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# Regional Level Perspectives on Progress towards the MIPAA in Developing Regions

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# International Journal on Ageing in Developing Countries

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# Editorial: Three challenges in realising the MIPAA in developing regions

**Rachel Bennett[1] and Asghar Zaidi[2]**

## Introduction

The year 2017 marked fifteen years since the adoption of the Madrid International Plan of Action on Ageing (MIPAA), deemed to be a major breakthrough in the way the world seeks to support older people. The MIPAA focuses on three priority areas: older persons and development, advancing health and wellbeing into old age and ensuring enabling and supportive environments, and sets out 239 recommendations in relation to its 35 objectives. The Madrid Plan is the successor to the Plan adopted during world's first international policy framework on ageing, the Vienna International Plan of Action on Ageing (VIPAA) introduced some thirty years earlier in 1982. Although a landmark agreement in its own right, the implementation of the VIPAA was perceived to be of most relevance to advanced economies which already had aged populations, and little progress was made in implementing its' recommendations in developing countries with younger age profiles (Sidorenkno & Zaidi, 2018). The MIPAA reaffirmed commitments made in the VIPAA, but also sought to be of increased relevance in developing as well as developed countries. Further, the MIPAA took an explicitly rights based approach and encouraged the mainstreaming of ageing issues into general policy and development discourses (Sidorenko & Walker, 2004; Marin & Zaidi 2007), with a key commitment being to 'build a society for all ages' (United Nations, 2002).

Fifteen years since the MIPAA's adoption, there are 962 million people aged 60 years or over globally, over twice as many as in 1980 when preparations for the VIPAA were underway (UNPD, 2017). This figure is projected to rise to 2.1 billion by 2050 with the biggest growth to be seen in developing countries. Indeed, almost eight in every ten older people globally will live in a developing region by the middle of the century (ibid.). Whilst the MIPAA is not legally binding and responsibility for its implementation lies primarily with national governments, information and best practice sharing at the international level is strongly encouraged. Indeed, the United Nations has been collating evidence for its' third five-year review on the implementation of the Plan (ECOSOC 2017). Thus, it is a timely opportunity to reflect on progress made in developing countries, as well as to analyse the challenges that lie ahead in regions set to grow old before they grow rich.

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This special issue of the International Journal on Ageing in Developing Countries brings together regional level perspectives on progress towards the MIPAA from Africa, Asia and Latin America and the Caribbean. A subsequent special issue on the same topic includes country-specific examples on implementing the Madrid Plan.

The authors of the papers in this issue include academics and policy professionals, and as such bring a range of expertise and insights to the issue. Whilst each paper provides its own unique contribution, analysis and conclusions, three common challenges in realising the MIPAA are evident across this collection of papers. We summarise these three challenges below.

*(1) The complex realities of ageing in developing countries*

Papers based on analysis from multiple regions in this issue highlight key nuances with the application of the MIPAA to their contexts largely linked to their developmental stage. For example, several papers highlight that high labour force participation rate reflects a lack of safety nets and alternatives rather than necessarily a success in supporting the choices of older workers (Padmadas et al. 2018; Salazar & Jenkins 2018; Sibai et al. 2018; Quashie et al., 2018). Whilst social pensions are yet to be the norm in many developing countries, there are examples of developing countries with well-developed social protection schemes analysed in this issue – for example Padmadas et al. describe Mauritius's long-standing scheme well as recently introduced social pensions such as Uganda's Senior Citizens Grant, whilst Salazar and Jenkins describe the Universal Social Security System in Cuba. Indeed, there is a growing body of evidence from across world regions that social pensions can be a key building block to development not only amongst older people but also their wider families and households (World Bank 2012; Mendizabal 2014). Further, in analyses of progress towards advancing health and wellbeing into old age, several papers describing limited progress in supporting mental health, training of medical specialists and prevention of non-communicable disease, but at the same time flagging up that the countries in their regions continue to face a substantial burden of infectious disease (Abla et al. 2018; Padmadas et al. 2018; Parry et al. 2018; Quashie et al. 2018).

As is eloquently argued in the conclusion of Sibai and colleagues (2018) paper, we need to strive to make supporting older people part of the development process, rather than implicitly conceptualising support for older people happening once a certain level of economic development has been achieved. This is reflected in Huber's (2005) UN paper on how the MIPAA should be implemented, which recognised diversity between and within countries. Thus, flexibility to recognise the differential starting position of different regions, such as with disease profiles, and the close interlinkages between some objectives, such as those linked to labour force participation and social protection coverage and adequacy is important.

*(2) Limited availability of data*

The shortage of high quality data is highlighted in multiple papers (Faye & Andrade 2018: Padmadas et al., 2018; Parry et al., 2018; Quashie et al. 2018; Sibai et al. 2018). At a population level, old age is associated with declining health and ability to engage in work, which can make older people a vulnerable group. However, this potential vulnerability is masked when statistics are only produced for the total population or total adult population. This makes older people invisible and difficult both to assess and celebrate progress in supporting older people in relation to the MIPAA, and to evidence where countries are falling short of their commitments. High quality evidence on the situation of older people is particularly valuable for resource-constrained settings where policymakers are faced with limited budgets and juggling multiple pressing priorities. Whilst in general there is greater availability of age-disaggregated data in developed countries, the issue is not exclusive to developing countries. For example, the lack of representative data on elder abuse mentioned in several of this issue's papers is in fact a global issue (WHO, 2014). Very limited information is available in many countries around the world on the extent of violence, abuse and neglect of older persons. Even where data are available, cases are often underreported and prevention policies are lacking.

There are examples of innovative use of existing data in developing countries to shed light on the relative situation of older people. Indeed, in their paper reviewing the data challenge for monitoring ageing in Asia and the Pacific, Parry and colleagues (2018) note disaggregating existing data by age group and removing the age cap on existing surveys may be the most realistic options for resource-constrained countries seeking to improve data availability on ageing. Faye and Andrade (2018) adopt the approach advocated by Deaton and Paxson (1995) of using USAID's Demographic and Health Survey (DHS) data to estimate wealth amongst households which include older people in Western and Central Africa countries. The DHS programme is a large household data collection effort in developing countries which samples households that include at least one woman aged 15-49 years. Information on all household members is then collected, and this enabled Faye and Andrade to demonstrate that households which include older people are more likely to be poor than household which do not include older people.

With sufficient political will and resources, there could be greater moves towards nationally representative surveys which specifically focus on the wellbeing of older people and thus provide evidence on progress towards the breadth of recommendations in the MIPAA. There are multiple models of high quality ageing surveys which are used for cross-country comparisons in developed countries, such as the Survey of Health, Ageing and Retirement in Europe (SHARE), and increasingly in developing countries, such as the Study on Global Ageing and Adult Health (SAGE) which includes six middle income countries. The new national survey on older persons in Iran, to be conducted during 2018, is a good practice example in this respect where policymaking communities in a resource-constrained country appreciate the value of high-quality evidence base on older persons. The formation of the new United Nations Titchfield City Group on Ageing and Age-disaggregated data also provides

us with a unique opportunity to ensure that countries learn from each other in the collection of age-disaggregated data and monitor progress in the implementation of the MIPAA.

*(3) Paucity of agreed arrangements for monitoring & implementation*

Part of the issue around lack of age-disaggregated data is the lack of clear guidance in the MIPAA documents on the need to collect this data in order to monitor progress. Indeed, the MIPAA lacked a comprehensive and consistent approach to its monitoring which makes it difficult to assess implementation and to fairly compare progress across countries and regions (Sidorenko & Zaidi, 2018). There are examples of successes at a regional level in introducing binding commitments, such as the Inter-American Convention on the Protection of the Rights of Older People described in the Montes de Oca et al.'s paper on policy developments in Latin America and the Caribbean. However, multiple papers in this issue cite the limitations of information on legislative change, pressures of resources and limited political will as obstacles to success in the implementation of the supporting older people (Padmadas et al., 2018; Quashie et al. 2018; Sibai et al., 2018). Inconsistent implementation and monitoring is perhaps to be expected given that the Madrid Plan is not a legally binding obligation.

However, in recent years, there is renewed momentum behind supporting vulnerable groups. In contrast to their predecessor, the Millennium Development Goals, the new 2030 Agenda of the Sustainable Development Goals (SDGs) makes specific mention of older persons and ageing as a cornerstone of sustainable development (Bennett and Zaidi, 2016). Key pledges in the Agenda are to 'leave no one behind' and 'reach the furthest behind first' (United Nations, 2015). In support of these commitments, an explicit target in the implementation of the SDGs is to increase the availability of high quality age-disaggregated data. These commitments clearly resonate with the MIPAA's pledge to 'build a society for all ages'. Therefore, a key opportunity ahead is capitalising on this renewed momentum to include the needs of older people in development planning and to build high quality metrics to assess progress over time, so that they can also contribute to monitoring and implementation of the MIPAA. Parry and colleagues (2018) provide an assessment of the challenges of monitoring active ageing in the Asia-Pacific region. They conclude that a dashboard of indicators which align with the Active Ageing Index of Zaidi et al. (2017) but also link with the MIPAA commitments could form part of the solution on how to monitor the MIPAA, stressing that the dashboard of indicators should be adapted according to context-specific factors in particular countries/regions and developmental stage and existing data infrastructure.

These overarching themes as well as the nuanced findings and analyses presented in each paper, show that whilst ageing is increasingly evident on policy agendas in developing regions there are still significant challenges and obstacles ahead as we strive to build a global society for all ages.

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# Monitoring active ageing in the Asia-Pacific region: Recommendations for future implementation of the MIPAA

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***Abstract.*** Being uniquely positioned in terms of population growth and rapid ageing, the Asia-Pacific region is of high importance in ensuring that the Madrid International Plan of Action on Ageing (MIPAA) monitoring and implementation framework is accessible and attractive to member States, the majority of which are developing and have varied resources and research infrastructures. This paper reviews the current data collection processes of 14 countries in the Asia-Pacific region, and discusses the various frameworks being used to monitor active ageing in the global context. We consequently suggest how a more functional and sustainable set of metrics can be developed to maximise countries' participation in the MIPAA implementation and to build ageing knowledge globally, in particular around developing countries. We conclude that a dashboard of indicators that both constructs the Active Ageing Index (AAI) and is aligned with the key priorities of the MIPAA should become part of the toolkit to monitor MIPAA implementation in the future, but so too this framework should incorporate Asia-Pacific indicators that reflect the region's unique demographic context and priorities, such as the community support.

**Keywords:** Asia-Pacific, active ageing, older population, monitoring, MIPAA, developing countries.

## Introduction: Ageing in the Asia-Pacific region

The Asia-Pacific region is among the fastest ageing and is the most populous region in the world (United Nations Development Programme [UNDP], 2016). It also comprises a diverse range of country circumstances, from developed countries like Australia and Japan, to transitionary Commonwealth of Independent States (CIS) countries, and taking in Confucian, Buddhist, Islamic and Christian value systems (Phillips, 2000). It is made up of countries that the United Nations classifies as developing, including China, Indonesia, India and Pakistan.

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Indeed 46 out of 58 (79%) of the countries represented by the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP, 2017a) are categorised as developing, and small island states make up a large proportion of these.

The Asia-Pacific region is undergoing dramatic transformation, both economically, encompassing some of the world's fastest-growing economies - change that is having dramatic impacts in terms of poverty reduction (UNESCAP, 2017a) - and demographically, with ageing occurring considerably more rapidly than in Organisation for Economic Cooperation and Development (OECD) countries. The older population of the Asia-Pacific region is expected to double by 2050, by when older persons will make up a quarter of the region's population (United Nations Development Programme, 2016; UNESCAP, 2017a). There is significant variation across this large and diverse region, which contains an estimated 60% of the global older population (UNESCAP, 2017a). For example, poverty reduction has been dramatic in China, falling from 67% to 1.9% over the period 2000-2013, and while life expectancy in countries like Japan and Australia is high at over 80, other countries such as India, Pakistan and Afghanistan lag significantly behind, with life expectancies under 70.

Quality of life is also changing in the region; at the same time as life expectancy trends have shifted upwards, the Asia-Pacific region retains some of the world's highest death rates for non-communicable diseases (NCDs), with a double-burden of communicable disease in many developing countries, where older persons are particularly at risk (UNESCAP, 2017a; United Nations Populations Fund [UNFPA], 2017). The United Nations Development Programme (UNDP, 2016) has distinguished the pace of ageing in the region in terms of 3 key groups of countries:

- Approximately one third of countries have more youthful populations that will experience ageing in two to three decades' time, and tend to be lower-income;
- Another middle group of just under half of the Asia-Pacific countries where the fastest growth is occurring among the working age population, including China which currently contains over 40% of the region's older population; and
- Another quarter of countries that are ageing rapidly and now have aged populations, which are concentrated in East Asia.

These demographic differences will necessarily require different kinds of policy responses. Notwithstanding gains in circumstances and longevity, 400 million persons in the region live in extreme poverty, an experience concentrated particularly in South Asia. Older persons are more vulnerable to poverty due to their weaker relationship with economic activity, with women and those in rural areas at higher risk (UNESCAP, 2017a). This is exacerbated by a relatively low retirement age, the effect of which is to prolong retirement and potential dependency, as well as increasing the risk of economic disadvantage in later life. Only about a third of the older population in the region are in receipt of a pension (UNFPA, 2012; United Nations Economic and Social Council [ECOSOC], 2017) identified improving older persons' access to good quality work as a future challenge.

Value systems that venerate the supportive multi-generational family are reinforced in developing countries (UNDP, 2016); however, shifting demographics can weaken these assumptions, as is already being seen in Japan and South Korea (Choi, 2010; Kumagai, 2014). The pace of ageing in the Asia-Pacific region will have major consequences for employment, health and long-term care, social protection, and disadvantage and income security in later life. Since countries are at distinct stages of demographic transition with divergent resources, infrastructures around these are uneven and policy actions varied, and developing and rapidly ageing societies are experiencing particular challenges. It is critical that robust and consistent mechanisms are applied to the collection of country-level ageing information to enable trends to be monitored and responded to. A trend to watch, likely to impact upon older persons' experience, is the outmigration of care workers, creating a shortage of qualified caregivers at the same time as the Asia-Pacific region is experiencing accelerated ageing (UNESCAP, 2017a).

**Current measurements around the Madrid International Plan of Action on Ageing**

At the international level, the Madrid International Plan of Action on Ageing (MIPAA) of 2002 provided a comprehensive framework on how to address population ageing and protect older persons' rights, through actively involving them in the development process, ensuring their health and well-being, and providing an enabling, age-friendly environment. These priorities were intended to reflect the ageing agenda of developing countries more than the MIPAA's predecessor, the Vienna International Plan of Action on Ageing (VIPAA) of 1982. Indeed, Sidorenko and Walker (2004) have described the broad formulation of the Vienna Plan as humanitarian in comparison to the more development-oriented MIPAA. Since the Vienna Plan, demographic ageing has taken hold in developing countries, and their accelerated ageing demands a more refined set of global indicators.

The MIPAA's strategic framework drills-down to ageing indicators around each of its three priority directions, through a suite of 18 issues, 35 objectives, and 239 policy recommendations, with the anticipation that monitoring is bottom-up. Countries were not expected to be mandated to provide information on all indicators, given their differential circumstances and resources. Indeed, Huber (2005) has emphasised the necessary variation in the speed and direction of countries implementing the MIPAA roadmap, reflecting developmental differences, but also in placing a specific priority on issues of an older population. Moreover, inconsistencies around national reporting problematise meaningful comparisons between countries, and make it difficult to assess when countries have effected progress in supporting ageing societies.

United Nations Guidelines (2006) were subsequently developed that populated the MIPAA objectives in attaching a mixture of instrumental and outcome indicators to each, which reflected a detailed set of actions on which countries were encouraged to collect and analyse data. This process of review and appraisal was intended to enable member States to identify gaps, priorities and emerging issues around ageing, feeding into responsive actions, and enabling more effective tracking of progress around goals.

In the Asia-Pacific region, review and appraisal of the MIPAA has been supported by the Economic and Social Commission for Asia and the Pacific (ESCAP), which produces Regional Implementation Strategies on a five-yearly basis. The first of the region's implementation strategies preceded the MIPAA, at the same time as it was aligned with its key priority directions: the Macao Plan for Asia and the Pacific, otherwise known at the Shanghai Implementation Strategy (SIS) of 1999. In a key distinction from the MIPAA, the SIS differentiated implementation and monitoring activity as a policy domain in its own right, and as key to supporting the shared priorities of development, health and environment (UNESCAP, 2003). ESCAP's current work is guided both by the MIPAA and by the 2012 Bangkok Statement on the Asia-Pacific Review of the Implementation of the MIPAA. The Macao Ageing Index (Table 1) was developed to complement the SIS in measuring policy progress, and totalled 88 policy implementation indictors (Chan *et al*., 2010).

Regular regional reviews enable ESCAP to agree a supportive framework for action around implementing the MIPAA, reflecting member States' diverse profiles. The third review of 2017 (UNESCAP, 2017a) has been strongly formulated with reference to the 2030 Agenda for Sustainable Development Goals around which there is global consensus on international development. The 2030 Agenda has pledged 'leave no one behind' and helped identify emerging issues in the region around learning opportunities throughout the life-course, broadening access to technology, and the need for age-disaggregated data: in particular around the provision of unpaid care by older persons (UNESCAP, 2017a). As part of the third review, for the period 2012-2017, ESCAP conducted a country survey, securing responses from 28 of the region's 58 countries, information that covered 89% of the region's population (UNESCAP, 2017a). Similarly, UNFPA's synthesis of Asia-Pacific countries' MIPAA progress drew upon a subsection of the region: 26 countries (UNFPA, 2017).

**The challenges of data collection and complementary approaches**

Our recent analysis of regional approaches to implementing the MIPAA for UNFPA (Parry and Zaidi, 2018, reports 1-5) indicated a large degree of variation in the United Nations regions' capacities to comply with the level of data compilation required to respond in full to the MIPAA. In particular, there was uneven progress across the Asia-Pacific region in the key MIPAA three priority areas, with: social protection programmes being uneven, particularly so in countries with extreme poverty, and women the most vulnerable (priority area 1); ad hoc responses to older persons' needs in emergency planning (1); limited access to free healthcare (2); geriatric facilities limited to higher-income countries (2); limited mental health services for older persons (2); and scarce data around elder abuse (3).

In large part, these gaps were most accentuated in developing countries. In terms of data collection, an extensive informal sector in the region has problematised monitoring around employment indicators. Given the Asia-Pacific region's unique position in relation to the ageing challenge, it is vital that high quality age-disaggregated data is collected to support this transition.

The first decade-and-a-half of regional monitoring around the MIPAA has highlighted the variability of practices, which raises the issue about how data monitoring frameworks can be usefully refined. Sidorenko and Walker (2004) have lobbied for more systematic evaluation processes, and, by illustration, developed a matrix linking thematic priorities and policy domains with desired quality of life goals. They argued that the demonstration of clearer linkages between outcomes and actions would simplify and strengthen monitoring processes, potentially enhancing participation among developing countries. Within each policy domain, the authors suggested that outcomes be measured in a continuum, for example, running from social exclusion through to integration and participation. This approach was intended to make goals more specific and impactful in older persons' lives, but also provides a ready-to-use evaluation template. In order to illustrate how this kind of monitoring could be implemented, the matrix was populated with examples of typical actions from the MIPAA under quality of life targets (*ibid*.).

