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MISSING VOICES

Views of older persons on elder abuse

World Health Organization
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International Network for the Prevention of Elder Abuse
INPEA

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Executive summary

Elder abuse, the mistreatment of older people, though a manifestation of the timeless phenomenon of inter-personal violence, is now achieving due recognition. Prevalence studies concerning abuse of older persons have so far been restricted to developed nations. In developing countries, though, there is no systematic collection of statistics or prevalence studies, crime records, journalistic reports, social welfare records and small scale studies to provide evidence that abuse, neglect and financial exploitation of elders are widely prevalent.

The World Health Organization (WHO) has recognised the need to develop a global strategy for the prevention of the abuse of older people. This strategy is being developed within the framework of a working partnership between the WHO Ageing and Life Course unit of the Department of Noncommunicable Disease Prevention and Health Promotion, the WHO Department of Injuries and Violence Prevention, the International Network for the Prevention of Elder Abuse (INPEA), HelpAge International and partners from academic institutions in a range of countries.

The initial step towards developing the global strategy was the set up of a study in eight countries: Argentina, Austria, Brazil, Canada, India, Kenya, Lebanon and Sweden. The study's main approach involved the conduct of focus groups with older persons in the community, and with primary health care workers, in order to establish components of elder abuse as identified by older people themselves and by those forming the primary health care teams. A focus on primary health care context was chosen as it is within this context that elder abuse can first be identified — or overlooked altogether. Making primary health care workers aware of the problem is thus a crucial step in preventing and/or managing elder abuse.

This report presents the design and findings of the study, and the conclusions of a meeting (Geneva 11–13 October 2001) aimed at identifying the indications for policy, research and action emerging from these study findings. Reports from each country prepared by the national teams were reviewed and analysed at the meeting.

Analysis of the major themes revealed remarkable similarities across the participating countries. Older people perceived abuse under three broad areas:

- Neglect — isolation, abandonment and social exclusion
- Violation — of human, legal and medical rights
- Deprivation — of choices, decisions, status, finances and respect

The conclusions contain recommendations for action, some of which are already being implemented, with others to follow in the near future. These recommendations can be summarised as follows:

- To develop a screening and assessment tool for use in primary health care settings
- To develop an education package on elder abuse for primary health care professionals
- To develop and disseminate a research methodology 'kit' to study elder abuse
- To develop a Minimum Data Set concerning violence and older people
- To ensure dissemination of the research findings through scientific journals
- To develop a global inventory of good practice
- To mobilize civil society through raising awareness of the widespread magnitude of elder abuse

Introduction

There are few studies that explore elder abuse from the perspective of older adults cross-culturally, and most of these begin with existing classifications of the meaning of abuse.

The World Health Organization (WHO), the International Network for the Prevention of Elder Abuse (INPEA) and partners decided to set up a study which challenges existing definitions. This study begins by asking older persons and primary health care workers themselves a series of questions in order to understand what their perceptions are, how they themselves classify elder abuse and what they perceive as the first steps needed for a global strategy against the abuse of older people.

Despite methodological constraints, this study provides the first multi-country set of information about elder abuse. While the data is limited it provides a richness from which to generate many future research projects as well as a platform for action. The individual and collective responses cannot be generalised either nationally or globally and, as with all such projects, many new questions have emerged. However, the findings do throw new light on how to perceive and approach elder abuse. Ultimately the challenge for us all is not only to listen to what has been said, but to believe and act upon it.

1. Background

1.1 The history of elder abuse

The timeless phenomenon of inter-personal violence has, in the latter part of the twentieth century, been framed within age-specific compartments. Societally hidden, but manifest in literature, child and wife abuse were the first to emerge. Both types of abuse were framed as family violence issues and were originally called baby battering and wife beating respectively. Eventually, the problem of elder abuse (which was initially called "granny battering") emerged. The abuse of older people was first described in British scientific journals in 1975 (Baker 1975, Burston 1977). In the US, these reports were immediately viewed as a socio-political concern, and quickly led to legislative action. In the UK, it took a further 15 years for the issue to receive research and political credence (Ogg and Bennett 1992). The growing world-wide focus on the abuse of older people since then has sought to parallel the focus upon human rights, gender equality and especially population ageing.

Elders in this context are persons 60 years and over. Predictions indicate that by 2025 the global population of this age group will double to 1.2 billion. One million people turn 60 every month and 80 % of these are in the developing world. Although the proportion of older people out of the total population is higher in developed nations, the percentage of increase of the elderly population is greater in the developing world. Aged populations in Germany, France or Sweden are expected to undergo 30 to 60% increases from 1990 to 2020, while developing countries such as Thailand, Kenya and Colombia are predicted to experience more than a 300% rise and a higher 400% rise in Indonesia. The proportion of older people in the developing countries will more than double,

reaching 12 percent of their total population in twenty years from now. By 2020, countries such as Cuba, Argentina, Thailand and Sri Lanka will have a higher proportion of older people than the US(UN, 1998).

Specific issues within this demographic scenario need to be considered, starting with gender. Women are the majority of the older population in virtually all nations. Today, 58% of older women live in the developing world. By 2025 this will increase to 75%. The AIDS pandemic, particularly in Africa, is changing the situation of older persons both quantitatively and qualitatively. Only 30 percent of the world's aged are covered by pension schemes. Structural inequalities in both the developed and developing world result in low incomes, high unemployment, poor health services, gender discrimination and a lack of educational opportunities. Over the last few decades in the developing world the risk of communicable diseases in old age has considerably decreased, in contrast with increasingly higher rates of non-communicable diseases. This explains the increased prevalence of long-term and often disabling diseases reaching now the levels of their counterparts in the developed world.

