Inclusive data collection: identifying the needs, concerns and roles of older people

Learning from the experience of older people affected by the earthquake in Türkiye, 2023

HelpAge International

Contents

Introduction

Conflict and disaster-related emergencies disrupt both social and economic life, and test the resilience of individuals and communities. Older people are particularly affected because of their social and physical vulnerabilities, and a lack of support and protection in times of crisis. The challenge during emergencies goes beyond just protecting older people and ensuring that essential services meet their needs as part of emergency responses and recovery – it also involves recognising the diversity within this group, acknowledging their strengths, and utilising their experience to enhance emergency preparedness and reduce the impact of crises.

In many societies, older people have an important role as community connectors, teachers of traditional practices, and witnesses of previous emergency events. This can make older people's knowledge fundamental to emergency preparedness, response, and recovery. But if excluded from these phases, the benefits of older people's knowledge are lost.[1]

This document provides guidance for service providers responding to humanitarian emergencies. It emphasises the inclusion of older people in data collection so that they are not left behind by humanitarian interventions, and so that the wider population is not deprived of their experience and knowledge.

Section 1 provides information about the risks that older people face in emergency situations in order to inform service providers about what to look for when collecting data. Section 2 puts the case for gathering sex-, age-, and disability-disaggregated data (SADDD), and using the Washington Group Questions (WGQ) in all data collection (quantitative or qualitative). Section 3 looks at quantitative and qualitative data collection and includes a comprehensive list of sample quantitative and qualitative questions to help researchers with different backgrounds and skills. Finally, Section 4 of the guideline outlines useful approaches when collecting data, and tips for safe and inclusive research with older people.

Annex I is drawn from HelpAge International's *Older people in emergencies: Identifying and reducing risks* report (2012).

Background to this research

The catastrophic earthquake that struck Türkiye and Syria on 6 February 2023 left thousands dead and many more without shelter or livelihoods, exposing many to the freezing winter conditions. One of the main barriers identified at the start of HelpAge and its partner organisations' post-earthquake response was the absence of data on the situation of older people, especially older refugees, to inform projects and policies.

In 2024, the Refugees and Asylum Seekers Assistance and Solidarity (RASAS) Association conducted a study in Istanbul to assess the functionality of crisis-affected adults aged 50 years and above using SADDD and the Washington Group Short-Set (WG-SS) questions. A total of **853 individuals** participated in the study – **295 men** and **558 women.** Of these, 90 per cent were refugees (87 per cent Syrian and 3 per cent other nationalities) and the remaining 10 per cent were Turkish. The study aimed to identify the prevalence and distribution of functional difficulties across six core domains: **vision, hearing, mobility, cognition, self-care**, and **communication**.

Findings from the RASAS study provide critical insights into the real-life experiences and prevalence of functional difficulties experienced by older crisis-affected individuals in Türkiye. By employing SADDD and WG-SS tools, the research highlights the importance of inclusive data collection in identifying the specific needs and concerns of older people – ensuring they are supported in humanitarian response planning. The research also provides insight on further research areas and capacity strengthening in humanitarian sector to improve inclusive data collection.

This guideline was developed following HelpAge's Mainstreaming Age Inclusion in Humanitarian Interventions workshop in Ankara in July 2024. From the perspective of service providers the workshop discussed areas of concern for older people and the enablers and barriers around inclusion of older people in humanitarian interventions.

This guideline benefits from the RASAS survey as a strong example of SADDD and WG-SS use in a real-life emergency context. The guideline was finalised with feedback gathered from the participants of the Age Inclusive Projects workshop held in Ankara in May 2025 by Rawan Khoury (Global Humanitarian Age Inclusion Specialist, Jordan) and Çiğdem Tozlu (Age Inclusion Specialist, Türkiye). The document serves as a resource to help service providers include older people in their standard and targeted data collection.

Context

Risks faced by older people in emergencies

The specific health, nutrition, social protection, and water and sanitation hygiene (WASH) needs of older populations affected by emergencies have been long overlooked by humanitarian actors. In principle, older people may be recognised as a vulnerable group, but in practice, data about them is often not collected; humanitarian programmes are not tuned to meet their specific needs; they are minimally consulted in the planning and execution of humanitarian operations; and their capacity to be active participants in recovery and response is ignored.[2] Furthermore, available data may not demonstrate differences between age cohorts for older males and females concerning their various needs and concerns, and the ways that programmatic activities and services are received or delivered.[3]

Older people face a range of specific risks during emergencies, often exacerbated by pre-existing marginalisation and a general invisibility to humanitarian actors. Health conditions, social and economic disadvantages, and insufficient coverage of social protection mechanisms can hinder the ability of many older people to prepare for and adapt to emergency situations.[4] Protection risks include being unable to leave their homes or displacement camps, which increases their vulnerability to abuse and separation from their families or communities.

Older adults may be at greater risk of housing insecurity, with shelters often being physically inaccessible or lacking necessary gender separation. In terms of basic needs, older people may not be registered for food or non-food distributions, struggle to reach or navigate distribution points, and receive inappropriate or insufficient provisions. WASH services can be particularly challenging to access or use, thereby increasing older people's health risks. Older people are more susceptible to untreated malnutrition and face difficulties accessing appropriate health care and psychological support. And these risks can be amplified if the older person has caregiving responsibilities to meet.

In recovery phases, older people are frequently excluded from rehabilitation or livelihood programmes, limiting their ability to earn an income and rebuild their lives. These risks underscore the urgent need for inclusive emergency planning that recognises and addresses the unique vulnerabilities of older populations. It is important to include specific questions and sections in research and assessments on the inclusion of older people to avoid further harm, violence, abuse and neglect. Annex 1 demonstrates the risks concerning older people in emergency situations.

Tools for identifying older people's needs

Integrated use of SADDD and the WG-SS ensures that **humanitarian action is not only needs-based, but rights-based**, promoting dignity, equity, and inclusion for all, especially older people and persons with disabilities. By linking the WGQ and SADDD data to real needs, humanitarian actors can go beyond general assumptions and implement targeted, evidence-based, and inclusive responses — ensuring older persons and persons with disabilities are not left behind.

Sex-, age- and disability-disaggregated data

Good-quality data on ageing and older people reveals how age intersects with other vulnerabilities, such as disability and gender. It can demonstrate how the needs of various age cohorts differ, highlight their particular needs and concerns, and strengthen the ways that programme activities and services are received or delivered, subject to local conditions and policies. It is recommended that 10-year age cohorts, preferably starting at the age of 50 years, are embedded in qualitative and quantitative data collection.[5,6] Diversity in the local context is another aspect to keep in mind when identifying most-at-risk groups and making sure that their needs are not lost in the wider picture, such as stateless people, Roma communities, LGBTQI+ people, etc, and older people in these groups.

Systematically collecting SADDD significantly enhances an organisation's overall strength by enabling data-driven decision-making, promoting inclusivity, and ensuring programmes and services are tailored to the actual needs of diverse populations. This not only strengthens internal planning and resource allocation but also improves the organisation's ability to advocate effectively and represent the voices of marginalised or underrepresented groups with accuracy and credibility.

Applying a targeted methodology enables organisations to understand the demographic composition, profile, and number of older people with whom they are working.[7] It helps identify the specific needs and vulnerabilities of different population groups, ensuring that programmes do not overlook marginalised individuals. SADDD data collection enhances accountability, improves resource allocation, and supports evidence-based decision-making, ultimately leading to more impactful and inclusive humanitarian or development interventions.

