos to stimulate discussion

When older persons with these needs are participating, smaller groups (4–6 participants) may be necessary. Group methods should be assessed and adapted beforehand to meet the needs of these participants and any interpreters arranged beforehand. Ideally, interpreters also meet and review the content with the FGD facilitators beforehand.

TIMING OF GROUPS

Group discussions are best conducted with 8–10 participants and should not last longer than 90 minutes. If teams have integrated questions and facing time limitations, determine ahead of time which questions you may need to cut. Try to cut questions from both the general questions asked to everyone and questions specific to old age. Do not simply cut questions regarding older persons and old age.

If teams are conducting the full FGDs on older persons and groups take longer than this to complete all activities in the Group Discussion Guide (see below), you may wish to conduct Parts A and B on one day, and Parts C and D another day, if participants are willing and able to return.

INTRODUCTION TO FOCUS GROUP

For any focus groups—older persons and caregivers, general FGDs with integrated questions—you should follow the standard guidelines for FGD introduction in your FGD tools. It may be useful to modify your approach with older persons and those with disabilities using the Instructions to Conduct an Accessible FGD and KII.

FACILITATOR'S GUIDE:

FOCUS GROUP DISCUSSION WITH OLDER PERSONS

INTRODUCTION

10 minutes

See your existing FGD guidelines for introducing yourself and your team and setting the frame for the focus group. Use this tool to ensure your FGD is accessible.

Have each of the participants introduce themselves and, if they would like, share what it means for them to participate in the group and why it is important to them.

PART A:

AGE DEFINITION IN YOUR CONTEXT

30 minutes

Guiding Question 1: Who do you consider as an older person within your community?

Facilitation: Ask participants to tell you about older persons in their community. Try to understand if there are differences between age for men and women. In displacement setting, ask if this is different from the area of origin.

Handout Activity – Age Definition: Put some paper on the wall with examples of elements, which could contribute to age definition and ask them to designate the ones that are applicable to their community.

Purpose: This question will help us understand the social definition of age in your specific context.

Guiding Question 2: How do you designate an older person within your community? [i.e., elderly, older person, elder, etc.]

Facilitation: Ask participants if there are terms or ways of referring to older persons within their communities. Which ones are positive and negative? Which terms would be best to use or worth using to interact with an older person? Why? In a displacement setting, ask if this is different from the area of origin.

Purpose: Ensure context sensitivity in language.

Guiding Question 3: What are the essential activities undertaken by older men and older women?

Facilitation: Ask group members to list as many essential activities that they undertake in their daily or weekly routines, either at home, or as members or staff of an organization. List these on a chalkboard or chart paper, separated by sex. In a displacement setting, ask if this is different from the area of origin. Take note of the differences in your notes.

Purpose: Understand the activities undertaken by older men and women within the community and family.

Guiding Question 4: Do older women own property and homes? What about older men?

Follow-Up Questions to Support the Discussion :

- Do older women control household income? What about older men?
- Which decisions in the home do older women typically make? Which decisions do older men usually make?
- Which decisions in the community do older women typically make? Which decisions do older men make?

Facilitation: In displacement settings ask if this is different from the area of origin.

Purpose: Understand the level of access to and control of resources for older men and women within the community.

PART B:

PERCEPTION OF ABUSE OF OLDER PERSONS

20 minutes

Guiding Question 1:

Now we are going to talk about abuse of older persons in the community/when older persons are hurt. I will provide some examples of the way abuse of older persons (or use term identified by the group) often manifests. Do you see examples of this in your community? If so, what are some examples of the way older persons experience abuse?

Purpose: Gain an understanding of manifestations of older person abuse in your context.

Facilitation: Put on the wall the categories and definitions of abuse of older persons from the handout. Begin by explaining to participants the ways older person abuse may manifest. You can refer to the handout that describes the forms of older person abuse and provide examples of abuse.

Facilitation: Ask participants to talk about the different manifestations of the type of violence in their community. In displacement settings ask if this is different from the area of origin.

Handout: Signs depicting forms of older person abuse and definitions.

Follow-Up Questions to Support the Discussion:

- Are older persons experiencing any type of violence represented on the wall in your community? In some families? Ask participants to think about older women and men, and label the violence type according to whether it's men, women, or both that experience it.
- What are some examples of the ways these types of violence occur?
- Are they experiencing other types of violence in your opinion which are not represented on the wall?
- Do older men and older women experience the same type of violence?
- Where does it occur?
- Who is committing the violence against older women? What about older men?
- Why do you think it happens to them?
- What are the consequences of such violence in families and communities?
- Do you think there are "seasonal" influences or patterns on abuse, for instance would abuse be related to the period of the month when a pension is cashed or around festivities that can trigger special stress in the community such as religious holidays, festivals, etc.?

PART C:
RESPONSE TO OLDER PERSON ABUSE

20 minutes

Guiding Question 1: Do older persons seek help when they experience elder abuse?

Purpose: Understand key strength and capacities of older persons experiencing violence. Understand the availability of services to respond to violence against older persons. Suggestion of activities to address the needs of older persons/caregivers.

Facilitation: Ask participants how older persons seek to address the abuse taking place in the community and if this is effective or not.

Follow-Up Questions to Support the Discussion:

- Do older persons seek help when they are experiencing abuse? If not, why not? Does this vary for older men versus older women?
- What role does stigma play in influencing whether or not someone reaches out for help? Does this vary for older men versus older women?
- Are there accessibility barriers to older people getting help? Does this vary for older men versus older women?
- What are examples of the types of sources of help in the community for addressing older person abuse? Are these sources helpful? Are there limitations?
- Is confidentiality a problem in seeking services?
- What type of services or assistance do you think would be helpful to provide in supporting older persons in the community experiencing or at risk of experiencing abuse?

WRAP UP

10 minutes

Thank participants for attending the focus group, share what you learned from them and how it will help to improve the program's work in the community with older persons.

Have each participant share what they got out of the focus group and what it meant to them.

AGE DEFINITION (QUESTION 1)

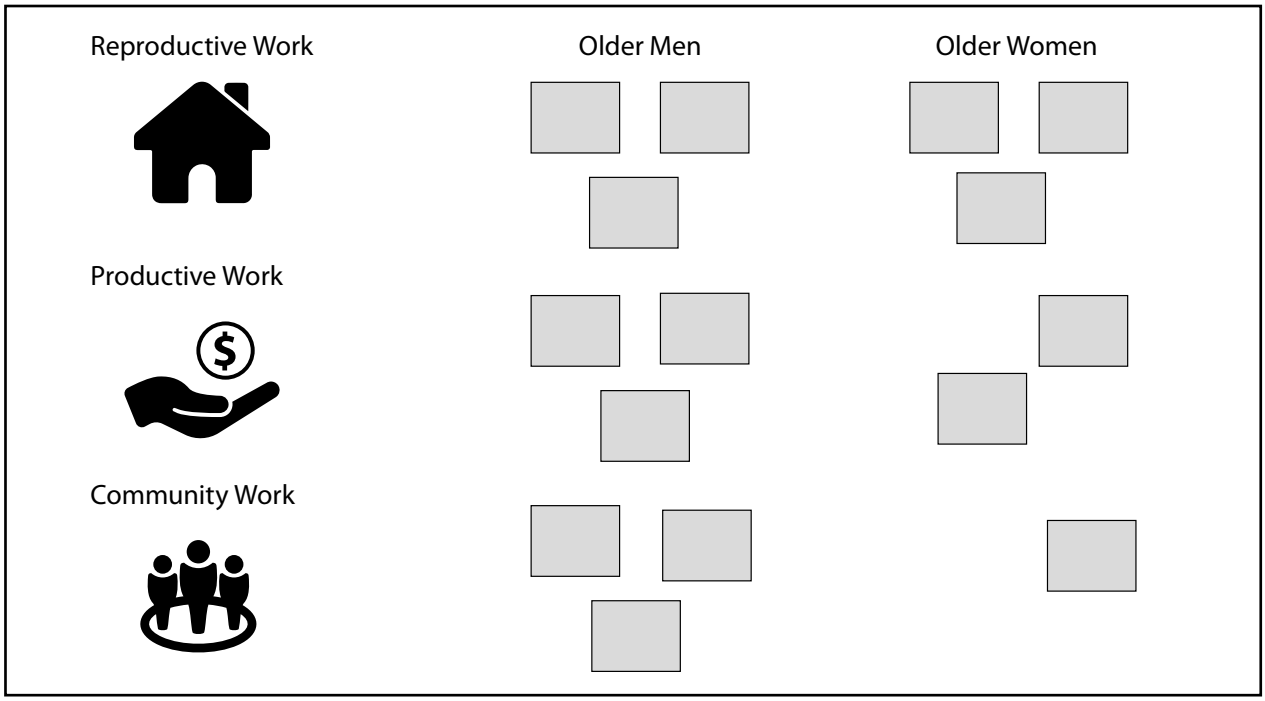
- Someone who is above ☐ years old
- Someone with a lot of experience in life
- Someone who has grandchildren
- Someone who owns assets
- Someone who owns a house
- Someone whose health status is declining
- Someone with mobility issues
- Someone who cannot work anymore
- Someone who depends on others on a daily basis
- Someone who has trouble understanding or gets confused easily
- Someone who is retired and earning a pension
- Someone who looks "old," with grey hair or wrinkles

AGE DEFINITION (QUESTION 3)

Ask participants to write on post it activities undertaken by older persons in the community. Ask them to then organize them next to the appropriate picture. Once organized ask participants to vote for the top three activities in terms of time on a daily basis for older men and women.

If adapting to meet literacy needs, a facilitator can ask participants to draw on the sticky notes or to call out activities while a co-facilitator writes down the responses. Participants can then direct the facilitators on where to put responses in terms of appropriate pictures.

Example of wall setting:



PERCEPTIONS OF ABUSE OF OLDER PERSONS (QUESTION 2)

PHYSICAL ABUSE

Physical Abuse is any act causing physical pain or injury to an older adult.

PSYCHOLOGICAL OR EMOTIONAL ABUSE

Psychological or Emotional Abuse is an intentional verbal or nonverbal act causing emotional pain, distress, or injury, or diminished self-esteem and dignity. It includes threatening or coercive actions that create a power imbalance between the individual of trust and the older adult.

NEGLECT

Neglect is the intentional or unintentional failure to provide for an older adult's basic needs such as food, water, clothing, hygiene, shelter, social interaction, and essential medical care.

FINANCIAL ABUSE

Financial Abuse includes fraud and the misuse, theft or exploitation of an older person's money, property, social benefits, possessions, or other assets.

SEXUAL ABUSE

Sexual Abuse is any kind of sexual contact to which the older person did not consent, was unable to consent, or was forced to consent. It includes non-consensual sexual interactions and any conduct based on sex or of a sexual nature.

FACILITATOR SUPPORT DOCUMENT:

INFORMATION SHEET ON OLDER PERSON ABUSE

Abuse of older persons can take a variety of forms and can be broken down into five different categories: financial abuse, psychological or emotional abuse, physical abuse, sexual abuse, and neglect. However, incidents of abuse may fall into more than one category and are often cross-cutting.

The most common forms of older person abuse are emotional/psychological abuse and financial abuse. In many cases, however, an older person will experience more than one type of abuse at a time, and it is important to assess for abuse along all categories listed below.

Financial Abuse includes fraud and the misuse, theft, or exploitation of an older person's money, property, social benefits, possessions, or other assets.

EXAMPLES:

- Stealing the money or possessions of an older person
- Selling or transferring property without the informed consent of the property owner
- Forging an older person's signature
- Forcing or deceiving an older person into signing a legal document or agreement
- Misuse of power of attorney, guardianship or other legal role designated to represent the interests and care of an older person

Psychological or Emotional Abuse is an intentional verbal or nonverbal act causing emotional pain, distress or injury or diminished self-esteem and dignity. It includes threatening or coercive actions that create a power imbalance between the individual of trust and the older adult.

EXAMPLES:

- Verbal assaults, insults, disrespect, or humiliation
- Use of threats, intimidation, or coercion
- Treating an older person like a child
- Isolating an older person from family, friends, regular activities, or services
- Excluding an older adult from making her or his own choices or decisions even though they are capable

Physical Abuse is any act causing physical pain or injury to an older adult.

EXAMPLES:

- Actions such as hitting, slapping, kicking, or pushing
- Misuse of medication/s
- Inappropriate use of physical restraint
- Any type of physical punishment

Sexual Abuse is any kind of sexual contact to which the older person did not consent, was unable to consent or was forced to consent. It includes non-consensual sexual interactions and any conduct based on sex or of a sexual nature.

