

**Thematic Report on the Human Rights of Older Women by the United Nations Independent Expert on the Enjoyment of Human Rights of Older Persons**

**For the 76<sup>th</sup> Session of the United Nations General Assembly**

**Report by the International Longevity Centre Canada**

Submitted : April 14, 2021



**Human Rights do not have a best before date**  
**Support a U.N. Convention on the Rights of Older Persons**

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# **Thematic Report on the Human Rights of Older Women by the United Nations Independent Expert on the Enjoyment of Human Rights of Older Persons**

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## **Introduction**

The International Longevity Centre (ILC) Canada is a human rights-based organization dedicated to the needs of older persons, we are part of the International Longevity Centre Global Alliance made up of sixteen countries. ILC Canada has partnered with the Life Research Institute at the University of Ottawa for this Report. We are grateful for the opportunity to respond to the request from the Independent Expert on the Enjoyment of Human Rights by Older Persons to bring the human rights concerns and challenges faced by older Canadian women. The pandemic has laid bare the inequities faced by older people around the globe and Canada has seen a shocking death rate of older persons, particularly in Long Term Care. Sadly, the human rights violations went far beyond that, into increases in elder abuse, in restricted access to health care, and technology and in mental health impacts due to social isolation.

As the following Report will chronical, the specific impacts of ageism, and age discrimination are multiplied by sexism. There are clear inequities and barriers faced by Canadian women in participating and assuming leadership roles in their communities, higher rates of poverty and the social isolation they experience, and the structural and systematic discrimination

they face in the workplace. Add to this scenario, a daunting increase in age-based violence up 10x during the pandemic. Clearly Canadian women face particular barriers to human rights that need immediate remedy.

ILC Canada has been leading the call for United Nations Convention on the Rights of Older Persons in Canada. We see a Convention as a method to address ageism and age and sex discrimination, transforming the lives of older women by addressing issues such as underfunding and neglect of Long Term Care and shining a light on the need for real societal change. We deliver the following Report as evidence of systemic ageism and discrimination and call once again for a legally binding document that addressed the gap in United Nations Human Rights Legislation, in regard to older persons.

### **1. Legal instruments, policies and programmes addressing older women and how they are implemented and monitored**

In Canada, human rights are protected by the *Canadian Charter of Rights and Freedoms* and by federal (national), provincial and territorial human rights laws. As part of Canada's Constitution since 1982, the *Charter* protects the fundamental freedoms (e.g., religion, expression), as well as the democratic, mobility, legal, and equality rights of all Canadians. The *Charter* applies to all governments – federal, provincial, and territorial – but there are no legal instruments pertaining specifically to *older* women. The equality rights provisions of the *Charter*, outlined in section 15, protect against discrimination on various grounds, including age and sex. Court decisions have also expanded the list of protected grounds to citizenship, marital status, and sexual orientation, thus allowing decisions to be made that recognize that multiple grounds of discrimination may intersect. Thus, older women may rely on the equality rights provision in cases of discrimination. Of relevance as well is section 28 of the *Charter* which guarantees that all rights covered in the *Charter* apply equally to men and women. This section does not create a separate regime and is largely understood as having only an interpretive function. Three important limits must

be noted about the *Charter's* application. First, the *Charter* applies only to governmental actions and laws and not to private individuals, businesses, or other organizations. Consequently, *Charter* challenges against private actors are not possible unless the claim is focussed on the unconstitutionality of a law or regulation. Second, Canadian courts have been largely unwilling to interpret the *Charter* as imposing positive obligations on governments to implement social programs (e.g., for older women) or to take positive action to protect equality and other rights. Thirdly, section 1 of the *Charter* states that *Charter* rights can be limited by law so long as those limits can be shown to be “reasonable” in a “free and democratic society”.

The *Charter* has had a profound impact on the promotion of women’s rights in Canada and has brought legislative changes benefiting women in areas such as athletics, reproduction, crime, family and employment (Baines, 2004). As noted by one researcher, “it has been modestly successful in contextualizing women, recognizing some needs -- those of some lesbian, racially identified and poor women -- while failing to recognize the needs of others, particularly aboriginal, young, immigrant and religious women. One problem is that many of these women require positive action by the state, action the Canadian Supreme Court seems reluctant to read into the new Charter rights protection regime.” (Baines, 2004). In addition, despite the advancements of women’s rights over the last 40 years, the voices of older Canadian women are conspicuously absent from the *Charter* discourse, with very few instances of claims based on *Charter* rights infringements before the courts<sup>1</sup>.

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<sup>1</sup> Tetreault-Gadoury v Canada (Employment and Immigration Commission) (1991) is one of the rare cases where the Supreme Court of Canada considered the claim of an older woman under Section 15 of the Charter. The case dealt with her entitlement to unemployment benefits after she lost her job shortly after her 65<sup>th</sup> birthday. In finding that the legislation was inconsistent with the impugned disposition “stigmatized her, regardless of her personal skills and situation, as belonging to a group of persons no longer part of the active population and perpetuated the insidious stereotype that a person who is 65 years of age or older cannot be retrained for the labour market”.

