FINAL REPORT

ANALYSIS OF THE SITUATION OF PEOPLE AGED OVER 50 YEARS IN HAITI

UNDER COORDINATION OF JUDITE BLANC

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LIST OF ACRONYMS

BIT: Bureau International du Travail (International Labor Organization – ILO)

CAS: Caisse d'Assistance Sociale (Social Assistance Fund)

CAL: Centre de Santé avec lit (Healthcare Center With Bed)

CAMEP: Centrale Autonome Métropolitaine d'Eau Potable (Autonomous Metropolitan Central for Drinking Water)

CSL: Centre de Santé sans Lit (Healthcare Center Without Bed)

DINEPA: Direction Nationale de l'Eau Potable et de l'Assainissement (National Directorate for Drinking Water and Sanitation)

DSNCRP: Document Stratégique Nationale pour la Croissance et la Réduction de la Pauvreté (National Strategic Document for Growth and Poverty Reduction)

ECVH: Enquête sur les Conditions de Vie en Haïti (Survey on Living Conditions in Haiti)

EMMUS: Enquête Mortalité, Morbidité et Utilisation des Services (Survey on Mortality, Morbidity, and the Utilization of Services)

IHSI: Institut Haïtien de Statistiques et d'Informatique (Haitian Institute for Statistics and Information Technology)

IBESR : Institut du Bien-Être Social et de Recherches (Institute for Social Welfare and Research)

ILO: International Labour Organization

INFP: Institut National de Formation Professionnelle (National Institute for Vocational Training)

MARNDR: Ministère de l'Agriculture, des Ressources Naturelles et du Développement Rural (Ministry of Agriculture, Natural Resources and Rural Development)

MAST: Ministère des Affaires Sociales et du Travail (Ministry of Social Affairs and Labor)

MENFP: Ministère de l'Éducation Nationale et de la Formation Professionnelle (Ministry of National Education and Vocational Training)

MCI: Ministère du Commerce et de l'Industrie (Ministry of Commerce and Industry)

MIPAA: Plan d'Action International de Madrid sur le Vieillissement (Madrid International Plan of Action on Ageing)

MSPP: Ministère de la Santé Publique et de la Population (Ministry of Public Health and Population)

OMS: Organisation Mondiale de la Santé (World Health Organization)

ONA: Office National d'Assurance-Vieillesse (National Office of Old-Age Insurance)

ONG: Organisation Non Gouvernementale (Non-Government Organization)

ONU Organisation des Nations Unies (United Nations Organization)

PIDESC: Pacte International relatif aux Droits Économiques, Sociaux et Culturels (International Covenant on Economic, Social and Cultural Rights)

SEA: Secrétairerie d'État à l'Alphabétisation (State Secretariat for Literacy)

SPSS: Statistical Package for the Social Sciences

UNESCO: Organisation des Nations Unies pour l'Éducation, la Science et la Culture (United Nations Education, Science and Culture Organization)

WHO: World Health Organization

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EXECUTIVE SUMMARY

ANALYSIS OF THE SITUATION OF THE ELDERLY AGED 50 IN HAITI
March 2013

For a few years, then recently in the post-seismic context, official programs and humanitarian organizations have been emphasizing the vulnerability of children and women, of pregnant women, of people living with HIV, among others. What about the elderly who, according to international legislations ratified by HAITI, and to which most humanitarian organizations adhere, constitute a group with specific needs, but with the same rights as society's other categories?

What is the fate of this segment of the population in a country economically exhausted and socially torn like Haiti, three years following a humanitarian disaster, unprecedented in its history?

This analysis of the situation of the elderly in HAITI places itself from the perspective of a complete and detailed diagnosis. It is sponsored by HelpAge International, in the framework of implementing its programs in the country.

The main objective of this endeavor aimed to construct a solid database from research and from other preexisting data (legislation, policies related to the rights and needs of the elderly in Haiti, etc.). In other words, the goal was to:

- Implement a precise and updated diagnostic of the situation of the elderly in Haiti, and
- Provide recommendations regarding development strategies, and support the reflection towards advocacy.

Consequently, based on the Human Rights approach spelled out in the Universal Declaration of Human Rights, and paying close attention to *the rights to health, to social security, to employment, to education, and to community participation,* this study presents a vivid picture of the living conditions of individuals older than fifty (50) years in the country. Data were collected over a three-month period (September-November 2012) in six of the country's geographical departments, according to the following geographical and socio-demographic criteria: coastal area, border area, rural area, urban area, at risk zone. Three key moments caracterized this analysis:

1. A documentary examination of secondary sources regarding the international and national legal framework related to the living conditions of the elderly in Haiti;

2. The realization of a qualitative survey via semi-directed conversations with participants and stakeholders (NGO's, civil society organizations, associations of the elderly, host facilities, etc.), as primary sources;
3. The empirical survey, to evaluate the degree of realization of fundamental rights, was carried out in two stages in November 2012. First, it involved a quantitative survey via questionnaires assigned to 1113 persons older than 50 years, both male and female, pertaining to the current population; second, it included a qualitative and participative survey of 16 focus groups, including 173 subjects of different gender and age bracket.

Primary results

The documentary review reveals **a rather poor legal literature regarding the elderly in Haiti**. Almost no laws specific to this social category, except for a few Civil Code articles promulgated in 1825, and for references made in the 1987 Constitution to the principles of the Universal Declaration of Human Rights, which was ratified by Haiti in as early as 1948.

Second notable fact, regarding the social security guaranteed by the 1987 Constitution, the National Office of Old-Age Insurance (0NA) was identified as one of the government entities in charge of organizing a pension system for the elderly. ONA is governed by the 21 September 1957 Law. Its purpose is to improve the living conditions of the elderly by providing them with a monthly stipend and other types of insurance. A variety of services are offered, such as: medical insurance, pension, and a grant in the event of death. Currently, **less than 3000 persons older than 55 years benefit from a retirement pension with ONA.** In spite of this demonstration of interest in supporting this segment of the population, this small sample of ONA pensioners appears negligible, given the fact that in 2010, persons aged 55 and more represented 930.974 individuals within the total Haitian population (IHSI, 2007, 2008)[1]. This suggests that currently, less than 0.32% of persons aged 55 years and more are covered by ONA's pension systems.

Regarding our survey administered by questionnaire, the proportion of beneficiaries aged 60 years and more represented a little more than 50%. The data revealed that 58% (645) came from rural areas, versus 42% (468) from urban areas. In our sample, 50.6% (563) of the elderly have never been to school, and 30.5% completed primary school.

[1] Those aged 60 years and older represented 646.243 people.

In what concerns income or means of subsistence, 15.9% (177) depend on the assistance from family abroad, 14.2% (158) survive thanks to agriculture, and **3.1% (34) would live of their retirement pension in Haiti**.

Another observation: most of the subjects, that is 60.6% (674), only have **occasional access** to essential contemporary medical care. Financial problems seemed to be the main obstacle preventing access to healthcare for those individuals aged 50 years and more (784, that is 75.7%), selected in urban and rural zones. A substantial number (more than 80%) of the elderly surveyed did not benefit from any type of health insurance coverage. However, those who were covered came mainly from urban areas. Consequently, there was a massive recourse, in all areas indistinctly, to medicinal plants (traditional medicine) as an alternative to mitigate the fact that modern medical care was inaccessible. Such recourse was much more frequent in rural areas (more than 60%). Most of the elderly who admitted having recourse to the services of Vodou priests and priestesses in the absence of modern medical care, would be between 80 and 90 years of age, representing more than 60% of the category. We counted 4.6% (51) physically handicapped individuals among the participants. If 80% (80) of participants surveyed in the North-East of Haiti admitted to being ill, the ones who revealed a physical handicap would be the group for which healthcare would be the least accessible: 25.5% would never have access, and 54.9% would have it SOMETIMES, and just 15.7% and 2%, respectively, declared having it OFTEN and ALL THE TIME. 70% of those with a physical handicap were prevented from utilizing the services of the nearest healthcare center due to their poor financial means.

Regarding awareness campaigns in times of disaster, according to answers provided to our questionnaires 12.9% (60) of urban area participants and 18.5% (119) of those from rural areas would never be accustomed to being touched by these activities. Thus, more than 90% of the people interviewed in the South-east of the country declared having access to these campaigns only SOMETIMES.

In the entire population surveyed, 69.8% (326) (urban) and 79.8% (513) (rural) deem to have not benefited from humanitarian aid in times of disaster. Considering the 10-percentage-point differential observed between the two groups, it is likely that the urban zones are more concerned with the humanitarian aid. Our results reveal that the aid would never arrive to the totality of subjects surveyed in the South-East and Nippes departments.

Admittedly, to a large extent, our surveys, then our causal analysis of the difficulties related to the living conditions of interviewed persons aged 50 years and more, allowed us to come up with problems of a structural nature. We must also consider the interaction between structural and cultural factors. Thus, in both the quantitative survey and the focus groups, a category of those surveyed indicated they do not use health services for lack of economic means, and they resort to traditional medicine when in need. Nevertheless, in focus groups

others did not hide their preference for that traditional medicine because of its effectiveness, compared to contemporary medicine. Still in the context of the discussion groups, the participants made it clear that their education came in second compared to their children's primary needs. Moreover, a category indicated it did not attend literacy programs because it feared being stigmatized by the literate.

In the end, it should be stressed out that questions about intergenerational relations raised in the focus groups show a minimization, on both sides, of the roles or the value of elders in Haiti's social fabric. Hence the need for a fresh look into the various actors of this segment of the population, for their full integration in social life.

Conclusion and Perspectives

This analysis of the situation of the elderly in Haiti made it possible to ring the alarm bell about the living conditions of a segment of the population, of which the poignant vulnerability is ignored, little known, or neglected. Our elders' exposure to financial insecurity or to poverty, which is exposed in our work, shows how large the gap is between the fact of having rights and that of being able to enjoy them, between the existence of laws and the enforceability thereof, between the normative ideal and the hard reality. The problems that were highlighted relate to almost all the aspects of their life (health, nutrition, education/training, protection, work, community participation, etc.). To our knowledge, this study on the situation of Haiti's elderly is one of the very few in existence. Thus, it should open the way to others on a larger scale, where all the strata of the Haitian society would be effectively represented.

In terms of perspectives and recommendations, our list could be endless since the outcomes of this research show that all the work for the integration of the elderly in Haiti is still outstanding. For the moment we are only suggesting a few guidelines while underlining the fact that, fundamentally, their execution points to structural adjustments that automatically involve the intervention of the Haitian government. In that sense, a close cooperation between HelpAge International, the Haitian government and all policymakers remains a crucial strategy if HelpAge International ever aims at a comprehensive response on a national scale. As a matter of fact, based on the conclusions derived from our study, a strategic choice articulated around two main, non-exclusive axes (**Advocacy and Implementation of targeted programs**) could lead to promising results. HelpAge International as well as any organization whose mission is the improvement of the living conditions of Haiti's elderly, should insist, as a priority component in its action plan, on a campaign to raise awareness with policymakers and the civil society, for **an overhaul of our systems of social security and social protection. Clearly, it is necessary to guarantee the safety of incomes through implementation of a universal retirement plan, to**

ensure the access to medical care, to reinforce the management of risks and disasters, and to widen access to education/training by taking into account the demographic ageing process within society, as well as its implications.

INTRODUCTION

"*First and before all, demographic ageing is a brilliant success of public health policies as well as economic and social development…*"

Gro Harlem Brundtland, Director-General, the World Health Organization, 1999[2].

For some time now fertility rates have been declining and longevity has been increasing in the world, which is not without consequence on the world's demographic structures. Population ageing was initially observed in high-income countries. The tendency is presently global, and there is evidence of a permanent increase in the median age of the world's population. Undoubtedly, population ageing now also involves the developing world, where it extends ceaselessly. Indeed, this rapid change in the structure of the population, which implies an increase in the percentage of the elderly currently and in the future, raises serious challenges for the various institutions that must adapt to meet adequately the needs of the population today and tomorrow.

In developing societies like Haiti, the political urgency of managing the repercussions of population ageing is eclipsed by other recurring emergencies. Nowadays, the Haitian population is rather young since more than 38% of citizens are younger than 15 years, while population ageing occurs at an accelerated pace. Nevertheless, despite the fact that, for some years and now in the post-seismic context, the elderly have represented a valuable resource contributing considerably to the social fabric, social and public health policies have neglected them and, instead, emphasized the vulnerability of children and women, pregnant women, workers, and people living with HIV, among others.

What happens to the elderly who, according to international legislations ratified by HAITI, and to which most humanitarian organizations subscribe, constitute a group with specific needs, but with the same rights as the other groups within society? What is the fate of this segment of the population in a country economically depressed and socially torn like Haiti, three years following a humanitarian catastrophe, unprecedented in its history? To consider the

[2] WHO, 2002

population ageing phenomenon in 2013 essentially amounts to drawing the attention of Haitian political leaders and social actors to many basic problems. What are the existing social policies, or those in need of implementation, that are capable of protecting our elderly from the financial insecurity that characterizes a good part of the Haitian society[3]? Considering the repercussions of ageing on the financing of healthcare systems and social services, is there a healthcare policy intended for the elderly? Given the fact that healthcare can be costly in life's later years, shouldn't there be advocacy for policies aimed at promoting health and the prevention of old age related diseases, such policies being congruent with the Haitian sociocultural context? Taking into account the ongoing extension of life expectancy in our society, what are the policies intended to improve the quality of life during old age? From the civil society's standpoint, what role do younger generations attribute to the elderly? Since Haiti is regularly hit by natural disasters, and beset by political conflicts, what are the programs aimed at the protection of this category, which is quite as vulnerable as the other segments of the population?

This report, which analyses the situation of persons older than 50 years[4] in Haiti, aims to be a complete and detailed diagnosis. It is sponsored by HelpAge International in the framework of implementing its programs in the country. The main objective of this endeavor aimed to construct a solid database from research and other preexisting data (legislation, policies related to the rights and needs of the elderly in Haiti, etc.). In other words, this document proposes:

- A precise and updated evaluation of the situation of the elderly in Haiti, and
- Recommendations regarding development strategies, particularly as regards advocacy, in order to improve the living conditions of the elderly in Haiti.

Inspired from the fundamental Human Rights approach spelled out in the Universal Declaration of Human rights, and paying close attention to *the rights to health, to social security, to employment, to education, to community participation, and to protection,* this study presents a vivid picture of the living conditions of individuals older than fifty (50) years of age in the country. This document of analysis of the situation of the elderly in Haiti contains three parts.

- The first part proposes a documentary examination of secondary sources, regarding the international and national legal framework related to the living conditions of the elderly in Haiti. It describes the results of a qualitative survey carried out among stakeholders

[3] According to World Bank estimates, 47% of the country's total population would be under the extreme poverty line ($1 per person per day, PPP based), and up to 68% of the population would be under the poverty line (less than $2 per day per person, PPP based). The disparity between the poorest and the richest is very important: 10% of the richest receive 50% of national income (ILO, 2010).

[4] 60 years is the UN's age of reference when considering the elderly (WHO, 2002).

and beneficiaries (decision makers, NGOs, Civil Society organizations, associations of the elderly, host facilities, etc.), as primary sources.

- The second part presents the outcomes of an empirical survey aimed to evaluate the degree of realization of the fundamental rights. That survey involved 1113 persons older than 50 years, both male and female, pertaining to the current population in Haiti.
- In order to cross-match the data, the third part presents the conclusions of a qualitative and participative survey of focus groups, including 173 subjects of different gender and age brackets.
- Finally, the last section recaps the main results of the study and provides prospects for future action implied by our conclusions, in order to improve the quality of life of the elderly in Haiti.

National Context

According to projections from the Haitian Institute for Statistics and Information Technology (IHSI, 2008), the Haitian population would grow in 2013 to 10,579,230 inhabitants. Women represent 52% of the total population. It is a young population. The 15-year-and-younger category counts for 38.5% of the population. An extension of life expectancy at birth is ongoing. In 2010, life expectancy was estimated at 62.40 years, it will reach 76.51 years in 2050.

Table 1: Distribution (%) of the total population aged 50 years and over, by gender, throughout the country (2003 Census data).

Five-year Age Bracket	Gender		
	Male	**Female**	**Both Genders**
50 -54	1.5	1.6	3.1
55 - 59	1.1	1.7	2.8
60 -64	1.2	1.4	2.5
65 -69	1.0	1.1	2.1
70 -74	0.8	1.0	1.7
75 - 79	0.5	0.6	1.1
80 - 84	0.3	0.4	0.7

85 - 89	0.1	0.2	0.3
90 -94	0.1	0.1	0.2
95 and older	0.1	0.1	0.2

Source: 4th General Census of the Population in Haiti, IHSI, 2003.

As we can see in Table 1, the share of those aged 60 years and older was 8.8% at the time of the last census. In 2010, the urbanization rate of the population in Haiti was 47.8%. The rate of urbanization is projected to rise substantially in less than forty years: it will reach 70.4% in 2050 (IHSI, 2007, 2008).

Table 2: Estimates and projections of the urban population aged 50 years and over by five-year age groups, period: 2010 - 2015

	2010		2015	
Age Group	**Number**	**%**	**Number**	**%**
50 - 54	138 580	40.4	179 664	44.5
55 - 59	107 391	37.7	134 262	41.7
60 -64	73 562	35.6	102 894	39.4
65 - 69	61 671	35.1	71 016	39.0
70 -74	44 448	34.3	55 213	38.1
75 -79	27 630	34.2	36 496	38.0
80 and more	17 992	33.8	25 097	37.7

Source: Estimate and Projection of the Urban and Rural, and Economically Active, Total Population, 2007-2008, page 65.

Table 2 evidences the increase in the population aged 50 years and older, over the 2010-2015 period.

General methodology

To properly conduct this situational analysis of the elderly in Haiti, a qualitative, quantitative, and empirical general methodology was adopted. It consisted of the following stages:

- a documentary examination of secondary sources appropriate to determining the international and national legal framework, as it relates to the welfare of the elderly in Haiti;
- the realization of a qualitative and quantitative survey through semi-directed conversations, and evaluation grids, with participants and stakeholders (decision makers, Haitian government, NGO's, Civil Society organizations, associations of the elderly, host facilities, etc.), as primary sources;
- the realization of a quantitative survey (administration of questionnaires) and a qualitative survey (focus group) of both the elderly and young people.

Developed instruments of observation[5]

a. *A questionnaire for personal survey*
b. *A grid to observe* housing conditions

The observation grid was used to observe the situation of households and institutions (health facility, retirement home, church, Vodou temple, etc.), on occasion of house and institution visits.

c. *A grid to analyze medical files*

This instrument was used to collect data about the health status of the elderly in the six geographical departments (attendance rate at health facilities, most current diseases, responsibility for medical costs, etc.).

d. *A guide to interview resource persons*

It was used for individual interviews with authorities and institutional leaders, in order to determine their perception of the fulfillment of the elderly's rights.

[5] Attached

e. *An evaluation grid of host facilities for the elderly*
f. *An evaluation grid of government programs benefiting the elderly*. This tool was based on the questionnaire prepared by Dominique Kern (2002, p 128).

The focus groups

A focus group grid dealt with eight (8) main themes: health, nutrition, social protection, hygiene and sanitation issues, education/training, community participation, gender and ageing, and perceptions and feelings about ageing. The treatment of the data resulting from the focus groups was done in two phases. First, a content analysis focusing on problems faced, depending on the group; second, a causal analysis allowing for the determination of causal linkages among the various issues that arose in the discussions.

Quantitative survey

The main purpose of the quantitative survey consisted in evaluating the degree of fulfillment of the rights of a sample of people older than 50 years, randomly selected in six geographical departments of Haiti. This important stage of the analysis of the situation of Haiti's elderly focused on the extent of fulfillment of fundamental human rights, such as: the right to life (survival), the right to health, the right to protection (response to emergencies, risk and disaster reduction, adaptation to change), the right to social protection, the right to work and leisure, the right to education and training, the right to a family support system (to belong to a family structure), among others. In the third part of this report, the results of this survey are explained in detail.