SADDD helps us to ensure that we have the data to facilitate adaptive programming, helping us strengthen our programmes; reach the right people in a more inclusive way; increase older people's visibility with external audiences; and provide data for advocacy messaging.[8] Table 1 demonstrates how SADDD is calculated compared to the total population.

Table 1: Estimating the percentage of older people in the total population

Age	Female	Male	Other	Total
50-59	Total sum (% of total population)	Total sum (% of total population)	Total sum (% of total population)	Total sum

60-69	Total sum (% of total population)	Total sum (% of total population)	Total sum (% of total population)	Total sum
70-79	Total sum (% of total population)	Total sum (% of total population)	Total sum (% of total population)	Total sum
80+	Total sum (% of total population)	Total sum (% of total population)	Total sum (% of total population)	Total sum
Total	Total sum (% of total population)	Total sum (% of total population)	Total sum (% of total population)	Total sum

Washington Group Questions

Given that almost half of older people are classified as having at least one disability,[9] it is essential to collect data on disability wherever possible. The Washington Group Questions aim to identify limitations in carrying out basic activities most commonly found in a particular context, and which are most closely associated with social exclusion.[10] A practical and inclusive way of integrating disability in data collection is by using the set of simple Washington Group Short-Set (WG-SS) of questions about daily functions (there is also an extended set, see https://www.washingtongroup-disability.com/question-sets/). These questions have been adopted by the UN's Washington Group on Disability Statistics[11,12] and can help humanitarian actors analyse the intersecting dynamics of age, gender and disability (see Box 1 for the WG-SS and their coded answers).

Box 1. Washington Group Short Set of questions

1. Do you have difficulty seeing, even if wearing glasses?
2. Do you have difficulty hearing, even if using a hearing aid?
3. Do you have difficulty walking or climbing steps?
4. Do you have difficulty remembering or concentrating?
5. Do you have difficulty with self-care such as washing all over or dressing?
6. Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?

Answers:

0 – No, no difficulty

1 – Yes, some difficulty

2 – Yes, a lot of difficulty

3 – Cannot do at all

Questions should be asked at the individual level and only take 3-5 minutes to administer. Following standard best practices, any reporting of data collected using the WG-SS needs to clearly articulate how the questions were used — including the setting in which they were asked (e.g., during intake, surveys, or interviews); the mode of administration (e.g., self-reported, enumerator-led); the amount and type of information or explanation provided to respondents; any adaptations made to the wording, order, or format of the questions to suit the context or population; the age range of participants; and the cut-off point used to determine the level of difficulty experienced by respondents. In addition to this cut off, further data disaggregation by sex and age is strongly advised.

Post-earthquake SADDD: analysis and interpretation of older people's needs

The RASAS Association study in Istanbul surveyed participants on six core domains: vision, hearing, mobility, cognition, self-care, and communication. Findings showed that for older people overall (all age cohorts), the most affected areas were mobility (37 per cent) and self-care (39 per cent), followed by hearing (11 per cent). Vision, cognition, and communication difficulties were less common, each affecting only 2 per cent of the total sample (Table 1).

Table 2. Reported difficulty with functional domains, by gender (all older-age cohorts)

Domain	% Total	% Male	% Female
Mobility	37%	41%	35%
Self-care	39%	45%	35%
Hearing	11%	17%	8%
Vision	2%	4%	1%
Cognition	2%	3%	1%
Communication	2%	4%	2%

The survey also revealed that **53 per cent of all participants reported at least one significant functional difficulty** (Table 2), with difficulty increasing consistently with age. Among males, 59 per cent reported functional limitations, compared to 50 per cent of females. This indicates that men were more likely to report difficulties than women across nearly all domains. This is a notable finding, as it contrasts with common global patterns where older women often report higher disability rates. This contrast indicates the need for further research (such as a barriers assessment) but possible interpretations in this context could include:

- Gendered roles may cause **underreporting by women** (due to normalisation of hardship or stigma),
- **Men may be more affected by chronic conditions or occupational injuries**, especially in refugee or displaced populations.
- **Sample composition** (age distributions, health backgrounds) may skew results.

Additionally, the dataset reports considerably lower difficulty rates in vision and cognition than indicated by recent profiling research conducted in Türkiye with Turkish nationals (as opposed to refugees).[13] While these differences may be the product of the different groups sampled, there is a need for further research to elaborate more on the difference in reporting difficulty in these domains. Possible reasons can be different survey instruments or wording, cultural perceptions and reporting bias, sampling differences, threshold differences, interpretation differences or enumerator errors.

Table 3. Functionality by age cohort and gender

% Functionality (overall) At least one domain with 'a lot' or 'cannot do' (coded as 2 or 3)	50-59			60-69			70-79			80-89			90-99			Total		
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
VISION	3	1	4	6	3	9	1	0	1	1	1	2	1	0	1	**12**	**5**	**17**
Percentage (vision)	*2%*	*0%*	*1%*	*6%*	*2%*	*3%*	*3%*	*0%*	*1%*	*10%*	*25%*	*14%*	*100%*	_	*100%*	**4%**	**1%**	**2%**
HEARING	9	11	20	21	25	46	14	6	20	4	4	8	1	0	1	**46**	**95**	**122**
Percentage (hearing)	*7%*	*3%*	*4%*	*19%*	*16%*	*17%*	*36%*	*18%*	*28%*	*40%*	*100%*	*57%*	*100%*	_	*100%*	**17%**	**8%**	**11%**
MOBILITY	39	102	141	52	69	121	22	20	42	8	4	12	1	0	1	**122**	**195**	**317**
Percentage (mobility)	*29%*	*28%*	*28%*	*48%*	*44%*	*45%*	*56%*	*61%*	*58%*	*80%*	*100%*	*86%*	*100%*	_	*100%*	**41%**	**35%**	**37%**
COGNITION	0	2	2	4	3	7	3	1	4	2	1	3	1	0	1	**10**	**7**	**17**
Percentage (cognition)	*0%*	*1%*	*0%*	*4%*	*2%*	*3%*	*8%*	*3%*	*6%*	*20%*	*25%*	*21%*	*100%*	_	*100%*	**3%**	**1%**	**2%**
SELF-CARE	45	92	137	57	80	137	22	20	42	8	4	12	1	0	1	**196**	**329**	**12**
Percentage (self-care)	*33%*	*25%*	*27%*	*52%*	*51%*	*52%*	*56%*	*61%*	*58%*	*80%*	*100%*	*86%*	*100%*	_	*100%*	**45%**	**35%**	**39%**
COMMUNICATIONS	2	2	4	5	3	8	2	3	5	2	1	3	1	0	1	**12**	**9**	**21**
Percentage (communications)	*1%*	*1%*	*1%*	*5%*	*2%*	*3%*	*5%*	*9%*	*7%*	*20%*	*25%*	*21%*	*100%*	_	*100%*	**4%**	**2%**	**2%**
OVERALL	**61**	**149**	**210**	**73**	**105**	**178**	**31**	**22**	**53**	**8**	**4**	**12**	**1**	**0**	1	**330**	**529**	**346**
Percentage (overall)	***45%***	***41%***	***42%***	***67%***	***67%***	***67%***	***79%***	***67%***	***74%***	***80%***	***100%***	***86%***	***100%***	_	***100%***	**59%**	**50%**	**53%**
Total sample	136	364	500	109	157	266	39	33	72	10	4	14	1	0	1	295	558	853

Notes: Functional difficulty was defined as reporting "a lot of difficulty" or "cannot do at all" in at least one of these domains; due to small sample sizes, data for age groups 80-89 and 90+ years are not representative. is

Table 2 also shows, when disaggregated by older-age cohort group, a stark increase in functional limitations in older cohorts. Among participants aged 50–59 years, only 42 per cent reported significant difficulty, while this increased to 67 per cent in the 60–69 age group, and 74 per cent in the 70–79 age group. While the data is not representative for the 80-89 and 90+ age groups, the progression clearly demonstrates that age is a strong predictor of functional decline.