Medical technology promises an old age with increasing periods free of disability for those who have access to or can afford it. Radical social and economic changes throughout the world — such as urbanisation, changes in family and participation of women in the paid work force, combined with persisting if not worsening poverty and inequality — provide a fertile ground for elder abuse. The challenges faced by ageing individuals are multiple. While recognition of these challenges will not prevent elder abuse, active involvement of all age groups and sectors in society could alter the conditions that allow it to develop.

1.2 Definitions of elder abuse

The UK's *Action on Elder Abuse* developed a definition subsequently adopted by the International Network for the Prevention of Elder Abuse. It states: "Elder abuse is 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" (Action on Elder Abuse 1995). In the research and policy literature so far, elder abuse has been categorised as:

- physical abuse: the infliction of pain or injury, physical coercion, physical/chemical restraint
- psychological/emotional abuse: the infliction of mental anguish
- financial/material abuse: the illegal or improper exploitation and/or use of funds or resources
- sexual abuse: non-consensual contact of any kind with an older person
- neglect: intentional or unintentional refusal or failure to fulfil a care-taking obligation

Definitions require a cultural context and other issues need to be included within the total framework. For example, in some traditional societies older widows are subject to abandonment and "property grabbing". Mourning rites of passage for widows in most of Africa and South Asia can include cruel practices, sexual violence, forced marriages and evacuation from their homes. Accusations of witchcraft are directed at isolated older women, often connected with unexplained events in the local community. These acts of violence are customs that have been firmly imbedded in the social structure and need to be considered in the broad context of elder abuse.

1.3 The scope of the problem

The accepted prevalence rates of abuse of older people are drawn from five community surveys carried out in developed countries. Two were national in scope, in Canada and the United Kingdom (Podnieks, 1992, Ogg & Bennett 1992). The other studies used the retired population of a small Finnish town and representative samples in Boston and Amsterdam. Although the methodologies varied the prevalence for all types of abuse ranged between four and six percent.

Despite the fact that a vast literature exists on quality of care issues in institutions, no prevalence or incidence data are available. A survey of nursing home personnel in one US state disclosed that 36% of the nursing and aide staff reported having seen at least one incident of physical abuse in the preceding year by other staff members and 10% admitted having committed at least one act of physical abuse themselves. At least one incident of psychological abuse against a resident was observed by 81% of the sample and 40% admitted to committing such an act (Pillemer 1990).

Although there is no systematic collection of statistics or prevalence studies in the developing world, crime records, journalistic reports, social welfare records and small scale studies contain evidence that abuse, neglect and financial exploitation of elders are much more common than societies admit.

2. The Project

2.1 Aims and objectives

Primary health care workers are often confronted with signs of elder abuse, but may not know how to recognise or act on them. The overall aim of the new WHO/INPEA Global Response Against Elder Abuse Project, started in February 2001, is thus to raise the awareness among health professionals and the public at large about the problem of elder abuse world-wide, and to develop a global strategy within the context of Primary Health Care for the prevention of elder abuse.

The specific objectives of the first stage of the project, in 2001, were to:

- Establish an advisory group (WHO /INPEA) to develop and monitor the project
- Carry out focus group research in urban settings in five developing countries (with the potential expansion into developed countries) as an initial exploration to identify key themes and issues relating to the perceptions, beliefs and attitudes about elder abuse among the persons most concerned: older persons themselves and primary health care workers.
- Involve national coordinators and facilitators to carry out initial qualitative analyses
- Hold a 3 day facilitated meeting to identify implications for policy action and research.
- Plan further more in-depth research within particular countries contexts to explore in more detail the nature, causes and impact of elder abuse.

The five developing countries **Argentina, Brazil, India, Kenya** and **Lebanon** were engaged through professional links of WHO, INPEA board members and HelpAge International. At a later stage representatives from three countries, **Canada, Austria** and **Sweden** offered to join the project at their own expense and support the project aims and objectives.

A key feature of this project is an emphasis on capturing and reporting older peoples' own views and perceptions of elder abuse and using these as a basis for discussions on the consequences for health and public health policy. WHO enjoys a unique position to convert this debate into concrete action points which will assist Primary Health Care workers globally to prevent elder abuse.

2.2 Research methodology

Focus groups were selected for their ability to explore people's knowledge and experiences and to examine not only *what* people think but also *how* they think and *why* they think that way. A major advantage of this method is the natural setting of the focus group. Participants can also provide mutual support in expressing feelings that are common to their group but which they consider to deviate from mainstream culture (or the assumed culture of the researcher). Themes and perceptions often emerge particularly well in the discussion and dialogue between participants of focus groups.

The advisory group identified in each country a coordinator to oversee the research project. The national coordinator appointed a facilitator to organise and run the focus groups according to detailed guidelines concerning the recruitment methodology and the management of the groups.

Eight focus groups, each with eight to ten people, were held in each country. Six groups comprised older people and two involved primary health care workers. Two groups of older people were held with older women only and two with older men only. The remainders, as well as the groups with primary health care workers were mixed. Groups represented as wide a range of social and professional backgrounds as possible and often existing social groups or clubs facilitated the process of engaging men and women to participate in the discussions. Participants were not expected to have been exposed to or had previous knowledge of elder abuse. The recruitment methodology for the focus group is described in detail the countries' research reports.