In Sidorenko and Zaidi's more recent analysis of the review process around the MIPAA (2018), they draw attention to a lack of clearly-defined appraisal criteria, leading to a disproportionate submission of anecdotal, descriptive and self-defined information, and little deeper evaluation of the relationship between outputs and policy impact. In particular, they critique the limited use of indicators in national reporting, an approach that has hampered assessment of country-level progress, as well as benchmarking exercises, at the same time as they note that inconsistency and varied reporting patterns is unsurprising in a voluntary system. They recommend a MIPAA monitoring toolkit with different layers of indicator, along the lines of the dashboard of indicators used in the Active Ageing Index (AAI), which are aligned with the MIPAA's three priority directions.

Amid the challenges of data collection across a diverse regional context, in this paper we review how data is currently being collected in different countries across the Asia-Pacific region, illustrating some of the variation and challenges of complying with the MIPAA amid different circumstances. Given the existing frameworks for monitoring active ageing across a global context, we then reflect upon their utility in developing a functional set of metrics that will maximise their adoption, and provide higher quality information to support monitoring of the region's MIPAA implementation. This is important both in terms of global comparison, but also at the national policy level, enabling the impact of initiatives to be evaluated and improved, and identifying gaps for future development.

A key recommendation of previous reviews of the MIPAA assessment process has been the need to establish a comprehensive international set of indicators that provide for sufficient nuance to make meaningful evaluation of national progress against its framework (Sidorenko and Zaidi, 2018). These authors' analysis of ageing policy frameworks proposes a closer engagement with key stakeholders, and a review process with three key components: comparative indicators on ageing for mutual learning; indicators that are accessible to national and international policy-makers; and a signal towards areas for future policy actions in different contexts across the world.

In the Economic Commission for Europe (ECE) United Nations region, in parallel to MIPAA data monitoring, efforts have been undertaken to quantify countries' responses to the ageing challenge by conceptualising them in terms of 'active ageing' (Zaidi and Stanton, 2015; Zaidi *et al*., 2017). In this, the UNECE has set out to identify where programmes and policies can stimulate older persons' contributions and potentials, drawing upon the World Health Organisation's definition of active ageing (WHO, 2002). Analysis is achieved through the projection of an index, populated by indicators around different priorities (employment, social participation, independent living, and capacity for active ageing), onto which countries' scores are plotted. This calculation enables policy makers to make accessible assessment of international differences, and to measure progress achieved in active ageing and its different components, identifying areas for intervention and support. Scores range from 0 to 100, providing a single indicator of country-level development on an issue, and enabling benchmarking and tracking of policy impact to be conducted. The first results of the Active Ageing Index (AAI), based on the 28 EU member states, were published in 2012, comprising information on 22 indicators, organised around four domains, and disaggregated by gender.

Active ageing values can be broken down by individual indicator, combined into policy domains, or summarised in an aggregated country score, facilitating global comparisons and the production of a league table of progress around active ageing. The 2015 AAI analytical report (Zaidi and Stanton, 2015) set the AAI goalpost score at 57.5. While developed in relation to EU countries, the AAI has been extended to cover Russia, the USA, Canada, Switzerland, Iceland, Norway, India and China, and is continually evolving to engage with global ageing factors. In recent analysis, Scandinavian countries scored high on the AAI (Zaidi *et al.*, 2017), and a gender disparity emerged in terms of healthy and active ageing. Given its success in testing, and in line with the momentum created by the ageing challenge in the Asia-Pacific region to find more functional ways of monitoring active ageing, the AAI has particular relevance to our discussions.

As the AAI gains traction beyond the EEC region, its advantages in terms of enabling rapid national comparisons and estimations of progress through the use of a single set of accessible indicators, are evident. There is a need to also ensure that meaningful monitoring systems around active ageing are synchronised with the sustainable development agenda (see below), which has received international buy-in, to ensure that demands for metrics speak to each other intelligently, and facilitate motivation among countries where data collection infrastructure is less developed.

The 2030 Agenda and its Sustainable Development Goals (SDGs) are committed to create development and prosperity for persons of all ages, including those in old age (United Nations, 2015). In contrast to their predecessor, the Millennium Development Goals, the new post-2015 SDGs make specific mention of older persons and ageing as a cornerstone of sustainable development (Zaidi, 2016; Bennett and Zaidi, 2016).

In monitoring the SDGs, there is broader commitment to disaggregating indicators by age and gender, characteristics that have often been lacking in data collection in developing countries. For instance, Goal 3: Ensure healthy lives and promote well-being for all at all ages, is

particularly relevant for older persons in positioning them as one of the main beneficiaries for future international development processes. The most critical implementation tool of the SDGs is its indicators framework. The 17 Goals and their 169 targets will be followed up and reviewed systematically using a set of global, largely quantitative indicators.

However, the development of the SDG indicators framework has been challenging as it must address all aspects included in the targets, at the same time as enlisting pragmatism regarding the means of implementation by national statistical authorities. In many countries, existing statistics are not suitable for this purpose. To better understand and promote the role of older persons in the development process, and to assess their economic, social, health and cultural conditions, it is crucial that countries develop systematic statistical systems. This will include not just data collection for older age groups, but also systematic analysis, with disaggregation by age and sex to fill evidence gaps. There could be three options:

(1) Disaggregate existing survey and administrative data by age for older age-groups;

(2) Remove the age-cap on existing surveys and include older persons in the survey;

(3) Develop new specialised survey instruments to collect data directly from older persons.

The first two options may be the only feasible options for many of the resource-constrained countries in Asia and the Pacific. However, it can be strongly recommended that all countries invest in collecting data using the specialised survey instruments and methodologies to collect data on older men and women.

The coverage of the ageing indicators respectively considered in the MIPAA, AAI and the Asia-Pacific Macao Index are compared in Table 1 below. As gaps are highlighted in each of the frameworks, MIPAA indicators may need to be supplemented in the future, evolving around MIPAA priorities as social conditions shift around ageing, an issue that we discuss in the conclusion.

These three frameworks indicate a large degree of convergence, but also gaps in indicators around: rural development (AAI and Macao); access to knowledge, education and training (Macao); emergency situations (AAI and Macao); older persons and HIV/AIDS (AAI); training of care providers and health professionals (AAI and Macao); and images of ageing (AAI). Some of these, such as a lack of indicators around emergency situations in the Macao Index, indicate a pressing gap given the history of natural disasters in the Pacific area.

In other respects, the MIPAA could be supplemented with indicators that other indexes collect information upon: social connectedness (AAI), physical exercise (AAI); social services and community support (Macao); regional mechanisms on ageing (Macao); and regional and international cooperation (Macao). This degree of convergence, but also differences between frameworks, provides actionable evidence for how monitoring frameworks might be refined to enhance their utility and maximise countries' participation in the future.

**Table 1: Comparison of ageing indicators: United Nations Guidelines on the MIPAA, the Active Ageing Index and the Macao Index**

| MIPAA Indicators | Active Ageing Index | Macao Ageing Index |
|---|---|---|
| **Priority 1: Older Persons and Development** | | |
| 1: Active participation in society: volunteering; voting; caring for grandchildren; decision-making | 2.1 Voluntary activities<br>2.4 Political participation | Active participation of older persons |
| 2. Work and the ageing labour force: employment rates; informal sector and business ownership | 1.1–1.4 Employment rate by 5-year age band | Older persons and market security |
| 3. Rural development: small-scale enterprises; community support services; migrant programmes | ➢ Gap | ➢ Gap |
| 4. Access to knowledge, education and training: educational attainment; literacy; education and training programmes; telephone and PC ownership | 3.8 Lifelong learning<br>4.4 Use of ICT<br>4.6 Education attainment | ➢ Gap |
| 5. Intergenerational solidarity: positivity and provision of support across generations | 2.2 Care to children and grandchildren | Older persons and the family |
| ➢ Gap | 4.5 Social connectedness | ➢ Gap |
| 6. Eradication of poverty: rates below poverty lines | 3.5 Poverty risk | Poverty and old age |
| 7. Income security, social protection/social security and poverty protection | 3.4 Financial security | Social protection/social security |
| 8. Emergency situations: appropriate assistance and targeting; contribution to rebuilding | ➢ Gap | ➢ Gap |
| **Priority 2: Advancing Health and Wellbeing into Old Age** | | |
| 1. Health promotion and well-being throughout life: risk reduction; life expectancy; disability; chronic morbidity; safe water and nutritional programmes | 4.1 Remaining life expectancy at age 55<br>4.2 Share of HLE at 55 | Health and nutrition |
| ➢ Gap | 3.1 Physical exercise | ➢ Gap |
| 2. Universal and equal access to healthcare services | 3.2 Access to health services | Access to healthcare services |
| 3. Older persons and HIV/AIDS: prevalence; social support; caring for adult children and grandchildren | ➢ Gap | Older persons and HIV/AIDS |
| 4. Training of care providers and health professionals, geriatric-driven healthcare services | ➢ Gap | ➢ Gap |
| 5. Mental health needs of older persons; incidence and treatment rates | 4.3 Mental well-being | Disability and mental health needs |
| 6. Older persons and disabilities: programmes preventing functional decline; adapted housing | 4.2 Healthy life expectancy | |
| **Priority 3: Ensuring Enabling and Supportive Environments** | | |
| 1. Housing and the living environment: sanitation, lighting; mobile services; transportation systems | 3.3 Independent living | Housing and the living environment |
| 2. Care and support for caregivers: support services; caregivers' satisfaction; older persons providing care | 2.3 Care to older adults | Care and support for caregivers |
| 3. Neglect, abuse and violence: prevalence | 3.7 Physical safety | Neglect, abuse and violence |
| 4. Images of ageing: positive attitudes of ageing | ➢ Gap | Productive ageing |
| ➢ Gap | ➢ Gap | Community support |
| ➢ Gap | ➢ Gap | Regional ageing mechanisms |
| ➢ Gap | ➢ Gap | Regional and international cooperation |

**Data feasibility for the Active Ageing Index indicators in the Asia-Pacific region**

At present, there is no single source that identifies all the countries and multi-country studies of ageing in the Asia-Pacific region. Several past attempts to review such studies in the region have relied upon reports or conference presentations delivered to the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), World Bank, or World Health Organization (WHO). The amount of detail available from published sources varies considerably. There are a few examples of the recent multi-country studies that focus directly on available data for ageing-related issues in the Asia-Pacific region. These include: available datasets from the ageing-related surveys in the Asia-Pacific region (Teerawichitachainan and Knodel,2015); policies and legislative development related to older persons from the 26 countries in the region (Williamson, 2015); current demographic trends in the process of ageing in the Asia-Pacific region (UNESCAP, 2017b); the policy and legislation development progress made by the countries in the region in implementing MIPAA (ibid., 2017a); analysis and evaluation on the current situation of the countries' welfare and labour markets, pension systems, health care and long-term care systems (World Bank, 2015); and the quality and accessibility of health data for older persons in the Western Pacific regions (WHO, 2014). Although these studies reveal substantial existence of relevant data on ageing in the Asia-Pacific region, the value of this resource is much dependent on its availability for research access.

In our analysis for ESCAP (Zaidi *et al*., 2018 forthcoming), we looked at the availability of nationally representative surveys in Asia-Pacific countries to ascertain the region's readiness for data collection around ageing, specifically countries' capacity to calculate the AAI. We thus evaluated the contents of available datasets, their cross-national comparability, dataset accessibility, and data gaps in relation to 14 Asia-Pacific countries: Australia, Bangladesh, Cambodia, China, India, Indonesia, Japan, South Korea, Malaysia, Myanmar, New Zealand, Philippines, Thailand and Vietnam. 11 of these countries (85%) are currently classified as developing by the United Nations. Pragmatic decisions were taken to exclude from the analysis some low- and middle-income countries with limited data availability and on which there were issues around comparability. These information gaps should be considered in implications about future data monitoring. This data is presented in Table 2 below.

The most valuable and comprehensive datasets for the purposes of monitoring active ageing were representative longitudinal age surveys conducted at a national level, along the lines of the US Health and Retirement Survey (HRS). Labour force and household surveys covering the over 50s were another constructive source of information, covering employment, income, and health and well-being. In large part, national censuses and surveys had not been specifically designed to record information on older persons as the main respondents. Nevertheless, they often constituted countries' key source of information, and provided the basis for calculating AAI information. Where censuses provided valuable information at the individual level on demographic characteristics and employment, they have tended to offer less information on income, health status, social participation, household economic activity, and older persons' wellbeing.

Of the 14 countries' data collection processes that we examined, all conducted population censuses on a regular basis. However, there was more limited availability of representative and comprehensive longitudinal surveys on ageing, with this being lacking in Bangladesh, Indonesia and Malaysia (all classified as developing countries). A number of countries were conducting surveys on older persons as part of as international collaborations to build data infrastructure that addressed issues related to global ageing. For example, China, Japan, Korea, and India were conducting longitudinal ageing surveys, along the lines of the US's Health and Retirement Study (HRS) and the English Longitudinal Study of Ageing (ELSA). The countries that were most advanced in population ageing, such as Australia, Japan, Korea, and New Zealand, had comprehensive and nationally representative ageing surveys, but so too did several other developing countries, including Thailand, India, and China.

Looking at the labour force surveys operating in 10 of these 14 countries, an issue emerged about comparability. This related to difference in the way that data was collected around age: although many countries disaggregated indicators by age and sex up to the age of 75, some countries used 65 and above as a combined upper age group. This is an important issue, given the diversity of labour-market circumstances of older persons of different ages in different countries. In contrast, the 11 reviewed surveys on older persons shared commonalities and differences in terms of sample size and indicators. In terms of age limit, different definitions of older persons were in operation: many of the surveys were limited to persons aged 45 or 50 and over, while others covered samples of adults aged 60 or 65 and over. The longitudinal surveys most similar to the US and English models (HRS and the ELSA), such as China Health and Retirement Longitudinal Study (CHALS), Longitudinal Aging Study in India (LASI), Japanese Study on Aging and Retirement (JSTAR), and Korean Longitudinal Study on Ageing (KLoSA), tended to interview respondents aged 45 and over. These surveys mainly covered key information for the AAI indicators for the Asia-Pacific region.

Through a content analysis of the 14 surveys on ageing, labour force, and family we ascertained the data available for the AAI for these countries, which is presented in Table 3. Our analysis indicates that a significant effort is being made towards collecting ageing-related data in countries where population ageing is at a more advanced stage, for example, Australia, Japan, Korea, and New Zealand. In contrast, in countries with a relatively younger age structure, such as Bangladesh, Malaysia, Myanmar, and Vietnam, less attention has been paid to ageing-related data collection. Census surveys and household surveys do not usually have specific information related to health, wellbeing, social participation, income and expenditure, and family support for older persons. Some notable gaps were identified in countries' ability to provide information in the second domain of the AAI, 'participation and relationship', the least comparable AAI indicator being 'volunteer activities'. Six of the 14 countries, namely Cambodia, India, Malaysia, Myanmar, Philippines, and Vietnam, did not have data for voluntary activities. In addition, there was no data available to assess the second indicator of 'political participation' in four countries: Bangladesh, Malaysia, Philippines, and Vietnam. The third indicator, 'provide care to children', was the most comparable as only Malaysia lacks this data. The last indicator, 'provide care to older adults', was also largely comparable, except in three countries.

**Table 2: Availability of data related to active ageing from the ageing surveys, National Census, and other health and labour surveys in 14 Asia-Pacific countries**

| Country | Labour related surveys | Census or living condition related surveys | Ageing Surveys |
|---|---|---|---|
| Australia | Household, Income and Labour Dynamics in Australia Survey (18 Waves available) | General Social Survey (2006, 2010, 2014) | Australian Longitudinal Study of Ageing (1988, 1993, 1994, 1995, 1997, 1998, 2001, 2005, 2006, 2008, 2009, 2011, 2013, 2014) |
| Bangladesh | Labour Force Survey (2015) | Household Income and Expenditure Survey (2010), Population Census, 2001, 2011 | - |
| Cambodia | Labour Force Survey (2007) | Cambodia Social Economic Survey (2004), Population Census, 2008 | Cambodia Elderly Survey (2004) |
| China | Labour Force Survey (2015) | Population Census, 2000, 2010 | - Study on Global Ageing and Adult Health (SAGE) 2008-10, 2014<br>- China Health and Retirement Longitudinal Study (CHALS) 2011, 2013, 2015<br>- Chinese Longitudinal Healthy Longevity Survey (CLHLS), 1998, 2000, 2002, 2005, 2008-9, 2011-12 |
| India | - | Population Census, 2001, 2011 | - Study on Global Ageing and Adult Health (SAGE), 2007-8, 2014<br>- Longitudinal Aging Study in India, 2010 |
| Indonesia | Labour Force Survey (2016) | Indonesia Family Life Survey, 1993, 1998, 2000, 2008, 2015<br>Population Census, 2000, 2010 | - |
| Japan | Labour Force Survey (2016) | Population Census 2005, 2015 | Japanese Study on Aging and Retirement, 2007, 2009, 2011 |
| Korea | Economically Active Population Survey 2016 | Population Census 2000, 2010 | Korea Longitudinal Study of Ageing (KLoSA), 2006, 2008, 2010, 2012, 2014 |
| Malaysia | Labour Force Survey (2016) | Population Census 2000, 2010<br>Malaysian Population and Family survey, 2014 | - |
| Myanmar | Labour Force Survey (2015) | Population Census 2014 | Myanmar Ageing Survey, 2012 |
| New Zealand | - | Population Census 2001, 2006, 2013 | - New Zealand Longitudinal Study of Aging (NLSA) 2013<br>- Health, Work and Retirement Study (HWR), 2006, 2008, 2016 |
| Philippines | - | Population Census 2006, 2011 | Philippines Longitudinal Study of Ageing (2007) |
| Thailand | Labour Force Survey (2015) | Population Census 2000, 2010 | - National Survey of Older Persons in Thailand, 2002, 2007, 2011, 2014<br>- Panel Survey and Study on Health, Ageing, and Retirement in Thailand, 2009, 2013-14 |
| Vietnam | Labour Force Survey (2015) | Population Census 2009 | Vietnam Ageing Survey 2011 |

*Note: The latest available questionnaire was examined.*

**Table 3: Summary of content availability for data related to Active Ageing Index calculation for 14 Asia-Pacific countries: Individual level information**

| | Basic Characteristics | | | | | | Employment | | | | Participation and relationship | | | | Independent, healthy and secure living | | | | | | | | Capacity and enabling environment | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Country | Sex | Age | Marital status | Religion | Ethnicity | Literacy | Employment rate (55-59) | Employment rate (60-64) | Employment rate (65-69) | Employment rate (70-74) | Volunteer activities (age 55+) | Political activities | Provide care to children | Provide care to older adults | Physical exercise | Access to health & dental care | Independent living arrangement | Relative median income | No poverty risk | No severe material deprivation | Feeling safe to walk (night) | Lifelong learning | Remaining life expectancy achievement of 50 years at age 55 | Share of healthy life years in the remaining life expectancy at age 55 | Mental wellbeing | Use of ICT aged 55-74 | Social connectedness | Educational attainment |
| Australia | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | - | - | V | V | V | V |
| Bangladesh | V | V | V | V | - | V | V | V | V | V | V | - | V | V | - | V | V | V | V | V | - | V | - | - | - | V | - | V |
| Cambodia | V | V | V | V | V | V | V | V | V | V | - | V | V | V | V | V | V | V | V | V | - | - | - | - | V | V | V | V |
| China | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | - | - | - | - | V | V | V | V |
| India | V | V | V | V | V | V | V | V | V | V | - | V | V | V | V | V | V | V | V | V | - | - | - | - | V | V | V | V |
| Indonesia | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | - | - | - | - | - | V | V | V | V |
| Japan | V | V | V | V | - | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | - | V | - | - | V | V | V | V |
| Korea | V | V | V | V | - | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | - | V | - | - | V | V | V | V |
| Malaysia | V | V | V | V | V | V | V | V | V | V | - | - | - | - | - | - | V | - | - | - | - | - | - | - | - | V | - | - |
| Myanmar | V | V | V | V | V | V | V | V | V | V | - | V | V | - | - | - | - | - | - | - | - | - | - | - | V | - | - | - |
| New Zealand | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | V | - | - | - | V | V | V | V |
| Philippines | V | V | V | V | - | V | - | V | V | V | - | - | V | - | V | V | V | V | V | - | - | - | - | - | V | V | V | V |
| Thailand | V | V | V | V | - | V | V | V | V | V | V | V | V | V | V | V | V | V | V | - | - | - | - | - | V | V | V | V |
| Vietnam | V | V | V | V | V | V | V | V | V | V | - | - | V | V | V | V | V | V | V | - | - | - | - | - | V | V | - | V |

Note: V denotes indicator available from the data sources; - denotes indicator not available from the data sources

Among the third domain, 'independent, healthy, and secure living', the least comparable AAI indicator was 'feeling safe to walk (at night)'. Only Australia and New Zealand collected data for this indicator. Limited data was also available for the lifelong learning indicator with four countries amassing data for this indicator. None of the survey data provided direct information related to the 'remaining life expectancy achievement of 50 years at age 55' and 'share of healthy life years in the remaining life expectancy at age 55' indicators. However,

similar information can be obtained through the international organisation database. Data on 'life expectancy at age 60' can be obtained from the United Nations population database, and 'healthy life expectancy (HALE) at age 60' can be obtained from the World Health Organization database for all selected countries in the Asia-Pacific region. The remaining four indicators in the fourth domain (capacity and enabling environment) were largely comparable.