Gender disparities were particularly notable in the mobility, self-care, and hearing domains, where men reported substantially higher levels of difficulty than women. For example, 41 per cent of men had difficulty with mobility compared to 35 per cent of women. Similarly, self-care difficulties were reported by 45 per cent of men compared to 35 per cent of women. These findings may reflect gendered health outcomes, occupational histories, or differences in care-seeking behaviour among older male and female populations.

In conclusion, the study provides critical insights into the needs of older adults who are either displaced or members of host communities. More than half of the population aged over 50 years experiences at least one significant functional limitation, with older age groups disproportionately affected. These findings underscore the urgent need for inclusive, age- and gender-sensitive health, rehabilitation, and accessibility interventions, especially focused on mobility and self-care support. Tailored services and proactive screening can help mitigate the risks of isolation, dependency, and diminished quality of life among older adults in refugee and low-resource settings.

Examples of how data can be used to inform emergency response

- Prioritise inclusion of older people in humanitarian planning.
  → With 53 per cent of individuals aged over 50 years reporting at least one functional difficulty, older adults must be recognised as a priority group in all sectors – health, protection, shelter, and food security.
- Ensure age and disability-inclusive health services.
  → High rates difficulty with mobility (37 per cent) and self-care (39 per cent) indicate the need for accessible health services, home visits, and rehabilitation support within refugee and host settings.
- Ensure all programmes are informed by data disaggregated by age, sex, and disability.
  → This dataset shows that older age groups experience more difficulty, reinforcing the importance of collecting and using disaggregated data to avoid excluding high-risk subgroups. The dataset also revealed that men report more difficulty than women.

SADDD may reveal underlying under-reporting, so groups that seem to have lower reporting rates should be screened for the possible skewing because of gender/norms.

- Adapt shelter and site infrastructure for accessibility.
  → Given that over 37 per cent of people over the age of 60 years face mobility challenges, humanitarian shelters and public infrastructure (toilets, entrances, waiting areas etc) should be physically accessible.
- Integrate functional assessments into protection and case management.
  → Use the WG-SS tool as part of protection screening to identify individuals who need referrals to services like personal care, assistive devices, or psychosocial support.
- Plan for targeted cash and food assistance for people with functional limitations.
  → Individuals with self-care difficulties (especially 45 per cent of men) may have reduced capacity to cook, shop, or collect aid – cash or food assistance should consider their accessibility needs.
- Deploy outreach and mobile teams for those with limited mobility.
  → Older adults with mobility and hearing difficulties may be unable to reach services – mobile units or community health volunteers should reach them in homes or informal settlements.
- Include older refugees in mental health and psychosocial support (MHPSS) services.
  → While cognitive and communication difficulties are less common than other functional difficulties, they still affect a vulnerable group, indicating the need for inclusive MHPSS programming.
- Inform preparedness and contingency planning.
  → With functional difficulty increasing with age, emergency plans should account for support to immobile or dependent older persons in evacuations and crisis response.
- Support inclusive, community-based protection mechanisms.
  → High rates of functional difficulty can lead to social isolation and increased risk of neglect or abuse – community protection mechanisms must monitor and include older persons.
- Advocate for donor and partner commitment to disability inclusion.
  → This data provides evidence-based justification for funding and designing interventions that are compliant with the Humanitarian Inclusion Standards for Older People and people with Disabilities; Core Humanitarian Principles; and the UNHCR Age, Gender and Diversity Approach.

Quantitative and qualitative data in the post-earthquake context, Turkey

Quantitative research for a needs analysis, Türkiye

Quantitative research are typically conducted with numerical data and analysed using statistical means. This method is suitable for studies involving large sample groups, using data collection techniques such as surveys, tests, or measurement tools. Quantitative research can also collect a large amount of data in a short time period. In the humanitarian sector, quantitative methods are often used in needs analysis, barrier and impact assessments, profiling research, gender analysis, baseline–endline surveys, and household

surveys etc. Box 2 provides an example of quantitative data-collection from the post-earthquake context in Türkiye.

Box 2. Needs analysis: Older people in the earthquake-affected Adıyaman, Hatay, Kahramanmaras and Malatya provinces, Türkiye [14]

In February 2023, a series of devastating earthquakes struck South-Eastern Türkiye, leaving a trail of destruction and displacement. An urgent humanitarian effort was required to provide shelter and assistance to the affected population. Millions of individuals, from both local and migrant populations, were compelled to seek shelter in both formal sites and informal settlements, significantly straining the region's existing infrastructure and resources. Amidst this complex landscape of recovery, it became evident that a comprehensive protection needs assessment was crucial to identify the specific vulnerabilities of older people in the region.

The International Organisation for Migration (IOM) conducted research on older people in the four most-affected provinces. The assessment aimed to encompass a diverse population, reaching older people from both local and migrant communities that were adversely affected by the earthquakes. Their assessment was based on a mixed-method of desk review, field mapping and quantitative surveys. By reviewing previous studies and conducting field-mapping surveys, the assessment employed a random household screening method to locate a representative sample of the target group among local and migrant populations in the provinces of Adıyaman, Hatay, Kahramanmaras and Malatya. A total of 753 older people (384 Turkish nationals, 369 Syrian nationals) were surveyed between 21 June and 11 July 2023.

The assessment included questions to identify the specific risks that older people may face during emergency situations, such as access to food, suitable shelter and living conditions, clean water and drinking water, sanitation, hygiene products etc. Questions were also asked about any limitations in access to food, challenges to independent living in the emergency context, respondents' economic situation and coping mechanisms. By recognising the distinct circumstances and experiences of older people and their urgent need for humanitarian support, this assessment contributed to the design of inclusive and equitable humanitarian responses in earthquake-affected provinces.

Qualitative research for a stakeholder assessment, Türkiye

More in-depth qualitative methods aim to explore social phenomena, individual experiences, and impacts of emergencies. Using this method, researchers typically collect and analyse qualitative data such as written and audio testimonies, and images. Qualitative studies often involve small sample sizes and utilise flexible and open-ended data collection techniques (such as interviews, observations, and focus group discussions), focusing on exploring participants' experiences. Qualitative data is important in creating a complete picture of the situation and provides opportunities to allow for community engagement. Qualitative data gives insight about how the numbers gathered resonate in people's lives and provides the opportunity to double-check existing data. Box 3 provides an example of qualitative data collection from the post-earthquake context in Türkiye.

Box 3. Hatay province ageing- and disability-inclusion stakeholder assessment

Yardım Konvoyu Humanitarian Assistance, Solidarity and Development Association (under its Enhancing the Inclusion of Ageing and Disability, Mainstreaming Protection, and Establishing an Advocacy Network in Hatay project) conducted an ageing and disability-inclusion stakeholder assessment in Hatay centre and its districts. The assessment had two components: Self-Assessment Checklist on Disability and Ageing Inclusion for Civil Society Organisations; and Public and Private Sector Service Providers and Stakeholder Consultation Meetings.