Instruments

Througout this study on the situation of the elderly in Haiti, data was collected among stakeholders. Beneficiaries were also consulted on their current situation. Two instruments were conceived to collect data.

1. *Individual case report notebook*

This instrument took the form of a questionnaire including 4 major sections: an initial section that addressed the socio-demographic situation of the subject; the second section was used to evaluate the economic situation (socioprofessional status, sources of income, nutrition, outstanding debts, etc.); the third section measured the conditions of fulfillment of the rights to health and social protection (physical condition, access to medical care, to health

insurance, etc.); finally, a fourth section informed about the situation of the participant vis-a-vis natural disasters, as well as risk and disaster management in his/her community (mode of adaptation to climate changes). The elderly were also interviewed at the end of the questionnaire on today's transmissible and chronic diseases that were not common in the past.

2. *Observation grid of housing conditions*

A number of participants (200) were interviewed on their housing conditions. The quality of the physical environment, the interactions with the entourage, among other attributes, were evaluated by this grid.

Sampling of the quantitative survey

To participate in the survey, the subject or any member of his/her family should sign at first a form of free and informed consent; be 50 years old or older at the time of the survey; and be able to communicate in one of the two official languages of the country (Creole, French). The subjects suffering from psychosis, Alzheimer disease, dementia, or from medico-legal constraints, hetero-aggressiveness, etc., were excluded from the survey. They were recruited based on a random sampling, particularly on the place of business, at church, in public squares, in market places, at retirement homes, and within households.

Statistical analyses

They were carried out using the **SPSS** software **(Statistical Package for the Social Sciences)**, version 19. Sociodemographic data, such as gender, age groups, residential environment, socioprofessional category, sources of income are taken into account in the descriptive statistical criteria. Chi-square tests were carried out for the analyses, depending on gender, income, and the milieu of origin. The significance level was established at 0.05.

PART ONE

LEGAL FRAMEWORK OF THE ELDERLY's RIGHTS

By Melior Joseph

The extension of life expectancy has repercussions not only in the economic, social and political domains, but also in the legal area. It seems that this phenomenon's impact was overlooked in Haiti. In this chapter, we propose to examine current legal provisions that guarantee the rights of the elderly at the international level. Then, we will index texts from the Haitian legislation that protect this social category; finally, we will stress the strengths and weaknesses of the legal framework in the area.

- INTERNATIONAL INSTRUMENTS:

The international instruments characterize all commitments made by nations at the international level. These commitments take several forms, with some being more restrictive than others, and they bear several names: Convention, Treaty, Protocol, Declaration, Agreement, etc. Internationally, the terms "agreement", "charter", "convention", "pact", "protocol" and "treaty" are indifferently utilized. Although, theoretically, one may appear more coercive than the other, these provisions have in common the inexistence of a specific body whose duty would be to force a government to abide by its obligations.

Thus, in this work, we will use the term "convention" to characterize all the agreements endorsed by the world's various States in order to achieve the improvement of the elderly's living conditions.

By Convention, we mean a written agreement between two or several States that express their duties and their rights in a particular area; the term "Treaty" is also utilized[6]. These conventions' main goal is to guarantee the basic rights of the human being, to enunciate principles destined to elevate both man and woman in dignity and, especially, to preserve peace in the world.

International Conventions represent the best way for countries to express their consent. Through these international legal instruments, States reach agreements on matters of concern for humanity as a whole. To achieve such a goal, representatives from various countries launch negotiation rounds; at the end of the process, a final text is adopted through signature by the

[6] Françoise Bouchet-Saulnier, Practical Dictionary for Humanitarian Law, La Découverte Edition, Paris, 2006.

contracting countries. The Treaty comes into force when the predetermined number of countries have ratified it, or have agreed to it.

This said, what is the international legal context in terms of rights of the elderly?

On the international level, several legal provisions[7] offer a normative framework encouraging nations to guarantee the rights of the elderly. Until today, there are really no specific conventions on the elderly. The few articles dealing with this social category's protection can be found in general instruments such as: **Universal Declaration of Human Rights, Convention Relating to the Status of Refugees, International Covenant on Economic, Social and Cultural Rights (ICESCR), Declaration on the Rights of Disabled Persons, Declaration on the Elimination of all Forms of Violence towards Women.**

The Madrid International Plan of Action on Ageing (MIPAA), or Madrid Plan, represents an international instrument specific to the elderly. Unfortunately, MIPAA's set of provisions comes down to simple recommendations, declarations of principles devoid of any constraining force that could coerce States to guarantee agreed upon commitments.

In spite of variations in the provisions contained in the various treaties, the principles put forth in the latter concern mainly: social protection, health care, community participation, training, the end of exclusion, abandonment and ill-treatment, the implementation of infrastructures to facilitate the elderly's circulation, protection in the event of natural disasters, respect of their dignity, social security, equality of chance in employment, the elimination of discrimination on the basis of physical or mental handicap, the elimination of all forms of violence, financial autonomy, etc.

Consequently, we estimate that the various principles spelled out in the many declarations or conventions convey the idea that the concept of the law symbolizes the values a society adopts at a given moment of history, that is, the grammar of the social fabric is entrusted to the law. To this end, the international society exhibits a strong will towards curbing the discriminatory effects of ageing. Indeed, this social phenomenon stands as the quintessential laboratory to test the solidity of our values and, at the same time, to question our practices and our institutions.

From the Universal Declaration of Human Rights, to the Declaration on the Rights of Disabled Persons, to the International Covenant on Economic, Social and Cultural Rights, and to the Convention Relating to the Status of Refugees, or to the Madrid International Plan of Action on Ageing, we can deduct a determination, wich is constantly renewed, to destroy negative perceptions related to the fact of ageing. These manifestations of will through international

[7] See Appendix 1: List of conventions regarding the elderly.

treaties witness to the fact that ageing represents a key element in the collective future of humanity. Thus, the various States of the world commit to defeat anti-elderly attitudes that are hard to overcome in a global context in which youth is celebrated, and to make advanced age a sign of social distinction.

This said, we notice palpable progress on the international front. Since its creation, the United Nations has not stopped regulating the situation of the elderly. Recommendations from the various conventions urge all States to ensure a pleasant living environment for this category. The UN General Assembly's decision to declare October 1st International Day of the Elderly attests to the ongoing attention paid by modern societies to the ageing phenomenon.

Moreover, a problem with the International Conventions is the issue of limited effectiveness or absence of a binding force. Indeed, one feature of International Law is its consensual character (Soft Law), that is, this branch of the law is dependent upon the will of nations. As a matter of fact, there is no international super Jurisdiction above the States that would be endowed with legal prerogatives to force them to apply a Convention. It is left to each country to decide whether to respect the provisions of a Treaty signed and ratified on its territory, and no foreign force can constrain it to do so.

In such a context, many States take advantage of the "soft" character of International Law to renege on commitments they made at international Assemblies. Consequently, Treaties on the protection of the elderly are likely to be reduced to abstract principles, wishful thinking devoid of any effective applicability that could redress situations of social exclusion, family abandonment or economic precariousness faced by men and women who are older than 50 years. In such a context, civil society organizations are expected to play a fundamental role in structuring the advocacy in favor of the development of conventions, as well as national legislations aimed to guarantee the respect of the elderly's rights.

NATIONAL LEGAL FRAMEWORK

By national legal framework, we mean the laws, the decrees and also the constitutional provisions that create legal tools to guarantee, within a specific territory, the socioeconomic rights of the elderly. The legal literature is particularly poor in what regards the elderly; there is really no law specific to this social category. Nonetheless, our literature review allowed us to detect a few broad-based articles that, in one way or another, take into account the situation of the elderly on the national territory:

The Civil Code: The Civil Code governs the system of Prohibition. The Legal Vocabulary of Gérard Cornu defines Prohibition or Guardianship of Adults as follows: "Protection system under

which can be placed an adult who, due to an alteration of his/her personal faculties, needs to be represented in a continuous manner in the acts of civil life" (Cornu, 2005).

In Article 399 the Code stipulates: "the adult who is in a state of imbecility, dementia or rage, should be prohibited, even when such a condition presents lucid intervals". But, according to Article 402, prohibition must be pronounced by a judicial body after examination by a medical expert: "any demand for prohibition will be presented to the civil court".

The Constitution: As the fundamental charter defining the political régime and the legal framework of the Haitian nation, the 1987 Constitution enunciates a number of principles that attribute specific rights to the citizens (and, consequently, to the elderly):

- Human rights:

Article 19: The State has the absolute obligation to guarantee the Right to life, to health, to Respect for the human person for all Citizens without distinction, in accordance with the Declaration of Human Rights.

- Social needs:

Article 22: The State acknowledges the right of all citizens to decent housing, education, nutrition, and to social security.

- On the medical front:

Article 23: The State must ensure all citizens in all Territorial Collectivities appropriate means to guarantee protection, to maintain and restore their health by the creation of hospitals, health centers and community clinics.

- Right to work:

Article 35: The freedom to work is guaranteed. Every citizen must devote him/herself to a job of his/her choice in order to provide for his/her needs and those of his/her family, to cooperate with the State in order to establish a social security system.

- Protection of the family

Articles 259//260: The State protects the Family, which is the fundamental base of society. // It must provide equal protection to all families, whether in the bonds of marriage or not. It must provide assistance and support to motherhood, to childhood, and to old age (Haitian Constitution of 1987).

As can be seen through these constitutional provisions, the Haitian State intends to assume its role of social regulator by ensuring public service to all citizens in the country, especially the most vulnerable. Whether in the realm of fundamental human rights or in that of social rights (work, housing, social security, health care, etc.), the Haitian authorities commit to work towards improving the population's living conditions.

As to the protection of the elderly, there is no specific reference in the Constitution, besides the fact that the lawmaker acknowledges that the State should provide assistance and support to the elderly (Art. 260). The fact that the lawmaker somewhat overlooks the elderly category is understandable when one considers that any Constitution only formulates general, abstract principles that determine a nation's broad guidelines. It is the lawmaker's responsibility to promulgate programmatic laws to regulate each situation that requires the government's intervention through decrees, laws, etc. However, we have not been able to find any law that guarantees the protection of the elderly.

Presumably, the absence of provisions specific to the elderly's situation reflects the fact that the Haitian authorities do not consider ageing as a definite phenomenon that requires treatments suitable to the needs of the elderly and to their social conditions. If the law is the expression of values that a society adopts to ensure its organization and its balance, the nonchalant attitude of the Haitian legislator towards the elderly reflects the social denial that this category endures.

Nonetheless, given the lack of regulations from the Haitian lawmaker, we refer to international conventions ratified[8] by Haiti. For, according to article 276-2 of the Haitian Constitution: "Treaties or International Agreements, once approved and ratified in the manners provided by the Constitution, are part of the country's legislation and abrogate any laws that contradict them". In this case, any elderly-focused Convention ratified[9] by the Haitian Parliament falls in the purview of the national legislation and can serve as a basis or a reason to claim the rights of this segment of the population.

This being said, although the Haitian legislator give little attention to the need of regulating the situation of the elderly, international conventions ratified by Haiti come in compensation, so to speak, of the laxity of the Haitian legislation and may be put forth when it comes to advocate for the actual fulfillment of the elderly's rights.

[8] See Appendix 1: List of conventions regarding the elderly.
[9] Ibid

EVALUATION OF THE CONDITIONS FOR THE FULFILLMENT OF THE ELDERLY's RIGHTS

By Melior JOSEPH and John JUSTAFORT

In this section we plan on analyzing different privileges (subjective rights) granted by Haitian laws to ensure a social environment conducive to the elderly's well-being. To that effect, we consider a set of socio-economic rights that, insofar as they are fulfilled, would reflect efforts by the Haitian State to ensure the protection of the elderly category. Thus, for each type of right, we will highlight the strengths as well as the gaps to fill.

RIGHT TO PROTECTION:

It is mainly through organizations defending the elderly's rights that we observe considerable progress in terms of protecting this segment of the population. The fact that civil society associations (Associations for the defense of the rights of the elderly[10]) are advocating for the acknowledgement and enforcement of the elderly's rights, represents a significant effort in the area. Further, the intervention of a number of Non-Governmental Organizations (NGOs) (for example, Caritas supplies food to a number of host institutions for the elderly, HelpAge International provides technical, financial and logistical support to various associations as well as shelters working in the area) comes in support of the actions of local associations, which most often suffer from a lack of human and material resources to make their case. The essential role played by host institutions (shelters) in protecting and supporting the elderly should also be noted. By providing shelter, a family environment, leisure and information to residents, these institutions represent direct entities for the elderly's protection.

RIGHT TO WORK:

Article 35 of the Constitution states: "The freedom to work is guaranteed. Every citizen must devote him/herself to a job of his/her choice in order to provide for his/her needs and those of his/her family, to cooperate with the State in order to establish a social security system." The fact that Haitian law enshrines such a principle commits and obliges the authorities to put in place necessary conditions to guarantee employment for all categories, labor protection and the eradication of all forms of discrimination based on gender or age. As one gets older, access to the formal labor market may be limited; it is the duty of the country's leaders to define a

[10] Appendix 2 – Table 30

framework of action to take advantage of the elderly's labor market potential. Our efforts with the Ministry of Social Affairs and Labor (MAST) did not allow us to obtain accurate data on any social policy towards people or workers well on in years.

Although enshrined in Article 35 of the Haitian Constitution, the enjoyment of the right to decent work appears as a luxury that the majority of older people would be hardpressed to afford. According to the National Strategic Document for Growth and Poverty Reduction *(DSNCRP)*, "The population over 65 years of age represents a very vulnerable category. Massive unemployment and absence of a social security system explain the very precarious situations in which many elderly find themselves". *(Document Stratégique National pour la Croissance et la Réduction de la Pauvreté, DSNCRP, 2008-2010, 2007, p. 34)*.

Within the workforce, the elderly would represent about 10% of the unemployed: "Almost half of the elderly (48.5%) are active with 10.5% unemployed. This group of actively working elders is certainly dominated by the 60-64 age group, the presence of which is an indication of the precarious situation of the elderly, many of whom are obliged to exercise an economic activity to ensure the survival of their households."(IHSI, 2009).

In the last IHSI Census (2003), the labor force consists of people aged 10 years and over. Overall, the unemployment rate is around 30% in the country. Among women aged 50-54, 17.7% are affected by this phenomenon versus 10.5% among men. For the 55-59 age group, the rate is 17.8% among women versus 13% among men; while in the 60-64 age group, the percentage was 11.8 for women and 9.2 for men (IHSI, 2009).

We need to offer some clarifications so that these figures do not lead us to assume a particularly low rate of unemployment in the country. To better understand the unemployment rate among the elderly, we must situate it with respect to the overall unemployment rate for the labor force, which is about 30%. With respect to the population of working age, the younger the population segment is, the higher the unemployment rate tends to be (for example, the unemployment rate among the youth aged 20 to 25 years is 50%[11]); proportionally, the older the category, the lower the unemployment rate (among those aged 65 years and over, the unemployment rate is 8.1%).

This dynamics is explained by the fact that with advanced age and the implications it entails (disease, disability, physical or mental disability, etc.), a large majority of the elderly leave the workforce to join the inactive population category, which consists of primary/secondary and college students (57% of the total), and also homemakers (25.7%), with an overwhelming majority of women, as well as retirees, pensioners, and the disabled.

[11] Source : IHSI, Survey on the Living Conditions in Haiti *(Enquête sur les Conditions de Vie en Haiti, ECVH, 2001).*

Ultimately, the interviews we conducted with resource persons from different organizations defending the rights of the elderly abound in the same direction as IHSI's survey: the elderly are generally excluded from the formal labor market in Haiti. This state of affairs is likely to aggravate the vulnerability of that population group.

RIGHT TO SOCIAL SECURITY

The National Office of Old-Age Insurance *(Office National d'Assurance-Vieillesse, 0NA)* is one of the governmental agencies in charge of organizing a pension system for the elderly. ONA is governed by the 21 September 1957 Act, the 8 November 1965 Decree, the 28 August 1967 Act and, finally, the 12 September 1990 Decree. One of ONA's goals is to improve the living conditions of the elderly by providing them with a pension and an insurance.

Although this entity does not restrict itself to the elderly, it offers them different types of services such as insurance, health care, pension, and even financial support in case of death. According to the latest, but non-officially confirmed data from November 2012, ONA would cover about **2,000[12] pensioners (less than 0.32% of people aged 55 and over) (ONA, 2012)**. Box 1 presents a detailed description of ONA's insurance system.

Box 1: The ONA insurance system

ONA's SYSTEM OF INSURANCE

1) **Presentation of the insurance system:**

The National Office of Old-Age Insurance (ONA) is a technical and administrative division of the Institute of Social Insurances of Haiti, an entity endowed with its own legal status. ONA's mission is to provide all employees of commercial, industrial and agricultural entities, and associated categories, who have reached the required age and number of years of service, or who are subject to physical or mental disability, with benefits to allow them to live in decent conditions in compensation for the services they rendered during the productive years of their lives.

Upon the death of the employee or the associated party, ONA also provides his/her dependents a portion of the benefits to which the deceased was entitled.

The **pension system of ONA is similar to the Bismarckian model**. The latter originates in the social solidarity program established by Bismarck, a German Chancellor at the end of the 19th century. "(Bismarck) developed a social security system funded by workers and employers, with government intervention for pensions. Benefits were linked to wages since the objective was to ensure that all workers

[12] ONA: Survey on Ageing (Enquête sur le vieillissement, Mach 2012)
http://www.lenouvelliste.com/article4.php?newsid=103568

maintain their standard of living in case certain risks would arise. We can therefore speak of solidarity between the workers."[13]

2) **Character of the insurance:**

ONA's insurance system is governed by the 28 August 1967 Act, which established the National Office of Old-Age Insurance. ONA's insurances are intended to provide coverage to all employees from the private sector and from certain autonomous public agencies such as Electric Company of Haiti *(Electricité d'Haiti, EDH),* the Autonomous Metropolitan Central for Drinking Water *(Centrale Autonome Métropolitaine d'Eau Potable, CAMEP),* the National Port Autority *(Autorité Portuaire Nationale, APN*), etc. The Organic Law of ONA orders all employees and employers in the private sector to contribute, except for members of the consular corps (diplomat, ambassador) and the priests.

According to that law, insurance is as required as it is optional.

III- Mandatory character

The following are subject to mandatory old-age insurance (art. 178):

- employees of commercial, industrial or agricultural businesses;
- all persons engaged in an income-generating manual or intellectual activity;
- teachers and supervisors of private schools, secular or religious;
- staff of private hospitals and clinics; persons living in Haiti who, under a contract of employment or due to travel or a mission on behalf of their employers, perform abroad any type of work;
- directors, managers of companies, of corporations, or of industrial, commercial and agricultural businesses, considered in terms of their employment and not because of their shareholder and associate status;
- Haitians working in Haiti for international institutions and foreign governments;
- any person who receives a fixed salary from a company.

All private companies must provide insurance to their employees. These contribute up to 6% of their gross salary, and the employer must also contribute 6%. As a result, ONA's costs of insurance is 12%.

Employees of autonomous public agencies (EDH, APN, CAMEP) must contribute a 2% fee for insurance: 1% from the employee's salary and 1% as the agency's share.

[13] *Social Security, all you wanted to know (La Sécurité Sociale, tout ce que vous avez voulu savoir),* Federal Public Service, Bruxelles 2011.

IV-Optional character :

Optional Insurance:

Art. 180. - Persons not included in the preceding article may optionally join the old-age insurance system established by this Act.

Art. 181. - The optionally insured will be subject to the same obligations and entitled to the same benefits and privileges as the mandatory ensured.

Art. 182. - To benefit from the optional old-age insurance, those interested should send a written request to the board of ONA, along with all necessary documents.

That request shall contain a detailed statement of income, thus allowing the agency to determine the amount of monthly contributions.

Civil servants in the public Administration are not required to pay ONA's insurances to receive a pension; they are covered by the Civil Pension, which is made up from an 8% withholding implemented by the Ministry of Economy and Finances from their salary.