Notably, the active ageing indicators were developed in Europe where the harmonised survey data is available and easily accessible. Our review of data availability in the Asia-Pacific region indicates that harmonised data is not replicated there, which can prove problematic in terms of compiling data for many of the active ageing indicators. Indicators on the social participation of older persons, such as voluntary activities, and those related to secure living or social connectedness, were among the most difficult to obtain. To fill the data gap, a number of publicly published data sources and other international databases can be useful. These data sources need to be evaluated further in order to develop a comparative tool to measure active ageing in the Asia-Pacific region. Countries that are not under consideration in this paper are mostly low-income countries in the Asia-Pacific region, namely Bhutan, Cook Islands, DPR Korea, Fiji, Iran, Lao PDR, Maldives, Mongolia, Nepal, Pakistan, Palau, Solomon Islands, Sri Lanka, Tonga, and Tuvalu. Notably about half of these are also not part of UNFPA's report on MIPAA progress in the area either (2017). This flags up a group of countries that we are lacking information on for ageing and older persons. In all these countries, there is no survey specifically targeting older persons or living condition surveys for older persons. In addition, we do not include low-income countries in this region due to a lack of comparable data availability for AAI calculation, and the greater difficulty in accessing some of the national survey data and documents. Only limited indicators for AAI calculation among unselected countries can be obtained through labour force surveys, health surveys, such as demographic and health surveys (DHS), and censuses.

**Conclusions: The future of monitoring progress around the MIPAA in the region**

Earlier we compared the indicators produced by the MIPAA with those used in other frameworks relevant for the Asia-Pacific countries. This paper has provided a detailed analysis of data sources in the same countries, mapping them against the domains of the AAI to indicate the feasibility of extending and applying this tool in the region. Our analysis of data collection around the MIPAA at a country level illustrates some of the challenges, as well as the existing infrastructures that can be drawn upon in monitoring regional progress around active ageing. This article now concludes with a discussion on the future of data monitoring around active ageing, and how a dashboard of indicators can be taken forward. This has implications beyond the Asia-Pacific region; our analysis identified a number of areas where information on MIPAA indicators was scarce, relating particularly to developing countries. Review of an indicators dashboard that appreciates these differences and identifies areas for development is valuable in producing meaningful information to track progress around the MIPAA in other regions too, particularly in the most rapidly ageing countries that have most to gain from this task.

Given that it will be necessary to include non-governmental organisations as well as national statistical communities in these considerations, and that research infrastructures are less established in developing countries, detailed guidance on data collection protocol, including clear timescales for reporting, is an area where investment will have significant impacts. The formation of the United Nations Titchfield City Group on Ageing and Age-Disaggregation is a timely initiative for this reason. Sidorenko and Zaidi (2018) make the case that an investment in universal assessment tools is vital to ensure that the MIPAA continues to be implemented in lasting and consequential ways. In practical terms, our analysis for ESCAP (Zaidi *et al*., 2018 forthcoming) suggests that future implementation and appraisal work for the MIPAA will be strengthened by continuing to elaborate and refine the indicators used to assess national progress in the recent United Nations regional Commission reviews. A dashboard of indicators needs to be selected by using comparable definitions, in order to identify where a country within a region, or a region in the global comparison, is doing well or falling short. In view of the national difficulties that have been experienced in obtaining high quality information across all indicators of the MIPAA, and in complying with data collection protocol that would enable systematic comparison, we suggest that the MIPAA looks at building capacity by utilising some of the more successful aspects of existing frameworks to ensure that feasibility is at the heart of an ageing index. A process of continually refining an achievable and accessible dashboard of indicators, organised around distinctive domains of ageing, would have strong benefits. The construction of an active ageing index would enable international comparison and highlight areas for policy actions to improve countries' scores on different aspects of achieving the MIPAA goal of 'a society for all ages'. The capacity of these indicators to be easily aggregated into a composite index, similar to the European version of the Active Ageing Index, will be key in allowing for benchmarking and providing a signpost into policy actions.

There is strong value in indicators being listed under different headings, enabling domain-specific indexes to be constructed around various aspects of active and healthy ageing. These aggregations will allow countries to be ranked based on their index value, in addition to against each of a long list of indicators, offering a more nuanced analysis, flexibility, and providing opportunities for mutual learning. A dashboard of indicators of this kind would be aligned with the priority areas, issues and objectives of the MIPAA. This will enable a closer MIPAA monitoring, but with the flexibility to import the most relevant indicators from frameworks such as the AAI and the Macao Index. Our analysis of existing data sources in the Asia-Pacific region aligns with data availability for the AAI indicators, rather than those suggested in the original MIPAA framework or in the Macao Index. Some of the issues around data feasibility in the Asia-Pacific region for an ageing index like the AAI include: different definitions used around age categories, which hamper comparability; a lack of age disaggregation in the surveys; and sampling and enumeration difficulties around older age groups in some countries, potentially leading to bias in data. These, however, underline the need to develop robust data collection protocols, rather than negate the currency of an index.

The conclusion of our analysis is that a dashboard of indicators that both estimates the AAI and is aligned with the key priorities of the MIPAA should become part of the toolkit to monitor MIPAA implementation in the future, but so too this framework should incorporate

Asia-Pacific indicators that reflect the region's unique demographic context and priorities, such as community support. For example UNFPA's (2017) analysis of progress on the MIPAA emphasised the importance of utilising pre-existing resources in the 'enabling environments' priority area, specifically the region's abundant older persons' associations, which are valuable in supporting social solidarity and encouraging broader participation in public life (and thus impacting too on priority area 1). The dashboard of indicators developed in the MIPAA framework would be a good starting point for supplementation. Due to the challenges around data collection witnessed since the MIPAA, it is essential that a dashboard of indicators is accompanied by high quality methodological guidance on establishing robust monitoring mechanisms, on production of age-disaggregated data, and on the kind of research infrastructure necessary to support this. This might include examples of good practice, guidance on how data collection might make use of existing frameworks, and research support.

A critical question remains: how can MIPAA implementation and progress be monitored in countries that lack age-disaggregated data? Furthermore, how can the issue of a lack of international data comparability be addressed? Reflecting countries' relative difficulties in capturing different kinds of information, a priority is to identify *achievable* data collection processes, and a simplified structure for the age-disaggregation of data. A pragmatic way forward will be to identify clustering of countries with the help of their developmental context, and availability and comparability of age-disaggregated data. An index and dashboard of indicators can then be prepared for many of the data-rich countries, such as those covered in detail above. They will then set examples, not just for policy learnings, but in the development of age-disaggregated data for other countries in the region. There may be scope to develop a reduced form index, especially for countries where population ageing is less accelerated and data disaggregated by age is scarce, on the basis that establishing a baseline for monitoring will pre-empt progression. Such a reduced form index could be piloted for its feasibility in a number of countries. Two-paced development of the MIPAA monitoring toolkit would offer mutual learnings for all countries concerned.

Last but not least, the 2030 Agenda of Sustainable Development Goals (SDGs) have presented new opportunities to include older persons in addressing challenges linked with poverty, gender equality, employment and decent work, inclusive cities, and climate change. Its two pledges 'leaving no one behind' and 'reaching the furthest behind first' underline a commitment that no development process is complete without the protection and promotion of the rights of vulnerable groups in society, and that the older population, when empowered, can serve as agents of development in line with the active and healthy ageing agenda, and the MIPAA's policy directions. The MIPAA has provided gerontologists and policymakers alike with an invaluable framework for assessing active ageing, and one that our analysis suggests contains abundant scope to build upon in responding to the monitoring challenge of a rapidly, and unequally, ageing world. The effective implementation of the MIPAA will be critical to achieving several Sustainable Development Goals, and in explicitly recognising the issues of ageing and older persons.

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# Appraising progress in the ageing agenda in Arab countries of Western Asia and North Africa: 15 years since the Madrid International Plan of Action on Ageing

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***Abstract***. As the pace of population ageing in the Arab region quickens, placing a majority of its countries on the cusp of significant demographic transitions with far-reaching social and economic implications, the ageing agenda has gained steam on both local and regional levels. This paper provides an appraisal of the results of the third review of the progress of the Madrid International Plan of Action on Ageing (MIPAA) conducted in countries belonging to the Economic and Social Commission for Western Asia (ESCWA) in 2017, with findings drawn from a regional mapping survey of member states and supplemented with desk and literature review. While many ESCWA countries have taken some progressive steps and advanced towards meeting the challenges of population ageing, steps forward have been hampered by gaps between the presence of policies and the reach and scope of operational programs on the ground and have been challenged by a lack of social awareness around population ageing, a scarcity of up-to-date data and evidence, limited access to financial resources and weak local and regional coordination on ageing issues. Regional or sub-regional response that consolidates efforts and encourages shared knowledge production and exchanges of experiences and best practices is needed.

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Progress on the implementation of MIPAA recommendations is vital to the achievement of the 2030 Sustainable Development Goals, and represents a renewed opportunity to ensure that the future holds productive, healthy, secure and empowered ageing societies for all, with 'no one left behind'.

*Keywords*: Ageing, ESCWA, Arab, MENA, MIPAA, SDGs

## Introduction

Worldwide, population ageing has gained steam as a key demographic priority area and as one of the most significant transformations of the twenty first century. In the Arab region, as with many regions composed of largely developing countries, the distinguishing feature of population ageing has been its rapid pace, sometimes exceeding the pace at which it occurred in the West. As such, while the overall population structure remains young, the majority of the countries in the region are on the cusp of significant demographic transitions and exponentially rapid population ageing (Saxena, 2008). Estimates from the World Population Prospects: 2017 Revision indicate that the number of people aged 60 years and older in the region has more than doubled from 9.4 million in 1985 to 22.5 million in 2015, and, due to consistently high fertility rates in many countries of the region, the number of older persons is anticipated to almost quadruple by 2050, reaching close to 85 million.

In this paper, we focus on the countries belonging to the Economic and Social Commission for Western Asia[6] (ESCWA), where the proportion of older persons is currently estimated at 6.6% of the population and is projected to increase to 9.3% by 2030 and 14.9% by 2050 (WPP, 2017). The fastest population growth is anticipated to occur among the oldest old (aged 80 years and older). Tunisia, Lebanon and Morocco include the highest proportion of older persons (11.7%, 11.5% and 9.6%, respectively). By 2050, the number of older persons are expected to exceed the number of children in 10 out of the 18 ESCWA member countries (namely Bahrain, Kuwait, Lebanon, Libya, Morocco, Oman, Qatar, Saudi Arabia, Tunisia and the United Arab Emirates) and only 4 countries are expected to remain in the 10% threshold by a small margin (8.8-9.9%) (WPP, 2017).

Preparing for an ageing population is vital to the achievement of the 2030 Agenda, and constitutes a core component of the Sustainable Development Goals' (SDGs) objective to 'leave no one behind' (UN, 2015). In 2002, the Madrid International Plan of action on Ageing (MIPAA) stressed the need for governments to develop policies, programs and services that allow older persons to benefit from development and to advance their health and well-being in enabling and supportive environments (World Assembly on Aging, 2002). The demographic transition comes with many challenges including a decline in extended family structures, underdevelopment in rural areas, and a rise in the burden of chronic degenerative

[6] ESCWA (Economic and Social Commission for Western Asia), is one of the five regional commissions under the administrative direction of the United Nations Economic and Social Council. It includes 18 countries – namely Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Sudan, Syria, Tunisia, United Arab Emirates, and Yemen.

diseases. The ESCWA region is additionally challenged by protracted wars, conflict and political instability, and the displacement and migration of youths seeking better opportunities in safer havens elsewhere, and hence weakening of family ties and diminished number of family members available to deliver old-age care (Kronfol, Rizk, & Sibai, 2015).

This paper provides an appraisal of the results of the third MIPAA review conducted in ESCWA countries in 2017. Findings presented within are largely derived from the responses obtained to a regional mapping survey from ten member states, namely Egypt, Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, Palestine, the Sudan and Tunisia, supplemented with desk and literature review, as necessary. Submissions from countries were validated in an expert group meeting convened by ESCWA with government focal persons on ageing in the region as well as independent consultants and experts. Unless otherwise indicated, data presented are derived from responses to a structured regional mapping survey. In this paper, we first present the findings on institutional arrangements and policy options, focusing on developments in the past five years. Departing from the three central themes outlined by MIPAA, the paper then reviews the progress made in social protection and participation of older people in development and discusses the challenges for advancement of health and wellbeing in old age and for the provision of enabling and supportive environments. The paper also appraises emerging issues, gaps and opportunities to the implementation of plans of action on ageing in the region, with linkages made to the 2030 SDGs, as relevant.

**Institutional response: governmental agencies, plans of action and data**

More than two decades since ageing was first addressed as a developmental issue in the United Nations International Conference on Population and Development's (ICPD) Programme of Action in 1994, and 15 years since MIPAA and the Arab Plan of Action on Ageing (APAA) in 2002, countries have taken considerable strides forward in mainstreaming ageing issues in governmental mandates, national policies and plans of action. Available data indicate that this has occurred irrespective of the pace of population ageing (ESCWA, in press).

Table 1 shows the various modalities of governmental arrangements on ageing in select ESCWA countries, including ministries, departments, divisions and offices. The year at which these were established varied across countries, with the "Department of Elderly Care" in Egypt, established in 1979, being among the earliest and the "Department of Elderly Affairs" in Oman, established in 2015, being the most recent. Institutional arrangements on ageing are almost always housed in the Ministry of Social or Family Affairs, except for Iraq where it is affiliated with the Ministry of Health. In Lebanon and Sudan, no specialized departments for ageing affairs have been established. However, in the case of Lebanon, the Department of Family Affairs houses the National Commission on Ageing; and, in Sudan, policies and programs for ageing are advanced following a Ministerial Decree issued in 2012 by the Ministry of Social Security and Development. Coordinating bodies for ageing agendas, such as national committees, in ESCWA countries are relatively recent (Table 1), with the first being the "Permanent National Commission for Elderly Affairs" established in Lebanon in 1999, around the year designated by the UN as the International Year of Older Persons. Among

reviewed countries, both the Ministry of Social Affairs and the Ministry of Health feature in the coordinating bodies of national committees. Other ministries such as the Ministry of Women or Family Affairs, Social Security and Pensions, Planning or Statistics, Justice and Education appear to be represented to a lesser extent. Delegates from the municipalities, civil society organizations (CSOs) and non-governmental organizations (NGOs) are commonly represented in coordinating bodies and engage in developing policies and implementing programs. Despite the importance of having representatives from the media and academia on board for advocacy and evidence-based policymaking, such arrangements rarely feature in coordinating bodies.

**Table 1: Governmental institutions and national committees on ageing in ESCWA countries**

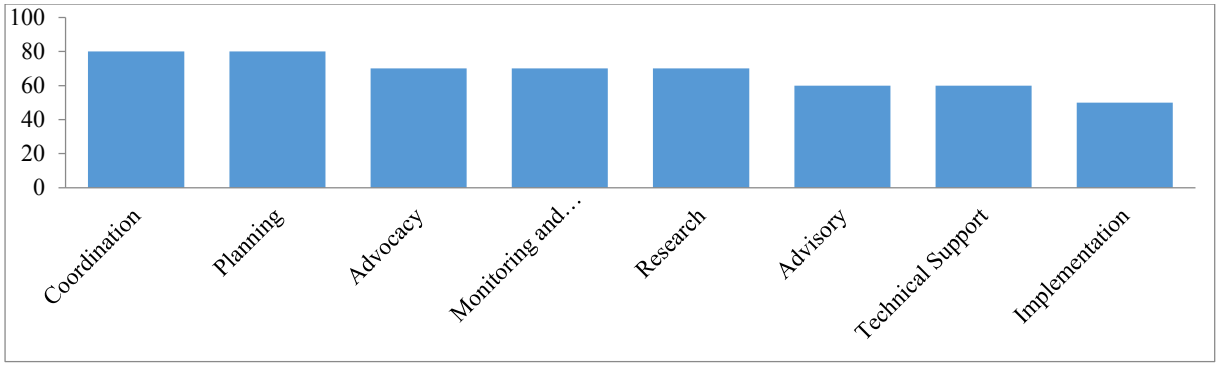
| | Country | Governmental Institutions (year established) | National Committees (year established) |
|---|---|---|---|
| SLOW pace of ageing | **Iraq** | Elderly Health Division (2013) & Technical Committee for the Development of Health and Social Services for the Elderly (2010), Public Health Directorate, Ministry of Health | National Committee for Older People, Ministry of Labor and Social Affairs (missing) |
| | **Palestine** | Department for Elderly Care, Ministry of Social Affairs (1994) | National Committee for Older Persons, Ministry of Social Affairs (2011) |
| | **Sudan** | Ministry of Social Security and Development (1999) | National Committee for the Care of Older Persons, Ministry of Social Security and Development (2012) |
| MODERATE pace of ageing | **Egypt** | Department of Elderly Care, Public Office for Family and Childhood, Ministry of Social Solidarity (1979) | Higher Committee for Older Persons in Beni Youssef University (In preparation) |
| | **Jordan** | --- | National Committee for Senior Citizens and National Follow-up Committee on the Implementation of the National Strategy for Senior Citizens, National Council for Independent Affairs (2012) |
| | **Kuwait** | Office of Elderly Care, Ministry of Social Affairs (2001) | National Committee for Elderly Care, Ministry of Health (2012) |
| | **Oman** | Department of Elderly Affairs, Ministry of Social Development (2015) – Ministerial Decree 51, 2015 Primary Healthcare Support Unit, Ministry of Health | Committee for Elderly Affairs, Ministry of Social Development (2005) |
| RAPID pace of ageing | **Lebanon** | Department of Family Affairs, Ministry of Social Affairs (1993) | Permanent National Commission for Elderly Affairs in Lebanon, Ministry of Social Affairs (1999) |
| | **Morocco** | Department of Protection of Older People, The Ministry of Social Development, Family and Solidarity (2002) | --- |
| | **Tunisia** | Office of Older Persons, Ministry of Women, Family and Childhood (2005) | --- |

National committees are mandated in the majority with planning, collaboration and coordination roles, and to a lesser extent with implementation (Figure 1). Committees in countries experiencing a rapid demographic transition appear to be responsible for a larger number of roles, which more often include technical support, advisory and resource

mobilization. This is especially the case in Morocco and Tunisia. Interestingly, countries experiencing a 'slow' pace of ageing, such as Palestine and Sudan, appear to carry more responsibilities than their 'moderate' counterparts.