In the first phase, Yardım Konvoyu released the online Self-Assessment Checklist with public, civil and private service providers. The 80 organisations invited were selected based on their relevance to the field prior to the earthquake; their local presence; diversity, migrant-inclusive ageing and disability efforts; and experience in working on disability- and ageing-inclusive protection and non-protection sectors in the post-earthquake context. A total of 45 organisations representing various sectors – including older people's associations (OPAs), organisations of people with disabilities (OPDs), older people's initiatives and organisations working on ageing and disability – responded to the Self-Assessment Checklist, providing a comprehensive perspective on their current standing in terms of ageing- and disability-inclusion through self-evaluation.

The Self-Assessment Checklist highlights the progress organisations have made in promoting inclusion, particularly for people with disabilities, while also revealing any significant gaps in addressing the needs of the older population. It draws attention to inequalities in information and resources between sectors – especially between protection and non-protection services – as well as among international, national, and local actors, and emphasises the need to target specific intervention domains (eg WASH, health etc).

In the second phase, two Stakeholder Consultation meetings were held with the 17 key stakeholders identified through the Self-Assessment Checklist that aimed to reflect local diversity and strengthen inclusion – prioritising civil society organisations founded, led, and/or represented by people with disabilities or caregivers from different disability groups, and taking into account refugee communities. These meetings focused on the growing challenges related to disability and ageing in the context of the Syrian crisis and the earthquake, exploring potential solutions and advocacy areas. The consultations also aimed to foster the development of an advocacy network among civil society organisations.

The Stakeholder Consultation Meetings provided a vital platform for dialogue, reflection, and collective learning among diverse civil society actors working on ageing and disability inclusion in the context of the Syrian crisis and the earthquake. By prioritising local representation, lived experience, and intersectionality, the sessions highlighted shared challenges, revealed unique community perspectives, and identified opportunities for more inclusive, coordinated advocacy. The active participation and insights of stakeholders demonstrated both the urgency and the potential for stronger, more equitable collaboration across sectors. As a key outcome, the meetings laid the groundwork for the formation of a sustainable advocacy network – anchored in local leadership and committed to advancing disability – and ageing-inclusive approaches in both protection and non-protection sectors.

Considerations when collecting data: an example from İzmir

Older people should actively participate at all stages of data collection, analysis, use and reporting, including in the development of surveys. It is always useful to conduct a stakeholder-mapping exercise before carrying out the research to identify if there are any community members or groups that can implement the survey. This will also enhance the outreach of the survey and build trust. It is, however, important to balance such an opportunity with data safety, safeguarding people of concern and ensuring data reliability.

Agency-led and **partner-led approaches** ensure direct, meaningful participation of people of concern to programmes. Local partners and community groups such as OPAs provide useful local resources for protection work, especially to help identify and reach the most vulnerable. Working in emergencies with local organisations and building or strengthening their capacities contributes greatly to the sustainability of activities. However, it must be remembered that gathering information related to protection issues requires specific skills and competencies. Never ask local partners to collect sensitive data if they have not been trained by protection staff and/or if you do not have the capacity to ensure proper monitoring.[15] Box 4 provides an example of an agency-led response in the post-earthquake context, Türkiye.

Box 4. İzmir – Age-friendly cities research[16]

Yaşlı Politikaları Derneği (YAPODER, The Association for Ageing Policies) carried out a research study in Bornova, a district that is part of a World Health Organization (WHO) initiative – the Global Network for Age-friendly Cities and Communities. This study involved 100 participants, all of whom are residents of Bornova and aged 65 years and over. Among the participants, 60 were women and 40 were men. In terms of education, 39 per cent of respondents were primary school graduates, 47 per cent had completed secondary school, and 14 per cent were university graduates. The findings from this study are viewed against WHO's guiding principles on age-friendly urban development.

The research aimed to understand the lived experiences of older residents in Bornova across several dimensions of city life. Participants were asked about the suitability of outdoor spaces and buildings for the use of older people; accessibility of transport systems; their awareness of Bornova Municipality's Healthy Ageing Centre; and which services they believe require improvement. Further questions explored the effectiveness of home-care services, opportunities for social interaction, and participation of older people in local decision-making processes. Other topics included the design suitability of their housing, their physical activity levels, satisfaction with cultural and artistic events provided by the municipality, and whether social facilities promote intergenerational engagement.

In conclusion, when assessed against WHO's criteria for age-friendly cities, Bornova was found to require development in all eight focus areas – community and healthcare; transport; housing; social participation; outdoor spaces and buildings; respect and social inclusion; civic participation and employment; communication and information. To address gaps, a range of recommendations was proposed, including increasing green and resting areas in public spaces, improving pavements for the safety of vulnerable groups, and establishing accessible and affordable public transport that fosters intergenerational connection. Furthermore, the development of

affordable housing suited to older people's use, expansion of social and cultural activities, and enhanced participation of older individuals in urban life – economically, socially, and politically – were seen as vital. Creating volunteer and paid work opportunities, improving communication strategies tailored to older populations, and expanding health services were also recommended to support healthy and active ageing in the district.

When conducting research involving older populations, particularly in diverse and vulnerable communities, it is crucial to adopt inclusive and sensitive approaches to ensure that the voices of all participants are heard, respected, and accurately represented. Older individuals, especially women and people with disabilities, often face unique challenges in expressing their needs and participating in traditional data-collection methods. By implementing measures such as conducting separate focus group discussions for older men and women, ensuring accessibility, and being mindful of cultural and health considerations, researchers can create an environment where older people feel valued and comfortable sharing their experiences. These practices not only promote inclusivity but also contribute to the collection of more accurate, nuanced data that reflects the diverse needs and capacities of older populations. Furthermore, fostering a respectful and open atmosphere, where active listening is prioritised, allows older participants to feel more empowered and encourages their autonomy and independence. Ultimately, these measures are essential for ensuring that research is ethical, effective, and truly representative of all segments of the older population, leading to more informed and responsive policies and interventions.

Tips for safe and inclusive research

Before data collection

- Where information is sought from groups, ensure separate focus group discussions for older women and men.
- Ensure that you have female facilitators for the women's discussion and ideally male facilitators for the men's discussion.
- When scheduling meetings with individuals and groups, consideration should also be given to the time, day, and location to ensure that the timing is appropriate and the location is accessible.
- Do not consult men on women's behalf.
- Caregivers should not be consulted on behalf of people of concern unless the research is specifically designed to gather information on people who are not able to express themselves.
- Liaise with authorities, OPAs, OPDs, informal community groups of older people and other relevant parts of civil society to identify and invite older people and people with disabilities to participate in the consultation.
- Use snowballing to reach older people who might be homebound. If they are homebound yet able to express themselves, consult directly with them.
- Ensure that the consultation venue is accessible.
- Be aware of participants' health issues prior to the focus group discussion and be aware if some older people are wearing hearing aids.

