grandmothers Advocacy Network

Mouvement de soutien des grands-mères

Advocating for Grandmothers, Vulnerable Children and Youth in Africa
Soutien aux grand-mères, enfants et jeunes vulnérables en Afrique

Older Women Count!

Understanding and Supporting the Rights of Older Women/Grandmothers in sub-Saharan Africa

Written by and for members of the Grandmothers Advocacy Network

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1. INTRODUCTION

Purpose of This Paper

Participants in the Grandmothers Advocacy Network (GRAN) identified the need and desirability of keeping a strong focus on older women as part of how we advocate our issues. This paper is designed to help us better understand the concerns, strengths, rights and situations of older women in sub-Saharan Africa (SSA) by:

- Reviewing relevant, up-to-date-information on older women in SSA as it relates to GRAN's work and current issues
- Providing the groundwork and rationale for the better integration of older women in advocating a feminist agenda that respects the rights of all ages
- Suggesting actions that protect and enhance the rights of older women and the vulnerable young people in their care in SSA.

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About This Paper

The structure of the paper is as follows:

- Section 1 provides information on SSA and the major challenges facing older women and grandmothers.
- Section 2 proposes a conceptual framework for action.
- Section 3 describes five pillars for action: Education and Lifelong Learning, Health, Freedom from Violence, Economic Security and Social Protection, and Human Rights, Dignity, Equality and Full Participation. Each pillar is discussed under the headings of Background Information (which includes reference to the applicable Sustainable Development Goals (SDGs)), The Situation for Older Women in sub-Saharan Africa, and some Implications and Opportunities for Action.
- Section 4 provides a summary of key messages.
- Section 5 provides the References. This includes a literature review prepared for GRAN by Jesse Whattam. Our thanks to Jesse and May Chazan's team at Trent University. The review is available on request from Peggy Edwards.
- Appendix A provides a Glossary of key terms. Words in the Glossary are highlighted in purple the first time they appear in the text.

This full-length report is accompanied by an Executive Summary, five 2-page Information Sheets, and a PowerPoint presentation. This paper, the Information

Sheets, Executive Summary and presentation are available on the GRAN website at http://grandmothersadvocacy.org/

There are some important things to consider when reading and using the information in this report:

- This report focuses on the region in Africa known as sub-Saharan Africa (SSA), where the HIV/AIDS pandemic is most prevalent and persistent.
- There are great variations between and among different countries. For example, older women living in very low-income countries or countries in conflict will have different life circumstances than those living in low- and middle-income countries with stable governments in place. There are also differences within countries themselves. For example, older women living in rural areas are more likely to be poor and to have less access to healthcare services than those living in cities. At the same time, older women who live in urban areas often face multiple disadvantages, including scarce access to clean water, adequate housing and security. Urbanization also tends to exacerbate inequities; for example, studies have shown greater disparities in childhood nutrition between rich and poor urban communities than between rural and urban areas.[1]
- "Older women" are not a homogeneous group. Life is very different at age 50, 60, 70 and 80, and is affected by culture, traditions, education, living conditions, social support, values and earlier life experiences. Aging may also constitute a continuum of independence, interdependence and dependence. This ranges from older women who are essentially independent, to those who require and give assistance in their day-to-day lives, to those who are dependent on others for support and care. Grandmothers in Africa are dealing with all of these stages as they support themselves and each other, and care for young people, middle-aged people who are ill, and older people in their families and communities

How Old is Older?

Statistics Canada defines "seniors" as aged 65 and above. The UN generally refers to older people as age 60 and above. However, in SSA it is not uncommon for women in their 40s and 50s to be grandmothers and/or to experience the physical declines associated with older age, as a result of early and mid-life deprivations. In many countries, policies and programs distinguish older women as those who are past the reproductive stage of life (age 50). Statistics in this report are based on the chronological age categories used by the research body. However, it is important to view aging and "older" as a culmination of life experiences and transitions, and to consider how aging women themselves perceive being "older" in various communities and cultures.

Older Women Count! The Challenges of Invisibility, Inequality and Discrimination

All over the world, older women speak of feeling **invisible** after leaving the reproductive years behind. In low-income countries, the challenge of invisibility is exacerbated by a lack of data. For example, very little or no data is collected on HIV status, and the experience of violence for women after the age 49.[2] In other cases (such as levels of education and literacy) data is limited and/or not disaggregated by age and sex. Older women are denied basic services and protection of their rights because they are absent from official records and are invisible to policy-makers and organizations providing development assistance.

Addressing **inequality** and achieving gender equality and the empowerment of girls and women (Sustainable Development Goal 5) is at the heart of GRAN's work. Gender equality is not only a fundamental human right, but also a necessary foundation for a peaceful, prosperous and sustainable world. Measuring progress for older women on the indicators in SDG 5 remains impossible when older women are excluded from the new world of data and information by language, poverty, lack of education, lack of technology infrastructure, remoteness or prejudice and discrimination. New ways of collecting information are required in addition to extending age cut-offs beyond age 49 (to include age groupings from 50 to 60, 60 to 75 and age 75 and above). Current targets in virtually all the SDGs need amendments if we are to understand inequality among older people.[3]

Women already face **discrimination** based on sex and gender. Aging brings additional vulnerabilities to discrimination and rights violations. The existing human rights instruments are not enough to provide the necessary protection for older people, both in law and practice. Discrimination based on age and gender may be exacerbated among older women who are members of certain groups including Indigenous peoples, minority ethnic, tribal and racial groups, immigrants and migrants, the LGBTTQ+ community, and older women with disabilities. Older women affected and infected by HIV/AIDS are often further stigmatized and isolated.

Sub-Saharan Africa: A Demographic Profile[4,5,6]

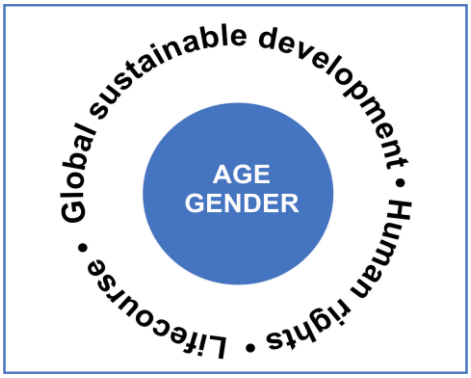
Note: additional, more detailed information is contained in the sections of this report that deal with the 5 pillars for action.

- Largely due to high fertility rates, Africa's share in the world population is expected to increase to 24% in 2050, up from 13% in 2012.
- Africa is the most youthful continent in the world. The median age in SSA is 19, compared to age 40 in Canada. More than one-third of the population in SSA is between the ages of 10 and 24.

- At the same time, the sheer number of older persons in SSA is rapidly growing. The number of people over age 60 has doubled since 1990 and is projected to more than triple between 2015 and 2050.
- In 2015, there were 46 million people aged 60 years or over--an increase from 23 million in 1990. In 2050, a projected 161 million older persons will reside in the region (13% of the population).
- The region has the lowest levels of life expectancy at birth in the world (55 years for men and 57 for women). In the 1990s, life expectancy at birth fell sharply in countries such as Zimbabwe, Botswana, the Republic of Congo, Kenya, Namibia and the Central African Republic, and only edged up in many others, due to the HIV/AIDS pandemic, conflict, and persistently high maternal and child mortality rates. Nonetheless, Africa is projected to see great strides in life expectancy (at birth) from 60 years in 2010-2015 to 71 years in 2045-2050.
- Life expectancy after age 60 has increased in the region. If a woman does not die of childhood diseases nor in childbirth and does not contract HIV or other life-threatening diseases in mid-life, she has a good chance of living quite a while beyond the reproductive stage of life.
- Thirty-three of the 48 countries on the UN's list of Least Developed Countries are in Africa. Despite impressive economic progress in recent years in some stable countries, the region still has the highest levels of extreme poverty (41% living on less than $1.90 per day in 2015).
- SSA has the highest prevalence of undernourishment (estimated at 23%). The situation is worst in Central Africa where progress has been hampered by conflict, rapid population growth, environmental fragility, and economic and political upheaval.
- Of the estimated 17 million children worldwide who have lost one or both parents to AIDS, 90% reside in SSA. In some countries, 60% (or more) of orphans live in skipped generation, grandmother-headed households. This occurs in both rural and urban areas.[7,8]

2. A FRAMEWORK FOR ACTION

Applying an Age- and Gender-Responsive Lens



The image above provides a conceptual framework for action. It suggests the mainstreaming of both an age- and gender-responsive lens by decision-makers, partners and other influencers when considering policies, programs, practices and treaties affecting countries in Africa (and here at home). This means asking a fundamental question: How will this policy, funding program, legislation, communication, etc. affect different genders and differing ages, with a clear inclusion and emphasis on older women?

This gender and age-sensitive lens takes into account three conceptual foundations for policy making, strategic planning and campaigns:

- **A Lifecourse Approach** understands aging and cumulative disadvantage as a process that spans the entire lifespan, and provides supportive policies and activities at key transition points in a woman's life.[9] Examples of life course events after the reproductive stage of life that affect women's well-being in older age include: caregiving responsibilities associated with grandmothering and looking after community members who are sick; domestic violence, which may begin in childhood, continue in marriage and is a common form of elder abuse; widowhood, which commonly leads to a loss of income and property; cultural traditions and other barriers that limit access to health care in older age; and a lack of end-of-life care and support. Because GRAN supports the lifecourse approach, we lobby for changes in how older women are viewed and treated as well as key changes in the lives of girls and young women (e.g., the elimination of child and forced marriage), and improvements in maternal health

and in midlife. We also encourage intergenerational solidarity and respect between generations as an essential part of a lifecourse approach.

- **Global Sustainable Development** (GSD) underlies Canada's emerging approach to foreign affairs and development aid. GSD describes the pursuit of a stable, inclusive, healthy and thriving global society that lives within nature's means and provides an adequate resource base for future generations.[10] A GSD approach is committed to achieving the Sustainable Development Goals (SDGs) and to "leaving no one behind". GRAN supports this approach and suggests that while grandmothers and older women in Africa are the backbone and heroes of development, older women are currently being left behind and/or left out in many ways.

- **Human Rights** also underlie Canada's approach to foreign affairs. It is a conceptual framework for the process of human development that is based on international human rights standards and directed to promoting and protecting human rights. It seeks to analyze inequalities which lie at the heart of development problems and redress discriminatory practices and unjust distributions of power that impede development progress.[11] Respecting human rights and GSD go hand in hand. Increased protection of the rights of older women enables them to participate in and contribute to their own development, as well as that of those around them. This results in more inclusive, equitable and sustainable societies. GRAN is committed to addressing and supporting older women in their fight for equality, dignity and fulfillment of their human rights. A feminist approach is integral to this work.

3. FIVE PILLARS FOR ACTION

This report suggests that GRAN and others consider taking action regarding older women in five areas or “pillars”:

Pillar 1: Education and Lifelong Learning
Pillar 2: Health
Pillar 3: Freedom from Violence
Pillar 4: Economic Security/ Social Protection
Pillar 5: Human Rights, Dignity, Equality and Full Participation

These pillars are discussed in the sections that follow under the headings of: Background Information (which includes reference to the applicable SDGs), The Situation of Older Women in sub-Saharan Africa, and some Implications and Opportunities for Action.

3.1 PILLAR ONE: EDUCATION AND LIFELONG LEARNING

Background Information

Education and lifelong learning is imperative for all girls and women, especially in the developing world. Female education benefits the individual, family and community. It positively affects family health and nutrition, fertility, agricultural productivity and the ability to earn an income. Yet there is still a wide gender gap in education.

Sustainable Development Goal (SDG) 4 is to "Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all".[12] The targets in this goal speak to providing education and training for "all adults" including the "vulnerable--persons with disabilities, indigenous peoples and children in vulnerable situations". Older adults are not specifically mentioned.

Sustainable Development in an Ageing World: a call to UN Member States on the development agenda beyond 2015 states that "Countries with an aging population need policy responses to support the elderly so as to remove barriers to their full participation in society while protecting their rights and dignity."[13]

Literacy and Adult Learning and Education

The International Council for Adult Education notes that basic literacy is generally understood as learning to read and write (text and numbers), and using reading and writing to learn other skills that are needed to meet basic needs. Beyond this definition, is the statement that "Literacy is more than the personal ability to read and write. It is a powerful vehicle to empower people and help them obtain adequate life skills and entrepreneurship capacities to tackle contemporary challenges and optimize opportunities for sustainable development".[14]

Functional Adult Literacy (FAL) links literacy to people's livelihood and needs. It incorporates skill-specific training in addition to literacy and numeracy.[15]

Adult Learning and Education (ALE) can be formal or non-formal. The UNESCO Recommendation for Adult Education (2015) emphasizes the interrelation of education with human rights, and that lifelong learning is integral to sustainable development, achieving equity and inclusion, and alleviating poverty.[16]

There are numerous challenges to providing adult education in low- and middle-income countries, including:

- Multi-ethnic and multi-linguistic diversity. For example, Nigeria has 300 languages and dialects; Chad has 120.
- Poverty and joblessness
- Lack of political will

- Inequities in access due to discrimination against women; lack of provision to people with disabilities, older people, and other groups with special needs
- Lack of resources and infrastructure: little or no funding, the need for infrastructure near where older adults live, some areas are hard to reach because of lack of transportation
- Gaps in the education system: lack of a comprehensive adult education policy, lack of core curriculum and supporting materials, lack of Open and Distance Learning (ODL)
- Lack of professional development: most adult educators are untrained.

Some countries have national adult education policies (e.g. Eritrea, South Africa). Zimbabwe has a lifelong education policy and in some countries, the right of adults to education is enshrined in the constitution (e.g. Burkina Faso, Uganda). However, in many situations, adult education is seen as an unenforceable right because of a lack of resources. "The overwhelming impression is that adult education is a marginal element".[17]

A recent UNESCO survey shows a growing emphasis on ALE in sub-Saharan Africa. Sixteen countries in the Region have introduced significant innovation in the quality of their ALE programs since 2009.[18]

Most countries with educational policies see ALE as needing to give special access to women. However, worldwide only 9% of countries see senior citizens/retired people as an "especially important target group in ALE policies and programs.[19]

When adult education is available, the dominant focus is on literacy (alphabetization and numeracy), which is seen as an "under-resourced variant of primary schooling provided for out-of-school children and youth". There is some vocational education. A few countries such as Namibia and Tanzania have a limited amount of Information and Communication Technology and Open and Distance Learning. Non-governmental organizations (NGOs) are increasingly participating in the delivery of adult education services.[20]

Cultural sensitivity is important in adult education. For example, grandmothers' perceptions about the causes and treatment of HIV may be influenced by a range of culturally-mediated beliefs that are not biomedical, but social and multidimensional. Those with regular access to culturally-sensitive education programs, publicity and media have increased understanding of prevention, nutrition, and the effectiveness of antiretroviral therapy.[21]

Increasingly, community-based grandmother groups are engaging in non-formal adult education to teach grandmothers about HIV/AIDS and other issues. Speaking at the 2013 Tribunal organized by the Stephen Lewis Foundation, Mariam Mulindwa, a leader in the Jinja District of Uganda said:

Every Wednesday, I meet with grandmothers like me and we share our challenges and achievements in life. … There is so much intensity and sadness, and the grandmothers are exhausted hearing what and what about AIDS. We use music, dance, and drama to entertain them, but also to raise awareness about HIV and AIDS, good hygiene and sanitation. Theatre and plays work because they help the grandmothers express themselves in a different way—they laugh, have some fun, and feel like part of the group. It is a skill to reach out to grandmothers who are grieving and isolated and help them feel better, understand their rights, their healthcare entitlements and how to access government programmes.[22]

The Situation of Older Women in sub-Saharan Africa

Most older women in sub-Saharan Africa have not had the opportunity to go to school and, even though they have great knowledge about their customs, values and environment, are not literate (see definition above). Because of this, they have difficulty or are unable to read and fill in forms to get bank loans, advocate for pensions, read or interpret policies and laws regarding land and property inheritance, take advantage of technology, gain independence in the community, and assist grandchildren with homework. In other words, older women cannot fully participate in society or achieve the rights and dignity they deserve.