EXAMPLES:

- Sexual harassment
- Sexual assault
- Forced nudity
- Taking sexually explicit photos
- Unwanted touching

Neglect is the intentional or unintentional failure to provide for an older adult's basic needs such as food, water, clothing, hygiene, shelter, social interaction, and essential medical care.

Within the broader category of neglect, advocates often distinguish between active, passive, and self-neglect.

- **Active neglect** describes an intentional failure to provide care.
- **Passive neglect** involves the unintentional failure to provide care, which can be due to lack of knowledge or awareness, poor caregiving skills, illness, or other causes.

EXAMPLES:

- Failure to provide needed aids such as eyeglasses, hearing aids, or other items
- Poor hygiene of older person
- Insufficient supervision or safety measures
- Withholding medical treatment or services
- Abandonment
- Caregiver is unable to adjust to changing abilities of older person in their care
- Caregiver presents with life stressors that prevent him/her from being able to care for older person

FACILITATOR'S GUIDE:

FOCUS GROUP DISCUSSION WITH CAREGIVERS

This guide will be used for focus group discussions with caregivers and/or support persons. Facilitators should practice these FGDs before conducting them. Participants in the practice session can be other staff members and they should be prepared to give feedback to the facilitators. Supervisors should observe practice sessions and give feedback as well.

INTRODUCTION

10 minutes

See guidelines at the start of this section for introducing yourself and your team and setting the frame for the focus group.

Have each of the participants introduce themselves and, if they would like, share what it means for them to participate in the group and why it is important to them.

EXERCISE 1:

MYTHS & TRUTHS ABOUT OLDER PERSONS AND ABUSE OF OLDER PERSONS

20 minutes

Purpose: To understand existing beliefs about older persons and elder abuse and to identify areas of consensus and disagreement within the group.

Steps for facilitator: Place three signs up around the room, one with the words "I AGREE," one with "I DISAGREE," and one with "I DON'T KNOW" or with images that represent these concepts.

Facilitation: Ask the participants to explore their understanding of older persons. If they agree with the below statement, they should stand by the sign with "I AGREE." If they disagree with the below statement, they should go to the sign with "I DISAGREE."

Read out loud the following statements and ask participants to move to the sign that represents their opinion about the statement. Ask a few participants on each side to explain their opinion. Probe about how common the belief is within the community. The facilitator may ask questions to stimulate discussion, but it is not necessary to provide "correct" answers.

- **OLDER PERSONS ARE KIND OF LIKE CHILDREN.**
  - ☑ **Probe:** How often do you hear this statement in the community—always, sometimes, or never?
  - ☑ **Probe:** When you hear this in the community are they speaking about older women, lder men or both?
- **OLDER PERSONS SHOULD NOT HAVE ANY FINANCIAL RESOURCES FOR THEMSELVES, THEY SHOULD GIVE EVERYTHING TO THEIR FAMILY MEMBERS BECAUSE THEY NEED IT MORE.**
  - ☑ **Probe:** How often do you hear this statement in the community—always, sometimes, or never?
  - ☑ **Probe:** When you hear this in the community are they speaking about older women, older men or both?
- **IT IS A WOMAN'S PLACE TO TAKE CARE OF OLDER PERSONS IN THE FAMILY, AND THEY SHOULD HAVE PRIMARY RESPONSIBILITY FOR THIS ROLE. THEY SHOULD NOT ASK FOR HELP FROM OTHERS OUTSIDE THE FAMILY.**
  - ☑ **Probe:** How often do you hear this statement in the community—always, sometimes, or never?
  - ☑ **Probe:** What is the role of older men in the family?

ELDER ABUSE DOES NOT EXIST IN OUR COMMUNITY BECAUSE WE HAVE A TRADITION OF RESPECTING OLDER PEOPLE.

- ☑ **Probe:** How often do you hear this statement in the community—always, sometimes, or never?
- ☑ **Probe:** What does respect for an older woman look like? What does respect for an older man look like?
- ☑ **Probe:** What happens when an older woman is not respected? What happens when an older man is not respected?

VIOLENCE IN THE HOME IS A FAMILY MATTER AND OTHERS SHOULD NOT GET INVOLVED.

- ☑ **Probe:** How often do you hear this statement in the community—always, sometimes, or never?

EXERCISE 2:
SOCIAL NORMS

15 minutes

Purpose: To understand social norms about older persons and older person abuse.

Facilitation: Thank participants for sharing all this information. Let them know that now you would like to ask about their community. You will be asking about community members who are people who live near them, who they see often, and who are not part of their home or family.

- How do community members describe older persons? What terms do they use? Does this differ for older women versus older men?
- What do community members say about older women? What about older men?
- Have you ever heard a community member say something about the older person you are caring for that you found hurtful? What did they say?
- If community members hear of a case where a family is abusing or neglecting an older person, what would they do? What would community members do or say to the family members of the older person who is being hurt? Who would they tell? Would this vary depending on if it was a man or woman?

EXERCISE 3:
FREE-LISTING CHALLENGES FOR CARETAKERS/SUPPORT PERSONS

30 minutes

Purpose: To create a list of the challenges that caregivers and support persons experience when providing care.

Facilitation: Explain that you want to better understand how to support caregivers. Ask participants to think about some of the challenges they are experiencing in their role as a caregiver/support person. What are some common challenges that caregivers/support persons experience when providing support to an older person? To an older person with disabilities? Why is it a challenge? When they think of an answer, they can share it with the group, and we'll make a list together.

1. Participants suggest challenges. The facilitator writes down the challenges onto sticky notes. The facilitator continues until 8–10 challenges have been identified, or until the group has no additional suggestions.
2. The facilitator should probe to get more information about the challenges identified, for example:

    a. Probe: Where does this challenge take place (in the home, in public, where in public)? Who experiences this challenge? (Caretaker, support provider, or both? Father, mother, sibling, or other relative? Age? Gender?)

3. The facilitator will place the sticky notes with the different challenges into groups based on similar themes/categories and confirm that the participants agree with these categories/themes.

Facilitation: Explain that that they have a list of challenges, let's think about the impact of each of these challenges. Who does this challenge impact, and how? What does this challenge mean for your daily life as the caregiver/support person? What is the impact for the person you support?

1. Use a different color sticky note to write down the impact and place it next to the relevant challenge.
2. Probe for each challenge: How does this affect the wellbeing of the older person we care for? For example, if it affects you as the caretaker or the support person, how does this relate to the well-being of the people we care for?

Facilitation: Explain that now you would like the group to think about which are the most important to address for the well-being of their families. Draw a line on the paper, and instruct them to place the challenges on that line based on which are the most important to address for caregivers.

For example, at the top of the line would be the main challenge you think needs to be addressed the most, and at the other end would be the challenge you experience the least frequently or that is the least urgent to address, and the rest would be placed in between.

Explain that they will all have the chance to talk together about the best order for the challenges, and will decide as a group. Ask if they have any questions on what they're going to do?

1. Participants then take the sticky notes and place them on the line, one at a time. When someone places a sticky note, the facilitator asks the rest of the group if they agree, and a sticky note can be re-ordered based on the discussion that takes place. Careful notes are taken as the group discusses and debates placement of items. This process continues until everyone agrees on an order.
2. As participants make suggestions, the facilitator prompts them for examples and further clarification of why particular challenges are prioritized. The facilitator should work to promote participation among all group members as much as possible, although not forcing anyone to speak if they are not comfortable, so that the discussion is not dominated by a few individuals.

Facilitation: Now that participants have a list of challenges and have ranked them in the right order, ask everyone to spend a few minutes talking about what skills or opportunities might help caregivers overcome these challenges. "For the various challenges we have identified, what would help you to overcome this?"

1. Use a third color sticky note to write down a suggestion and place it next to the relevant challenge.
2. Probe for each challenge: Resources? Skills? Other types of support?
3. At the end, if possible, take a picture.

Facilitation: Note that you also want to know what parts of being a caregiver makes them happy and proud to help an older person. Ask them to share some of the positive aspects of being a caregiver.

WRAP UP

10 minutes

Thank participants for attending the focus group, share what you learned from them and how it will help to improve the program's work in the community with older persons.

Have each participant share what they got out of the focus group and what it meant to them.

ANNEX 3:

SERVICES INCLUSIVITY ASSESSMENT FACILITY ASSESSMENT TOOL

This facility assessment tool is modified from the GBV Safe Spaces Inclusive Assessment tool. This tool should be completed with older persons in the community you serve.

DIRECTIONS

Preparing To Use the Tool

- Managers should assign two focal points (ideally staff who don't work in the facility) to complete the tool.
- Staff should review the tool in advance.
- Make sure to plan for reasonable accommodation prior to holding the focus group; please refer to the Introduction and the process outlined below to plan for reasonable accommodation. This may include organizing transport, planning for a support person to be present, planning for a sign language interpreter, or transcribing documents into braille. An older person will know best what they need, so ask directly!

Using the Tool

- This tool requires a focus group discussion.
  - **For GBV:** It is recommended to hold two focus groups: one with older women with disabilities and one with older women without disabilities.
  - **For Protection:** It is recommended to hold four focus groups: one with older women with disabilities and one with older women without disabilities, one with older men with disabilities, and one with older men without disabilities.
  - **For Child Protection:** It is recommended to hold one focus group with older adult caregivers.
- Each focus group should have one facilitator and one note-taker with a maximum of 10 participants in your group. Make sure to taken into account the diversity of participants and include older persons with disabilities, from a variety of backgrounds, socio-economic status, education, religious affiliation, language, ethnic group, and so on.
- Please note a couple of additional questions are available related to services received in the space. These questions should only be asked among a group of participants who have accessed the services of the facility prior.

Steps in Brief

- Identify the facility you would like to assess.
- Identify older persons from the community who are available to participate in the assessment. They may include those already receiving services (or in the case of CP, older caregivers of children we are serving) and those we don't yet work with.
- **Plan for reasonable accommodation. See more below.**
- Invite older persons to the assessment.
  - Ask for their informed consent/assent for the focus group.
  - Do a tour of the space with the participants.
  - Ask participants about the space to gauge its accessibility.
  - Transcribe focus group discussion and type up notes.
  - Submit report to the program manager.

STEPS FOR THE PROVISION OF REASONABLE ACCOMMODATION

For the purpose of this tool, and following the guidance provided by the Inter-Agency Guidelines on Inclusion of Persons with Disabilities, the provision of reasonable accommodation will be provided according to the following process:

1. The possibility of requesting reasonable accommodation measures will be proposed by organization staff in advance to any meeting, interview, or focus group discussion; it will be also proposed, at any needed time, to any person with a disability who finds barriers to participating in the consultative process on an equal basis with others, and regardless of previous measures taken to make the consultative process as accessible as possible.

   E.g., "Would you require any adaptation or support to access this discussion and communicate during the interview with us?"

2. Requests will be managed on an individual basis and through an interactive and transparent dialogue, where persons with disabilities requiring reasonable accommodation will have an opportunity to express their requirements.

   E.g., "Yes, I am a deaf woman, and I use sign language."

3. Options to address identified barriers will be tailored to meet the person's requirements and designed together with the person.

   E.g., "Do you know any person who could do sign language interpretation for you, and whom you trust for this discussion, or would you like us to identify a professional sign language interpreter?"

4. Options to address existing barriers will then be evaluated, will given available resources, and will consider the following components: budget provisions, time required to develop the solution, and availability of service providers, technical or human resources required.

   E.g., "The sign language interpreter preferred by the person would require a financial contribution and transportation to the center."

5. A solution will be offered within given resources; this solution will be verified with the person, to find out if the proposed solution meets its purpose.

6. If a solution is found and can be provided within available resources, it will be provided.
7. If no solution is found, an alternative and/or equivalent way of participation will be proposed and verified with the person.
8. If no solution is finally found, the person will be given the option of participating, assuming that there will not be additional support, or withdraw their interest in participating, in which case the organization should send an apology to the person. In addition, the denial of reasonable accommodation will be objectively justified according to the following criteria:

   We regret not being able to provide this adaptation…

   - It is impossible to provide this adjustment because it is not available (in context); OR…
   - It is impossible to provide this adjustment because it is not affordable given available financial resources dedicated to this project; OR…
   - It is impossible to procure this adjustment in time to meet its purpose; OR…
   - It is illegal to provide this adjustment (e.g., requiring a personal assistant or family member who has to cross a border without having adequate documentation).