Previously, Public Sector employees could not benefit from ONA's insurance services, which were reserved exclusively for employees of the Private Sector. Nowadays, with the creation of the Voluntary Insurance service, a Public Sector employee is free to join.

I- Requirements to qualify for old-age insurance:

According to the 28 August 1967 Act establishing the National Office of Old-Age Insurance:

Art. 183: The State recognizes and guarantees the right to a pension of any person insured under this Act and fulfilling the following conditions:

1º) to have fully reached the age of 55;

2º) to have paid contributions for at least 20 years.

To qualify to be entitled to ONA's retirement, the insured must have contributed for at least 120 months. From 120 to 239 months, the insured will benefit from a prorated pension (in proportion to the amount paid); from 240 months and more, he/she will be entitled to a retirement pension (complete coverage: health care, allowance, death, etc.).

According to the latest figures, released in November 2012, ONA has 274,291 active registered, that is, persons with a contribution booklet who should receive old-age insurance benefits when they are no longer of working-age.

Anyone who comes to ONA is registered. The person has a booklet with an account number. If the registered person contributes for more than 20 years, she/he will be entitled to a retirement pension; but if she/he has ceased to contribute (either due to disability, death or unemployment), she/he is entitled to

compensation depending on the number of years, as well as the rate at which, the contribution occurred. This is true for both public sector and private sector employees.

In spite of what is published in the local press, the ONA officials whom we met did not want to confirm the estimate that the agency takes charge of 2000 to 3000[14] pensioners every year (i.e., the number of contributors who come to enjoy their monthly pension after twenty years of regular contributions) (Désiral, T., 2006; Alterpresse, 2011; ONA, 2012).

Services offered by ONA are twofold:

1 - The pension, which is a monthly stipend paid to the contributor of more than 55 years of age, who has contributed for more than 120 months (10 years).

2 - The Refund, which is a one-time payment for incapacitated persons who are insured and have contributed for less than 120 months.

Thus, ONA offers its ensured several types of pension:

a- Retirement pension: a set of social benefits received by a person beyond a certain age because he/she or a spouse has been employed and has contributed to an old-age insurance system.

b- The survivor's pension: pension available to an entitled party upon the death of the beneficiary of a retirement pension. Survivor's pension may be granted to a widow (er) or to an orphan. It is commonly said about the latter that they are pensioners from derived rights.

c- The disability pension: pension granted to insured persons who have paid premiums for 120 or more months, but less than 240, and and who are victims of total disability that was not caused by a work accident. This pension is also called proportional pension.

The institution provides its insured more than benefits:

- Mortgage lending

- Health care for those who have a pension. There are two types of pension:

1 - Pension at a reduced rate, when the person has contributed up to 1%. In this case, health care is covered at 30%, and 20,000 gourdes are allocated for the funeral of the insured (in a province area).

2 - Pension at full rate for persons who have contributed for 240 months at 12% of their salary. In this case, health care is covered at 70% and the person receives 100,000 gourdes in case of death. If the deceased lived in the metropolitan area, 80,000 gourdes will be paid to funeral homes such as l'Ange Bleu, Pax Villa, etc.

[14] As of September 2006, ONA counted 1,926 pensioners with a minimum pension of 750 Gdes. (Tony Desiral, 2006). Final degree research. Notre Dame University of Haiti.
http://www.memoireonline.com/08/08/1501/rapport-de-stage-ona-direction-administrative.html
http://www.alterpresse.org/spip.php?article12108

- Banking-related services: expenses on contribution, savings account

- Voluntary insurance

II- Operating framework of the old-age insurance system.

Art. 183.- The State recognizes and guarantees the right to a pension to any person insured under this Act and fulfilling the following conditions:

1º) to have fully reached the age of 55;

2º) to have paid contributions for at least 20 years.

Art. 184.- This pension, which will be paid on the basis of one third (1/3) of the average wage of the insured over the ten years preceding the pension application, will be paid monthly.

Art. 185.- The State recognizes and guarantees the right to a prorated pension to any person meeting the following conditions:

1º) to have paid the contributions required under this Act for at least 15 years;

2º) to be totally incapacitated and unable to work, and not following any work accident.

III-Management of ONA's Funds

ONA's funds are managed by the Financial Division of the Institution and are deposited at the Bank of the Republic of Haiti (BRH), in the metropolitan area, and at the various branches of the National Bank of Credit (BNC), in the provinces.

All things considered, the goal of any social security system is to secure against the risk of income loss (unemployment, disease, old age, occupational injury). Social security benefits are financed with wage-based contributions (as in a private insurance) and, thus, are reserved to those who contribute.

The insurance system provided by ONA relates to the Bismarckian model, i.e. it's a social security system financed through the contribution of both the workers and the employers, with an intervention of the State for pensions. However, all of those registered with ONA do not always succeed in benefiting from the old-age insurance, because most of them do not fulfill the requirements (to have fully reached the age of 55 and to have contributed for at least 120 months). This investigation of ONA's old-age insurance revealed the gaps of Haiti's social security system.

Although there is evidence of a certain interest in supporting the elderly, the small sample of ONA pensioners (**less than 3,000) seems negligible given that in 2010 those aged 55**

years and more amounted to 930,974 persons in the whole country, according to IHSI's estimates (2007, 2008)[15]. As a result, **less than 0.32% of persons aged 55 years and more receive a retirement pension from ONA.**

The social protection problem seems to exceed the confines of ONA's decision making power and, due to its complexity and cross-sectoral character, becomes a societal problem (political and economic). In a country where the rate of unemployment reaches 30%, how many people will be able to contribute from their wages over 15, 20 years? What is the percentage of contributors who really own an ONA insurance booklet? How will former wage earners prove that they did contribute, if they worked for companies or NGOs that no longer exist? What about seniors, aged today 55 years and more, who never worked in the formal sector? As already explained in this analysis, in a contribution-based retirement system like ONA's, to benefit from a retirement pension, it is necessary to have contributed for a given period of one's active life. We know that in many developing countries like Haiti, a majority of the elderly never worked in a formal system offering pension benefits, nor have they ever performed any income-generating activity. In this context, does ONA have the means of improving the living conditions of inactive agents currently at retirement age? Consequently, despite the limitations spelled out at the start of this paragraph, wouldn't it be urgent for ONA to strive to extend pension benefits to a larger share of the population in age to retire?

RIGHT TO EDUCATION AND TRAINING

In Haiti, the State Secretariat for Literacy *(Secrétairerie d'État à l'Alphabétisation, SEA)* is the entity concerned with the instruction of the elderly. This institution provides vocational training and basic literacy for people from age 13 and for as long as they remain clear-headed (a time when the elderly remains lucid, with mental faculties allowing for continued learning). This means that literacy campaigns in Haiti are not limited to the youth, but encompass all social categories that are in a position to benefit from them. SEA works with public agencies such as the National Institute for Vocational Training *(Institut National de Formation Professionnelle, INFP)*, as well as with international organizations such as UNESCO. As a public entity under the administrative supervision of the Ministry of National Education and Vocational Training *(Ministère de l'Éducation Nationale et de la Formation Professionnelle, MENFP)*, SEA was not able to provide data on the number of people aged over 50 years who benefited from the literacy campaign in Haiti since its creation.

However, a publication from the Haitian Institute for Statistics and Information Technology *(Institut Haïtien de Statistiques et d'Informatique, IHSI),* informs us that the

[15] Those aged 60 years and older represented 646,243 inhabitants.

illiteracy rate is very high among the elderly: "This is a population that has been hardly schooled: 78% can neither read nor write" (IHSI, 2009). It is obvious that the problem of education and illiteracy is a major handicap in the lives of the elderly. The fact of not knowing how to either read or write probably accentuates their socioeconomic dependence. In this context, the State Secretariat for Literacy would have a major role in supporting these people with vocational training (at least, the ones that still have the ability and willingness) and the universalization of the national program of literacy.

RIGHT TO HEALTH OF THE ELDERLY

It is the State's duty, through the Ministry of Public Health and Population (MSPP), to conceive a structural framework so to implement a public policy that guarantee the population's right to health care. For their part, health institutions must provide adequate health services, in line with health standards and the healthcare needs of patients. However, according to what is summarized in Box 2, we note that, in what regards MSPP's healthcare policies, the elderly category has been treated as the 'poor relative'.

Encadré 2: The healthcare system in Haiti

The Healthcare System in Haiti

Presentation of the MSPP and its policy

The 17 November 2005 decree on the organization and functioning of the MSPP establishes the latter as the: "government entity responsible for formulating, implementing, orienting and enforcing the government's health policy" (article 4, p 3). Thus, the MSPP[16] "is entrusted with the mission to ensure the health of the Haitian people" (MSPP, September 2011, p 3).

The four (4) guiding principles that orient the National Health Policy[17], as defined by the Ministry, are: universality, comprehensiveness, equity and quality.

Thus, the orientation of care and services is structured around the determinants of the Haitian people's health status. These determinants are demographic, biological, environmental, social, economic/financial, anthropological/cultural, and institutional. According to the statement of national health policy, the control of these aspects must be able to guarantee the population a state of physical, mental and social wellbeing. This matches exactly the definition of the concept of **HEALTH**, according to the World Health Organization (WHO).

Medical institutions

Health institutions have the obligation of providing adequate health services, complying with health standards and with the needs of patients (the elderly, in what regards our study) in terms of health care.

[16] *Ministère de la Santé Publique et de la Population* (Ministry of Public Health and Population)
[17] Official Document, National Health Policy, July 2012.

They can be presented by category: Community Clinic, Healthcare Center Without Bed (HW/oB), Healthcare Center With Bed (HWB), Hospital. They can also be presented also by status: Public, Mixed, and Private. Thus, according to the latest list of the Ministry (MSPP, August 2011), **Haiti has 908 health institutions (but more than 300 are located in the West), of which 470 community clinics, 232 HW/oB, 92 HWB, 107 hospitals** (56 are located in the West), and 7 unidentified. Depending on the status of these facilities, we can count **278 public institutions, 416 private, 211 mixed, and 3 that could not be identified**.

Health services

The Minimum Health Package (MHP) includes:

- Taking charge of the overall health condition of the child
- Taking charge of pregnancy, childbirth, and reproductive health
- Taking charge of medical and surgical emergencies
- The fight against communicable diseases
- Basic dental care
- Participatory health education
- Environmental sanitation and drinking water supply
- Availability and access to essential medicines.

Note that an institution is not required to offer all services.

In the Minimum Health Package (MHP) defined by the Health Services Organization Department *(Direction d'Organisation des Services de la Santé, DOSS)*, there are, among other things, provisions to take charge of children and pregnant women, but the elderly are not listed. **It is necessary to note that this package is neither automatically nor necessarily related to some form of health insurance or grant.**

The cost of services

According to the report on the health map of the country, the average cost of services provided by mixed and public First-Level Health Services *(Services de Santé de Premier Échelon, SSPE)* are lower (23.12 gourdes[18] per consultation; dental care, 38.28 Gdes; childbirth, 141.78 Gdes; emergency care, 53.80 Gdes) than private SSPE's (consultation, 41.43 Gdes; dental care, 30.77 Gdes; childbirth, 186.47 Gdes, emergency care, 92.35 Gdes), except for dental care (38.28 versus 30.77).

Table 3: Average costs (in gourdes) of health services in hospitals

[18] The gourde (Gde) is Haiti's currency.

Health services	Public and mixed hospitals	Private hospitals
Consultation	24.88	75.25
Dental care	60.14	82.33
Prophylaxis	111.06	128.33
Extraction	71.27	92.43
Amalgam	81.85	213.33
Childbirth	360.60	2014.84
Emergency care	98.36	431.96
Surgical operation	1540.49	2653.57
Radiology	131.49	251.60
Hospitalization	130.18	927.27

Source: MSPP (2011). Report on the health map of the country.

According to Table 3, it is clear that services are more expensive in private hospitals.

The survey of healthcare institutions

Our survey of health facilities is characterized by two highlights:

First, among a number of central entities in order to analyze programs set up by the Ministry of Public Health and Population (MSPP) to benefit people older than 50 years in Haiti;

Then, among institutions that provide health care directly to the beneficiaries, in order to evaluate the conditions in which services are delivered.

The survey of MSPP's central directions

To perform the survey among the Ministry's central directions, we first contacted the Direction of Family Health *(Direction de Santé de la Famille, DSF)*, which then referred us to the Direction of Health Promotion and Environmental Protection *(Direction de Promotion de la Santé et Protection de l'Environnement, DPSPE).*

None of the above mentioned entities provided information on eventual programs (policies, insurances, etc.) of the Ministry in favor of the elderly. In what regards the DFS, the evidence of the abandonment of this category is blatant, given the absence of specific plan designed for this age group of the population. The DPSPE indicated that projects aimed to promote health do not specifically target persons older than 50 years. The person we met at this direction of the Ministry revealed that they were contacted by an organization focused on defending the rights of the elderly, and they are waiting for it to develop a plan of action to benefit this category of the population. In the end, no formal data related to interventions targeting the elderly was collected from the Ministry.

The survey of healthcare facilities

Identification of the institutions

We inventoried a list of 65 health facilities scattered in the various geographical departments targeted for the survey on the situation of persons older than 50 years in Haiti: 12 in Artibonite, 3 in the Center, 44 in the West, 1 in the Northeast, 3 in the Southeast, and 2 in Les Nippes. Out of the 65 grids that we distributed to the health facilities (community clinics, hospitals, healthcare centers without bed, healthcare centers with bed), only 33 could be recovered. Several reasons explain this fact: destruction of the facility, the shutdown of the facility, the decision by those in charge not to take part in the study, or quite simply the inexistence of the facility in the locality mentioned by the MSPP.

Table 4: Presentation of health facilities visited by category and status

Categories	Status			
	Private	Public	Mixed	**Total**
Community clinic	3	1	2	**6**
HW/oB	6	6	5	**17**
HWB	1	2	1	**4**
Hospital	2	2	2	**6**
Total	12	11	10	**33**

Results of the survey

We're going to perform a diagnostic of the 33 health facilities we visited; we will present the types of services available to the elderly in order to assess the extent to which these facilities succeed in respecting the inalienable right of those people to health.

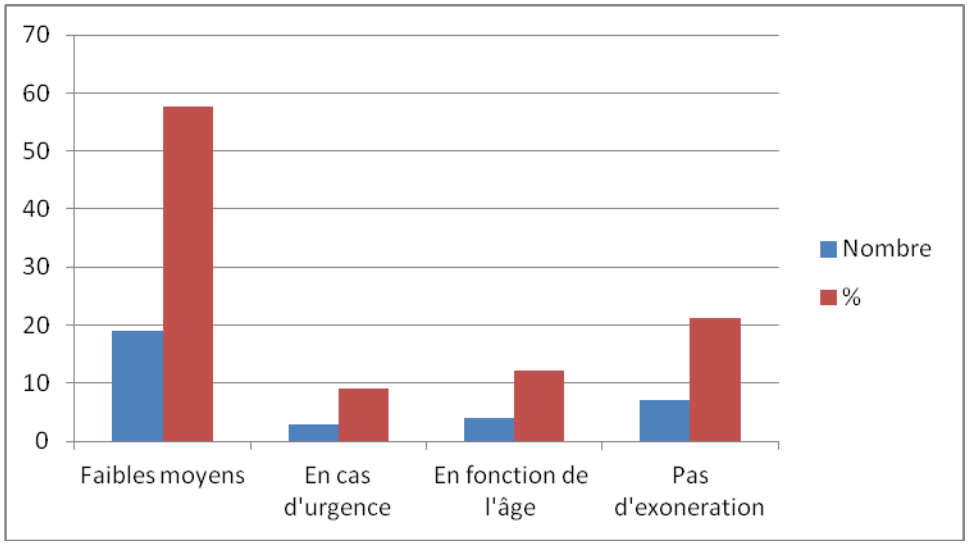
75% of the health facilities visited have neither priority space nor specific space layout for the circulation of patients with reduced mobility. None of them has specialized geriatric service. **71.9% of facilities did not answer the question of whether the elderly pay for services**, while 15.6% said that they customarily pay and 12.5% reported that this category pays nothing for the care it received. The persons in charge reported that **many patients had no health insurance** (75%).

Most facilities provide an internal medicine service (14 facilities, i.e. 42.42%). **They also perform global health care (4 facilities, i.e. 12.12%**: Charity Missionaries of Gonaïves, General Hospital of Pernier, Community Clinic of Perches, and Charles Colimon Hospital of Petite-Rivière de l'Artibonite). **Others provide the following services: ophthalmology, training (on diseases and measures to adopt to avoid catching them**), orthopedics, urology, surgery, laboratory, pharmacy, blood pressure control, first aid, injection, internal medicine, otorhinolaryngology (ENT), gynecology, dermatology and, to a lesser degree, dental services.

Services most used by people older than 50 years are: general consultation, 45.45% (15); internal medicine, 15.15% (5); emergency, 9.09% (3); chronic disease, 3.03 % (1); clinical TB, 3.03%; control of hypertension, 3.03%; dental services, 3.03%; hospitalization, 3.03%.

Because of the lack of financial coverage and given the costs of health care, some facilities provide exemptions for the poorest (see the four health institutions mentioned above). In this case, the elderly do not pay consultation fees, and sometimes they can even receive drugs for free, depending on the severity of their medical condition. The reasons for exemption (Figure 1) of the elderly depend on their economic means and the policies of each institution.

Figure1: Presentation of reasons for exemption in the 33 medical facilities visited (%)



Source: Maintenance grid of the health facilities

According to Figure 1, there are 19 institutions out of 33 (i.e, 57.57%) that exonerate the elderly with low income. There are 4 institutions (12.12%) that have a system of exemption based on age. Three institutions (9.09%) grant exemption of service fee in the event of an emergency. Seven institutions (21.21%) don't.

In what regards material conditions of functioning, only **12.5% of health facilities maintain some form of filing atuned to the elderly's specific needs.** The large majority of facilities (90.6%) does not have statistics on the utilization rate of their services by people older than 50 years.

The level of utilization of these facilities by individuals older than 50 years is considerable. On average, there are 80.64 people older than 50 years treated per day, across all institutions and services. A share of 31.3% complains about all forms of pain, **often of a physical nature (62.5%).** They visit the facilities for various ailments: depression, diabetes, bedsores, flu, fractures, Alzheimer, cardiovascular problems, cold sores, osteoporosis, pathologies of the eye, hearing impairment, anxiety, etc. **These patients frequently suffer from all kinds of chronic diseases (31.3%),** and 46.9% present a comorbidity.

According to persons in charge of these facilities, the **most current diseases among female elderly are high blood pressure and diabetes**. **For the male elderly, high blood pressure, affections of the prostate, and urinary infection are more frequent**.

Half of the health facilities visited have programs to ensure community care for individuals of more than 50 years of age. Those programs rely on community-based mobilization and awareness campaigns, as well as health education campaigns and focus groups. An important number of facilities have no hospitalization service: out of the 33 institutions visited**, only 10 (4 HWB and 6 hospitals) are able to provide care in hospitalization**. As a result, 23 of the 33 institutions surveyed do not provide such care specifically for people older than 50 years. Another major problem is in the fact that **patients older than 50 years admitted in these facilities do not have medical insurance.** Adding to that, the poor physical condition of a number of health facilities, the lack of well trained staff in most facilities, the absence of ongoing supervision by the MSPP, the lack of adequate equipment, the inexistence of geriatric services make it even more difficult for the elderly to enjoy their right to health.

Ultimately, the survey of the healthcare system as well as the healthcare delivery structure to the elderly further underlines the evidence of how little consideration public policies on health grant to such system and structure. Health facilities visited had neither geriatric services nor alternative approach to the elderly's health. MSPP harbors programs designed for children, for pregnant women, but not for the elderly.

RIGHT TO COMMUNITY PARTICIPATION

To reinforce the participation of the elderly in the recovery and the rebuilding of communities, as well as the restoration of the social fabric, following emergency situations is one of the objectives that the group of countries that implemented the Madrid International Plan of Action on Ageing (MIPAA) in 2002 gave itself. Considering the importance of the elderly in perpetuating traditions, in maintaining oral knowledge, as well as the status they've acquired as 'wise members' in many societies, it is essential that these living assets participate actively in society's daily life.