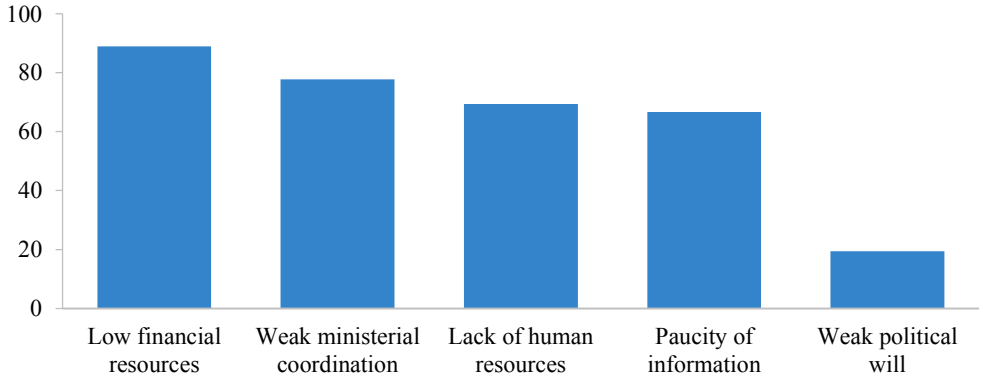
Mainstreaming ageing in policies and legislations is on the rise in ESCWA countries and there is evidence of increasing political support for the ageing agenda in the past five years. In spite of the encouraging developments in legislations and plans of action, there remain significant challenges for implementation. Most countries ranked low financial resources as the primary challenge, closely followed by weak ministerial coordination and scarcity of human resources (Fig. 2). Political will and translation of research to policy were ranked as least challenging. Other noted challenges include a paucity in national and international organizations focused on ageing in the ESCWA region and the absence of capacity building programs.

**Figure 1: Mandated roles within 'National Committees on Ageing' in descending order (%) of reporting ***




*Based on responses from Iraq, Oman, Lebanon, Jordan, Tunisia, Kuwait, Morocco, Sudan and Palestine.

**Figure 2: Challenges to issuing and implementing national strategies and plans of action on ageing in descending order (%) of reporting ***




*Based on responses from Oman, Lebanon, Jordan, Tunisia, Kuwait, Morocco, Sudan and Palestine.

Census data disaggregated by age and gender, and data repositories on ageing are fundamental for identifying emerging issues and evidence-based decision making. Except for Lebanon, where the last and only census was conducted in 1932, all countries have updated their census data over the past ten years. Yet, countries report challenges with documentation of census data, including incomplete or inconsistent birth records of older persons in Oman, approximation of ages in Jordan, missing data for older persons in Tunisia, and absence of a standardized questionnaire for census-taking in Morocco. While offices for national statistics play a key role producing data on the population at large, specialized centers and a strong research infrastructure on ageing are lacking (Rizk et al., 2015). Only three such initiatives exist in the ESCWA region, the National Institute of Longevity Elderly Sciences in Egypt hosted within Beni Suef University, the National Observatory for Older Persons in Morocco with strong intersectoral collaboration between the government, civil society organizations, academics, and experts, allowing it to dynamically monitor demographic changes and track social and economic conditions of older persons at the national level, and the Centre for Studies on Ageing in Lebanon (CSA). The latter acts as a think tank and a platform for advocacy forging much-needed links between researchers, policymakers and service providers. Through conferences, round table debates and policy briefs and reports, the CSA has led the way towards placing older adult issues in Lebanon at the forefront on national agendas and international scientific community[7].

**Ageing, employment and development**

While the conditions of older persons in the ESCWA region and the opportunities available to them vary by each country's respective level of socio-economic development, the current generation of older people share baseline vulnerabilities that have important implications for their care. These include low levels of educational attainment, dwindling economic safety nets, and workforce participation into the last years of life due to the absence of, or insufficient, pension plans. Among older women, the situation is particularly precarious. As such, ageing and development form a nexus that revolves around the need for age-equity in access to education, training, employment, social security and pension.

Historically, access to education of earlier cohorts of older persons in the ESCWA region was limited, making a substantial proportion of today's older persons illiterate. Literacy rates vary across ESCWA countries, ranging from as low as 20.4% among older persons in Iraq to as high as 87.7% in Jordan (Table 2) (UIS, 2017), with men gaining access to education earlier and completing higher levels of education than women (Yount & Sibai, 2009). Hence, literacy programs are common in the region, with some specifically tailored to older persons (e.g. in Kuwait, Palestine, Sudan, Tunisia) while others targeting the entire populace (e.g. Morocco). A few countries, namely Egypt, Iraq, Lebanon and Palestine, offer courses that aim specifically at improving older people's information technology and computer skills. An inspiring lifelong learning program, the University for Seniors program established in Lebanon in 2010, remains the only initiative in the region that promotes education in old age, positive images

[7] For more informaiton on the Center for Studies on Ageing in Lebanon: http://www.csa.org.lb/en/index.asp.

of ageing and provides space for older persons to share their own wisdom and experiences. The program offers a variety of courses and activities that suit older adults' interests, and provides them with an opportunity to remain intellectually challenged, socially connected and useful in their communities[8].[3]

**Table 2: Literacy rates among persons aged 65 years and older, by year of latest available data**

| Country | Literacy rate (65+)[1] | | Labour force participation (65+)[2] | | | |
|---|---|---|---|---|---|---|
| | *Latest available* | *%* | *Latest available* | *Total* | *Male* | *Female* |
| **Bahrain** | 2010 | 49.3 | 2015 | 23.6 | 39.9 | 6.4 |
| **Egypt** | 2013 | 43.2 | 2016 | 13.8 | 23.7 | 3.1 |
| **Iraq** | 2013 | 20.4 | 2008 | 11.9 | 21.3 | 2.2 |
| **Jordan** | 2012 | 87.7 | 2013 | 4.8 | 4.8 | 0.2 |
| **Kuwait** | 2015 | 69.5 | 2016 | 40.5 | 63.5 | 14.5 |
| **Lebanon** | 2009 | 60.2 | 2007 | 14.7 | 27.7 | 1.6 |
| **Libya** | -- | -- | -- | -- | -- | -- |
| **Mauritania** | 2007 | 26.6 | -- | -- | -- | -- |
| **Morocco** | 2012 | 32.8 | 2012 | 18.4 | 28.7 | 8.5 |
| **Oman** | 2015 | 35.0 | 2016 | 5.5 | 10.1 | 0.7 |
| **Palestine** | 2016 | 63.9 | 2015 | 9.0 | 17.6 | 2.5 |
| **Qatar** | 2014 | 78.9 | 2015 | 51.9 | 67.2 | 11.4 |
| **Saudi Arabia** | 2013 | 51.4 | 2016 | 13.9 | 26.9 | 0.6 |
| **Sudan** | 2008 | 24.3 | 2009 | 38.0 | 56.0 | 14.0 |
| **Syrian Arab Republic** | 2004 | 39.0 | 2009 | 13.3 | 21.6 | 1.4 |
| **Tunisia** | 2014 | 39.8 | 2012 | 8.6 | 15.4 | 1.9 |
| **United Arab Emirates** | 2005 | 42.1 | 2016 | 26.9 | 46.6 | 3.0 |
| **Yemen** | -- | -- | 2015 | 17.4 | 29.0 | 1.2 |

*Source*: Adapted from UNESCO Institute for Statistics (UIS) (2017); [2] Adapted from the International Labour Organization Statistics database (ILOSTAT, 2017)

Strategies, policies and rationales towards old-age employment vary across the ESCWA region. Employment is often presented as a subject of generational conflict around income and national resources. Early retirement in the public sector may be encouraged as a means to reduce public spending and hence relieve the strain of salaries on governmental budgets, as in Palestine for example, or as a strategy to meet the demands of the high percentage of working age youth, such as in Libya. In Iraq and Tunisia, early retirement is allowed in the case of specific social and familial hardship situations. In Morocco, pension funds are reported to be strained and early retirement is therefore not encouraged. In Sudan, Iraq, and Jordan, micro-credits programs are provided by governments to advance income-generating projects, and ultimately counteract high poverty rates among older persons deprived of familial support. The right to work and age-based discrimination in the labor force have gained increasing recognition by international human rights agencies (Fredvang & Biggs, 2012; HelpAge International, n.d). This has been scarcely recognized regionally or locally, with the exception of income-generating programs in such countries as the Sudan and such programs as the Elderly Empowerment Project, established in Lebanon in 2016. The Project works

[8] For more information on the University for Seniors: https://website.aub.edu.lb/rep/cec/uni_seniors/Pages/main.aspx.

towards creating jobs and volunteering opportunities with local businesses and municipalities, and aims at promoting social and economic inclusion of older people.
Several modalities of social protection systems exist in ESCWA countries. Whereas there are considerable variations in the level of basic benefits for retirees across countries, these are commonly characterized by inequity in coverage across sectors of employment and by gender. In contrast to civil servants and those in the public sector, the self-employed and those in the informal sector are less likely to qualify for old-age pension plans, thus adversely affecting agricultural workers who fall sharply out of the social security umbrella. This also means that women, often engaged in unpaid work in family income or in caring for grandchildren, are denied access to social and health benefits as they age. As a result, prolonged participation in the labor force beyond retirement age is a common phenomenon in the region. This is in marked contrast to several countries in the West, where withdrawal from the labor force is a natural phenomenon at an advanced age. Among ESCWA countries, labor participation rates of older men, in particular, range between 26.9% in Saudi Arabia and 67.2% in Qatar among Gulf oil-rich countries, and between 4.8% in Jordan and 56.0% in Sudan among the remaining countries (Table 2, ILOSTAT, 2017). While, in the former, old-age labor participation is likely to be a reflection of sustained economic opportunities in old age and a personal preference of the older person to remain active, high labor participation rates in the latter may be more indicative of economic necessity and a strategic response to the weak public safety nets and the pervasively small old-age pensions in certain countries in the region. Pension schemes are powerful instruments for poverty reduction and income security in old age. Laws regulating social security and pensions were drafted and implemented in the region across a wide range of years from as early as 1950 in Egypt to as late as 2002 in Qatar (SSA, 2017). Despite major economic changes and geopolitical developments in the region, there are still four ESCWA countries, namely Bahrain, Lebanon, Oman and Syria, that have not made revisions or updates to their pension laws since their initiation (SSA, 2017).

ESCWA countries value older persons' accumulation of wisdom and experience as an asset that is often mobilized through their active involvement in development. In Oman, older people are encouraged to participate in provincial and local committees, and to engage in civil society organizations (CSOs) that reflect their interests, an example of which is the Omani Association for Elderly Friends. In Morocco, the mediating role of CSOs is combined with an embedded participatory approach for ministries, which ensures older persons' direct involvement at all levels of development. Yet, involvement in civic life and public participation of older persons appear to be related more to one's own position in the society than to institutionalized policy structures and processes; and independent bodies such as advocacy groups and older people associations are totally lacking in the region. Despite the advancements in policies and programs targeting older persons in the ESCWA region, these remain suboptimal, and the scope of their implementation is uncertain. Ageing poses important challenges and opportunities for development and change. Addressing these challenges and working on promises are particularly relevant to the 2030 SDG Agenda to 'end poverty in all forms' (SDG 1), promote 'lifelong learning opportunities for all' (SDG 4), achieve 'gender equality', promote 'decent work for all' (SDG 8), and 'reducing inequalities within countries' (SDG 10) (UN, 2015).

**Health and wellbeing in old age**

Health related data targeting specifically the older people are still nascent in ESCWA countries; and while there is marked diversity in the experiences at the country and sub-regional levels, there are general trends that characterize older population health. Regardless of where people live, longer life expectancy is generally accompanied with higher rates of non-communicable diseases (NCDs), degenerative conditions, and changes in functional ability. ESCWA countries that are still early in this epidemiological transition continue to experience a double burden of disease, with high rates of both communicable and non-communicable diseases. Moreover, increasing environmental exposures, hazards and stressors are likely to drive the risk of cancers and cardiovascular disease upward.

It is estimated that nearly 60% of all deaths in the region are due to NCDs, with more than 65% occurring in individuals older than 60 years (Rahim et al., 2014). All countries covered in the MIPAA review have noted NCDs, namely cardiovascular diseases, hypertension, diabetes, and cancers, to be the most prevalent health conditions among older persons. Untreated and undiagnosed hypertension, though not well researched in the region, remains a concern (Tailakh et al., 2014). During the past three decades, the prevalence of obesity has escalated, reaching an alarmingly high level of around 66% among older adults in high income countries such as Kuwait (Al Rashdan & Al Nesef, 2010). Also, five of the top ten countries with the highest prevalence rates of diabetes worldwide are from the region. Cancer rates vary in the region, with notably much higher mortality rates in Lebanon and Jordan compared to other countries (Abu-Rmeileh et al., 2016).

Whereas data on psychiatric morbidity among the older populations in ESCWA countries are greatly lacking, some countries, including Iraq, Jordan, Tunisia and Egypt, have reported concerns about mental health. According to the Alzheimer's Disease International (2015), the estimated number of people with dementia in the region is expected to grow from two million in 2010 to four million in 2030. A recent pilot study from Lebanon reported an age-adjusted dementia prevalence rate of 9.0% for persons older than 65 years of age, comparable to worldwide estimates from the West (Phung et al., 2017). Only a few countries, such as Lebanon, have endorsed mental health of older persons in their national policies and programs.

Overall, countries experiencing rapid and moderate pace of ageing have advanced on streamlining programs for older persons within existing health-related initiatives and primary care centers to a larger extent than those experiencing slow paces of ageing. Examples of these initiatives include NCD screening in primary health care centers and awareness campaigns for early detection notably in the area of breast cancer, hypertension and diabetes, smoking cessation programs and subsidized care and free medications for older persons. In a number of countries, such as Lebanon, Morocco, and Tunisia, civil society organizations, including charities and religious associations, appear to play an important role in promoting and implementing national policies and in providing primary health care programs to older persons.

Governments' main preoccupation remains to treat illness and provide medical care. Consequently, health care delivery is largely built around cure rather than prevention and around acute, episodic models of care that are ill-equipped to meet the requirements of those with chronic and multiple health problems (Sibai et al, submitted). Only a few countries, such as Lebanon, Egypt and Tunisia, recognize geriatrics as a specialty on its own, and, with the exception of Tunisia, there remains a gap in the supply of geriatricians and gerontologists across the region. This is counterbalanced by the presence of postgraduate training programs, particularly for nurses and social and healthcare workers.

The Madrid Plan calls on governments to take actions towards universal and equal access to health services. While free health services are provided in oil-rich countries, out-of-pocket health expenditures represent the most important source of financing healthcare in most ESCWA countries. Generally, the poorer the country, the larger the share of out-of-pocket expenses (Yount & Sibai, 2009), and the main challenge for health services in most ESCWA countries lies in their affordability and accessibility. Here, a comprehensive model of patient-centered care for older persons within existing primary health care centers and coordination between state and non-state actors, notably civic agencies, needs to be enhanced and empowered (Sibai et al., submitted). Ageism, where treatment may be perceived to be less worthy for older persons than the younger ones, is likely to be encountered in the provision and, hence, accessibility of services. This is essentially heightened in times of wars and conflicts, where older persons often fall off the radar of international relief agencies.

Ageing raises questions of whether longer lifespans equate with more years of healthy life or increased morbidity and dependency with age (Beard et al., 2016; Mehta & Myrskylä, 2017). The exigencies of new economic realities and emerging chronic diseases in ageing populations challenge healthcare systems in most countries and raise the importance of health reforms. This challenge, however, is not insurmountable. Adopting a life-course perspective that focuses on health promotion and healthy behaviors early in life, disease prevention (SDG 3.4), integrated care that span the care continuum, and equitable and universal health coverage (3.8) exert powerful influences on offsetting barriers and prioritizing healthcare for older persons, all of which are necessary conditions for the achieveing of the overall goals of the SDGs to ensure health and well-being "for all ages" (SDG 3) (UN, 2015).

**Enabling and supportive environments**

A key indicator of the level of development and its impact on wellbeing for older persons is a country's capacity to provide supportive environments for older persons that would promote 'ageing in place', in homes and in communities, and ensure ease of mobility. The term 'environment' extends beyond the physical living environment, but also includes social and structural arrangements, at the macro and micro levels, that are crucial to advance older people's potential to independently engage in their communities. Accordingly, this section addresses the four pillars of supportive environments, namely intergenerational solidarity, age-friendly communities, protection from neglect, abuse and violence, and embracing the needs of older persons in emergencies and crisis situations.

In ESCWA countries, the family remains one of the pillars of ageing policies and is treated as the core safety net for the care of older parents. Legislations have been founded on the vital role of informal family support channels and the web of relationships within it; and as such, the focal unit concerned with ageing issues in a number of countries in the region is intricately connected with councils and directorates of family affairs (e.g. Qatar, Egypt, Jordan and Lebanon (Sibai & Yamout, 2012). Yet, demographic realities, socioeconomic advances and, political tensions and conflicts across the region have triggered various forms of alienation from the traditional multigenerational family configuration, resulting in increasing independent living in late-life, with considerable heterogeneity across countries. For example, whereas the proportion of solitary living does not exceed 1.2% in Kuwait (Shah et al., 2002), this exceeds 10% in Lebanon (Tohme et al., 2011). More recent data from Labor Market Panel Surveys in Egypt, Jordan and Tunisia conducted show higher percentages, with women being 3 to 5 times more likely to be living alone than men (3.5-6.5% for men and 16.4-26.3% for women) (Angeli & Novelli, 2017). The challenge in the care of older people is to develop strategies for interventions that aim at maximizing functional autonomy, prolong independency at home, and delay institutionalization. Homecare programs that incentivize ageing-in-place, while nascent, continue to expand and include volunteer programs for elderly sitters in Oman, surrogate family programs in Tunisia, meals-on-wheels services in some parts of Sudan, Palestine and Lebanon, mobile units for the care of older persons in Tunisia, Morocco and Kuwait, and respite services for caregivers in Lebanon.

Governments across the ESCWA region are making efforts to enhance older persons' mobility outside the home environment. Countries like Palestine, Oman, Lebanon and Jordan are facilitating older persons' mobility through the construction of age-friendly infrastructures that include ramps and priority seats in governmental buildings. Meanwhile, older persons in Morocco, Tunisia and Kuwait have granted subsidized rates on public transportation, and, in Kuwait, older persons are exempted from paying registration fees for their own vehicles and receive earlier appointments in public clinics. Clubs for older persons, in Lebanon, Jordan and Morocco, provide opportunities for engagement with social life and community building.

Arab societies consider social and religious obligations to be sufficient for the protection of older persons against maltreatment, which often remains cloaked by family secrecy. Similarly, the absence of legal action against perpetrators of violence deters older victims from reporting mistreatment to the authorities. Hence, this topic is vastly under-researched, and figures, when present, are likely to be underestimated. Literature search identified only one study conducted in a rural community in Egypt that presented prevalence estimates from the region. Findings from this study point to a prevalence rate of 42.4% for neglect, 5.7% for physical abuse, and 3.8% for financial abuse, with women being more likely to report mistreatment than men (Abdel Rahman & El Gaafary, 2012). In Jordan, 787 complaints of violence, verbal and/or physical, were reported in 2016. Here, complaints are rarely referred to judicial action and are often dealt with locally by a pledge to ensure that maltreatment or violence is not repeated. Policies addressing violence against older persons are generally embedded within family protection and personal status laws that benefit all age groups. Yet, response to the issue of abuse and violence against older people has been very slow compared to the West.