IRC SAFE SPACES FACILITY ASSESSMENT

Introduction

- Hello, my name is ..... and I work with (Organization Name) . Can I ask you to participate in a group discussion? It will take about one hour.
- I want to talk with you today about the facilities at (Organization Name) to understand your perception of safety and accessibility. We are interviewing older persons to understand how they access and use the facilities at _(Organization Name) to make them better.
- We will do a tour of the space and then I will ask you a series of questions and this information will be compiled with others and shared with our head office.
- I cannot promise all your recommendations will be implemented, but they will inform our planning for the future.

Confirm Consent and Confidentiality

- Your participation in this discussion is voluntary.
- You are not obligated to respond to any questions if you do not wish.
- You are not obligated to share personal experiences if you do not wish.
- If you do have a sensitive situation you want to share, [Name of Service Providing Organization] is available to speak with you after the group discussion. We can refer you to [Name of Service Providing Organization]'s social worker/protection team. I am able to do so.
- Our discussion is confidential and anonymous; your name will not be listed on our notes.
- This discussion will be audio recorded. (Note only where audio is planned for.)

- If you have any concerns about this interview and how it is conducted, you can contact the management team using the numbers listed on this brochure.
- We will have a note taker during the discussion to ensure that the information collected is accurate.
- Do I have your consent to proceed?

Tour of the Facility

- I would like to show you around our facility where we provide services to (insert relevant group).
- As we move around the facility, I would like you to consider three things: (1) whether or not it was easy to enter the facility, (2) whether or not it is easy to move around the facility, and (3) what information is available to you in the facility and whether it is easy to understand.
- Do you have any questions about the tour?
- Great! Let's start. (Take participants on a tour of the space, or if that is not possible, have a pictoral representation of the space and show them all the spaces. You may wish, for example, to take pictures of the space, and to have copies of the materials you use with clients available.)

Discussion About the Space

- How did you find information about the [Organization's] services? Was information easy to understand?
- Did you try to contact [Organization Name]? Was it easy for you to get in contact with us and have the information you needed? If not, did you face any problem?
- How did you arrive at this space? Did you face any problems in getting here? (e.g., difficulty finding the facility, difficulty leaving home, difficulty finding transport, and so on).
- How was it to enter the facility? Were there any problems?
- How was it to move around in the facility? Were there any problems?
- Was information available to you in a way you could understand about the services available here (pictorial information, braille, and so on)?
- Are there any safety concerns with this facility (e.g. leaking water, slippery floor, exposed wires, stair-only access, etc.)?
- What would you change about this facility so that all women and girls could use it equally?
- I'm going to ask for your overall rating of this facility by showing you three pictures. One picture is of a smiley face, one picture is of a concerned face, and one picture is of a sad face. I will show you each image and ask you to raise your hand to indicate which one picture reflects how you feel about the space.
  - Here is a picture of a happy face, raise your hand (or indicate in another way) if you are generally satisfied with this facility, meaning it is comfortable and accessible for you.
  - Here is a picture of a concerned face, raise your hand (or indicate in another way) if you think the space is okay but have some substantial concerns, meaning it needs improvements to be safe, comfortable, and accessible for you.
  - Here is a picture of a sad face, raise your hand (or indicate in another way) if you think this space is not safe, comfortable, or accessible for you.
- How do you access information about [Organization's] services?

Additional Questions for Older Persons Who Have Accessed the Services Previously

- Did the persons who provided you with a service treat you with dignity and respect?
  - Here is a picture of a happy face, raise your hand (or indicate in another way) if you feel you were treated with dignity and respect
  - Here is a picture of a concerned face, raise your hand (or indicate in another way) if you think you were treated okay, but there is room for improvement.
  - Here is a picture of a sad face, raise your hand (or indicate in another way) if you think the service providers did not treat you well.
- Have you safely received the services you need?
  - Here is a picture of a happy face, raise your hand (or indicate in another way) if you feel you received the services you needed.
  - Here is a picture of a concerned face, raise your hand (or indicate in another way) if you think you were received some, but not all, of the services you needed.
  - Here is a picture of a sad face, raise your hand (or indicate in another way) if you did not receive any of the services you needed.
- Did our staff support you if you experienced any difficulty while accessing our services?
  - Here is a picture of a happy face, raise your hand (or indicate in another way) if you feel you received the support you needed.
  - Here is a picture of a concerned face, raise your hand (or indicate in another way) if you think you received some, but not all, of the support you needed.
  - Here is a picture of a sad face, raise your hand (or indicate in another way) if you did not receive any of the support you needed.

Thank You and Closing

- Thank you for taking the time to meet with us today.
- Is there anything else you'd like to share?
- There is someone here today who can help you if you are feeling uncomfortable after our discussion. Please come talk to me afterwards, and I will introduce you.
- Do you have any questions?
- Thank you again for meeting with us. Your feedback will help improve our services.

ANNEX 4:

ACCESSIBILITY & SAFETY CHECKLIST FOR OLDER ADULTS

This checklist can be used as a supporting tool for the services inclusivity assessment. It provides a framework to assess a facility through direct observation. Older persons may experience barriers to services that are important to take into consideration and these may not be apparent without particular guidance on what to assess and look for to ensure accessibility. By assessing and supporting clients to access a specific service we are ensuring our services are client-centered and uphold our client's participation and safety.

How To Use the Form To Assess Physical Accessibility?

- Staff should have received training on protection principles and inclusion and have been trained on how to administer the form prior to use.
- To complete the form staff will have to walk through the physical space or center. At least two staff members should complete the form independently and then cross-reference it with their colleague at the end. A discussion should take place where they have come to different conclusions.
- Based on the findings, compile a list of the key barriers to access and the key recommendations to enable access to the facility. The list should include reasonable accommodations that may be required for clients to access the facility. Make sure to share these with staff who will update the service-mapping template.

PHYSICAL BARRIERS

Please check yes or no for each box. If the question is not relevant, check N/A and provide a brief explanation.

REACH:

THIS SECTION ADDRESSES REACHING SERVICES, INCLUDING ACCESSING INFORMATION AND TRANSPORT TO/FROM

Ask what information is available in different formats and how everyone, including people with disabilities, can reach the service. Yes / No / n/a

REACH: Information

❓ Are outreach or awareness activities conducted in the community regarding the services available?
☐ Yes ☐ No ☐ n/a

IF YES, please describe the channels you use (check all that apply):

a. ☐ Community meetings
b. ☐ Local radio
c. ☐ Billboards
d. ☐ Leaflet and brochures
e. ☐ SMS

f. ☐ Email

g. ☐ Through staff member

h. ☐ Through community volunteers

i. ☐ Through local leaders

j. ☐ Other (please specify): ____

❓ Is specific outreach done for people who are caregivers, non-literate, older persons, and people with disabilities regarding the available services? ☐ Yes ☐ No ☐ n/a

IF YES, does the outreach involve alternative communication channels such as sign language translation or availability of documents in braille or easy-to-read formats? ☐ Yes ☐ No ☐ n/a

IF YES, please describe:

❓ Do you have a hotline? ☐ Yes ☐ No ☐ n/a

❓ Does the hotline offer options for alternative forms of communication? ☐ Yes ☐ No ☐ n/a

REACH: Physical Access

❓ Is transportation available to assist someone to reach the service? ☐ Yes ☐ No ☐ n/a

IF YES, please circle the type of transportation (check all that apply):

a. ☐ Public transportation

b. ☐ Walking accompaniment

c. ☐ Personal vehicle

d. ☐ Hired car, i.e., taxi

e. ☐ Other (please specify):

❓ Is the facility clearly signposted? (e.g., The building has a clear sign. The entrance is easy to identify.) ☐ Yes ☐ No ☐ n/a

REACH: Safety

❓ Are there any potential threats along the road for someone with mobility issues travelling to this facility? (i.e., checkpoints from key towns/villages, poorly surfaced or uneven road, heavy traffic, etc.) ☐ Yes ☐ No ☐ n/a

IF YES, what?

ENTER, CIRCULATE, & USE THE SPACE:

THIS SECTION ADDRESSES ACTUAL BUILDING STRUCTURE AND INTERNAL FACILITIES.

Can all persons, including persons with a disability, easily enter the space, use, and circulate inside the space including the bathrooms? Yes / No / n/a

ENTER: Physical Access Considerations Related to the Entrance

❓ Please verify the following, place a check mark where each item is available:

a. ☐ Gate is easy to open once entrance is allowed.
b. ☐ Gate is secure or guarded.
c. ☐ Door is easy to enter (no less than 800mm in width, without lip or stair).
d. ☐ Stairs are clear of material and safe to use (e.g., non-slip surfaces, presence of handrails).
e. ☐ Step edges are highlighted.
f. ☐ Stairs are slip resistant.
g. ☐ A ramp is available, safe, and easy to use independently (e.g., non-slip surfaces, presence of handrails, not too steep).
h. ☐ Entrance door handles are mounted 800–900mm above the floor.
i. ☐ Door handles are easy to use (not round).
j. ☐ Ramp is at least 1000mm in width (1800mm is ideal).
k. ☐ Entrance is free of obstructions.
l. ☐ Entrance is well-lit.
m. ☐ Main entrance is clearly sign-posted.
n. ☐ Other/Comments (Are there any other hazards not mentioned or further details on any aspects listed as No? Please specify.):

ENTER: Safety

❓ Are there any safety concerns within the facility? (e.g., leaking water, slippery floor, exposed wires, stair only access etc.) ☐ Yes ☐ No ☐ n/a

IF YES, please specify the safety and accessibility concerns present:

CIRCULATE & USE: Safety and Dignity

❓ Are separate male and female bathrooms available in the facility? ☐ Yes ☐ No ☐ n/a

USE: Dignity

❓ Are the bathrooms clean? ☐ Yes ☐ No ☐ n/a

IF NO, what adjustments are required to ensure cleanliness?

❓ For the bathrooms, are there adequate supplies? (e.g., waste bin, soap, toilet paper, etc.)
☐ Yes ☐ No ☐ n/a

IF NO, what supplies are needed?

CIRCULATE & USE: Accessibility

❓ Are separate bathrooms accessible for males and females with disabilities at the facility
☐ Yes ☐ No ☐ n/a?

IF NO, what adjustments are required to ensure accessibility? (Circle those that apply.)

a. ☐ They are clearly sign-posted (includes pictures and not just words).
b. ☐ There are no exposed wires.
c. ☐ Water points are accessible.
d. ☐ Toilet paper/hose pipe is accessible from toilet.
e. ☐ The doors are wide enough to allow wheelchair access.
f. ☐ There are handlebars present close to the toilet and on the back of the door.
g. ☐ There is a ramp in addition to stairs to reach the bathroom if necessary.

Please specify additional features required:

❓ Are all areas of the facility accessible for all persons including persons with disability to move around from one room to another and across different floors. (Circle those that apply.)

a. ☐ They are clearly sign-posted (includes pictures and not just words)?
b. ☐ There are no exposed wires.
c. ☐ There is sufficient and safe space to wait in reception area.
d. ☐ Temperature is adequate (not too cold, not too hot).
e. ☐ Water points are accessible.
f. ☐ Lights are functional.
g. ☐ Wheelchair users can access all parts of the building.
h. ☐ Interior doors are wide enough for wheelchair users.

i. ☐ Door handles are mounted 800–900mm above the floor.

j. ☐ Door handles are easy to use (not round).

k. ☐ Materials such as posters, leaflets, etc. in the facility are available in a variety of formats (braille, pictorial, easy-to-read).

Please specify additional features if required:

COMPLAINT & FEEDBACK

Can all persons including persons with disability submit a complaint or provide feedback independently in a way, which preserves their anonymity and privacy? Yes / No / n/a

❓ Are the various channels for service users to submit a complaint or to provide feedback clearly marked in the facility? ☐ Yes ☐ No ☐ n/a

IF YES, please specify (consider whether different formats are being used):

❓ Are these complaint and feedback channels easily accessible for persons with disability to use independently? (Circle those that apply.)

a. ☐ They are mounted 800–900mm above the floor (complaint box, phone).

b. ☐ They are positioned in rooms which are wheelchair accessible.

c. ☐ They are clearly sign-posted in a variety of formats (braille, pictorial, easy-to-read).

d. ☐ Posters in the facility are in a variety of formats (braille, pectoral, easy-to-read).

e. ☐ They are positioned in a place which is private and preserves confidentiality.

