

Tracking progress towards the Madrid International Plan of Action on Ageing (MIPAA) in East and Southern Africa: milestones and challenges

Sabu S. Padmadas¹, Richmond Tiemoko^{2*},
Nyovani J. Madise³, Fiifi Amoako Johnson⁴,
Saseendran Pallikadavath⁵ and Asghar Zaidi⁶

Abstract. Although share of older population, an indicator of population ageing, is relatively low in most African countries, the number of older people has been steadily increasing across the region. The UN projections show that by 2050, the percentage of population aged 60+ currently estimated at 5% will reach 9% on average in Africa, and the number of older people will be almost three times higher. These trends clearly highlight the need to systematically monitor population ageing in Africa, and the Madrid International Plan of Action on Ageing (MIPAA) has offered a unique policy framework for this purpose. Moreover, the distortions in economic growth suggest that African populations might become old before getting affluent. The MIPAA strategy adopted in 2002 and implemented globally, covers three priority areas for investment in older people: development; health and wellbeing; and supportive environment. This article provides a summary of an extensive review of literature and data from national and international sources to assess the progress and gaps in the implementation of MIPAA in East and Southern Africa (ESA) of UNFPA, with a focus on six countries: Ethiopia, Kenya, Mauritius, Mozambique, Tanzania and Uganda. These countries represent diverse demographic, economic, social, cultural, political and geographic characteristics. Although there are some key developments in terms of new legislations and policies on older people since 2002, it was difficult to evaluate the impact and effectiveness of these measures due to lack of appropriate comparable data. We conclude that while many of these countries have included policies for older people, institutional and governance structures, data collection systems, target setting and programme implementation strategies remain weak, and poverty remains widespread amongst older people in low-income settings across the ESA region.

Keywords: MIPAA; Africa; population ageing; development; policy

¹ Department of Social Statistics and Demography, Faculty of Social Sciences, University of Southampton, UK. (S.Padmadas@soton.ac.uk)

² United Nations Population Fund, East and Southern Africa Regional Office. (tiemoko@unfpa.org)

³ African Institute for Development Policy (AFIDEP), Nairobi, Kenya. (nyovani.madise@afidep.org)

⁴ Department of Population and Health, Faculty of Social Sciences, University of Cape Coast, Ghana. (pfago@hotmail.com)

⁵ Portsmouth-Brawijaya Centre for Global Health, Population, and Policy, University of Portsmouth, United Kingdom; and the University of Brawijaya, Malang, Indonesia. (sasee.pallikadavath@port.ac.uk)

⁶ Centre for Analysis of Social Exclusion, London School of Economics and Political Science, London, UK. (A.Zaidi@lse.ac.uk)

Introduction

The Madrid International Plan of Action on Ageing (MIPAA) adopted at the Second World Assembly in April 2002 called for a global agenda to facilitate changes in attitudes, policies and practices at all levels to respond to the opportunities and challenges of population ageing in the twenty-first century (United Nations, 2002). MIPAA underscores three priority areas for investment: (i) older persons and development, (ii) advancing health and wellbeing into old age and (iii) enabling supportive environment. This paper summarises the review of literature and data resources from national and international sources to assess the progress since 2002, and the gaps in the implementation of MIPAA in the East and Southern African (ESA) region

Population ageing as measured by the proportion of older population is less in most African countries when compared to other global regions. However, in recent years, the number of older persons has steadily increased across the region. For example, the number of people aged 60 years and over in Africa as a whole has increased from 42.4m (million) to 64.3m between 2000 and 2015, and is projected to increase to 107.1m by 2030 and further to 225.8m by 2050 (United Nations, 2017). The ESA region currently holds about 36% of the share of older people in Africa. In East Africa alone, the number of people aged 60 and over has increased from 11.7m to 18.4m between 2000 and 2015, and is projected to increase to 30.9m by 2030 and 72.9m by 2050 (ibid). In southern Africa, on the other hand, the number of people aged 60 and over has increased from 3.2m to 4.9m over the same period, and is projected to increase to 7.5m and 13.1m by 2030 and 2050, respectively (ibid). These trends clearly show that the number of older people will continue to increase in the region. The latest UN projections clearly show that by 2050, the percentage of population aged 60+ currently estimated at 5% will exceed 10% in most parts of Africa. The gradual increase in population life expectancy across Africa is partly explained by the reduction in HIV mortality among older adults attributed to an increase in the coverage of antiretroviral therapy (UNAIDS 2017; Mutevedzi and Newell, 2014). Alongside, there has been a steady decline in malaria case incidence and associated mortality rates particularly during the last decade (WHO, 2016).

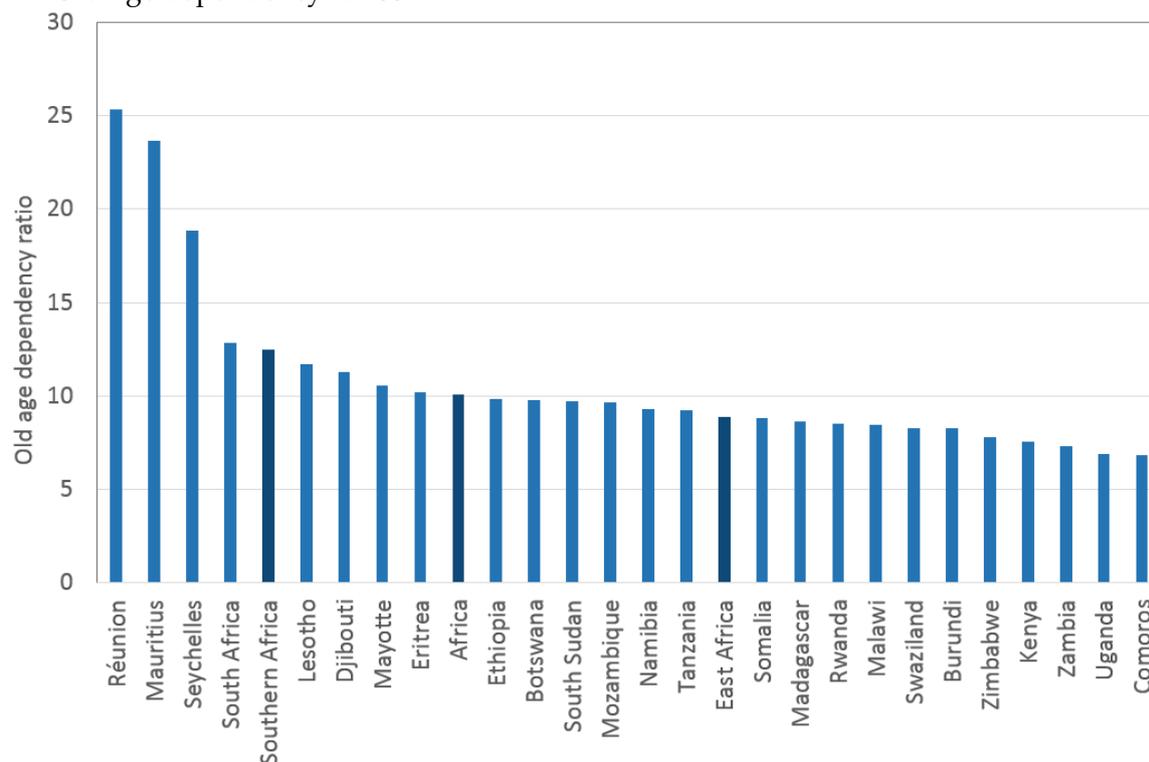
The pace of population ageing is also determined by the changes in fertility and child mortality rates. Between 2000 and 2015, under-five mortality rates declined by about a third in the whole of Africa and by two-fifth in the ESA region particularly in Rwanda, Ethiopia, Kenya, Botswana and Namibia. During the same period, the total fertility rates in the whole of Africa declined by 8% from 5.1 to 4.7 children per woman whereas in the ESA region fertility levels declined by 15% from 5.8 to 4.9 children per woman (United Nations 2017). However, fertility rates vary considerably within the ESA region. For example, in Ethiopia and Djibouti, the total fertility rate declined by about 26% from 6.1 to 4.6 children per woman and 4.3 to 3.1 per children respectively. In Rwanda, fertility rate declined from 5.4 to 4.2 children per woman during the same period. In the United Republic of Tanzania, fertility rate declined by only about 7% from 5.7 to 5.2 children per woman and the corresponding decline in Uganda was 12% from 6.8 to 5.9 children per woman during the same period. In 2015, about 80% of ESA countries had a fertility above 4 children per woman and 35% had a fertility above 5 children per woman (United Nations 2017). In Africa, Mauritius is the only country with a

total fertility below replacement level. However, the southern region of Africa had generally low level of fertility with an average of 2.6 children per woman (United Nations 2017).