Human rights in Canada are also protected by federal, provincial and territorial laws. These acts focus only on equality rights and protect Canadians from harassment and discrimination based on several grounds including age and sex. At the *federal level*, the *Canadian Human Rights Act* applies to federally regulated private companies (e.g., banks, airlines), to individuals who work for or receive services/benefits from the federal government and to First Nations governments. At the regional level, each province and territory in Canada has its own human rights legislation, and all of them offer protection based on age and sex. These laws apply to the provision of goods, services, government-funded facilities (including schools and hospitals), employment, and housing within the province or territory. Older Canadian women who believe their rights have been infringed can complain before specialized human rights tribunals. While there is no cost per se to file a complaint and self-representation is possible, the process has been criticized as daunting and long-drawn (Pinto, 2012). Furthermore, in older Canadians with more advancing age, where health conditions that affect communication or cognition are more prevalent, it is difficult to entertain how they might file a complaint in such a system.

Generally, older adults are unlikely to complain before administrative tribunals or start legal actions before the courts to voice their concerns about discrimination based on age. While access to justice is a serious problem in Canada – for all Canadians and in relation to a myriad of topics – this lack of accessibility for older adults is very concerning, especially given that, at least a portion of older adults have fixed incomes, lower than average literacy and educational levels, face the onset of health and activity limitations, experience cognitive disabilities, live in environments that reduce their autonomy and community inclusion, and deal with physical, financial or other forms of abuse (Law Commission of Ontario, 2012). Compared to men, low-income older women can also outlive their savings (Healthcare of Ontario Pension Plan, 2017), rendering the challenges of filing a complaint more onerous financially. Hence, the hurdles associated with complaints about human rights are compounded for older women, especially if they are at-risk

or marginalized due to disability, low-income, immigration status, or other issues. As identified in a recent report on the situation of older women in the province of British Columbia, barriers to access to justice include the lack of legal representation for older women with caregiving responsibilities for children, the lack of knowledge about options for legal assistance, and the lack of language interpretation to support access to legal advice for immigrant women (Canadian Centre for Elder Law, 2017). At least one-fifth of immigrant women were over 65 in 2011 (Hudon, 2015).

Federal and provincial income support programmes address the challenge of low-income among older Canadians. The federal Guaranteed Income Supplement (GIS) is an income-tested transfer payment to supplement the incomes of persons aged 65 and older who have no or minimal income other than the universal Old Age Security pension (OAS). Spouses and widowed spouses aged 60-64 of OAS pensioners receiving GIS, most of whom are women, are also eligible for the Spouse's or Survivor's Allowance, an amount equivalent to an individual GIS payment. In 2016, the federal government increased the GIS benefits for single older persons. Most provinces have top-up programmes to provide benefits to low-income seniors who receive the federal GIS. Tax credits offered by the federal and some provincial governments that help adults offset costs associated with disability and illness include the Caregiver Tax Credit, the Disability Tax Credit and the Medical Expenses Tax Credit. Older women are far more reliant than older men on publicly funded federal income supports. In fact, 30% of an older Canadian woman's total income is supported by OAS and GIS, compared to 18% of their male counterparts (Canadian Labour Congress, 2015).

## **2. Statistical data collection and disaggregation and definition of older women in law, policy and data collection.**

As the age of eligibility for the universal Old Age Security (OAS) pension is 65 years, this age is used as the definition of seniors (older persons) for old age policies and data collection in Canada. Demographic data (Census) are collected on all residents of all ages every 5 years, with the exception of Indigenous persons living on-reserve, and are disaggregated by all demographic variables. Cross-tabulated data are collapsed or not reported on the basis of concerns related to privacy or lack of statistical reliability. Beyond the Census, data on persons living in long term care institutions and retirement homes (about 7 % of the older adult population, most of whom are women) are not collected beyond a yearly count of residents by age and sex. Regular health, social and labour and income surveys are conducted for non-institutionalized persons aged 12+ (health) or 15+ (social, labour and income). Data for older persons are disaggregated by sex, but are usually grouped as '65 and older' when the sample sizes at older ages are not statistically reliable or when there is no expressed request for more disaggregation. However, occasional or periodic health and social surveys are conducted on issues that most concern older adults and are disaggregated by age and sex, but often not by other diversity characteristics. The paucity of disaggregated data by sex and age makes it difficult to determine gender differences and age/gender related trends.

Besides official statistical data, the current analysis of older women in Canada draws on research studies and on community and societal practice that may use ages other than 65 (e.g., 50, 55, or 60 and over), to define 'older'.