Participants were provided with refreshments, or a meal, and reimbursement for their travel and related expenses. Other forms of remuneration were not provided.

The focus groups did not aim to seek to obtain testimonies from those who might have experienced abuse. Instead, the discussions were used to explore older people's and health care professionals' attitudes and beliefs concerning elder abuse. The aim of the focus group discussions was to obtain a better understanding of common perceptions about the following:

- Main problems faced by older women and men
- Older people's role within their communities
- Perceptions of what elder abuse is and what are the different kinds
- Perceptions of the contexts in which abuse occurs, and its perceived causes
- The consequences of elder abuse for older people, their families and the community
- Whether elder abuse is common in the area and why
- Whether 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
- Perceptions of elder abuse as a health issue and as an issue of concern for health care workers.
- Identification of existing/needed health and social services and community support in relation to violence and abuse
- Definition of gaps, needs and views for future responses to abuse, care and prevention

2.3 Qualitative data analysis: national reports

Each national coordinator developed and wrote a report detailing the themes emerging in their group discussions and illustrating with verbatim quotes. All non-English reports were translated into English. (country reports are available upon request and can be viewed at http://www.who.int/hpr/ageing/elderabuse)

A member of the project team reviewed the translated national reports and performed a content analysis. Because of the variability in the reports, the main goal of the content analysis was to identify recurrent themes linked to the central questions of the study. The remarks in the national reports were coded into thematic categories, following a systematic reading. The chief investigator of the advisory team performed an independent reading of the reports in order to further identify major themes. In spite of some limitations in the chosen methodology as well as resource constraints, the final analysis revealed the unique richness of the information gathered by the study.

The central concern of the analysis was to begin to understand how older adults and health care professionals understand the roles of older adults in their societies as well as the problems they face, and how they understand the problem of elder abuse and its possible solutions. Certain themes emerged in all the reports, although often taking different shape, depending on the local context. These themes were of particular interest, as they reflected aspects of elder abuse and experiences of older adults that could reveal universal treads. Other themes were more specific to one or a few countries, also of interest in reflecting the contextual specificity of elder abuse.

3. Findings and discussion

The data emerging from the focus groups has provided a unique insight into how the complex subject of elder abuse is perceived by older persons and primary health care teams.

Several key categories of elder abuse emerged in respondents' accounts of their perceptions and experiences. While some of these categories were the same as those found in the literature, others have not so far been recognised in the usual taxonomy of abuse. Furthermore, the emphasis that participants placed on certain types of abuse often does not match those concerns identified in the literature by health care professionals as being the most important.

The elder abuse literature so far places the focus on individual and familial factors. Research often focuses on the characteristics of the perpetrator and the victim, and on the interpersonal dynamics within the family unit. There is an emphasis on pathology, with substance abuse, mental illness, and cognitive disabilities playing a major role in elder abuse. The effect of such an analysis is that elder abuse remains a family problem, rather than being viewed as a larger societal concern. This study challenges such an individualistic focus by documenting the vital importance of structural-societal factors, underpinning virtually all aspects of elder abuse reported from developing countries.

The following are the key categories of abuse identified by participants:

- **Structural and societal abuse**
- **Neglect and abandonment**
- **Disrespect and ageist attitudes**
- **Psychological, emotional and verbal abuse**
- **Physical abuse**
- **Legal and financial abuse**

The study has also established how difficult elder abuse is as a topic for some older adults to discuss — a fact mentioned in several of the reports being **discomfort/denial of the problem**. Spouse and sexual abuse, for example, though discussed, were not regarded as being of major concern to the majority of focus groups. Similarly physical abuse was very difficult for participants to discuss, unless they displaced it or otherwise put it outside of themselves or their communities. This form of abuse was often considered as a separate category from the other forms of mistreatment. While there was admission that it could and did happen in their community (perhaps even to the participants themselves), there was actually very little direct mention of physical abuse, although it sometimes surfaced in stories. However, it seemed like it was always lurking on the margins of the narratives.

This phenomenon was particularly pronounced in the India report. The focus group facilitators in India were careful not to mention the term "abuse" at the beginning of the focus groups. When asked about abuse, later, participants linked abuse to extreme cases of very violent behaviour. There was a general uneasiness about discussing cases of physical abuse and a genuine attempt was made to avoid the issue. The groups all denied the existence of physical violence in their communities. This created an issue in getting definitions of "abuse," because for them, "abuse" does not exist in India. What they would talk about was

> "emotional problems," "lack of emotional support," "neglect by the family members," "feeling of insecurity," "loss of dignity," "maltreatment," "disrespect by the family." However, not a single person was willing to label it as "abuse." (India)

Psychological, emotional and verbal abuse were frequently discussed. As perpetrators of these kinds of abuse were said to be found in families and in society, they are present in the report within the categories of structural and societal abuse; disrespect and ageist attitudes and within concrete contexts described below.

There was a clear dichotomy between the concepts of "abuse" (which does not happen in their communities) and "mistreatment" (which they admit does happen).