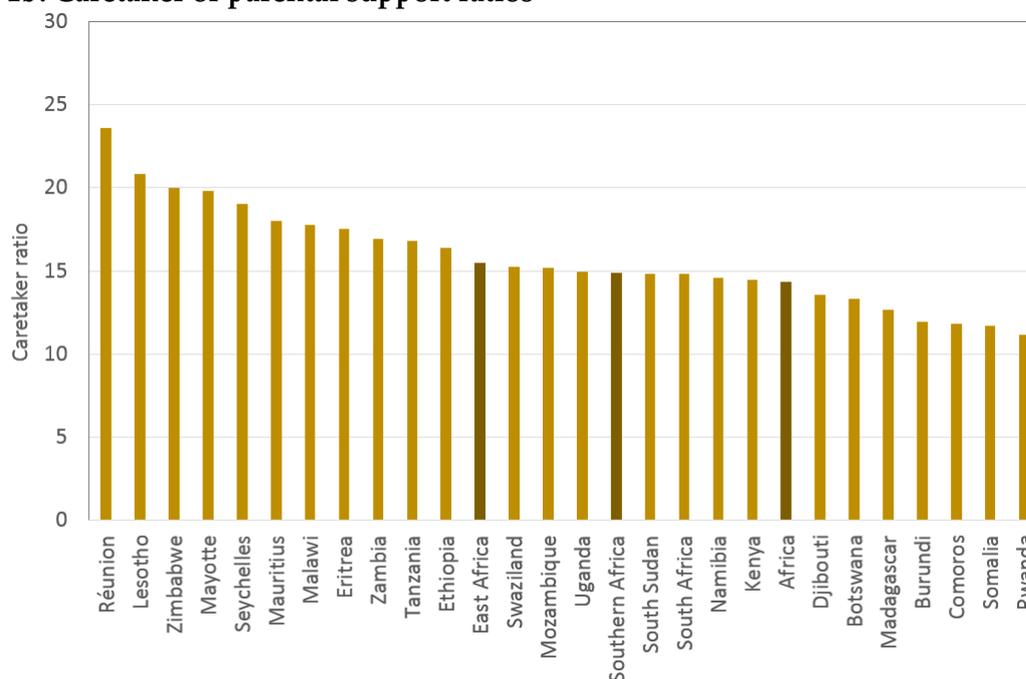
The observed changes in fertility and mortality rates over the last 15 years had impact on the population age structures especially in eastern Africa. Figure 1 illustrates the demographic old-age ratios of countries in the ESA region. The old-age dependency ratios or more appropriately the demographic old-age ratios, defined in terms of population aged 60 and over divided by working age population (15-59), show estimates ranging from 7 to 9 older persons for every 100 working age population in the eastern region to as high as above 20 in Réunion and 25 in Mauritius (Figure 1a). On the other hand, the patterns of caretaker dependency or parental support ratio, defined in terms of population aged 75 and above over 50-64 (caretakers), were slightly different in ESA countries, mostly determined by the proportion of survivors in the older ages (Figure 1b). For example, for every 100 caretakers 20 persons were aged 75 and above in Lesotho and Zimbabwe when compared to only 14 in Kenya. Most countries in the eastern region had almost similar ratios when compared to southern African countries.

Figure 1: Age adjusted dependency ratios, ESA countries, 2015

1a. Old age dependency ratios



1b. Caretaker or parental support ratios



Data source: UN World Population Prospects 2017 revision (United Nations 2017); Notes: Old-age dependency ratio is population aged 60 and over divided by the working age population (15-59); Care-taker ratio is population aged 75 and over divided by population aged 50-64.

The changing demographic landscape in the ESA region highlights the need to systematically monitor consequences of population ageing in Africa, more so within the context of the MIPAA. Moreover, the continuous distortions in economic growth suggest that African populations might become old before getting affluent. In the subsequent sections of this paper, we shall address the MIPAA agenda especially the progress in policies and practices related to population ageing over the last 15 years (2002-2016) with a focus on six countries: Ethiopia, Kenya, Mauritius, Mozambique, Tanzania and Uganda, which represent diverse demographic, economic, social, cultural, political and geographic characteristics. These countries together account for 58% of the ESA population (United Nations, 2017). Among the selected countries⁷¹, Ethiopia (99 million) has the largest population and Mauritius (1.3 million) has the smallest population with a mature age structure. The life expectancy at birth is the highest in Mauritius (74 years) and the lowest in Mozambique (56 years), whereas Kenya, Ethiopia and Tanzania have a life expectancy at birth above the ESA average of 61 years (United Nations, 2017). Except the island of Mauritius, the selected countries are geographically close to each other.

⁷ In terms of economic development, Mauritius is classified as an upper middle-income country, Kenya in the lower-middle income category, and Ethiopia, Mozambique, Uganda and Tanzania represent low income economies (<https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups> - 10 January 2018).

Legislation and welfare schemes for older persons since 2002

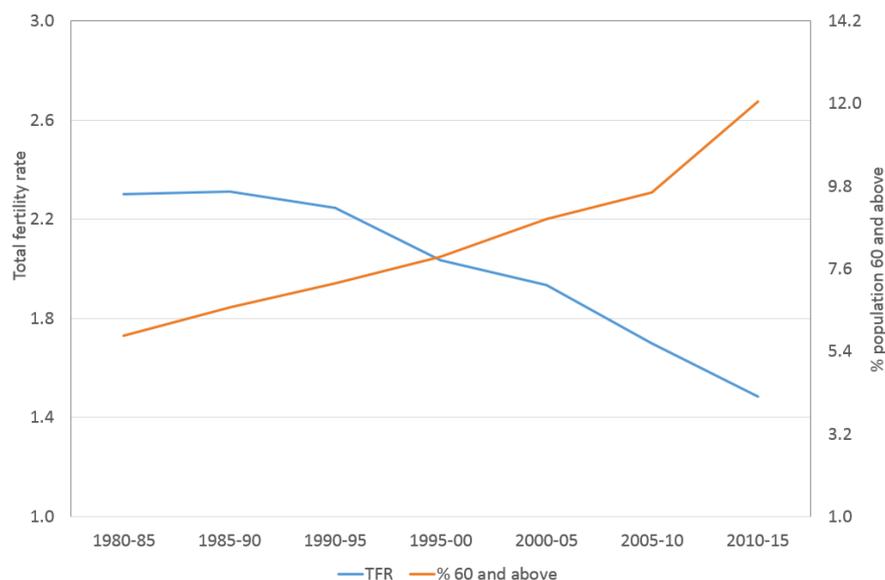
Population ageing has been gradually recognised in the national policy agenda of most African nations. The websites of government departments and international agencies including HelpAge International provide information of national ageing policies, highlighting the policy implementation, coordination, political commitment, resource mobilisation, documentation and reviews. Most official documents reviewed emphasise the relevance of population ageing across different sectors and the approaches needed to strengthen inclusion and participation of older people in development processes and decisions. However, there is little evidence of monitoring and assessment of the effectiveness of policy actions at the individual or community level.