### **3. How women take part in participatory mechanisms.**

Older women contribute to society through civil and political engagement. However, many experience barriers to participating and assuming leadership roles. Older women activists, in particular, tend to be invisible in analyses of civic engagement or subject to common stereotypes about aging and gender, including the ageist assumption of declining ability and the theory that feminist activism in the current third wave is a domain exclusively for younger people (Chazan and Baldwin, 2017).

While older women may be under-represented in leadership positions in nongovernmental organizations overall, they are prominent in organizations advocating for the rights of older persons in Canada and internationally. For example, older women (age 55 and older) are Presidents of the Fédération de l'Âge d'or du Québec, the Ontario Society of Senior Citizens' Organizations and the British Columbia Council of Senior Citizens' Organizations, the International Federation on Aging and of the International Longevity Centre Canada. Some advocacy organizations are comprised mainly of older women, e.g., the Raging Grannies (Roy, 2021) and the Canadian Federation of University Women (with over 100 CFUW Clubs). Some are built on the leadership of women who are now "older", e.g., the Canadian Voice of Women for Peace (VOW), Canada's oldest national feminist peace group. GRAN (Grandmothers Advocacy Network) and the Stephen Lewis Foundation Grandmother to Grandmother Campaign also have older women leadership and membership .

Politically, women have achieved gender parity within the federal Cabinet in the recent elections, and near-parity in the Senate and the Supreme Court of Canada. Older women (age 50 and older) comprise 17% of Cabinet members. In the Senate, 48 of the 100 seats are occupied by older women. Of the 10 judges who sit on the Supreme Court, 4 are older women. More women were elected to federal parliament in 2019 than ever before, but they occupy 29% of the seats, which is lower than the UN recommended minimum of 30% (UN, 1996). Only 12 women have served as the premier of a Canadian province (8) or territorial government (4);

six of these were older women (age 50+), and about 10 older women have been federal or provincial party leaders. At the municipal level, the Federation of Canadian Municipalities (2021) reports that women (no age specified) hold 18% of mayors' positions and 28% of councillors' seats.

Promising practices to increase the representation of older women in participatory processes include *Engaging Older Women in your Community* (James & Dickinson, 2016), a tool that identifies strategies for engaging older women in meaningful, older women-led volunteering as a method to combat systemic inequalities against older women, and support the leadership potential of older women, as well as *Equal Voice*, a national multi-partisan organization that advocates for the equal representation of women in politics and prepares women and gender-diverse leaders to participate in political life.

Despite some advances, there is still considerable work to do to elevate women in leadership positions that bring about changes to areas such as economic action. Despite women outnumbering men in Canadian universities, leadership positions and inclusion of women, young and old, still needs to be improved. In 2019, university and college enrollment in Canada recorded 1.2 million women and 941,900 men and this trend continues to rise. Organizations such as the Canadian-led Elevate International ([www.elevateinternational.ca](http://www.elevateinternational.ca)) is working towards inspiring and empowering younger women to take leadership positions but the initiatives do not, for the moment, include older women. In 2017, it was reported that women occupied 40% of full-time academic staff at Canadian universities. As this trend continues, there are opportunities for older women to increase their involvement in all participatory mechanisms.

#### **4. Specific challenges and concerns faced by older women**

Women account for a higher proportion of the older adult (age 65+) population overall (54% in 2020) which increases with advancing age: women comprise 60% of the population aged 85-89 and 66% of Canadians aged 90-94 (Statistics Canada, 2020a). Almost 30% of older women live alone in the community, in contrast to 16% of older men (Hudon & Milan, 2016). Living alone in old age is linked to social isolation, to loneliness, to poverty and to the need for support and care from outside the home. Because older Canadians receive government transfer payments that protect them from deep poverty, older adults in general had the lowest rate of poverty (5.6%) among all age groups (11%) in 2018. Nevertheless, older persons living alone experienced higher rates of poverty (13.4%) (Statistics Canada, 2020b), which, as mentioned, is a sector of Canada's population that is primarily comprised of older women. Even older women who are employed may not supplement their income adequately, since the majority work part-time or part-year, and tend to be employed in lower-paying gendered occupations (office support, retail sales) (Statistics Canada 2017a).