There is a paucity of information about education and lifelong learning for older women in Africa. Few African countries regularly collect data on literacy and education among older people. Data on gender differences in older age are rare. Recognizing the limitations in available data, we do know that:

- Globally there are 57 million out-of-school children of primary school age (in 2015); 33 million of these children are in sub-Saharan Africa, and more than half (55%) are girls.[23]
- Nearly two thirds of the world's 750 million illiterate adults are women, and almost all of them live in developing regions.[24]
- The lowest national literacy rates are observed in SSA and in Southern Asia. Adult literacy rates vary greatly within and among countries in the region. Reported adult literacy rates are below 50% in Benin, Burkina Faso, Central African Republic, Chad, Cote d'Ivoire, Ethiopia, Guinea, Mali, Mauritania, Niger, Senegal, Sierra Leone and South Sudan. The majority of those who are illiterate are women.[25]
- Youth literacy rates in SSA, for the population aged 15 to 24 years, are generally higher than adult literacy rates, reflecting increased access to schooling among younger generations. Nevertheless, youth literacy rates remain low in several countries in SSA, which suggests problems with low access to schooling, early school leaving or a poor quality of education. [26]

- In 2015 in SSA the literacy rate among women aged 16 to 49 was 65%, the lowest in the world.[27] As these women age, they have few opportunities to participate in adult education programs. Without adult education, these women will become older women who will have great difficulty understanding and creating written material.
- The vast majority of older persons (age 65+) are illiterate in SSA (literacy rate of 34% in 2014). In 2015, literacy rates for women aged 65+ were lower than men in the same age category--estimated to be 26%–a modest increase of 2.5% since 2005.[28]

> ***We must have the resources to build our own capacity to raise healthy families and assist one another. We call for more training in critical areas such as home-based care, HIV/AIDS education, on parenting orphaned children and adolescents, health care, literacy, and financial management.*** … Manzini Statement, 2010[29]

Examples of Successful Education Programs for Adults in Africa

The *Kha ri Gude* program in South Africa (which means "Let Us Learn"), has enabled 4.7 million adults over the age of 15 to become literate in one of the eleven official languages. Many older people are participating. Initiated and managed by the Department of Education, the program enables adults to read, write and calculate in a mother tongue and to learn English.[30]

A delightful example of education for older women is the story of *Priscilla Sitienei*, aged 90 who has been a midwife for 65 years. She attends school with six of her great-great-grandchildren and takes part in all of the classes including math, English, physical education, dance, drama and singing. She is, according to a classmate, the best in math. Besides her academic work, she helps by telling stories about tribal traditions and teaching the children about herbal plants. She encourages all the out-of-school children to go to school. She says, "I want to say to the children of the world, especially girls: Education will be your wealth. Don't look back".[31]

A successful non-formal education program is taking place in the north-east corner of Ghana. *Veronica Abugrago, the Queen Mother of the Bawku Traditional Area*, meets with the network of divisional and sub-Queen mothers she has appointed in each community. She provides education on the harmful effects of female genital mutilation. Through her work and influence, the bride price has been decreased and she continues her efforts to have it eliminated completely. Queen Veronica has also been influential in the decision to ban widowhood rites in the region, and

in helping girls get into school.[32]

Reflect, an innovative approach to adult learning and social change, was developed in the 1990s through pilot projects in Bangladesh, Uganda and El Salvador and is now used by over 500 organizations in over 70 countries worldwide (including some in Africa). Reflect provides an on-going democratic space for people to meet and discuss issues relevant to them. Underpinning the approach is a large range of participatory methods. Prominent among these are the use of graphics, drama, songs and storytelling, which enable participants to communicate their knowledge, experience and feelings without being restricted by literacy and language barriers. The STAR program, which evolved out of Reflect provides a participatory approach to HIV prevention. Organizations working with Reflect won UNESCO literacy prizes in 2003, 2005, 2007, 2008 and 2010.[33]

Two successful examples of adult education programs for grandmothers are part of the PEFO and ARUWE projects in Uganda, which are supported by the Stephen Lewis Foundation Grandmothers Campaign.

Uganda Phoebe Education for Orphans (PEFO)[34]

PEFO introduced the concept of Functional Adult Literacy to grannies at the vocational training centre. It was anticipated that just a few younger grannies would enroll in the classes since they are the ones that initiated the idea. However, the demand for inclusion in the program by older grannies has been overwhelming, and even the visually impaired grannies are expressing interest in the classes. The grannies of Babonere kwife (meaning: let them see from us) have formed a supplementary class where grandmothers with the ability to read and write coach others for at least 2 hours once every week. It should be noted that this is the very group that has embraced market information record keeping more effectively than others.

Action for Rural Women's Empowerment (ARUWE)[35]

Due to illiteracy and gender roles, the participation of women/grandmothers in leadership both in political and technical areas is still low, which causes them to have less influence over development issues. Grandmothers groups are therefore given training in various aspects of group dynamics including developing a constitution, defining group membership, registration, record keeping, roles and responsibilities, leadership skills, conducting meetings, communication skills, team building, and savings mobilization. All groups are encouraged to be consistent, transparent and accountable to each other and in their group work so that efficiency and sustainability is achieved. The greatest challenge that arose during the training was the inability of 90% of grandmothers to read and write. The 10% who could read and write were the group leaders.

Lack of literacy and numeracy skills is a major challenge among grandmothers. It also subjects them to exploitation by middlemen as they cannot accurately read

scales and measurements for their produce, especially grains. They are also not able to keep proper farm records. Some of the grandmothers have unknowingly bought expired herbicides and pesticides from the agricultural supply outlets in the area. This has caused loss of money and effort.

> ***Because I am not able to read the weighing scale figures, I am at times cheated by middlemen who come to purchase my crop produce especially maize and beans. I am only saved during those times when a neighbour is present to help me make accurate readings. This not only affects my income but my independence and privacy as a person because I have to depend on others to help me ascertain the accurate prices for my produce. I hope grandmothers can be supported with literacy and numeracy programs*** … grandmother in ARUWE project, Uganda

Family Literacy and Learning Programs[36]

In 2017, the UNESCO Institute for Lifelong Learning published *Learning Together Across Generations: Guidelines for Family Literacy and Learning Programmes,* which provides an introduction to the concepts, as well as guidelines and examples of materials. The materials are based on pilot projects in SSA. Family literacy and learning focus on intergenerational interactions within families and communities. It recognizes the vital role that parents, grandparents and other caregivers play in their children's education. It seeks to break down artificial barriers between learning in formal or non-formal settings. Very often, the desire to help children with schoolwork motivates grandparents to re-engage in learning themselves and improving their own skills. The focus of family literacy and family learning is therefore on both child and adult' learning.

Educating with Mobile Phones[37]

Text to Change provided HIV/AIDS education via a text messaging quiz to 15,000 mobile phone subscribers during three months in Uganda. The quiz produced a 40% increase in people who came in for HIV testing and counselling—from 1,000 to 1,400 during a six-week period. Currently, 80% of the population in developing countries has access to a mobile phone (which are sometimes shared in villages). Text messages are an easy, scalable, and anonymous way to gain access to people, including grandmothers and the children in their care.

Education and Lifelong Learning: Implications and Opportunities for Action

What can we do to protect and enhance older women's'/grandmothers' rights to education and lifelong learning?

1. Recognize that education and lifelong learning is a human right and pillar of healthy aging.[38] Continue to insist that education and lifelong learning is imperative for all girls and women, including older women.

2. Stress the importance and benefits of addressing and resourcing the second part of SDG 4: "to promote lifelong learning opportunities for all".

3. Ask the Global Partnership for Education,[39] the Forum for African Women Educationalists[40] and other groups working in education to encourage and advocate for quality education programs for older women that are taught by trained educators.

4. Share the stories of how community-based grandmother groups are engaging in lifelong learning and functional adult literacy. Press for financial support for these initiatives.

5. Continue to press for an increase in Canada's budget in international aid that supports quality, safe education and lifelong learning for all. This should include new money committed for the education of older women, who are most often left out.

6. Promote intergenerational exchange as a means of lifelong learning. Maximize opportunities for intergenerational learning within families, communities and workplaces. Foster the valuing of skills, experiences, perspectives, memory and accumulated wisdom, and their transmission to other generations.[41]

7. Celebrate International Literacy Day[42] in September through op-eds, letters to the editor etc., which focus on intergenerational education and the need for lifelong learning.

3.2 PILLAR TWO: HEALTH

Background Information

Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all at all ages.

SDG 3 embraces the well-established fact that prevention and health promotion from birth throughout the life course leads to better health outcomes, particularly at older ages. It also heralds equality in health at all ages as critical to leaving no one behind. However, none of the health priorities and healthcare needs of older persons articulated in the Madrid International Plan of Action on Ageing are expressed within the existing targets of the SDGs. The Madrid Plan, which was adopted at the Second World Assembly on Ageing in 2002 sets out a global agenda for enhancing the well-being of older people and addressing the key challenges of "building a society for all ages".[43]

Within the SDG framework, the relevance of indicators for measuring targets on communicable diseases (Target 3.3) depends very much on the upper age limit recommended by the guidelines for data collection. In most developing countries, prevalence rates for HIV/AIDS are currently only calculated for ages between 15 and 49, even though it is known that people above the age of 49 are still at great risk for contracting HIV/AIDS. The data situation is similar for malaria and tuberculosis. The exclusion of data on older persons reduces the relevance of the indicators for measuring targets

The suggested indicator for Target 3.4, "By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being" excludes those above 70 years of age. This ageist target suggests that people over the age of 70 are not important human beings and may result in discriminated access to healthcare.[44]

In many countries in Africa, the high cost associated with the treatment of chronic diseases and HIV/AIDS leaves the most disadvantaged, including older persons, without access to healthcare and life-saving medicines.[45] This makes Target 3.8, to "achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all", a challenge for older women. This challenge is exacerbated by a lack of knowledge among practitioners about the health issues and needs of older persons, coupled with the limited availability of age-friendly healthcare in many countries.

The growing mental health needs of an aging population and the substantial growth in the incidence of dementia is not addressed within the framework of the SDGs. Similarly, the contribution and strains of caregiving to the health and

well-being of women of all ages is ignored in the SDGs.

Several other SDG goals are particularly relevant to the health of older women. These include: Goal 2: Zero hunger (Target 2.2 specifically mentions older people), Goal 6: Clean water and sanitation, and Goal 11: Sustainable cities and communities (Targets 11.2 and 11.7 specifically mention older people).

Causes of Death [46,47]

Estimating cause-specific mortality in SSA is a challenge due to a lack of data, the complexity of defining one cause when an individual has multiple health problems, and the great diversity among countries within the region. The cause of death may be attributed to the contributing cause, such as tuberculosis rather than the underlying cause (HIV/AIDS). Accuracy is further hampered because those issuing death certificates often do not know individuals' HIV status, and because many individuals do not get tested for the virus.

In 2015 in SSA, more than 3 million people died from the five leading causes of death. All of the 5 leading causes of death are preventable. The Africa Check factsheet based on WHO (2015) data identifies the five major killers as:

1. ***Lower respiratory tract infections***, which stem from many viruses and bacteria and occasionally fungi or parasites. The most common illnesses are bronchitis and pneumonia. Pneumonia is single-handedly responsible for 16% of global deaths of children younger than five, with a significantly greater share in Africa. The notable exclusion from this category is tuberculosis as the disease can infect anywhere in the body even if initially limited to the lungs. People who are HIV+ are at particular risk of an active TB infection. The World Health Organisation classifies deaths in cases of patients with both TB and HIV as the result of a complication of HIV.

2. ***HIV/AIDS*.** The Human Immunodeficiency Virus targets the immune system, restricting someone's ability to mount a defence against infections and cancers as it progresses. The most severe phase of the disease is known as AIDS, or acquired immunodeficiency syndrome, and can take between 2 to 15 years to develop, depending on the person infected. In 2015, there were an estimated 760,000 deaths from HIV/AIDS and related complications in Africa, compared to 1 million in 2010. This 24% decrease is due to better diagnosis and treatment and more information on the condition. The near-halving in HIV/AIDS mortality is a trend seen over the last decade – 1.5 million people died of HIV/AIDS in 2005. Despite this, the number of deaths due to AIDS-related illnesses in SSA still amounts to the largest share of the world total: 70% of global deaths.

   AIDS-related illnesses remain the leading cause of death among women of reproductive age (15–49 years) globally, and they are the second leading cause of death for young women aged 15–24 years in Africa (2016). In 2010, 6% of

under-five deaths in sub-Saharan Africa were associated with HIV. In some countries, the rate is much higher, e.g., 28% in South Africa and 23% in Swaziland. Overall, the number of children (aged 0–14 years) dying of AIDS-related illnesses has been nearly cut in half in just six years. Much of the decline is due to steep reductions in new HIV infections among children, and increased access to paediatric antiretroviral therapy.

3. ***Diarrhoeal diseases*.** Diarrhoea, which is defined as the passage of three or more loose or liquid stools per day or more than is normal for a person, are largely due to unsafe water, poor sanitation and insufficient hygiene. It is the second leading cause of death of children younger than five worldwide. Compounded by malnutrition, death is caused by dehydration, poor absorption of nutrients or infectious complications, such as damage to the intestinal wall. Since 2010, deaths due to diarrhoeal illnesses have decreased from 725,000, or 8% of the region's deaths, to 643,000 (7%) in 2015.

4. ***Stroke*.** A stroke happens when blood flow to a region of the brain is interrupted by either a clot or bleeding, depriving the body of oxygen and nutrients. Often, the person dies or suffers permanent damage. Stroke deaths in SSA increased over the past five years from 406,595 (4.4% of deaths) to 451,000 deaths (4.9%) in 2015.

5. ***Ischaemic heart disease*.** Ischaemic heart disease refers to the narrowing of the arteries of the heart due to the buildup of plaques. Death occurs when an artery suddenly becomes fully blocked, causing severe damage to the heart. More commonly this is known as a heart attack. During 2015, an estimated 441,000 deaths (or 4.8% of the total) were due to ischaemic heart disease. In 2010, this category had a significantly smaller number of deaths at 389,785 (or 4.2% of total deaths). Risk factors for stroke and heart attack include high blood pressure, smoking, diabetes, being overweight, high cholesterol levels, an unhealthy diet, stress and lack of exercise.

After these top five killers, the next leading causes of death in Africa were tuberculosis (456,000 or 4.7% of total), malaria (403,000, or 4.4%), preterm birth complications (344,000 or 3.7%), birth asphyxia or trauma (321,000 or 3.5%) and road injury (269,000 or 2.9%).

Causes of death vary across the lifecycle

Child mortality: Despite significant progress in some countries, **t**he highest rates of child mortality are still in SSA —where 1 in 9 children dies before age five, more than 16 times the average for developed regions (1 in 152). Sub-Saharan Africa, which accounts for 38 percent of global neonatal deaths, has the highest newborn death rate (34 deaths per 1,000 live births in 2011). Many children die from diseases that can be prevented through vaccines. In 2011, African immunization

coverage was estimated at 77%. The World Health Organization (WHO) estimates that 20% of under-five deaths—approximately two million deaths annually—could be prevented with existing vaccines.[48]

A report from Save the Children (2017) ranks countries on seven childhood-ending events (death under 5 years of age, severe child malnourishment, being out of school, engagement in child labour, child marriage, adolescent birth, and subjection to extreme violence). Most of the lowest ranked countries are in central and west Africa where many children are affected by conflict and displacement, which puts them at twice the risk of dying before they reach the age of 5 years than children living in stable contexts.[49]

Adolescents and the young adult population is at significant risk of premature death from HIV/AIDS-related illnesses, armed conflict, gender-related violence, road traffic accidents, tuberculosis, and among women, causes related to pregnancy and childbearing.