Despite growing wars and conflicts in the region, there is a distinct lack of considerations for older people in emergencies and the topic is vastly under-researched (Sibai, Rizk, Costanian & Beard, 2016). A recent report revealed that less than 5%, only 93 out of 1,912, humanitarian assistance projects explicitly address older persons as a vulnerable group (HelpAge International & Handicap International, 2013). One national symposium convened in 2013 by the Center for Studies on Aging in Lebanon on "Seniors in Emergencies" drew the attention of relief actors to older refugees, as both a vulnerable group requiring distinct care and attention as well as a resource with the potential to make important contributions in emergency situations. HelpAge International recently opened a regional office in Amman in 2015, and this has been instrumental in promoting inclusion and mitigating the social and economic impact of the Syrian crisis on both Syrian refugees and host communities.

Overall, governmental actions towards an enabling environments remain modest and continue to have a limited scope in most countries. Planning for an age-friendly city and MIPAA considerations for a supportive environments cut across several SDG goals and targets of making cities inclusive, safe, resilient and sustainable (SDG 11) and promoting peaceful and inclusive societies for sustainable development (SDG 16) (UN, 2015).

**Concluding remarks**

Overall, many ESCWA countries have taken progressive steps over the past five years towards meeting the challenges of population ageing. Reported efforts range from strengthening institutional arrangements on ageing to including older persons in development agendas, attending to the healthcare of ageing population, and making modest strides forward towards constructing age-friendly and enabling environments for older persons. Despite this, steps forward have been hampered by gaps between the presence of policies and the reach and scope of operational programs on the ground. Concurrent with broader introspections around the pace of the progress of MIPAA globally (Sidorenko and Zaidi, 2018), challenges towards implementation include social awareness around population ageing, a scarcity of up-to-date data and evidence that would enhance the urgency of such developments, limited access to resources and weak ministerial coordination when ageing is not prioritized on national agendas.

Population ageing has far-reaching economic and social implications for all sectors of society, and this is becoming a growing regional concern. Hence, population ageing requires a regional or sub-regional response. Coordination and collaboration and cross-country initiatives for knowledge production, exchange and sharing of best practices may save limited resources and encourage leaps forward in achieving key health, social and legal realizations for the welfare of older persons. The 2030 Agenda for Sustainable Development, cutting across several goals including poverty eradication, economic growth, good health, safe environments and sustainable cities, provides an impetus to further advance on meeting the recommendations of MIPAA (HelpAge, 2017). To realize truly inclusive and sustainable development outcomes, the ageing agenda needs to continue to advocate for, firstly, an attitudinal shift on ageing that would overcome marginalization and exclusion and realize the potentials of living longer; and secondly, a paradigm shift, where the potentiality for

advancing the ageing agenda is no longer conditioned on achieving economic development, but rather becomes part and parcel of developmental processes. Progress on the implementation of MIPAA's goals fits hand-in-glove within wider efforts to meet the 2030 agenda of the SDGs, representing a renewed opportunity to ensure that the future holds healthy, secure and empowered ageing societies for all, with 'no one left behind'.

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# Poverty, Social Protection and Participation of Ageing Adults in Working Spaces. A Description of Eight Countries

**Pablo Salazar[1] and Lorna Jenkins[2]**

***Abstract***. As the Montevideo consensus on population and development states, it is important to understand the economic and social transformation related to the age structure, particularly because the population in the Latin America and the Caribbean Region is rapidly aging (3.77%) and continues to be the most inequitable region in the world. This paper summarizes the situation and the progress related to ageing and the rights of the elders in eight Latin American countries. This paper identifies three different country profiles in the LAC region: the population of the first group of countries is considered young, at the initial phases of the demographic and epidemiological transition, countries as Bolivia, Guatemala, Haiti and Honduras are included. The second group of countries, including, Brazil, Colombia, Peru, and Dominican Republic are at an intermediate level of transition, where the total fertility rate and the death rates are declining, but still with a large proportion of young population. The third group of countries are aged societies, advanced in the demographic transition, with fertility rates below replacement levels, such countries are Cuba, Uruguay and Costa Rica. Based on the three profiles the paper summarizes the existing programs and initiatives related to poverty, social protection and participation of ageing adults in working spaces, as well as proposed recommend interventions to mitigate the impact of ageing societies in social, economic and inclusive development.

*Keywords:* ageing, demographic transition, social development, development, pension, ageing adult in the workplace

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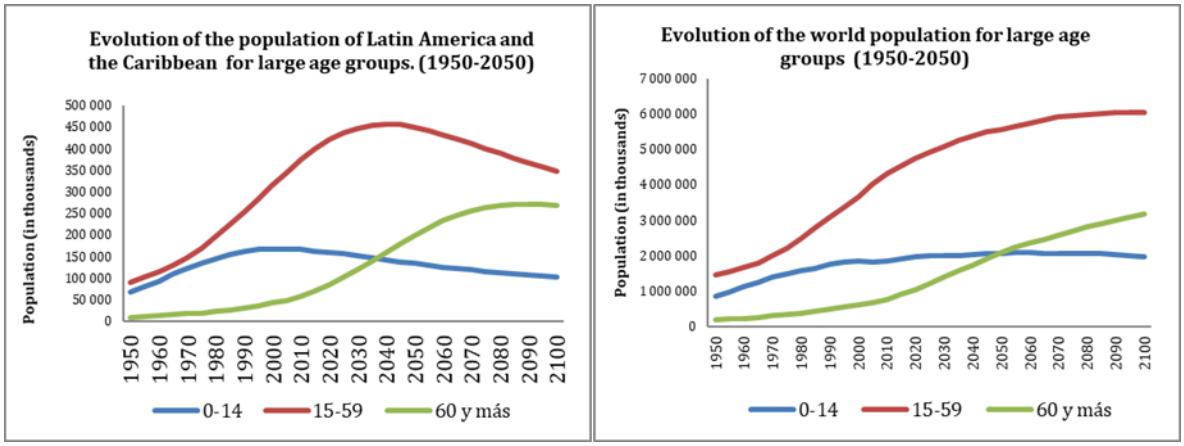
## Introduction

In Latin America and the Caribbean (LAC) the growth rate of the population 60 years or older is expected to be greater (3.77%) than at the global level (3%), during the period of 2015-2020 (Figure 1) (UN DESA, 2017). This rapid ageing of the population of LAC poses important challenges as the region continues to be the most inequitable of the world and has not reached the human development indexes achieved by other regions with similar ageing levels.

**Figure 1. Population age structure by broad age groups. Comparison between Latin America and the Caribbean and the world (1950-2050).**




The ageing process in LAC will not happen at the same pace in all the countries. It depends on the stage of demographic transition in each country: its progress to decrease infant and total mortality, the value of total fertility rates, as well as life expectancy at birth. Based on those values there are three distinguishable scenarios among the LAC countries (Table 1). As the Montevideo Consensus on Population and Development promotes the inclusion of population dynamics into public policy, it emphasizes the relevance of considering the epidemiological heterogeneity of the LAC region as, with different overlapping stages, as well as the rights of older persons.

**Table 1: Demographic Transition in LAC**

| | Demographic Transition | | |
|---|---|---|---|
| | **I** | **II** | **III** |
| **Global Fertility Rate** | ↑ | ↑↓ | ↓ |
| **Death Rate** | ↑ | ↑↓ | ↓ |
| **Life Expectancy** | ↓ | ↑↓ | ↑ |
| **Countries** | Bolivia, Guatemala, Honduras, Haiti | Brazil, Colombia, Peru, Dominican Republic | Cuba, Uruguay Costa Rica |

*Source*: UNFPA – LACRO

On the other hand, the *Madrid International Plan of Action on Ageing* of 2002 and the Charter of San Jose, its regional expression, highlight older persons as right-holders who have contributed to development, and should be included in the formulation of policies related to ageing. The ageing process poses new challenges to families and to societies in several aspects, such as: (i) the ageing index, which refers to number of individuals aged 65 and older correlated to the number of individuals aged 15 and younger; (ii) the dependency ratio of the ageing population (in other words, the number of people of working age corresponding to each elderly person), and (iii) the demographic window of opportunities, that measures the time in which the percentage of population in productive age (15 to 64 years) is greater than the percentage of the population in non-working age (0 to 14 plus 65 and older. The aforementioned elements might raise the pressure of social protection programs, shape governmental investment in education and health, and public and private savings. Using as a framework the Madrid International Plan of Action on Ageing of 2002, the Charter of San Jose, which was adopted during the Latin America Regional Intergovernmental Conference on Ageing that took place in 2012, as well as the Montevideo Consensus on Population and Development, this paper conducts a descriptive secondary analysis summarizing the situation and the progress related to ageing and the rights of the elders in eight Latin American countries: Bolivia, Brazil, Colombia, Costa Rica, Cuba, Mexico, Dominican Republic and Uruguay.

## The profile of older persons in Latin America and the Caribbean

Latin America and the Caribbean (LAC) maintains the tendency observed at a global level: the life expectancy at birth has increased by over 30 years during the last century (WHO, 2016), and between 1950 and 2050, the number of persons 80 years or older will increase 26 times, going from 14 million to 379 million (Palloni & Souza, 2013).

**Table 2: Latin American and Caribbean countries by older population.**

| Country | TFR 2015-20 | Life expectancy at birth (2020) | % population 65+ (2020) | % population 65+ (2050) |
|---|---|---|---|---|
| Cuba | 1.72 | 80.03 | 16.1% | 31.3% |
| Uruguay | 1.98 | 77.72 | 15.0% | 21.6% |
| Costa Rica | 1.76 | 80.14 | 10.4% | 23.6% |
| Brazil | 1.70 | 75.80 | 9.5% | 22.9% |
| Colombia | 1.83 | 74.65 | 8.7% | 20.9% |
| Mexico | 2.14 | 77.41 | 7.5% | 18.8% |
| Dominican Republic | 2.38 | 74.14 | 7.6% | 15.9% |
| Bolivia | 2.83 | 69.61 | 7.1% | 12.4% |

*Source*: UNFPA

The sources of information were narrative reports and excel templates summarizing qualitative, and quantitative data from countries, prepared by the United Nations Population Fund (UNFPA) Country Offices to inform the discussions at the Global Symposium on Ageing, Seoul 2017. In Latin America and the Caribbean, UNFPA relies on a network of experts across 22 countries as staff or consultants, many of which collaborated during the reporting process that took place 15 years after the adoption of the Madrid International Plan of Action.

**Results: Social development and economic security in old age**

*Coverage of the pension system*

The population dynamic of the LAC region is shifting the age structure of its population, and the dependents (children and ageing adults) are increasing at a faster pace than the adults of working ages, mainly due to older persons. The balance of the contributive systems depends on the age structures of the population, because it depends on the intergenerational solidarity to transfer quotas from the active economic population to the non-working population.

In Cuba, access to services and basic care, especially for ageing adults, are the cornerstones of the dignity and well-being of It citizens. Universal social security system and social assistance based on a method of contributions and distribution guarantee 100% coverage of social security, the system includes governmental businesses, and worker´s contributions (including new forms of non-governmental work). Social security coverage is universal, including independent workers. Those who have not worked receive, if necessary, a non-contributive coverage from the Social Security System. In Uruguay, there is a high level of social security coverage during retirement, in 2014, 83.8% of senior men and 62.2% of senior women were receiving retirement payments. At the same time, recent reforms adding flexible conditions to access retirement pensions is, without doubt, a substantial progress to ensure elders economic rights. The progressive and substantial increase in the amounts of retirements and pensions experienced in recent years also stands as an aspect that underlines the relationship of economic security of older people.

Finally, the systems recognise the intermittent participation of women in the labor market, secondary to reproductive events, it computes one year of work per child in order for them to access retirement funds. In Colombia, the Political Constitution established the Pensions General System with two modalities: (1) a traditional distribution system with defined benefits (RPM), and (2), a system of individual capitalization for those who work in the formal sector of the economy (RAIS). At a national level, the pension coverage for ageing people is 23% (875,981 people), of whom 65% are men and 25% women. Coverage is five times higher in urban zones than in rural zones, a result of the high informality of labor in the rural zones. According to the survey of Quality of Life in 2015, 27% of the working population reported affiliation to a pension system and pays quotas for their retirement. 65% of the people are not affiliated because they do not have sufficient income or because they are unemployed. According to the OECD, 86% of the pension subsidies granted by the State is received by the wealthiest 20% of the population, and the lowest fifth of the population receives only 0.1% of

these subsidies (OECD, 2015). In order to widen the financial security of ageing adults, the country relies upon various additional schemas: Voluntary and complementary savings system (for those who have capacity to save); as well as the Periodic Economic Benefits (BEPS), a mechanism of individual savings for the informal population complemented by a governmental subsidy of 20% to the individual savings. Last, there is a non-contributive pension program called the Ageing Colombia, which guarantees a minimum income for the most vulnerable elderly in the population. This provides coverage for 25% of the population aged 60 years or more (approximately 1,468,799 people) of whom 83% is older than 65 years living below the poverty line. The coverage consists of a direct economic subsidy, which matches approximately 10% of the minimum salary in Colombia, or a social services subsidy such as food, basic supplies, healthcare, etc.). Mexico possesses a pension system created through the decree of May 23 of 1996. The pension system includes workers affiliated to the Mexican Institute of Social Security (IMSS) and the ISSSTE. In the year 2010, only 26.4% of people aged 65 or more possessed a retirement fund or pension (SEDESOL, 2013). It should be emphasized that the people who work at the informal sector do not have access to the pensions systems. The accounts administered for the population of 60 years or more numbered 2,509,845, of which three out of four corresponded to men.

In the Dominican Republic, the system of individual capitalization was established in 2003, with 5,468 affiliated. Ten years later (2013) the total affiliation is 84,938 from which 60% corresponded to old age, disability and survival (National Bureau of Statistics, 2016). There are three affiliation plans: (1) a contributive plan with programed retirement; (2) a solidarity plan, which established a subsidized pension for those with incomes inferiors to 50% of the minimum national wage; (3) a contributive subsidized plan that contemplate those who were not able to complete the minimal pension of 300-month quota by age 65. The Protection Program for the Ageing in Extreme Poverty (PROVEE) stands out. It provided conditional transference to more 115,000 seniors in 2014, through the 'Solidarity' card. In Bolivia, the Comprehensive System of Pensions is composed by three regimens of distribution: (1) the contributive, which refers to the payments of workers during their working life and can finance their retirement on their own; (2) the semi-contributive, that are those who paid different amounts during a fraction of their working life and require help from the Solidarity Fund to increase their incomes; and (3) the non-contributive, which applies to those who never participated in the system and receive, the majority of them, only the "Dignity Program", as a specific provision from the Plurinational State. The "Solidarity Fund" was created, to elevate the lowest contributions of workers, i.e. the Elderly Solidarity Pension provided to the workers who have contributed at least 10 years so that they can reach the basic income. The retirement age is 55 for men and 50 for women. In accordance with the Households Survey of Bolivia from 2005, only one out of every five ageing adults receives a pension (UNFPA, 2007). And according to the survey of Ageing Adult (UDAPE, 2013) senior citizens have a low coverage of pensions, only 10.7% of the retirees between 60-64 years have access to a pension and 16% of those aged 65 or more. The group less representative receiving a pension are women in rural areas (5%). The dignity Program is a universal benefit to increase the income of elders, and it represents Bs. 250 monthly (36.00 USD) if the person does not receive any pension, and Bs. 200 monthly (28.80 USD) for those who receive a retirement pension.

As seen in this section, there are different institutional arrangements in LAC Countries, with a common factor of with large amounts of the population not entitled for a pension in the future, with the exception from Cuba, mostly women not participating formally in the labor market, as well as males participating in the informal sector.

*Participation of ageing adults in the workforce*

The participation of older workers may be possible with a more flexible working environment and retirement laws. In many cases, senior citizens need to remain in the labor market because their pensions or retirement funds are lower than the salaries they have earned during their working life (especially for women). But it is also important to take advantage of their vast knowledge and experience as an input for the societies of their countries. The Cuban Parliament, as of 2008, allows the rehiring of workers beyond the age of retirement, which has permitted the 'rescue' of thousands of workers with experience, capacity, and health to do so. According to the results of the *National Survey of Ageing Population 2010-2011*, almost 20% of people aged 60-plus were working or were retired or pensioners but still working. This last group makes up half (10.4%) of the total retirees. For the Census of 2012, these percentages have increased and there are currently more than 330 thousand who work outside of the labor age and more than half of them are retirees. In regards to senior citizens' labor participation in Uruguay, even if the proportion of older people who continue to work is low (in relation to other countries in the region), the proportion of those who do it in conditions of informality is high (61.7%). Senior citizens placed at the lowest quintile are those who continue participating in the labor market (Martínez Franzoni, 2008).

In Colombia, it is estimated that 25% of the Colombian population older than 60 years are working outside the home on a fixed salary (MINSALUD, 2011). Men show greater labor participation (45%) than women (16%). The labor market participation of those aged 70 years and more is 35% for men and 12% for women. Around 10% of senior citizens do not receive remuneration for their work outside of the home, and this also happens with most of older adult women who work in the home. In regards to the work at home, almost 70% of women do household work from age 60 to age 79, a percentage that declined to 11.5% at the age of 95; this implies that women are doing household work (that is generally unpaid) until advanced age, in contrast with the low participation (less than 20%) of the men older than 60 years in household tasks. One of the major problems in the country is the informality that affects 64% of the workforce in Colombia (DANE, 2015), especially in rural zones and predominantly those who are women. This informality affects 85% of those 60 years and older. In the Dominican Republic, the total employment rate for senior citizens in 2012 was 35%, predominantly men (52%) over women (19%) (ONE, 2012). Senior citizens occupied themselves in basic labors such as service workers, sellers for shops and markets, agriculture, farming, forestry, and fishing laboUrs. In Bolivia, in the year 2002, 51% of senior citizens formed part of the economically active population, and 65.3% worked for themselves or as paid workers (20.7%) under precarious working conditions (INE, 2002). Currently, according to data from The Office of the Ombudsman, around 56% of men and 30% of women from urban areas continued working after the age of 60, and senior citizens in rural areas who were found to be economically active are proportionally more than in the urban areas (78.3% to

61.6% for the population between the age of 60 and 64). Senior citizens have opted to continue as active in the labor market for as long as possible. If they are added to the percentage of senior citizens who are already retired (26.8%), the percentage of those who continue working (12.5%), results in almost 40% of senior citizens earning their own subsistence (HelpAge International, 2012).

**Discussion**

The rapid ageing of the population in Latin America and the Caribbean is the result of science, technology, health and social protection successes; to the extent that the age group with the fastest growth is the 65 years and older. But in LAC, most of the older persons do not have access to retirement funds or pensions that allow them to have economic stability, especially those who didn't participate in the formal labor market or had an intermittent labor trajectory (especially women), it varies depending on the urban and rural distribution, as well as the situation of older women, which is the result of accumulated inequalities in the course of her life, especially related to unpaid work related to care and household activities. One of the most important achievements of the countries has been the establishment of non-contributive pensions for older persons who would otherwise not have access to them because they worked primarily in the informal sector. CEPAL (Prado & Sojo, 2010) has pointed out that countries could finance a minimum non-contributory pension, as long as future reforms are put in place to increase funding resources for social security considering the age structure of each country. They have proposed, as part of their agenda of equality, a tributary structure with redistributive effect for strengthening the role of public policy and, in this way, guaranteeing the thresholds of well-being.