However, our conversation with the resource-persons revealed the marginalization of the elderly. Younger generations find several excuses to justify the exclusion of the elderly: their weakness, loss of lucidity, and senility. Moreover, the erroneous social representations associating old age with sorcery fuel their exclusion within the society.

Lastly, the absence of mechanisms to facilitate freedom of movement, as well as that of recreational and exchange areas, considerably limits this group's access to public places. This is not without impact on the extent of the elderly's community participation.

Summary

The extent of fulfillment of the rights stated in this section of the Report shows a gap between stated standards and their effectiveness. In other words, between the principles and the reality there is an enormous gap preventing the respect of the rights of the elderly. Would this be only for lack of means, or absence of will? Our observations show that stakeholders responsible for fulfilling the various rights do not manage to guarantee a favorable environment, which would support the basic rights of this section of the population. Although a lot of efforts have been deployed by a few stakeholders, few elderly are really touched. In this context, associations defending the rights of the elderly, residential facilities and non-governmental organizations working in the sector would have an inevitable role in the awakening of the Haitian collective conscience in what regards that noble cause, the rights of the elderly in Haiti.

PART TWO

THE QUANTITATIVE SURVEY OF BENEFICIARIES OVER THE AGE OF 50 IN RELATION TO THEIR SOCIAL AND ECONOMIC CONDITION AS WELL AS THEIR HEALTH STATUS

By Judite BLANC

The main purpose of this quantitative survey was to quantitatively assess the level of fulfillment of the rights of a sample of people aged over 50 years, randomly recruited in most of the country. This important step in the analysis of the situation of the Elderly in Haiti took interest in the fulfillment of basic human rights such as: the right to life (survival), the right to health, the right to social security, the right to work, the right to education and training, the right to family support (belonging to a family structure), the right to protection (emergency response, and disaster and risk reduction, adaptation to change), among others. This section of the report presents in detail the data collected from people aged 50 years and over in Haiti. The results are discussed in stages, and in light of two national surveys: Survey on Living Conditions in Haiti *(Enquête sur les Conditions de Vie en Haïti*, 2003) and Survey on Mortality, Morbidity, and the Utilization of Services *(Enquête Mortalité, Morbidité et Utilisation des Services*, EMMUS IV, 2005-2006). These two surveys were conducted within different strata of the Haitian society, with the support of international publications on ageing in the world.

Socio-demographic characteristics of the participants

A cross-sectional survey was conducted over a week in early November 2012, with 1113 people aged 50 years and older. Within the population, **54.7% were women (609) and 45.3% men (504), from six departments**: West (39.1%), Artibonite (21 5%), Southeast (3.7%), Center (12.6%), Nippes (14.3%), and Northeast (8.8%). They came from the following 10 cities and towns: Port-au-Prince, Croix des Bouquets, Kenscoff, Pétion-Ville, Côte de Fer, Fond des Nègres, Gonaïves, Petite Rivière de l'Artibonite, Perches and Belladère ; **58% (645) were from rural areas versus 42% of participants (468) from urban areas.**

Table 5: Distribution of the surveyed population according to 5 age groups

Age groups	Number	Percentage	Cumulated percentage
50-60	546	49.1	49.1
60-70	286	**25.1**	74.8
70-80	179	**16.1**	90.8
80-90	80	**7.2**	98.0
90 and older	22	**2.0**	100.0

Table (5) shows the distribution of our population according to 5 age groups. As we can notice, the proportion of those aged 60 years and older represents a little more than 50%. For all the subjects, 54.7% were women (609).

At the national level, according to data drawn from the 4th General Census of the Population and the Habitat in Haiti *(Recensement Général de la Population et de l'Habitat en Haïti*, RGPH) from 2003, in the whole country persons aged **between 50 and 59 years accounted for 5.9%, and 8.9% were 60 years old and older** (IHSI, 2003)[19]. Life expectancy at birth for the five-year period 2010-2015 is estimated at 58.95 years for men, and 62.40 years for women (IHSI, 2007).

Place of residence

The urbanization rate of the population in Haiti amounted to 47.8% in 2010 (IHSI, 2007-2008). Worldwide, particularly in developing countries, a greater percentage of the elderly is found in rural areas, except for Latin American and Caribbean countries where that percentage would be slightly higher in urban zones (United Nations, 2009).

[19] Survey on Living Conditions in Haiti, page 68.

Table 6: Distribution of quantitative survey participants according to the age and the place of residence

Age groups		Area		Total population
		Urban	Rural	
50-60	Number	229	317	546
	%	41.9%	58.1%	100.0%
60-70	Number	119	167	286
	%	41.6%	58.4%	100.0%
70-80	Number	79	100	179
	%	44.1%	55.9%	100.0%
80-90	Number	30	50	80
	%	37.5%	62.5%	100.0%
90 and more	**Number**	**11**	**11**	**22**
	%	**50.0%**	**50.0%**	100.0%
Total	Number	468	645	1113
	%	42.0%	58.0%	100.0%

It can be noted in Table 6 that subjects form all age groups, except for those aged 90 years and older, came primarily from rural zones.

Education

In low-income countries like Haiti, while progress has been made in terms of schooling of young generations, the illiteracy rate remains fairly widespread amongst the elderly, especially women. The proportion of illiterate elderly aged 65 and over in these regions is around 46%. That proportion amongst men living in Latin America and the Caribbean is 23%, versus 29%

among women, hence a gap of only 6 percentage points. In Haiti, by contrast, if 75.4% of young people aged 15-29 are widely literate, the percentage is very small in the case of persons aged 60 years and over (18.1%), as shown in the following table, drawn from the RGPH (IHSI, 2003).

Table 7: Literacy rate (in %) of the population aged 15 years and more, according to gender and by age group in Haiti (IHSI).

	Age group				
Gender	15 -29	30 - 44	45 - 59	60 and more	Together
Male	**78.1**	60.8	**37.9**	**23.6**	60.1
Female	72.4	44.8	**23.9**	**13.6**	48.6
Both genders	75.4	52.3	**30.3**	**18.1**	54.1
Sample	8615	5029	3422	3008	20074

Source: IHSI/Survey on Living conditions in Haiti (ECVH), July 2003.

Regarding the level of education attained by subjects we met with in the course of our analysis of the situation of persons aged 50 years and more in Haiti, the illiteracy rate was as high, with a higher proportion among women. 50.6% of participants (563) had never been to school, 30.5% have completed primary school, 5.8% have started secondary school, and 3.9% have a level corresponding to the end of secondary school. A tiny minority of 1% (14) reported having a university degree, and 2.8% (31) have benefited from a literacy program.

Of the 50.6% of illiterates in our sample, 60% (338) were female. The proportion of men with an early secondary level accounted for 7.5% (38), versus 4.3% (26) of their peers. Finally, 2.4% (11) of males indicated having a university degree versus 0.5% (3) of women. The following table describes the low level of education among women compared to men at different levels (primary school, vocational school, and university).

Table 8: Distribution of the population by gender and educational attainment
(PE = primary education; SE = secondary education; VS = vocational school)

Educational Attainment			Gender		Total population
			Male	**Female**	
	No schooling	Number	**225**	**338**	**563**
		%	**40.0%**	**60.0%**	**100.0%**
	Certificate of PE	Number	161	178	**339**
		%	47.5%	52.5%	**100.0%**
	Early SE	Number	**38**	**26**	**64**
		%	**59.4%**	**40.6%**	**100.0%**
	SE almost completed	Number	22	21	**43**
		%	51.2%	48.8%	**100.0%**
	SE completion diploma	Number	6	**14**	**20**
		%	30.0%	**70.0%**	**100.0%**
	Attended VS	Number	5	4	**9**
		%	55.6%	44.4%	**100.0%**
	VS diploma	Number	**6**	**3**	**9**
		%	**66.7%**	**33.3%**	**100.0%**
	University diploma	Number	**11**	**3**	**14**
		%	**78.6%**	**21.4%**	**100.0%**
	University student	Number	1	0	**1**
		%	100.0%	0%	**100.0%**
	Literacy program	Number	15	16	**31**
		%	48.4%	51.6%	**100.0%**
	Others	Number	14	6	**20**
		%	70.0%	30.0%	**100.0%**
Total		Number	504	609	**1113**
		%	45.3%	54.7%	**100.0%**

Social environment and size of the household

Living conditions

With regard to housing before the earthquake hit in Haiti on 12 January 2010, 75% (835) of the participants lived in their own house, 19.7% (219) lived in a rented apartment, and 0.4%

(5) lived under a tent. Following the catastrophe, 72.7% (809) still live in their private house, 19.1% (213) live in a rented apartment, and 2.8% (31) currently live under a tent.

Marital status

The marital status can strongly influence the emotional and economic wellbeing of the elderly. It often conditions the household structure and the social support available for the elderly. The male elderly were found to live more routinely with a wife than their female counterparts (United Nations, 2009), an important factor to take into account when conceiving social policies for the elderly and addressing demographic ageing (Vézina, 2010). Regarding our sample, **41.2% (459) of the people surveyed were married**, 1.9% (21) were divorced, 12% (134) were widowed, 5.5% (61) had never been married, **and 19% (221) lived in a de facto union**[20] at the time of the survey. In the table below, we note that the percentage (44.2%) of married males older than 50 years exceeded that of married women (38.8%).

Table 7: Distribution of the elderly by gender and marital status

Gender		Marital status						
		Married	**Divorced**	**Widowed**	**Separated**	**Single Person**	**De facto union**	**Total population**
Male	Number	223	10	48	24	83	116	504
	%	**44.2%**	2.0%	9.5%	4.8%	16.5%	**23.0%**	100.0%
Female	Number	**236**	11	86	37	134	**105**	609
	%	**38.8%**	1,8%	14.1%	6.1%	22.0%	**17.2%**	100.0%
Total	Number	459	21	134	61	217	221	1113
	%	41.2%	1.9%	12.0%	5.5%	19.5%	19.9%	100.0%

Size and composition of the household

Studies quoted by Vézina (2010) reveal that in developing countries "support for the elderly is provided by close relatives". Thus, of all the people interviewed during our survey, there are on average 5.56 (≈ 6) occupants in their place of residence. 40% (450) currently live with one or several of the following people: *Spouse, Child, Grandchildren, Relatives, Friends*. A small

[20] Usually referred to as "plaçage" in Haiti, (IHSI 2003).

proportion of **2.9% (32) stated *to live alone,*** contrary to what was observed in many Caribbean countries, where the proportion of subjects aged 60 years and more accounts for 20% of people living alone (United Nations, 2009). According to our results, a share of 2.2% (24) would cohabit with *other people* and **40.8% would live with several of the above mentioned people**. This probably tells the level of social support available for the people we met.

The table below shows that women, compared to their male counterparts, are more likely to cohabit with children, grandchildren and other relatives. In constrast, **65.6% (21) of the group of 32 subjects living alone would be men.** For our Latin-American and Caribbean neighbors, 12% of elderly women and 9% of elderly men would live alone (United Nations, 2009).

Table 8: Distribution of the subjects according to their gender and family ties with other people composing the household

Other occupants of the house		Gender		Total population
		Male	**Female**	
Spouse	Number	56	52	108
	%	51.9%	48.1%	100.0%
Child	Number	156	**190**	346
	%	45.1%	**54.9%**	100.0%
Grandchild	Number	13	**51**	64
	%	20.3%	**79.7%**	100.0%
Relative	Number	24	**40**	64
	%	37.5%	**62.5%**	100.0%
Friends	Number	6	10	16
	%	37.5%	62.5%	100.0%
Others	Number	9	15	24
	%	7.5%	62.5%	100.0%
Living alone	Number	**21**	1	**32**
	%	**65.6%**	34.4%	**100.0%**
Several of these people	Number	216	34	**450**
	%	48.0%	52.0%	**100.0%**
Total	**Number**	**501**	**603**	**1104**
	%	**45.4%**	**54.6%**	**100.0%**

NB: 9 subjects did not answer this question.

Table 9: Percentage of the elders according to their age and family relationship with the other people composing their household

Table:

Household structure		Age groups					
		50 – 60	**60- 70**	**70 - 80**	**80-90**	**90 and more**	**Total population**
Spouse	Number	66	28	12	1	1	108
	%	61.1%	25.9%	11.1%	.9%	.9%	100.0%
Child	Number	**184**	**83**	**52**	**19**	**8**	346
	%	**53.2%**	**24.0%**	**15.0%**	**5.5%**	**2.3%**	100.0%
Grandchild	Number	28	18	12	5	1	64
	%	43.8%	28.1%	18.8%	7.8%	1.6%	100.0%
Relative	Number	30	14	14	4	2	64
	%	46.9%	21.9%	21.9%	6.3%	3.1%	100.0%
Friends	Number	8	4	3	1	0	16
	%	50.0%	25.0%	18.8%	6.3%	.0%	100.0%
Other	Number	10	6	3	3	2	24
	%	41.7%	25.0%	12.5%	12.5%	8.3%	100.0%
Live alone	Number	11	9	6	4	2	**32**
	%	34.4%	28.1%	18.8%	12.5%	6.3%	**100.0%**
Several of these people	Number	**204**	**123**	**74**	**43**	**6**	**450**
	%	**45.3%**	**27.3%**	**16.4%**	**9.6%**	**1.3%**	**100.0%**
Total	**Number**	541	285	176	80	22	1104
	%	49.0%	25.8%	15.9%	7.2%	2.0%	100.0%

We observe in Table 11 that, according to answers provided by the subjects, independently of the age, most of them live with at least one member of their family, with friends or other.

Table 10: Percentage of participants with dependent small grandchilren based on gender

	Percentage with dependent small grandchildren		P
Sex	**Yes**	**No**	
Male	**36.0% (181)**	64.0% (322)	**<001**
Female	**48.2% (292)**	51.8% (314)	

Table (12) reveals that the percentage of women having currently small dependent grandchildren is higher than for their male counterparts. Wfe find that 48.2% (292) of women and 36.0% (181) of men of this sample support small children aged from 0 to 3 years, and from 3 to 6 years.

Means of subsistence and access to basic economic rights, and satisfaction of basic needs

The percentage of the elderly still economically active in the labor market is very important in low-income countries. In these areas, the scope of old-age insurance programs and retirement pension systems is often limited. If "75% of people aged over 65 in industrialized societies perceive one form or another of retirement benefit, only 20% enjoy such a benefit in low-income countries, and in those countries, the average is just over 7%" (ILO, 2010). Such a very limited coverage largely explains the important presence of the elderly in the labor force in these parts of the world. Further, in many countries, the coverage is sometimes limited to formal sector workers, who are found in the civil service, in large corporations, etc. For their part, the elderly generally work either on their own in the informal sector or in the field of agriculture (European Commission, 2007, reported by United Nations, 2009). In 1980 and 2009, individuals aged 65 and more represented 27% of the labor force in developing countries.

In Haiti, the data from the 2003 RGPH indicate that among individuals aged 60 years and older, **61.8% were heads of household**. The latter represented 21.3% of the total number of heads of household in the country. In this group, 235,130 actively working individuals were accounted for, mostly **(92.6%) self-employed workers** (IHSI, 2003).

Table 13 indicates that most survey participants would live mainly off the informal economy: 26.6% (296) run small-scale trade, while agriculture was cited by 14.2% (158) as first source of income; 11.7% (130) had their own private business. Those who would depend mainly on the financial support of their family living in Haiti accounted for 15.9% (177). **Only 3.1% (34) of our participants would live mainly off a retirement pension in Haiti**. Such results are congruent with prior statistics from low-income countries, which establish a connection between the extent of social coverage and the vulnerability of the elderly in these countries to financial insecurity or poverty (United Nations, 2009; ILO, 2011). Haiti seems not to escape from this phenomenon.

Table 11: Distribution of the participants according to their primary sources of income

Source of income	% (number)	cumulative %
1-Wages from an employment	7.9% (88)	7.9%
2-Small-scale trade (informal)	**26.6% (296)**	34.6%
3-Private business	11.7% (130)	46.3%
4-Financial assistance from the family living in Haiti	**15.9% (177)**	62.2%
5-Financial assistance from the family living abroad	5.3% (59)	67.5%
6-Financial assistance from friends living in Haiti	4.2% (47)	71.7%
7-Financial assistance from friends living abroad	.8% (9)	72.5%
8-Pension from retirement in Haiti	**3.1% (34)**	75.6%
9-Pension from retirement from abroad	.7% (8)	76.3%
10-Agriculture	**14.2% (158)**	90.5%
11-Rented landholdings	0.5% (5)	91.0%
12-Others	4.5% (50)	95.5%

13-Several of these sources of income	1.4% (15)	96.8%
14-Did not answer	3.2% (35)	100.0%
Total	100% (1111)	

NB: 2 participants did not answer this question.

We note in Table 14 that the subjects included in age groups 50-60 and 60-70 years are economically very active in the labor market, in this case in the informal sector. By contrast, there were many participants, regardless of age, who depended on the solidarity of their family in Haiti to make a living. Of the 177 people in the latter group, 38 (21.5%) were aged 50-60 years, 44 (24.9%) were included in the 60-70 bracket, 48 (27.1%) were aged 70-80 years, and 9 (5.1%) of them were in the 90 and over bracket.

Table 12: Distribution of the participants according to the age group and their primary sources of income

	AGE GROUPS					
	% (number)					
Source of income	**50-60**	**60-70**	**70-80**	**80-90**	**90 and more**	**Total Population**
1-Employed	**69.3 (61)**	18.2 (16)	9.1 (8)	2.3 (2)	1.1 (1)	100% (88)
2-Small-scale trade (informal)	**60.8 (180)**	**25.7 (76)**	**10.5 (31)**	2.7 (8)	0.3 (1)	100% (296)
3-Private business	**56.2 (73)**	**27.7 (36)**	14.6 (19)	0.8 (1)	0.8 (1)	100% (130)
4-Financialassistance from the family living in	**21.5 (38)**	**24.9 (44)**	**27.1 (48)**	**21.5 (38)**	**5.1 (9)**	100% (177)

Haiti						
5-Financial assistance from the family living abroad	33.9 (20)	18.6 (11)	31.5 (18)	13.6 (8)	3.4 (2)	100% (59)
6-Financial assistance from friends living in Haiti	**51.1 (24)**	19.1 (9)	17.0 (8)	6.4 (3)	6.4 (3)	100% (47)
7-Financial assistance from friends living abroad	22.2 (2)	**66.7 (6)**	11.1 (1)	0.0 (0)	0.0 (0)	100% (9)
8-Retirement in Haiti	**50.0 (17)**	**20.7 (7)**	**11.8 (4)**	**14.7 (5)**	**2.9 (1)**	**100% (34)**
9-Retirement from abroad	12.5 (1)	25.0 (2)	25.0 (2)	25.0 (2)	12.5 (1)	100% (8)
10-Agriculture	**51.3 (81)**	29.7 (47)	16.5 (26)	1.9 (3)	0.6 (1)	100% (158)
11-Rented landholdings	60.0 (3)	0.0 (0)	20.0 (1)	0.0 (0)	20.0 (1)	100% 5
12-Others	56.0 (28)	30.0 (15)	6.0 (3)	8.0 (4)	0.0 (0)	100% 50
13-Several of these sources of income	46.7 (7)	40.0 (6)	13.3 (2)	0.0 (0)	0.0 (0)	100% 15
14-Did not answer	31.4 (11)	28.6 (10)	22.9 (8)	17.1 (6)	0.0 (0)	100% 35
Total	49.1 (546)	25.7 (285)	16.1 (179)	7.2 (80)	21 (1.9)	100% 1111

In several areas of the world, the retirement age is often identical for both genders. However, this age of entitlement may at times be less for women. In a list of 157 countries in 2009, the legal retirement age for men was 65 years. For 45% of Latin American and Caribbean countries, the legal age of entitlement is over 60 years. Haiti is the only country in the region where the insured can retire at age 55 (United Nations, 2009). The next table (15) shows that small-scale businesses, in the informal sector, is the primary source of income most often cited by the surveyed, particularly by women: 33.4% (93) versus 18.5% (203) of men.