Please specify additional obstacles if present:

SUPPORT OPTIONS & IDEAS TO ADDRESS BARRIERS

What support options are provided to address existing barriers? What additional ideas can be presented to address barriers? Yes / No / n/a

❓ Are any support options provided to address identified barriers? ☐ Yes ☐ No ☐ n/a

IF YES, are these provided by the agency providing the service? ☐ Yes ☐ No ☐ n/a

IF NO, are they provided by another agency? Please state who:

If support options are not provided to address identified barriers, what options may be able to address them?

ANNEX 5:

SIGNS AND SYMPTOMS OF ABUSE AND NEGLECT OF OLDER PERSONS

PHYSICAL

- Acute or immediate physical injuries, such as bed sores, bruises, abrasions, lacerations, punctures, burns and bites as well as fractures and broken bones or teeth
- Serious injuries that can lead to disabilities, including injuries to the head, eyes, ears, chest, and abdomen
- Gastrointestinal conditions, long term health problems and poor health status incl. chronic pain syndromes, headaches, and frequent somatic complaints
- Death, including femicide and AIDS-related death
- Malnourishment and/or dehydration (not related to deprivation conditions faced by the family or community)
- Smelling of poor hygiene

PSYCHOLOGICAL

- Depression
- Sleeping (too much or too little)
- Eating disorders
- Stress and anxiety disorders (e.g., post-traumatic stress disorder, panic attacks)
- Self-harm and suicide attempts
- Poor self-esteem
- Passive, unable to make decisions
- Resignation, loss of interest
- Shame
- Nightmares
- Numbing
- Sense of disconnection from their body, thoughts, feelings, and memories

SEXUAL

- Sexually transmitted infections including HIV
- Vaginal bleeding or infections
- Chronic pelvic infections
- Urinary tract infections
- Fistula
- Painful sexual intercourse and sexual dysfunction not commensurate with changes women may notice with age

SOCIAL

- Lack of social contact or activities
- Restricted access to telephone, food, bathroom, facilities, family, service providers and other activities outside the home
- Constant, overly protective, or overly watchful presence of the carer/family member
- Person frequently cancels social activities or events they expressed an interest in joining or had attended in the past

PSYCHOLOGICAL

- Depression
- Sleeping (too much or too little)
- Eating disorders
- Stress and anxiety disorders (e.g., post-traumatic stress disorder, panic attacks)
- Self-harm and suicide attempts
- Poor self-esteem
- Passive, unable to make decisions
- Resignation, loss of interest
- Shame
- Nightmares
- Numbing
- Sense of disconnection from their body, thoughts, feelings, and memories

FINANCIAL

- Possessions disappear
- Lack of money for food, necessary clothing, glasses, hearing aids, walking aids, or other necessities when income seems adequate to cover these items
- Pension or benefits checks withheld
- Older person reports they signed papers, but isn't sure what for
- Unexplained or sudden withdrawal of money from a bank account or loss of money from place it was stored

BEHAVIORAL

- Harmful alcohol and substance use
- Cringing or flinching behavior
- Rocking
- Crying
- Agitated
- Lack of eye contact

ANNEX 6:

COMMUNICATING WITH PEOPLE WITH DISABILITIES AND OLDER PEOPLE: TIP SHEET

INCLUSIVE LANGUAGE

To guarantee inclusion and respect of the human-rights-based approach of disability, it is essential to use appropriate vocabulary. To know what terminology to use, the best option is just asking the person what words they prefer/identify with. This can be different in different contexts and languages.

If this is not possible, as per the table below, it is recommended the use of "person-first language," which puts the person before their impairment. For example, we will say "person with disabilities" instead of "disabled."

Labels NOT To Use	Person-First Terminology
Handicapped/ Disabled/ PWD	Person(s) with disability/ies
Mental patient Mentally handicapped Mentally defective	Person(s) with psychosocial disabilities Person(s) with intellectual disabilities Person(s) with learning disability Person(s) with cognitive disability
Blind Visually impaired	Person who is blind Person with visual impairment, partially sighted person
Hearing impaired Deaf	Person with hearing impairment Person who is hard of hearing Person who is Deaf/deaf Person who experiences communication difficulties
Invalid/ Handicapped person Wheelchair bound/ confined or restricted to a wheelchair	Person with a physical disability Person who uses a wheelchair Wheelchair-user
Old person/ Oldies	Older person

COMMUNICATION TIPS

There are some general recommendations[1] to improve communication and interaction skills when interacting with older people and persons with disabilities:

- ☑ Do not make assumptions about the skills and capacities of persons with disabilities and older people; this can affect the way we communicate and interact with them. Remember that persons with disabilities are people, first and foremost. Just like all people, they have different opinions, skills, and capacities.
- ☑ Address older people and persons with disabilities in the same way as you talk to everyone else and speak directly to them, even if there is an interpreter or a caregiver.
- ☑ Use a normal tone of voice; do not patronize or talk down.
- ☑ Look at what they can do. This can often give insight into how they can communicate and participate in your activities.
- ☑ Ask first when offering assistance, wait until your offer is accepted before you help, and follow the instructions of the person.
- ☑ Be patient and let the person set the pace in talking and doing things.
- ☑ Greet persons with disabilities in the same way you would other people. For example, offer to shake hands (if culturally appropriate), even if they have an arm impairment or artificial limb.
- ☑ Be close to the person but keep an appropriate distance.
- ☑ Ask for advice. If you have a question about what to do, how to do it, what language to use or the assistance you should offer—ask them. The person you are trying to work with is always your best resource.

You should always support older people and persons with disabilities to participate in a survey, an interview, or submit feedback and complaints on their own behalf, and if required, you must provide reasonable accommodation. Alternatively, if an older person or a person with a disability requires and authorizes someone else (such as a caregiver, personal assistant, or family member) to participate, allow them to do so. However, you must always check with the person that their advocate has conveyed the correct message on their behalf and that you have understood it correctly.

In addition to these general recommendations, below are some tips when relating with specific difficulties:

People With Difficulties Seeing

- ☑ Always identify yourself and others who may be with you.
- ☑ Indicate when you move from one place to another and if you leave or return to a room.
- ☑ When conversing in a group, remember to say the name of the person to whom you are speaking to give vocal cues.
- ☑ Speak in a normal tone of voice.
- ☑ Avoid vague language, such as “that way” or “over there” when directing or describing a location.
- ☑ Let the person know when the conversation is at an end.
- ☑ Do not touch the person without asking.
- ☑ When you offer to assist someone with a vision loss, allow the person to take your arm to better guide this person.
- ☑ Use specifics such as "left at 2 meters" when directing.
- ☑ When offering seating, place the person’s hand on the back or arm of the seat.

[1] *Bridging the gap: Inclusive and accessible communication guidelines.* https://bit.ly/3kktPLt

EXAMPLE OF REASONABLE ACCOMMODATION:

Ask persons with vision impairments if they would like documents in alternative formats, such as Braille or large print. In some contexts where people have access to computers, persons with vision impairments may prefer electronic documents that are accessible through screen reader software (e.g., Word documents).

People With Difficulties Hearing

- ☑ Find out how the person prefers to communicate. People with hearing impairments may use a combination of writing, lip reading, and/or sign language. This can be done by following the person's cues to find out if they prefer and use sign language, gesturing, writing, or speaking or other alternative communication methods.
- ☑ Get the person's attention before speaking, by raising your hand or waving politely.
- ☑ Face and talk directly to a person who is deaf, not to the interpreter (as they are only facilitating the communication).
- ☑ Look directly at the person and speak clearly, slowly, and expressively without overreacting/overemoting to establish if the person can read your lips.
- ☑ Speak in a normal tone of voice; do not shout.
- ☑ Keep your hands and food away from your mouth when speaking. Avoid communicating while smoking or chewing gum.
- ☑ Try not to sit or stand with your back to the light; this can put your face in the dark and make it difficult to lip read.
- ☑ Try to eliminate background noise.
- ☑ Written notes can often facilitate communication.
- ☑ Encourage feedback to assess clear understanding.
- ☑ If you have trouble understanding the speech of a person who is deaf or hard of hearing, let him/her know, and offer to try again or use alternative communication methods.

EXAMPLE OF REASONABLE ACCOMMODATION:

Provide sign language interpretation.

People With Difficulties Communicating (Understanding or Being Understood)

- ☑ Ask the person (or if appropriate the persons accompanying them) about how best to communicate with them.
- ☑ Encourage the person to communicate in whatever way/s work for them and encourage them to ask questions.
- ☑ Check how the person indicates yes and no.
- ☑ Keep your manner encouraging rather than correcting.
- ☑ Allow extra time for communication and check understanding regularly. Do not attempt to finish a person's sentences; let them speak for themselves.
- ☑ Formulate simple sentences and use precise language incorporating simple words. Do not give too much information at one time. If necessary, ask short questions that require short answers or a nod or shake of the head.

- ☑ Use hand gestures, notes, easy-to-read forms, pictures/photographs.
- ☑ Be patient, do not speak for the person. Take the time necessary to ensure clear understanding and give time to put the thoughts into words, especially when responding to a question.
- ☑ Give the person time to respond to your question or instruction before you repeat it. If you need to repeat a question or point, then repeat it once. If this does not work, then try again using different words.
- ☑ Give whole, unhurried attention when talking to a person who has difficulty speaking. It is okay to say, "I don't understand." Ask the individual to repeat their point, and then say it back to them to check that you have understood it correctly.
- ☑ Always check if the person has understood and if you have understood him/her correctly. Verify responses to questions by repeating each question in a different way.
- ☑ Revisit any areas of misunderstanding and try to articulate more clearly and simply.
- ☑ Use real life examples to explain and illustrate points. For example, if discussing an upcoming medical visit, talk the person through the steps they are likely to go through both before and during the appointment.
- ☑ Give exact instructions: for example, "Be back from lunch at 12:30," not "Be back in 30 minutes."

EXAMPLE OF REASONABLE ACCOMMODATION:

Provide Easy-to-Read consent form and formats, if required ensure a support person is part of the process if needed.

People With Difficulties Walking (Including Wheelchair Users)

- ☑ When speaking with someone in a wheelchair, talk directly to the person and try to be at their eye level, but do not kneel. If you must stand, step back slightly so that the person does not have to strain his/her neck to see you.
- ☑ When giving directions to people with mobility limitations, consider distance, weather conditions, and physical obstacles such as stairs, curbs, and steep hills.
- ☑ Arrange the interview space to provide for movement in a wheelchair or other assistive devices.
- ☑ Do not lean on or move someone's wheelchair or assistive device without their permission.
- ☑ If a person transfers from a wheelchair to a car, toilet, etc., leave the wheelchair within easy reach. Always make sure that a chair is locked before helping a person transfer.
- ☑ Move at their speed. Do not walk ahead of them if they are moving slower than you.
- ☑ Discuss transportation options for activities and events. Consider what is going to be safest, most affordable, and the least amount of effort for the individual and family.

EXAMPLE OF REASONABLE ACCOMMODATION:

Provide transport cost if the location is not accessible.

More information on accessible communication product, meeting, and events, check this very useful guidance from the Bridging the Gaps initiative: https://bit.ly/3kktPLt

ANNEX 7:

REMOVING COMMUNICATION BARRIERS[1]

HOW TO
COMMUNICATE WITH PERSONS WITH A VISUAL IMPAIRMENT

- When meeting for the first time, introduce and describe yourself.
- Identify yourself so the person with the visual impairment knows who you are.
- If you get closer in your relationship, a blind person may want to feel your body features as part of getting to know you better.
- Inform the person if you are moving away. Do not leave without telling him or her that you are leaving.
- Describe the space you are in as well as any things you see to the person.
- Be specific in your descriptions. Say, "The table is in front of you", NOT "The table is here."
- Avoid comments like "over there" when giving directions. Rather, be specific and direct them to their right or left (and not your right or left).
- When you are in a group, tell them who is present, or let the group members introduce themselves.
- When conversing in a group setting, address persons by their names.
- When you are talking in a group, use the person's name when you are directing the conversation to him or her.
- Always talk directly to the person. Do not use a third person to answer your questions.
- Do not move things or leave things on the floor where someone can fall over them.
- Speak naturally and clearly. There is no need to shout.
- Avoid noisy places so that he or she can hear you clearly.
- Always ask first if the person wants help. Do not help someone without asking him or her first.
- For people with low vision use clear signs and documents. These can be in large letters or with letters that you can feel.
- For blind people who can read braille, you can give written information in braille.
- When preparing printed information for persons with low vision, ask the person his/her preferred formats for personal documents. General information is usually given in Arial, 18 point, bold.
- Do not be surprised to hear or scared to use phrases like "I will see you later." People who cannot see use such phrases, too.
- If you are at a table together for a meal, give a description of the food. If possible, describe where each food is on the plate.
- Do not play with or remove the white cane of a person who is blind from where s/he places it. If it is unavoidable for you to place the white cane elsewhere, remember to inform the person. S/he needs the white cane for mobility purposes.