A summary of key legislative interventions for older people in selected countries reflecting on MIPAA strategy is illustrated in Table 1. Mauritius is the first country in the ESA region to initiate legislative measures to safeguard the rights, health and wellbeing of older population. In Mauritius, there has been a steady decline in total fertility towards sub-replacement levels since 1980s, which in turn accelerated the pace of population ageing (Figure 2). The government of Mauritius was among the first to introduce a range of national level policies for older population, and particularly since 2002 in line with MIPAA recommendations. In May 2001, the Ministry of Social Security in Mauritius implemented a National Policy for the elderly. The broader agenda incorporated a theme entitled 'Ageing with dignity', reflecting on the guiding principles adopted in the Vienna Plan of Action on Ageing (1982) and the 1991 United Nations principles for older people⁸². Prior to this, in 1985, the Government of Mauritius established a Senior Citizen Council under the Act No. 66 which was subsequently amended under Act 5 of 1995 and recently in 2011. There are a range of welfare schemes, entitlements and public services for senior citizens in Mauritius including basic retirement pension, free public transportation, rent allowance, access to day care centres and so on.

Since 2002, Mozambique introduced several national level policies on ageing with an emphasis on protection of rights, financial support for disabled and health related policies including the National Strategic Plan for HIV and AIDS. Ethiopia strengthened the previously introduced legislative measures to address the needs of elderly and especially those with disabilities, particularly the Social Policy (1994), Constitutional amendment (1995) and the Development Social Welfare Policy (DWSP, 1996). MIPAA strategy is reasonably well represented in the National Social Protection Policy in Ethiopia (2012), the National Ageing Policy in Tanzania (2003), the Older Persons Act in Kenya (2006) and the National Plan of Action for Older Persons in Uganda (2013). Unfortunately, there is no systematic documentation, monitoring and evaluation of these enactments to assess the extent of coverage, effectiveness and population impact. In addition, there is little evidence/documentation of the practical and logistic challenges in terms of target setting and implementation strategies of policies for older people.

⁸ Ministry of Social Security, National Solidarity and Environment and Sustainable Development, (<http://socialsecurity.govmu.org/English/Department/Senior%20Citizens/Pages/Policy.aspx> - Accessed 3 December 2017)

Figure 2: Trends in total fertility and population aged 60 and above, Mauritius



Data source: UN World Population Prospects 2017 revision (United Nations 2017); Notes: Old-age dependency ratio is population aged 60 and over divided by the working age population (15-59); Care-taker ratio is population aged 75 and over divided by population aged 50-64.

Table 1: Key legislation measures for older people addressing MIPAA domains in selected ESA countries, 2002-2015

Country	Legislation enacted since 2002	Domain/ level of representation		
		Older persons and development	Advancing health and wellbeing into old age	Ensuring enabling supportive environment
Mauritius	The Protection of Elderly Persons Act, 2005, Amended 2016	**	***	***
	Senior Citizen Council Amendment Act, 2011	**	**	***
	National Policy on Ageing, 2008	***	***	***
	The Residential Care Homes Regulations 2005 under Section 25 of the Residential Care Homes Act 2003	**	**	***
Mozambique	National Basic Social Security Strategy, 2016-2024	***	***	**
	Law of Promotion and Protection of rights of older people, 2014	*	*	**
	National Strategic Plan for HIV & AIDS, 2010-2015,	*	***	*
	National Policy on Ageing, 2007	*	**	**
	Article 95: Right to Assistance of the Disabled and the Aged	*	**	*
	Article 124: Right to Special Protection for Elderly by family, society and the state	***	**	***

Table 1: Key legislation measures for older people addressing MIPAA domains in selected ESA countries, 2002-2015 (contd.)

Mozambique	National Plan for Older People, 2006-2010	*	**	**
	National Policy on Older Persons, 2002	**	**	**
Ethiopia	National Social Protection Policy, 2012	**	**	**
	National Plan of Action on Older Persons (2006 – 2015), 2006	***	***	***
Tanzania	National Strategy for Growth and Reduction of Poverty MKUKUTA I and II, (2005, 2010)	**	**	***
	National Ageing Policy, 2003	***	***	***
	Social Security Policy, 2003	**	**	***
Kenya	Social Assistance Act, 2013	**	*	*
	Cash Transfer for Persons with Severe Disability, 2011	***	**	**
	Older Persons Act, 2006	***	***	***
	Older Persons Cash Transfer (OPCT) National Safety Act, 2007	***	*	*
Uganda	National Plan of Action for Older Persons, 2012/2013-16	***	***	**
	National Council for Older Persons Act, 2012	***	**	**
	National Development Plan, 2010-15	***	*	*
	National Policy for Older Persons, 2009 (Social Assistance Grant for Empowerment Programme)	***	***	**
	Equal Opportunities Commission Act, 2007	**	*	**
	National Planning Framework (Poverty Eradication Action Plan-PEAP; Social Development Sector Strategic Investment Plan-SDIP)	***	**	***
	Convention on the Rights of Persons with Disabilities, 2006	**	***	**

Notes: *** High; ** Medium; * Low. The ratings are based on the level of representation of a specific domain in each of the legislation enacted since 2002. A high rating indicates higher representation of the domain in the specific legislation or policy whereas a low rating indicates that the domain is either vaguely or inadequately represented in the legislation. The ratings are authors' judgement, based on a detailed review of official policy documents/reports from the government websites.

Older persons and development

MIPAA strategies for development reflects broadly on poverty reduction, financial security, social integration, employment, skills and experience, and inclusion of older people in disaster preparedness and rescue efforts during conflict and natural disasters. There is a lack of systematic national level research on poverty dynamics in older population. Population data on old-age poverty are restricted both in terms of availability and sample size representation. Most of the evidence on old-age poverty are from small-scale surveys and case studies

implemented by *HelpAge International*⁹. Measurement of poverty in older ages is also difficult because of complex living arrangements, changing health status and health care and consumption behaviours. A study conducted by Ezech et al. (2006) in urban slums of Nairobi reported evidence of widespread poverty in older people living alone in informal settlements. Older women with low educational attainment are highly vulnerable to poverty, exacerbated by their low participation in employment activities. Ageing in informal urban settlements is also driven by economic opportunities, and older generations are generally reluctant to return to their native villages instead remain resilient in financial hardship and experience poor health outcomes (Zulu et al., 2011). On the other hand, the situation of older people living in poor conditions in rural areas, especially women, is worsened by the care burden of left-behind grandchildren because of migration of adults (parents) to urban areas or those impacted by HIV/AIDS (Oppong, 2006). The level of poverty is wide ranging across the ESA region. The population living below US\$1.9 a day varies from 69% in Mozambique, 47% in Tanzania to a little more than a third in other selected ESA countries (Table 2). On the other hand, multidimensional poverty population headcount is as high as 88% in Ethiopia, 70% in Mozambique and Uganda and 36% in Kenya. Multidimensional poverty takes into account of measures of deprivation based on non-income indicators derived from equally weighted dimensions of education, health and living standards (UNDP, 2016; Alkire & Housseini, 2014).

The multidimensional poverty applied to general population headcount translates to 4.6 million older people in poverty in Ethiopia, 1.7 million in Tanzania, about 1 million each in Mozambique and Uganda and 0.7 million in Kenya. With the exception of Mauritius, the scale of old-age poverty is considerable in the selected ESA countries¹⁰. On the other hand, evidence from population-based surveys show that, in sub-Saharan Africa, households with older people and particularly those with only older people or those with both elderly and children are more likely to be poor than those without any older people (Zimmer and Das, 2014; Kakwani and Subbarao, 2005).