Table 13: Distribution of participants according to their gender and primary sources of income

Source of income	**% (number) Male**	**% (number) Female**
1-Employed	**9.3 (47)**	**6.7 (41)**
2-Small-scale business	**18.5 (93)**	**33.4 (203)**
3-Private business	10.7 (54)	12.5 (76)
4-Financial assistance from the family living in Haiti	**15.7 (79)**	**16.1 (98)**
5-Financial assistance from the family living abroad	5.4 (27)	5.3 (32)
6-Financial assistance from friends living in Haiti	3.4 (17)	4.9 (30)
7-Financial assistance from friends living abroad	0.8 (4)	0.8 (5)
8-Pension from Retirement in Haiti	**3.2 (16)**	**3.0 (18)**
9-Pension from Retirement from abroad	1.0 (5)	0.5 (3)
10-Agriculture	**19.1 (96)**	**10.2 (62)**
11- Rented landholdings	0.6 (3)	0.3 (2)
12-Others	7.8 (39)	1.8 (11)
13-Several of these sources of income	1.4 (7)	1.3 (8)
14-Did not answer	3.2 (16)	3.1 (19)
Total	45.3 (503)	54.7 (608)

Regarding the situation of employment, of all the persons surveyed 262 declared not to be able to work any longer; the majority of them, namely 65.3% (171), were from urban areas. Moreover, according to responses to the questionnaires, individuals with no activity and staying home rather came from rural areas, that is 61.2% (90), compared to their urban area counterparts -- 38.8% (57). However, some indicated being owners of real estates such as dwelling (24.4%), land (11.9%), dwelling and land (32.9%), while 28.4% would possess nothing. They were 78.7% (322) in urban areas to report having the privilege of enjoying those landholdings, versus 81.2% (406) in rural areas. And for those cohabiting, 26.9% (299) state that other occupants of the house, particularly their offspring, would have access to personal income, in 15.4% (171) of cases.

Food represents a great part of the total expenditure for a good number of the participants, namely 61.5% (683). Medical care comes in second, according to 21.5% (239) of people surveyed. A significant number, 59.9% (665), declare being in debt at the time of the survey. The amount of debt for 42.1% (469) was between less than 5.000 and 25.000 gourdes. The most evoked reasons for indebtedness were connected to food expenses (13.7%, or 152 of the subjects) and to running the small-scale business (13.9%, or 155). As for the number of daily meals, only 7.3% (81) affirm they can afford them if necessary; thus, for 41.7% (463) of them, the number of meals would depend on sheer chance.

Access to healthcare and social protection

> "If ageing must be something positive, it is necessary that a longer life come with possibilities of enjoying good health, of participating, and of being safe."
> The World Health Organization, 2002

In addition to economic difficulties, low-income countries like Haiti have, for decades, been facing serious public health problems, such as high mortality rate at birth and infectious diseases, namely the HIV pandemic. As their economy grows, exposure to chronic or non-communicable diseases will become consistent with the change in lifestyle (World Health Organization, 1998). Nonetheless, demographic ageing is also a major issue for all countries in the world. In the 21st century, a challenge is the need to implement measures that can prevent or delay the onset of diseases and the loss of autonomy, while maintaining the good health of the elderly. Indeed, it has been established that for patients aged 65 years and older, health care is

7 times more costly than for persons who have chronic disability (World Health Organization, 2002).

In Haiti, life expectancy at birth in 1955 was 37.56 years. Estimated at 64.33 years for the 2010-2015 five-year period, it will be 67.85 years in 2025 (IHSI, 2007). The proportion of the elderly aged 60 years and older accounted for 7.4% according to the last census, held in 2003. Within the Survey of the Living Conditions in Haiti (ECVH), a section focused on self-assessing the overall health status of the population. Compared to younger generations, 41.0% of persons aged 60 years and more deemed their health status rather average, 35.7% found it poor, and 18.4% deemed it very bad; hardly 4.8% of them felt very healthy (2003).

Table 14: Distribution (%) of RSI[21] based on self-assessment of the overall health status per age group according to the last General Census of the Population

	Age bracket				
General Health Status	15-29	30-44	**45-59**	**60 years and more**	Together
Good/Very Good	48.6	29.1	**13.7**	**4.8**	32.8
Average	43.3	54.1	**57.7**	**41.0**	47.7
Bad	6.4	13.7	**20.9**	**35.7**	14.3
Very bad	1.7	2.9	**7.7**	**18.4**	5.1
No answer	0.0	0.2	0.0	0.1	0.1
Total	100	100	100	100	100
Sample	2667	1983	1180	1259	7089

Source: IHSI/ECVH, 2003

Across the country, **7.7% of the elderly aged 60 years and over reported having at least one disability.** The proportion of people with disabilities accounted for 1.51% of the total population of the country. Among them, 57.5% comprised the group of 15-64 years, and 31.5% accounted for those aged 65 years and over.

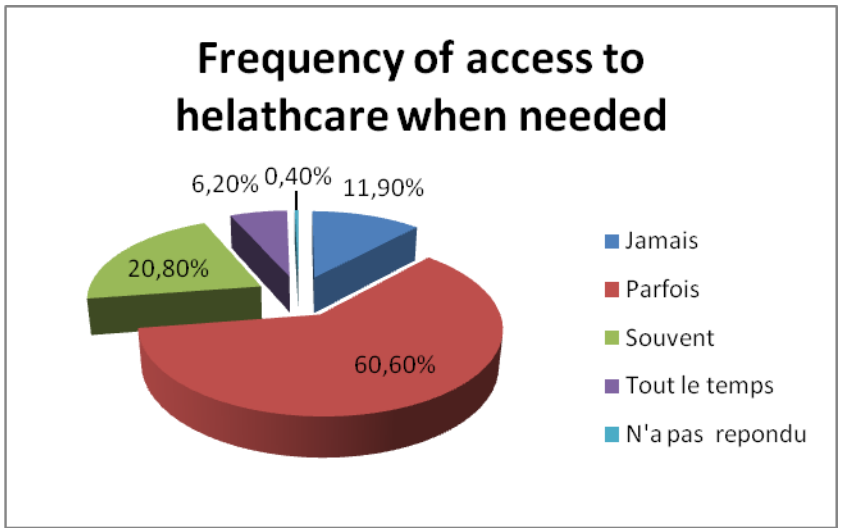
[21] Randomly Selected Individuals

Now, let's see what came out of the health status of the 1113 elderly we met in the course of our study on the situation of the elderly aged over 50 years in Haiti.

Use of health services

According to the elderly in our sample, at the time of the interview 61.4% (683) felt sick and 4.6% (51) would have a physical disability, compared to 31.1% (346) who declared themselves healthy.

Figure 2: Frequency of access to medical care among respondents

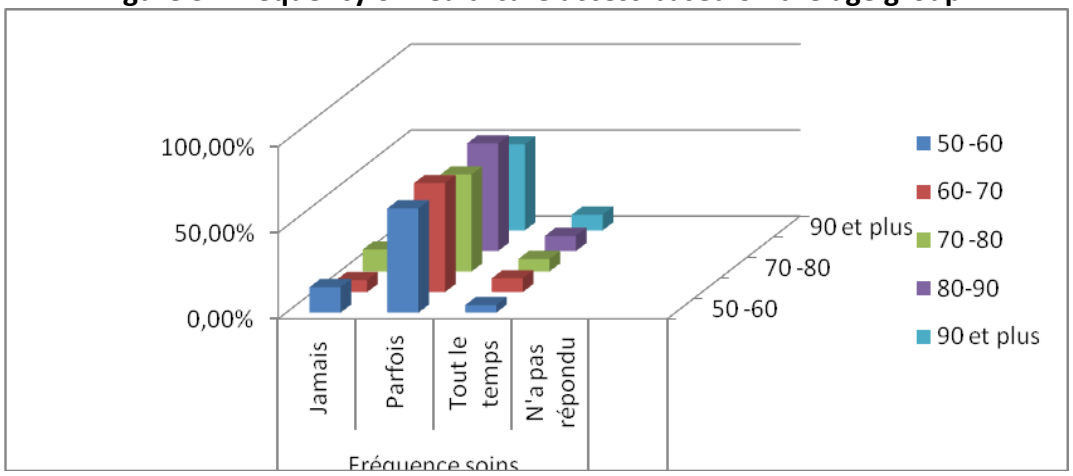


Translation note: Jamais = never, Parfois = sometimes, Souvent = often, Tout le temps = all the time, N'a pas répondu = did not respond

According to the data in Figure 2, most of the subjects, 60.6% (674), receive necessary medical care only **sometimes**. 62.3% (292) of the elderly in urban areas and 59.2% (382) of those in rural areas were concerned —a small difference of 3 percentage points. This surprising result needs to be considered with caution, given that the results of EMMUS IV 2005-2006 (Cayemittes, M. et al., 2007, page 316), revealed that in Haiti "the proportion of people living close to a health facility is higher in urban areas than rural areas (67% versus 48% at less than 5 kilometers)". As one can note, this insignificant gap could be explained by the wording of the question put to participants in both studies. Indeed, in our questionnaires our elderly had to assess only the frequency of access to health care, while in the Survey on Mortality, Morbidity, and the Utilization of Services (EMMUS) 2005-2006, participants from specific age groups (<15, 15-49, 50 and over) were asked to evaluate the distance between their household and the health facility they attended most. Another factor to consider while comparing with the

EMMUS is the sample size. Whereas ours included 1113 individuals selected in 6 administrative (geographical) departments, the EMMUS sample included all 10 administrative departments of the country and touched approximately 10,310 households.

Figure 3 : Frequency of healthcare access based on the age group



Translation note: Jamais = never, Parfois = sometimes, Souvent = often, Tout le temps = all the time, N'a pas répondu = did not respond

We notice in the figure above that, for the subjects we interviewed, age does not seem to have too big of an incidence in the frequency of access to medical care.

The trend towards similarity in the availability of health care between urban and rural areas is again observed, now in what regards the availability of medication adapted to the health status of our population's elderly. In urban areas, 63.0% (294) indicate they have access sometimes versus 62.4% (402) of their counterparts in rural areas.

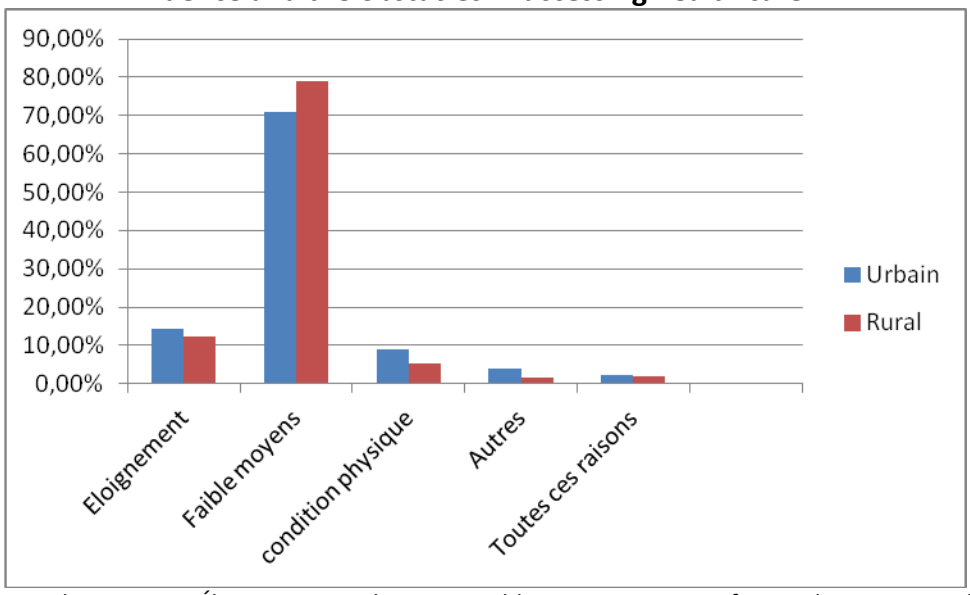
The EMMUS IV (page 320, 2006) also took interest in the reasons why sick people in the household would have not been brought to a health facility. Thus, independently of the place of residence, the cost was the reason most frequently evoked to justify the non-utilization of health services. 44.7% of individuals aged 50 years and more also evoked the financial aspect, while for 19.9% the facility was too far, and 14.2% preferred to consult with a traditional healer[22] or a Vodou priest or priestess[23].

The results of IHSI's ECVH (2003) concur with those findings: 59.4% of ill or injured individuals aged 60 years and more, versus 48.1% of those included in 45-59 age bracket, had never consulted a health professional for financial reasons (page 187). The data presented in **Figure 4**

[22] *Medsenfey* in Haitian Creole
[23] Hougan or Mambo

concur with those previously found in the national surveys that were evoked before. **Economic problems seem the principal obstacle to access to healthcare for all individuals older than 50 years (75.7%, i.e. 784),** recruited in urban zones (71%, i.e. 301) and rural zones (79.1%, i.e. 483) in our study.

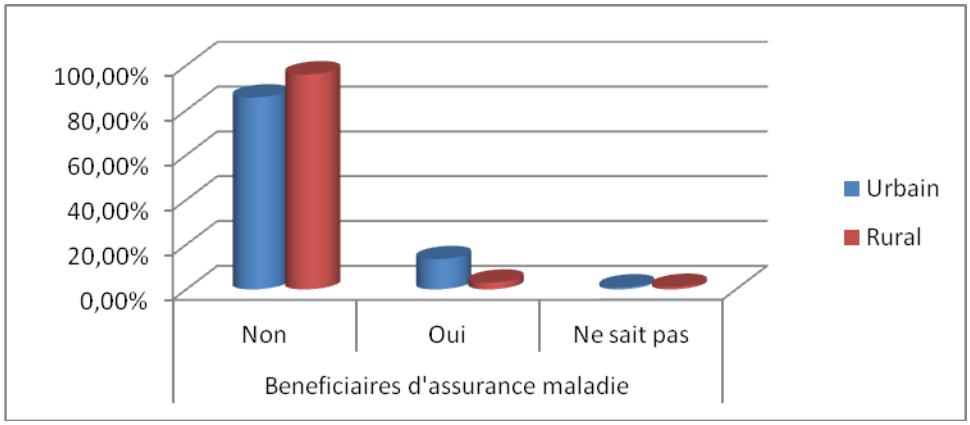
Figure 4: Distribution of individuals surveyed based on the place of residence and the obstacles in accessing health care



Translation note: Éloignement = distance, Faibles moyens = poor financial means, Condition physique = physical condition, Autres = others, Toutes ces raisons = all those reasons

More than half of the elderly from urban (53%, 248) and rural (55.0%, 354) areas declare being sometimes satisfied of the medical care they receive. For the first group, a number of subjects (26.8%, 325) are rather often satisfied, and so are their counterparts from the second group (27.3%, 176). Finally, out of the total population, only 1.9% (9) to 1.4% (9) would be always satisfied of the medical care they receive.

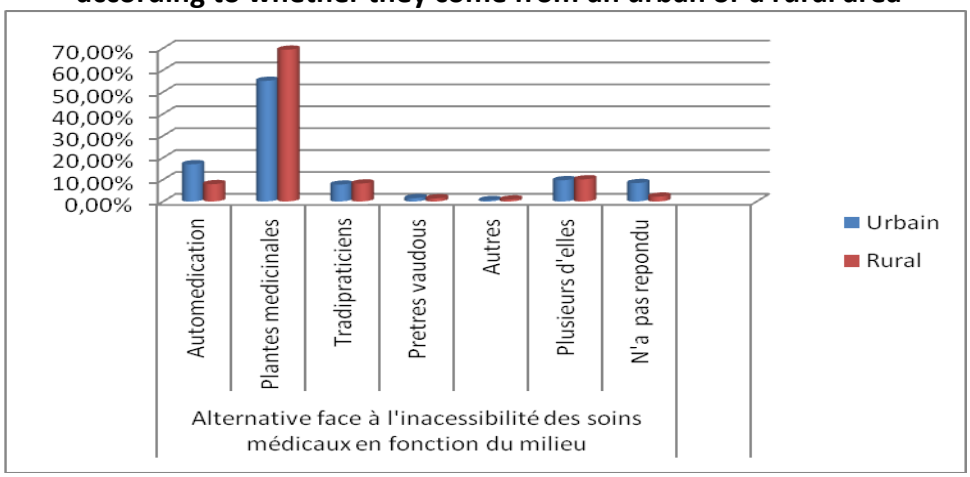
Figure 5: Distribution of our sample according to whether the subjects have health insurance or not



Translation note: Non = no, Oui = yes, Ne sait pas = doesn't know, Bénéficiaires d'assurance maladie = health insurance beneficiaries

Figure 5 shows that the large majority (more than 80%) of persons older than 50 years do not enjoy any form of health insurance. However, those who are covered generally come from urban zones. This result goes well with the conclusions of the ECVH carried out nationwide approximately 10 years earlier, which indicated a **health insurance coverage rate of only 3.1% for the total population of the country.** In this category of covered people, 49.5% of the subjects resided in the metropolitan area, versus 25.1% in urban areas and 10.6 in rural areas.

Figure 6: Alternatives used by participants in the absence of medical care according to whether they come from an urban or a rural area

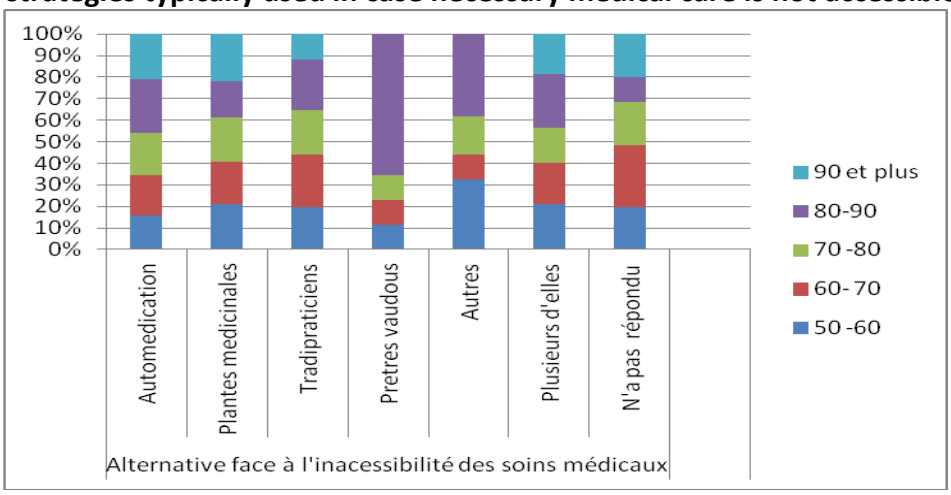


Translation note: Automédication = self-treatment, Plantes médicinales = medicinal plants, Tradipraticien = traditional healer, Prêtres Vodou = Vodou priests, Autres = others, Plusieurs d'entre elles = several among them, N'a pas répondu = did not respond. Alternatives face à l'inaccessibilité des soins médicaux en fonction du milieu = Alternatives used in case of incaccessibility of medical care, depending on the setting

This figure illustrates the **massive recourse by all categories to medicinal plants as alternatives, in order to mitigate the inaccessibility of modern medical care. It should be noted that this practice appears much more frequent in rural zones (more than 60%).** In addition, it is observed that self-medication is used more (17%) in urban areas than in rural areas (7.9%). By contrast, for approximately 10% of subjects from both groups, the combination of the various alternatives is most cited, of which traditional healers and Vodou priests' consultations (visit to the Hougan or the Mambo).

It was also proven in EMMUS IV (Cayemittes, M. et al., 2007) that 14.2% of the subjects aged 50 years and more who required healthcare prefered to consult a traditional healer instead of going to a healthcare facility. Moreover, in rural areas this alternative was more often evoked than in urban areas (19% versus 8%).