**Conclusions**

Longevity is an achievement of society that should be accompanied by the eradication of poverty, and financial stability of older persons in the region. Public policy, laws and programs need to generate opportunities for economic participation, addressing the challenges of an ageing population, focusing on human rights. National policies should consider the challenges derived of the population dynamics of their population. This would help to identify the economic, social and human resources needed to guarantee access to social security and assistance to make development sustainable. This article summarizes areas of public policy intervention in employment and contributive and non-contributive pensions based on three country profiles (Table 3 and Table 4), establishing a basis for differentiated policy design. The three country profiles should promote labor market and economic policies to prevent financial and social vulnerability in older persons, as well as promote voluntary savings, and develop programs of financial education from early ages in order to encourage savings and economic preparation of the population for their elderly years.

**Table 3: Main typology by country profile**

| Topics | Advanced Ageing | Moderate Ageing | Oncoming Ageing |
|---|---|---|---|
| Employment | • To reintegrate senior citizens to the labor market as in the case of Cuba<br>• Promote the stability of older persons in the formal labor market, taking advantage of their experience, as Uruguay has encouraged<br>• To improve and adapt the office spaces considering the age of employees and possible limitations.<br>• To promote job flexibility (part-time, work from home) | • To strengthen the labor markets to increase incomes throughout all working years<br>• To encourage the creation of formal and decent jobs for youth and senior citizens | • To promote a formal, stable and inclusive labor market, to increase the number of workers that can access the pension during their elderly years. |

**Table 4: Main recommendations by typology of country**

| Topics | Advanced Ageing | Moderate Ageing | Oncoming Ageing |
|---|---|---|---|
| Contributive and non-contributive pensions | • Increase coverage and equity of contributive and non-contributive pensions to reach all the elders.<br>• Evaluate the value of the pensions so they allow older persons to live a life with dignity.<br>• Consolidate the pensions derived from private schemes.<br>• Promote individual savings | • Redesign the pension system in a way that allows them to include the population with the lowest incomes and the furthest behind.<br>• Improve women's conditions so they can obtain a pension, reducing the gender differences in the retirement ages (such as, for example, providing a pension bonus that compensates for maternity and recognizing the weeks of coverage for each child that they have had like Uruguay has done)<br>• Recognize the unpaid household work and caregivers, to which could be assigned a pension bonus. | • Widen the coverage and quality of the social protection systems, with inclusive, democratic and cohesive societies with clear parameters of intergenerational solidarity, decreasing the inequity and the intergenerational transmission of disadvantages, such as in the case of the Dignity Program in Bolivia.<br>• To control the evasion of contributive payments into social security on the part of employees and employers who are already contributing to their vulnerability in later years. |

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# Population Ageing and Sustainable Development in the Caribbean: Where are we 15 years post MIPAA?

**Nekehia T. Quashie[1], Francis Jones[2], Lydia Rosa Gény[3], and Abdullahi Abdulkadri[4]**

***Abstract.*** The Caribbean is undergoing increasingly rapid population ageing with the proportion of older persons (60 and over) increasing from 10% in 2000 to 14% in 2015, and projected to reach 25% by 2050. Since the adoption of the Madrid International Plan of Action on Ageing (MIPAA), in 2002, Caribbean States have developed national policies on ageing and strengthened their programmes and services for older persons, particularly in the areas of pensions, health, and care services. Nevertheless, with insufficient funds, limited political will and inadequate administrative support, implementation is lagging and significant gaps still exist between policy and practice. Drawing primarily upon national reviews of the MIPAA carried out in 2017, this paper examines the progress made by Caribbean States in addressing issues that include income security, later life health, social care, active ageing, social and economic participation, and elder abuse. Country-specific examples are provided to illustrate good practices from the sub-region, such as the incorporation of older persons into disaster and emergency preparedness and management. The paper considers outstanding and emerging challenges which States will need to address in order to further implement the MIPAA One critical challenge is the need for improved prevention, treatment, and management of lifestyle-related diseases such as diabetes. Recommendations are made for future actions to achieve a society for all ages in which the protection and promotion of the rights of older persons also serve to mitigate the health and socio-economic challenges associated with population ageing.

*Keywords:* Caribbean, ageing, care, gender, human rights, public policy

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## Introduction

This paper presents a broad overview of the progress made by Caribbean States[5] to develop and implement social policies to prepare their societies for population ageing since the adoption of the 2002 Madrid International Plan of Action on Ageing (MIPAA).

Population ageing is a consequence of the demographic transition from high to low levels of fertility and mortality. In Latin America and the Caribbean (LAC), this transition began in the mid-1960s and has continued unabated giving rise to a rapid ageing of the region's population (Saad, 2011).

As shown in Table 1, within the Caribbean sub-region specifically, between 2000-2005 and 2015-2020, the average total fertility rate declined from 2.5 to 2.2 children per woman, and is estimated to continue a downward trend, while life expectancy at birth across the sub-region increased from 70 to 73 years during the same time period and is projected to continue increasing.

Consequently, the proportion of older adults, aged 60 years and over, has increased from 10% at the beginning of the 21st century to 13 % in 2015, and is projected to approach 25% of the sub-region's total population by 2050. Importantly, the largest share of older adults within Latin America and the Caribbean currently resides within the Caribbean sub-region (Pan American Health Organization [PAHO], 2017).

There is considerable cross-national variation in the pace of the demographic transition that is often obscured by the regional averages. Utilizing the classification provided by the Economic Commission for Latin America and the Caribbean (ECLAC) in 2008, Barbados and Cuba are at a very advanced stage of demographic transition and among the forerunners of population ageing in Latin America and the Caribbean (CEPAL [Economic Commission for Latin America and the Caribbean], 2008). Most countries within the Caribbean sub-region can be classified as being at an advanced stage of demographic transition with the exception of Belize, Guyana, Jamaica and Suriname where ageing is not so advanced. All countries, however, are experiencing a rapid shift in their population structure as the shares of older persons increase.

[5] In this paper, the Caribbean region refers to the Member and Associate Member Countries of the Economic Commission for Latin America and the Caribbean and the Caribbean Development and Cooperation Committee (ECLAC/CDCC). Member Countries are: Antigua and Barbuda, The Bahamas, Barbados, Belize, Cuba, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago. Associate Member Countries are: Anguilla, Aruba, Bermuda, British Virgin Islands, Cayman Islands, Curaçao, Guadeloupe, Martinique, Montserrat, Puerto Rico, Sint Maarten, Turks and Caicos Islands, and United States Virgin Islands. Every effort is made to provide data on all countries where possible.

**Table 1: Caribbean countries according to the stage of demographic transition**

| Stage of Demographic Transition | Region/Country | Total Fertility Rate | | | Life Expectancy at birth | | | % Population 60+ | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 2000 - 2005 | 2015 - 2020 | 2045-2050 | 2000 - 2005 | 2015 - 2020 | 2045-2050 | 2000 | 2015 | 2050 |
| | **Latin America and the Caribbean** | 2.5 | 2.0 | 1.8 | 72.1 | 75.7 | 81.3 | 8.1 | 11.2 | 25.4 |
| | **Caribbean** | 2.5 | 2.2 | 1.9 | 70.0 | 73.4 | 78.3 | 10.4 | 13.3 | 25.4 |
| **Very Advanced** | **Barbados** | 1.8 | 1.8 | 1.8 | 73.8 | 76.1 | 80.7 | 15.1 | 19.8 | 31.0 |
| | **Cuba** | 1.6 | 1.7 | 1.8 | 77.2 | 80.0 | 84.9 | 13.8 | 19.4 | 38.2 |
| **Advanced** | **Antigua and Barbuda** | 2.3 | 2.0 | 1.8 | 74.0 | 76.6 | 81.2 | 8.6 | 10.1 | 24.9 |
| | **Aruba** | 1.8 | 1.8 | 1.8 | 74.0 | 76.1 | 80.3 | 11.5 | 18.4 | 27.7 |
| | **Bahamas** | 1.9 | 1.8 | 1.7 | 73.2 | 75.9 | 80.4 | 8.1 | 12.6 | 27.7 |
| | **Curaçao** | 2.1 | 2.0 | 1.9 | 75.0 | 78.6 | 83.5 | 14.5 | 21.9 | 29.5 |
| | **Grenada** | 2.4 | 2.1 | 1.8 | 70.9 | 73.8 | 77.9 | 10.4 | 10.2 | 25.1 |
| | **Guadeloupe** | 2.1 | 1.9 | 1.8 | 77.9 | 81.7 | 86.5 | 13.9 | 22.4 | 32.8 |
| | **Martinique** | 1.9 | 1.9 | 1.8 | 79.0 | 82.3 | 87.1 | 16.3 | 24.3 | 36.9 |
| | **Puerto Rico** | 1.9 | 1.5 | 1.6 | 76.8 | 80.2 | 84.9 | 15.6 | 19.7 | 34.8 |
| | **Saint Lucia** | 1.9 | 1.4 | 1.6 | 72.1 | 75.8 | 81.1 | 10.1 | 13.1 | 32.0 |
| | **Saint Vincent and the Grenadines** | 2.2 | 1.9 | 1.7 | 70.7 | 73.3 | 77.0 | 9.7 | 10.9 | 25.7 |
| | **Trinidad and Tobago** | 1.8 | 1.7 | 1.7 | 68.7 | 70.8 | 74.5 | 9.6 | 14.2 | 28.4 |
| | **United States Virgin Islands** | 2.1 | 2.2 | 1.9 | 77.1 | 80.0 | 85.0 | 13.2 | 24.0 | 31.9 |
| **Full** | **Dominican Republic** | 2.8 | 2.4 | 1.8 | 71.1 | 74.1 | 79.3 | 7.5 | 9.7 | 21.2 |
| | **Belize** | 3.4 | 2.5 | 1.9 | 68.5 | 70.7 | 75.5 | 5.6 | 5.9 | 15.1 |
| | **Guyana** | 3.0 | 2.5 | 2.0 | 65.2 | 66.8 | 70.0 | 6.0 | 8.1 | 15.3 |
| | **Jamaica** | 2.5 | 2.0 | 1.8 | 72.8 | 76.1 | 80.3 | 10.4 | 13.0 | 29.0 |
| | **Suriname** | 2.8 | 2.3 | 1.9 | 68.1 | 71.6 | 75.4 | 8.2 | 9.9 | 20.5 |
| **Moderate** | **Haiti** | 4.0 | 2.9 | 2.0 | 58.3 | 63.7 | 69.5 | 6.3 | 7.1 | 15.2 |

*Source*: United Nations, (2017)

Moreover, this demographic shift is happening within diverse socio-economic conditions throughout the region. As shown in Table 2, countries at a very advanced stage of demographic transition as well as those at an advanced stage differ considerably in their standards of living including some being high income and others being upper-middle income according to the World Bank's classification (World Bank, 2017). The 2011 gross national income per capita at purchasing power parity ranged from $7,455 in Cuba, one of the forerunners of the demographic transition, to $28,049 in Trinidad and Tobago, which is at an advanced stage of demographic transition. Countries also vary in their level of government debt. Among countries with available data, in each of Barbados, the Bahamas, Grenada, and Saint Lucia, government debt as a percentage of GDP more than doubled between 2000 and 2014. This presents significant variation in economic resources for States to develop and implement measures to address the challenges, as well as capitalize on the benefits, of population ageing for the development of all population sub-groups within their societies.

**Table 2: Socio-economic indicators for Caribbean countries**

| Stage of Demographic Transition | Country | Income Level[1] | Gross National Income (GNI) per capita (2011 PPP $)* | Central Government Debt, total(%GDP) ** | | Human Development Index 2016[1] |
|---|---|---|---|---|---|---|
| **Very Advanced** | **Barbados** | High income | 14,952 | 63 | 129 | 0.795 |
| | **Cuba** | Upper middle income | 7,455.00 | na | na | 0.775 |
| **Advanced** | **Antigua and Barbuda** | High income | 20,907 | 97 | 83 | 0.786 |
| | **Bahamas** | High income | 21,565 | 24 | 60 | 0.792 |
| | **Dominican Republic** | Upper middle-income | 12,756 | na | na | 0.722 |
| | **Grenada** | Upper middle-income | 11,502 | 41 | 89 | 0.754 |
| | **Saint Lucia** | Upper middle-income | 9,791 | 37 | 73 | 0.735 |
| | **Saint Vincent and the Grenadines** | Upper middle-income | 10,372 | na | na | 0.722 |
| | **Trinidad and Tobago** | High income | 28,049 | na | na | 0.78 |
| **Full** | **Belize** | Upper middle-income | 7,375 | 67 | 77 | 0.706 |
| | **Guyana** | Upper middle-income | 6,884 | na | na | 0.638 |
| | **Jamaica** | Upper middle-income | 8,350 | 99 | 120 | 0.73 |
| | **Suriname** | Upper middle-income | 16,018 | na | na | 0.725 |
| **Moderate** | **Haiti** | Low income | 1,657 | na | na | 0.493 |

* United Nations Development Programme, (2017)
** World Bank, (2017)

Ageing is as a lifelong process that can be associated with both gains and losses across all life domains (Settersten Jr., 2003). Existing research shows that the early life course conditions in which individuals are born, live and work exert significant influence on mid- and later - life health and well-being outcomes (McEniry, 2013).

Thus, adopting a life course perspective of population ageing can be conceived as the foundation upon which national development plans should be based. Social policies designed to invest in human development within the realms of education, employment, and health for younger cohorts not only enhances the potential for the healthy and successful ageing of future cohorts of older adults but also contribute to sustainable development (Bennett & Zaidi, 2016). This raises a critical question: how are Caribbean States performing with regard to public policies to create societies for all ages that consequently prepare their populations to age successfully?

The following review primarily draws upon analysis of country reports prepared by governments and non-governmental organizations throughout the sub-region in response to a survey conducted by the Economic Commission for Latin America and the Caribbean (ECLAC) Subregional Headquarters for the Caribbean to fulfill the 2017 regional review of the MIPAA. We present an overview of the implementation of the MIPAA within Caribbean countries as they pertain to the three overarching areas: 1) Older persons and Development, 2) Advancing health and well-being into old age, and 3) Enabling and Supportive Environments. The review concludes with a discussion of the implications of the current status of social policies and perspectives for future research and actions.

**Older persons and development**

The MIPAA was designed as a series of recommended actions to be taken by government and non-governmental actors to not only transform their societies to prepare for population ageing across the life span but also advocates for promoting and protecting the human rights of older persons, including the right to participate in their nation's development (United Nations, 2002).

Beginning with adoption of the *Regional Strategy for the Implementation of the Madrid International Plan of Action on Ageing* in 2003 to the *2012 San Jose Charter on the Rights of Older persons in Latin America and the Caribbean*, only 12 Caribbean countries have drafted and/or implemented national policies on ageing. Although governments and non-governmental organizations across Latin America and the Caribbean acknowledge the need to adopt human rights-based approach to population ageing (Montes de Oca et al., 2018), no Caribbean country nor overseas territory has explicitly adopted laws to protect the rights of older persons (Jones, 2016).

*Income Security*

Income security remains one of the most formidable challenges facing older persons in the Caribbean but pension coverage varies across countries. Based on the most recent available data, Guyana, the Bahamas and Barbados recorded the highest coverage at 80%, 74% and 69%, respectively. In Jamaica, Saint Vincent and the Grenadines, Belize, and Saint Lucia, coverage was much lower with 40%, 34%, 31%, and 22% of older persons of retirement age, respectively, receiving a contributory pension (Jones, 2016).

Most countries have, however, instituted non-contributory pension schemes in an effort to ensure older persons have some form of income security. As shown in Table 3, Barbados and Trinidad and Tobago have the oldest non-contributory pension schemes, established in 1937 and 1939, respectively. Non-contributory or social pensions can be 1) universal pensions that are offered to persons based on age, residence and citizenship (e.g. Guyana and Suriname), 2) offered to those who have no other pension (government, private or occupation based), although they may receive income from other sources, or 3) targeted to alleviate poverty through a means-test, which is the most common in the Caribbean.

Although available as a source of income for later life, contributory and non-contributory pensions may not be adequate to maintain a decent quality of life. Three countries, Barbados, the Bahamas, and Dominica index contributory pensions so that their value is protected against inflation (Jones, 2016).

There is also marked cross-national variation in the adequacy of social pensions whereby non-contributory pension benefits, as a percentage of the GDP per capita, range from 3% in Jamaica to 27% in Trinidad and Tobago (Table 3). To mitigate, to some extent, the economic insecurity of older persons, several countries have introduced policies to assist older persons with their monthly living expenses. Based on the recent review of the MIPAA, in Guyana the government subsidizes water bills for senior citizens and in Trinidad and Tobago, households headed by pensioners benefit from free electrical and plumbing services provided by the National Social Development Programme (NSDP) (Gény, 2017). While social pensions are critical to older persons' economic security, the sustainability of these systems presents another concern, especially in countries such as Trinidad and Tobago that provide substantial benefits, given the increasing shares and numbers of older persons along with extending life expectancy.

*Ageing and the labour force*

Given that income security through pension coverage, and its adequacy, remains a precarious aspect of later life, many older persons rely on employment as their main source of income.

Labour force participation rates among older persons reflect the extent of pension coverage in their countries. For instance, Jamaica, Belize, and Saint Lucia have higher labour force participation rates of older persons 65 years and over relative to Trinidad and Tobago, Suriname and Barbados. Moreover, gender inequality in labour force participation extends to later life such that men's labour force participation rates almost double that of women's in all countries for which data are available (Jones, 2016).

The MIPAA includes specific recommendations addressing older persons' continued engagement in work, should they so choose. Since the adoption of the MIPAA, however, the majority of Caribbean countries have not introduced programs for older persons to continue working beyond retirement age, nor have they trained older persons to enter or re-enter the labour market, or introduced programs to assist older persons in the informal economy.

The exceptions include Anguilla, Bermuda, and Trinidad and Tobago. In those countries where programs have been introduced, however, they are often limited to the formal labour market, and within the public sector such as the recall of retired teachers, nurses, dentists or senior civil servants on short term government contracts (Gény, 2017).

The challenge of job creation and employment also extends to younger cohorts in the region. Several countries have experienced increasing unemployment particularly among youth (aged 15-19) and young adults (20-24), which has been explained by the vulnerability of

Caribbean labour markets to external economic shocks and limited job creation during periods of economic growth (Kandil, et al., 2014). Even among the employed working-age population, social protection remains elusive in some countries.

Analyses of contributions to pensions systems among the working age population (15-64) in Caribbean countries with available data, indicate that the percentage of workers contributing to a pension scheme ranges from 30% and 60% in Jamaica and Trinidad and Tobago, respectively, to 80% and above in Barbados and the Bahamas (Bosch, Melguizo, & Pagés, 2013). Moreover, gender inequalities in labour force participation rates and earnings persist such that women remain disadvantaged relative to their male counterparts (Bellony, Hoyos, & Ñopo, 2010). This affects women's abilities to accumulate financial capital for later life.

**Table 3: Social pension programmes in Caribbean Countries, 2017**

| Country | Year Established | Age of eligibility | Targeting | Number of recipients | % population 60+ covered | % of population over eligibility covered | Benefit Level | | | Total cost (% of GDP) |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | US $ | PPP $** | % of GDP per capita* | |
| **Antigua and Barbuda** | 1993 | 85 | Means-tested | 152 | 2 | 10 | 94 | 151 | 8.3 | 1.637% |
| **Bahamas** | no data | 65 | Means-tested | 1847 | 4 | 6 | 237 | 240 | 11.3 | 0.065% |
| **Barbados** | 1937 | 66 | Means-tested | 8791 | 16 | 24 | 299 | 309 | **22.6** | 0.710% |
| **Belize** | 2003 | 67 (men) and 65 (women) | Means-tested | 3396 | 16 | 28 | 50 | 87 | 13.0 | 0.120% |
| **Bermuda** | no data | 65 | Pensions-tested | no data | no data | no data | 451 | ∞ | ∞ | no data |
| **Guyana** | 1944 (first scheme introduced), 1993 (scheme became universal) | 65 | Universal | 42397 | 67 | 110 | 84 | 144 | **24.0** | 1.269% |
| **Jamaica** | 2001 | 60 | Means-tested | 51846 | 18 | 18 | 8 | 17 | 2.4 | 0.040% |
| **Saint Vincent and the Grenadines** | 2009 | 67 (in 2009 - the time of implementation) | Means-tested | 1203 | 11 | 23 | 60 | 95 | 10.4 | 0.113% |
| **Suriname** | 1973 | 60 | Universal | 42818 | 92 | 92 | 152 | 253 | 19.8 | 1.563% |
| **Trinidad and Tobago** | 1939 (first scheme introduced), 2010 (entitlement to a pension legislated) | 65 | Means-tested | 79942 | 45 | 68 | 470 | 750 | **27.6** | 1.614% |

*Source*: Adapted from HelpAge International Social Pensions Database.