During the data collection

- Practice active listening as it makes older people feel they are taken seriously, being respected, and being treated as a full human being. Active listening provides a basis for the autonomy and independence of older people, and it encourages older people to express themselves more openly while reducing feelings of fear, stress, and anxiety.
- Reduce background noise and be attentive to the surrounding environment to make sure that nothing can be overheard by passers-by.
- Make eye contact and speak clearly using short and clear and precise sentences with language they understand.
- Allow extra time for older people to answer.
- Stick to one topic and move to the next after completing the first to avoid confusion.
- Show respect: interviewers should be open-minded, non-judgmental, and aware of their own prejudices and biases so they can set them aside when meeting and interacting with older people.
- Be aware of the cultural context and anything else you may need to take into consideration (eg participants' care responsibilities, or safety measures for the specific location, curfews etc)

Conclusion

Ensuring the inclusion of older people in data collection, assessment and research, particularly in emergency and disaster contexts, is essential for creating more effective, ethical, and responsive interventions. Older individuals, particularly women and people with disabilities, hold valuable knowledge and experience that can significantly contribute to emergency preparedness, response, and recovery efforts. Excluding them from these processes not only limits the effectiveness of these interventions but deprives communities and decision-makers of critical insights.

By adopting inclusive research methods – such as separate focus group discussions, ensuring accessibility, and using disaggregated data – researchers can better understand the diverse needs and vulnerabilities of older populations. This approach fosters a more comprehensive and nuanced understanding of the challenges faced by older people and ensures their voices are heard, respected, and integrated into decision-making. Ultimately, prioritising the participation of older people in research strengthens the foundation for more inclusive and adaptive programming, leading to policies and interventions that are better aligned with the needs of all members of society.

Key takeaways

- **Older people in emergencies:** Older individuals are disproportionately affected by emergencies due to their social, physiological, and functional vulnerabilities, as well as inadequate preparedness and protection measures.
- **The value of older people's knowledge:** Older people serve as key community connectors, holders of traditional knowledge, and witnesses of past emergencies, making their involvement in emergency preparedness, response, and recovery crucial.
- **Inclusion in research and data collection:** It is essential to include specific questions addressing the needs and vulnerabilities of older people in research, ensuring that age, disability, and gender are accounted for in data collection and analysis.
- **Importance of SADDD:** Collecting sex-, age-, and disability disaggregated data is critical for understanding the demographic composition of older populations and ensuring that programmes are inclusive and adaptive to their specific needs.
- **Integrating disability in data collection:** Given the high prevalence of disability among older people, the inclusion of questions on disability – such as through the WG-SS – is vital for more inclusive programming and advocacy.
- **Value of quantitative research:** Quantitative research, using tools like surveys, enables large-scale analysis to identify trends and relationships between variables, helping to shape effective emergency programmes.
- **Value of qualitative research:** Qualitative research provides deeper insights into individual experiences and the lived realities of older people, helping to contextualise quantitative findings and engage the community.
- **Participatory approach:** Older people should be central to the assessment process, with their input taken seriously to identify their specific protection needs, ensuring a gender-balanced approach in focus group discussions.
- **Recognising existing coping mechanisms:** It is important to analyse the coping strategies older people have put in place to handle risks and abuses, identifying both positive and negative outcomes.
- **Avoiding exclusion of older people:** The exclusion of older people from decision-making processes results in the loss of valuable knowledge, undermining their autonomy and independence and affecting community well-being, creating an epistemic disadvantage that harms both the individuals and the community.
- **Inclusive research methods:** Conducting research with older people requires creating a respectful, open environment where their experiences and diverse needs are acknowledged, contributing to more effective and inclusive policies and interventions.

Annexes

Annex 1: Risks concerning older people in emergencies

Risks	Explanatory notes	Key actions
General concerns		
Worsening of pre-existing marginalisation and exclusion	The drive towards the market economy of a growing number of societies around the world, combined with the erosion of traditional social and cultural values, results in older people being marginalised and sometimes outright abandoned by families, communities and society at large. Contrary to common beliefs, older people are not always cared for by family and community: these patterns of discrimination may be accentuated in the drive for survival in humanitarian crises. When excluded by their own communities and families, older people may become isolated and be unaware that humanitarian assistance is available.	Before the crisis, undertake community-based preparedness activities that include the identification of older people living alone, the planning of outreach activities in case of an emergency, and the provision of mobility and adaptive aids. After the crisis, ensure that information on the impact of the disaster and on the humanitarian response and services is accessible to older people (taking into account any hearing or visual impairments) and is communicated in a way and in a language they understand. Ensure that older people have appropriate documentation to identify themselves to access both humanitarian and state-provided social services.
Invisibility to humanitarian actors	In principle, older people may be recognised as a vulnerable group. In practice, however: • data about them is often not collected; • humanitarian programmes are not tuned to meet their specific needs; • they are minimally consulted in the planning and execution of humanitarian operations; • their capacity to be active participants in recovery and response is ignored.	Collect assessment, registration and monitoring data disaggregated by age and sex, including ages 60-69, 70-79 and 80+ years. Document specific vulnerabilities faced by older people – who are living alone, caring for children, or are housebound etc. Support the creation of older people's committees, a well-established way of ensuring that old people's voices are heard. Identify older people as key resources.
Protection		

Not being able to leave home even if one wants to	Older people may be left behind as families are displaced by conflict or natural disasters – because they are unwilling or unable to travel or are left to guard family property and belongings. They remain without access to services and potentially become targets for armed groups (including security forces), bandits, mafia thugs or those seeking retaliation, but also are at risk of potential secondary impacts where they continue to stay after a natural disaster. At risk of being abandoned and isolated at the best of times, many older people have no one to turn to during emergencies.	Consider the following actions: • advocate and liaise with authorities, especially parties to armed conflict, to enable access for the most vulnerable who remain behind; • assist with transport and movement for the most vulnerable; • support family tracing and reunification for older people; • attend to older people arriving alone or with children at displacement reception centres; • increase focus on areas that are accessible but remain outside core displacement centres and camps where older people are likely to be; • integrate, involve, and prioritise older people in evacuation, preparedness and disaster risk reduction (DRR) plans and activities prior to crises.
Not being able to leave an internally displaced person's (IDP) or refugee camp even if one wants to	Older people may be left behind as families return – because they are unwilling or unable to travel, or because the family faces an uncertain future in terms of shelter and livelihood.	Consider the following actions: • monitor the return process, identify older people failing/struggling to return; • provide a comprehensive return package for older people; • build shelter in the area of return for isolated older people and those without family support; • provide agricultural/livelihood support, especially for older people caring for children. • provide transport; • assist communities to re-integrate older people.
Being separated from family or community	Isolation is possibly the most important factor in creating vulnerability. Older people find that the problems they face	Include older people in reunification and family tracing.

	are compounded by the fragmentation and dissolution of their families and communities. This may include the loss of the support mechanisms on which they had relied. Older women live longer and are more likely to be widowed and less likely to re-marry.	Train community workers to identify isolated older people. Integrate home-based care into programmes.
Being victim of abuse	Untested assumptions about the care and respect offered to older people, combined with the lack of consultation, create an environment in which serious abuses, such as rape, gender-based violence (GBV), prostitution, theft, and confinement of older people, go unseen and unchallenged.	Include older women in GBV prevention and response programmes. Recognise that older women may be both victims of abuse (sexual, physical, and mental) as well as perpetrators (e.g. female genital mutilation).
Having to care for children	If they were not doing so already before the crisis, many older people find themselves looking after young dependants whose parents are missing. Those who were already doing so before the crisis may find themselves suddenly having to care for many more.	Identify older care givers in assessments specifically including registration of older widows/single carers. Ensure that child protection programmes recognise the role of older carers and that support is extended to them as well as children. Ensure that information on child protection and services for children is communicated to older caregivers. Consult older caregivers on their priority needs and challenges in caring for young children post-crisis.
Having housing, land and property (HLP) rights ignored	In a "survival of the fittest" environment, the already difficult issue of HLP rights may become intractable if the rightsholder is an older person. Older widows are regularly the victims of discrimination and exclusion due to prevailing traditional beliefs, social norms and accepted cultural practices. Older people may lack legal documentation to	Provide legal and administrative support to older people to obtain documentation that may have been lost during a crisis and to regain possession of land or property. If such services are already available to younger people, make sure older people are included.