Lack of pension support and high levels of poverty are often reported as the main reasons for high labour force participation among older people (Lam, Leibbrandt & Ranchhod, 2006). For example, in Mozambique, 85% of people aged 65 and above are engaged in some form of informal employment, and the trends remain unchanged since 2002 (Table 3). Similar patterns are observed in other ESA countries including those aged 55-64 years mostly in informal sectors. In contrast, old-age labour force participation rates are the lowest in Mauritius (16%). Although older women are less likely to work than older men, the rates of female labour participation are as high as 76% in Mozambique and about 60% in Tanzania and Uganda respectively. Older people in rural areas generally work in agricultural sectors whereas their urban counterparts work in informal sectors and other petty trading related jobs (Ezech et al., 2006).

⁹ Various case studies on East and Southern Africa available at <http://www.helpage.org/resources/publications/>

¹⁰ Ethiopia and Kenya made good progress in economic development over the last 15 years.

Table 2: Poverty and human development indicators, selected ESA countries

Indicators	Country					
	Mauritius	Mozambique	Ethiopia	Tanzania	Kenya	Uganda
Population¹						
Population aged 60+ (% , 2015)	15.4	4.8	5.2	4.6	4.1	3.3
Number of people aged 60+ (000s, 2015)	194	1,353	5,222	2,504	1,943	1,344
Economy²						
Gross National Income (GNI per capita, 2011 PPP\$)	17,948	1,098	1,523	2,467	2,881	1,670
Population living below PPP \$1.90 a day (%)	0.5	68.7	33.5	46.6	33.6	34.6
Multidimensional poverty, population headcount (%)	na	70.2	88.2	66.4	36.0	70.3
Multidimensional poverty, population headcount (000s)	na	17,552	79,298	30,290	16,170	24,088
Estimated number of people 60+ in multidimensional poverty (000s)	na	950	4,606	1,663	699	945
Human Development						
Literacy rate (% 65+) ³						
Total	69.6	24.3	14.5	49.6	50.9	40.5
Male	82.5	44.8	22.5	66.2	67.6	62.6
Female	60.2	9.4	7.5	35.1	36.9	23.0
Gender parity index	0.7	0.2	0.3	0.5	0.6	0.4
Human Development Index						
HDI (total)	0.781	0.418	0.448	0.531	0.555	0.493
HDI (male)	0.796	0.540	0.484	0.546	0.577	0.523
HDI (female)	0.759	56.8	0.408	0.512	0.531	0.459
HDI global rank	64	181	174	151	146	163
Inequality-adjusted HDI	0.669	0.280	0.330	0.396	0.391	0.341
Overall loss in HDI due to inequality (%)	14.4	33.0	26.3	25.4	29.5	30.9

Data source: ¹United Nations (2017); ²UNDP (2016); na: not applicable. ³UNESCO Institute for Statistics database (2017); estimates relate to most recent period (2013-15). Gender parity index measures relative levels of literacy (number of females over number of males). <http://data.uis.unesco.org/>

The extent of poverty is further reflected in the overall human development index; most ESA countries are below the regional threshold ranking, within the bottom 25% of all countries in the world¹¹. The patterns of human development are unequal across selected ESA countries from 0.781 in Mauritius to below 0.500 in Mozambique, Ethiopia and Uganda (Table 2). The overall loss in human development attributed to inequality is pronounced in Kenya and Uganda. The vulnerability of older people is also reflected in their ability to read and write. For example, in Ethiopia, four out of five people aged 65 and above cannot read or write.

¹¹ There is little progress in human development in most countries within the ESA region (data not shown separately for each individual country).

Older women are relatively more disadvantaged in their abilities to read and write than men. Most countries in the ESA region have pension related benefit schemes in place (Table 3). The standard pensionable age is 60 years for males and females in the selected ESA countries, except for 55 years in Uganda. In Mozambique, the pensionable age for females is 55 years. Mauritius has a basic retirement pension scheme with universal coverage since 1950. Uganda has a Senior Citizens Grant scheme introduced in 2011 with universal and pensions-tested non-contributory type whereas Ethiopia has a social insurance scheme in existence since 1992. However, the coverage is very low in most countries. For example, the social insurance scheme reaches only 15% of older people in Ethiopia (Table 4). The percentage of older people benefiting from public pension is disproportionately low in Tanzania (3.2%) and Uganda (6.6%). The active contribution of working age population to pension scheme is also negligible. Most of the ESA countries, except Mauritius and Mozambique, draw pensions through non-governmental sources. The cost of pension in terms of percentage of GDP is 2.9% in Mauritius and less than 0.1% in other ESA countries. The universal social pension schemes seem to have had little measurable impact on poverty reduction in older people particularly in very low income settings (Guvén and Leite, 2016).

The most obvious problem is the implementation error which relates to the failure of systems to correctly identify the programme beneficiaries. In addition, high costs make the programme difficult to sustain in countries with limited government resources. Among ESA countries, Mauritius has a sound basic non-contributory pension system along with occupational compulsory and voluntary pensions, which have evolved in various forms since the late 1950s. There is a speculation that government finances will be insufficient to meet the future pension demand due to projected substantial increase in the share of older population (Soto, Thakoor & Petri, 2015). On the other hand, poverty-targeted cash transfer or small grant programmes have had relatively better outcomes for older people in sub-Saharan Africa. For example, the Social Assistance Grants for Empowerment (SAGE) programme in Uganda had a positive impact on the poverty reduction and improvement in the livelihood and food security of older people, and even reduced the elderly economic dependency burden on other household members (OPM, 2016).

Table 3: Trends in labour force participation rates of population aged 65+ (%), selected ESA countries

Country	% of population aged 55-64*						% of population aged 65+							
	Male			Female			Male				Female			
	2002	2006	2011	2002	2006	2011	2002	2006	2011	2015	2002	2006	2011	2015
Mauritius	63.3	62.8	68.6	23.5	23.6	30.3	16.3	13.4	16.1	16.2	4.2	3.7	5.3	5.7
Mozambique	93.9	94.5	94.4	90.3	90.4	89.8	88.5	88.5	87.3	85.4	79.7	79.2	77.4	76.1
Ethiopia	93.9	95.6	95.6	63.0	70.5	70.9	71.3	76.1	74.9	73.1	33.4	39.6	38.0	37.2
Tanzania	96.5	96.8	96.5	87.5	92.9	92.4	77.6	74.3	73.8	72.7	53.8	62.4	61.6	60.3
Kenya	88.2	86.3	86.4	76.1	75.2	75.3	68.7	62.9	61.9	61.1	56.2	51.7	50.4	49.6
Uganda	92.8	92.2	91.7	84.2	87.3	86.6	72.9	73.1	72.0	71.4	53.7	62.2	60.5	59.6

Data source: World Bank (2017). *2015 data not available

Table 4: Pensionable age and related benefit schemes, selected ESA countries

Indicators	Country					
	Mauritius	Mozambique	Ethiopia	Tanzania	Kenya	Uganda
Pension age (years)						
Male	60	60	60	60	60	55
Female	60	55	60	60	60	55
Scheme and year	Basic Retirement Pension (1950)	Basic Social Subsidy Programme ¹ (1992)	Social Insurance System (1963)	Zanzibar Universal Pension Scheme (2016)	Older Persons Cash Transfer (2006-07)	Senior Citizens Grant, (2011)
Type of programme ²	Universal	Means-tested non-contributory	Social insurance	Social insurance	Means-tested non-contributory	Universal and pensions-tested non-contributory
Old age pension beneficiaries (%)						
Total	100.0	17.3	15.3	3.2	24.8	6.6
Male	100.0	20.0	na	na	na	na
Female	100.0	15.9	na	na	na	na
Source of financing (%)						
Government	total cost	total cost	none	none(recent total cost)	none	none (recent total cost)
Insured person	na	na	7	10	6	5 (10 if voluntarily insured)
Employer	na	na	11	10-20	6	10
Self-employed	na	na	18	na	200 shillings a month	na
Active contribution of working age population (15-64) to pension scheme (%)	39.7	4.9	na	3.6	11.3	3.8
Non-contributory pension effective coverage, most recent period, number of recipients (000s)	184	341	na	27	310	60
Cost (% of GDP)	2.9	0.3	na	0.00317	0.0153	0.0324