Older adults: About 20% of mortality in the region occurs among individuals age 60 and older. This is much less than is observed in high-income countries. For instance, in Canada over 80% of deaths occur above the age of 60. In SSA, the major causes of death after age 60 are cardiovascular disease, chronic obstructive pulmonary disease, diabetes, infectious diseases (including tuberculosis and HIV/AIDS) and cancers (especially prostate cancer in males, cervix and breast cancer in females).[50]

Disease and Disability

All over the world as people live longer and living conditions improve, formal and informal public health care is faced with an epidemiological transition from communicable diseases (such as hepatitis, influenza, HIV/AIDS, malaria) to non-communicable diseases (such as heart disease, dementia, cancer and diabetes). In Africa, most countries are caught in the middle of this transition. While they are facing a rapid increase in non-communicable diseases and chronic health problems, they are also disproportionately affected by communicable, infectious diseases. SSA accounts for 90% of malaria deaths, more than 70% of all people living with HIV, and 28% of all tuberculosis (TB) cases. More than 75% of all estimated HIV-incident TB cases are found in sub-Saharan Africa.[51]

Studies show that older African people have high rates of hypertension, musculoskeletal disease, vision impairment, functional impairment, nutritional deficiencies, cardiovascular disease, diabetes and depression.[52]

It is difficult to find statistics on disability in SSA due to differing uses of the term and a lack of data. What we do know is that older people are highly likely to be dealing with disabilities related to aging (e.g. declines in vision and hearing),

disease (for example, as a result of a stroke), injury, and/or a lifetime of poor nutrition and heavy work (e.g. carrying water). Grandmothers with disabilities have difficulty accessing healthcare services and performing the self-care and caregiving tasks required in day-to-day life. Persons with disabilities are often prevented from equitable access to HIV/AIDS prevention and treatment services because of both attitudinal and physical barriers.[53]

HIV/AIDS [54]

- SSA remains the region in the world most affected by the HIV/AIDS pandemic. In 2014, it was estimated there were 24.7 million people living with HIV, nearly 71% of the global total. This included some 2.9 million children (aged 0–14), some 3 million young people (aged 15–24), and more than 2.5 million people aged 50 years and older. Nearly 1 in every 20 adults was living with HIV. Women accounted for 58% of the total number of people living with HIV.
- From 2010 to 2016, the annual number of new HIV infections (all ages) has declined by 16% to 1.8 million. The pace of decline varies by age group and between men and women. Among children, new infections have declined 47% since 2010. Coverage of antiretroviral medicines provided to pregnant women living with HIV to prevent transmission to their children rose from 47% to 76% over the same period.
- In 2016, new infections among young women (aged 15–24 years) were 44% higher than they were among men in the same age group. Young women remain at unacceptably high risk of HIV infection. In eastern and southern Africa, for example, young women accounted for 26% of new HIV infections in 2016 despite making up just 10% of the population. These infections may well be a result of gender-based violence and early sex with older partners. In some settings, up to 45% of adolescent girls report that their first sexual experience was forced.[55]
- The large majority of people living with HIV who are affected by conflict, displacement or disaster live in SSA. Girls and women of all ages are highly vulnerable to sexual violence and HIV infection in conflict and displacement settings.
- There is a paucity of research in marginalized groups such as men who have sex with men, people who inject drugs and sex workers; however, emerging data suggests that HIV prevalence is significantly higher in these groups than in the general population. Discrimination and the criminalization of sex work, drug use and same-sex relationships deters the prevention of HIV, and hinders disclosure and reaching people at high risk of HIV infection with services to prevent and treat HIV/AIDS.[56]
- The growing number of people aged 50 years and older who are living with HIV/AIDS is a significant trend all over the world. In high-income countries such as Canada approximately 30% of all adults living with HIV are aged 50 and over. It is estimated that it is now 10% in low and middle-income countries

(including those in SSA). This "aging" of the HIV epidemic is mainly due to three factors: the success of antiretroviral therapy in prolonging the lives of people living with HIV; decreasing incidence among children and the often-overlooked fact that older people exhibit many of the risk behaviours found among younger people.[57]

- While relatively few HIV surveys have been conducted among individuals aged 50 years and older, those available reveal a high HIV prevalence in this age group. For example, in Mpumalanga Province in South Africa in 2010, HIV prevalence was 35% among men aged 55-59 and 27% among women in the same age category. For age 60-64, it was 20% for men and 13% for women; for age 65-69 it was 17% and 10%. A study in Swaziland found 13% of men and 7% of women aged 60-64 were living with HIV (compared to 27% among men and women aged 15-49 years.)[58]

The Situation of Older Women in sub-Saharan Africa

Today, global reports provide data on AIDS deaths, new infections and numbers of people living with HIV for all adults over the age of 15 (with no upper age limit). However, UNAIDS still uses indicators that collect HIV prevalence data (percentage of the population with HIV) for those aged 15-49 only. Similarly, core indicators used to track progress on access to voluntary counselling and testing, and sexual behaviour and condom use generally exclude those aged 50 and over. There is also limited data available on who is providing care to vulnerable children and people living with HIV, and on what support caregivers need and are receiving. If we are to convince governments and donors to mount effective action we need a comprehensive picture of the impact of the epidemic at the local, national and international levels. Data must be collected for all people and disaggregated by age, sex and socioeconomic status – particularly in high-prevalence areas.

For the first time, the 2015 GAP Report from UNAIDs used modeling and what data is available to profile the situation of older people and HIV. There is a regrettable lack of gender analysis; generally, the report provides information on persons aged 50-plus, including men, women and transgendered persons as a single group. Here are some of the highlights from that report, and from studies and analyses undertaken by HelpAge International.[59,60]

- More than 2 million people living with HIV aged 50 and older reside in SSA, which represents about 10% of adults living with HIV in that region. In high-income countries like Canada, the sub-population of people aged 50 and older represents approximately 30% of the adult population living with HIV. All over the world, this demographic is expected to grow. As it does, so will the need for long-term access to medicines and to HIV and other health services. In SSA, recent modeling projects suggest that the total number of people living with HIV aged 50 or older will nearly triple in the coming years.

- Every year, 100,000 people in low- and middle-income countries aged 50 and older acquire HIV. Seventy-four per cent of this population lives in SSA.
- Stereotypical beliefs suggest that older people are not sexually active. But first-hand accounts and a few surveys suggest otherwise. In a survey in South Africa, more than half of people 50 years and older reported having had sex 1-4 times in the previous 30 days.
- HIV prevention and other services, including condom distribution and tuberculosis screening, rarely include older people or reflect their specific realities and needs. Excluding older people from prevention programs not only increases their own risk of exposure to HIV, but also prevents them from informing the young people in their care.
- Sexually active women aged 50 and older are at high risk of acquiring HIV, owing to biological changes. The thinning of the vaginal wall after menopause increases the chances of lesions and tears, thereby increasing the risk of HIV transmission during sex.
- People aged 50 and older generally have a low perception of their own risk of acquiring HIV. Studies show that the majority of people aged 50 and older with multiple partners do not use condoms.
- Little is known about whether older people are accessing testing and voluntary counselling. In one small-scale study, older people said they felt that many services were aimed at younger people, and voiced fears about discussing their sexuality with younger staff. They were concerned about a lack of confidentiality, especially if they were hard of hearing and the counsellors had to raise their voices, or if they were unable to read the results for themselves.
- Many older people need access to treatment for HIV and related conditions, either for themselves or for those in their care. But with data on antiretroviral treatment rarely disaggregated by age, it is not clear how many older people are obtaining treatment or what prevents them from doing so.
- Providing treatment is challenging if the older person living with HIV also has one or more chronic conditions (which is very often the case).

> ***My own life I am not enjoying just like any other woman. My husband died, my two children died, and I found out that I am HIV positive. I am also diabetic and taking treatment for hypertension. Aging with HIV/AIDS is difficult because of the increased treatment I must take, and dealing with the various treatment complications alongside my role as a caregiver.*** … Thulisile Dladla, Manzini Region, Swaziland, speaking at the African Grandmothers Tribunal, 2013.[61]

- The timely initiation of antiretroviral therapy is especially important, since the immune systems of people 50 and older tend to recover more slowly compared with those of younger people.

- People aged 50 and older are more likely than their younger counterparts to remain on antiretroviral therapy. But adherence can suffer when individuals are experiencing several chronic conditions simultaneously or facing poverty and food insecurity.
- Health communication and health services are not geared towards people aged 50 and older living with HIV. Clinicians are less likely to be trained on the specific needs of people 50 and older. This combined with poor quality and delayed services in healthcare settings significantly reduce the potential for positive outcomes from HIV.

The misconception that women past reproductive age will not become HIV-positive, ageism and invisibility mean that older women are likely to be the "last in line" to be tested for HIV status and to receive appropriate ART when it is needed. This is particularly ironic since grandmothers/older women often act as the primary caregivers of community members with HIV/AIDS and help them manage their medications.

Grandmothers also face the difficult tasks of telling a child of their HIV-status and what this means, and then ensuring that the child gets and takes the medicines he or she needs. Paediatric ART, especially in formats that are easy to administer, is often difficult to get. Even when the medication is available, there is widespread paediatric ART failure—a fact that receives very limited attention. Problems range from children starting ART very late, a large number of young people who have never achieved viral load suppression, a low amount of program evaluation even if it is not working, and a high percentage of pre-adolescents and adolescents who have not gone through the disclosure process.[62]

> ***We will continue to struggle, and we will not give up the fight against HIV/AIDS. We will never give up because this grandmothers movement is powered by love. But we should not have to do this alone.*** … 2016 South African Grandmothers Statement[63]

UNAIDS Targets: Older People Falling Through the Gap[*64*]

UNAIDS has launched a set of fast track targets to help achieve the goal of ending AIDS by 2030 and having a world in which HIV is no longer a global health threat. What do the new targets mean for people living with and at risk of HIV in older age, and how will they be met?

- By 2020: 90% of all people living with HIV will know their HIV status. Evidence shows that older people have lower levels of HIV-related knowledge than younger groups and are less likely to have been tested for HIV. If this target is to be met, considerable focus will be needed on raising awareness among older people and ensuring that appropriate testing is delivered to them.

- By 2020: 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (ART). Because little data on access to ART is disaggregated by age, we don't have a clear picture of whether older people are able to access treatment. The findings of a study conducted in Ethiopia, South Africa, Tanzania and Uganda by HelpAge International suggest older people do not have equitable access and are more likely to access treatment later. If 90% of people diagnosed with HIV are to receive ART much greater emphasis will be needed on ensuring access is not only scaled up, but also equitably distributed, with no population group left behind.

- By 2020, 90% of all people receiving ART will have viral suppression. When older people access ART, they adhere well to treatment and are more likely to continue with medications than younger people. However, older people have more complex health needs, often experiencing a number of conditions at the same time. If 90% of people receiving ART are to reach viral suppression the health challenges of people living with HIV in older age, and the potential interactions of drugs for different conditions, will need to be better understood and addressed.

Healthcare

History has shown that universal healthcare and the strengthening of health systems are important parts of an effective response to HIV/AIDS.[65] Older women/grandmothers need ***age-friendly*** primary healthcare[66] that addresses their physical and mental health concerns, outside of and in the context of HIV/AIDS. Age-friendly healthcare enables older people to get to health centres and to be treated with dignity and respect. It provides and supports home- and community-based care for people who cannot get to health clinics and for those who are frail and dying.

Older women who are caring for others, or are sick themselves, need home- and community-based support. However, few policies, programs and guidelines address the specific needs of older people or the needs of older people caring for others in their homes. Currently, much of this kind of care is voluntarily provided by older women/grandmothers. They need recognition, training and compensation for this important work.

Recommendations for better support systems and structures include mobile health units, accessible satellite centers and transportation for grandmothers living in rural areas. Also, ways need to be found to ensure that local community organizations have grandmothers' voices heard by governments. Social services and health care providers could, through understanding the assets and needs of grandmother-headed households, better provide adequate assessment, crisis intervention, counselling and case management.[67]

As older women, we face challenges that are still ignored. The health system is failing us and HIV-positive grandmothers have special needs that are not met. We wait in lines at clinics for hours, meet with healthcare workers who are often uncaring and do not have the medication we need. … 2016 South African Grandmothers Statement[68]

Access to Medicines

Research identifies barriers to successful access to medicines and treatment for (older) women in SSA on several levels: [69]

- Structural barriers: gender and age-related inequalities, a lack of transport to obtain medicines, gaps in health systems including over-burdened staff and facilities, poor staff-client interactions, staff shortages, poor service accessibility, limited mental health services and counselling, limited attention to conditions and non-communicable diseases associated with aging.
- Community level barriers: stigma and fear of HIV status disclosure to partners, family or community members; a lack of support for community organizations; cultural traditions and preferences for traditional healers and birth attendants.
- Individual level barriers: lack of knowledge about HIV, antiretroviral treatment (ART) and vertical transmission, and about conditions such as high blood pressure and joint pain; lower educational levels; and psychological issues following HIV diagnosis.
- Poverty-related barriers: competing demands in resource-limited settings, lack of universal healthcare insurance, food insecurity and a weak social-safety net.

Older women in SSA also face limited access to affordable medicines and devices for themselves and their families, needed to deal with other infectious diseases such as tuberculosis and malaria; non-communicable diseases such as diabetes, high blood pressure, heart disease and cancer; mobility problems; and chronic conditions associated with aging such as declines in eyesight and hearing.

While barriers such as lack of transport to clinics remain important, affordability remains the greatest barrier to access to medicines of all types. Countries, states and organizations cannot afford to buy medicines at patented prices. Individuals, particularly older women who are supporting households, have little or no money to spend on medicines and assistive devices.

There has been an expansion in the coverage of HIV treatment to record numbers of people in SSA over the past five years. At the same time, in 2015, in eastern and southern Africa just over half of adults living with HIV (59% of women and 44% of men aged 15 and over) were accessing ARV therapy. Millions of others who likely need treatment are not getting it because they are unaware of their HIV status. Older people are especially unlikely to be tested.[70]

There are also significant differences between countries. In 2015, in South Africa, 3.4 million people had access to treatment, followed by Kenya with nearly 900 000. Botswana, Eritrea, Kenya, Malawi, Mozambique, Rwanda, Swaziland, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe all increased treatment coverage by more than 25% points between 2010 and 2015.[71]

The majority of children living with HIV are infected via mother-to-child (vertical) transmission, during pregnancy, childbirth or breastfeeding. Vertical transmission of HIV from mother to child can be virtually eliminated, as long as expectant mothers have access to Prevention of Mother-to-Child Transmission (PMTCT) programs.