With respect to health, older women report a higher prevalence in 21 out of 26 chronic conditions, as compared to older men (Statistics Canada 2020c). At all ages, women reported more functional limitations as a result of problems with vision, mobility, flexibility, pain and mental health issues (Statistics Canada 2020c). For instance, women are more likely to be injured as a result of a fall (Public Health Agency of Canada, 2018) and rates of dementia are higher among women than men, with an increase in this gap as age increases: from age 80, prevalence is about 1.3 times higher for women (20.8%) than men (15.6%) (Canadian Institutes for Health Information, 2018). More than half of women aged 85+ reported receiving help with daily activities and, as a consequence of living alone, a higher proportion of women than men report receiving assistance from family members and friends, as well as assistance from community support services (Statistics Canada, 2020d). Canadians experiencing unmet needs for home care are more often women, older persons and persons living alone (Gilmbour, 2018). The inadequacy of housing options and of support and care in the community has been recognized for decades but never properly addressed (Picard, 2021). The fall-back has been placement in

collective dwellings – seniors’ residences (mostly private) and long-term care institutions (mostly public) – where about 7 out of 10 residents are women (Hudon & Milan, 2016). Living in a collective dwelling can represent a loss of control over one’s life and of one’s community, and other insults to dignity, safety and quality of life may be common if not part of the institution’s primary approach to care. The nature of government directives, adherence to these by collective dwellings and staff culture and attitude can lead to impingement on the rights of the large number of older women living in these homes. Problems identified include: lack of flexibility or choice in care; difficulty receiving culturally appropriate or culturally safe care; inability of staff to spend sufficient time with residents and patient-to-patient aggression (National Institute of Aging, 2019). COVID-19 has underlined the neglect and dangers for both residents (who are largely older women) and staff (the majority of whom are women and often new immigrants).

#### **5. Forms of gender-based discrimination and inequality experienced by women throughout the life cycle that have a particular impact on the enjoyment of their human rights in older age**

Women face gender-based discrimination and inequality throughout their lives and in all settings because gender inequality is rooted in social, political, and economic norms, practices, and systems in Canada (Government of Canada, 2019). At the individual level, this discrimination translates into insults, disrespect, mistreatment, harassment, and exclusion, impacting women’s safety, physical health, and mental health (Statistics Canada, 2020e; Vigod & Rochon, 2020). At the societal level, it creates underrepresentation of women in important spheres of society such as in science, technology, engineering, and mathematics and computer science (STEM) fields of study (Statistics Canada, 2019a), politics (Elections Canada, 2001) and in leadership positions (Catalyst, 2020). It creates what is termed “gendered work” (Messias et al., 1997), where women traditionally occupy professional positions such as personal care workers, cleaners, nurses, and teachers (International Labour Organization, 2020), as well as being responsible for raising children and managing a household. These factors result in the lasting gender wage gap in Canada (Statistics Canada, 2019b), less financial literacy and confidence among older women (Statistics Canada, 2018) including among the 11%

of older women who reported having never worked for pay in their lifetime (Statistics Canada, 2016), and lower income and poverty in older age (Statistics Canada, 2016). Compared to older women with more financial resources, older women from lower socioeconomic backgrounds are at greater risk for abuse and neglect (Pillemer et al., 2016), enjoy poorer physical and mental health (Wanless et al., 2010), and have lower life expectancy (Statistics Canada, 2020f).

## **6. How COVID-19 has differentially affected older women and older men**

The longer lifespan and greater prevalence of chronic conditions makes older women vulnerable to COVID-19 infection. Family and professional caregiving has exposed them to contagion as have social risks such as low income, reduced pensions and overwork. As data on older women are often not collected or inadequately sampled, the lack of evidence based on age and sex makes it difficult to advocate for policy interventions.

In every age demographic but one (60 to 69 years), the number of women diagnosed with COVID-19 slightly exceeds the number of men (Dyer, 2020). More men have died from COVID-19 the disease across the world than women — except in Canada (Global News, 2020

<https://globalnews.ca/news/6920505/more-women-have-coronavirus/>).

According to the latest data from, Public Health Agency of Canada, more women have been diagnosed with COVID-19 than men, and more women have died as a result. As of May 15, 55 per cent of confirmed cases of COVID-19 are women, and 45 per cent are men. Of the total deaths, 53 per cent are women and 47 per cent are men.

As of June 2020, among the reported deaths, the male to female ratio of deaths among confirmed cases was 0.85, generally attributed to factors such as more women with underlying conditions in the older age groups due to their longevity and therefore higher incidence of pre-existing multiple chronic health conditions, higher female nursing home population and high number of women among the front-line workforce of caregivers (Lien et al., 2020). Deaths were concentrated in

collective dwellings where three quarters of residents aged 85 and older were women, increasing to 86% among centenarians (Statistics Canada, 2017b). According to the Canadian Institutes for Health information, by May 25, 2020, 81 percent of all reported COVID deaths in Canada were long term care residents, one of the highest rates among countries (Szklarski, 2020). Moreover, though the short-term effects of “long COVID” such as breathlessness, fatigue and brain fog experienced by those older women who survived are known, the long-term effects of the disease, likely related to severity, are still unknown. Public health officials in Canada are also concerned about delayed or cancelled medical or dental appointments where untreated conditions could negatively affect older adults’ physical and mental health irreparably. Many of the surgeries such as joint replacements (typically more women than men), cancer, cardiac and cataract operations that were cancelled continue to be of concern as they will undoubtedly affect longer term health outcomes and quality of life. Finally, older women could face heightened threats of violence. Statistics Canada crowd sourced survey indicated that women in all age groups were more likely than men to report being very or extremely anxious about the possibility of violence in the home during the pandemic, further putting older women in harm’s way (Statistics Canada, 2020g).