In addition to the main categories of abuse, the respondents' accounts highlighted several concrete contexts in which elder abuse occurs as part of social or institutional arrangements. These included:

- **Retirement and social roles of older adults**
- **Long term care institutions**
- **Health care professionals as abusers and as victims**
- **Culture- specific influences on abuse**

Finally, two key factors emerged as underpinning virtually all forms or contexts of abuse: **Gender and Socio-Economic Status**. Whilst participants described different ways in which these factors affect elder abuse in their respective countries, two crucial points emerged. First, there was a prevailing view that women, particularly the (poor) childless and widow, are the most affected. Second, and more generally, although elder abuse affects all social classes, respondents agreed that it is the poor older people who suffer the most.

Using extracts from the national reports as well as verbatim quotes, the following sections discuss in detail the main categories and concrete contexts of elder abuse identified by the focus group

participants. Quotation marks indicate a participant statement within a focus group and the boxed areas indicate statements made by the national coordinators in their reports:

3.1 Key categories of abuse

A) Structural and societal abuse

Participants, particularly from developing countries, primarily blamed governments and structural factors for the mistreatment they experience in their homes, in public, and in health care institutions. Even in some focus groups in developed countries, such as Sweden, the responsibility for elder abuse prevention and intervention was placed at government level. The prevention of elder abuse is clearly viewed as a public responsibility, and part of governments responsibilities is to care for vulnerable people in their respective societies. Participants frequently mentioned issues such as budget cuts, wrong priorities in public spending, cutbacks in health care, and insufficient supervision of health care institutions as concrete instances of governments' failure to fulfil their responsibilities towards older people.

Although different expressions were used in the various reports, participants from all the developing countries referred to what the Argentinian report called *societal abuse*. Many of the countries saw this as the most important type of abuse and as the root cause of most of the other types of abuse they experience at a more personal level. Societal abuse covers a very wide range of issues such as income security and accommodation.

The Argentinian participants defined societal abuse as age discrimination manifested particularly in **inadequate pensions**. Pensions, which were already considered low, have been recently lowered in Argentina to the point that many people find it difficult to cover the basic necessities and minimal luxuries they were able to previously afford.

The issue related to **accommodation**, feeling secure in the ability of living in their own home was referred to by participants from different countries.

> On many occasions children take over their parents household management and slowly but steadily the elders lose their place within their own territory and even sometimes have to leave the premises in pretty bad conditions such as going to live in a smaller place, sharing with another relative like a sister or brother, or even get admitted to an old people's home. (Brazil)

The Indian report exemplified the problem through the situation of a retired widower who owns his own apartment but is presently sharing it with his only son, his daughter-in-law and their two children.

> He has lost his freedom of choice around meals, bedtimes, housekeeping, etc. If he makes suggestions, he is told to mind his own business.Although he has asked his son and his family to leave, they have refused. In fact, he has even suggested that he would like to remarry for the sake of a companion so they must leave the apartment for his exclusive use. They do not move out of his apartment but continue to neglect him. The problem of adult children living with their parents in their accommodation is worse for lower income families, because lodgings are smaller. (India)

Several of the reports traced how economic crises in their countries resulted in elder abuse and participants clearly blamed governments for this.

Beyond the issue of how accommodation is physically shared, participants in all countries spoke about how **changes in social roles** have created situations where they end up abused or neglected. They claim that formerly, women remained at home and were the primary caregivers for children and dependent older adults and looked after the household. Now that all adults in the family have to go out to paid jobs, there is no capacity left for caregiving. This results in widespread emotional neglect and often also physical neglect of older adults. Stress levels are high due to the pressures on the middle generation, who come home from their jobs and lack patience in dealing with their older family members. The result is often verbal abuse and sometimes even physical abuse. However, many older adults, even while naming such behaviour as abusive, excuse their children. They recognize that their children are living under a great deal of stress and instead place the primary blame on government social and economic policies. An older participant justified a case of financial abuse by saying

" He must have needed the money" (Canada)

Many groups across the countries also spoke of difficulties related to **access to health and social services** as well as the lack of services for older people, both in terms of quality and quantity. In countries, such as Kenya, Lebanon and India, participants claimed that there is no government health care and medication plan, or that existing plans are not universal. Some of the most extreme and physical forms of abuse and neglect were referred to in these countries.

It emerges from these reports that inadequate government policies and lack of funding for basic services is viewed as placing pressure on families and older adults and thus leading to elder abuse. The pressure takes the form of direct financial pressure, such as not being able to afford to provide medical care to older family members, as well as overall stress and a sense of the older person being a burden on the family. Issues around the health care system were often linked to socio-economic status and ability to pay. The poorest members of society are the worst off, and many older adults (especially older women), fall into this category.

There was a general consensus that women were the worst sufferers, with no income of their own and dependent on spouses for everything. They also tended to underplay their health problems for the sole reason of causing inconvenience to the other family members by way of escorting them to the doctor and/or spending money by way of consultation fee and medicines. They further voiced that if the women were widows, the situation was even worse, because the finances then came from children for their welfare and it was the sole discretion of children to "decide whether she needed medical assistance or not" even if she said she did. (India)

B) Neglect and abandonment

At its most extreme, lack of care for older adults results in abandonment and in health care settings fatal outcomes can occur due to deprivation of essential non-funded care. Both Brazil and Kenya reported the practice of abandoning older family members in health care facilities such as hospitals. Families leave older members there and do not return to pick them up. Thus hospitals have no place to discharge older adults into the community. This has both severe physical and emotional impact on the older person.