Figure 7: Distribution of participants according to the age group and to strategies typically used in case necessary medical care is not accessible



Translation note: Automédication = self-treatment, Plantes médicinales = medicinal plants, Tradipraticien = traditional healer, Prêtres Vodou = Vodou priests, Autres = others, Plusieurs d'entre elles = several among them, N'a pas répondu = did not respond. Alternatives face à l'inaccessibilité des soins médicaux en fonction du milieu = Alternatives used in case of incaccessibility of medical care

According to Figure 7, the majority of the participants who revealed the use of the services of Vodou priests/priestesses, in the absence of modern medical care, would be between 80 and 90 years of age: more than 60% of the category. While self-medication and the use of medicinal plants were relatively common in all the age groups.

Health status of participants who declared a physical disability

According to data collected, 4.6% (51) of subjects declared a physical handicap. A substantial portion (80%, 80) of the subjects interviewed in Haiti's North-East department declared themselves sick. However, among all the geographical departments the South-East department (41) is where we found the strongest percentage of people with a physical handicap (19.5%, i.e. 8 out of 41 interviewed), as shown in Table 17.

Table 15: Distribution of the population according to the geographical department and self-declared physical conditions

Departments		Physical condition				Total
		Good health	Sick	Physical handicap	Did not know	
West	**Number**	183	231	**7**	13	434
	%	42.2%	53.2%	**1.6%**	3.0%	100.0%
South-East	**Number**	3	28	**8**	2	41
	%	7.3%	68.3%	**19.5%**	4.9%	100.0%
North-East	**Number**	16	80	**4**	0	100
	%	16.0%	**80.0%**	**4.0%**	.0%	100.0%
Artibonite	**Number**	84	137	**16**	2	239
	%	35.1%	57.3%	**6.7%**	.8%	100.0%
Center	**Number**	54	84	**2**	0	140
	%	38.6%	60.0%	**1.4%**	.0%	100.0%
Nippes	**Number**	6	123	**14**	16	159
	%	3.8%	77.4%	**8.8%**	10.1%	100.0%
Total	**Number**	346	683	**51**	33	1113
	%	31.1%	61.4%	**4.6%**	3.0%	100.0%

Table 16: Distribution of the population according to the physical condition and the frequency of access to medical care

Physical condition		Frequency of access to necessary medical care					
		Never	**Sometimes**	**Often**	**All the time**	**Did not answer**	**Total**
Good	Number	21	212	84	27	2	346
	%	6.1%	61.3%	24.3%	7.8%	.6%	100%
Sick	Number	91	414	139	39	0	683
	%	13.3%	60.6%	20.4%	5.7%	.0%	100%
Physical handicap	**Number**	**13**	**28**	**8**	**1**	**1**	**51**
	%	**25.5%**	**54.9%**	**15.7%**	**2.0%**	**2.0%**	**100%**
Did not know	Number	8	20	1	2	2	33
	%	24.2%	60.6%	3.0%	6.1%	6.1%	100%
Total	Number	133	674	232	69	5	1113
	%	11.9%	60.6%	20.8%	6.2%	.4%	100%

The above table shows that the people who reported a physical handicap are the group for which medical care would be the least accessible: 25.5% never have access and 54.9% have it SOMETIMES; hardly 15.7% and 2% indicated having it OFTEN and ALL THE TIME.

Table 17: Distribution of participants according to their physical condition and the main obstacles in accessing the nearest hospital

Physical condition		Obstacles in accessing the hospital					
		Distance	Weak financial means	Physical condition	Others	Several of them	Total
Good	Number	73	194	21	10	3	301
	%	24.3%	64.5%	7.0%	3.3%	1.0%	100%
Sick	Number	54	530	40	13	15	652
	%	8.3%	81.3%	6.1%	2.0%	2.3%	100%
Physical handicap	**Number**	**4**	**35**	**8**	**0**	**3**	**50**
	%	**8.0%**	**70.0%**	**16.0%**	**0%**	**6.0%**	**100%**
Did not answer	Number	4	25	1	2	0	32
	%	12.%	78.1%	3.1%	6.3%	.0%	100%
Total	Number	135	784	70	25	21	1035
	%	13.0%	75.7%	6.8%	2.4%	2%	100%

According to the data exposed in Table 19, only 16.0% (8) of the subjects with a physical handicap have difficulties going to the nearest hospital because of their physical condition. For 70% of them, poor financial means is the factor that prevents them from using the nearest hospital's services.

Within the framework of this study on the situation of the elderly in Haiti, a section of the questionnaire invited the subjects to enumerate subjectively current pathologies of today that did not exist in the past. From Table 20, the cholera pandemic, according to those who, among the elderly interviewed, came from rural (57.6%) and urban (45.8%) areas, comes on top of the list, before the HIV-AIDS infection and the other non-transmissible chronic diseases. According to answers from the two groups, the elderly unanimously think that a number of current diseases of today were unheard of in the past: 95.1% (443) (urban areas) and 94.1% (607) (rural areas).

Table 18: Percentage of diseases non current in the past that were evoked by the subjects according to the place of residence

	Today's current pathologies						
	Number (%)						
Place	Cholera	HIV-AIDS	High blood pressure	Filariasis	Diabetes	Cancer	Several of these pathologies
Urban	**205**	51	3	3	3	12	**164**
	45.8%	11.4%	.7%	.7%	.7%	2.7%	**36.6%**
Rural	**355**	55	8	4	2	5	**169**
	57.6%	8.9%	1.3%	.6%	.3%	.8%	**27.4%**

The prevalence of HIV-AIDS among the elderly in Haiti

With regards to the epidemiology of the HIV infection in the population of those older than 50 years in Haiti in 2012, our efforts to obtain information from the Haitian Group for the Study of the Kaposi Sarcoma and of Opportunistic Infections *(Groupe Haïtien d'Étude du Sarcome de Kaposi et des Infections Opportunistes,* GHESKIO) were unproductive. However, we know that the World Health Organization sounded the alarm concerning the underestimation of the rate of infection to HIV-AIDS among the elderly. There is a tendency to undervalue the risk incurred by this category, perceived as being less active sexually than the younger generations. In epidemiologic studies of HIV, the emphasis is often put on the groups included in the 15-to-49-year age groups (ONUSIDA, 2012). Consequently, even in sub-Saharan African countries strongly affected by this pandemic, there is scarce data about the HIV epidemiology within the population of those older than 50 years (United Nations, 2002b; World Health Organization, 2010). In developed countries like the United States, statistics reveal that 24% of cases of HIV infections reported back in 2005 were among people older than 50 years (115,871). This progression of the prevalence of HIV infection among the American elderly can be understood from two angles: 1) an increase in the percentage of new diagnoses of the infection among the elderly; and 2) the effectiveness of antiretroviral treatments, which prolong the life expectancy of HIV infected patients (Myers, 2009).

In Haiti, data from the Survey on Mortality, Morbidity, and the Utilization of Services (EMMUS) carried out at the end of 2005, reveal a prevalence rate of the HIV infection of 2.2% among persons aged 15-49 years (World Health Organization, 2010)[24]. Women in this age group appeared more vulnerable than their male counterparts. **The prevalence of the infection was 3.1% among men aged 50-59 years,** thus slightly higher than for subjects aged 15-49 years. But no data were reported on HIV prevalence among women aged 50-59 years. Basically, 103,669 adult subjects from the survey's sample were tested HIV positive (EMMUS-IV, 2006).

Situation of the subjects with respect to the risks and management of disasters, and to climate changes in Haiti

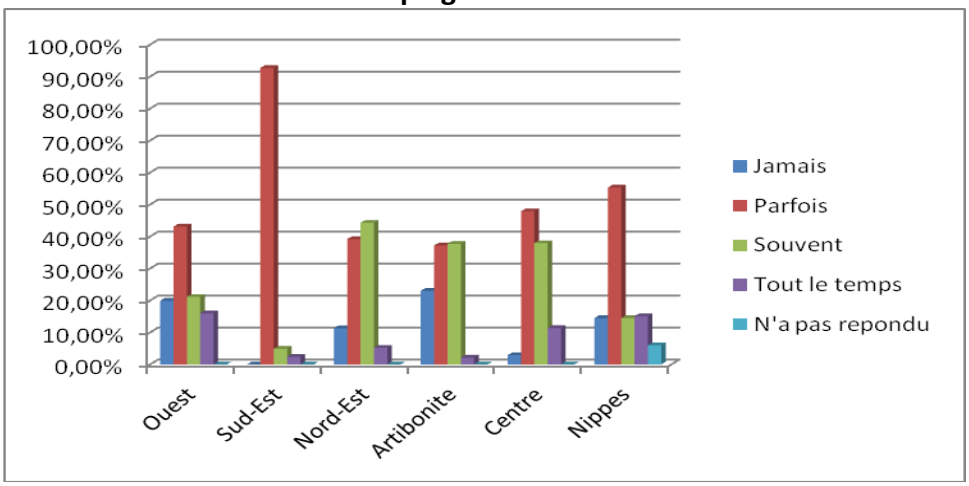
> "The elderly are entitled to an equal protection according to the international humanitarian law and humans rights. Recent events shed light on the disproportionate impact of natural disasters as well as crises on the elderly…"
> IASC (WHO/HelpAge International, 2008)

Actually, the recognition of the elderly's rights to a level of protection equal to that afforded to other vulnerable groups is slow to materialize. Indeed, according to the results of a study carried out jointly by *Handicap International* and *HelpAge International* on the financing of 6,003 projects launched by the United Nations between 2010 and 2011, there is a substantial difference between the needs of the elderly and/or disabled, and the level of humanitarian assistance provided to meet these needs. **Only 1 % (61) of the international humanitarian aid is specifically intended for these categories** of population, yet that are strongly impacted in times of crisis. Nonetheless, Haiti was among the countries where the percentages of projects dedicated to handicapped people were highest (4.7%). It should be noted that this happened in the context subsequent to the 12 January 2010 earthquake (HelpAge International and Handicap International, 2012).

The data we collected from persons aged 50 years and more at the end of 2012 show that for 47.4% of subjects living in urban areas and 44.4% in rural areas, awareness campaigns in times of a disaster would be accessible only SOMETIMES. While a share of 18.5% (119) of subjects residing in rural areas versus 12.9% (60) of those living in urban areas would never be accustomed to being touched by these campaigns. The following figure shows that **more than 90% of the people interviewed in the South-East department estimate to have access to these actions only SOMETIMES**.

[24] World Health Organization, World Health Statistic, 2010 (p 32)

Figure 8: Distribution of participants according to their localization and access to campaigns in times of disaster

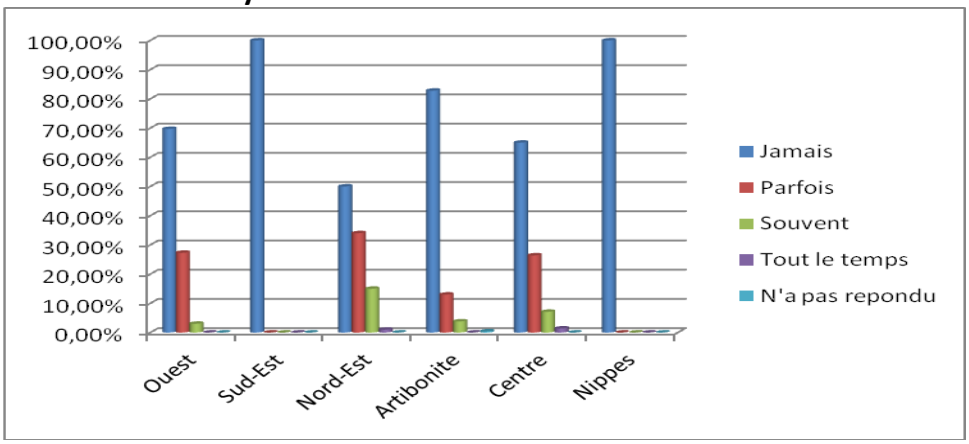


Translation note: Jamais = never, Parfois = sometimes, Souvent = often, Tout le temps = all the time, N'a pas répondu = did not respond

As for the humanitarian aid, a considerable proportion among the elderly, **in both areas — 79.8% (513) (rural) and 69.8% (326) (urban)—, affirmed they do not benefit from it in times of catastrophes**. This 10-percentage-point gap between the two groups suggests that rural area subjects were more concerned with this deficiency.

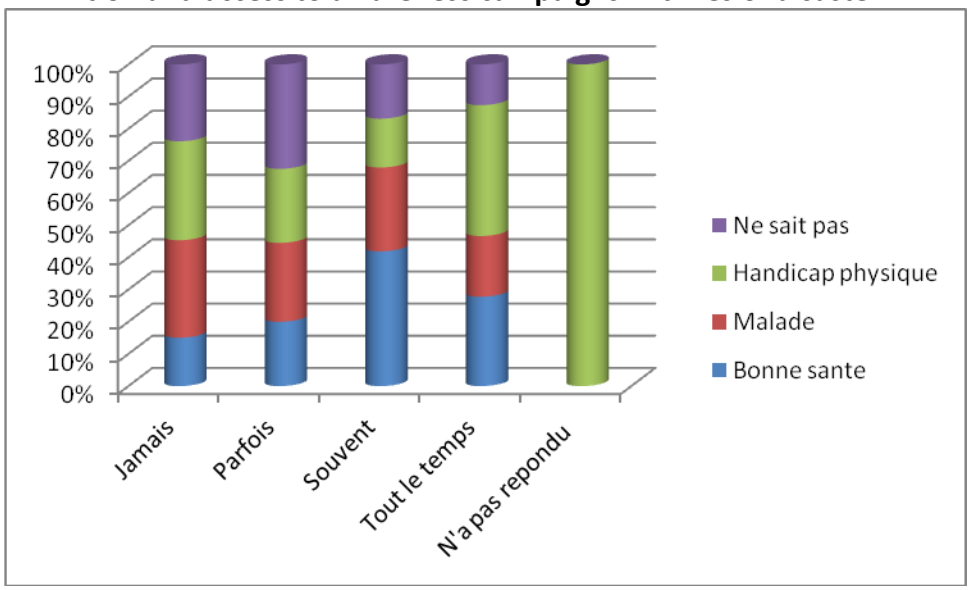
The results presented in Figure 9 indicate that the humanitarian aid would never reach the whole (100%) population interviewed in the South-East and Nippes departments.

Figure 9: Distribution of participants by department and level of accessibility of humanitarian aid in times of disaster



Translation note: Jamais = never, Parfois = sometimes, Souvent = often, Tout le temps = all the time, N'a pas répondu = did not respond

Figure 10: Distribution of the subjects according to their physical condition and access to awareness campaigns in times of disaster



Translation note:
Jamais = never, Parfois = sometimes, Souvent = often, Tout le temps = all the time, N'a pas répondu = did not respond
Ne sait pas = doesn't know, Handicap physique = physical disability, Malade = sick, Bonne santé = good health

Table 19: Percentage of the elderly having been touched by awareness campaigns in times of disaster according to their physical condition

	Access to awareness campaigns in times of disaster				
Health status	Never	Sometimes	Often	All the time	Did not answer
Good health	9.60%	39.20%	37.80%	13.40%	0.00%
SIck	**19.30%**	**48.10%**	23.50%	9.10%	0.00%
Physical disability	**19.60%**	**48.10%**	13.70%	19.60%	2.00%
Did not know	15.20%	63.60%	15.20%	6.10%	0.00%

Figure 10 and Table 21 show a variation in the frequency of access to information aimed to raise awareness among the subjects in times of disaster. The portion of the handicapped (19.60%) to have already been able to benefit from this kind of activity was slightly higher than that of the two other groups: 13.40% for those in good health and 9.10% for those with illnesses. Yet, the majority of people who are sick (48.10%), disabled (48.10%) and in good health

(39.2%) had access only SOMETIMES. There were more sick (19.30%) and disabled (19.60%) participants who would have never benefited from these campaigns, compared to those who declared having good physical health (9.60%).

Table 20: Distribution of participants according to their physical condition and the accessibility of humanitarian aid in times of disaster

		Access to humanitarian aid in times of disaster					
Health		Never	Sometimes	Often	All the time	Did not answer	Total
Good health	Number	207	119	18	2	0	346
	%	59.8 %	34.4%	5.2%	0.6%	0%	100.0 %
Sick	Number	553	96	29	1	1	680
	%	81.3 %	14.1%	4.3%	0.1%	0.1%	100.0 %
Physical disability	**Number**	**47**	**4**	**0**	**0**	**0**	**51**
	%	**92.2 %**	**7.8%**	**0%**	**0%**	**0%**	**100.0 %**
Did not know	Number	32	1	0	0	0	33
	%	97.0 %	3.0%	0%	0%	0%	100.0 %
Total	Number	839	220	47	3	1	1110
	%	75.6 %	19.8%	4.2%	0.3%	0.1%	100.0 %

From the data reported in the table above, **92.2% of handicapped elderly** affirmed they have not benefited from humanitarian aid in the aftemath of disasters. This result is in line with the conclusions of the study of Handicap International and HelpAge International (2012) mentioned in the beginning of this section. That study pointed out the negligible percentage (1%) of international humanitarian aid that went to the elderly and to handicapped people. Nevertheless, this result must be interpreted with caution. For, that study also revealed

that Haiti was on top of the list among countries that received the biggest percentages of financed projects destined to the disabled, that is, 4.7%.

Discussion

From the results presented early on in this report, in terms of diagnostic of current public policies or programs, it appears that practically everything remains to be done by stakeholders in charge for the effective realization of the elderly's basic rights in Haiti. Particularly, we refer to the rights to health, to education and training, to work, to social security, and to protection. This finding is in congruence with the conclusions of the quantitative survey that we have just exposed.

Thus, participants aged 50-90 years would not be immune from the financial insecurity that prevails in Haiti. Like in other low-income countries, they came especially from rural areas (58.0%) and benefited very little from social coverage (United Nations, 2009).

There is progress in terms of the literacy training of new generations, but the illiteracy rate remains high among the elderly at the national level, in particular among women (IHSI, 2003). As a matter of fact, half of our sample (50.6%) has never been to school and 30.5% had a primary education level. Women accounted for 60% of illiterate in our population.

Contrary to what was observed in many Caribbean countries and industrialized societies, very few subjects (2.9%) in our population declared living alone. In this context, on the one hand we can assume that support for the elderly we met would be provided by the immediate family, given the fact that their household was described as having on average 6 occupants. On the other hand, we discovered that they represented a resource for a few of their family members. Indeed, a portion of 48.2% of surveyed women versus 36% surveyed men were in charge of infants. In general, 40.8% of the participants lived with one or several of the following people: Spouse, Child, Grandchildren, Relatives and Friends.

The percentage of subjects receiving some form of retirement pension was lower than 4%, whereas the average in low-income countries was higher than 7% (United Nations, 2009). In our survey we discovered a significant number of individuals older than 50 years who were economically active in the labor market, particularly in the informal sector. 26.6% lived mainly off the proceeds of a small-scale trade, 14.2% of agriculture, and 11.7% of a private business. However, 15.9% depended on the financial support of their family in Haiti. The percentage of

women small retailers (33.4%) exceeded that of men (18.5%). Food took a good share of the overall population's total expenses.

In the matter of social protection and access to medical care, 61.4% of interviewed subjects declared they were sick, and 4.6% had a disability. In IHSI's ECVH (2003), compared to young people 41% of those aged 60 years and more believed their health status to be rather average, and 35.7% found it bad. Over the whole group we surveyed, 60% (674) would profit from medical care they needed only SOMETIMES. Economic problems were the first obstacle in accessing medical care for 75.7% (784) of the group. Those results are in line with those obtained by EMMUS IV (2005-2006) and the ECVH (2003), in which it was found that cost was the main reason for the non-utilization of health services by sick or injured people aged 50 years and more.

In the matter of medical coverage, more than 80% of the subjects interviewed had no health insurance, particularly in rural areas. In accordance with the Survey on Living Conditions in Haiti (ECVH), at the national level hardly 3.1% of the total population had any kind of insurance (IHSI, 2003). Moreover, a massive recourse (more than 60%) to traditional medicine (use of medicinal plants) was noted, no matter the area, to alleviate the lack of access to modern health services. The combination of alternatives, for example consultation of traditional healers and Vodou priests, was quoted by 10% of our participants. A percentage very close to the one stated in the Survey on Morbidity, Mortality and the Utilization of Services, which was 14% (EMMUS IV, 2006).