Social isolation is another consequence of the impact of COVID-19 on older women. Over half of women, but only 27 per cent of men, aged 85 and over live alone in the community (Tang et al., 2019), which means that during the pandemic more women than men may miss the contact, support and care from family and home services alike; placing themselves at increased risk of exposure should they decide to receive such contact. According to Statistics Canada (2020g), 89.9% of men avoided leaving the house but 94.8 % of women did so during the pandemic so far. Thus, while more women practiced risk avoidance, in so doing, they may have more socially isolated themselves in their own homes. These situations continue to be exacerbated as adherence to health directives often includes reduced or no access to adult children and grandchildren. It is therefore not surprising that stress, anxiety and depression were reported by more older women than men (Statistics Canada, 2020h).

In women who do not live alone, the situation may not be easier. Older women with caregiving responsibilities for spouses or parents with pre-COVID-19 chronic conditions have also seen their situations worsen throughout this pandemic. As home services are diminished, and access to home care services are paused, older caregivers in the community are left to manage the care of their loved ones on their own. Grandparenting has also taken on extra importance, with grandmothers assuming the responsibilities of caring for young children, (particularly under 5) and home schooling as their adult children return to work or are working full time at home. This has meant unusually long hours with no breaks. Even before COVID-19, the care economy depended a lot on supplementary unpaid work, primarily done by women but during the pandemic they were further undervalued and overworked. Of the 7.8 million caregivers, many are spouses caring for their partners and others are adult children in their sixties and seventies caring for parents aged 85 and over (Statistics Canada, 2020i). Among older women who provided less than 10 hours of care per week, 17% reported that their overall health suffered because of their caregiving responsibilities. This proportion rose to 31% for women who provided from 10 to 19 hours of care and close to half (46%) of those who provided 20 hours or more (Arriagada, 2020). Caregivers' unmet support needs are associated with lower life satisfaction, more daily stress and worse self-reported mental health. Health care providers who are managing the pandemic at the same time as their personal lives are feeling the impact on their quality of life more significantly. One in ten nurses is aged 60 and over (Zafar, 2020) and the majority are women. Though poorly paid and exposed to stress and infection, frontline health workers worked long hours while still taking care of home and family during the pandemic.

The national strategy to contain the pandemic included economically disruptive measures such as lockdowns, socially isolating measures such as quarantines and behavioral rather than medical measures (Brink, 2020). The lockdowns affected schools and educational institutions, commercial establishments and the hospitality/tourism sector, all of which employ large numbers of women. In the first two months, 1.5 million women lost their jobs which will later affect their retirement options. In this time span, the pandemic reduced women's participation in the labour force down from a historic high to its lowest level in 30 years

(Desjardins, 2020). In 2015, 56% of Canadian women were employed in jobs in the “five Cs” – Caring, Clerical, Catering, Cashiering and Cleaning according to the Canadian Women’s Foundation (Payne, 2020). “Late career workers” faced higher exposure to infection risk, lower job security, job loss and poor chances of re-employment resulting in lower retirement income and reduced savings. Older women in both low-income jobs and professional jobs paid a price in terms of increased work load both at home and at work, reduced support and poor physical and mental health. A McKinsey and Lean In study (2020) said that older women were much more likely than men to feel under pressure to work more and more likely to be burned out. They were also 1.5 times more likely than senior-level men to consider downshifting or leaving the workforce, the majority citing burnout as the main reason.

#### **7. How older women participate in and contribute to economic, social and cultural life, including inter-generational solidarity and support.**

Older women in Canada are active in the paid labour force although somewhat less than men. The proportion of older women in the paid labour force grew sharply since 1995, with almost 40% of women aged 65, 17% of women aged 70 and 10% of women aged 80 reporting they worked in 2015. The majority worked part-time or part-year. Employment income was the main source of income for 43.5% of working older adults, particularly for those working full-time (no gender disaggregation provided). Older women working full-time were most commonly in traditionally female occupations (see data above from Statistics Canada, 2017a).

In the arts and cultural industries, a study commissioned by the Ontario Arts Council (Coles, MacNeill, Vincent, Vincent & Barrie, 2018) reported equal gender participation, although information specific to older women was not provided. As well, women are well represented in organizational leadership roles in the visual arts, publishing, theatre and orchestral music, albeit with a continued gender-based income gap.