Thanks to a massive increase in the use of PMTCT programs, the rate of HIV transmission from an HIV-positive mother to her child has dramatically declined. In 2011, Swaziland, Botswana, and South Africa all achieved over 90% coverage of the most effective medicines for Preventing Mother-to-Child Transmission (PMTCT).[72]

However, in some countries at least one in three pregnant women living with HIV still did not receive effective antiretroviral medicines to prevent the transmission of HIV to their children. Barriers to accessing PMTCT include fear of testing and disclosure associated with stigma and violence, and the cost and availability of medicines. [73]

World Health Organization guidelines state that all HIV-positive expectant mothers should be given ART for life, regardless of their CD4 count after breastfeeding.[74] Increasing access to ART for pregnant women living with HIV is critical to saving the lives of women and their children. At the same time, all women of all ages have a right to be treated for HIV infection, not simply because they are bearing a child. Providing women with access to high quality healthcare for themselves and their families, whether they are HIV-positive or not, is also imperative.[75]

It is vital that infants and children who are infected via mother-to-child transmission receive appropriate treatment early and consistently. If they are not on antiretroviral treatment, a third of children living with HIV will not reach their first birthday, and half will not reach their second birthday.[76]

> ***It is not enough to simply measure the number of children who have access to ARVs (life-saving HIV medicine). Community-based organizations know full well that a lifetime of adherence to these medications, especially for children, is impossible without also addressing nutrition counselling and food security, transportation to clinics, stigma at school, grandmother training around how and when to administer the drugs, ongoing psychosocial support, and a host of other challenges that arise as a child grows from infant to teen.*** … Stephen Lewis Foundation Impact assessment[77]

Increasingly, the world is recognizing the vital role that community-based organizations and support groups play as the lifelines in the health of older women/grandmothers and the young people in their care.

> ***The reality is that even with the gains that have been made, and those that might come—from treatment as prevention, to the availability of drugs for all who need them—community-based organizations will always be necessary. We are crucial for ensuring access, and for understanding and addressing the challenges faced by grandmothers and others in the community, so that they can benefit from these developments.*** … Siphiwe Hlope, Founder and Director, Swaziland Positive Living, speaking at the African Grandmothers Tribunal, 2013.[78]

This short review of access to medicines suggests the need for:

- Increased access to affordable medicines of all types, as well as to assistive devices such as eye glasses, hearing aids and mobility devices
- Systemic changes that address the barriers to access and the successful use of medicines including transportation, food security, stigma, discrimination in healthcare, lack of training, and other factors.
- An increased emphasis on community-driven and societal-level strategies to improve HIV interventions and access to life-saving medications (including preventive vaccinations)
- Increased support for community-based organizations and grandmother support groups
- Increased use of preventive strategies (e.g., condoms, male circumcision) to avoid the transmission of HIV and the need to use expensive medicines for a lifetime
- Improved case findings and treatment of HIV-infected children and adolescents, and of older women and men
- Enhanced access to age-friendly testing and counselling
- Community support for disclosure and the removal of stigma associated with HIV-status
- Inclusion and support of vulnerable populations, including the LGBTTQ+ communities, sex trade workers, adolescent women and older women
- Scaling up research to develop and distribute a vaccine to prevent HIV/AIDS
- Continuing to increase access to PMTCT programs for expectant mothers who are HIV positive and to lifetime ARV therapy to all women who are HIV-positive.

Funding the AIDS Response[79]

Worldwide financing for HIV and AIDS was about US$19·2 billion in 2015, with funding by affected governments accounting for 57% of all investments. However, political and fiscal momentum is faltering and international funding is expected to flat line in the next 5 years. In the coming years, both domestic and international funding must be not only sustained, but also steadily increased to meet the 2030 targets. Indeed, "If we fail to act, all the hard-earned gains made in HIV in SSA over the last 15 years could be reversed".[80]

HIV prevention is the point of greatest convergence between life-saving and cost-saving by avoiding future treatment costs. The UN political declaration calls for a quarter of HIV and AIDS spending globally to be devoted to evidence-based prevention measures.[81]

Older Women as Caregivers

While the gendered identities of caregiving are well known in the community, much of the literature fails to point out that it is older women that mainly provide care and support not just for vulnerable young people and HIV-affected people, but also the whole household and community.[82]

The literature review prepared for GRAN by Jesse Whattam describes how older women caregivers face a number of stresses in the context of the AIDS pandemic, including:

- Financial: insufficient incomes and resources, financial insecurity (further discussed in Pillar 4)
- Emotional: stress, depression
- Physical: exhaustion, illness, chronic conditions and pain
- Social: stigma, discrimination, alienation.[83]

> ***It's so hard for older women, you know, because we are supposed to be relaxing at this moment, but instead we are now busy looking for jobs, selling vegetables, and scouting for food because our children died and left a trail of grandchildren behind to look after. The whole day grandmothers work for those children because we cannot see those children suffering and out of school.*** … Mama "F", from Zimbabwe, testimony read at the African Grandmothers Tribunal, 2013.[84]

Along with endemic poverty and feelings of lacking control, caregivers' limited health often hinders them from accessing resources they need and choosing activities that have meaning to them. Compromised health affects their capacity to perform the daily tasks of caring for their homes and families expected of them in the context of the epidemic. Community-based, context-specific interventions and

policies that provide social and medical support for common mental and physical health concerns would have real impact on older persons' well-being and their capacity to continue to give care and support their families and communities.[85]

Often, grandmothers take on the parenting and head-of-household roles when their adult children are sick and dying. Nursing them and watching them die is traumatizing for both the grandmothers and the children who become orphans.

As these children grow, new challenges emerge to keeping them healthy, happy and secure. Girls, in particular, are faced with issues related to sexual and reproductive health (including sexual exploitation and violence) and pressure to drop out of school to help their grandmothers and care for younger siblings.

> ***We have learned how to be parents to orphaned children in a time of crisis, developing new strategies to help them stay safe, heal their emotional wounds, and regain hope. Yet these youngsters are your citizens, and they deserve more, including good quality education that feeds their souls as well as their minds, protection from violence, and opportunities for decent, safe employment. Our government must help nurture these children and youth who will lead Africa out of the AIDS pandemic.***[86]

When orphaned children do not have a grandmother or "auntie" to take them in, they become sibling-headed families, looking after themselves as best they can. Community organizations, which often include older women, work diligently and in innovative ways to provide the care these young people need and to ensure that they remain in a community of loving support.[87]

While caregiving in the context of the AIDS pandemic is a strain for the African grandmothers, they continue to demonstrate resilience, strength and resourcefulness to ensure the survival and progress of their families and communities. They are challenging the stereotypes of older women/ grandmothers as passive victims and exploring how being a caregiver and a leader in their community is (re)shaping their identity and lives. They gain strength from caregiving and each other as they fight against HIV/AIDS and other health problems, poverty, stigma and violence.[88]

Health Challenges of Older Slum Dwellers[89]

Sub-Saharan Africa (SSA) is rapidly urbanizing, with the share of the region's population residing in urban areas expected to rise from 37.9% today to 55% by 2050. A majority of urban residents in SSA live in informal settlements, or slums. For many rural to urban migrants, such settlements are a first stop in their transition to city life. For many, they are also a last stop as migrants age and grow old within the slums, often despite an envisaged return to their rural homes.

While older people increasingly are living in slums, most of the discourse on slum health is focussed on younger generations. The health concerns and caregiving role of grandmothers living in slums are rarely considered.

Health challenges for older slums dwellers include:

- Adverse physical and built environments in terms of both access and mobility for older adults with capacity limitations, overcrowding and a deficient quality of shelters
- Economic insecurity that reflects the pervasiveness of poorly paid, insecure, informal sector work in these communities. In two Nairobi slums, 43% of households containing an older person live in absolute poverty (less than 1.90 USD/day). When a social protection scheme for vulnerable older adults does exist, only a relatively small number of older adults benefit from it.
- Raised levels of social ills, such as alcohol and substance abuse, domestic violence, elder abuse and crime. Estimating the numbers of reported cases of maltreatment of older persons of either sex is difficult given a lack of age-disaggregation in official records at the chief's office and in police occurrence books.
- Lack of access to required, even basic, health services that are able to offer effective responses on the management of, especially, cardiovascular conditions, musculoskeletal disease and mental health.
- Emotional stress and anxiety about the poor prospects of their children and grandchildren, or the threats of violence, disrespect, or aggression from younger generation kin. Such stress appears exacerbated by the lack of space within households, inadequate housing and sanitary conditions, and by older slum dwellers' care responsibilities for younger generation kin. Many grandmothers are raising their grandchildren alone after the death of the parents.
- Pronounced inequalities in opportunities and well-being within the older slum population that emerge along gender, socioeconomic, and age axes. Older women are generally poorer and have more health and mobility problems than older men.
- Constrained opportunities to participate in local decision-making and agenda setting.

Key global and regional development and urban agendas relevant to older slum dwellers' health include:

- Sustainable Development Goal (SDG) 3: Ensure healthy lives and promote wellbeing for all at all ages.
- SDG 11: Make cities and human settlements inclusive, safe, resilient and sustainable.

- The African Urban Agenda offers a framework that proposes investments in enhancing basic services and education and health as the top two priority areas for action, particularly in slum areas.
- The Age-Friendly Cities movement provides direction on advancing the well-being of older adults living in urban areas; however, it does not, thus far, extend to slums.

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Health: Implications and Opportunities for Action

What can we do to protect and enhance grandmothers'/older women's right to health?

1. Support and advocate the actions regarding HIV/AIDS outlined in the Madrid International Plan of Action on Ageing:
   - improve the assessment of the impact of HIV and AIDS on the health of older people who are infected and affected
   - provide older people with adequate information, training in caregiving skills, treatment, medical care and social support
   - recognize the contribution of older people as caregivers. [90]

2. Continue to press for increased funding in the AIDS response: e.g. Global Fund to Fight to AIDS, TB and Malaria, and in Canada's international aid programs.

3. Count older women in. Include older women (over age 50) when collecting and using data and information on HIV/AIDS prevention, infection, treatment, and care. Ensure that all data on health is disaggregated by gender and age.

4. Inform civil society, governments, students and international agencies about the health issues faced by older women/grandmothers in sub-Saharan Africa. Be a voice for older women in local, national and international forums.

5. Seek support for policies, legislation, campaigns and programs that:

- address older women living with disabilities and those who need long-term care
- address the need for universal health care, affordable transportation and age-friendly health services
- prohibit discrimination against people living with HIV and AIDS
- halt the alarming increase in HIV infection occurring among young women age 15 to 24, and address their reproductive health needs

6. Urge the Canadian government, the international community, civil society and the private sector to complement effective programs that support children orphaned or made vulnerable by HIV/AIDS in countries at high risk, with direct special assistance to SSA.[91]

7. Work with and support agencies working in HIV/AIDS (e.g. Interagency Coalition on AIDS and Development, HIV/AIDS Legal Network, Médecins Sans Frontières) and with organizations and campaigns related to aging and health (e.g. International Federation Aging, HelpAge International and HelpAge Canada, International Longevity Centre Canada).

8. Advocate improved access to affordable, life-saving medicines and vaccines for all. Engage in activities to:

- Prevent the acceptance of restrictive international trade laws that limit access to affordable medicines.
- Enable African states, international funding programs and humanitarian organizations to purchase and distribute lower-cost medicines, vaccines and assistive devices such as eyeglasses, hearing aids and mobility assisting devices.
- Ensure that all HIV-positive women (including those past reproductive age) have appropriate treatment and access to affordable ARTS and other required medicines.

9. Advocate for policies and programs that address older women and non-communicable diseases (e.g. diabetes) and conditions associated with older age (e.g. cataracts and mobility problems).

10. Insist that improved HIV/AIDS services (prevention, testing, treatment and care) for grandmothers/older women be a priority. HIV responses need to account for the sexual rights and evolving family, economic and overall health contexts of older women.

11. Support Canada's leadership in gender equality and maternal and child health. Work with the Canadian Partnership for Women and Children's Health (CanWaCH) and other organizations working to protect and promote the sexual and reproductive health and rights of all ages and all genders.

12. Support and advocate the following recommendations from the African Grandmothers Tribunal:

- Include grandmothers as a key target population in national *(and international)* plans to scale up access to HIV and AIDS treatment
- Develop and finance community-level programs to address the challenges older women face in accessing treatment
- Eliminate all out-of-pocket costs for HIV and AIDS testing and treatment.

13. Recognize and support the contribution of older women as caregivers. Address the special needs of grandmother-headed households, and children orphaned or made vulnerable by HIV/AIDS in countries at high risk, with direct special assistance in SSA.

14. Support the Age-Friendly Cities/Communities movement in Canada and around the world and an expansion of the concept to include slums.[92] Make policy-makers and others aware of the situation of older women/grandmothers living in city slums and informal settlements.

3.3 PILLAR THREE: FREEDOM FROM VIOLENCE

> ***We demand an end to violence against grandmothers, whether it is domestic violence, elder abuse or rape.*** …Ugandan Grandmothers Statement, 2015.[93]

Background Information

Sustainable Development Goal 5: Achieve Gender Equality

The goal of SDG 5 is to achieve gender equality and empower all women and girls. Target 5.2 aims to "eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation". Target 5.3 aims to "eliminate all harmful practices, such as, child, early and forced marriage and female genital mutilation".

Regrettably, no specific ages or lifecourse stages are mentioned in the goals as they are now written. Nor does Target 5.3 make any reference to violent practices against older women such as wife inheritance and abusive widowhood rights. The indicators and suggested methods for collecting information do not include women over the age of 49.

It is telling that the targets related to freedom from violence are rooted in the goal of gender equality. Gloria Steinem, speaking at the African Grandmothers Tribunal said:

> ***The problem is making one group of people powerful over another by dividing human beings into gender prisons of "masculine" and "feminine," the leaders and the led, those who own property and those who don't or even are property, those who own children in marriage and those who do the work of raising them—all of this inequality requires violence to maintain. And it is that violence that normalizes all other violence, and that false division of gender roles that normalizes roles and violence based on race, caste, class, tribe, nation or culture.***[94]

A Widespread Violation of Women of All Ages

Women across the world, regardless of income, age or education, are subject to physical, sexual, psychological and economic violence. The experience of violence can lead to long-term physical, mental and emotional health problems; in the most extreme cases, violence against women can lead to death.[95]

Violence against women is a widespread and systemic violation of human rights. It also persists as women age. Violence against older women may take the form of

physical, sexual or psychological abuse, as well as financial exploitation or neglect, often perpetrated by intimate partners, family members, or caregivers.[96]

Based on available worldwide data (2012), reported prevalence of **physical** violence against women is highest in the African region, with half of countries reporting lifetime prevalence of over 40%. The range of prevalence was also widest in Africa, from 14% in Comoros (2012) to 64% in the Democratic Republic of the Congo (2007). While some African countries showed a decline over the year, in the majority of countries, the prevalence of violence against women stayed almost constant.[97]

Psychological violence includes a range of behaviours that encompass acts of emotional and verbal abuse and controlling behaviour. These often coexist with physical and sexual violence by intimate partners and are acts of violence in themselves. In a 2011 UN summary, the prevalence of **reported** intimate partner emotional/ psychological violence experienced in the last 12 months or over the lifetime (from a limited number of countries in Africa with data) ranged from 6% in Azerbaijan (2006) and the Comoros (2012) to 40% in Equatorial Guinea (2011). By comparison, the proportion of women age 18 to 74 in Europe who experienced psychological violence ranged from 32% in Ireland to 60% in Latvia and Denmark.[98]

Few low- and moderate-income countries collect data on women's experience of financial violence/abuse (which is usually measured in surveys of elder abuse) although first-hand reports describe financial abuse happening, especially when families are living in poverty. WHO studies have found that the prevalence of financial elder abuse to be 1 to 9% in high or middle-income countries and that women over age 74 are at higher risk.[99]

A 2013 report by the World Health Organization on the prevalence of two forms of violence against women — violence by an intimate partner (intimate partner violence) and sexual violence by someone other than a partner (non-partner sexual violence) found: [100]

- The global *lifetime prevalence of intimate partner violence* among ever-partnered women is 30%. The prevalence was highest in the WHO African, Eastern Mediterranean and South-East Asia Regions, where approximately 37% of ever-partnered women reported having experienced physical and/or sexual intimate partner violence at some point in their lives. Prevalence rates (global) were high at a young age (29%), escalated to a peak of 38% in the age category of 40-45, then declined in older age groups (22% in the age category 65-69). The authors, however, point out that data for the older age groups come primarily from high-income countries since surveys in middle- and low-income countries are almost exclusively conducted with women aged 15 to 49. For this reason, it should not be interpreted that older women have experienced lower levels of partner violence, but rather

that less is known about patterns of violence among women aged 50 years and older, especially in low- and middle-income countries

- Globally, 7.2% of women reported ever having experienced *non-partner sexual violence*. The highest prevalence was in the high-income area (12.6%) and the African region (11.9%;) while the lowest prevalence was found for the South-East Asia Region (4.9%). These differences need to be interpreted with caution due to the difficulty of collecting data in conflict zones and under-reporting due to the stigma and fear attached to reporting sexual violence. There was insufficient data to determine age differences.