Furthermore, disabled people were the category for which medical care was the least accessible. Among them, 25.5% would never have access to the medical care their situation required, but 54.9% would sometimes.

In what regards the situation of people older than 50 years vis-a-vis HIV-AIDS, epidemiological studies seldom take into account patients beyond the age of 49. However, the data collected in EMMUS IV (2006) reveal that 3.1% of men aged 50-59 years got infected with HIV at the end of 2005. But, no percentage was reported for the women of this age bracket.

We observed that 47.4% of urban area participants, versus 44.6% from rural areas, would have access to awareness campaigns in times of disaster only SOMETIMES. By contrast, rural areas would be less touched by humanitarian aid (79.8%, 513) than urban areas (69.8%, 326).

Lastly, according to the report published by Handicap International and HelpAge International in 2012, only 1% of international humanitarian aid was dedicated to the disabled and the elderly. Haiti was among the countries to have benefited from the highest percentage of financed projects, intended for the disabled (4.7%); however, 92.2% of the handicapped sub-

jects older than 50 years whom we interviewed would have never been touched by humanitarian aid.

The next section analyzes the similarities and particularities that could have emerged from the qualitative survey's causal analysis.

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PART THREE

The QUALITATIVE SURVEY AND THE CAUSAL ANALYSIS

By John Kersnid JUSTAFORT

> *"[…] qualitative research […] allows […] to build an explanation that is not exclusively centered on specific events, but on systems of practices, values, etc. Indeed, it can aim at the knowledge of social relations, norms, social structures, and processes that undergird social life."* (Pires, 1993)

The richness of this study rests on the original attempt to cross-reference the empirical, quantitative and qualitative data. Thus, after the statistical analysis of the data from the survey by questionnaire, it is now good to try to determine the influence of the social relations, the norms and the social structures on the living conditions of the elderly in Haiti.

In the course this work, the qualitative survey mainly consisted of the realization of focus groups in order to evaluate aspects of the reality of the population older than 50 years, not only through their own words, but also through those of the youth.

Presentation of the composition of the focus groups

We implemented 16 focus groups, composed as follows:

Table 21: Composition of the focus groups

Characteristics of the groups	Quantity
Mixed participants older than 50 years	5
Male older than 50 years	1
Female older than 50 years	2
Elderly and young people from both genders	2
Young people from both genders	6
TOTAL	**16**

Table 22: Distribution of participants according to the place of residence and the age

Zone	Elderly people	Young people	Total
Port-au-Prince	11	11	**22**
Carrefour	20	2	**22**
Pétion-Ville	21	0	**21**
Gonaïves	10	11	**21**
Belladère	11	10	**21**
Perches	11	16	**27**
Fonds-des-Nègres	6	16	**22**
Côtes-de-Fer	7	10	**17**
TOTAL	**97**	**76**	**173**

Table 23: Presentation of participants according to the place of residence and the gender

Zone	Male	Female	Total
Port-au-Prince	3	19	**22**
Carrefour	4	18	**22**
Pétion-Ville	11	10	**21**
Gonaïves	13	8	**21**
Belladère	8	13	**21**
Perches	17	10	**37**
Fonds-des-Nègres and Côtes-de-Fer	26	13	**39**
TOTAL	**82**	**91**	**173**

Educational attainment of focus group participants Table 24: Distribution of participants according to their educational attainment

Educational attainment	Young people	Elderly people	TOTAL
College	10	0	10
Secondary	53	8	61
Primary	12	16	28
Non-schooled/literate	0	12	12
Non-schooled/illiterate	1	61	62
TOTAL	**76**	**97**	173

Table 25: Presentation of participants by place of residence and field of activity

Activities	P-au-P	Carrefour	Pétion-Ville	Gonaïves	Belladère	Perches	Fonds des	Côtes-de-Fer	Total

							Nègres		
Agriculture	-	-	-	-	4	8	4	4	**20**
Trade	-	15	-	-	5	1	2	1	**24**
Teaching	-	-	-	-	1	1		1	**3**
Liberal profession	-	-	15	-	1	-	-	1	**17**
None	11	5	6	10	-	1	-	-	**33**
TOTAL	**11**	**20**	**21**	**10**	**11**	**11**	**6**	**7**	**97**

CONTENT ANALYSIS

For each set of themes, the situation of the elderly will be described in accordance with the subjects' own words. Thus, this part of the report implements a synthetic statement of the discursive contents developed in all the focus groups.

Table 26: Presentation of the situation according to specific themes

Set of themes	Situation
Health (current diseases, access to care, availability of the services, etc.)	- The most current diseases among the elderly are chronic pathologies (arterial hypertension, diabetes, etc.) that require continuous care that they can't afford. There are also illnesses of the cervix for the women and prostate for the men. Ophthalmic affections are also frequent. - Difficulty of access to the medical institutions. - No medical services specialized for the individuals older than 50 years. - An insufficient number of health facilities (for example, there is one community clinic for the whole locality of Perches). - Difficulty to buy needed medication because of lack of money.

	- Recourse to therapy based on medicinal plants. - Preference for traditional medicine. - The 11 elderly individuals from Perches think that they can let their body cure by itself. A way of avoiding going to the Hospital.
Nutrition	- According to participants of all groups, their low incomes undergird all their nutrition problems. - There were thoughts that the few local products are too expensive. - Rural area elderly and young people report difficulties to carry out agricultural production due to repeated floods, periods of drought, absence of policymaking regarding production, environmental degradation, and erosion. - The participants from Perches (11 elderly and 16 young people) and Belladère (11 elderly and 10 young people) think that imported products are of less quality than local ones. - Disinterest of rural area young people for agriculture (Perches, Belladère, Fonds-des-Nègres and Côtes-de-Fer).
Protection	- According to the subjects interviewed at Les Perches, the elderly are abandoned by their family. - Participants from Gonaïves, Perches, Fonds-des-Nègres et Côtes-de-Fer know of elderly persons who, at times, can count only on the support of neighbors. - No shelters have been noticed in rural zones (Perches, Belladère, Côtes-de-Fer, Fonds-des-Nègres). - For the low-income elderly, **the terms: *retirement*, *pension* and *insurance*** only concern **rich people (“*nou menm se lanmò ki retrèt nou*”[25], “*asirans mwen se nan bondye*”[26]).** - Elderly participants from Côtes-de-Fer (7), Fonds-des-Nègres (6) and Pétion-Ville (2) would not know about protection and emergency response mechanisms. - But, one must note the presence of the Office of Civil Protection in Port-au-Prince, Carrefour, Gonaïves, Belladère, and Perches, which coordinates the response to emergencies in favor of the elderly. **They declare that young people are the ones with more frequent access to risk- and disaster-focused training or information sessions.** - The elderly from Pétion-Ville (21) and Perches (11), as well as the

[25] Death is our retirement.
[26] Our insurance is in God.

	young people from Gonaïves (11), reported cases of abuse and violence toward the elderly. - Most rural area elderly were farmers. Among 35 subjects met in rural areas (Belladère, Perches, Fonds-des-Nègres, Côtes-de-Fer), **20 were farmers.** - More than half of the elderly (32 out of 62) interviewed in urban areas (Port-au-Prince, Pétion-Ville, Gonaïves) declared having no income-generating activity. - **In Perches (11), Gonaïves (10), Côtes–de-Fer (7) and Fonds-des-Nègres (6), the subjects confirmed having dependent grandchildren.** - The majority of the participants (76/97), besides those from Perches (11/97) and Gonaïves (10/97), think that they are still a productive force.
Hygiene and sanitation	- In urban areas like Port-au-Prince, Pétion-Ville and Gonaïves, drinking water and means of water treatment are accessible (companies selling treated water, *Aquatab, Dlo lavi*, etc.). - In rural areas (Perches, Belladère), people consume rainwater as well as drinking water from *wells* and sources. - Scarcity of water treatment means. - Limited access to toilets in rural areas and some urban areas (Perches, Belladère, Fonds-des-Nègres, Côtes-de-Fer, Carrefour). A number of subjects relieve themselves in cesspools, near rivers and in the sea. Modern toilets and rudimentary latrines are built in a few urban areas (Pétion-Ville, Port-au-Prince). - Existence of agencies responsible for sanitation (DINEPA, CAMEP, etc.), especially in urban settings. - In Côtes-de-Fer, the participants do not understand the utility of integrating toilets in their residences (houses with several rooms are sometimes built without toilets). - Some subjects (in Perches and Gonaïves) refuse drinking treated water, alleging it has bad taste.
Education and training	- A significant number of elderly participants have never been to school (73 out of 99) (see Table 26). - The elderly don't have specific occupations. - Continuing education programs intended for the elderly have not been found in some communities (Côtes-de-Fer, Fonds-des-Nègres, Perches, Carrefour). - By contrast, **there are areas with good literacy programs (Belladère,**

	Gonaïves, Port-au-Prince). - Urban area participants older than 50 years feel overwhelmed by new technologies. - **A group of subjects question the rationale of spending time educating themselves when they are not able to feed their families ("*sa dwòl pou fanmi m ap mouri ak feblès epi pou m al chita sou ban lekòl*"[27]), or they are going to die soon.** - In Belladère (rural area), there are literaccy programs coming from the initiative of a few churches. - In the past, school was reserved for society's high classes ("lekol se zafè gran don"[28]), and agriculture was given more importance.
Community participation	- **The elderly's community participation is carried out through religious activities.** - The elderly in rural areas represent a database of historical events for the younger generations, rather within a restricted family environment. - A portion of Pétion-Ville's elderly are involved in community activities (mostly during election). However, others do not see the utility of their participation in community life, since they are going to die. - There's no structure offering entertaining activities for them. - Many elderly (in rural areas only) play the role of advisers for their young relatives, and of guardians of the traditions. - The stock of experience and knowledge of the population older than 50 years is not taken advantage of by the community. - Nowhere are the elderly consulted about activities related to tourism in the visited areas. - Several elderly people see themselves as a burden for society, and denounce the hostility of the community with respect to their desire for productive, fulfilled lives. - The constant degradation of values was also highlighted. - **The group of elderly infected with the HIV** virus participates in activities aimed to fight this epidemic (Gonaïves). - However, they **deem being stigmatized from a double standpoint**. For, people don't understand that a person older than 50 years can

[27] It would be weird that I go sit in a classroom when my family is dying of starvation.
[28] School is a matter for wealthy people.

	catch the HIV/AIDS virus. **They are called "*granmoun kannay*", that is, "old wanton"[29].** - **The "vye granmoun"[30] are despised (Perches).**
Gender and ageing	- Elderly women still undergo abuses and ill-treatment according to participants older than 50 years from Gonaïves (10), Pétion-Ville (21) and Perches (11). - **Elderly men have more importance than elderly women" (Côtes-de-Fer and Fonds-des-Nègres).** - Reproduction of social roles (Côtes-de-Fer, Fonds-des-Nègres). - The elderly are considered in the same manner, independently of the sex (Port-au-Prince, Pétion-Ville, Carrefour, Gonaïves, Perches, Belladère). - Elderly women and men perform the same kinds of activity (Port-au-Prince, Pétion-Ville, Carrefour, Gonaïves, Perches, Belladère, Côtes-de-Fer, Fonds-des-Nègres). - **Elderly women from rural areas (Côtes-de-Fer, Fonds-des-Nègres, Belladère, Perches) engage in jobs traditionally performed by men (agriculture).** - The majority of elderly men (84/97) and all the young people (76) who participated in the focus groups deem that there is no difference between elderly men and women (Port-au-Prince, Pétion-Ville, Carrefour, Gonaïves, Perches, Belladère).
Ageing (perception and feeling)	- Participants from Carrefour (20) and Pétion-Ville (21) view **ageing as a blessing.** - By contrast, others believe that **it is a heavy burden**. - All participants, young and elderly, think that ageing is a natural phenomenon. - The elderly are described as ***"Lougarou[31]"*** by young people from Fonds-des-Nègres and Côtes-de-Fer. - Some young people from Perches think that elderly men must remain in bed, or play dominos and cards. - Negative feelings such as: stress, discouragement, sadness, fear, sorrow, the regret to have had too many children, shame, frustration, and disappointment were expressed. - In all the groups, older participants who have children and grandchil-

[29] Translation by us.
[30] Very old
[31] Old people (pejoratively)

	dren express great concerns about their future. - **All interviewed young people perceive ageing like a burden, taking into account the living conditions of the elderly in Haiti.**

CAUSAL ANALYSIS

"The concept of causal analysis refers quite simply to the methodological field, and designates the activity consisting in building a sociological explanation by taking into account an empirical material." (Pires, 1993).

The importance of the causal analysis comes from the "essential character of the causal thought" in the human being, which is a universal way of thinking, consisting in seeking relations of causality among phenomena. But the causal thought is not reduced to the mere search for "what makes what happen" in the most primitive sense; it "includes event-driven and structural explanations, and contingent and necessary explanations, simultaneously.

Within the framework of this work, causes will be classified as perceived by the participants in stages. Thus, the cause can be:

1. Immediate, if it is the most obvious cause that directly affects individuals and households;
2. Underlying or implicit, if it normally implies the provision of services and the behavior
3. Deep (a root cause), if it includes elements like politics, tradition, economic resources, ideology, etc.

These three levels of cause will be presented for each set of themes or problem dealt with in the focus groups.

- **Problems of health**

Immediate causes: the immediate causes appertain to the problem of nutrition (inadequate and irregular food intake). A portion of participants believes that many imported food products contain chemical and toxic substances.

Underlying causes: they are connected to health services. They rather relate to the unavailability of primary and specialized health services, and to limited access to medical care (accessibility, distance between households and health facilities). An important underlying cause, according to participants, concerns the behaviors consisting in preferring the services of traditional healers to modern medical care, because of alleged better quality care.

Root causes: they are explained by a traditional attitude consisting in seeking the help of traditional care, preferably (traditional healers, *Oungan, Mambo,* etc.) and by pervasive poverty. These factors constitute the main causes of the elderly's health problems.

- **Problems of nutrition**

Immediate causes: lack or deficiency of resources for a healthy, balanced and regular nutrition of households ("**nou pa monte chodyè chak jou"[32])**.

Underlying causes: most causes of participants' nutrition problems appertain to limited access to quality food products, the unavailability of nutritional information, the absence of technical aid to farmers, and the preference for imported products compared to the ones produced locally.

Root causes: this refers especially to the irresponsibility of the Government in implementing national production policies (bad soil management, inadequate tools, inadequate food conservation), the absence of regulation of food product prices, household's low income, ecological problems (risks and disasters), etc.

- **The social protection problematic**

Immediate causes: the low level of education, the loss of autonomy, the lack of family support for the elderly (some of them live alone), and the fact that they are in charge of other members of their families.

[32] We don't eat everyday.

Underlying causes: inexistence of social protection services (insurance and retirement systems, etc.), numerous elderly don't have access to formal employment (33 out of 97 participants in the focus groups have no activity). Women engaged in small-scale trade (24/97) complain about the insecurity of this type of activity (Carrefour, Belladère). This segment of the population does not often have access to awareness and training sessions related to response to emergencies. According to our quantitative survey, 12.9% of urban area subjects and 18.5% rural area subjetcs affirm that awareness campaigns about risk and disaster management do not reach them.

Root causes: The weakness of the Government, the inexistence of social protection policy, the indifference vis-a-vis the elderly's potentials (young people perceive the elders as disabled persons), and massive unemployment are all major causes explaining the absence of social protection, as perceived by this group.

- **Hygiene and sanitation issues**

Immediate causes: the discussions did not clarify immediate causes of the problems related to hygiene and sanitation; the causes are especially of a practical and structural nature.

Underlying causes: the upholding of a number of practices, such as the use of spring water, defecating in the open air, construction practices, among others. This category of people does not always benefit from medical education programs (recycling of garbage, water treatment). Many elderly don't want to consume treated water because of its taste.

Root causes: the absence of Government structure (CAMEP, DINEPA, SNEM, SNEP) in rural zones (Perches, Belladère, Côtes-de-Fer, Fonds-des-Nègres), the mentality[33] and beliefs of some among the elderly (**"sak pa touye fe gra"[34]** - ***"mikwòb pa touye Ayisyen"[35]***) constitute major causes of the problems of hygiene and sanitation.

- **Education and training**

Immediate causes: the majority of the elderly we met (61/97) can neither read nor write (Table 26).

Underlying causes: Formerly, under the supervision of their parents, the elderly of today devoted themselves to agricultural activities instead of going to school. There would not be any

[33] The set of intellectual habits, beliefs, and mental inclinations that characterize a group: To study mentalities. (Larousse)
[34] What doesn't kill, fatten.
[35] Germs don't kill Haitians.

continuing education programs in favor of this population. The inefficiency of illiteracy programs has been evoked. Their social exclusion is important to highlight. The fear of stigmatization of the beneficiaries of these activities and the absence of measures aiming at utilizing their competences and their experiences are as many causes mentioned.

Root causes: the insufficiency of education and training policies, and the fact that people of this category feel too old to learn are the first causes to be raised. Misery plays a key role. The subjects reveal that the responsibility of bringing up their children and grandchildren is more important than their personal training: "*nou paka kite timoun nou ap mouri grangou epi pou nal chita lekòl*"[36]. For them, family constitutes the number 1 priority.

- **Ineffectiveness of community participation**

Immediate causes: the causes expressed for community participation are not of an immediate nature.

Underlying causes: no access to recreational activities. The elderly are marginalized. Moreover, they do not have time for community activities. They are too much worried about finding out how to feed their children and grandchildren. They underestimate themselves (some see themselves as a burden for society).

Root causes: ignorance and underestimation of the elderly's roles in society; negative social perception vis-à-vis the elderly.

- **Gender and ageing**

Immediate causes: the participants did not identify immediate causes for the problems involved in gender issues. They are especially of an underlying and fondamental nature.

Underlying causes: changes in the social norms stemming from the fight for the respect of women's rights; discriminations are kept against the women; perpetuation of male chauvinism: these are all causes put forth by participants.

Root cause: Absence of policy to protect the rights of the elderly.

[36] We can't afford to go to sit in a school while our children are dying of starvation.

- **Ageing (perception and feeling)**

Immediate causes: family abandonment, loneliness, fear of death. These subjects affirm that they do not have anything to offer society.

Underlying causes: the low level of education, social exclusion, and eventual past choices in life are blamed in the difficulties encountered today by the elderly.

Root causes: the socio-economic situation of the country.

This causal analysis, which relies on a causal stratification (immediate, underlying and root causes) of the problems confronted by the elderly, helps to understand on which level each problematic is posed, for an effective adjustment of the actions. From this point of view, **each problematic is at three levels: family (immediate), provision of services (underlying) and structural (deep, root). For the most part, the causes raised by the participants of the focus groups to explain the problems are underlying or deep**.

It is easy to notice an interaction between the empirical, quantitative and qualitative data of this study on the situation of the elderly older than 50 years in Haiti. However, a number of features emerged from this qualitative survey of the elderly aged more than 50 years and the youth. For example, many of the subjects interviewed in rural areas (through our quantitative and qualitative surveys), did not hide their preferences for traditional care. For participants in the quantitative survey, this attitude may be an effort to find alternative care to offset the difficulty in accessing modern care. Moreover, the focus groups revealed the view that traditional care is presumed of better quality: "**genyen nan nou ki chwazi al lakay ougan paske yo bay pi bon rezilta**"[37]. The Gonaïves group criticized the fact of not being welcomed by some care providers, an experience that destabilizes them. However, these HIV positive participants (PVVIH[38]) from Gonaïves were the only group to have reported the existence of regular services of exemption for drug purchase.

Another distinctive feature of the focus groups shows that this discsussion space offered the participants a place where they could talk freely. They openly exposed their perceptions, feelings and emotions vis-a-vis the phenomenon of ageing. According to them, shame and regrets are hardly expressible. They are ashamed for not having been able to play their role as parents and regret a number of choices in life (too many children, refusal to go to school, for example.)