[1] These guidelines are taken directly from the following resource. Light for the World. (2017). Resource Book on Disability Inclusion. Accessed at https://bit.ly/3j0pL2E. October 7, 2021.

- Avoid revolving doors. On stairs, assist by putting his/her hand on the railing. Let the person know whether the stairs are going up or down.
- To guide a blind person, walk alongside and slightly ahead of him/her. Do not hold the person's hand. Allow him/her to hold your arm. Bend your arm to your back when passing through a narrow space. S/he will get directly behind you to avoid obstacles.
- To seat a blind person, put the person's hand on the back of his/her chair. S/he will be able to sit. If the chair is backless, put his/her hand on the seat for him/her to be able to sit.

Most importantly, ask someone themselves how they want to be addressed and how they want to be supported or treated.

HOW TO
COMMUNICATE WITH PERSONS WITH SPEECH DIFFICULTIES

- Allow time for the person to speak. He may speak slower than you are used to.
- Avoid the urge to interrupt or complete the sentence for the person.
- Do not take over the conversation.
- If you do not understand what the person said, ask for repetition.
- Do not pretend you have understood if you haven't.
- Ask if there is somebody close by who may be able to interpret.
- If despite all your efforts, you are unsuccessful, ask if the message is urgent.

Most importantly, ask someone themselves how they want to be addressed and how they want to be supported or treated.

HOW TO
COMMUNICATE WITH PERSONS WHO ARE DEAF AND HARD OF HEARING

- Get the attention of the deaf person. Position yourself where they can see you. If they do not react, gently touch their arm or shoulder, or wave.
- Ask the person how he or she prefers to communicate.
- Face the person. People with hearing disabilities want to see your face so they may read your lips and see your facial expression. Get on the same level as the person (e.g., sit if the person is sitting). Do not put your hand in front of your face.
- Talk slowly to someone who has partial hearing.
- Stand nearby so the person who is hard of hearing may hear you in the best possible way.
- Ask short and clear questions that require short answers.
- Move to a quiet area so there is no or little background noise.
- Position yourself, the person, and (if present) their interpreter in a place where there is adequate lighting.
- Speak clearly and at usual volume. Do not shout.
- Check if the person has understood, for example by asking for feedback.
- Reword instead of repeating your sentence if he does not understand you the first time.

- Repeat key messages, e.g., by writing them down.
- Use facial and body expressions to support what you say.
- Face and speak directly to the person. Do not direct your speaking to the family member or interpreter of the deaf person.
- In your building, have clear signs to help deaf and hard of hearing persons identify where to go.
- Provide information in writing if the person can read and write. Have pen and paper with you just in case you need to communicate in writing.
- Do not call them even if they give you their mobile number. Rather, send text messages.
- Feel free to use phrases like "Did you hear?"

Most importantly, ask someone themselves how they want to be addressed, and how they want to be supported or treated.

HOW TO
COMMUNICATE WITH PERSONS WITH A PHYSICAL IMPAIRMENT

- Address the person who has a physical impairment, not his or her companion.
- Try to place yourself at eye level with the person (i.e., sitting in a chair or kneeling down). Particularly if you are engaged in a long conversation!
- Don't lean on a wheelchair or other assistive device. Treat the wheelchair as part of his/her body space.
- Do not give your items to a wheelchair-user to carry for you.
- Do not condescend to a person in a wheelchair by treating him or her childishly, such as patting on the head or shoulder.
- Ask if the person would like your assistance pushing the wheelchair.
- If a person is having a problem with opening a door, offer to assist.
- Ensure a clear pathway to intended destinations, and at meetings and restaurants, make a chair-free space at tables for a wheelchair-user to sit.
- When assisting a wheelchair user up or down a stair, ask if he prefers going forwards or backwards.
- When telephoning a person, let the phone ring long enough to allow time to reach the phone.
- Feel free to us words like "run" or "walk"; wheelchair users use them, too.
- Do not remove people's assistive devices (e.g., crutches, wheelchairs, artificial limbs) from where they have placed them. If you do temporarily, remember to return them to where the person has placed them initially.

Most importantly, ask someone themselves how they want to be addressed and how they want to be supported or treated.

HOW TO
COMMUNICATE WITH PERSONS WITH INTELLECTUAL DISABILITIES

- Keep in mind that there are different degrees of intellectual impairments, and some people function at higher levels than others.
- Be genuine.
- Take time and create trust first for the person to feel comfortable with you.
- Speak clearly and use short sentences and easy words.
- Repeat or rephrase what you have said.
- Use pictures or other visuals.
- Do not use a childish voice or exaggerate.
- Use easy-to-read material with simple messages and short sentences.
- Have a quiet and calm place for talking.
- Take your time and don't hurry.
- Use gestures and facial expressions. For example, look sad when you are talking about being unhappy.
- Be patient if the person also has a speech impairment.
- Check with the person if they understand what you are saying. You can ask if s/he understands what you have just said. If not, repeat yourself or reword your sentence, and check if your language is simple enough.

Most importantly, ask someone themselves how they want to be addressed, and how they want to be supported or treated.

HOW TO
COMMUNICATE WITH PERSONS WITH LEARNING DIFFICULTIES

- Some people have difficulties with writing, others with reading, writing or listening. These are specific learning impairments, not intellectual impairments.
- Such persons may be of average or above average intelligence.
- If a person reacts to situations in an unconventional manner, keep in mind that s/he may have limited processing skills which affect social skills.
- Allow him/her time to respond.

Most importantly, ask someone themselves how they want to be addressed and how they want to be supported or treated.

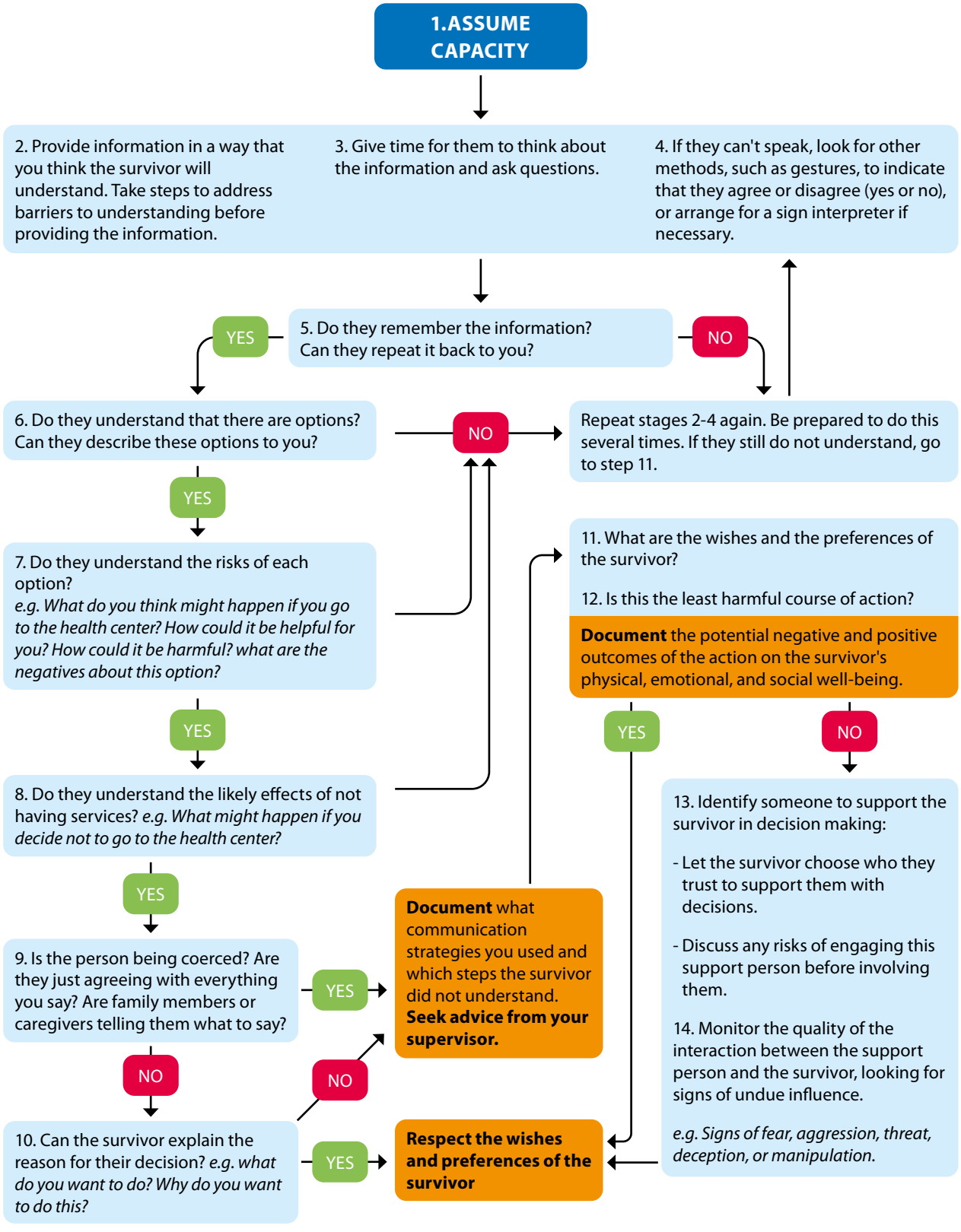
HOW TO
COMMUNICATE WITH PERSONS WITH PSYCHOSOCIAL DISABILITIES

- Social interaction may be difficult. Be non-judgmental; allow time for interaction and decision-making.
- If s/he appears unfocussed or speaks slowly, the person may be experiencing side-effects of medications or sleep disturbance.
- If the person is responding to events/perceptions that you do not share, he might have lost touch with reality.
- If she is displaying an unusual/inappropriate behavior, be calm and patient.
- Read the body language to assess the situation.
- Allow the person his/her space and avoid both direct eye contacts and touch.
- Empathize with his/her feelings without necessarily agreeing with what is being said, e.g., "I understand that you are frightened by your experiences…"
- Do not take things personally. The person may not have insight into his behavior or how it impacts others. Even if the person does, s/he may not have control over it.
- Ask how you may help.
- To minimize confusion, use short, clear and direct sentences. Keep your voice tone low and unhurried.
- Next time you meet, do not be afraid to talk with the person. Mental illnesses are not there all the time.
- Do not refer to what happened the last time. Relate normally.

Most importantly, ask someone themselves how they want to be addressed and how they want to be supported or treated.

ANNEX 8:

CAPACITY TO CONSENT AND BEST INTEREST FLOW CHART



ANNEX 9:

APPLYING THE SURVIVOR-CENTERED APPROACH TO WORKING WITH OLDER SURVIVORS

RESPECTING THE WISHES, RIGHTS, AND DIGNITY OF SURVIVORS

With the onset of older age, older survivors are more likely to experience medical health conditions or worsening of existing ones and/or acquire impairment (sensory, physical, intellectual, psychosocial), which could result in difficulties in functioning (for example in communicating or walking). In interaction with barriers (attitudinal, information, physical, and institutional), this could result to loss of autonomy, changes in social standing, and changes in social conditions.[1] Older survivors may face loss of loved ones, particularly partners and children. The cultural beliefs and norms reinforced by both ageism and gender inequality that interact with these losses can result in changes in perception of the older survivor and lead to further risks of discrimination (e.g., witchcraft accusations).

The individual and social changes that come with the onset of old age may make an individual case more complex but does not change the guiding principles. An older survivor should always be believed. The caseworker should affirm and validate survivors' experiences while clarifying they are never to blame for the violence they experienced. Survivors should be empowered through the case management process, with the caseworker affirming that the survivor knows what is best for them and the caseworker is here to listen and support them.