Data source: various database, extracted from ILO (2017). *Notes:* ¹also known as Programa de Subsidio Social Basico (PSSB); ² In Tanzania, universal non-contributory system was introduced in 2016 (pensionable age: 70), and in Uganda, universal and pensions-tested non-contributory scheme was introduced in 2011 with 65 years as pensionable age for men and women (60 in Karamoja region);

Also, the Senior Citizen Grant (SCG) which directly contributes to the National Social Protection Policy in Uganda had spill over effects on local markets, asset accumulation, access to credit and increased purchasing power among the recipients (OPM 2016; Ibrahim and Namuddu, 2014). In Kenya, both financing and coverage of beneficiaries enrolled under the Old Persons Cash Transfer Programme (OPCTP) increased substantially since it was introduced in 2006 (Mathiu and Mathiu, 2012; Ikiara, 2009). The programme was later expanded to include additional reforms and services such as operational capability, complementary services, empowerment and small investments for older people (Mathiu and Mathiu, 2012). The neighbouring South Africa also had a mixed success with their Old-Age Pension grant, with a large proportion of rural older persons who meet eligibility criteria but not yet receiving pensions (Ralston et al. 2015). The government policies to engage older people in disaster preparedness and community resilience are generally weak in the ESA region. However, international donors, NGOs and relief agencies such as HelpAge International and Red Cross have clear strategies and mandate to involve older people in extreme natural disasters and rescue efforts. Mauritius has a National Disaster Risk Reduction and Management Centre and a National Emergency Operations Command which involve older people in disaster preparedness and rescue efforts. In Uganda, the Office of the Prime Minister has established a Directorate of Relief, Disaster Preparedness and Refugees. Unfortunately, there is no systematic documentation of these initiatives such as resources allocation, implementation strategies, monitoring and evaluation.

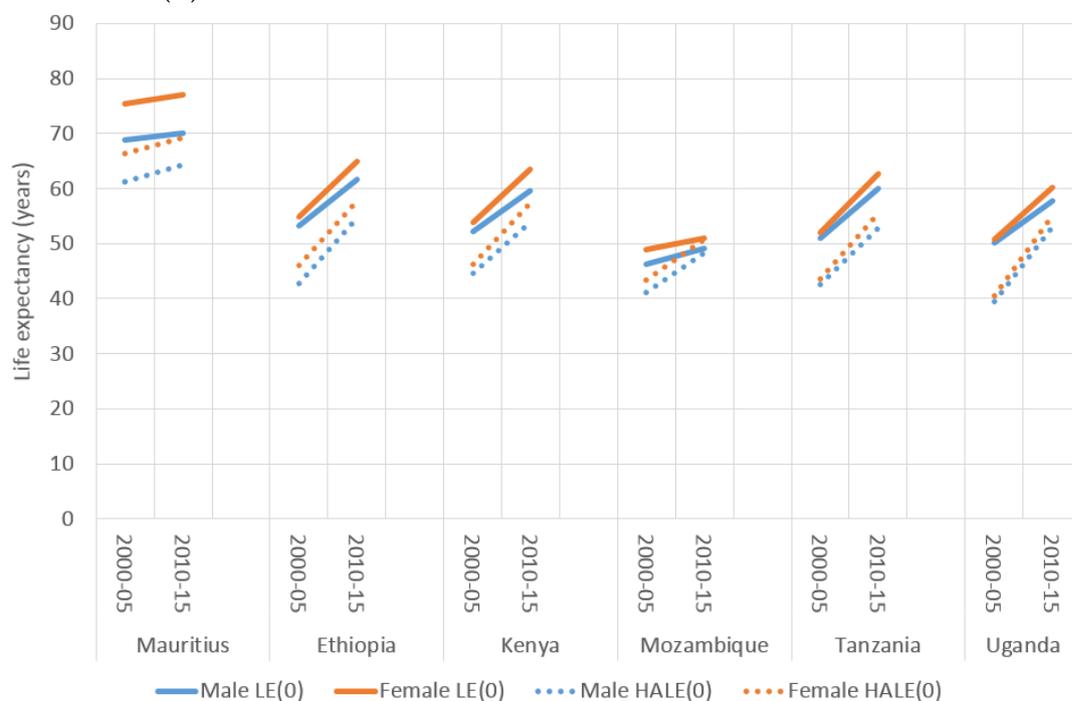
Advancing health and wellbeing in older age

The physical and mental health effects in older people are cumulative across the life course. In order to ensure successful and healthy ageing, older people should have equal access to preventive, curative and rehabilitative care, along with social protection and supportive social and economic environment (United Nations, 2002)

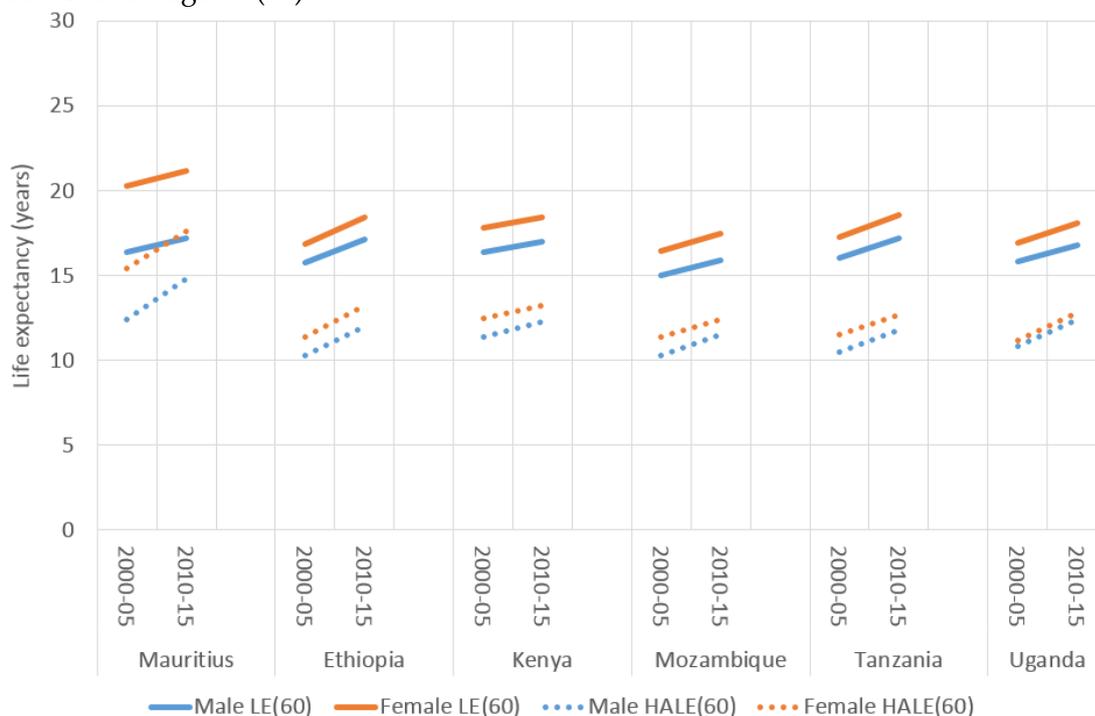
There has been a steady increase in life expectancy since 2000 in the ESA region, while trends in Mozambique have been mediated by gains in life expectancy prior to 2000 (Figure 3a). The increase in life expectancy is attributed to sustained reductions in under-five mortality along with gradual improvements in the diagnosis and treatment of communicable and non-communicable diseases. However, there is persistent gender gap in life expectancy and healthy life expectancy across all ESA countries. For example, the gender difference in both life expectancy and healthy life expectancy is the largest in Mauritius which also has the highest life expectancy among selected ESA countries. There is no perceptible gender gap in healthy life expectancy at age 60 in Uganda (Figure 3b).