[37] Some of us prefer to consult *ougan* (Vodou priests) because they give better results.
[38] Persons living with HIV

It should be stressed that the data resulting from the three types of survey (quantitative, qualitative and the one carried out among institutions) exhibit striking commonalities. The facts reported by beneficiaries through the focus groups and the quantitative survey are corroborated by the results gathered from our visits to specific institutions.

As for the healthcare system, the issue of availability and quality of services had been underlined by both beneficiaries (survey by questionnaires) and stakeholders in this study. For example, there are no specialized services (geriatrics, gerontology, etc.) to take charge of this demographic category. It should be noted that 61.4% of the quantitative survey sample declared being sick. While a strong proportion, more than 80%, does not have a medical coverage (see quantitative data concerning medical insurance recipients).

Concerning the right to education, the results showed previously in this report indicate that conditions for the realization of this fundamental DUH right are far from being met in Haiti. Among the 97 participants older than 50 years of our focus groups, 73 were never schooled. Similarly, the quantitative survey shows that 50.6% of the sample of 1113 subjects were never schooled. **It should be noted that, at the time of our survey, at the level of government entities responsible for fulfilling the right to education, data on eventual programs or policies aiming at the training and education of Haitians older than 50 years was available neither at the** Ministry of National Education and Vocational Training (MENFP), nor the National Institute for Vocational Training (INFP), nor the State Secretariat for Literacy.

Ultimately, this causal analysis should support the identification of specific actions aimed to reinforce the capacity of stakeholders to satisfy the elderly's needs. The analysis of all the results obtained from the 3 stages of this study should lead to prospects that are relevant and adapted to the reality of the 50-year-plus population in the country. The major challenge will be to develop them according to resources that can be mobilized in the communities in order to effectively fulfill the basic rights of this social category.

Summary

The results of this qualitative survey show that few of the elderly's rights are completely recognized in Haiti. The majority of the participants complain not to be able to satisfy their primary needs. The more critical aspects of the precariousness of their situation appertain to issues of social security (income, health) and education. Let's take as an example the inexistence of public policy related to the elderly's health, as well as weak measures aiming at reducing the illiteracy rate, which is considerable in this category. From their standpoint, their low level of education undergirds all their misfortunes. Moreover, the concept of social security meant nothing to them.

Lastly, the causal analysis made it possible to identify and classify the causes of the problems confronted by this segment of the population. A good share of the causes identified by the participants is of a structural nature. **Consequently, the fulfillment of the elderly's rights would imply, essentially, the implementation of structural changes and the development of social policies to guarantee access to the quality services which this subgroup of the society is entitled to, on an equal footing with the other groups**.

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GENERAL CONCLUSION

PROSPECTS FOR FUTURE ACTION

By Judite BLANC and Phygelle OBAS

This analysis of the situation of people older than 50 years in Haiti allowed us to ring the alarm bell on the condition of a segment of the population, of which the essential rights are hardly recognized. The elderly's exposure to financial insecurity or poverty, which was exposed in our work, shows how large the gap is between the fact of having rights and that of being able to enjoy those rights, between the existence of laws and their effectiveness, between the normative ideal and the sad reality.

Throughout this study's three moments, a common point emerged from our observations of the stakeholders, the beneficiaries older than 50 years, and of the younger generation: **a quasi-total absence of public and social policies aiming at the satisfaction of the elderly's needs in the urban and rural areas we visited**, which included 6 departments of the national territory. Social security[39] covers only a tiny minority of the population interviewed, according to data from the National Office of Old-Age Insurance *(Office National d'Assurance-Vieillesse,* ONA) and the Ministry of Public Health and Population *(Ministère de la Santé Publique et de la Population, MSPP*). In November 2012, **274.291 formal sector workers paid a monthly contribution worth 12% of their wages to ONA, which has 1700 employees; however, less than 3000 people received a retirement pension from that institution**. A majority of working people support the pension of a minority of non-working ones, without the guarantee that in the future, they will be able to enjoy the same privilege, considering the conditions imposed by ONA's retirement systems. **Hardly 3% of interviewed individuals older than 50 years would benefit from retirement income**. In regard with public health policies, MSPP's authorities did mention programs in favor of children, pregnant women and HIV-infected people. However, not one single allusion was made about possible programs intended for the elderly. Same story for the public or private medical institutions we visited, where geriatric services were non-existent. The majority of beneficiaries (63% in urban areas and 62.4% in rural areas) had access to essential medical care only sometimes. While more than 80% of quantitative survey participants were not covered for diseases, mainly those from rural areas (more than 90%).

This absence of social coverage would cause the number of older workers in the labor market to swell, particularly in the informal sector (small-scale trades, agriculture, etc.). In some cases, they represented a resource for members of their family, such as small grandchildren.

[39] According to the International Labor Organization (ILO), the concept of social security encompasses 2 dimensions: "income security" and "access to medical care".

Moreover, regarding institutions of the Haitian education system, in this case the Ministry of National Education and Vocational Training (MENFP) and its entities, namely the National Institute of Vocational training (INFP) and the State Secretariat for Literacy (SEA), a number of authorities had not even condescended to grant our requests for a meeting. Within the SEA, statistics on people older than 50 years surveyed were not archived because it was not in their habit to do so. It should be noted that there was an issue about data validity in the case of many public entities targeted in this study, such as the Ministry of Social Affairs and Labor (MAST), the Institute for Social Welfare and Research (IBESR), and the Social Assistance Fund (CAS), to name only those.

Among the participants touched by questionnaire or in the focus groups, more than half of the subjects (50.6%), particularly women (60% of the group), have never been schooled. Progress in literacy concerned mainly the younger generations.

Admittedly, to a large extent, our surveys, then our causal analysis of the precariousness of the living conditions of those aged at least 50 years whom we interviewed, allowed us to bring up problems of a structural nature. Nevertheless, we must also consider the interaction of structural aspects and cultural factors. Thus, in both the quantitative survey and the focus groups, a number of subjects (75.7%) indicate they don't use health services for lack of economic means, and that they have recourse to traditional medicine when needed. In focus groups, others did not hide their preference for this traditional medicine, presumably because of better results compared to modern medicine. Still in the focus groups, participants admitted that their education was less important than the need to fulfill the primary needs of their children. Moreover, for another category, not frequenting literacy programs would be related to the fear of stigmatization by the literate.

In the end, we must also stress out that issues of intergenerational relations raised in the focus groups were marked on both sides by a minimization of the elderly's roles or value Haiti's social fabric. Efforts to fully integrate this group imply indeed, and above all, that the various actors within the social life take a new look on this segment of the population.

Prospects and Recommendations

In terms of prospects and recommendations, a close cooperation between HelpAge International, the Haitian government and all policymakers and other actors remain a crucial strategy, inasmuch as the organization aims at a comprehensive, nationwide response. Accordingly, based on our study's conclusions a strategic choice articulated around two main, non-mutually exclusive axes **(Advocacy and Implementation of targeted programs)** could lead to effective results. HelpAge International and any organization with a mission to improve the liv-

ing conditions of Haiti's elderly should, in their plan of action, emphasize the urgency of implementing crucial reforms and new ideas in Haiti's Social Security/Protection system.

Advocacy

Restructuring the Social Security and Social Protection system

1. An ongoing collaboration with the Haitian **Government** and **Parliament**, drawing their attention to the issue of the elderly's living conditions, in order to strengthen the State's service providers and promulgate new laws that take into account the needs of this category of the Haitian society, as is done in developed countries and a few developing regions.

2. For pension plans to effectively impact the standard of living of the elderly, it is capital that policymakers, the Haitian legislator in particular, and the Ministry of Social Affairs and Labor (MAST) consider the question of restructuring of our contributive retirement system, of which the National Office of Old-Age Insurance (ONA) is a cornerstone. According to the data collected, this entity does not yet have the means to fulfill its mission, which boils down to improving the elderly's living conditions in Haiti. A vast majority of non-working individuals and workers who reached the age of retirement[40], all from underprivileged social sectors, are not covered by this system of pension. This contributive system touches only a minority of formal sector workers, from the public sector and large companies, for example. Consequently, to reform the retirement system in a low-income country like Haiti boils down in priority to fighting poverty among the elderly and in the whole country. Given the weight of the informal sector in the Haitian economy, as recommended by the International Labor Organization (ILO, 2010), the implementation of a non-contributive social security system would contribute to reducing poverty; at the same time, to a certain extent, it would contribute to improving the significant limitations of the current social coverage. "The innovations that are most promising and likely to help offset the absence of coverage are money transfer regimes, with or without conditions. These are social assistance regimes financed by taxation". Examples are programs like *Bolsa Familia* in Brazil*, Opportunidades* in Mexico, social assistance benefits in South Africa, and rare universal retirement plans in countries such as Namibia, Nepal, Botswana, etc. (International Labor Organization, 2010; Dupuis et al., 2011). The publications reported by Dupuis et al. (2011) assert that so-

[40] 55 years for Haiti, but after 60 in many other foreign countries.

cial pensions would play a major role in the fight against the elderly's poverty in developing countries. In Haiti, the gap between the poorest and the richest is very wide, since 10% of the richest receive 50% of national income (ILO, 2010). Based on this observation, in order to **achieve an equitable distribution of wealth** a portion of the financing of **a non-contributive social security system in Haiti could rest on a tax levied on this minority of rich persons who take in a substantial share of national income**. Recently, in 2008, a similar measure was implemented in Bolivia. With the most recent retirement reform instituted by president Evo Morales, Bolivians aged 60 years and more receive a universal allowance (worth two fifths of the minimum wage) financed with a tax on Hydrocarbons (Perez, 2008)[41]. However, we must stress questions triggered by the funding formula as well as the viability of retirement systems reform in developing countries. From this point of view, Box 3 presents the position of an expert, Robert Holzmann of the World Bank, who recommends, in a context of retirement reform, adopting a multi-tiered system financed on a pay-as-you-go basis as well as a defined-benefit basis. Lastly, the implementation of non-contributive pensions in low-income countries was proposed not only by the above mentioned international organizations (Dupuis et al., 2011), but also by the humanitarian organization HelpAge International, which advocates for the improvement of the elderly's living conditions in the world (HelpAge International, 2004).

Box 3: Retirement reform

Retirement reform: the World Bank approach[42]

Robert Holzmann*, the World Bank, Washington, D.C.

Indeed, no pension reform can be Pareto-optimal for, even if future generations on the whole will be better-off at a certain point in time, someone's consumption will suffer from whatever the reform. However, a reform inspired from a multi-tiered system is likely to draw positive social consequences.

I would argue that the multi-tiered approach has several distinct advantages. First, it

[41] http://www.legrandsoir.info/En-Bolivie-Evo-Morales-instaure-une-rente-universelle-des-60.html

[42] http://siteresources.worldbank.org/SOCIALPROTECTION/Resources/SP-Discussion-papers/Pensions-DP/9807French.pdf

allows for a distinction between the poverty reduction goal and that of compensating for lost income. Then, it builds risk diversification into a country's provisions aimed to support retirement income. Another benefit is that it minimizes the fiscal burden of the transition while preserving the economic gains of the system totally through capitalization. Finally, it brings to the reform debate obvious gains for younger workers and for those who are hit by globalization.

First, the multi-tiered approach allows a reforming country to delineate between poverty reduction and income replacement goals. The former goal can be achieved through relatively limited pay-as-you-go (PAYG) schemes or through social assistance benefits funded by the government budget. The latter goal can come from a mandatory retirement system funded with contribution rates of, say, 10 to 13 percent. Unfortunately, thus far most reforming countries have chosen to target relatively high replacement rates, thus leaving to the PAYG scheme the dual responsibility of poverty reduction and income replacement.

The main advantage of a multi-tiered pension scheme actually lies in risk diversification. Not all of the population's retirement portfolio will be held hostage to political and demographic risks, if only because the PAYG system no longer weighs so heavily on the country's public finances. As emphasized above, almost all of the questions related to prudential regulation, to capital market development, and to market fluctuations also emerge with a multi-tiered approach, and require answers. But because it is only one factor among others, the funded component can operate with fewer governmental constraints on long-run investment options available to contributors.

More importantly, the multi-tiered approach recognizes that countries face a variety of risks over the long term, and that no single one instrument can fully anticipate all those risks. In fact, some non-systemic risks, such as natural or financial disasters, cannot be diversified away at all.

In strictly economic terms, a portfolio of pension assets (PAYG) and financial assets (funded by capitalization) can increase social welfare because it allows for the reduction of the risk of income loss. While financial assets are internationally highly correlated, this is true of neither domestic wages nor national and international financial markets. As a result, a multi-tiered system provides a better risk/return balance than a single-tiered system, even if it is an international financial portfolio (and even if we ignore the exchange rate risk). The appendix provides calculations showing that it is better not to put all of one's eggs into one basket, even if it is an international basket.

For a theoretical argument of this issue, see Merton et al. (1987) and Dutta et al. (1999). For an additional empirical illustration, similar to the data in the appendix, see Boldrin et al. (1999). ISSA – International Social Security Review 1/00 13.

One of the other major advantages of the multi-tiered approach lies in a net reduction of transition problems. Modeling indicates that, for most countries examined so far (Latvia, Hungary, Poland, Croatia and Mongolia), some sensible reforms of the PAYG system, such as raising the retirement age, are enough after a decade of transition to free up space for the implementation of a sizable funded component. The combination of the proceeds from privatization and a modest debt financing can fill the deficit in the first 10 years. In some of these countries, the transition benefits from a temporarily favorable demographic situation, which, however, will not continue.

The multi-tiered approach provides most of the economic gains typically associated with funded systems. Alhough some of the implicit pension debt, by becoming explicit, demands repayment, this is offset by the benefits of reducing distortions in the labor market and by more efficient financial markets and, perhaps, by higher total savings. **Pension reform also creates parallel reforms in broader economic areas, such as macroeconomic stabilization, public sector reform and improvement of public institutions.**

The multi-tiered approach also offers the younger generations the prospect of a relatively high return on some of their contributions. In Hungary, this factor was decisive and helped break the political barrier and reform the PAYG system. Things that, alone, were not possible became possible within a larger package that included a funded component. The same trend is currently observed in Poland.

The multi-tiered approach is finally a way to control implicitly fears about globalization. Most people derive their income from work and are mostly interested in high wages and job security. Information highlighting the disadvantages of pursuing these objectives, or of a high taxation of capital, is usually ignored. The transition to funded pensions opens prospects for the population, encouraging them to understand the role of capital and its performance. This is a particularly critical step in a world where workers think they are suffering from the negative impact of globalization on their wages, but may not fully appreciate its positive consequences in terms of the efficiency of the overall economy (Holzmann, 1997b).

3. Reform of the public health system

In the public health policy of the Ministry of Public Health and Population *(Ministère de la Santé Publique et de la Population, MSPP)*, there is no mention of a publicly funded medical insurance scheme. The MSPP has identified **908 health institutions, including 278 public entities distributed throughout**

the national territory[43]. Although it was reported that healthcare becomes costly in the last years of an individual's life (Vézina, 2010), most of the elderly respondents did not have medical insurance. They had access to medical care necessary to their health only *sometimes*, because of economic difficulties. This led them to fall back on the use of medicinal plants. These findings could serve as a starting point for an awareness campaign with the MSPP and any other entity involved in the health area, to support this social category in their health policy the same way they do in the case of children, pregnant women and the PV-HIV. Restructuring the system of social security/social protection in Haiti cannot happen without reforming our system of health. For, if social security guarantees the *safety of incomes* to beneficiaries, access to the medical care must also be assured (ILO, 2010). Until the implementation of a State-sponsored medical coverage mechanism in favor of all impoverished people, a number of new or existing measures could provide the elderly with access to necessary medical care. Here is a non-exhaustive list:

- In the medical facilities, exemption offered to the elderly patients who are unable to pay for the care (consultation, drug, etc.).
- Training of personnel specialized in geriatrics.
- Promotion of vaccination programs in favor of adults on a preventive basis.
- Implementation of public awareness campaigns in order to undermine the inappropriate use of medicines by the elderly (self-treatment), as well as the use of drugs (alcohol, tranquillizers, etc.).
- Construction of more primary care centers in the communities in order to reduce distance-related difficulties.
- Elaboration of health education programs for the elderly in order to establish the limits between traditional medicine (consultation of traditional healers), beliefs and practices (consultation of Vodou priests/priestesses) and contemporary medicine.
- The government and/or the private sector could set up a system of scholarship in geriatrics and in gerontology for medical students, as well as students in the Social Sciences, in order to achieve a better comprehension of problems related to ageing and its support.

[43] Data gathered from the sanitation survey presented in this document.

- Outline and implement projects of construction of latrines, as well as teaching how to use them, in rural zones where they are inexistent or of reduced accessibility.
- In areas where water from sources, from wells and rainwater are still utilized, ensure the accessibility of treated water or water treatment methods (Aquatab for example).
- Construction of public geriatric hospitals or creation of geriatric services in existing hospitals in order to better deal with frequent non-transmissible diseases among the elderly.

For the introduction of these aspects in the national health plan, advocacy with the MSPP could learn from the position of the World Health Organization (WHO), which emphasizes a systemic, holistic solution as regards health policy for the elderly, one of the determining factors of the *Active Ageing* principle. This concept encompasses several other factors from the individual's environment, his family and his country. Thus, "to promote active ageing requires that health systems adopt a conception of life as a whole that emphasizes health promotion, the prevention of diseases, equitable access to primary health care and quality long-term care" (WHO, 2002). In terms of health promotion, the goal would consist in enabling the elderly to play an active role in maintaining their health. And disease prevention activities would concern prevention and treatment of common diseases in the elderly: non-communicable diseases and injuries. The adoption of this philosophy could be relevant in the case of Haiti, given what little attention is granted to the elderly in public health policies, as well as the importance of cultural factors and traditional medicine for the health status of the population.

4. Working with the **Ministry of Agriculture, Natural Resources and Rural Development** *(Ministère de l'Agriculture, des Ressources Naturelles et du Développement Rural, MARNDR)* and the **Ministry of Commerce and Industry** *(Ministère du Commerce et de l'Industrie, MCI)* to better support professionals from **Agriculture, Food processing (Agribusiness), and Agro-industry**, offering special attention to those from rural areas. Agriculture represented the principal source of income in 14.2% of the cases of elderly interviewed.

5. Concerted actions with civil society organizations, as it were UN entities, and with NGOs campaigning for the respect of human rights, are essential. Starting with an awareness campaign with the media, the general public, and Haitian society on the fate of our elders in the Haitian environment, particularly regarding their vulnerability to risks and disasters.

SOCIAL ASSISTANCE PROGRAMS

1. The continuation of the policy to support existing local organizations supporting the elderly is important. Very limited in number, they are often short of resources, both financially and on the structural and organizational level. According to our observations, **they do not have the means of their mission**. The assistance they provide to the elderly in reality is far from satisfying the needs for this population, even targeted.

2. The establishment and strengthening of **microcredit programs specifically designed for this social category, which is very active in the informal economy, could have dramatic impact on its access to incomes**. For 26.6% of the subjects met in the field, small-scale trade was their primary source of income.

3. Finally, considering the high illiteracy rate among the elders noted at the national level and in this study, and its repercussions at the social and medical levels, any private or state initiative aiming at the education and training of this group should be supported.

This list of prospects could be longer, since the results of our research revealed that **public policies aimed to integrate and fulfill the elderly's needs in Haiti are still to be implemented**. We stop at these few guidelines while specifying that their execution requires structural rearrangements involving, in the process, **the intervention of the Haitian Government**.

To our knowledge, this study is one of the few, if not the only one that could draw as complete a diagnosis of the situation of the elderly in Haiti, three years after the most devastating disaster in the country's history. Therefore, it should pave the way for other studies on a larger scale, where all social strata and the country's 10 administrative departments would be truly well represented, in order to put at the disposal of social actors a wide range of sources of reliable data for policy direction with respect to the elderly in Haiti.

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