	prove ownership of land and assets.	
Being excluded by communal shelters	In some cases, such as in cyclone shelters, exclusion from communal shelters may represent a direct threat to personal survival.	Ensure older people's needs are considered in evacuation plans.
Food		
Not being registered for food distributions	If the registration of beneficiaries for food distributions does not include a systematic outreach process, older people may easily be excluded, as other, more mobile and vocal population groups are registered.	Ensure that data collected during the registration process is disaggregated by sex and age, including at least one "older people, 60+" category. Where possible, cross-check this against census data to identify discrepancies. Use outreach programmes (e.g. community health, home-based care) to reach unregistered older people and register them.
Having difficulties reaching the food distribution point or market	Older people find it difficult to access centralised relief and service delivery points because of the distances involved, poor mobility, or being confined to their homes because of the need to guard property, care for dependants, or through physical infirmity.	Hold distributions at locations that are physically accessible – for example, in central locations on level ground. Support older people with limited mobility to reach distributions.
Having difficulties at the food distribution point	If receiving a food ration requires, as is often the case, standing in a queue for a long time, in heat/rain with no shelter, water, etc, in the absence of separate queues for older people and the mobility-impaired, these groups may completely miss the distributions.	Set up a separate distribution line for older people and those with disabilities.
Having difficulties transporting the food back home	Dry rations at the food distribution points are generally handed out in bulk, as a stock for up to four weeks. For a single person, this means a load of many kilos, and may be difficult or impossible for an older, weaker	Set up a proxy collection system, where younger, able-bodied relatives or neighbours collect the food on the person's behalf. Information on the proxy person can be communicated either on the registration card or with the distributing agency to make sure the proxy can access the

	or mobility-compromised person to transport.	distribution and to avoid fraudulent collection of assistance. Arrange "home" delivery for the most vulnerable older people.
Not receiving an equal share of food within the family	Even when food reaches the household, it may be consumed in varying quantities by different members of the family. Older people are also apt to share their rations, especially with male household heads and children.	Introduce home visits to monitor that food intake by older people is sufficient for their nutritional and calorific needs. Consider hot meal distribution for older people. This will not change the cultural expectations for food distribution, but the provision of a hot meal is a guaranteed way to ensure that older people receive at least one meal a day.
Having inappropriate food	Older people may be unable to eat food rations because they have few teeth, cannot digest the food, have not eaten a particular food before, or cannot find cooking fuel. Furthermore, food ration content usually does not take account of the protein and micronutrient ratios needed by older people.	Advocate for World Food Programme (WFP) and other emergency food rations to include foods that are easier to chew and appropriate for older people. Ensure that the food rations are culturally and regionally appropriate. Provide fuel and cooking sets as an accompaniment to food distributions.
Non-food items (NFI)		
Not having enough warm clothes /blankets	Older people may find that circulatory problems make it harder for them to manage or endure cold temperatures. They may need extra layers of clothing or blankets compared to other adults.	Provide double sets of blankets and clothing to older people.
Not having culturally acceptable clothes	The cultural acceptability of clothing supplied in an emergency is likely to be a particular issue for older women, who may find it impossible to abandon traditional forms of dress.	Ensure that NFI packages for older people include traditional forms of dress. Introduce a system of distribution that involves proxy delivery to protect older women's dignity.
Not being included in NFI distribution lists	If the registration of beneficiaries for NFI distributions does not include a systematic outreach process, older people may easily be excluded, as other, more mobile and vocal population	Ensure that the data collected during the registration process is disaggregated by sex and age, including ages 60-69; 70-79 and 80+ years. If possible, cross-check this data with the overall census of

	groups are registered and aid agencies a) have the impression they have registered everybody and b) assume that older people will use the NFIs given to their families.	the beneficiary population looking for discrepancies. Use outreach programmes (e.g. community health, home-based care) to reach unregistered older people and register them.
Shelter		
Not being automatically given shelter by family	Older people whose family has lost a house must often find shelter by themselves, as younger members may think of their own needs first.	On the one hand, ensure that shelter projects, both temporary and permanent, consider older people as individual households. On the other hand, try to avoid fragmentation of extended multi-generation households.
Having inaccessible shelter	Temporary or rebuilt shelter made available by aid organisations may be inaccessible for mobility-impaired people. Simple things such as ramps, handrails, grab bars and lighting are often ignored in the design and construction of the dwellings. Even the entrance door to the dwelling can be too narrow or difficult to open.	Incorporate age-friendly features, following international guidelines on accessibility, into temporary shelters and latrines and into those being repaired or constructed to include ramps, handrails, grab bars and lighting. Ensure that there is sufficient space to enable dignified use of "assistance" for those needing help when using the toilet.
Having to sleep on cold, hard or damp surfaces	Chronic but manageable joint problems become acute and severely debilitating.	Recognise that people's mobility declines with age and adapt shelters accordingly. For instance, in camps or temporary shelters, sleeping on a mattress can make a substantial difference to older people's health. Raised beds are easier for older people to get in and out of. Provide mattresses as part of NFI packages.
Not having proper gender separation	Shelters do not offer gender separation, increasing the likelihood that older single women would not use them due to cultural prohibitions.	Ensure that, where families are being relocated into temporary shelters, gender-specific communal shelters exist for people on their own.
Being grouped with unknown people	For example, to make up the numbers required to qualify for shelter or for allocation of supplies. This can lead to	Ask for older people's preferences regarding placement in communal temporary shelters.

	problems of exclusion and abuse as the larger group rejects or resents the presence of the older people.	
WASH		
Not being included in water distribution schemes	Older people are at risk of being ignored when designing and building water distribution schemes.	Ensure that the data collected during the registration process is disaggregated by sex and age, including at least one "older people, 60+ years" category. If possible, cross-check this data with the overall census of the beneficiary population to spot discrepancies. Ensure representation by older men and women on water committees.
Having difficulties reaching water distribution points, wells or sources	Older people find it physically difficult to access water distribution points.	Establish community systems of water delivery to ensure that the housebound are provided with clean water daily. Work with shelter actors to design roofs so that rain run off can be collected in water butts/containers for washing and small-scale kitchen garden irrigation.
Having difficulties transporting water back home	The typical jerry can distributed as NFI in humanitarian operations is 20 litres, which mean it weighs 20 kilos and is impossible to hand carry by most older people.	Distribute smaller jerry cans – ideally 5 litres maximum – to older people who would otherwise be unable to collect large amounts of water in 20 litre jerry cans. Consider a proxy system of delivery to enable sufficient water to those who cannot transport it.
Having difficulties reaching sanitation facilities	Older people find it physically difficult to access latrines and other sanitation facilities.	In camp settings, when constructing new shelter or revitalising damaged shelter, be sure that latrines are built in close proximity to older people. In collective centres and camps, be sure that older people are allocated sites near water sources and latrines. Ensure that the pathway to the latrines is marked by string for