Figure 3: Life Expectancy (LE) and Healthy Life Expectancy (HALE) in selected ESA countries, 2000-2015

3a. At birth (e_0)



3b. At exact age 60 (e_{60})



Data source: WHO 2016b; UN Ageing and Development Database 2017.

There is steady increase in additional years gained at 60 in most ESA countries, partly attributed to a significant decline in HIV mortality triggered by a steady increase in the coverage of antiretroviral therapy – ranging from 53-59% in Kenya, Mozambique, Tanzania and Uganda to 31% in Mauritius (UNAIDS 2017). Among selected ESA countries, Mozambique has the highest percentage of older adults (50+) living with HIV followed by Uganda, Kenya and Tanzania. The estimates from mathematical models show that about 3 million older people currently living with HIV in sub-Saharan Africa is predicted to increase further substantially by 2040 (Hontelez et al. 2012; Negin et al. 2012; Negin and Cumming, 2010). Older people living with HIV are also at heightened risk of social isolation, poverty, disease risk and care burden (UNFPA and HelpAge International 2012).

With increase in HIV survival rates and potential shift in disease burden towards older ages, the gap between life expectancy at age 60 and remaining years spent in healthy state is likely to shrink over the next few decades. Both communicable and non-communicable diseases are widely prevalent in the ESA region (Table 5). In Mauritius, with a relatively higher representation of older population, non-communicable diseases tend to dominate, mainly CVDs among those aged 70 and above, and increasingly diabetes, Urogenital, Blood and Endocrinal (UBE) conditions among 50-69 year old. On the other hand, there is a gradual shift in the causes of death from communicable to non-communicable diseases. For example, HIV/AIDS and Tuberculosis, neglected tropical diseases, malaria and diarrhoeal diseases prevalent in 2005 especially among 50-69 year old appear to have shifted downward in the ranking of causes of death. More generally, cardiovascular diseases (CVD), diabetes mellitus, endocrinal conditions, cancers and musculoskeletal diseases dominate the top five causes of death in ESA region. In terms of years of life lost to disability, there is a high burden of falls and cataract conditions among older women aged 70 and above especially in Ethiopia, Mozambique and Tanzania whereas their male counterparts have high burden of hearing impairment (WHO, 2016b). On the other hand, epidemiological data on dementia, cognitive impairment and other mental health disorders among elderly remain scant in the ESA region (Alzheimer's Disease International, 2017; Mavrodaris, Powell and Thorogood, 2013).

The increasing disease burden and shift towards non-communicable conditions among older population exert significant burden on health resources. Unfortunately, nationally representative data on healthcare and related expenditure among elderly are either non-existent or patchy in the ESA region, including those on health insurance coverage, premium and exemptions. However, general and employer specific health insurance schemes do exist in some countries such as the National Health Insurance Fund in Kenya, non-profit voluntary community-based insurance in Ethiopia, National Health Insurance Fund and Social Health Insurance Benefit scheme in Tanzania (NBS and ICF International 2015; Ali, 2014; Musau et al. 2011). Mauritius has relatively better provision of healthcare and financing options including private health insurance schemes for elderly than other countries. Uganda has provision of informal community-based health insurance and a National Health Insurance scheme has been initiated recently (Uganda Ministry of Health, 2015).

Table 5: Top five causes of death in selected ESA countries, 2005-15

2005				2015			
50-69		70+		50-69		70+	
Male	Female	Male	Female	Male	Female	Male	Female
Ethiopia							
CVD	CVD	CVD	CVD	CVD	CVD	CVD	CVD
HIV/AIDS & TB	HIV/AIDS & TB	Diarrhoea/LRI	Diarrhoea/LRI	HIV/AIDS & TB	Neoplasms	Diarrhoea/LRI	Diarrhoea/LRI
Diarrhoea/LRI	Neoplasms	HIV/AIDS & TB	Neoplasms	Diarrhoea/LRI	Diarrhoea/LRI	Neoplasms	Neoplasms
Neoplasms	Diabetes/UBE	Neoplasms	HIV/AIDS & TB	Neoplasms	HIV/AIDS & TB	Diabetes/UBE	Other NCD
Diabetes/UBE	Other NCD	Diabetes/UBE	Diabetes/UBE	Diabetes/UBE	Diabetes/UBE	Other NCD	Diabetes/UBE
Kenya							
HIV/AIDS & TB	HIV/AIDS & TB	Diarrhoea/LRI	Diarrhoea/LRI	Diarrhoea/LRI	Neoplasms	Diarrhoea/LRI	CVD
Diarrhoea/LRI	Diarrhoea/LRI	CVD	CVD	HIV/AIDS & TB	Diarrhoea/LRI	CVD	Diarrhoea/LRI
CVD	Neoplasms	Neoplasms	Neoplasms	CVD	CVD	Neoplasms	Neoplasms
Neoplasms	CVD	HIV/AIDS & TB	Other NCD	Neoplasms	HIV/AIDS & TB	Diabetes/UBE	Other NCD
Diabetes/UBE	NTDs & Malaria	Diabetes/UBE	HIV/AIDS & TB	Diabetes/UBE	Other NCD	Other NCD	Diabetes/UBE
Mauritius							
CVD	CVD	CVD	CVD	Diabetes/UBE	Diabetes/UBE	CVD	CVD
Diabetes/UBE	Diabetes/UBE	Diabetes/UBE	Diabetes/UBE	CVD	CVD	Diabetes/UBE	Diabetes/UBE
Neoplasms	Neoplasms	Neoplasms	Other NCD	Neoplasms	Neoplasms	Neoplasms	Other NCD
Musculoskeletal	Musculoskeletal	Chronic Resp	Neoplasms	Musculoskeletal	Musculoskeletal	Chronic Resp	Neoplasms
Cirrhosis	Other NCD	Other NCD	Chronic Resp	Other NCD	Other NCD	Other NCD	Neurological
Mozambique							
HIV/AIDS & TB	HIV/AIDS & TB	CVD	CVD	CVD	CVD	CVD	CVD
CVD	CVD	Diarrhoea/LRI	Diarrhoea/LRI	HIV/AIDS & TB	Neoplasms	Diarrhoea/LRI	Diarrhoea/LRI
Diarrhoea/LRI	Neoplasms	Neoplasms	Neoplasms	Neoplasms	HIV/AIDS & TB	Neoplasms	Neoplasms
Neoplasms	Diarrhoea/LRI	HIV/AIDS & TB	NTD & Malaria	Diarrhoea/LRI	Diarrhoea/LRI	Diabetes/UBE	Diabetes/UBE
NTD & Malaria	NTD & Malaria	Diabetes/UBE	Other NCD	Diabetes/UBE	Diabetes/UBE	HIV/AIDS & TB	Other NCD
Tanzania							
HIV/AIDS & TB	CVD	CVD	CVD	CVD	CVD	CVD	CVD
CVD	HIV/AIDS & TB	Diarrhoea/LRI	Diarrhoea/LRI	HIV/AIDS & TB	Neoplasms	Diarrhoea/LRI	Diarrhoea/LRI
Diarrhoea/LRI	Diarrhoea/LRI	Neoplasms	Neoplasms	Diarrhoea/LRI	Diarrhoea/LRI	Neoplasms	Diabetes/UBE
Neoplasms	Neoplasms	Diabetes/UBE	Diabetes/UBE	Neoplasms	Diabetes/UBE	Diabetes/UBE	Neoplasms
Diabetes/UBE	NTD & Malaria	HIV/AIDS & TB	Other NCD	Diabetes/UBE	HIV/AIDS & TB	Other NCD	Other NCD
Uganda							
HIV/AIDS & TB	CVD	CVD	CVD	CVD	CVD	CVD	CVD
CVD	Neoplasms	Diarrhoea/LRI	Diarrhoea/LRI	Neoplasms	Neoplasms	Diarrhoea/LRI	Diarrhoea/LRI
Neoplasms	HIV/AIDS & TB	Neoplasms	Neoplasms	HIV/AIDS & TB	Diarrhoea/LRI	Neoplasms	Neoplasms
Diarrhoea/LRI	Diarrhoea/LRI	Diabetes/UBE	Diabetes/UBE	Diarrhoea/LRI	HIV/AIDS & TB	Diabetes/UBE	Diabetes/UBE
Diabetes/UBE	NTD & Malaria	Injuries (uninten)	NTD & Malaria	Diabetes/UBE	Diabetes/UBE	Chronic Resp	Other NCD