- Globally, 35.6% of women have ever experienced *either non-partner sexual violence or physical or sexual violence by an intimate partner, or both*. This combined estimate demonstrates just how common physical and sexual violence is in the lives of millions of women. The lifetime prevalence of intimate partner violence (physical and/or sexual) or non-partner sexual violence or both among all women (15 years and older) was highest in Africa (46%) and lowest in Europe (27%)

- The magnitude of the association between intimate partner violence and selected health outcomes is startling, including HIV infection, sexually transmitted infections, induced abortion, low birth weight, premature birth, growth restriction in utero and/or small gestational age, alcohol use, depression and suicide, injuries, and death from homicide. The authors point out there are other serious consequences not described in this report, including adolescent and unintended pregnancy, miscarriage, stillbirth, nutritional deficiency, abdominal pain and other gastrointestinal problems, neurological disorders, chronic pain, disability, anxiety and post-traumatic stress syndrome. in some regions (including SSA), women who experience sexual violence are 1.5 times more likely to acquire HIV.

- Across all countries with available data since 1982, the median prevalence of intimate partner homicide was approximately 13%, with as many as 38% of all murdered women (in contrast to 6% of all murdered men) being killed by an intimate partner. The median prevalence of intimate partner homicide among all murdered women was highest in the South-East Asia Region (5%) and the high-income region (41%) followed by the African Region (approximately 40%). Once again, the authors caution of under-reporting and regional differences data availability.

In many instances, violence against older women is not given the attention it deserves. Sometimes this bias is reflected in data collection methods and indicators, leading to significant data gaps for older women. For example, the African Demographic and Health Surveys, which are an important source of information on violence against women, includes only women aged 15 to 49 in their sample.

This focus on women of reproductive age is "a manifestation of the intersection of ageism and sexism that sees women reduced to their reproduction function and only counted as 'women' depending on their childbearing ability. If left unchallenged, it promotes a harmful misbelief that violence only happens in younger age. This leaves older women's experiences invisible to policy and program designers.[101]

Data on violence against older women in vulnerable settings or from marginalized populations is very limited; however, several studies, complemented by observations from development practitioners working with older populations, have identified factors that can magnify older women's risk for violence and abuse. These include isolation, cognitive decline and dementia, disability and care dependency, and prior history of abuse. Intersecting forms of marginalization make women at greater or unique risks for violence throughout their lifespan and in older age. Older women face triple jeopardy when they are immigrant and ethnic minority women, sexual and gender minority women, living in emergency settings and living with HIV/AIDS.[102]

Abuse and gender-based violence in the home and community affects older women. Many older women who are abused or neglected were and sometimes still are caregivers to those who abuse them; e.g., they are parents who provide their adult children and/or grandchildren with food, shelter and love; or partners who are looking after spouses who are ill.[103]

Abuse at younger ages increases vulnerability to poor health in older age. Child marriage (before the age of 18) is found throughout the world and is acknowledged to be a harmful practice, as well as a manifestation of discrimination against women and girls. More than 700 million women alive today were married before the age of 18. In Niger, for example, 77% of women aged 20 to 49 were married before age 18, compared to 5% of men in the same age group.[104] Negative effects of child or forced marriage that persist into older age can include health problems related to giving birth at a very young age, and the disadvantages associated with not having the opportunity to stay in school.

Older women are highly vulnerable to neglect and being left behind in cases of natural disasters and emergencies. Since 2010, HelpAge International has conducted an annual analysis to quantify how far the specific needs of older people are reflected in humanitarian programming in emergencies, using humanitarian funding as a proxy indicator. In 2010 and 2011 less than 1% of analyzed projects included activities for older people – a figure that rose marginally to 2.1% in 2012, but dropped back to 0.5% in 2013 and 1% in 2014.[105]

Conflicts and wars have devastating consequences, including increases in violence against girls and women. Women often have fewer resources to protect themselves and, with children, frequently make up the majority of displaced and refugee populations. War tactics such as sexual violence specifically target

them.[106] In conflict and situations where law has broken down, older women are not excluded in the widespread incidences of rape and other human rights violations linked to gender- based violence.[107]

Vulnerability to sexual violence remains high in refugee camps, and single women or unaccompanied girls may be at higher risk if they are not accommodated separately from men or if there is not sufficient privacy. Long walking distances out of the camps to collect water and firewood for cooking and heating may also expose women to the threat of rape. In some cases, refugee women engage in survival sex to support their families.[108]

Violence is also pervasive in human trafficking. Due to its underground nature, accurate data on the scale of human trafficking are difficult to collect. According to a 2014 report published by the United Nations Office on Drugs and Crime (UNODC), adult women accounted for almost half (49%) of all human trafficking victims detected globally. Women and girls together accounted for about 70%, with girls representing two out of every three child trafficking victims.[109]

Women's equality and leadership are central to eliminating conflict and violence. The international community has recognized that women's participation is vital to achieving and sustaining peace. Women are proven agents of change and have the capacity to do even more. In 2000, the UN Security Council passed the historic Resolution 1325 on women, peace and security. It calls for women to participate in peace-building, be better protected from human rights violations, and have access to justice and services to eliminate discrimination.[110]

Older Women Left Behind

The Madrid International Plan of Action on Ageing highlights the fact that older women "face greater risk of physical and psychological abuse due to discriminatory societal attitudes and the non-realization of the human rights of women".[111]

Based on a combination of age and gender discrimination, older women are routinely denied access to health services, care, support for independent living, education, social security, information, appropriate housing, financial services, employment, transport, and other facets of economic, social, and community life. Such exclusion undermines the development of protective factors against violence and heightens their risk for violence and abuse.[112]

As part of the Beijing+20 review, HelpAge International (HAI) looked at 131 national reports to see how governments are implementing the Beijing Platform for Action recommendations. HAI found that despite a growing body of evidence on discrimination affecting women in older age, and the adoption of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) General Recommendation 27 on the rights of older women in 2010, older women and population aging remain a low priority for the vast majority of countries.[113]

For example, HAI noted that only 21 country reports (16%) specifically mentioned older women or aging in their review of achievements and challenges. The only areas where older women received any significant attention were in relation to poverty and barriers to employment. Older women's sexual and reproductive health was almost completely ignored and there was no recognition of, or data on, the violence they face in the different settings where they live.[114]

Despite some increase in the availability and quality of data on violence against women, significant challenges remain. Different survey questionnaires and methodologies are sometimes used in different countries, leading to a lack of comparability at the regional and international levels. Willingness to discuss experiences of violence may also differ according to the cultural context, and this can affect reported prevalence levels.[115]

National policies on gender equality and domestic violence rarely include the violence perpetrated against older women. Their rights are not systematically addressed either in State reports or in NGO shadow reports (to CEDAW). In most cases, older women and the discrimination they experience remain invisible.[116]

One of the reasons for this patchwork protection is the absence of any universal rights standards that specifically address violence against older women. Many NGOs argue for the need for a new legal human rights instrument such as a UN Convention on the Rights of Older Persons that includes specific measures to combat age discrimination, neglect, abuse and violence (see Pillar 5).

A group of NGOs in consultative status with the UN Economic and Social Council submitted a statement to the Commission on the Status of Women in March 2016, noting the lack of attention given to older women's lives, and to issues such as violence against older women. They note that existing surveys, including the few which include women over the age of 49, fail to capture the various forms of violence faced by older women, including financial and psychological violence and neglect. These types of violence are more likely to be captured in surveys on elder abuse than on violence against women.

Research on elder abuse, however, is scarce and largely confined to high-income countries.[117] The WHO Global Report on Healthy Ageing (2015) states that "Victims of elder abuse are more likely to be female and to have a physical disability, be care-dependent, have poor physical or mental health, or both; have low income, and lack social support,"[118]

> ***"Discriminatory laws and practices against older women in all spheres of their political, economic, social and family lives fuel violence and abuse."***[119]

The Situation of Older Women in sub-Saharan Africa (SSA)

Older women in SSA face multiple challenges to their physical security, including:

- the failure by law enforcement and the legal system to protect them and ensure their right to well-being and safety
- domestic abuse (by intimate partners, and others in the household)
- elder abuse, including physical, emotional and financial abuse (i.e. stealing of money and possessions, fraud)
- neglect and failure to provide food and support when an older woman is unable to care for herself
- abusive traditional practices including witchcraft allegations and cruel, dehumanizing widowhood practices
- attacks and killing of older widows in order to grab their property
- wife inheritance
- sexual abuse and exposure to HIV infection in conflict areas and as a result of wife inheritance and domestic violence.

Older women may be afraid or ashamed to report abuse perpetrated by a family member. At the same time, grandmothers and community groups in SSA are actively speaking out about the violence faced by older women/grandmothers. For example, at the 2013 African Grandmothers Tribunal, several witnesses provided personal testimonies about their experiences with land grabbing, wife inheritance, and physical, psychological, financial and sexual abuse.[120]

> ***Violence is a constant threat, whether it is rape and assault on our bodies, or physical abuse and intimidation from family members and loan sharks who are after our small savings. We suffer without protection. And when we look to Parliament, there is no one who stands for our interests, no one who speaks for us.*** …
> South Africa Grandmothers Statement[121]

Violence and abuse against older women also occurs as a result of harmful traditional beliefs. Where belief in witchcraft is strong, older women are often targeted with witchcraft accusations and related violence. In Tanzania, for example, police reports from 8 regions between 2004 and 2009 showed that 2,585 older women were killed as a result of witchcraft accusations. In the Mwanza region alone, 698 older women were killed during that period, which is two killings every two to three days. In Kenya, it was reported in the media that an average of six people were lynched every month in 2009 in the Kisii district for allegedly practising witchcraft.[122]

Informal reports from older women suggest that allegations of witchcraft are sometimes linked to HIV/AIDS in the family (i.e., the witch has brought it) and/or to property grabbing (i.e. when a widow is banned or killed because of witchcraft, relatives can then seize her property).

Communities can change social norms regarding gender-based ageism and the harm of older women. In the Sukumaland region of Tanzania, older women cooperated with local spiritual leaders and traditional healers to conduct community workshops to break down stereotypes that contribute to violent accusations of witchcraft and killings of older women. From 2001 to 2007, the Sukumaland Older Women's Program challenged harmful beliefs and practices by winning understanding and support in the communities, conducting sensitization meetings at the local level; empowering older women to access basic rights, and practical interventions on problems identified as key correlates to witchcraft allegations, including improved shelter, HIV/AIDS community awareness, fuel-efficient stoves that do not irritate eyes and lungs; and capacity-building for a wide range of stakeholders. As a result of these trainings, traditional healers agreed to ban the practice of divination, which was responsible for a large proportion of witchcraft allegations This significantly reduced murders of suspected "witches" in the region, which had previously totaled close to 100 per year.[123]

Older women in Africa often live in conflict zones and are not excluded in the widespread incidences of rape and other human rights violations linked to gender-based violence. Violence perpetrated by militia, military personnel or the police during conflict is an important aspect of non-partner sexual violence.[124]

A 2010 report on sexual violence in the Democratic Republic of Congo found that more than 15% of displaced people seeking health services for sexual violence were over age 55, and women over 49 experienced rates of sexual violence on par with the rest of the population. Older women represent less than 10% of the overall population in DRC, showing just how vulnerable this group is. The report notes that "Women and girls of all ages, from toddlers to great-grandmothers, were brutally attacked".[125]

Older widows are often among the most marginalized in cultures where inheritance codes dispossess them on their husband's death. A woman widowed by AIDS or a disaster may be stripped of her last resources. Older widows are less likely to remarry than widowers, leaving them isolated and often reliant on the goodwill of relatives or the charity of neighbours. In an emergency, these factors undermine the capacity of older women to fend for themselves and can obstruct their access to protection and essential services.[126]

HIV/AIDS is associated with increased violence against women, including older women. Wife beating, which is still an acceptable practice in some communities, is exacerbated in the context of HIV/AIDS. Studies suggest that one in seven HIV infections might be prevented if intimate partner violence was eradicated.[127]

The stigma of HIV and age make older women more vulnerable and less willing to report violence, especially sexual violence, that has been done to them. Perhaps hardest for a grandmother caring for HIV orphans, is reporting the violent behaviour of one of her troubled and traumatized grandchildren.

Violence and the fear of violence from their husbands and family members not only exposes grandmothers to infection, but can also intimidate them from getting tested. Once they do know their status, there can be a high price to be paid for disclosure, in the form of physical assault, divorce, abandonment, and homelessness. Seeking treatment from public hospitals and clinics can seem too dangerous for older women who know that their immediate safety depends on secrecy.[128]

Community-based interventions with gender equality components, economic empowerment, and consciousness raising show promise in decreasing intimate partner and sexual violence that impact HIV transmission rates. The literature review prepared for GRAN suggests some other potentially helpful policy and program activities:

- Screening and interventions related to violence within the setting of HIV counselling and testing and other healthcare settings
- Educational and awareness raising initiatives that include men and focus on the role of patriarchy and gender inequality
- Short-term responses (e.g. shelters, rape crisis centres) combined with long-term structural changes (e.g. legal mechanisms, improved police responses)[129]

Freedom from Violence: Implications and Opportunities for Action

What can we do to protect and enhance older women/grandmothers' right to live free of violence?

1. Be a voice for older women in local, national and international fora. Point out the invisibility of older women and the importance of eliminating violence throughout the lifecourse, with specific reference and targets for older women.

2. Include older women in the development and implementation of policies, programs and practices to prevent and respond to violence against women and girls.

3. Press for the recommendations identified at the Grandmothers Tribunal: enacting and enforcing laws to prohibit domestic violence, marital rape and sexual violence; making courts, policing and legal aid more accessible and responsive to grandmothers' claims; strengthening community-level mechanisms to prevent, investigate and punish acts of violence; eliminating harmful traditional practices such as wife inheritance; and raising community awareness about older women's right to be free from violence.

4. Include a focus on violence against older woman in activities related to the UNITE Orange campaign. Bring the issue of violence and older women to the attention of organizations participating in the Orange Campaign.

5. Make a statement on World Elder Abuse Awareness Day (June 15). Submit editorials, blogs, etc. on the right to violence-free living by older women and the shameful neglect of this issue.

6. Lobby on the need to ensure that women over age 49 are included in data collection on violence against women within Canada's sphere of multilateral diplomacy and in international forums. Suggest that Canada is well positioned to assist low-income countries with data collection. Advocate the need for specific surveys developed and conducted by the United Nations and other multilateral organizations such as the Commonwealth and La Francophonie, respecting women over the age of 50 and including the intersections between ageism, HIV/AIDS, systemic discrimination and gender-based violence.