*Emergency Situations*

The Caribbean sub-region, due to its geographical location, is acutely vulnerable to disasters such as hurricanes, flooding and landslides, and earthquakes. Disasters, however, disproportionately affect some countries and population sub-groups within countries. As a heterogeneous group, older persons can be particularly vulnerable to the challenges posed by disasters if they are unhealthy, experience functional impairments or are economically insecure but they can also be extremely resourceful if they are not experiencing such health and income challenges. Some Caribbean countries have improved their efforts to address this component of the MIPAA. As examples, Anguilla and Barbados, as part of their national disaster preparedness plans, have established registers of older persons at risk. In Guyana, the government conducts disaster preparedness workshops with older persons and supplies emergency kits to homes for older persons (Gény, 2017).

**Advancing health and well-being in older ages**

Older persons in the Caribbean can live an average of 21 years beyond age 60 (PAHO, 2017). As observed globally, women in all countries, however, have a survival advantage relative to their male counterparts (Table 4). Whilst in most countries the male-female gap in life expectancy is about 4 years, Haiti records the smallest gap with a one-year difference. Increasing longevity is not exempt of disease, disability or functional impairments that reduce one's quality of life. This is particularly relevant to older women who have higher exposure to life course social and economic disadvantages that lead to poorer health outcomes in later life, relative to men (Zunzunegui et al, 2009; Pandey & Ladusingh, 2015).

**Table 4: Life expectancy and health life expectancy at age 60 for Caribbean Countries**

| | | Life Exp. at age 60* | | Health Life Exp. at age 60** | |
|---|---|---|---|---|---|
| **Stage of Demographic Transition** | **Region/Country** | **2015-2020** | | **2015** | |
| | | **Males** | **Females** | **Males** | **Females** |
| | **Latin America and the Caribbean** | 20.6 | 23.2 | na*** | na |
| | **Caribbean** | 20.8 | 23.7 | na | na |
| **Very Advanced** | **Barbados** | 18.2 | 21.6 | 14.3 | 16.6 |
| | **Cuba** | 22.3 | 25.1 | 16.6 | 18.3 |
| **Advanced** | **Antigua and Barbuda** | 20.4 | 23.3 | 15.5 | 17.5 |
| | **Aruba** | 18.3 | 22.0 | na | na |
| | **Bahamas** | 20.9 | 24.2 | 15.9 | 18 |
| | **Curaçao** | 21.4 | 24.6 | na | na |
| | **Grenada** | 17.9 | 20.4 | 13.8 | 15.4 |
| | **Guadeloupe** | 23.0 | 27.2 | na | na |
| | **Martinique** | 23.2 | 27.5 | na | na |
| | **Puerto Rico** | 21.8 | 26.5 | na | na |
| | **Saint Lucia** | 19.8 | 23.5 | 15 | 17.5 |
| | **Saint Vincent and the Grenadines** | 19.2 | 21.2 | 14.8 | 15.9 |
| | **Trinidad and Tobago** | 16.2 | 20.5 | 12.8 | 15.6 |
| | **United States Virgin Islands** | 20.8 | 24.8 | na | na |

**Table 4: Life expectancy and health life expectancy at age 60 for Caribbean Countries (contd.)**

| | | Life Exp. at age 60* | | Health Life Exp. at age 60** | |
|---|---|---|---|---|---|
| **Stage of Demographic Transition** | **Region/Country** | **2015-2020** | | **2015** | |
| | | **Males** | **Females** | **Males** | **Females** |
| **Full** | **Belize** | 15.9 | 18.8 | 12.5 | 13.9 |
| | **Dominican Republic** | 20.8 | 23.6 | 15.9 | 17.7 |
| | **French Guyana** | 20.7 | 25.7 | na | Na |
| | **Guyana** | 15.5 | 16.7 | 12.4 | 12.9 |
| | **Jamaica** | 21.3 | 23.8 | 16.7 | 18 |
| | **Suriname** | 16.9 | 20.4 | 13.7 | 15.7 |
| **Moderate** | **Haiti** | 17.0 | 18.8 | 12.7 | 13.5 |

* United Nations, (2017)

** World Health Organization. Global Health Observatory Data Repository;

*** data not available

As shown in Table 4, among countries with available data in 2015, the healthy life expectancy of older men and women was approximately 5 to 6 years less than their total estimated life expectancy.

The rapid ageing of Caribbean nations is accompanied by shifts in their health profiles due to the epidemiological transition whereby communicable or infectious diseases are increasingly replaced by lifestyle related non-communicable diseases (NCDs) as the primary causes of mortality (Santosa et al., 2014).

NCDs, particularly cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes, are the leading causes of death globally, and approximately 85% of preventable deaths due to NCDs occur in low and middle income countries (World Health Organization, 2014). This process is not gender-neutral as women are more likely than men to experience non-fatal chronic conditions such as arthritis or depression, and disability, while there is a higher prevalence of cardiovascular diseases among men (Crimmins, Kim, & Solé-Auró, 2010). Although the Pan American Health Organization has identified that the Caribbean sub-region has the highest prevalence of NCDs within the Americas, persistent and emerging communicable and infectious diseases such as HIV-AIDS, dengue, and Zika, present a double health burden to many countries (PAHO, 2009; 2017).

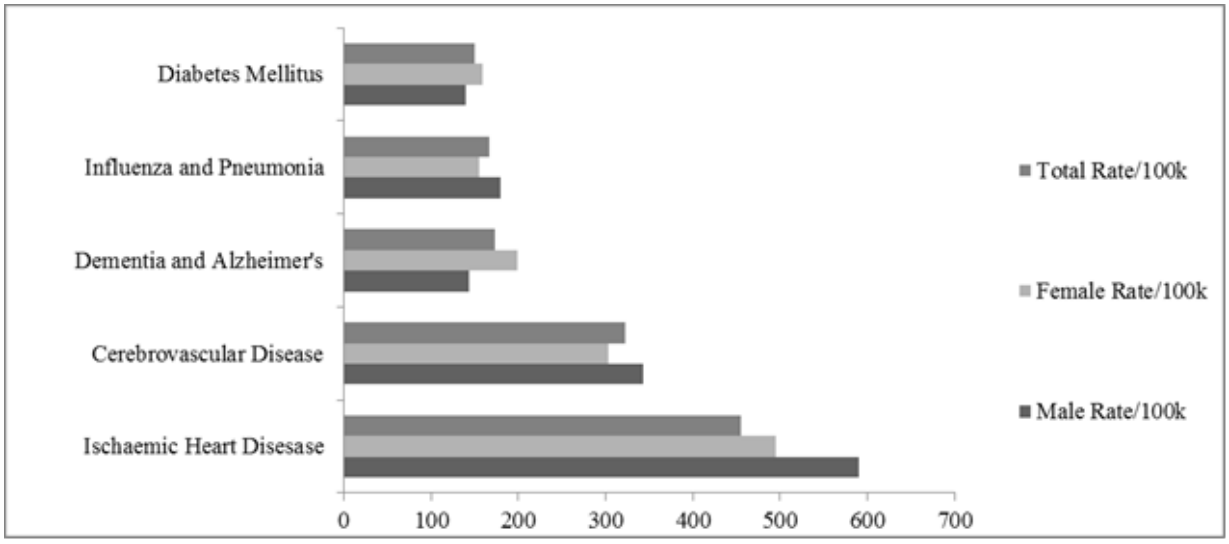
Nevertheless, as shown in Table 5 based on the most recent available data, regardless of the level of economic development, NCDs account for the majority of all deaths in Caribbean countries. Furthermore, the probability of premature mortality, which is dying between ages 30 and 70, due to the four main NCDs, was highest in Guyana (37%), Trinidad and Tobago (26%), and Haiti (24%). Likewise, Figures 1 and 2 show that among older adults 60 years and over, NCDs accounted for the five leading causes of mortality among both English and Latin Caribbean countries in 2012 (PAHO, 2018). On average, despite variation in the rates of specific causes of mortality among countries in the region, ischaemic heart diseases, cerebrovascular diseases and diabetes were among the five leading causes of death.

**Table 5: Mortality due to non-communicable diseases for Caribbean countries, 2012**

| Country | Income Group (2012) | Total Population, 000 (2012) | Proportion (%) of population aged 30-70 years (2012) | Proportion (%) of mortality (all deaths, both sexes, all ages) due to NCDs (2012) | Probability (%) of dying between ages 30 and 70 due to the 4 main NCDs (2012) |
|---|---|---|---|---|---|
| **The Bahamas** | High | 372 | 48 | 72 | 14 |
| **Barbados** | High | 283 | 52.4 | 84 | 14 |
| **Belize** | Upper-middle | 324 | 34.1 | 65 | 15 |
| **Cuba** | Upper-middle | 11, 271 | 54 | 86 | 17 |
| **Dominican Republic** | Upper-middle | 10,277 | 38.4 | 70 | 15 |
| **Guyana** | Lower-middle | 795 | 35.8 | 67 | 37 |
| **Haiti** | Low | 10,174 | 32.2 | 48 | 24 |
| **Jamaica** | Upper-middle | 2,769 | 40.8 | 79 | 17 |
| **Suriname** | Upper-middle | 555 | 42.6 | 68 | 13 |
| **Trinidad and Tobago** | High | 1,337 | 49.5 | 80 | 26 |

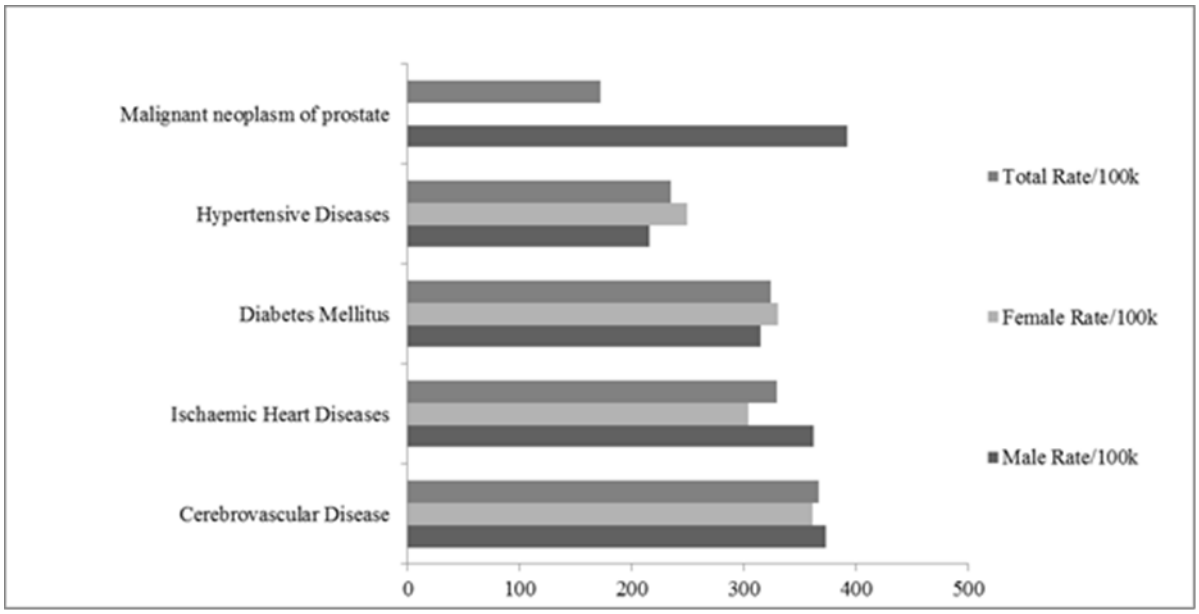
*Source:* World Health Organization, (2014).

**Figure 1: Five leading causes of mortality among older adults 60 years and over in Latin Caribbean* countries, 2012**




* Latin Caribbean countries include: Cuba, Dominican Republic, Puerto Rico, Guadeloupe, and Martinique
*Source*: Pan American Health Organization. (2018, April 10).

**Figure 2: Five leading causes of mortality among older adults 60 years and over in English Caribbean* countries, 2012**




* English Caribbean countries include: Anguilla, Antigua and Barbuda, Aruba, The Bahamas, Barbados, Bermuda, Dominica, Grenada, Montserrat, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, and the United States (US) Virgin Islands.

*Source:* Pan American Health Organization. (2018, April 10).

NCDs also present significant economic burden to Caribbean nations. The annual estimated cost of the burden of diabetes, for instance, ranges from 0.5% of GDP in the Bahamas to 5.2% of GDP in Trinidad and Tobago (Abdulkadri, Cunningham-Myrie, & Forrester, 2009). Given the magnitude of the health burden, addressing NCDs is critical to the post-2015 sustainable development of low and middle-income countries (Alleyne, et al., 2013). This calls attention to examine the Caribbean's response by establishing preventive measures to address the NCD risk factors and to develop their health systems to advance health and well-being across the life course.

*Health promotion and well-being throughout life*

Caribbean States have identified chronic diseases as a regional challenge (Eldemire-Shearer, et al., 2011). In an effort to promote the healthy ageing of their populations, several countries in the region have prioritized the reduction of chronic NCDsthrough the adoption and implementation of national strategic plans (see Table 6). In addressing health behaviors and promoting healthy lifestyles, a few Caribbean countries such as Anguilla, Barbados, Sint Maarten, and Jamaica have introduced programs to promote "Active Ageing" with physical activity being a core component of these programs (Gény, 2017).

**Table 6: National non-communicable disease programmes in Caribbean Countries**

| Country | **National NCD program** |
|---|---|
| Anguilla | Non-Communicable Diseases Action Plan 2016-2025 |
| Antigua and Barbuda | 2015 Cabinet approved National Policy on the Prevention and Control of NCDS<br>Medical Benefits Scheme- NCD prevention activities aimed at younger cohorts |
| Aruba | National Plan 2009-2018 aimed to address overweight, obesity, and other health problems |
| Bahamas | The Healthy Bahamas Coalition 2017 |
| Cayman Islands | No mention in PAHO report |
| Guyana | 2013 "Guyana Health Vision 2020" |
| Montserrat | 2016-2019 Strategic Plan focus on reducing communicable and non-communicable diseases |
| Puerto Rico | Chronic Disease Action Plan 2014-2020<br>2016 Obesity Prevention Plan<br>2016 Alzheimer's Action Plan<br>2016 Strategic Asthma Plan<br>2016 Tobacco Control Plan |
| Trinidad and Tobago | National Strategic Plan for the Prevention and Control of NCDs 2017-2021 |
| Turks and Caicos | National Plan of Action for Prevention and Control of NCDs 2016-2020 |

*Source:* Pan American Health Organization, (2017).

These initiatives, however, focus on the sub-group of older persons rather than adopting a life course perspective. Intergenerational programmes are also crucial to promote active ageing. Trinidad and Tobago, for instance, has conducted, through the Health Promotion and Health Education Units, annual outreach intergenerational programmes, which include walking/running, promoting health and active ageing. In Belize, the National Council on Ageing is piloting the 'Adopt-A-Grandparent' programme aimed at connecting older persons living on their own with young people (Gény, 2017).

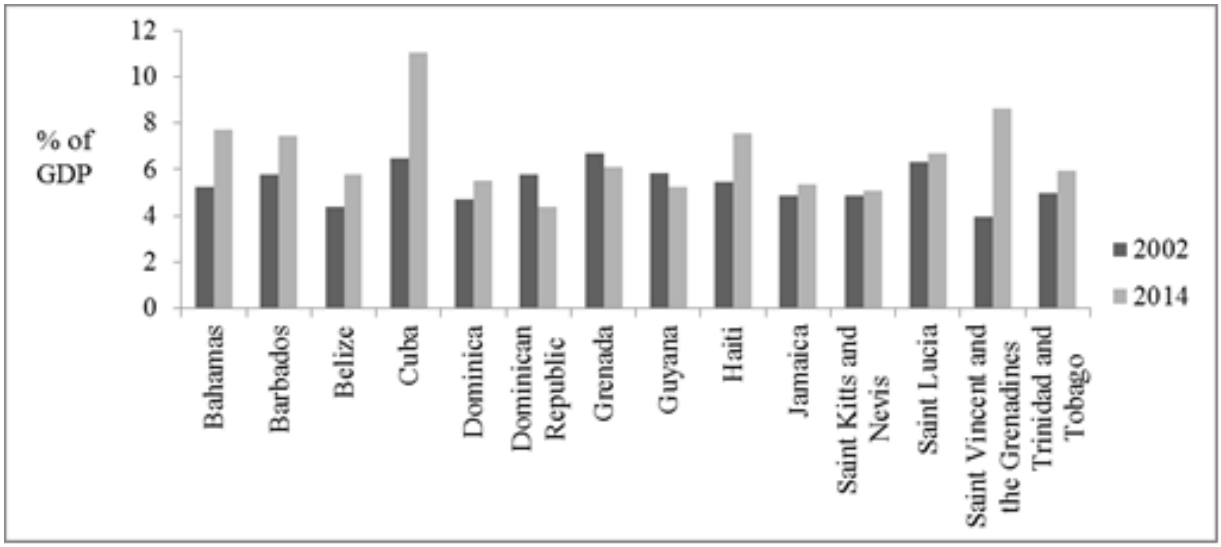
Healthy ageing is a lifelong process. Therefore, social policies and programs that address the four main lifestyle risk factors for chronic NCDs, such as tobacco use, alcohol consumption, unhealthy diets, and physical inactivity, need to involve the wider population, especially among younger cohorts (World Health Organization, 2011). Recent assessments of the prevalence of NCD risk factors within LAC indicate that several Caribbean countries are already at a high risk for three of the four risk factors, namely alcohol use, physical inactivity and unhealthy diets (overweight or obesity) among youth ages 10 to 24 years (Baldwin, Kaneda, Amato, & Nolan, 2013).

Some Caribbean countries have developed policies and established programs to curb NCD risk factors. These include, but are not limited to, health promotion and education programs in schools as instituted by the Cuban government; developing recreational fitness programs for all age groups in Saint Lucia; and country level controls on the sale of tobacco products in Bermuda's 'Tobacco Control Act 2015' as well as the Jamaican government's introduction of taxes on tobacco products and designating smoke-free environments (PAHO, 2017).

*Universal and equal access to healthcare services*

In light of the increasing health burdens that are associated with the demographic and epidemiological transitions, there will not only be an increased demand for all levels of health care but also high quality care. This requires States to increase their investment in health care. Drawing on data provided by the World Health Organization's Global Health Observatory repository, Figure 3 shows total health expenditure (public and private) for Caribbean countries, for 2002 and 2014. Regardless of the level of economic development, health expenditure for most Caribbean countries represented between 4 to 7% of their total gross domestic product (GDP) in both 2002 and 2014. Among all countries, Cuba and Saint Vincent and the Grenadines showed the most marked increases in total health expenditure as a proportion of their GDP.