When working with older survivors, to assure their wishes, rights, and dignity are upheld, the caseworker should consider:

1. Communication[2]

Caseworkers must adapt their communication approach to the needs and desires of the older survivor. Caseworkers should never make assumptions about the communication needs of the older survivor. To communicate with the older survivors in a way that respects their wishes, rights, and dignity, utilize the following approaches:[3]

- Establish a rapport with older survivors by greeting them in a way that denotes respect in your context. Avoid using overly familiar relational terms that could sound patronizing. For example, a younger caseworker may want to avoid calling an older survivor by their name and instead use another local term that denotes respect linked to wisdom and experience. Some examples include using surnames, using names that denote roles, or using titles.
- Assure that the older survivor is comfortable, that the temperature in the space is appropriate (where it's possible to manage that), and that the seating arrangement is comfortable (e.g., sitting on a chair versus the floor).
- Ask older survivors if there is anything you can do to make the discussion more comfortable or whether they have preferred ways of communicating. Be prepared to take steps such as identifying an interpreter or speaking in a different way.

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1 *Humanitarian Inclusion Standards for Older People and People with Disabilities.* https://bit.ly/3BGThSi

2 See Annex 2: Inclusive Communication and Annex 3: Removing Communication Barriers for more information.

3 The below communication points are adapted from the National Institute on Aging. https://bit.ly/3Lvqvcm

- Build rapport. Introduce yourself but do not speak too slow or too quickly. Ask a couple of introductory questions to put the older survivor at ease rather than jumping directly into the reasons the survivor has come for services.
- Make sure the survivor can hear you. Do not shout or speak in a raised voice as this distorts language. Similarly, do not use a high-pitched voice as it is harder to hear.
- If appropriate for the context, face the survivor when speaking so that they can lip read or pick up on visual cues. Be conscious of how background noise may be affecting the communication.
- If you are changing the subject, give visual or auditory clues such as pausing briefly, gesturing toward something that will be discussed, or asking a question, as appropriate to the context.
- If possible, try to assure adequate lighting in the space, including on your face.
- Consider diverse forms of communication such as pictures or diagrams. If sharing forms with the older survivor, make sure the print is large enough for her to read, 14-point font is usually the minimum, and Arial, bold, 18-point font is recommended.
- Take your time asking questions and do not hurry the older survivor in their responses.
- Do not interrupt older survivors as they are less likely to divulge their experience and concerns once they have been interrupted.
- Be sensitive to language. Certain terms may have different meanings to older survivors based on their cultural or ethnic background. Words, for example "rape," may be understood differently or trigger a reaction in the older survivor.
- Be aware that older survivors may feel increased stigma or shame when disclosing their experience because they may believe these experiences don't happen to older persons. You may want to consider some specific healing statements such as "You are not alone in having this experience," Or "Some people may have trouble sharing their experiences because they believe this shouldn't have happened to them."
- At the end of the session, summarize the key points, clarifying next steps, what you will do, and what the survivor should do.

2. Caregiver Involvement[4]

Societal attitudes, stigma, and discrimination relating to older age may affect how a caseworker approaches an older survivor. While in many societies older women are afforded respect and dignity in a way they were not as younger women, the onset of an impairment or cognitive decline could mean that the older survivor enters a caregiving relationship. This typically means another younger woman from the family cares for the older survivor. A caseworker should never assume that an older woman engaged in a caregiving relationship is incapable of making decisions for herself or immediately defer to others to make decisions on her behalf. When caseworkers make assumptions about the older woman in a caregiving relationship, they risk not fully investigating her capacity to consent and reinforce disempowerment she may already be feeling.

There may be situations where an older survivor's caregiver might need to be involved in the case management process. However, this does not mean the older survivor herself cannot be empowered throughout the process. The caseworker should make sure to always:

- Address her questions to the survivor first.
- Ask permission from the survivor to consult with the caregiver from the very beginning and over the course of the conversation. Acknowledge that even if a survivor consents to caregiver involvement at one time, they can withdraw that consent.
- Check back in with the survivor throughout the process.

[4] This section has been adapted from GBV Disability Toolkit, Tool 8. Available at https://bit.ly/3vopE7n

3. Lifetime Experience of Violence and/or Loss and Change in Older Age

An older survivor may have a life course history of experience of violence. This may appear in several ways, for example, an older survivor who has experienced repeated incidents of intimate partner violence through the course of a long-term relationship or a survivor who experienced caregiver perpetrated violence as a child, incidents of IPV as an adult, and IPV or other forms of violence in older age. Evidence shows that life course history of violence, sometimes called poly-victimization, affects the long-term physical and mental health of the survivor.

Additionally, the older survivor may be traversing a period where they have lost a partner, family members, or close friends who are also aging. These losses are traumatizing and may be affecting the older survivor in a number of ways, including loss of social support, change in physical or monetary resources, feelings of deep sadness, stress, and in some cases suicidal ideation.

Caseworkers should ensure their approach to engagement with older survivors is trauma-informed. This includes:

- Recognizing signs and symptoms of trauma, including how age associated co-factors of trauma, cognitive decline, particularly dementia, and the associated stress and confusion can exacerbate trauma symptoms.[5]
- Understanding that most older adults will have experienced at least one traumatic event during their lifetime[6] but may have greater difficulty recognizing the impact or have shame and stigma surrounding traumatic experiences.
- Responding with culturally appropriate, age-specific, and trauma-informed behaviors and actions. Support groups with age mates can be particularly helpful for older adults experiencing trauma.
- Resisting re-traumatization. Understand that an older person may be experiencing compounding effects from a lifetime of trauma that continue to manifest or manifest after a time of being symptom free.
- Trauma symptoms can emerge for the first time in older age as survivors experience compounding adverse events like changing familial roles, loss of work identity, emerging and worsening health problems, decreased independence, and loss of partners and loved ones.[7] Do not feel the need to know every type of trauma the older person has experienced. Focus on alleviating symptoms and addressing coping mechanisms.

4. Safety

All aspects of the case management process must prioritize the older survivor's safety in both the short and long term. Some ways in which the caseworker can assure physical and emotional safety for the older survivor include:

- Paying attention to the case management environment. Is the physical space where the case management discussions are held safe and accessible? This means assessing any physical risks such as lose cords, presence of steps, uneven ground that could affect the older survivor's ability to use the space without risk of harm, presence of ramps into the building, accessible information being displayed, and sensitivity of staff toward older survivors.
- If the older survivor requests interpretation including sign language, working with the survivor to identify the best person to take on this role, assuring that the older survivor's confidentiality will not be violated through the interpretation process.

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5 Tips to Identify & Manage PTSD in Seniors. https://www.caringseniorservice.com/blog/ptsd-seniors

6 Aging and Trauma https://bit.ly/3MEfLs4

7 *Ibid.*

- Getting to know the older survivor—their likes and dislikes and the way they behave and communicate—as this may help us understand when the older survivor does not feel safe talking to us.
- Considering how best to approach caregiver involvement. While many caregivers play a supportive role in the survivor's disclosure of abuse and healing, there may also be cases when the caregiver is the perpetrator of abuse, or we have concerns that the survivor will be harmed if the caregiver finds out about the abuse and/or the survivor's disclosure.
- Remembering that in many GBV cases, a survivor seeking help can significantly increase their risk of further harm if the perpetrator or perpetrator's family and friends find out. In such cases, safety is paramount, and we need to support the survivor in telling us who and where is not safe for her and with whom and where she feels safe. It may be possible, then, with the survivor's consent, to involve this person/people in the survivor's care and to make sure the survivor has a safety plan in place.[8]

5. Confidentiality

All standard rules of confidentiality apply when working with older survivors. Caseworkers and service providers should only share information about a survivor with the survivor's explicit permission. They should never discuss case details with family and friends, nor with colleagues unless knowledge of the abuse is necessary for service provision. Caseworkers should, however, consult with their supervisors when they believe that a survivor does not have capacity to consent and when making decisions that are in their best interests.

Caseworkers and service providers should only share information without the permission of an older survivor if they believe that the individual may hurt themselves or others, or if there are mandatory reporting requirements in the local setting. For example, if the person has a legal guardian, caseworkers and service providers may be required by law to provide information to that guardian, but this will vary across settings. Caseworks should ensure:

- Any support person engaged in the case management process, be they family members, caregivers, and/or interpreters, are briefed on the principles of confidentiality.
- Caseworkers consider strategies to appropriately manage confidentiality if seeking further advice from family members and caregivers on communication methods and/or in decision-making processes.
- Wherever possible, the decision about who to involve and when is made in partnership with the survivor and includes an analysis of risks to the survivor's safety.
- Caseworkers think through what additional steps need to be taken with the caregiver in order to ensure that they are a supportive person in the survivor's life. For example, do you need to set up a different meeting with the caregiver in order to explain what happened and provide information about how they can be supportive in the survivor's healing process? (E.g., by maintaining confidentiality, by not judging or blaming the survivor, by reinforcing their strength and courage to tell someone and seek help, and by not pushing a particular action or service in response to the incident.)

[8] This text is taken directly from GBV Disability Toolkit, Tool 8. Available at https://bit.ly/3vopE7n

6. Equality

All caseworkers should be aware of the inherent power dynamic that may be involved in a caseworker-survivor relationship. The older survivor may feel an imbalance in the power dynamic with the caseworker based on the caseworkers age (if younger), languages spoken, level of education, access to resources etc. It is the job of caseworker to assure that the older survivor feels empowered through the case management process. Some ways a caseworker may offset a perception of a power imbalance includes:

- Pausing at the end of the meeting to ask if the survivor has any questions for you, and then taking the time to answer them in-depth.
- Sharing your contact information and when and how the older survivor can best reach you.
- Acknowledging when you have not communicated in appropriate ways (i.e., shouting at a survivor with a hearing impairment) and changing behavior immediately.
- Placing yourself in the older survivor's shoes and ensuring all interactions are coming from a place of empathy.

7. Respect[9]

The survivor is the primary actor, and the role of helpers is to facilitate recovery and provide resources for problem solving. All actions taken should be guided by respect for the choices, wishes, rights, and dignity of the survivor.[10] Examples of ways a caseworker can demonstrate respect to an older survivor include:

- Greeting the client appropriately, including using verbal language of respect and proper body language.
- Using polite and courteous manners and dress that aligns with local standards.
- Providing a comfortable place for the older survivor to sit.
- When working with a caregiver, arranging seats to convey status of the client in her family.
- Ensuring that you continue to honor the survivor's beliefs, ideas, and values even when she may be experiencing cognitive decline or impairments to thinking and memory associated with aging (to the extent possible). Do not inadvertently infantilize the older survivor and assume you know better.
- Remembering that the above treatment may help the survivor feel empowered, and that in some cases, conveying respect may be very powerful for the older survivor's own healing process.

8. Non-Discrimination

This guiding principle means that we provide the same quality of service to every survivor regardless of their sex, age, ethnicity, or disability. By learning the best practices for how to adapt our communication and informed consent processes to survivors with different types of disabilities, we can maintain a survivor-centered approach and deliver quality services to this population. If a caseworker is upholding the other principles and taking care to adjust the case management approach to meet the needs of the older survivor, non-discrimination can be upheld.

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9 Adapted from *How Social Workers Demonstrate Respect for Elderly Clients.* Journal of Gerontological Social Work. Accessed at https://bit.ly/38Dq6pK

10 Inter-Agency Standing Committee. *GBV Coordination Handbook.* Accessed at https://www.refworld.org/pdfid/52146d634.pdf

ANNEX 10:

ASSESSMENT FOR ACTIVITIES OF DAILY LIVING

INSTRUCTIONS

Case workers may determine a need to assess daily living activities with the older persons. Understanding the relationship between the caregiver and the older person as well as the capacity of both individuals can help to examine risks for burnout or neglect and abuse. The dynamics of the relationship, coupled with the capacities of both caregiver and older person will create different risk and protective factors. Supporting the caregiver and preventing or mitigating caregiver burnout can be an important step in prevention of neglect or abuse in some situations.

Because caregiving assistance with daily living activities can be a source of strain and burnout, assessing these can help the caseworker and older person identify which activities they need the most assistance with, whether assistive devices or services may increase independence, and how activities may be modified for greater independence. If greater independence cannot be obtained, assessing daily living activities can also help the caseworker, older person and their caregiver plan for meeting daily living needs in more sustainable ways or as conditions progress. The caseworker can also seek to address and note that the caregiver's role is also always evolving based not only on changes with the older person's situation, but also the caregiver's capabilities and capacities. Changes in the caregiver's health, financial circumstances, familial responsibilities for others, etc. may impact the tasks associated with caregiving.