Adapted from IHME (2016)

Non-communicable diseases

Communicable or infectious diseases

UBE: Urogenital, Blood and Endocrine Diseases; CVD: Cardiovascular Diseases; Injuries: (Unintentional); NCD: Non-Communicable Diseases; NTD: Neglected Tropical Diseases; TB: Tuberculosis.

Nonetheless, older people are subject to high burden of out-of-pocket expenditures in ESA countries. All selected ESA countries, except Uganda, have increased their budgetary provision for healthcare expenditure over the period 2000-2014 (see Appendix, Figure A1). However, the trends over time are rather modest. Most countries in the ESA region have high out-of-pocket expenditures, particularly Mauritius, Ethiopia and Kenya (Appendix, Figure A2). Data on out-of-pocket expenditures show generally fluctuating trends or have almost remain unchanged over the last few years, except in Tanzania where the decline was uniform between 2003 and 2007. Although similar decline was noted in Mozambique where the overall level is low, there has been an increase in out-of-pocket expenditure in recent years. However, it has to be noted that these data pertain to general population and not older population.

Unfortunately, there are no comparable data on healthy ageing indicators in the ESA region. In addition, there is little documentation of training of health providers specifically for geriatric care and related services.

Enabling and supportive environments

The immediate social environment and living arrangements of older people are fundamental to enhancing their quality of life and wellbeing. Older people are vulnerable to social isolation, stigma and discrimination, physical and verbal abuse and violence. Data on indicators of enabling and supportive environment are limited in Africa, particularly ESA region. We made a comparison of summary indicators of the GlobalAge Watch Index estimated by HelpAge International (HelpAge International, 2015; Zaidi, 2013).

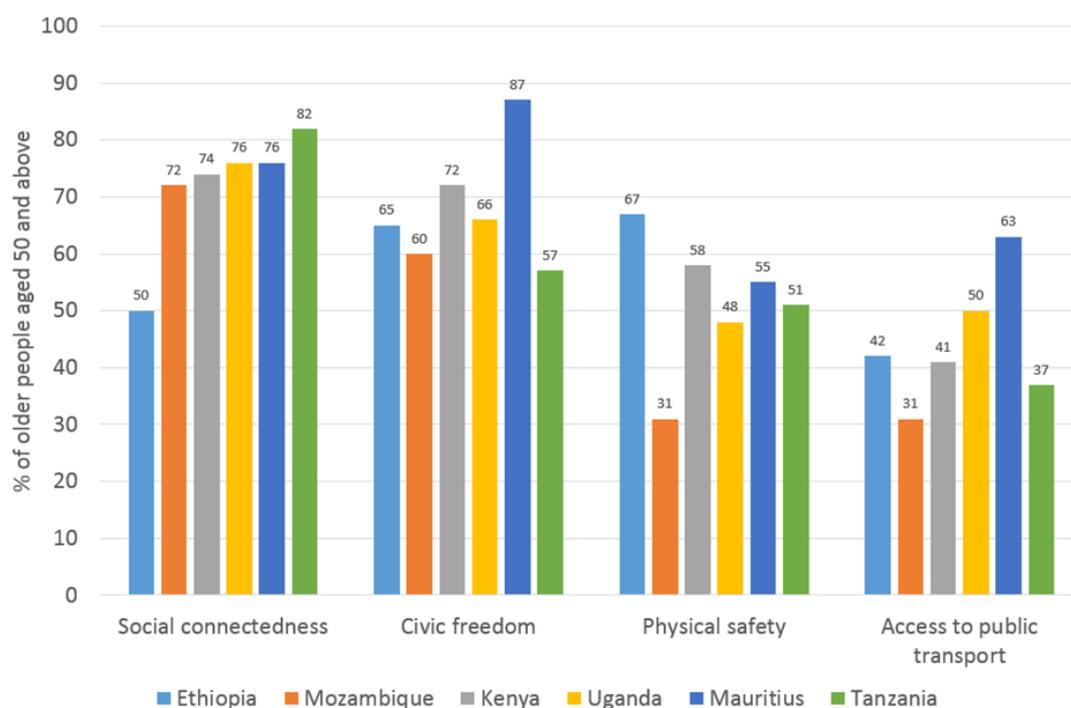
Figure 4 shows selected indicators of enabling environment for people aged 50 and above in ESA countries. The data for these subjective indicators are drawn from the Gallup World Poll Database¹². The indicators focus on people's perceptions about social connectedness, physical safety, civic freedom and access to public services such as transport. Social connectedness is perceived to be better in most ESA countries, except in Ethiopia where only 50% of the respondents provided affirmative responses. About 87% of respondents in Mauritius reported affirmative about civic freedom when compared to only 60% in Mozambique and 57% in Tanzania. On the other hand, physical safety and access to public transportation ranked the lowest amongst all indicators. For example, only about a third of respondents in Mozambique perceived to have better physical safety and public transportation access. While these data are interesting and comparable, it is difficult to validate and disaggregate the indicators by social, economic and spatial characteristics.

Many African countries are experiencing rapid urbanisation and older people are gradually becoming part of this transition. Based on data from the UN Ageing and Development database, one in two older people aged 65 and above in Mauritius live in urban areas whereas in Mozambique and Tanzania one in five live in urban areas (United Nations 2014). On the other hand, the majority of older people in Ethiopia, Kenya and Uganda live in rural areas. Migration is less common among older population. The share of older migrants aged 65 and above varies between 6-7% in Tanzania, and Uganda, and less than 4-3% in Ethiopia, Mauritius, Mozambique and Kenya (data not shown separately).

Yet another indicator of supportive environment is the living arrangements of elderly. Figure 5 shows the percentage of older people aged 65 and above living independently in the selected countries. Mozambique and Ethiopia are the only countries in two extremes where the percentage of older females living alone is higher than males, and the opposite is the case in Uganda and Tanzania. In Kenya and Uganda, one in five live alone when compared to one in ten in Ethiopia. In Kenya, older males living alone are vulnerable to high risk health behaviours such as excessive drinking and poor dietary behaviour due to inferior feelings of isolation and neglect, and they are generally hesitant or incapable of undertaking routine domestic chores (Bennett et al. 2016; Mudege and Ezech, 2009). However, older females are more likely to report functional difficulties and poor quality of life than older males (Wilunda, Ng and Williams, 2015; Ng et al. 2010). There are no comparable data on support of caregivers of older people and elderly abuse in the study context.