		those with visual disabilities and that it is flattened and smooth to facilitate accessibility for those with mobility challenges or those in wheelchairs.
Having difficulties using sanitation facilities	Latrines and other sanitation facilities made available by humanitarian stakeholders (including government) may be inaccessible for mobility-impaired people. Simple things such as ramps, handrails, grab bars and lighting are often ignored in the design and construction. Even the entrance door to the latrines can be too narrow or difficult to open.	Incorporate age-friendly features into temporary shelters and latrines and into those being repaired or constructed, including ramps, handrails, grab bars and lighting. Ensure that there is sufficient space to enable dignified use of "assistance" for those needing help when using the toilet.
Having difficulties disposing of waste	When mobility is a problem, waste can be disposed of immediately outside the dwelling and pile up in great quantities, becoming a health hazard.	Set up community support networks to help the housebound manage their waste. Also, work with local government or camp authorities to do this.
Nutrition		
Having malnutrition unchecked	Older people are never included in nutritional surveys and are rarely screened for malnutrition.	In displacement crises, organise the systematic screening of older people at reception centres using mid-upper-arm circumference (MUAC) tapes. In other cases, try to involve older people in nutritional surveys. Train community health workers to actively detect malnutrition in older people through a process of ongoing screening with MUAC tapes. In all cases, use more sensitive case definition.
Having malnutrition untreated	Selective feeding programmes for nutrition rehabilitation rarely include malnourished adults.	Include malnourished older people in supplementary and therapeutic feeding programmes. Community-based Management of Acute Malnutrition (CMAM) can be extended to older people. Train community health workers to identify and address acute

		malnutrition in older people, and to provide nutrition education. Ensure that severely malnourished older people are referred to the nearest hospital for assessment.
Health		
Being more subject to ill health or injury	Poor health and reduced mobility increase the risk of serious injury and illness in crisis situations. Even normal physical changes associated with ageing that may not greatly impair daily functioning, such as reduced mobility and failing eyesight, can become significantly disabling during an emergency.	Ensure that older people are included in health assessments. Ensure that mobility aids and adaptive devices that have been lost or damaged during the crisis are made urgently available to older people so that impairments do not become disabling.
Having difficulties accessing health services	Older people find it difficult to access centralised relief and service delivery points. Community-based health programmes often exclude older people. Financial accessibility might also be an issue for older people.	Use community health workers to identify older people who are unable to reach health posts and consider either providing home-based care or transport for referral to the health centre or the hospital. It is often necessary to make sure that someone accompanies older people. Train community health workers to provide health education on healthy ageing to older people, and train them in self-management of their chronic condition Promote free access for healthcare to older people: free hospitalisation, free consultation, free laboratory exams and free drugs, at primary and secondary levels.
Having inappropriate health services	When healthcare is accessed, it generally focuses almost exclusively on communicable diseases, for which older people are at increased risk. However, non-communicable, chronic diseases, which are the main concern for older people, are rarely considered.	Ensure that emergency health kits include medication to treat chronic illness, especially high blood pressure, diabetes and hypertension. Ensure that older people are identified as at higher risk for

		communicable diseases particularly when there is an outbreak. Palliative care should be considered in order to allow older people to die in dignity. Ensure that appropriate mobility aids and adaptive devices (such as spectacles and hearing aids) are provided during the initial days of the response to avoid creating disabilities out of impairments.
Having difficulties accessing psychological support	The loss of their worldly possessions is a psychological shock. Loss of children, relatives and friends is a big trial. Rebuilding is a slow and painstaking process. Very little psychological support is available to older people.	Include older people in psychosocial activities. Explore ways to increase intergenerational and community support. Include opportunities for older people to engage in cultural rituals, such as puja and funerals, to enable grieving and initiate the process of emotional recovery and closure.
Recovery		
Being excluded from rehabilitation and livelihood projects	Older people are excluded, often systematically, from rehabilitation programmes such as the distribution of seeds and tools, cash and food for work, micro-credit, cash transfers and skills training. Even when older people organise their own projects, they find it difficult to source funds or other inputs.	Ensure that the data collected during the registration process for rehabilitation/livelihoods activities is disaggregated by sex and age, including at least one "older people, 60+ years" category. If possible, cross-check this data with the overall census of the beneficiary population looking for discrepancies. Advocate with communities and humanitarian actors to help them recognise the contributions older people can make.
Not being able to earn a living	Producing an income can be exceedingly difficult in crisis situations, and few countries affected by humanitarian crises have old age pension schemes to begin with.	Help older people access social protection mechanisms (old age pension, disability allowance, widows' pension), particularly through legal and administrative support.

Source: HelpAge International, 2012. *Older People in Emergencies: Identifying and Reducing Risks*

Annex 2: Sample research questions

The following are sample research questions intended to support humanitarian actors in identifying the needs, capacities, roles, and concerns of older people in displacement and crisis-affected settings. These questions serve as a general framework and are not designed for direct use without modification. To ensure cultural relevance and effectiveness, the wording of each question should be carefully localised, based on the context, language, and sensitivities of the target population.

Similarly, response formats – such as multiple-choice options or open-ended prompts – should be adjusted to reflect local realities, literacy levels, and social norms. Researchers and practitioners are encouraged to select and adapt only the most relevant and appropriate questions for their specific assessment objectives, ensuring they align with the humanitarian principles of dignity, inclusion, and meaningful participation.

Demographics

- What is your marital status (married, divorced, widowed, single)?
- What level of education do you have?
- How many people live in your household (i.e. are living with you)?
- Household composition:
    - **Total number of household members: _____**
    - **Number of children (under 18): _____**
    - **Number of older people (60-79 and 80+): _____**

Protection

- Do you live alone? Or, With whom do you live? (Alone; with spouse; with spouse and children; with son/daughter-in-law, with daughter/son-in-law and grandchildren; other older people (siblings, friends), other).
- Are you head of the household? Or, What is your role in the household?
- Do you look after children? (Yes/no)
- How often do you look after your grandchild, or someone else? (Sometimes; every day; every weekday; a few days a week; at the weekend)
- Do you have a regular role in your household? (Yes/no)
- If yes, what is your responsibility in the household? (Caring for grandchildren, caring for and supporting sick/disabled family members, managing the home, watching/cleaning the home, other)
- Is the care responsibility physically or mentally challenging for you? (Yes/no)
- Is somebody taking care of you? Helping you? (Yes/no)
- What is your preferred way to receive humanitarian assistance? Or, What would be your preferred way to receive basic needs assistance? Cash, or distribution of materials? Why?
- Do you think humanitarian assistance is provided in a fair and adequate manner to vulnerable groups, including people with disabilities, older people, women? (Yes/No) Why?