7. Lobby to ensure that a provision on the complex and intersecting forms of violence against women in older age is included in any new legal instrument, such as a UN Convention on the Rights of Older People (see Pillar 5).

8. Work with the Women, Peace and Security Network (WPSN-Canada) and other organizations making the link between women and peace. Use every opportunity to inform these organizations about the situation of older women in

SSA, and the leadership role of older women and grandmothers in peacemaking.

9. Participate in plans to implement resolution 1325 on Women, Peace and Security and ensure that older women are recognized and included in the plan.

10. Provide knowledge and lobby for the explicit inclusion of the violence concerns of older women/grandmothers with organizations working in aging, health, education, corporate responsibility, international development and the elimination of violence against girls and women.

11. Advocate the enactment and enforcement of laws to prohibit rape and sexual violence in war, land grabbing and harmful practices such as forced marriage and wife inheritance at any age.

12. Support community-level organizations and mechanisms to prevent, investigate and punish acts of violence and to support older women in their right to non-violence.

13. Support the inclusion of older women in screening and interventions related to violence in healthcare settings, including HIV testing and counselling, and in international programs to combat HIV/AIDS (e.g. Global Fund, WHO, UNAIDS).

14. Build the capacity of healthcare personnel, social workers, community healers and law enforcement to recognize and respond to situations of violence, abuse and neglect among older adults.

15. Promote age- and gender-responsive disaster preparedness planning, and policies and legislation that prevent and address the heightened risk of violence and neglect among older women in emergency settings and displacement camps**.**

16. Support Canada's feminist agenda in international development (with Global Affairs Canada). Continue to press for gender equality at all ages and to emphasize the right of older women to violence-free living in Canada's approach to international development, and to fully include older women in the Federal Strategy on Gender-Based Violence (Status of Women Canada).

3.4 PILLAR FOUR: ECONOMIC SECURITY AND SOCIAL PROTECTION

Background Information

> ***The economic empowerment of women is fundamentally a human rights and social justice issue. Research shows that it is also critical for poverty reduction, economic growth and human development. Women's economic empowerment must address issues of access to and control over resources, but also structural gender inequalities such as unpaid work*.**"[130]

Poverty rates in older age in developing countries are hard to find. For example, when HelpAge International was compiling the 2015 Global AgeWatch Index,[131] data on income security for older people was only available in 11 out of 125 countries in Africa.[132]

We do know, however, that older people in developing countries are over-represented among the poor and the extremely poor, especially in countries that do not have social protection for older adults.[133] We also know that poverty in older age has a strong gender dimension. Women's life expectancy is higher than that of men, so that they may spend more time living in poverty than men. They are more likely to lose their partner, and less likely to remarry. Lower education levels and the need to combine work with childcare means that women are more likely to work in the informal sector and to have less access to pensions related to work participation. They are often paid less than men or paid nothing for the work that they do in caregiving, food production and in home and community work.[134]

Particular groups of older women are more at risk of poverty in all countries, including those who live alone, are widowed, divorced or living with disabilities, and those caring for grandchildren and vulnerable young people orphaned by AIDS.[135] Even in Canada where most seniors enjoy relative economic security, 30% of older women who are alone live below the poverty line.[136]

At the same time, older women/grandmothers in sub-Saharan Africa (SSA), play critical roles in the economic well-being of their countries. As primary caregivers, they are raising and shaping younger generations' access to health, education and other capabilities, and thus their future human capital. Outside the family, most older Africans remain in the labour force, particularly in small-holder agriculture, which encompasses the bulk of food production and must be revitalized if nutrition security and sufficient job opportunities are to be ensured for younger generations.[137] Grandmothers who are raising the next generation are central to a sustainable future and the economic growth of developing countries.

HelpAge International suggests four pathways to income security in older age: 1) social protection and public welfare, 2) pensions, 3) work and employment, 4) informal family and kinship support.[138] Each of these is discussed in this chapter.

Sustainable Development Goals (SDGs)

SDG 1: *End poverty in all its forms everywhere*. While there is no specific mention of older people in this goal, all of the targets are particularly relevant to the African grandmothers who often fall into the category of "the poorest of the poor".[139]

Target 1.1 aims to eradicate extreme poverty by 2030 (people living on less than $1.25 a day) and Target 1. 2 to reduce at least by half the proportion of men, women and children of all ages living in poverty ($1.90 or below per person per day). Goal 1 also aims to ensure social protection for the poor and vulnerable, increase access to basic services and support people harmed by climate-related extreme events and other economic, social and environmental shocks and disasters. Target 1.4 stresses equal rights of the poor and the vulnerable to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology and financial services, including microfinance.

SDG 2: *End hunger, achieve food security and improved nutrition and promote sustainable agriculture.* Targets 2.2 and 2.3 are particularly relevant to the African grandmothers: 2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons; 2.3 By 2030, double the agricultural productivity and incomes of small-scale food producers, in particular women, indigenous peoples, family farmers, pastoralists and fishers, including through secure and equal access to land, other productive resources and inputs, knowledge, financial services, markets and opportunities for value addition and non-farm employment. Target 2.3 will be particularly hard to achieve in SSA, where climate change is likely to lead to frequent occurrences of extreme heat, increasing aridity, and changes in rainfall.

SDG 11: *Make cities and human settlements inclusive, safe, resilient and sustainable*. This speaks to economic security and social protection for older women who live in urban communities and cities. This goal aims to upgrade slums and to ensure access for all to adequate, safe and affordable housing, transport and green public spaces, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons. (See Pillar 2 for a discussion on the situation of older women living in city slums.)

Understanding Some Key Terms

Economic security refers to "an assured and stable standard of living that provides individuals and families with a level of resources and benefits necessary to participate economically, politically, socially, culturally, and with dignity in their community's activities."[140] Thus, economic vulnerability is not only about insufficiency of income, but also about loss of dignity and social inclusion.

From a human rights perspective, economic security is called **social security**--a concept enshrined in the Universal Declaration of Human Rights.[141] Advocates for social justice argue that the persistence of extreme poverty, inequality, and vulnerability are symptoms of social injustice and structural inequality, and see social security and social protection as a right of citizenship.

Social protection programs include social assistance, such as cash transfers, school feeding and targeted food assistance, universal health insurance, and social insurance and labour market programs, including old-age pensions (social pensions), disability pensions, unemployment insurance, skills training and wage subsidies, among others. Expanding social protection programs and targeting appropriate schemes to the poor and most vulnerable can reduce poverty.

Despite progress over the past decade, increasing social protection for those most in need remains a priority. In low-income countries, only 1 out of 5 receives any type of social protection compared with 2 out of 3 in upper-middle-income countries. The coverage gap is particularly acute in SSA and southern Asia, where most of the world's poorest people live.[142]

Access to affordable, age-friendly healthcare and essential medicines is also an important factor in social protection. Without healthcare coverage, older women may spend the last of their resources on medicines, treatment and care for themselves and other family members affected by HIV/AIDS and other diseases.

Social Pensions (sometimes called old age pensions) are non-contributory cash transfers paid regularly to older people. They are widely acknowledged to be an essential tool to reduce old age poverty and invest in human capital development. Evidence shows that not only do social pensions reduce old age poverty, but they also reduce intergenerational poverty. For example, when pension income is spent on children in the household, this leads to significant improvements in their education and health. Recent examples of several low-income countries that have implemented a social pension system show that they are neither complicated nor very costly; taking less than 3% of a national budget.[143]

Land ownership and use is an essential form of social security for women in rural areas. Women use land for household farming, cash crops to supplement household income, and for collecting firewood, water, fruit and medicinal plants. Rural women's options outside of farming are limited; they do not enjoy the mobility of men, and employment opportunities in rural areas are scarce.

Land Grabbing happens in two ways:

1. Large scale land acquisitions involving thousands of hectares of land without respect or acknowledgement of land users' entitlements. Large sections of land are allocated to foreign investors (assisted by the national elite and governments in need of foreign capital), usually on long-term leases of between 25 and 99 years; often renewable.[144] Africa is the global centre of land grabbing; the amount of land acquired by foreigners is the equivalent to all the farmland of France, Germany, Italy and the UK combined.[145]

2. Family members taking land and property from a woman after the death of her husband. This practice is exacerbated because of policies, practices and traditions that deny women their right to land inheritance. Women's entitlements are weak and depend on male survivors; they are frequently denied equal rights in land and property ownership.

Gender inequalities underlie property and land ownership, inheritance and use. Compensation for land is awarded to men. As a consequence, women lose their source of household food production. Primary claimants of land are male and women become increasingly vulnerable to landlessness, homelessness, marginalization and food insecurity.[146] Women without a partner, widows, female-headed households and orphaned children are even more disadvantaged than their married counterparts.[147]

It should be noted that under International Human Rights Law, women and men are entitled to equal legal protection of their property rights.

The Situation for Older Women in sub-Saharan Africa

The countries that comprise SSA are among the poorest in our world. Some 41% of the population in this region live in extreme poverty (less than US$1.25 per day)[148] and one in four people are hungry/undernourished – the highest prevalence of any region in the world.[149]

Traditionally in low-income countries, adult children have provided a home and financial support for their older parents and relatives. This has changed in many cases due to migration for work by adult children and the loss of the middle generation due to AIDS, conflict and displacement.

In line with customary African values, providing long-term care rests overwhelmingly with families. However, in the context of HIV/AIDS, older women who are disabled or sick may find themselves alone and destitute, without a family to care for them. While some under-resourced, charitable institutions address the long-term and end-of-life care needs among the older poor, public (government) support for long-term care is almost non-existent.[150] In some cases, community organizations and grandmothers who are healthy are filling this gap in care.

The HIV/AIDS pandemic has led to a sharp increase in the number of poor, female-headed households and SSA has the highest average proportion of female-headed households on the continent.[151]

The extent of older people's caregiving (predominately women) is increasingly recognized in the context of HIV/AIDS. For example, in Namibia and Zimbabwe more than 60% of orphaned children are looked after by their grandmothers.[152] In the urban slums of Nairobi, Kenya, more than 30% of older women and 20% of older men (aged 60 years or older) care for one or more young children in their household.[153]

The cost of full-time parenting and raising grandchildren and other vulnerable young people is substantial and can push older women into further poverty. For example, in Mozambique in 2006, caring for an orphaned or vulnerable child cost an average of US$21 a month, while caring for someone with HIV cost US$30. However, older people had an average monthly income of just US$12.[154] From these figures it is clear that most older people simply cannot meet all the costs of even one child in their care – let alone several children plus adults living with HIV and other chronic diseases.[155]

Grandmothers raising vulnerable young people need enough money to support the household, including expenses for food, housing, utilities, transportation, education, health and burials. They have no financial room to deal with additional shocks, such as a personal illness, changes in food prices, and disasters (natural and man-made).

> ***These families are living precarious lives, under the constant threat of extreme poverty, and one bad financial turn can lead to hunger, the end of the children's schooling, inability to access HIV treatment, or homelessness.***[156]

Some countries in Africa are addressing the issue of women and poverty (including older women).[157] For example, the Tanzanian government has proposed a new constitution, which sets out to end the cycle of poverty for women and girls.[158] Achieving this will require the systematic implementation of measures to ensure the social protection of older women and the vulnerable children in their care.

Social Protection and Pensions

Households consisting of older people and children are particularly at risk of poverty.[159] Where other forms of social assistance are limited or non-existent, universal pensions can be a straightforward and cost-effective way to improve the health and income security of children and older people.[160] Pensions also increase older people's status, material security and access to health services, and make it easier for them to send children in their care to school.

In SSA, fewer than one in five (17%) older persons receive an old-age pension, and only a few countries offer this social protection measure.[161] Most grandmothers take care of their ailing adult children, orphaned grandchildren and other vulnerable young people, and hold informal jobs or work without wages. Because most have not worked in the formal sector they have no contributory pensions. With a few exceptions, they have little or no reliable source of income.

In the few countries in SSA that do offer them (e.g. Namibia, Botswana, South Africa and Lesotho), non-contributory pensions are acknowledged as a vital income support. They are used by older people and other household members for healthcare expenses, such as drugs or clinic fees, or related costs, such as transport and food – helping older people to maintain their health and livelihoods.[162]

Social protection instruments, such as non-contributory pensions and health and disability insurance, have been shown to dramatically improve the welfare of older people who are living with HIV themselves or caring for their children and grandchildren affected by HIV. For the urban and rural poor, even small, predictable payments enable them to buy food, pay transportation costs and contribute to their families' expenses.[163]

One example is the KwaWazee Project in rural Tanzania, which provides a pension to grandmothers in a region with very high HIV prevalence and a growing number of orphans who are dependent on grandmothers. It has had a positive impact on promoting children's school attendance and progress by enabling households to purchase school materials, uniforms and kerosene for lamps.[164]

However, old age pensions alone are not sufficient, as they are usually inadequate to support a family and eligibility depends on age. For example, in Lesotho, where the minimum eligibility age is 70, pensions do not help grandmothers in their forties, fifties and sixties. Universal pensions therefore need to be part of a wider package of social protection measures that include free basic healthcare, free education, child and disability grants, community social-assistance funds, and credit schemes.[165]

> ***Our country created protections for grandmothers. There are pensions, foster care grants and stipends for home-based care workers. To see these measures put in place to protect our rights, gave us hope that our burden would be less heavy. But they are not working. When it can take years for a foster care grant to be processed, when grandmothers have to travel long distances to visit government offices who turn them away again and again, when pensions are hopelessly inadequate and don't start until 60, then we are dealing with a system that is in desperate need of change.*** … South African Grandmothers Statement[166]

Grandmothers in some African countries are advocating for pensions and cash transfers to young people who have been orphaned in order to help with the costs of raising them.

Cash transfers and social protection schemes have been shown to improve child welfare and mitigate the risk for HIV infection. For example, the Mchinji social cash transfer programme in Malawi provides predictable financial assistance (about US$14 per month) to all families who are in the lowest income quintile and are under- or unemployed. A study of the program found lower rates of infection among adolescent girls and improved access and adherence to HIV treatment resulting from reduced transportation barriers to health services.[167]

In South Africa, among more than 3,000 families receiving regular child support or foster child grants, adolescent girls showed a 53% reduction in the incidence of transactional sex and a 71% reduction in age disparate sex.[168]

It is important to remember, however, that cash transfers alone will not stop all new HIV infections among adolescent girls and young women. Protection from sexual violence and support for staying in safe schools beyond primary education is critical. In addition, this population must be provided with essential HIV prevention services that include sexuality education, access to sexual and reproductive health services, HIV testing and counselling, and access to treatment.[169]

> ***Seven of my grandchildren live with me because their parents – my children – have passed away. They all had HIV. I care for my sick son too. I was very sad when he was diagnosed because he was so supportive. I receive a state pension which I spend on food and rates. The Muthande Society for the Aged are also helping me apply for grants and school fee exemptions so that my grandchildren can continue going to school. My biggest fear is that everybody depends on me – I worry about what will happen if I pass away.*** …
> Nokwazi, age 62, from South Africa[170]

Land and Property Ownership

Up to 80% of agricultural production in SSA is done by women's labour either for substance/household needs or for the market – but they control less than 2% of the land.[171]

Women's inheritance rights[172] in SSA cannot be generalized since each country has its own laws and traditional rights, and ways of interpreting these laws and rights. However, there are several key commonalities, related to patriarchal customary practices and systems of land controls.

- Very few countries have legislation protecting women's access to land and property. Even when laws are in place, women frequently do not have knowledge of the laws or the money they need to gain access to it, or they face

community backlash for exercising their rights.