With regard to social participation, data from the 2008-09 Canadian Community Health Survey shows that older women (age 65+) were more likely than men to participate in community activities such as volunteering and that more women indicated a desire to participate in more activities (Naud et al., 2019). About one third of older women engaged in volunteer work, including serving on committees and boards, organizing events and fundraising, and delivering goods (Statistics Canada, 2016). Older women's paid and unpaid work enable charities and non-profit organizations across the country to deliver their programs and services to fellow Canadians (Statistics Canada, 2012). They not only enable them but also directly participate in the programs and services that are offered to them, such as cultural, educational, and faith-based organizations targeting older adults, among others (Statistics Canada, 2016). In terms of barriers to social participation, older women were more likely than older men to identify a lack of available public transportation, resulting in a reliance on driving to access activities, especially in rural areas. Not wanting to go alone to an activity was reported more often by women than men, especially in metropolitan areas, and underlying concerns included fears about safety, rejection and exploitation (Naud et al., 2019).

In the family unit, older women are often the primary caregivers for their older parents or parents-in-law, spouse or partner, children, and grandchildren (Statistics Canada, 2020j). Their roles are varied and may include, among others, helping with scheduling, banking, household chores, medical treatments, and personal care (Statistics Canada, 2016). A study on older women caregivers (Orzeck, 2016) reported that reclaiming, or re-negotiating their personal identity and sense of meaning can be difficult after bereavement.

## **8. Forms of structural and systematic discrimination faced by older women and measures that have been taken to address them**

Older women commonly face structural and systematic discrimination in both the workplace and in health care. Often, older women are not given certain career advancement opportunities, are being forced to retire, lose their jobs, and face difficulty in getting rehired as mature candidates (Beaton, 2018; Employment and Social Development Canada, 2018; Rikleen, 2016).

To address discrimination against older women in the workplace, federal and provincial human rights legislation prohibits discrimination. Some provinces also require businesses to adopt an anti-discrimination policy. Industry leaders share identified best practices to educate managers and employees and root out systemic biases that foster gender discrimination (e.g., Business Development Bank of Canada, no date; Employment and Social Development Canada, 2019; ) and age discrimination in the workplace (Employment and Social Development Canada, 2018).

One of the eight areas of action in the WHO- inspired (WHO, 2007) Age friendly cities and communities programme is Social inclusion and respect. Promoted by the federal government, provinces and municipalities across Canada (Government of Canada, 2016), age friendly city and community initiatives raise awareness of, and address structures and practices that exclude older persons in the community. Encouraging employers to adopt best practices to make their workplaces more age friendly is the aim of a public-private partnership led by the Employment and Social Development (2018). For instance, employers are encouraged to implement effective policies such as flexible work arrangements to help retain older female workers in the workplace while helping them manage their various responsibilities outside the workplace.

Older women also face discrimination in the Canadian health care sector. Considering that older women continue to live longer than men (Statistics Canada, 2014), they have more interactions with the health care system and are

therefore not unknown to ageist communication and attitudes from health care professionals (Chrisler et al., 2016; Law Commission of Ontario, 2009; Ryan et al., 1995; Schroyen et al., 2018) and ageist systems in general. At a structural level, older women are less likely to be referred for screening and may be perceived as too frail to receive treatment (Chrisler et al., 2016; Law Commission of Ontario, 2009). Older women are often omitted from clinical trials for a chance to access and contribute to life-saving treatments (Wyman et al., 2018). Conversely, they may receive inadequate care and be encouraged to take too many prescriptions for specific medical conditions (Skirbekk & Nortvedt, 2014).

To address these issues in the health care sector, the Canadian Geriatrics Society has been promoting greater geriatric education to help medical trainees better communicate with and care for older women (Senger, 2019). Similar to other workplaces, hospital policies and guidelines need to shift to ensure the respect of older female patients. The Ontario guideline was developed for all adult hospitals across the province of Ontario to ensure that care and services were age-friendly (Tran & Wright, 2019). Two noteworthy recommendations are “train and empower a clinical geriatrics champion(s) to act as a peer resources and to support practice and policy change across the organization” and “provide all staff, clinical and non-clinical, with seniors sensitivity training to promote a senior friendly culture throughout the hospital’s operations” (Tran & Wright, 2019; Wong et al., 2011). Similar initiatives are underway throughout the country (Edwards, 2015).

## 9. How intersectional factors exacerbate the combined effects of ageism and sexism.

When age and sex intersect with other social factors and aspects of identity, an older woman's risk of experiencing unequal access to legal and political resources. According to the Canadian Centre for Elder Law (2017), older women, especially if they are at-risk or marginalized due to disability, low-income, immigration status, or other issues encounter barriers to access to justice, such as lack of knowledge about options for legal assistance and lack of language interpretation to support access to legal advice. The historic exclusion of women from political processes and power structures is exacerbated for women of colour, new immigrants and Indigenous ancestry, women with disabilities, and women in the LGBTQ2+ community (Andrew et al, 2008). Intersectionality among identity and social factors also leads to a cascading risk for poor health and wellbeing.