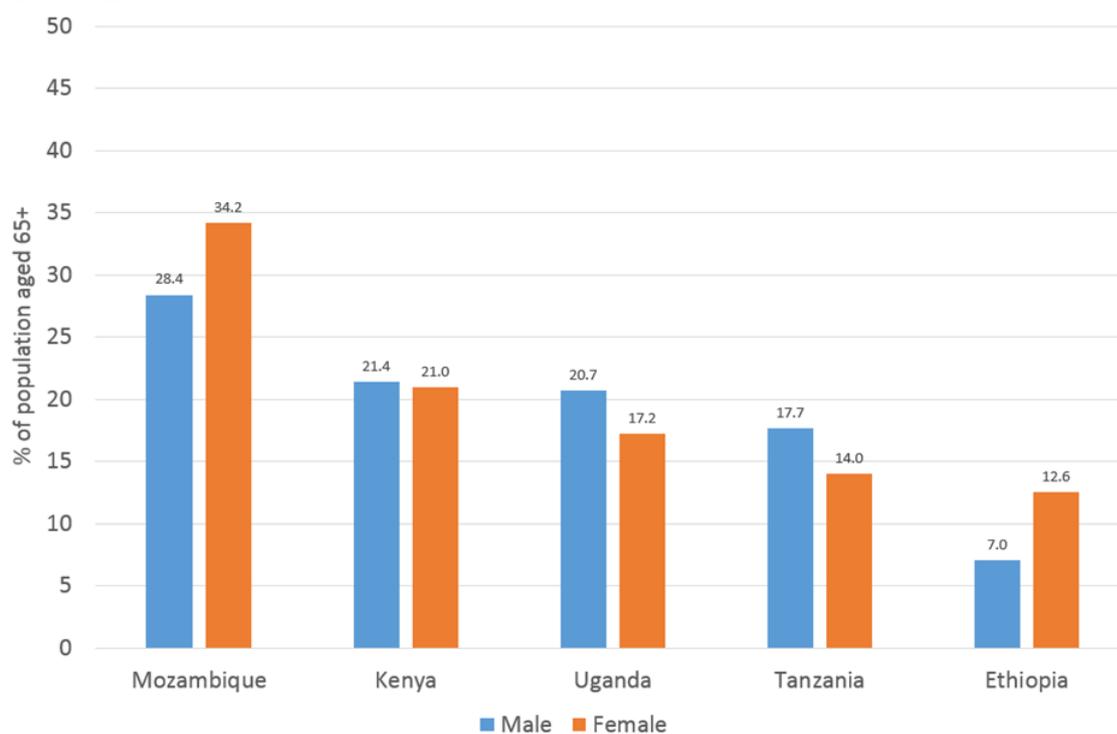
¹² <http://worldview.gallup.com>

Figure 4: Indicators of enabling environment for older people aged 50 and above in ESA countries.



Data source: HelpAge International (2015)

Figure 5: Percentage of older people aged 65 and above living independently in ESA countries.



Data source: UN Ageing and Development Database 2017. Data on Mauritius not available.

Discussion

We conducted a progress review of MIPAA milestones in selected countries within the ESA region of UNFPA, namely Ethiopia, Kenya, Mauritius, Mozambique, Tanzania and Uganda. There are some key developments and initiatives in terms of legislations and policies on older people in the region especially since the introduction of the MIPAA in 2002. However, it was difficult to conduct a systematic assessment of the impact and effectiveness of these measures due to lack of representative, consistent and comparable data at the country level. While most of the selected countries have initiated policies for older people, there was little systematic data collection and documentation of target settings, implementation strategies, outputs and outcomes (United Nations, 2016; Nabalamba and Chikoko, 2011; Aboderin, 2010). Mauritius is ahead of other countries in terms of legislations and government policies for older people, and the position of the country is reaffirmed by its rank in the Global AgeWatch Index (see Zaidi 2013). Apart from that, there is little internationally comparable scientific evidence on the health and wellbeing outcomes of older people. Although we have not been able to include all countries in the ESA region, the countries selected for this review represent different social, economic, demographic, cultural and geographic contexts. The findings presented in this report are based on an extensive review of literature and analysis of relevant data from national and international sources. We did find an array of research studies focused on living arrangements, health and wellbeing of older people. However, many of these are confined to small geographies or communities (e.g. slums) with no comparable indicators for the countries in the ESA region. Some of the indicators presented in the analysis are proxy indirect measures, and hence the findings should be interpreted with caution.

The countries in the ESA region are undergoing rapid demographic, economic and social transitions. Rapid urbanisation and migration (national, international and cross-border migration) of younger population have considerable implications on the living arrangements and wellbeing of older population. The share of older people living in big cities and large urban areas including slums is likely to increase in the future. To enable active and healthy ageing in African cities and urban areas, based on evidence from the WHO framework of global age friendly cities, would require multi-sectoral interventions to address the complex and insecure living conditions, health challenges, economic and social hardships that older people face especially in informal settlements or slums (Aboderin, Kano & Owii, 2017). On the other hand, the improvements in life expectancy and the characteristic shift in disease patterns from communicable to non-communicable diseases suggest potential increase in the disease burden and years spent in poor health. Older people are also vulnerable to experiencing high out-of-pocket expenditures related to both general and specialist healthcare. There is little documentation of financial barriers and the outreach and functioning of health insurance schemes especially in rural areas. It is also important to understand the factors associated with poverty and financial insecurity among older people, not entirely possible without the availability of credible age-disaggregated data. In addition, the extent of benefit of pension systems, insurance schemes and other welfare measures should be systematically monitored and evaluated. Unfortunately, there is also no evidence of actual involvement or engagement of older people in disaster preparedness and rescue efforts during conflict and natural disasters.

It is important to identify appropriate, comparable and context-specific indicators to accurately measure psychosocial, cultural and health dimensions of old-age vulnerability, at the individual, household and community levels. Equally important is the need to systematically validate the meaning and implication of vulnerability indicators (e.g. living alone, elderly abuse, social exclusion) in different sociocultural contexts. Based on the review of existing data and published literature including policy documents and official reports, it can be concluded that the progress of the MIPAA in the ESA region is mixed and inconclusive. This is mainly attributed to lack of appropriate measurable indicators and comparable data. From the programme evaluation perspectives, it is crucial to develop a coherent and standard toolkit for monitoring MIPAA progress (Sidorenko & Zaidi, 2018), and the efforts should focus on harmonising data collection and analysis, and capacity building. These efforts should be coordinated at the regional level and linked to relevant targets and indicators of the 2030 agenda of the UN Sustainable Development Goals and actions embraced under the 2003 African Union Policy Framework and Plan of Action on Ageing. We need to also ensure that population ageing challenges are systematically addressed in the mainstream developmental agenda, where appropriate identifying and redressing the ambiguities in policies and programmes, and documenting the information needs (Aboderin & Ferreira, 2008). We propose a set of key recommendations for monitoring and evaluating MIPAA strategies in the ESA region:

- (i) Foster national and regional high-level multi-sectoral cooperation for the systematic acquisition of official statistics on ageing and related indicators;
- (ii) Build technical capacity for collection, management and monitoring of data on older people, engaging national and international stakeholders, policy/programme specialists and academic researchers;
- (iii) Refine and develop new measurable indicators on ageing reflecting on the broader political, environmental, social, economic and cultural context of Africa region;
- (iv) Collect quality, comparable and population representative cross-national data through routine, repeated cross-sectional or panel household surveys specifically on living arrangements, health and wellbeing of older people; and
- (v) Undertake evaluation research for assessing the effectiveness and impact of legislations and policies on health and wellbeing of older people.

The ongoing policies, social protection programmes and legislative reforms aimed at including older people in the development process should be strengthened, monitored and, where appropriate, modified to address the psychosocial, economic and health needs of older people particularly those at risk of financial insecurity and social/family isolation

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