- In most patriarchal customary systems when a woman marries she severs affiliation with her natal family and is from then on affiliated with her husband's family.
- Land and property rights belong to the males of the family and although a widow may be allowed to continue to live in her marital home and farm the land she does not own this land, cannot inherit it and therefore lives there at the goodwill of her husband's family. Such goodwill is often not present. Widows are disproportionately likely to lose their homes, land and other assets – placing their children and grandchildren at risk of destitution and exploitation.

To further complicate the situation, there are in most countries two sets of laws – customary laws or traditional legal systems and modern legal systems as codified by the government and interpreted by the judicial system. Modern systems are less accessible than traditional ones, especially for poor rural women. Most rural women are married under customary law and are told to pursue their claims under customary law which is based on the patriarchal, exploitive system of land control.

Denial of property rights means that women are totally dependent on marriage and other relationships with men. This makes them and their children vulnerable to losing their homes. It threatens their ability to secure food and other essentials and exposes them and their children to sexual exploitation.

Older Women in Cities

In SSA today, slightly more older people live in rural areas than in urban communities. However, as more and more Africans of all ages migrate to cities in search of jobs, mobility and healthcare, issues such as housing, sanitation and safety intensify. Already in 2014, 55% of the urban population lived in slum-like conditions in SSA, the highest of any region in the world.[173]

Older women/grandmothers are likely to be part of the urban poor. They face triple discrimination based on age, gender and low income. If they have disabilities, barriers to mobility and recognition are heightened. Like women who live in rural areas, they require social protection measures that will allow them to age well, to look after themselves and their families, and to live in dignity and safety in the urban environment.

The World Health Organization's Age-friendly Cities and Communities model has led to improvements in cities all over the world. It suggests eight domains that cities and communities can address to better adapt their structures and services to the needs of older people. These are: housing, transportation, outdoor spaces and buildings, social participation, respect and social inclusion, civic participation and employment, community and health services, and communication and information.[174]

Work

The labour force participation of older persons in Africa is the highest in the world. In the poorest parts of Africa, it is extremely high for both women and men. For example, in Malawi, the rate is above 95% for men and women aged 60-64 and above 90% for men and women aged 65 years and above. Older people only stop working when illness or discrimination forces them to "retire".

Older women/grandmothers in SSA make vital contributions to their families and communities, doing work that is not recognized by labour-force surveys as "employment", such as caregiving, child-minding, community care and running the household so that other members of their families can garner paid employment. Despite this, they often experience economic exclusion, and are often denied paid employment and access to insurance or credit schemes and development programs.

In order to survive and look after the children in their care, grandmother caregivers need multiple sources of income, including income from work. Few are engaged in the formal economy or have access to contributory pensions. In addition to small-scale farming and selling agricultural products, many engage in the unregulated informal economy with work such as street-selling, scrap-picking, domestic work and small-scale enterprises. They may use their special skills as health care providers, herbalists and birth attendants.

Work in the informal economy is not recognized or protected under legal and regulatory frameworks. Informal workers receive little or no legal or social protection, and are rarely able to organize for effective representation. The International Labour Organization calls these *decent work deficits* and makes the case for the right to "decent" work for all.[175]

Factors that reduce and limit older women's capacity to earn income through work include diminished physical strength, poor health, low status, landlessness, absence of or limited family or community support, lack of capital, and a lack of education and training opportunities. Other key issues include the need for better access to markets, accessible and affordable transportation, government assistance, development programs and microloans. Working with others in community

organizations and cooperative programs can assist grandmothers in earning an income through decent work.

The grandmothers at the Ugandan gathering summed up the concerns expressed in this chapter:

> ***We must be protected from land grabbing and our property rights guaranteed; not just on paper but in reality. Our efforts to secure livelihoods for our families must be supported. Economic opportunities should be expanded for those of us still able to work, and social benefits extended to those who cannot. Protection from theft is essential, as well as greater access to credit and markets.*** [176]

Economic Security and Social Protection: Implications and Opportunities for Action

What can we do to protect and improve grandmothers'/older women's rights to social protection and economic security?

1. Advocate along with women in sub-Saharan Africa, to secure women's rights to land and natural resources, participation in governance, regulatory frameworks and legislation, and the strengthening of women's empowerment movements locally, nationally and internationally.

2. Support and encourage the education of older women about their rights to social security and property inheritance and to better understand laws which are in place.

3. Support the recommendations from the African Grandmothers Tribunal to protect grandmothers' rights to housing, land and property by reforming laws and legal systems to eliminate discrimination; ensuring local administrations protect grandmothers' rights in the division of marital property and inheritance; returning all property that has been taken illegally; and providing new housing to grandmothers who have been left homeless.

4. Support the recommendations from the African Grandmothers Tribunal to protect grandmothers' right to income security by granting pensions and cash transfers to grandmothers; expanding their economic opportunities; compensating grandmothers for their work as community caregivers; and eliminating all fees and costs for primary and secondary schooling.

5. Work towards instituting constitutions and poverty reduction strategies to end the cycle of poverty for girls and women of all ages.

6. Monitor Canada's budget for international development assistance and advocate for increases, including monies targeted especially to older women and the young people in their care.

7. Monitor and comment on Canada's contribution to the SDGs on poverty and equality, especially as it relates to older women. Continue to remind governments that if we are to achieve the goals of eliminating poverty and leaving no-one behind, we must return to a strong focus on SSA with deliberate attention to the often unrecognized, uncounted, and frequently unpaid older women and grandmothers who are caring for the next generation of African youth and sustaining their communities with little or no support and assistance.

8. Continue to build awareness with other civil society organizations of the situation of older women/grandmothers in Africa.

9. In communications, include the message of older women's positive role and impact on the socioeconomic development of SSA, to enhance the image of older women as contributors and key agents of development. Recognizing and supporting older women in SSA as caregivers and contributors is essential to global sustainable development.

10. Research and analyze the specifics of poverty in old age in SSA and other developing regions and ensure the collection and analysis of age and gender disaggregated data.

11. Explore and support policies to achieve full social protection and sufficient benefits to guarantee income security in old age.[177]

3.5 PILLAR FIVE: HUMAN RIGHTS, DIGNITY, EQUALITY, AND FULL PARTICIPATION

> ***Older persons' human rights are often invisible in national and international legislation and policy-making.*** … United Nations High Commissioner for Human Rights [178]

Background Information

In many parts of the world, including sub-Saharan Africa (SSA), the rights of older women are violated in a number of ways, including:

- The right to freedom from discrimination based on age and gender. Older women are often denied access to services and jobs or treated without respect because of their age and gender. Other factors such as disability, Indigenous heritage and low socioeconomic status can exacerbate this discrimination.
- The right to freedom from violence. Many older women are subjected to physical, verbal, sexual, psychological and financial violence, neglect and abuse.
- The right to economic/social security. Many older women do not have financial protection such as pensions and other forms of social security. Lack of a secure minimum income drives older people and their families into poverty.
- The right to health. Older women may not have the basic resources required for health, e.g. nutritious food, clean water and adequate housing. They may not receive appropriate health and social care (including support for preventing, treating and caring for grandmothers infected and affected by HIV/AIDS) because of their age and gender. Affordable treatment, medicines and ability aids such as corrective glasses and mobility supports may be unobtainable.
- The right to work and earn an income. Sometimes older people are deemed unemployable because of their age, sex and gendered roles such as caregiving. This discrimination is most severe for older women in low-income countries who most often engage in informal work such as farming and street-selling. Older women are often excluded from development income-generating activities and programs.
- The right to property and inheritance rights. In some regions and countries, inheritance laws, both statutory and customary, deny older women the right to own or inherit property. Family members often force widows off their land or seize their property, which is a violation of their right to equality of ownership, management and the disposition of property.
- The right to education. All over the world, older women are the most likely to have had limited or no access to education growing up. This affects their ability to earn an income, advocate their rights, maintain their health and look after a family. Their right to lifelong learning and adult education is often ignored and denied, especially in low-income countries that have limited resources and are primarily focused on educating young people.

Ageism is behind much of older people's struggle to enjoy their rights.

> ***For many years, I have advocated for the rights of older people as a leader in my community, but to get here I have had to overcome the various barriers women like me face in society. As an older woman, people presume that I am not knowledgeable enough, that the ideas I put forward are not worthy of attention or should be taken seriously. This ageism extends to policy and our decision-makers who do not prioritize our needs. In their eyes, we are spent, we have had our share and should step aside for younger generations.*** … Margaret Kabango, Ugandan activist, Age 72[179]

A UN Convention on the Rights of Older Persons

After adopting the non-binding *Universal Declaration of Human Rights* in 1948, the member states of the United Nations approved nine core, legally binding human rights conventions (or treaties) over the next several decades. These conventions protect a range of rights including civil, political and social rights, and the rights of women, racial minorities, children, migrant workers and persons with disabilities.

None of the foundational rights treaties explicitly identify age as a prohibited ground of discrimination. Commitments to the rights of older people exist, such as the *UN Principles for Older Persons* (1991)[180] and the *Madrid International Plan of Action on Ageing* (2002)[181] However, they are not legally binding and therefore only impose a moral obligation on governments to implement them.

A UN Convention on the Rights of Older Persons would help ensure that older women and men can realize their rights. When a UN member state ratifies a convention, it must revise its own laws in line with the convention, introduce policies and programs to implement it and report on progress to a committee of Independent Experts. Although a convention would only be legally binding on ratifying states, it would also provide standards for the private and voluntary sectors that respect older people's rights.

Support is growing for a new Convention on the Rights of Older Persons.

- The African Union has approved a protocol/treaty on the rights of older people.[182]
- The Organization of American States approved the *Inter-American Convention on Protecting the Human Rights of Older Persons* during the last General Assembly of the institution. It was immediately signed by the governments of Argentina, Brazil, Chile, Costa Rica and Uruguay. It was NOT endorsed by Canada and the United States of America.[183]

- The Committee that monitors the implementation of CEDAW (the Convention on the Elimination of all forms of Discrimination Against Women) has published a general recommendation on older women's rights.[184]
- The Open-Ended Working Group on Ageing (OEWG), established in 2010 is a UN working group that meets in New York. The OEWG's main purpose is strengthening the protection of the human rights of older people. Any Member State of the UN can participate in the OEWG and NGOs can apply for accreditation.[185]
- In 2014, the UN Human Rights Council appointed an Independent Expert on the human rights of older persons. Her report (2016) concluded that existing national and international legal frameworks are inadequate to ensure the full enjoyment of human rights by older people.[186]

The global community of nongovernmental organizations has also banded together to strengthen the voice of older people and to advocate for a Convention on the Rights of Older Persons.

The Global Alliance for the Rights of Older People[187] reaches out to older people in all regions of the world to ensure their voices are heard by UN member states nationally, regionally, through UN institutions, UN Commissions and the UN General Assembly. The Global Alliance includes both international and national organizations such as:

- International Network for the Prevention of Elder Abuse: www.inpea.net
- International Longevity Centre Global Alliance: www.ilc-alliance.org
- International Federation on Ageing: www.ifa-fiv.org
- International Association of Homes and Services for the Ageing: www.iahsa.net
- International Association of Gerontology and Geriatrics: www.iagg.info
- HelpAge International: www.helpage.org
- Action on Ageing Ghana
- PEFO (Phoebe Education Foundation for AIDS Orphans), Uganda
- Reach One Touch One Ministries (ROTOM), Uganda
- AGE Platform Europe: www.age-platform.eu
- Age UK: www.ageuk.org.uk
- AARP (American Association Retired People): www.aarpinternational.org

HelpAge International spearheads ***Age Demands Action***--a global campaign that challenges age discrimination and fights for the rights of older people. Over 200,000 people have joined the campaign. The campaign aims to convince governments to better support older people, and for all people to recognize that older people are valuable members of society. At a national level, older people take action on issues that matter to them; at a global level, older people campaign for a UN convention on the rights of older people.[188]

While the content of a Convention on the Rights of Older people would be subject to international negotiation, we get some idea from treaties already approved by the African Union and Organization of American States. These include the right to equality and non-discrimination because of age; and the rights of older women to freedom from violence, sexual abuse and discrimination based on gender, and to protection of inheritance rights and abuses related to property and land rights. Interestingly, the African Union treaty also requires older persons to mentor and pass on their knowledge to younger people, and to foster and strengthen intergenerational dialogue and solidarity.

Research and practical experience have shown that international rights instruments work. While they are not magic bullets, they are strong tools that can be used to protect people's rights. Opposition (which mainly comes from high-income countries) to a Convention on the Rights of Older People argue that existing treaties and "soft laws" already protect the rights of older persons; the cost of treaty making and implementing are too high; and that having to continually report on so many conventions has led to "treaty fatigue", which results in a failure to report. These arguments have been countered by the experience with other rights conventions (such as the Convention on the Rights of the Child).[189]

Canada and an Older Persons' Rights Convention

Canada has been a leader in establishing human rights conventions and in influencing other states to ratify them. The pursuit of an older persons' rights convention is also consistent with current federal government foreign policy which includes a commitment to address discrimination based on gender, age, sexual orientation, disability and barriers based on social or economic status.[190] Despite the fact that Canada did not endorse the Inter-American Convention on Protecting the Human Rights of Older Persons (under the previous government), the current government is well placed to lead and champion an international Convention on the Rights of Older People.[191]

Dignity, Respect and Full Participation

Respecting people's rights results in better development when ***respect, dignity*** and ***full participation*** are recognized alongside economic security as important and essential to equality and well-being.

Older women in Africa are often denied full participation in the development process, elected assemblies and decent work because of age- and gender-based discrimination, a lack of acknowledgment and respect for their strength and roles in the community, and their limited access to education and lifelong learning.

In 2016, HelpAge International invited older women involved in the Age Demands Action platform to take part in a consultation on their rights to non-discrimination and equality, and freedom from violence. Just under 250 older women participated

from 19 counties, including five in south and east Africa. Older women living in different social and economic contexts said:

- They were discriminated against in many areas of their lives including employment, healthcare, financial services, access to development programs and ownership and disposal of property.

- Discriminatory, harmful ageist attitudes and practices were particularly strong against widowed or single older women, older women with disabilities, rural and migrant older women.

- Equality for them was having equal rights under the law as well as equal access to opportunities and services in practice.

- At the heart of their understanding of equality was their autonomy, their right to participate in decision-making processes, to make personal choices and express their opinions freely.

- They had encountered violent and abusive acts perpetrated against them as individuals and more systemic structural violence, abuse and neglect.

- They wanted their governments to take steps to prevent violence and to ensure justice for the survivors.

- Older women subjected to intersectional discrimination included those living with HIV/AIDS, dementia and low levels of literacy, those without proper documentation, those considered of lower social status, and older women living in poverty.[192]

> ***"Solicit and put aside funds for older women only, not women in general and make it accessible to older women."*** Age 68, Uganda

> ***"To ensure there is equality for older women, the government should provide education to the general public on rights and equality."*** Age 50, Tanzania

> ***"Older women's dignity and integrity must be maintained throughout the course of their life."*** Age 51, Zimbabwe[193]

Grandmothers' Leadership

In SSA, grandmothers are advocating for an end to discrimination and violence, encouraging women to claim their rights, and helping them get protection and redress. Grandmothers are feeding whole neighbourhoods of children, and helping to remove the stigma that impedes the HIV/AIDS response. They are advising on the boards of NGOs, and they are becoming part of local governance. Perhaps most significantly, grandmothers are joining together, forming mutual support groups and creating their own organizations, to help advance the work to which they are so committed. In short, grandmothers are showing inspirational leadership—and they deserve support to make that leadership count fully.