In Kenya, abandonment of older adults at hospitals was considered *the most significant issue in elder abuse,* directly connected to the fact that the older person or the family has to pay directly for health care services. The hospital staff included in the study estimated that between 15 to 30 percent of older patients end up abandoned in the hospitals. This does not include older people who had already been abandoned in their homes or in the streets and brought by a stranger to the hospital, charitable institutions or emergency services. Such indigent older patients are refused medical care until an administrative process to provide a fee waiver is completed and in the interim, patients may seriously deteriorate or even die. In one hospital, the Chief Nursing Officer estimated that 90% of abandoned older people go into clinical depression. Another hospital matron noted that depression makes older patients uncooperative in the treatment process, rendering medication ineffective and leading to refusal to consent to necessary procedures.

In both Kenya and Brazil the **patterns of abandonment were presented as seasona**l. In Brazil, it was linked with long weekends, Carnival, school holidays and Christmas as described by a respondent:

"Over school holidays, the first thing a family who has a place to go in the countryside does, is to grab the elder and put him/her in a hospital". (Brazil)

In Kenya, seasonal abandonment was more linked with agricultural conditions. Most of the Kenyan economy is agricultural and pastoral, thus local economies are very dependent on climatic conditions. Abandonment of older persons is thus higher in times of drought, poor crop yields or loss of livestock.

C) Disrespect and ageist attitudes

The experiences of disrespect reported by participants need to be understood as viewed by older persons both as a cause of all other forms of abuse and as an important form of abuse in itself. Disrespect is the most painful form of mistreatment identified by older adults in all countries. While the reports included some dramatic stories of physical abuse and neglect, it was clear that an attitude of disrespect towards older adults is universal. The report from Lebanon contained a poignant quote, which seemed to speak for the experiences of older adults throughout the study:

"One rude word said to an old man is stronger than stabbing him with a knife". (Lebanon)

While public and professional concern about elder abuse focuses on the more evident physical health impact, the theme of disrespect emerged as a major theme in older participants' perceptions and experiences of elder abuse:

"People talk down to us- call us 'sweetie' or 'dearie'- tell us what to do". (Canada)

"…just shut up, take what we give you, and just enjoy". (Canada)

"Respect is better than food and drink". (Lebanon)

Time and again, participants spoke of disrespect everywhere they turn. While disrespect is linked to verbal and emotional abuse as well as to neglect, it is more pervasive and all-encompassing. Disrespect is ultimately an indicator of poor social attitude towards older people. Many groups considered the **younger generations** as being particularly disrespectful. There was a general agreement that social values and attitudes have dramatically changed, and that

"it was better in the old days" (Sweden).

Blame was given to the **influence of the media** in promoting ageist attitudes and negative stereotypes about older people, influences to which youth are particularly vulnerable. **Westernization** was also blamed by some as the carrier of new attitudes and values. The analysis performed by the Lebanese team was particularly succinct and reflected themes that were found in most of the other reports:

> Participants also accused the media of neglecting issues concerning older people, and promoting abusive actions. Moreover, the interviewees added that the reason behind neglecting old people is the modernization of the society by trying to imitate the Western culture. They mentioned that in previous generations people were more sensitive, caring and polite towards their parents or grandparents. By contrast, today's young people are disrespectful and careless towards older people. The participants believe that family bonds are collapsing, and that there is less respect for the elder, with the authority being shifted to the children. (Lebanon)

The Kenyan and Brazilian reports were especially clear about how societal attitudes are also reflected in the **disrespect within the health care system.**

At the health care facilities, older persons suffer violence from the entrance door to care delivery. (Brazil)

The disoriented elder, who may be intoxicated by medication is taken [and treated] as a head-strong child. This is quite violent; a professional to take out the prosthesis, take out the device, remove the eyeglasses [from the elderly], then he [the elderly]agitates. When he agitates [the professional] medicates … this is violence; there are also cases in which he [the professional] says, "I won't let your daughter in if you keep [behaving] like that." (Brazil)

Abusive situations in the health care systems were also described in Canada and Argentina:

"He was kept in diapers and never taken to the bathroom" (Canada)

"Elder abuse is to have to wait for two months for a free medical consultation which you have paid for in a way all your life" (Argentina)

The Kenya report, which differed from the other country reports in its exclusive focus on the health care system, developed the theme of disrespect towards older people in the health care system very strongly. Participants consistently told of how older people are seen as difficult, are unwanted in hospitals and considered a waste of resources. Particularly shocking was the report of the head of one hospital, who confided to the interviewer:

"Older people are a big headache and a waste of scarce resources, the biggest favour you could do to me as an older people's organisation is to get them out of my hospital." (Kenya)

This disrespect appeared to permeate the health care system in Kenya at all levels and translates into all kinds of serious forms of abuse, exploitation and neglect.

Disrespect is also encountered in various **governmental and commercial institutions.** A number of country reports referred to excessive waiting times by older adults, often in very uncomfortable circumstances, at banks, in government offices, at police stations and in the health care system. Disrespect is also shown in other ways in public settings.

"At the post-office or at the railway station you are supposed not to speak too slowly and you are treated badly when you have a hearing problem." (Austria)

Public transport was mentioned in most of the reports as a further source of mistreatment. Most strongly in the Brazilian and Austrian reports, the main underlying problem is again identified as disrespect:

Disrespect starts from the moment the elder gets to a bus stop. When he hails the bus to stop, the first thing the driver says [to himself] is, 'don't stop here, as it is full of six five [people 65 years or more].' The elder hails, but them [drivers] keep going. Or they stop way ahead, so the poor old guy has to run to catch the bus. It is mean. (Brazil)

" The bus driver closed the door just before this old woman with two crutches could enter the bus. Well, he opened the door again but was angry and scolding her" (Austria)

"Recently, in the street-car, some youth were sitting next to me; when some elderly persons were entering the car the young people did not offer their seats but rather said: 'What do they want here now – they have time all day long." (Austria)

Bus drivers are said to accelerate without concern for their older riders, who find it difficult to keep their balance and sometimes fall down as a result.