**Immigrant women** (particularly those belonging to a visible minority) experience disadvantages due to the interplay of various social determinants of health including the physical and social environment; economic conditions; cultural beliefs; gendered norms; and the healthcare delivery system (Guruge et al., 2015). In 2011, visible minorities accounted for 60% of the total female immigrant population in Canada (Hudon, 2015). Older immigrant women tend to have more health problems, underutilize preventive services, such as cancer screening, and experience more difficulties in accessing healthcare services (Guruge et al., 2015). A lack of proficiency in either official language (English or French) is especially common among older immigrant women and those with a lower level of formal education; refugee women have reported the greatest difficulty in learning an official language (Anisef et al., 2012). A low level of comprehension and comfort in speaking in a foreign language is a significant risk factor for social isolation, access to health services and low-income. Further, older immigrant women may disregard their health-related needs due to traditional and cultural practices (including dependence on reliance on men for transportation) thereby making

gender a significant barrier to the uptake of health promotion and preventive health practices (Ahmad et al., 2004). Multigenerational living is more common for older adults in immigrant families. While living with family can be a bonus, the burden of care for grandchildren and others falls disproportionately on older women in these families (Spitzer et al., 2003). This full-time job can lead to social isolation and an inability to integrate into the broader community. Immigrant older women have no or minimal access to government income security benefits because they do not meet residency requirements and no access to employment retirement incomes that are based on years of contribution. Those who do have worked typically have not been able to put aside money for retirement or have invested in their children expecting that they would support them in old age (Bow Valley College, 2017).

**Living with disabilities** Women with disabilities in Canada face intersecting and compounding obstacles to the enjoyment of their rights. They experience disproportionate rates of poverty and low income, violence, unemployment and low wages. Women with disabilities are more likely to spend over 50% of their before-tax income on their housing and to need costly accessibility modifications. Women with disabilities report experiencing higher rates of violence than women without disabilities: emotional or financial abuse (11.8%), physical assault (4.4%) and sexual assault (6.1%) (Canadian Feminist Alliance for International Action and DisAbled Women's Action Network, 2017; Burlock, 2017).

**LBTQ2+ Women.** It is estimated that at least 400,000 older adults are members of LGBTQ2 communities in Canada. (Wilson et al. 2016). While older LGBTQ2+ adults share many of the experiences and concerns of all older people, theirs are also informed by historical social exclusions linked to their minority sexual orientations and/or gender identities (McLemore, 2018). For example, in 2017, the youngest seniors (those 65 and over) were 17 when homosexuality was decriminalized in 1969. It was only in 2017 that gender identity and gender expression were added to the Canadian Human Rights Act, thereby expanding protections to transgender and gender diverse people. Findings from the Canadian Longitudinal Study on

Aging showed a pattern of health disparities among sexual minority participants (Stinchcombe et al., 2018). In particular, older lesbian and bisexual women had greater odds of heavy drinking and being a former smoker compared to heterosexual women (Stinchcombe et al., 2018). They also had greater odds of reporting that they had been diagnosed with either mood disorders (including depression) or anxiety disorders. Despite these health disparities, older LGBTQ2+ adults are less likely to use health care services for fear of stigma and discrimination by care providers and care systems (Putney et al., 2018). Older LGBTQ2+ adults are less likely to be married, more likely to live alone, and have fewer children in comparison to majority peers (Stinchcombe & Wilson, 2018), which may increase their risks for social isolation and access to informal care (Ismail et al., 2019).

**Indigenous Ancestry.** Senior women in Indigenous communities have faced numerous challenges over the course of their lives that follow them into older age. These include higher levels of unemployment and poverty, substandard housing, higher rates of crime and abuse, separation from families during the residential school period, higher mortality and morbidity rates, fewer health care, residential and community services (Wister & McPherson, 2014) and racism in healthcare services. While both older Indigenous men and women are more likely to live with food insecurity, poverty and the presence of at least one chronic illness than non-Indigenous older Canadians, slightly more women than men experience these conditions (Economic and Social Development Canada, 2018).

#### **10. Data and statistics on the forms and prevalence of gender-based violence and abuse against older women take, including femicide.**

There is evidence that abusers change their tactics as they grow older, reducing the frequency of physical violence and instead controlling their partners through economic coercion, psychological abuse, and verbal threats that deeply affect older women's physical and mental well-being (Stöckl & Penhale, 2015). A recent international study involving Canada, Albania, Brazil, and Colombia found a

lifetime prevalence of psychological intimate partner violence (IPV) of over 40% (dos Santos Gomes et al, 2018). Globally, the reported prevalence of intimate partner violence (IPV) experienced by older women ranges from 16.5% to 54.5% (Pathak et al, 2019). When given the chance to speak openly about their experiences, older women share that nonphysical abuse often leaves scars more damaging than those of physical violence (Mezey et al., 2002). According to Dawson (2018), there are no official national data on femicide in Canada; however, in 2015, police reported 604 homicide victims (1.68 per 100,000 population) of which about 29 percent or 173 were female homicide victims (David, 2017). The highest rate of femicide was reported for females aged 18 to 24, followed closely by females aged 25 to 34 (David, 2017). Canada's rate of femicide is significantly lower than other countries. An Ontario study of all femicides and homicides from 1974 to 2012 reported a total of 2,134 female victims, 452 (21%) of which were 55 years and older (Sutton & Dawson, 2017). Recently, the Canadian Femicide Observatory for Justice and Accountability (no date) released their femicide data for 2020: that year, of the 160 females killed by violence in Canada, women aged 55-64 comprised the largest proportion of victims (19%).