To advance grandmothers' leadership, the judges at the African Grandmothers Tribunal have recommended: including grandmothers in all national and local bodies that make HIV/ AIDS-related decisions; increasing grandmothers' representation in community-level bodies that make decisions on issues that affect them; strengthening the community-based organizations that facilitate grandmothers' advocacy and organizing; and ensuring that funding is available for local and national-level advocacy.[194]

In 1991, the UN General Assembly adopted the United Nations Principles for Older Persons. These principles serve as critical foundations underlying the rights of older people and encouraging governments to incorporate the principles into their national programs whenever possible. The principles are: dignity, participation, independence, care and self-fulfillment.[195]

Gender equality is critical to protecting and enhancing the rights of older women. It will lead to more active citizenship, greater social and economic justice and a more inclusive and comprehensive culture of care.[196]

Intergenerational solidarity is also important. Intergenerational exchanges within the family, community and workplace break down stereotypes and help society value the skills, experiences, memories and accumulated wisdom of older people. At the same time, older people appreciate the skills, experience and perspectives of younger people.

> ***It should not be a competition between generations. Older women like me and girls growing up now in Uganda both face challenges. We can work together for the betterment of all women and girls. With the support of younger generations, it is older female leaders like me who can advocate for greater equality and empower the girls of today.*** …
> Margaret Kabango, Ugandan activist, Age 72[197]

Human Rights, Dignity, Equality, and Full Participation: Implications and Opportunities for Action

What can we do to protect and promote the human rights, dignity and full participation of older women/ grandmothers?

1. Spread the word! Be an active voice for the rights of older women.

2. Engage older women in the development of policies and structures that articulate and protect their rights. Include underrepresented groups such as Indigenous people, LGBTTQ+ communities and people with disabilities.

3. Inform and educate ourselves, civil society organizations, media, the interested public and all levels of government on specific human rights issues that resonate with older women/grandmothers in SSA.

4. Stimulate change in social norms that perpetuate ageism, sexism and other forms of discrimination. Support intergenerational cooperation and positive images of aging, to promote the respectful treatment of older women.

5. Ensure proposed legislation as well as current legal and customary practices do not discriminate against people based on gender and age.

6. Take advantage of special international days and designations to inform people about the rights and problems associated with particular issues (e.g., International Day for Elder Abuse)

7. Support a UN Convention on the Rights of Older People to ensure that older women can realize their rights in all countries of the world.
   - Consider joining the Global Alliance for the Rights of Older People (civil society organizations).
   - Engage in dialogue with policy-makers and leaders about older women's rights and the need for a Convention.
   - Encourage the Canadian government to take part in the Open-Ended Working Group (OEWG) on Ageing and ratify a Convention on the Rights of Older People.
   - Get involved with the OEWG and consider participating in sessions organized by the group.

8. Mainstream aging and gender concerns into international development programs, policies and research, and in the implementation of the SDGs at local, national and international levels.

9. Support “community-driven” development that is inclusive of older persons and empowers older women by ensuring they have decision-making powers and leadership positions.

4. KEY MESSAGES

This section provides some key overall messages. Please review each of the 5 pillars to determine and craft key messages for each pillar.

Older women face double, triple or even quadruple disadvantage. Older women are discriminated against based on both gender and age. They are further stigmatized when they are associated with certain communities, including Indigenous peoples, minority racial and ethnic groups, the LGBTTQ+ community, people who are illiterate and/or poor, people with disabilities and those affected and infected with HIV/AIDS.

Older women deserve protection of their rights. These include the rights to: health, social/economic security, decent work, property and inheritance, education and lifelong learning, and freedom from violence and discrimination.

Older women count and they deserve to be counted in. Data collection must include people over the age of 50, and all data should be disaggregated by sex and age.

Leave no one behind. Grandmothers/older women are among the poorest of the poor. If we are to achieve the SDG goals and leave no-one behind, we must return to a strong focus on sub-Saharan Africa with deliberate attention to the often unrecognized, uncounted, and frequently unpaid, older women and grandmothers who are caring for the next generation of African youth and sustaining their communities with little or no support and assistance.

Include older women/grandmothers in the HIV/AIDS response. Increase funding and scale up effective programs in the HIV/AIDS response that specifically include grandmothers/older women in sub-Saharan Africa and the young people in their care, who are infected and profoundly affected by HIV/AIDS.

Older women are contributors and key agents of development. Recognize and support their critical roles as caregivers, heads of households, community leaders and contributors to the economy.

Mainstream gender and aging into all research, programs and policies, and in the implementation of the Sustainable Development Goals at the local, regional, national and international levels.

Canada has the opportunity and means to contribute more (through funding, policy leadership and programs) in international and development aid that:

- Supports quality, safe education and lifelong learning for all, including support earmarked for older women, families that are headed by older women/grandmothers and adult learning that includes older people.

- Supports access to affordable medicines and assistive devices, universal healthcare, and age-friendly transportation and health services.
- Recognizes and enhances the leadership potential of older women/ grandmothers by increasing their participation in local and national decision-making bodies.
- Supports community-based organizations and grandmother groups who advocate and work toward better conditions, gender equality and the rights of older women.
- Exposes and deals with violence against older women, which is widespread yet mostly invisible and hidden.
- Takes a lifecourse, feminist and rights-based approach that stresses the inclusion of older women and supports intergenerational solidarity.

A UN Convention on the Rights of Older Persons would help ensure that older women/grandmothers can realize their rights. These include the right to equality and non-discrimination because of age and gender, and the right to freedom from violence of all kinds, and from abuses related to inheritance, land and property rights and harmful traditional practices such as wife inheritance.

Intergenerational exchanges and solidarity break down stereotypes, value both the young and the old, foster sustainability and build resilient families, communities and societies.

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APPENDIX A

GLOSSARY: UNDERSTANDING SOME KEY TERMS

Adult Learning and Education (ALE) can be formal or non-formal.

- **Formal** including literacy and basic education skills, and job skill training and professional development, which take place in schools with teachers;
- **Non-formal** (also known as community, popular or liberal education) aims to empower people to engage with a range of social issues. This type of adult learning is often lead by community leaders and nongovernmental organizations to address functional adult literacy.

Functional Adult Literacy (FAL) links literacy to people's livelihood and needs. It incorporates skill-specific training in addition to literacy and numeracy and shows learners how literacy can be used for personal development in their everyday lives. FAL targets women and men, older people and youth, and groups of marginalized people, such as people with disabilities and ethnic minorities. Its ultimate aim is to build a culture of lifelong learning among adults.
Source: UNESCO Institute for Lifelong Learning, 2015.

Illiteracy is commonly defined as the inability to read or write.

Ageism: The systemic stereotyping of and discrimination against people because they are considered old. Source: WHO. *World Report on Ageing and Health*, 2015.

Aging (ageing) is both a biological and social construct. Physiological changes such as a reduction in bone density and visual acuity are a normal part of the aging process. At the same time, socioeconomic factors such as living arrangements, income and education greatly affect how individuals and populations experience aging.

The concept of **Age-Friendly Cities and Communities** was developed in 2006 by the World Health Organization. This project brought together cities from around the world that were interested in supporting healthy aging by becoming more age-friendly in eight domains: the built environment, transport, housing, social participation, respect and social inclusion, civic participation and employment, communication, and community support and health services. Thousands of cities and communities are now part of the Global Age-Friendly Network, including over 400 communities in Canada.
Sources: www.phac-aspc.gc.ca/seniors-aines/afc-caa-eng.php ;
www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf

CD4 Count: A CD4 cell count is the measurement of the number of blood cells in a cubic millimeter of blood (a very small blood sample). A higher number indicates a stronger immune system. The CD4 cell count of a person who does not have HIV

can be anything between 500 and 1500. People living with HIV who have a CD4 count over 500 are usually in pretty good health. People living with HIV who have a CD4 cell count below 200 are at significant risk of developing serious illnesses. In the past, CD4 cell counts were used to guide decisions about when to start HIV treatment. However, we now know that all people living with HIV can benefit from HIV treatment and that treatment should begin sooner, rather than later. Source: CATIE-- www.catie.ca/en/home

Discrimination: Discrimination is the selection for unfavourable treatment of an individual or individuals on the basis of gender, race, colour or ethnic or national origin, religion, disability, sexual orientation, social class, age, marital status or family responsibilities, or as a result of any conditions or requirements that do not accord with the principles of fairness and natural justice. Source: UNESCO, www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/discrimination/

Discrimination can be complex. It can be based on more than just one characteristic or take place on more than one occasion.

- *Intersectional discrimination* is discrimination based on a combination of two or more different characteristics, for example, age, sex or disability.
- *Cumulative discrimination* is where the impact of discrimination that happens more than once over a period of time, or on a number single occasions but based on different characteristics, cumulates. It is also sometimes called 'additive' discrimination. Source: HelpAge International. *Entitled to the same right*s.

Elder Abuse: is defined by the World Health Organization 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". Elder abuse can take various forms such as physical, psychological or emotional, sexual and financial abuse. It can also be the result of intentional or unintentional neglect. Source: WHO- www.who.int/ageing/projects/elder_abuse/en/

Equality and Equity: Equality in older age is the full participation and inclusion of older persons in all aspects of society based on equal respect for their dignity. Formal equality is when people have the same rights under the law, regardless of their age or sex or any other characteristic. Substantive equality is where people in different situations are treated differently in practice to ensure that everyone has equal access to opportunities and services**.** Source: HelpAge International. *Entitled to the same right*s.

Equity brings in the quality of being fair and impartial in seeking equality.

All of the SDGs speak to equality and inequalities with one exception--Goal 4.1: By 2030 to ensure that all boys and girls complete free, *equitable* and quality education. This reflects the understanding in education that equity measures are required to ensure fairness and equality in outcome. This includes special

measures to reverse the social, cultural and historical disadvantages that prevent girls and women (and some other learners) from accessing and benefiting from education on equal grounds. For example, unless education systems deal with the need for safe toilets and access to adequate hygiene products during a girl's menstrual period, young women will not have equal opportunities to attend and be successful in school.

Similarly, the word equity and inequities is commonly used in global and Canadian discourse in health. The World Health Organization defines health inequity as "*avoidable"* inequalities in health between groups of people within and between countries". For example, older women in Africa are far more likely to be blind than Canadian women and compared to older men in Africa because they have less access to eyeglasses and cataract surgery. These inequalities are inequities because they are avoidable. Interventions that aim to redress inequities must typically go beyond remedying a particular health inequality and also help empower the group in question through systemic changes, such as law reform or changes in economic or social relationships.
Source: WHO. www.who.int/healthsystems/topics/equity/en/ . Accessed July 2016.

[Note: The definitions below for ***gender, gender equality*** and ***(gender) mainstreaming*** are abbreviated from the UN Women's publication *Important Concepts Underlying Gender Mainstreaming*. The reader is encouraged to read the full fact sheet at www.un.org/womenwatch.]

Gender refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. Gender is part of the broader socio-cultural context. Other important criteria for socio-cultural analysis include class, race, poverty level, ethnic group and age.
Source: UN Women. *Important Concepts Underlying Gender Mainstreaming*

Third gender (or third sex) is a concept in which individuals are categorized, either by themselves or by society, as neither man nor woman, being both man and woman, being in an intermediate state between man and woman, or the ability to cross or swap genders. The term "other" is usually understood to mean the third gender, although some cultures and anthropologists have described fourth, fifth and other genders.
Source: MacMillan Dictionary www.macmillandictionary.com/buzzword/entries/third-gender.html . Accessed July 2016.

Gender equality refers to the equal rights, responsibilities and opportunities of women and men, girls and boys and other genders. Equality does not mean that women and men will become the same but that women's and men's rights, responsibilities and opportunities will not depend on whether they are born male or female. Equality between women and men *(and other genders)* is seen as both a human rights issue and as a precondition for, and indicator of, sustainable people-centered development.

Source: UN Women. *Important Concepts Underlying Gender Mainstreaming*

(Gender) Mainstreaming is not an end in itself but a globally accepted strategy and means to achieve the goal of gender equality. Mainstreaming involves ensuring that gender perspectives and attention to the goal of gender equality are central to all activities--policy development, research, advocacy, dialogue, legislation, resource allocation, and the planning, implementation and monitoring of programs and projects.
Source: UN Women. *Important Concepts Underlying Gender Mainstreaming*

Gender-based violence is violence perpetrated against someone based on their gender identity, gender expression, or perceived gender.

Gender-based violence includes violence against women and girls, as well as violence against LGBTQQI2S (lesbian, gay, bisexual, transgendered, queer, questioning, intersex and two-spirit) and gender-nonconforming people.

Gender-based violence includes any act of violence or abuse that can result in physical, sexual or psychological harm or suffering. Examples of types of violence and abuse include: physical violence, financial abuse, sexual violence (including child sexual abuse, sexual harassment, sexual exploitation), emotional and psychological violence (including threats and intimidation), harassment and stalking, online violence/technology-facilitated violence.

LGBTTQ+: lesbian, gay, bisexual, transgender, two-spirited and queer communities.

Sex is biologically determined and generally relates to the physical differences between men and women. Increasingly, however, sex is considered to be a continuum as opposed to two mutually exclusive categories. For transgender people, their own internal gender identity does not match the sex they were assigned at birth. Both sex and gender influence the well-being and life situations of women as they grow older. Source: Medical News Today, www.medicalnewstoday.com/articles/232363.php . Accessed July 2016.

Prevention of Mother-to-Child Transmission (PMTCT) programs provide antiretroviral treatment to HIV-positive pregnant women to stop their infants from acquiring the virus. HIV can be transmitted from an HIV-positive woman to her child during pregnancy, childbirth and breastfeeding. Effective PMTCT programs require women and their infants to have access to antenatal services and HIV testing during pregnancy; use of antiretroviral treatment (ART) by pregnant women living with HIV; safe childbirth practices and appropriate infant feeding; uptake of infant HIV testing and other post-natal healthcare services. The World Health Organization promotes a comprehensive approach to PMTCT programs, which includes: preventing new HIV infections among women of childbearing age; preventing unintended pregnancies among women living with HIV; preventing HIV transmission from a woman living with HIV to her baby; providing appropriate

treatment, care and support to mothers living with HIV and their children and families. Source: Avert-- www.avert.org/professionals/hiv-programming/prevention/prevention-mother-child

Skipped-generation households occur when an older person, often a grandmother, becomes the primary caretaker for a child who has lost one or both parents, or whose parents are absent for a prolonged period of time. This is distinct from an older person-headed household where the middle generation may still be present. In a child-headed household, there are usually no older people present, or if they are present they may be too sick to act as a household head.
Source: Samuels F and Wells J. HelpAge International and Overseas Development Institute. *The loss of the middle ground: the impact of crises and HIV and AIDS skipped-generation households*, 2009.

sub-Saharan Africa (SSA), according to the United Nations, consists of all African countries that are fully or partially located south of the Sahara. North Sudan and Somalia are geographically part of SSA but are often politically grouped with north Africa, whose states are part of the Arab, largely Muslim world. Recently, some UN Agencies have used a different regional breakdown, i.e. east, west, north and south Africa (not to be confused with the country of South Africa). GRAN is largely concerned with countries in the east, south and west, where the AIDS pandemic is most problematic.

Survival sex: The sale and exchange of sex for goods in humanitarian and post-conflict settings is often referred to as survival sex, but the term can also refer to the practice of individuals exchanging sexual services for shelter, food, or other necessary items as an alternative to homelessness outside the context of emergencies. Source: Violence Against Women and Girls. *Brief on Violence Against Older Women*, 2016.

Sustainable Development Goals (SDGs) are a set of seventeen aspirational "Global Goals" with 169 targets between them. Their development was spearheaded by the United Nations, through a deliberative process involving its 193 Member States, as well as global civil society. For a review of the SDGs go to www.un.org/sustainabledevelopment/sustainable-development-goals