As the report from Austria describes, in general, older adults

> feel disregarded, insulted, ignored by government or social security agencies or mistreated in shops, in public transport, etc; the general feeling is that the elderly are pushed to the edge of society. (Austria)

D) Legal and financial abuse

Legal abuse was named as a particular type of abuse in both India and Lebanon, although each country has its own specific version of this. The Indian expression of legal abuse is through abuse of the dowry laws by daughters-in-law:

> In India, there is a law that is intended to protect daughters-in-law from abusive in-laws. A daughter-in-law can go to the police station and lay a complaint that she is being abused by her in-laws, and the in-laws are arrested on her word alone. However, the focus group participants reported that some daughters-in-law are using this law as a form of elder abuse, by making false police reports. In general, participants stressed that the lack of a caring attitude by daughters-in-law was a major problem. (India)

In Lebanon, legal abuse was said to occur because there are no laws to protect the rights of older adults, particularly regarding inheritance issues. Religious courts are responsible for deciding on the division of the inheritance among the beneficiaries, but these courts are not well equipped to understand certain issues. An example was given of a person who presented to the religious court a doctor's evaluation that his father was mentally incompetent, which was enough to deprive the father of his money.

3.2 Concrete contexts of abuse

A) Retirement and the social roles of older persons

Retirement is considered the point when everything suddenly changes, especially for men. There is a loss of productive capacity and a loss of one's former professional or vocational role. This theme may reflect the fact that former professionals were over represented in some of the older adults' focus groups. While the issue of retirement emerged in most of the reports for developing countries, it

did not appear to be a concern to participants from Austria, Canada or Sweden The findings from Brazil indicated that retirement is seen as particularly linked to social exclusion and abuse:

"For an older person, to be retired means to be abused by part of the social system, personified by government officials." (Brazil)

Receiving the first pension cheque in Brazil is a long process, involving a "burdensome bureaucracy," long waits in several different government offices and a long waiting period before receiving the first cheque. Newly retired persons may suffer major deprivations during this waiting. Then they discover that the pension cheque is usually not enough to survive. All this is government abuse.

Uselessness is associated to being retired. It doesn't matter what he was when active in the labor force. He might have worked in a number of different professions, bottom line he is characterized as only retired. (Brazil)

B) Long-term care institutions (LTCI)

While the proportion of older people living in LTCI varies widely among the participating countries (8-10% in Canada to less than 1% in Lebanon), elder abuse within that context was referred to by many focus groups.

In developing countries, placement into long-term care is regarded as a last response for the very poorest people with no family to care for them. Sentiments about long-term care institutions were mixed. While participants largely dreaded them, there was also an acknowledgement that they were essential institutions, and that in many of the developing countries more were needed to accommodate destitute and/or abandoned older adults.

Participants agreed that institutionalisation needs to be a choice that is made by the older person. If someone else makes this decision, it is considered abusive. A participant in Argentina expressed:

"To institutionalise an old person is like kidnapping someone." (Argentina)

Most of the reports touched on the reality of abuse in long-term care institutions. Several noted the need for more safeguards and closer supervision of these institutions.

"Deportation to homes is abuse. A home for the elderly is nothing more than an entrance hall of death." (Austria)

C) Health care professionals as abusers and as victims

Throughout the reports, health care professionals are perceived as part of the problem.

"They won't tell my mother what medications she is on — her control is gone". (Canada).

This ranges from simply not being adequately trained to understand ageing and the problems of older people, or not having enough time to listen to reports of health care professionals perpetrating clearly abusive acts. The latter were mostly reported in the Brazil and Kenya reports. The Kenya

report, which focused only on abuse in the primary health care system, contains one serious story after another:

> *"In … District Hospital, the sick are slapped, rudely rebuked and pushed by health workers." (Kenya)*

> *"I witnessed a case whereby an elderly woman was charged one and a half times the usual rate for medicine at … District Hospital. She waited for six hours for the medicine as health workers attended to other issues and cases. A Good Samaritan paid for her because she was incapable of raising the required money for medication. Even after someone had paid for her the inflated charges, she waited for so long and died four hours later before receiving the medication." (Kenya)*

However, this report also clearly notes the role of structural factors in creating poor working conditions for health care professionals. The Argentinian and Kenyan reports suggest a relationship between the treatment of health care workers and the ways in which they, in turn, treat their older patients.

In Argentina, health care professionals spoke extensively about the difficulties they experience in working with older people, which they believed were universal. For example, the majority felt that there was some prejudice against geriatrics as a field, with it being considered as second class and less qualified by other professionals and administrators. They also referred to low salaries in this speciality as well as to mistreatment by older patients and their families.

All these experiences were strongly perceived as abusive. Few claimed they had never received mistreatment in their professional lives. This raises some interesting questions about the ability of health care professionals to be sensitive to and respond to situations of elder abuse, when they themselves feel so mistreated.