- What do you think are effective measures to make humanitarian assistance more inclusive, e.g. should they be more accessible for certain groups like women, people with disabilities, older people?
- Have you had any problems that made you feel unsafe or at risk for the past year?
    - If yes, what are the most important issues that concern you about your safety inside or outside the living space?
    - Is a particular group in the community affected by this problem more than others (e.g. women, men, people living with disabilities, widows, those living alone)?
- Are there specific safety measures or support systems that you think would improve your sense of security?
- What do you know about the violence, abuse and neglect among the older people in your community? Do you think violence against and neglect of older people is common in your community? Have you witnessed or heard any incidents? Do you think there are (or know of) groups of older people that are more at risk of violence and neglect in your community?
- Do you feel that the support you receive is tailored to meet the specific needs of older people? (Yes/no)
- Are you able to meet your basic needs (e.g., food, shelter, healthcare) without external support? (Yes/no)
- Are there any challenges for older people that cause them to have limited access to basic needs? (E.g., food, shelter, clothing, heat, water, etc)?
- Do you have freedom of speech and expression within the household (do your relatives consult you in family issues)? (Yes/no)
- Do you experience discrimination within the household? (Yes/no)
- Have you ever faced an abuse or rights violation that undermined your dignity? (Yes/no)
- Can you leave your home alone? (Yes/no/no answer)
- If no, why? (E.g., my health does not let me leave the home, I have full-time responsibilities, I am not allowed, it is not safe, other)
- What are the three most important concerns to you at present? (Select three options: food, shelter, clothing, health, psycho-social support, income, social cohesion, other)
- If there were one thing that would help you have a better life, what would that be?
- Do you feel alone at home? (Yes/no/no answer)
- How do you socialise? (I don't have the opportunity to socialise, people visit me at my home, visit neighbours, attend older people's social centres, attend other community centres, other)
- Do you have someone that you can ask for help in emergency situations? (Yes/no)
- Do you feel safe at home (or, in your current living environment)? (Yes/no/no answer)
- What is your preferred living arrangement in later years? (I would go to a care home; I would live with my son/daughter; I would receive home-care services; I would receive day-care services; I have no opinion; other)

- Do you know of any organisations in your area that are working on the rights of older people and support you to in dealing with social affairs/problems?
- In your opinion, what are the main challenges older people in your community currently face? Do you think certain groups face those challenges more than others?
- In your opinion, how best can you/your household/community be supported to cope with the current issues faced by older people?
- Is there support from service providers for those who might be struggling to meet basic needs?
- Are there things that make you worried or unsure about the future, especially in terms of protection and well-being?
    - Looking ahead, what are your main concerns for the future?
    - In your experience, are the trends improving/worsening?
- Do you have a role or responsibility in your community? (Yes/no)
- Do you feel connected to your community? Do you participate in social activities?
    - Is there any ageing community group or committee of older women, men (with or without disabilities), caregivers?
    - What activities related to physical, mental, psychosocial, health and wellbeing are available to the older women, or men (with or without disabilities)?
- If yes, what is your role? (Traditional health services – herbal medicine/healing, local elder or mediator, older people's committee, government institution, other)
- In the past month, have you received any of the following visitors to your home? (Family/relatives, neighbours, members of older people's committees, staff of care and support organisations, health and nutrition staff, community volunteers, other)

Housing and living environment

- Have you fallen inside or outside your house in the last 12 months? (Yes/no)
- If yes, where? (bathroom/toilet, kitchen, balcony, room/living room, getting up, lying down on the bed, getting on/off a vehicle, walking on the street/crossing street, another building other than the house, other)
- Do you require home-care support? Have you received home-care services in the past 12 months?
- Is your house (or where you currently live) suitable for you to live without any hazards when bathing, dressing, moving, sitting, standing up, moving around?
    - Is your house (or where you currently live) suitable for living in the summer and winter seasons?
- Are there specific challenges related to housing, sanitation, or accessibility that you face because of age or disability?
    - Can you get to the places and services you need in the camp easily, especially considering your age or disability?
- Do you need medical or assistive devices to help you move around of perform daily activities in your current living environment?
- Does your house need any repair/fixing? If yes, what kind?
- What are the main facilities that should be added to settlement areas to improve living conditions?

- How do you dispose your household waste? Are you able to take your household trash out by yourself?
- Are there any environmental risks in the place where you live?
- Where do you live? (Tent, container, apartment, single-storey house, etc)
- How long have you lived there?
- Have you had to change your house or living environment for any reason? If yes, why? Was it a permanent or temporary change? If temporary, for how long?
- Are you happy where you live? Are you able to cover your basic personal hygiene needs inside?

Recovery, income and access to entitlements

- What sources of income do you have? More than one answer is possible, but please, prioritise (Full-time job, secondary job, social benefits from government/NGOs/others, pension, other)
- Do you currently receive any social protection benefits? If yes, what type of benefit do you receive?
- How long have you been receiving social protection benefits?
- What is the average amount of financial support (or income/pension) you receive per month?
- Is the amount sufficient to meet your basic needs? (Yes/no)
- If no, what do you do to raise extra income? (Reduced non-essential expenditure, send children out to work for cash, borrow money from relatives, borrow money from informal money lenders, sell assets, initiate or expand a home-based employment, beg, reduce number of meals, reduce medication, other)
- How often do you receive these benefits?
- Are there employment or income-generating opportunities available for older people in your area? (Yes/no/I do not know)
- If no, what do you think are the major factors that have prevented older people in your area from engaging in employment or income-generating opportunities? (Lack of skills of older people, unavailability of income-generating opportunities, lack of finance for older people, health problems of older people, physical weakness of older people, other)

Health, wellbeing and nutrition

- How would you rate your current health status? (Very poor/poor/fair/good/very good)
- When you are sick, what do you do? (Visit a public doctor, a private doctor, go to the pharmacy, use traditional medicine, rely on family members and/or friends, other)
- Have you been ill during the past month?
- If yes, what was it? (Diabetes, high blood pressure, pain, infection, diarrhoea, eye disease, heart disease, cardiovascular disease, rheumatoid arthritis, respiratory disease, urinary incontinence, dental disease, kidney disease, liver disease, nerve problems, gastritis, cancer, other)
- Do you take medicines regularly? (Prescribed drugs, not traditional medicine)
- If yes, what for? (Diabetes, high blood pressure, pain, infection, urinary incontinence, diarrhoea, other)

- Where do you buy them?
- If you do not see any doctor, what is the reason? (Don't know where it is, too far, could not go alone, no drugs available, too expensive, language problem, the attitude of health staff, other)
- Have there been challenges in accessing healthcare services for older people in your community?
    - Are there specific health-related vulnerabilities or risks that you have observed among older people?
    - Do you have adequate access to medication/assistive devices/aid that you need?
- Do you have a disability report issued by a hospital?
- If yes, which category? (Vision, hearing, speech, orthopaedic, cognitive, mental or emotional, chronic, other)
- How often do you engage with physical activity, exercise or sports? (Every day or almost every day, at least once in a week (but not every day), 1–3 times in a month, rarely, never)
- How many meals did you eat yesterday?
- How is your appetite?
- Do you have problems chewing food?
- Do you give some of your food away to members of your family?
- In the past month was there ever no food to eat of any kind in your house because of lack of resources to obtain it?
- Do you have to skip meals or pursue a limited diet to a certain type of food, for instance based mainly on carbohydrates?
- If yes, how often did this happen in the past month?
- How often during the past month did you feel nervous? (All of the time, most of the time, some of the time, a little of the time, or none of the time)
- During the past month, about how often did you feel hopeless? (All of the time, most of the time, some of the time, a little of the time, or none of the time)

Knowledge, skills, roles and capacities

- How have you coped with any feelings of nervousness or hopelessness up to now?
- What work did you do when you were younger?
- How do you think you can contribute to addressing the problems in your house or in your community?
- What will enhance your skills to contribute to your community?
- Are there barriers to your income-generation activities and efforts?
- Do you think there are older people willing to participate in education services? Or, if there were education services available for older people, would you be willing to participate? (Yes/no/don't know)
- If yes, what type of education would you want to receive?
- Which technological devices can you use without support? (Basic mobile phone; smartphone; tablet; computer; smart watch; other technological devices)

Endnotes

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