USING THE ASSESSMENT OF DAILY LIVING ACTIVITIES

Before moving into specific questions about daily living activities, caseworkers should seek to understand the care that an older person is receiving and their satisfaction with the care they are receiving. Caseworkers should be aware of potential signs and symptoms of abuse and should not have a joint conversation with the older person and their caregiver if abuse is suspected.

If abuse is not suspected or disclosed but the older person has concerns about the care they are receiving, the assessment can be used with the caregiver as well. If using this assessment with the caregiver, the caseworker can discuss their current capacity, strain caregiving may be causing, and attempt to identify areas where additional support is needed.

These daily living considerations are meant to be used as discussion points. They can be used as discussion points for both the older person and their caregiver. Any identified concerns added to an existing assessment. These discussions can then inform a case plan. They are not exhaustive of all daily living activities that may be of concern to older persons and their caregivers. They are some of the most common, but others can be added based on the situation of the older person. Many of these subjects may be hard to speak for the older person. Always respect their wishes in what they discuss with you and the level of detail they choose to share. Any of the questions can be skipped based on the wishes of the older person. Remember that your goal is to work with the older person, to assess along a continuum ranging from complete dependence to complete independence in order to identify potential actions, changes to their routine, and assistive devices that might help them maintain their current level of independence or regain additional independence.

ACTIVITIES OF DAILY LIVING ASSESSMENT QUESTIONS

Bathing: Do you have any difficulties in bathing?

- ☐ No difficulties
- ☐ Some difficulties (Example: Needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.)
- ☐ A lot of difficulty (Example: Needs help with bathing more than one part of the body, getting in or out of the tub or shower.)
- ☐ Cannot do it at all.

Dressing: Do you have any difficulties in dressing?

- ☐ No difficulties (Example: Gets clothes independently and puts on clothes and outer garments. Able to launder clothes completely)
- ☐ Some difficulties (Example: Needs help tying shoes or with buttons, clasps and other fasteners. Needs help with some parts of laundering clothes)
- ☐ A lot of difficulty (Example: Needs help with dressing, needs help with most parts of laundering clothes)
- ☐ Cannot do it at all (Example: Needs to be completely dressed by family member/carer, Needs someone to launder clothes completely)

Getting in and out of bed: Do you have difficulties moving into or out of the bed?

- ☐ No difficulties (Example: Moves in and out of bed or chair unassisted.)
- ☐ Some difficulty (Example: Needs help in moving from bed to chair.)
- ☐ A lot of difficulty (Example: Needs help moving from bed to standing, chair, or walking once out of bed.)
- ☐ Cannot do it at all (Example: Needs complete transfer in and out of bed.)

Market/shopping: Do you have difficulties going to the market, shopping, or returning?

- ☐ No difficulties (Example: Able to go to market or shopping alone, procure needed items and return home with items unassisted)
- ☐ Some difficulty (Example: Able to complete most aspects of shopping unassisted, needs help to complete some aspects of shopping)
- ☐ A lot of difficulty (Example: Able to complete some aspects of shopping unassisted, needs help to complete most aspects of shopping)
- ☐ Cannot do it at all (Example: Needs help with all aspects of shopping)

Cooking: Do you have any difficulties in preparing or cooking meals independently?

- ☐ No difficulties (Example: Able to prepare and cook all meals independently)
- ☐ Some difficulty (Example: Needs some assistance with preparing or cooking meals)
- ☐ A lot of difficulty (Example: Needs assistance with both preparing and cooking meals)
- ☐ Cannot do it at all (Example: Cannot prepare or cook meals without assistance)

Feeding: Do you have any difficulties in feeding yourself?

- ☐ No difficulties (Example: Gets food from plate into mouth without help)
- ☐ Some difficulty (Example: Needs partial help with some aspects of feeding)
- ☐ A lot of difficulty (Example: Needs partial help with most or all aspects of feeding)
- ☐ Cannot do it at all (Example: Needs total help with feeding or requires feeding tube or other method because unable to chew/swallow)

Home Upkeep: Do you have any difficulties in cleaning or upkeeping the home?

- ☐ No difficulties (Example: Can clean and upkeep home without assistance)
- ☐ Some difficulty (Example: Needs help with strenuous cleaning activities)
- ☐ A lot of difficulty (Example: Needs help with most cleaning activities)
- ☐ Cannot do it at all (Example: Needs help with all cleaning and upkeep activities)

Socialization: Do you have trouble keeping in contact with your friends or family?

- ☐ No difficulties (Example: In contact with many age mates/friends. Is able to leave home to meet with others)
- ☐ Some difficulty (Example: Needs assistance moving from home to community)
- ☐ A lot of difficulty (Example: Needs assistance to contact others, move from home to community, move throughout community)
- ☐ Cannot do it at all (Example: Has no contact with others outside of home)

Going to the Toilet: Do you have any difficulties in going to the toilet?

- ☐ No difficulties (Example: Goes to toilet, gets on and off, arranges clothes, cleans genital area without help)
- ☐ Some difficulty (Example: Needs help transferring to the toilet or cleaning self)
- ☐ A lot of difficulty (Example: Needs help transferring to toilet and cleaning self)
- ☐ Cannot do it at all (Example: Uses bedpan or requires help with all aspects of toileting)

Continence: Do you have difficulties controlling your bladder and/or bowels?

- ☐ No difficulties (i.e., Exercises complete self-control over urination and defecation)
- ☐ Some difficulty (i.e., Is partially incontinent)
- ☐ A lot of difficulty (i.e., Is mostly incontinent)
- ☐ Cannot do it at all (i.e., Is totally incontinent)

ANNEX 11:

QUESTIONS TO ADD TO GBV EMERGENCY ASSESSMENT TOOLS

A number of tools exist to assess the situation of women and girls in conflict and disaster settings. They include individual interviews, focus group discussion tools, community mapping, GBV safety audits, service mapping, and rapid assessment checklists. Below are some suggestions on how you may deepen your understanding of risks older women may face to GBV while using these standardized tools.

Focus Group Discussion Tool

When doing emergency assessments, GBV responders aim to hold discussions with diverse women and girls in the community. Focus group discussions may divide women and girls into groups for adolescent girls and for women. However, GBV responders may also consider further delineating focus groups for women of reproductive age and older women. Whichever route you take, below are some considerations.

When holding a discussion with a mixed group of adult women, here are some considerations for your discussion and the tool:

- When noting the age of the participants, further break down the category over 40 years to include, 40 to 49 years, 50 to 59 years, 60 to 69 years, 70 to 79 years, and 80 and above.
- Ask if older women experience safety differently—either feeling safe or unsafe.
- Ask if older women have the same sources of assistance in case of a security problem as women of reproductive age.
- Ask if there is anything specific that can be done to make older women feel safe.
- Ask if older women face different forms of violence than women of reproductive age.
- Ask if actors of violence toward older women are treated differently than those of reproductive age.
- Ask if a family would treat an older woman who is victim of rape or sexual assault differently than a woman of reproductive age.
- Ask about any specific self-protection strategies for older women.
- Ask questions to understand if there is difference in help seeking or access to services for older women.
- Ask questions about older women's specific experiences while using services.
- Adapt the sample case studies to include a story of an older woman.

When holding a discussion with a group of older women only (above about age 50, but may vary based on your context):

- Ask the woman how older age is defined in their context.
- Include the points noted above, adapted from the existing FGD.
- Try to include older women from a variety of ages, for example, one woman in her 50s, one woman in her 60s, one woman in her 70s, and one woman in her 80s.
- Try to include women from different backgrounds including women of different ethnic backgrounds, older women without and without disabilities, women of different educational status, women with diverse language use, and so on, in order to understand how they may experience safety and risk differently.

- You may consider including a question about property rights and income as this is a common concern for older women who face denial of resources.
- Consider some additional questions about abuse of older women by caregivers.

Individual Interview Tool

- When noting the age of the participants, further break down the category over 40 years to include, 40 to 49 years, 50 to 59 years, 60 to 69 years, 70 to 79 years, and 80 and above.
- Add a question, "What services are safely available to older women in the camp? If relevant, please note the organization offering these services." When adding this question make sure to define older women according to your context.
- Add a question, "What are the most significant safety and security concerns facing older women in this community?" (Select all that apply.)
- Add a question, "What types of violence have older women reported?"
- Add a question, "To whom do older women most often go for help, when they've been victims of some form of violence?"
- Add a question, "What are some reasons that older women survivors of GBV may not be able to access health services?"
- Add a question, "Do older women need different psychological or support systems than women of reproductive age?"

Service Mapping Tool

- On the service mapping tool, update Question 14, "What specific age groups do your activities serve?" to include the following categories:

  - ☐ Children (0–9)
  - ☐ Young adolescents (10–14)
  - ☐ Older adolescents (15–19)
  - ☐ Women ages 20–29
  - ☐ Women ages 30–39
  - ☐ Women ages 40–49
  - ☐ Women ages 50–59
  - ☐ Women ages 60–69
  - ☐ Women ages 70–79
  - ☐ Women above age 80

ANNEX 12:

SUICIDE AND SELF-HARM IN OLDER ADULTS

Expressing suicidal behaviors, suicidal ideation, or self-harm can be a particularly stressful disclosure for caseworkers. Many caseworkers have not received the training and supervision necessary to address suicide or self-harm through a suicide safety plan. This does not mean that caseworkers cannot take any action in these situations. Caseworkers can, no matter their training and experience levels, (1) recognize the seriousness of what is being disclosed, (2) respond with empathy and care, (3) recognize the unique risk factors with older adults and suicidal thoughts, and (4) facilitate appropriate, and when needed, immediate referrals.

Definitions

It is important that caseworkers understand key differences in terms relating to suicide and the potential lethality they represent.

Self-harm: Intentional, self-inflicted poisoning or injury of oneself, which may or may not have a fatal intent or outcome.

Suicide: When someone intentionally takes their own life.

Suicidal Ideation: When someone is thinking about taking their own life.

Suicidal Behaviors: Actions or plans that one uses to take their own life.

Suicide Attempt: When someone actively takes action to end their life.

Self-harm can be lethal but is often a coping mechanism not intended to take one's own life. Depending on the type of self-harm being used, the risk of lethality increases. Suicide refers to intentionally taking one's own life; however, suicidal ideation, behaviors, and attempts all represent different precursors to suicide. When seeking to understand and recognize the risks of suicide, suicidal ideation, and suicidal behaviors with older adults, caseworkers must understand that risk factors and warning signs are the same as in younger persons. However, the compounding nature of various risks and warning signs coupled with old age results in higher levels of suicide completion, particularly for older men.[1] Reasons that older adults may have higher rates of completion include the fact that they tend to plan more intentionally and use more lethal methods when attempting suicide. Because of the increasing social isolation with age, they are more likely to have more time alone and less likely to be discovered and rescued in time. As adults age, their increasing health issues and overall physical decline means they are less likely to recover from an attempt that is not immediately lethal.[2]

In order to make appropriate referrals, caseworkers should be aware of general risk factors and protective factors as well as warning signs. While none of these change significantly with age, the number of risk factors can and does increase while protective factors decrease.

1 Suicide Prevention Resource Center. https://www.sprc.org/populations/older-adults

2 *Ibid.*

Risk Factors

Health	History	Environment
Substance abuse, self-harm	Prior history of suicide attempts Family history of suicide	Isolation/lack of social support
Physical illness(es) Chronic pain	History of trauma/abuse	Barriers to accessing care, support, or basic needs
Certain mental health conditions and the presence of multiple mental health conditions	Feelings of hopelessness Stigma associated with care seeking Impulsive or aggressive behavior	Loss (relational, social, work, financial, etc.) Access to lethal means

In old age, many adults will begin to experience comorbid health conditions and increasing physical illness. Some older adults will have conditions that they can recover from while others will be faced with chronic conditions, many of which (cognitive decline, dementia, etc.) will progressively get worse. Older adults may also face chronic pain in the joints (arthritis) associated with aging and/or chronic pain associated with particular illnesses or disabilities. Older people, particularly older women, may have histories of chronic, multi-faceted experiences of trauma and abuse throughout their lives. Both older men and older women face increasing issues of isolation as they age and barriers to accessing care and basic needs. Further, as we age, experiences of loss also begin to compound. For men, the loss of livelihood and financial contribution to their home and family may be acute. For both older men and women, loss of relationships, including friends, family, and spouses increase in likelihood as aging progresses. While the loss of social opportunities for both older men and women are associated with age, women often have more restricted social opportunities throughout their lives, so the narrowing of social opportunities can become severe as women age.