In Kenya, the health care system is grossly overburdened and staff work under extremely difficult conditions. There is a lack of norms, policies and procedures for handling older patients in Kenyan hospitals. This makes it virtually impossible to analyse the abuse of older patients within the system and to deal with perpetrators. Furthermore, it means that older patients are

> *"vulnerable to the whims and moods of staff." (Kenya).*

Kenyan hospitals were perceived by the focus groups participants to be rife with widespread corruption and conflict of interest, perhaps partly because the working conditions are so poor. Some of the nurses at one hospital confessed that part of why they *"do not look kindly upon older patients who have trouble settling their bills"* is because they realize that their working conditions will only improve with larger revenues from patients. Thus they directly link indigent older patients with their own mistreatment as health care professionals.

D) Culture-specific influences on abuse

Although most of the themes relating to elder abuse have a culturally specific context and form of expression, certain themes emerged from the reports as being particularly linked to certain cultural contexts. Although these are themes that were only mentioned in certain of the reports, it may be

that other countries also have fainter echoes of some of these manifestations of abuse which were not specifically mentioned

Witchcraft accusations can be added to the themes above, as reported in a recently WHO-conducted study (also reported in other Sub Saharan African countries) in Mozambique. The author reported extreme cases of elder abuse in her country consisting of accusations of witchcraft against older women (Da Silva 2002).

Daughters-in-law were specifically mentioned as important perpetrators of elder abuse in three of the reports: India, Lebanon, Austria. In Lebanon, the conflict between mothers-in-law and daughters-in-law was almost universally mentioned by the female participants. There is a lot of mutual jealousy, and various kinds of family dynamics were discussed. These dynamics result in various forms of abuse and neglect, including physical abuse and sometimes placement of the in-laws in institutions against their will.

> Many participants reported in-law-relationships as being often strained and characterised by an absence of warmth; in particular, life-long oppression of women by their mothers-in-law can result in revenge actions later in life, especially when the daughters-in-law have take over the carer's role. (Austria)

Religious issues were not focused upon, but brief references to them in a few of the reports may indicate a topic to be explored in susequent studies.

In Lebanon, religion is seen as a protective factor for elder abuse, because of strong religious injunctions of respect and care for older adults, particularly one's parents. In Kenya, religious institutions are often those who care for destitute older adults.

In Kenya, **traditional healers** predate modern medicine and are key elements of religious practices. These roles are generally carried out by older people. Traditional healers provide an alternative to the health care system, which is underfunded, inaccessible to those who are poor and considered rife with corruption and mistreatment. Kenyan participants reported:

> *"I have never been to hospital in 14 years. It is too expensive. I get most of my medicines from the healer. His prices are lower and payment terms are negotiable." (Kenya)*

These healers offer an important alternative to the health care system, and this is reflected in the recommendations of the Kenyan study, which propose increased collaboration between the two systems of health care and government regulation and coordination of traditional healers. While use of traditional healers has the potential to provide an empowering choice to this population, it also has the potential for abuse by unscrupulous healers.

4. Implications — strategies for the prevention of elder abuse

4.1 Strategies proposed by the focus groups participants

Participants proposed a wide variety of prevention and intervention strategies. There was a strong convergence across countries in terms of these recommendations. The major strategies that emerged from the focus groups can be grouped together as follows:

- **Awareness and education:** this was a universal recommendation and covered a number of different areas. People need to be educated to perceive older adults more favourably as positive contributors to society. They need to be encouraged to form closer relationships with older adults. This education needs to start very early, in primary school. The general population also needs to be aware that elder abuse happens and is a problem. Older adults need to be aware of the problem and of their rights, as well as available services and resources.
- **Intergenerational relationships:** this is linked to the first recommendation and places an emphasis on the need to encourage a closer and positive contact between generations. The social isolation and neglect of older adults needs to be broken, through intergenerational relationships, among others. Also, most of the reports mentioned the perceived negative attitudes and values of the younger generation and the disrespect they show to the older generation. All of these issues need to be addressed through education and through different programs to build positive relationships.
- **Training of professionals:** participants often mentioned lack of knowledge on the part of health professionals about ageing and older people, and also about elder abuse. Providing training so that health care professionals can recognize the signs and symptoms of elder abuse and how to intervene needs to be made widely available.

- **Empowerment of elders:** some reports emphasized the need for older adults to act for themselves and on their own behalf. Many participants felt strongly about the need for older adults to exercise their full citizenship rights and advocate for their own interests. In Sweden, organisations and associations of and for older people were seen as important ways of addressing the problem.
- **Role of the media:** the media was often blamed as one of the sources of the negative images of older adults in society. It was seen as important to work with the media to change these negative images, to raise awareness and to educate the population about elder abuse.
- **Recreation facilities:** the loneliness of older adults was a persistent theme throughout most of the reports. One problem, especially in developing countries, is the lack of adequate recreation facilities. The need for recreational facilities was mentioned by most of the countries.
- **Structural solutions:** these suggestions were less direct than some of the others, but centred around the need for strong protective laws, improved health care plans, and similar structural issues. Kenya argued for the need to involve NGOs as partners in advocating for some of these changes.
- **Research:** most of the researchers in developing countries noted that there is very little known about elder abuse in their countries. This was echoed in the recommendations by focus group participants, who called for more research to obtain more information about the problem in their country.

4.2. Strategies and recommendations for action by the project team

WHO and INPEA, in stating the process of developing a global strategy, chose the primary care context as involving primary care workers aware of the problem of elder abuse being crucial in preventing and/or managing the issue.