#### **11. How the life cycle perspective is integrated into policies and programmes to prevent and address gender-based violence against women and girls.**

Historically, inattention to violence against older women has rested on data showing younger women face significantly higher rates of abuse, but there is evidence to suggest a smaller gulf between younger and older women's experiences. Assuming a strictly negative correlation between age and risk of abuse has fueled a paucity of research on violence across the lifespan, thereby underestimating violence against older women (Crockett et al, 2015). One major hurdle to integrating older women into VAW research that has been suggested is lack of consensus on the definition of elder abuse (Crockett et al 2015), exacerbated by the reluctance of the elder abuse field to include IPV within its scope of work (Aitken & Griffin, 1996; Penhale, 1999). This definitional problem

raises questions about whether older women’s victimization stems from vulnerabilities associated with aging, patriarchal power dynamics, or both.

The lack of attention to violence against women across the life course has led to insufficient knowledge of how older women experience abuse (Crockett et al, 2015). The definition for elder abuse could include intimate partners as perpetrators of abuse and neglect, or denote IPV in later life as a form of elder abuse (Crockett et al. 2015). Enhancing visibility of late-life IPV in defining terminology could have a significant impact in encouraging research representative of all populations of women. One of the ways the life cycle perspective is integrated into programs is in elder abuse prevention programming, delivered by Elder Abuse Prevention Ontario, for example.

## **12. Reporting, accountability, remedy and protective mechanisms available and targeted to older women victims of gender-based violence and discrimination.**

Legislation prohibiting all family violence, with civil remedies such as emergency protection orders, exist in all provinces and territories. Adult protection legislation has been adopted in three provinces, for vulnerable and incapable adults (Nova Scotia, Newfoundland and Labrador) and, for older adults (New Brunswick). This approach remains controversial with some believing that this is the best way to guarantee the rights of adults and protect those who are most vulnerable, whereas others argue that this approach infantilizes older adults and violates their right to self-determination (Harbison, 1999; McDonald & Collins, 2000). Quebec is unique in having enshrined protection against exploitation of older persons and of persons with a disability in provincial human rights legislation. In jurisdictions where there are no adult protection laws involving intervention via the criminal justice system, services for older adult victims of abuse are often delivered through health and social services agencies, hospitals, and geriatric services. Intervention models in these health care settings commonly use



multidisciplinary elder abuse teams alongside a case management model (Lithwick et al, 2000). Case management provides a means of addressing the complex, multidimensional needs of abused older persons detected in these settings by providing a range of health and social services. In a study of 109 elder abuse cases in Quebec (Lithwick et al.,2000), the most common services provided for all types of elder abuse were medical services (more than half the cases) and homemaker services (41%). In one fifth of the cases, the abuse was resolved by placing the abused older person into a long-term care setting. Legal services were used in one fourth of the cases, most often to institute a protective regime and place one of the parties under guardianship. Other interventions included the use of private home care services (33), interim placements (13%), psychiatric interventions (15%), and placement of the perpetrator into care (9%).

### **Conclusion:**

While Canada has robust human rights frameworks such as the Charter of Rights and Freedoms and provincial/territorial rights legislation, these legal remedies are not always easily accessible to older adults. For older women, human rights violations continue and social action is required in regard to their predominate role in caregiving, as health care providers and as residents in long term care institutions, to name a few. As in other countries, there is not always data to supplement anecdotal rights violations such as the impact of financial abuse and neglect and there are not many options for older women in these situations.

While older women participate in leadership mechanisms they still have far to go for full equality, for instance in the political sphere or in the boardroom. Older women are also more financially vulnerable , having lower paying jobs and suffering from discrimination in the workplace. Once the pandemic is over it will be important to document the impact on older women, for instance, were they let off from employment first, were they hired back last, if at all, and what was the impact of increased caregiving responsibilities. While women live longer in Canada, they are faced with health problems in later life that need particular care

and the failure of long term care has impacted them heavily. The pandemic illustrated this, killing more women than men in Canada.

ILC Canada continues to call for a United Nations Convention on the Rights of Older Persons. It is one tool that could lead to a better life for all Canadians. We call on the Canadian Government to lead and support this initiative and work for equality of all citizens regardless of age.

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