Protective Factors

In addition to the increasing number and severity of risk factors for suicide in old age, protective factors can also decline in old age. Protective factors for suicide include strong personal relationships and social supports, including access to social networks and peer community support. Positive coping skills and problem solving skills, both of which can decline with cognitive conditions, are also protective factors. Religious faith and cultural beliefs, participation in meaningful activities, and positive self-image are important protective factors. Access to quality care (including mental health and protection services) and being able to meet basic needs are protective factors for suicide.

As we age, some protective factors may increase while others decrease. Access to social networks and peer groups often decrease in older age. Strong familial relationships may increase. They can also decrease as older adults and their children navigate changing relationships and responsibilities, especially if a child becomes a caregiver for their parent. Caseworkers should seek to assess both risk factors and protective factors with older adult clients when they are concerned about self-harm and suicide risk.

Warning Signs

Health: Exhibiting one or more of the following moods	**Talk:** Speaking about the following things	**Behavior:** Engaging in the following behaviors
Depression	Killing themselves	Increased drug or alcohol use
Irritability	Saying things like "I wish I had never been born" or "I should just disappear"	Looking for information regarding suicide
Loss of interest	Feeling trapped or like there is no way out	Withdrawal/isolation.
Anxiety	Feeling hopeless	Telling others goodbye
Agitation/Anger	Being a burden	Giving away prized possessions
Humiliation/Shame	Unbearable pain	Reckless or aggressive behavior that seems to disregard life
Sudden improvement in mood/ relief		Sleeping too much or too little

Caseworkers should be aware of common warning signs and recognize that amount of risk factors coupled with warning signs increase risk of the lethality of suicide attempts. If a caseworker is speaking with an older adult, they can safely probe and ask questions when the older adult expresses or demonstrates warning signs.

Identify Warning Signs

If an older adult client has expressed thoughts of suicide, caseworkers can ask the client about their experience with the following questions:

- When do you usually start to think about killing yourself or wanting to hurt yourself?
- Are there certain events, places or situations that tend to trigger these thoughts?
- What do you feel?
- What do you think about?
- What are the signs that it is hard for you to handle these feelings without acting on them?

If they have had these feelings before, you can ask them to think about things they have done in the past that were helpful. You can ask:

- "When you had thoughts about killing yourself before, what stopped you?"
- "Tell me some things you might do to help yourself feel better when you start to think about hurting yourself or wanting to die. What has helped you in the past?

An older adult is considered high risk for suicide if they have:

- Multiple risk factors across all three categories of risk
- Multiple warning signs OR demonstrates any one of the following warning signs:
  - Talks specifically and openly about wanting to kill themselves
  - Has begun giving away prized possessions
  - Has begun engaging in reckless or aggressive behavior
  - Has shown a sudden improvement in mood without significant changes to environmental factors

- Lacks strong protective factors
- Expresses a plan for committing suicide that has a high chance of lethality (gunshot, hanging, etc.)
- Has access to the method they have planned to use

If a caseworker identifies that an older adult is meeting any of the above factors, they should facilitate an immediate referral to a health care provider, ideally a mental health care professional. If higher level mental health care services are unavailable, an immediate referral to general health services should still be made. The caseworker should also immediately inform their supervisor of the situation and the actions taken.

Making an Immediate Referral

When an older adult client expresses suicidal ideation or engages in suicidal behavior, a referral to available mental health care should always be offered. An immediate referral is not always needed. However, when an immediate referral is warranted, caseworkers must facilitate this referral. In these situations a caseworker should:

❶ State that they are very worried about the older adult and want to ensure that they will be safe when they leave.

❷ Explain that they are worried for the older adult's safety and would like to refer them to available health care to try to further address how the older adult is feeling.

❸ Offer to accompany the older adult to available health services immediately.

❹ Seek consent to accompany the older adult to health services AND to speak with the doctor/nurse/health care worker about the situation.

❺ Accompany the older adult to available health services (if possible, notifying health services in advance about the situation)

❻ Stay with the older adult until they are seen by the health provider

What to do if an older adult refuses the health referral:

While an older person has the right to refuse a referral, if the caseworker believes they are at imminent risk of attempting suicide or self-harm, the caseworker must make a referral despite this refusal. If a caseworker is in this position, they should explain to the older person that they are worried about the older person and believe the older person is at risk of suicide. The caseworker should explain that they must make an exception to confidentiality and make a referral. The caseworker should explain that they are going to tell the supervisor about the older person's situation. The caseworker should ask the older person to be involved in the discussion with the supervisor and work to involve the older person despite the need to make a referral against her or his wishes.

Caseworkers can, with a supervisor and the older person, discuss options around engaging a non-offending caregiver or other supportive person to work together with the older person to ensure their safety. This might mean bringing an identified person to the location, discussing their concerns and safety needs, and engaging them to assist the older person to complete the health referral. A referral to health should be completed in these circumstances but the caseworker should aim to complete this referral with the older person and support persons as collaboratively as possible.

ANNEX 13:

LEGAL FRAMEWORK ANALYSIS

This tool aims at providing guidance on how to understand the legal framework related to older persons' rights and abuse in your context in linkage with the international and regional frameworks. Anyone intending to work with older persons on addressing abuse should be aware of legal components. It is indeed instrumental that caseworkers have relevant legal information to be able to share it with clients especially at the stage of safety and action planning which require the caseworker to explain benefits and risks of any actions.

GLOBAL AGENDA TOWARDS A BETTER PROTECTION OF OLDER PERSONS' RIGHTS AT THE INTERNATIONAL LEVEL

- **In 1982:** A General Assembly Resolution 37/51 endorses the Vienna International Plan of Action on Ageing.
- **In 1991:** A General Assembly Resolution 46/91 adopts the United Nations Principles for Older Persons.
- **In 2002:** The General Assembly endorsed the Political Declaration and Madrid International Action Plan on Ageing.
- **In 2010:** General Assembly Resolution 65/182 creates the establishment of the Open-Ended Working Group on Ageing for the purpose of strengthening the human rights protection of older persons.
- **In 2013:** The Human Rights Council adopts Resolution 24/20 establishes the mandate of the Independent Expert on the Enjoyment of All Human Rights by Older Persons.
- **In 2019:** The situation of older persons in the context of emergencies is put forward as a priority by the Human Rights Council and the Independent Expert.
- **In 2021:** The Human Rights Council adopted its first-ever thematic resolution on combatting ageism and age discrimination. It requests that the UN High Commissioner for Human Rights prepare a report on normative standards and obligations under international law in relation to the promotion and protection of the human rights of older persons, and to convene a multi-stakeholder meeting to discuss the report, with a view to developing recommendations on addressing possible gaps and the dispersiveness of international human rights law with regard to older persons.

LEGAL ANALYSIS FRAMEWORK

Purpose of Data Collection [Primary and/or Secondary]	**Questions to Support Analysis** [Indicative and Non-Exhaustive]
INTERNATIONAL & REGIONAL FRAMEWORKS	
Binding International & Regional Conventions	
The 2021 Thematic Resolution on Ageism and Age Discrimination is brand new and information is still forthcoming. You may wish to draw an understanding of binding international and regional conventions according to your intervention country. Keep in mind that the reference to age might be done under the "other status" terminology **Sources:** International and Regional Instruments on Older Persons' Rights Human Rights by Country **Literature To Refer to on Gaps in the International Framework:** Mapping of existing normative frameworks and guidelines relevant to older people in conflict and disasters: Implications for policy and practice, Dr Supriya Akerkar, Senior Lecturer, Disaster Risk Reduction, Oxford Brookes University, Oxford	• What are the binding dispositions protecting older persons in case of abuse at the regional and international levels? • What are the gaps in the legal framework?
NATIONAL LEGAL FRAMEWORK	
Protection Framework	
Look for any specific laws which would focus on the rights of older persons, including information on abuse. If available, it might provide you with specific definitions to be applied in your context. Always bear in mind that legally the most specific laws and policies have the priority over more general dispositions. **Tip:** You might find some specific and relevant dispositions on older persons in legal framework which relates to persons with disabilities.	• Is there any available definition of abuse/neglect of older persons in the national legal framework? • Is there a local or national action plan to address violence against older persons? • Is there any disability legal framework which could apply to protecting older persons? • Are there any women-related frameworks which could apply to protect older women?
Sometimes abuse of older persons can result in different criminal acts which imply that you should look into the criminal law of your intervention country. You will therefore look for the different categories of abuse in the available criminal laws and assess whether or not it would apply to older persons. However, in some national legal framework some of the abuse of older persons categories might not require the involvement of police or criminal justice system but other actions from individuals and community.	• Is abuse of older persons codified as a crime in the national legal framework? [Physical assault, sexual assault, financial abuse, theft, fraud, etc.]

Purpose of Data Collection [Primary and/or Secondary]	**Questions to Support Analysis** [Indicative and Non-Exhaustive]
Keep in mind that even if some dispositions do not mention the age itself the principle of non-discrimination might be of help in analyzing how this might or not apply to older persons. Bear in mind that the age might also be an element taken into consideration by a judge at the sentencing moment even if not explicitly mentioned in the laws/policies.	• Is any specific mention of age made in these legal frameworks?
"Ageism is a negative social attitude towards older adults. Ageism is based on negative beliefs about aging and assumptions that older adults are weak, frail or incapable. People who make ageist assumptions view older adults in demeaning, discriminatory or dismissive ways."[1] Ageism can lead to some discriminatory practices which might have legal consequences in your national legal framework. You can look into laws/policies which relate to any denial of access to services or discrimination as a whole and the potential remedies an older person would be entitled to seek.	• What are the potential legal consequences of ageism? Is there non-discrimination or hate crime laws that specifically include gender and older age as special protected statuses?
Age and Gender are social constructs which might influence the laws in your country of intervention, and as such, it is really important to draw a first understanding of gender influence on the legal framework that regulates your operating context.	• Are there laws that penalize widowhood or single, unmarried women? Are there laws that limit the full empowerment and inclusion of older women? • Are inheritance laws and access-to-pension laws the same for women and men?
In some contexts, customary laws/rules might have more weight on dispute resolution and abuse of older persons. It is therefore instrumental to draw an understanding of such practices in your context.	• Is customary law present? To which extent does it influence your legal framework? • How does customary law treat older women, and widows in particular, with respect to land and property rights and/or other rights?

[1] Canadian Centre for Elder Law. (2011). *A practical guide to elder abuse and neglect law in Canada.*

Purpose of Data Collection [Primary and/or Secondary]	**Questions to Support Analysis** [Indicative and Non-Exhaustive]
Case Management Related Framework	
Legal Framework Around Confidentiality As for any type of case management provision, confidentiality is one of the main guiding principles. As such, the case worker is supposed to keep personal information of a client confidential. There are, however, some exceptions to confidentiality which might be regulated by laws in your context. It is therefore important to draw an understanding of such obligations prior to the provision of case management services. It is important to also assess and gather information on legal framework on confidentiality for stakeholder you might interact with throughout the case management cycle. *[i.e., Is confidentiality ensured between older survivors reporting abuse and civil servants such as police officers?]*	• What is the legal framework regulating confidentiality in country? • What is the legal framework around confidentiality for stakeholder you may interact with? [police, social services, health services] • What are the code of conducts' rules around confidentiality for NGOs you might interact with?
Legal Capacity & Consent Legal capacity definitions vary from one legal framework to the other. It has linkages with abuse of older persons as it relates to the individual's ability to make decisions which might have legal or other consequences. These guidelines entail some guidance on how to assess for capacity and find alternative ways, for example, to obtain informed consent when cognitive capacities might be reduced; however, it is crucial to know if the legal framework in your country of intervention might entail specific obligations on this specific topic.	• How is legal capacity organized in your country of intervention? • What is the framework related to guardianships and judicial protection?
Mandatory Reporting on Abuse of Older Persons In some contexts, mandatory reporting of abuse of older persons might be part of the legal framework. You may be legally required to notify a designated person, organization, or government authority about concerns of abuse of older persons, neglect, or risk.	• Do stakeholders, which are part of your referral system, have an obligation to report cases of abuse of older persons? • Do you have a legal obligation to report abuse of older persons cases to the State?
National Social Support We mean by national social support any pension system or social support which might be dedicated to older persons in your context. Understanding such national system in your country of intervention might help you in developing your service mapping as well as potential partnerships with national services to support your client and build your case management services.	• Does the State in which you operate provide social support? What are the eligibility criteria? Is there a numerical age component to the provided support? • Is there a disability-related social support which could apply to older persons?