At the international meeting held at WHO in Geneva 11–13 October 2001, the advisory group and the national coordinators of the countries participating in the project agreed to pursue the following nine strategies as part of their joint global response to elder abuse:

- To develop an education package on elder abuse for the training of primary health care professionals
- To develop and pilot a screening and assessment tool for primary health care professionals in developing countries
- To develop and disseminate a Research Methodology 'Kit' to expand the study of elder abuse in developing countries
- To develop a Minimum Data Set on elder abuse
- To promote intergenerational pilot studies of older and younger people in their organisations
- To develop a global inventory of good practice in the prevention of elder abuse
- To mobilize civil society through raising awareness of the widespread magnitude of elder abuse
- To promote policy change to address elder abuse
- To ensure dissemination of the research findings through scientific journals

4.3. Conclusions — the way forward

This report turns the first few pages in what promises to be a long and complex journey. While it cannot claim to speak for all older people, it can share the perceptions of some. These perceptions will shock and sadden in equal measure and will, one can hope, lead to reflection, action and change.

The strategies and action plans agreed will give some answers but inevitably pose further questions. This process, however, will not only raise awareness but will start the journey towards greater empowerment of older people and, maybe even, societal change. Older people do not want more than others, they want equality — a human right.

For so many to live to be old is one of the most remarkable achievements of the twentieth century. To be old and live in dignity free from all forms of abuse and violence must be a common goal for all societies of the twenty-first century. It all starts with respect as in the words of one of the older respondents:

"Respect is better than food or drink".

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Notes

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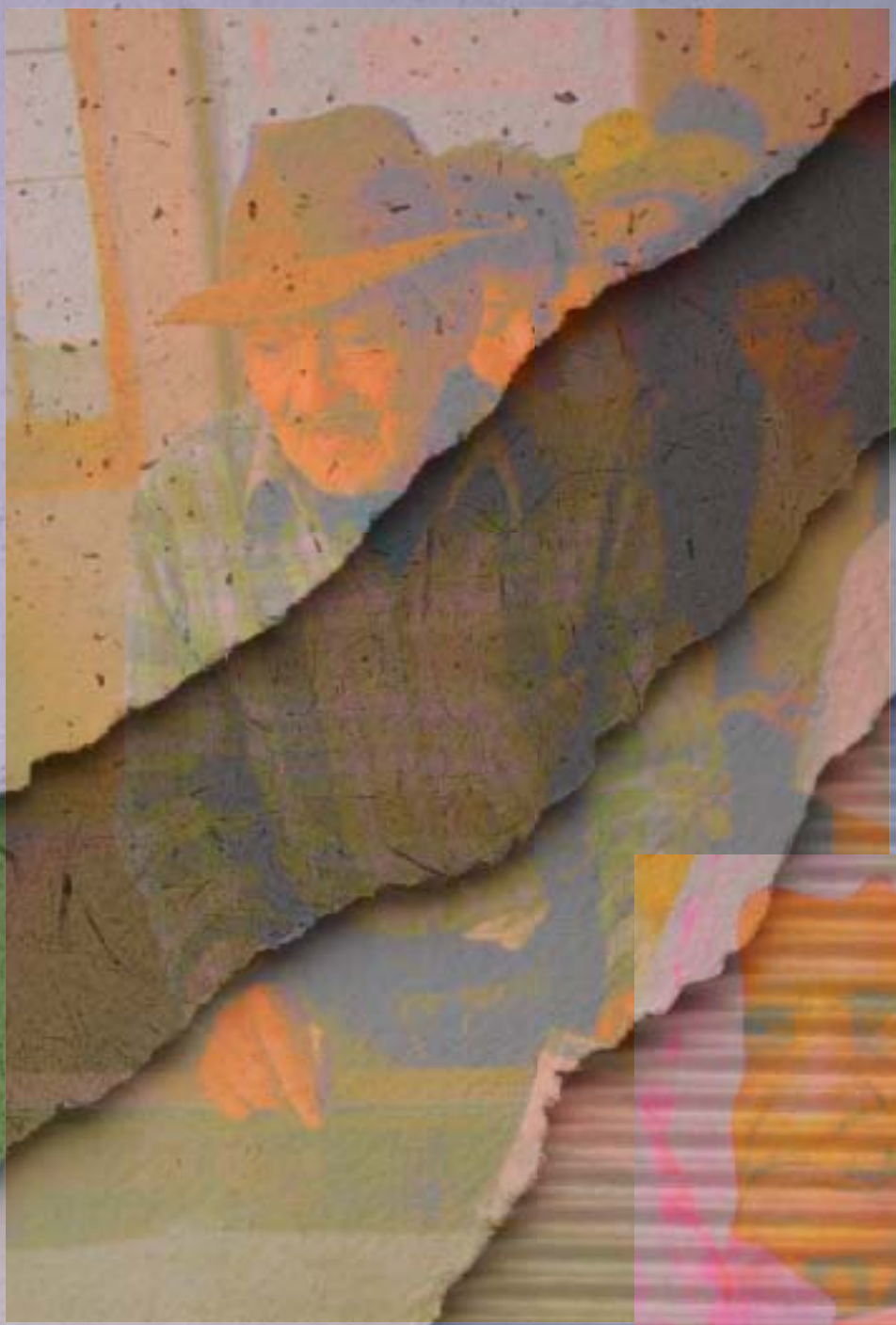

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