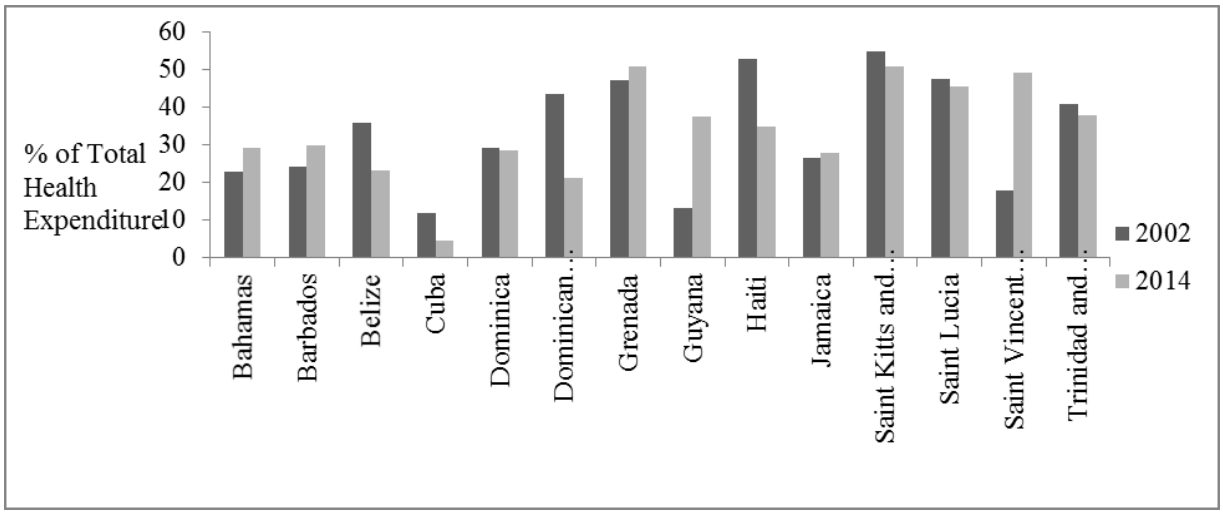
**Figure 3: Total health expenditure as a percentage of gross domestic product for Caribbean countries, 2002 and 2014**




*Source*: World Health Organization. Health Expenditure Ratios by Country, 1995-2014. Global Health Observatory Data Repository.

Health care systems in the Caribbean are designed as a mix of public and private systems. Generally, public spending accounts for 60% of total health expenditure and private systems 40% but private expenditure is predominantly out of pocket expenditure (Jones, 2016). High levels of out-of-pocket expenditure are characteristic of Latin American and Caribbean countries (Cavangero et al., 2015). There is variation across countries, however, such that higher levels of out-of-pocket payments are more prevalent in higher income Caribbean countries such as Barbados and Trinidad and Tobago (Jones, 2016). Figure 4 shows that out-of-pocket expenditure account for approximately 30-40% of total health expenditure in most countries. Grenada, Saint Kitts and Nevis, and Saint Lucia record the highest share, near 50% in both 2002 and 2014.

**Figure 4: Out of pocket expenditure as a percentage of total health expenditure for Caribbean countries, 2002 and 2014**




*Source:* World Health Organization. Health Expenditure Ratios by Country, 1995-2014. Global Health Observatory Data Repository

Cuba had the lowest levels of out of pocket payments in both 2002 and 2014 as well as a decline in the share between both periods. Saint Vincent and the Grenadines showed the sharpest increase in out of pocket payments, near 30 percentage points, between 2002 and 2014.

The relatively high financing of health care through private out-of-pocket expenditure is not only indicative of deficiencies in public health care services or market based health security but also presents an indicator of inequality in access to quality care. Individuals or households with higher incomes or insurance coverage will likely pursue and be able to afford better quality care (Scott & Theodore, 2013). Since the adoption of the regional strategy for the implementation of the MIPAA in 2003, Caribbean countries have made noteworthy strides toward universal health care coverage thereby reducing the income barriers to accessing health care. This is especially evident in the elimination of user fees for health care services at public health facilities and/or the provision of free medication for older adults (Jones, 2016). Some exemplary country strategies include Saint Kitts and Nevis where medical care is available at all levels of care, for all residents of Saint Kitts and Nevis who cannot afford the cost, regardless of their citizenship status (PAHO, 2017).

Few States have implemented or adopted strategies to provide national health insurance. The Turks and Caicos Islands, in 2010, implemented a National Insurance Plan which is based on social insurance and provides a basic package of care free of charge at the point of care to all residents. Furthermore, the health insurance system includes a provision to cover the cost of medical care received overseas if such care cannot be provided domestically and coverage includes travel and subsistence expenses (PAHO, 2017). According to the latest

review of the MIPAA, the recent health plans adopted by the Bermudan government, 'Bermuda Health Strategy 2014-2019' and the 'Future Care Benefits' programme are aimed at ensuring access to basic health insurance for all residents of Bermuda (Gény, 2017).

Many countries have, however, introduced tangible measures directly related to addressing the health care needs of persons with chronicNCDs. These run the gamut of free screenings to providing free medication and medical services for those with chronic conditions (Gény, 2017). Importantly, these initiatives address high out-of-pocket expenditure for health conditions that account for the highest burden of disease. Although older persons account for the majority of the beneficiaries of these programs, there is no explicit age discrimination for the programs designated for those with chronicNCDs.

*Disabilities and mental health*

Regarding formal support systems for disabilities, several countries including the Bahamas, Barbados, Bermuda, the Cayman Islands, Dominica, Sint Maarten, and Trinidad and Tobago have adopted programs to meet the demands of later life physical disabilities. These include financial assistance, material assistance through the provision of assistive devices such as wheelchairs, as well as instrumental support through home care or rehabilitation services. Yet, other countries such as Anguilla, Grenada, and Belize have severely limited or no state support available for persons with disabilities (Gény, 2017).

Mental health services remain underdeveloped but some countries are building support systems. The Cayman Islands is in the process of adopting a Mental Health Policy and constructing a mental health facility to serve older persons. Montserrat, in 2015, adopted a National Mental Health Policy and Plan and in the same year implemented mental health services within the primary health care system. Sint Maarten's government, in 2014, launched the National Mental Health Plan 2014-2018. Bermuda has state managed centres to provide homes and support for persons with cognitive disabilities and is investing in the education of nursing professionals to provide dementia care and fall prevention (Gény, 2017; PAHO, 2017).

*Challenges*

Despite these advances, several challenges remain that impose limits upon individuals' access to quality and affordable health care. For instance, health care inequalities and inefficiencies within the health care systems such as the frequent unavailability of medications at public health facilities; the need to improve the quality of service at public health facilities; shortages of medical professionals particularly critical in primary care facilities within the public sector and even more limited for specialized secondary and tertiary care. A few countries have, however, begun to incorporate geriatric and gerontological training for health professionals and informal care providers. Anguilla and Barbados provide examples of good practice as geriatric and gerontology courses have been introduced into the Anguilla and Barbados Community College, respectively (Gény, 2017). According to the most recent PAHO report, Cuba expanded its geriatric services to 36

facilities in 2014, and in Sint Maarten, state funded agencies such as the White and Yellow Cross provide geriatric care for older persons (PAHO, 2017).

**Ensuring supportive and enabling environments**

*Housing and the living environment*

Accessibility to housing, and the quality thereof, is a fundamental aspect of older adults' physical and social environments that influence their health and well-being (Oswald, Jopp, Rott, & Wahl, 2011). Governments in LAC recognize the importance of providing or improving quality housing that meets the needs of the older adult population (Montes de Oca et al. 2018). As such, several of the higher income Caribbean countries such as Barbados, Trinidad and Tobago, Bermuda, the Bahamas, and the Cayman Islands have introduced state-funded initiatives to increase the accessibility as well as improvements in the physical condition of housing for older persons.

Many of these programs include financial assistance for home repairs. The governments of Bermuda and the Bahamas also have programs to offer affordable rentals to older persons. In other countries, such as Belize and Grenada, the housing needs and demands of older persons are not prioritized. Increasing attention has also been given to improving older persons' accessibility to public transportation either through reduced fares, fare exemptions or specialized services. Despite this, many of the public transportation services are generally not designed to accommodate older persons with disabilities (Gény, 2017).

*Care and support for caregivers*

Many States have established programs to provide care and instrumental support to older persons within their homes. These services include personal care, nursing, emotional support or companionship. Notably, Bermuda, the Cayman Islands and Grenada have adopted programs to address the psychological health of caregivers of older persons as well. Bermuda's government is exceptional in offering additional health security through a subsidy for health insurance for those in need of long-term care in their homes (Gény, 2017). These States' directed measures of support do facilitate the option for older adults to age well within their usual place of residence. This is critical given that long-term care residential facilities are not well-established in many countries of the Caribbean.

*Neglect, abuse and violence*

The World Health Organization has identified that elder abuse, as a violation of human rights, can be categorized as physical, verbal, sexual, emotional, financial, psychological or neglect (World Health Organization, 2008). Elder abuse is a risk factor for morbidity and mortality (Dong X., et al., 2009), and especially among those with lower psychosocial resources (Dong X. , et al., 2011).

Caribbean countries have been more attentive to the need to increase public awareness of elder abuse through public campaigns. A few countries such as Anguilla and Bermuda have established specific Acts to prevent elder abuse. Furthermore, Bermuda's Senior Abuse Register Act of 2008 covers financial exploitation as punishable by law. Other countries such as Guyana provide direct assistance in the form of shelters for older adults who are victims of abuse. Other countries are in the process of developing systems to prevent elder abuse, but more should be done to effectively eliminate all forms of violence and abuse against older persons in the sub-region, by conducting research, surveys, studies and data collection, in order to give visibility to this problem (Gény, 2017).

**Conclusion**

Whilst there has been notable progress in the implementation of the MIPAA within Caribbean countries over the past 15 years, this has been quite uneven across countries and thematic areas of the MIPAA. Caribbean countries have given the most attention to advancing health and well-being into later life but there has been less attention to the wider spectrum of human rights, for example, those relating to decision-making and legal capacity; access to justice and rights to work and culture.

High-income countries such as Barbados, Bermuda, the Bahamas, and Trinidad and Tobago have made significant progress with social policies in all three key priority areas of the MIPAA. In upper-middle income countries such as Belize and Guyana, fewer resources are devoted to social programmes and initiatives have tended to be on a smaller scale or dependent on non-governmental organizations.

Regardless of the level of economic development or stage of demographic transition, Caribbean governments have been unable to fulfill a substantial number of the recommended actions within the three priority areas. In particular, there has been limited investment in lifelong learning, encouraging older adults' employment, and a relative lack of attention to older persons with mental and physical disabilities.

Declining fertility coupled with longer life expectancy reduces the availability of kin-based support networks in later life and the proportion of the working age population to support pension systems in their current design. Systems of income security need to be reviewed, contributory pension systems strengthened and funding for non-contributory pensions increased.

Caribbean nations can consider adopting and implementing strategies from other rapidly ageing developing countries, such as Thailand, where taxes on alcohol and tobacco products are used to fund health promotion and education programs and, recently approved, to provide pension income for older persons (Thai Health Promotion Foundation, 2017; The Bangkok Post, 2017). This would help to reduce the prevalence and incidence of risk factors for non-communicable diseases while also improving income security for later life.

This review highlights the urgency for greater investment in research to collect data, disaggregated by sex and age, to understand later life health and well-being, along with program evaluation to assess the efficacy of implemented policies for improving older persons' quality of life. Whilst research on population ageing that incorporates academic networks, research centres and political organizations is more established in Latin American countries (Montes de Oca et al. 2018), few examples of such institutionalization exist in the Caribbean sub-region (Eldemire-Shearer, 2012). Thus, Caribbean States need regular data collection to guide policy development across national and sub-national contexts.

In sum, Caribbean countries face multiple challenges that threaten the implementation of the MIPAA including, but not limited to, global economic shocks, climate change and disasters, and limited capacity within public administration systems. Thus far, policies and programmes do not fully encompass a human rights-based approach, are not explicitly sensitive to the gendered dimensions of ageing, and do not account for other dimensions of structural equality such as ethnicity, sexual orientations and gender identities, place of residence, or nativity/citizenship status.

Last but not least, the ageing discourse surrounding the implementation of the MIPAA within the Caribbean ought to adopt a life course perspective in education, employment, and care to ensure healthy older populations that can sustain and contribute to the development of their nations.

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# Older persons and human rights in Latin America and the Caribbean

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***Abstract.*** The Madrid International Plan of Action on Ageing (MIPAA), drafted at the Second World Assembly on Ageing (SWAA) in 2002, gave rise to a debate on older people in three spheres: political, social and scientific. At the Assembly, governments reflected on ageing and the construction of old age in developing countries and the characteristics of population groups aged 60 and over; this process was expanded at successive intergovernmental meetings in the region. Civil society organizations (CSO) have also been outlining by their position on ageing at international, national and subnational levels. In term, scientists have contributed an increasing production of research and sources of information that have resignified their role in the design of public policies. This triad of dimensions and actions has moved in Latin America and the Caribbean (LAC) since 2002, from an assistance focus, without a clear budgetary, educational or political adjustment, towards a human rights perspective that seeks to put older people at the centre of the actions through their participation in the design, management and supervision of policies. This article analyses the changes and/or permanence in the positions expressed in the programmatic documents drafted at governmental meetings and civil society's regional meetings, as well as two general documents in LAC: the Montevideo Consensus (2013) and the Inter-American Convention for the Protection of the Rights of Older Persons (2015).

*Keywords:* human rights, ageing, policies, civil society organizations (CSO), Latin America.

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## Introduction

After the Second World War, when the United Nations emerged, the Economic Commission for Latin America and the Caribbean (ECLAC, thereinafter CEPAL in Spanish) was set up in 1948 to promote discussion on population and development (Villa & Rivadeneira, 2000). Technical advice in demographic matters and training of human resources, as government support activities, were among its main functions. In the 1980s, when the First World Assembly on Ageing (FWAA) (United Nations, 1983) was held, discussions focused on the problems and needs that affected older persons as individuals and demographic ageing in developed countries. Although there was a dominant vision from the biomedical perspective, population ageing was placed on the international public agenda (Rovira, 2016). Demographic analysis and projections were announcing that the world population would increase 3.7 times in a century from 1950, while the population aged 60 years and over would rise tenfold, and that of 80 years and over twenty-six-fold (Kalache, 2013). This process also affected developing countries and especially the LAC ones, due to demographic transition.

In LAC, the region's pioneering demographers indicated the first tendencies towards population ageing as an expression of the transition from high mortality and fertility rates to decreasing levels. Few understood that an effect of the so-called "demographic explosion" was population ageing, but some countries would experience it early as a result of dissimilar demographic trends (Chackiel, 2000). In 1970 Latin America reported a proportion of 6% of people aged 60 and over, which rose to 7.4 in 1995 and 9.4 in 2010. At the start of the 21st century, there were LAC countries with an incipient, moderate, but also advanced demographic transition, such as Argentina, Cuba and Uruguay, so the population ageing issue gained greater legitimacy on the regional and governmental agenda. In general, population ageing is linked to the 'demographic dividend' and to the countries' economic conditions to influence in health care and social security (Saad, 2011). In 2002 the Second World Assembly on Ageing (SWAA) (United Nations, 2002) was held, which placed emphasis on the demographic transformation in developing countries, the need for a social perspective, the active ageing as promoted by the World Health Organization (WHO), and on having a positive image of ageing (Rovira, 2016). Above all, the inclusion of ageing in the Population and Development agenda was addressed for the first time. The notion of dignity in ageing was the focal point from which the human rights approach would emerge in the following decades. This change in the treatment of ageing has been highly significant for the region. This meeting led to the MIPAA (United Nations, 2002).

The CSO Forum, held days before the SWAA, was a pioneer in giving social actors a voice, but it also triggered a link with LAC scientists, government institutions and companies[5]. This decade marked the beginning of a historic stage in the construction of a common agenda on ageing and the situation of older persons. One of the key aspects was the well-known demographic projections that warned that many LAC countries would move towards high

[5] This Forum, predecessor of the CSOs meetings in LAC, aimed to encourage the participation of civil society in the debate on ageing, sharing their experiences as social structures of older people organized (Foro Mundial ONG sobre Envejecimiento, 2002).

percentages of 60 and over people, from having 12 per cent in 2017 to 25 per cent in 2050 (United Nations, 2017). Fertility rates would keep on dropping in the region, with 15 countries under the replacement level in 2017, while falling mortality would increase the longevity of older people, a life expectancy of 81.3 years being calculated by 2050 (United Nations, 2017). CEPAL, through its Population Division, the Latin American Demographic Centre (CELADE), began organizing two types of strategic meetings in 2003, with experts and with governments, to produce reflections and evidence with the region's data censuses, surveys and statistics. Emphasis was placed on quantitative and qualitative methodologies. Meetings also searched for reflecting on three central issues for older people in the region: 1) the economic situation of older persons and development, 2) health and well-being, and 3) social support networks and favourable social and physical environments (Huenchuan, 2013; CEPAL, 2017a). In this process, specialists comment on the importance of observing changes in concepts, in their definitions, in what topics and how they are included and what role is assigned to the State and to civil society (Rovira, 2016). The following pages analyse, as the general objective, the main guidelines presented in government and civil society documents in LAC. Part of this context of social progress lies in the Montevideo Consensus, especially in chapter C on Ageing, Social Protection and Socioeconomic Challenges, as well as the Inter-American Convention for the Protection of the Rights of Older Persons. Both documents express the countries' position on human rights of population and in the special case of older persons.

**Government and CSO debates on ageing in LAC**

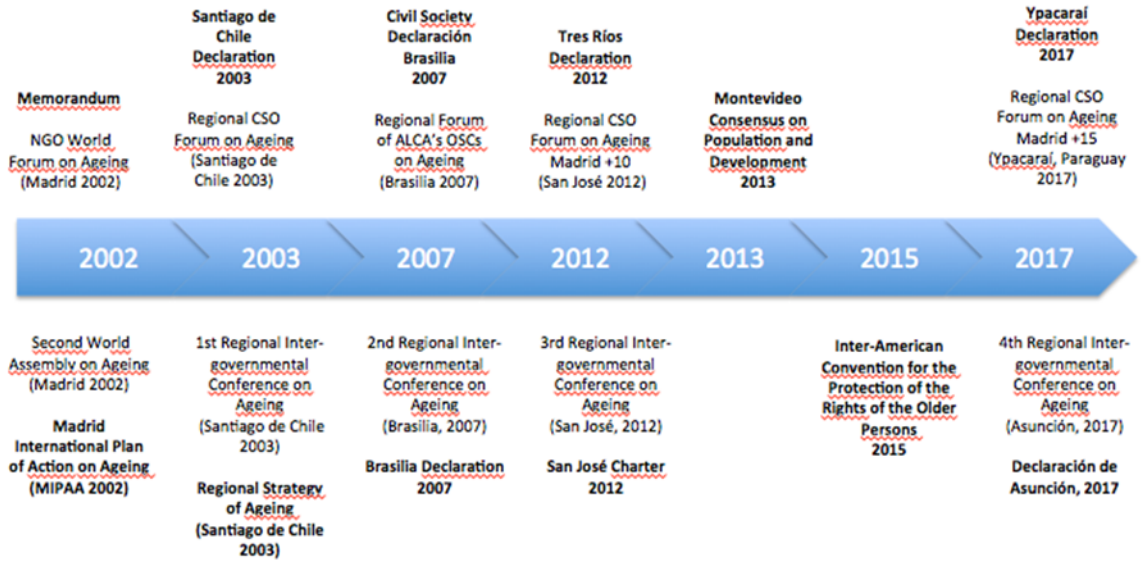
As mentioned before, the SWAA (United Nations, 2002) put the issue of ageing and old age on the international agenda. The dominant arguments grounded on demographic evidence: the increased life expectancy and the decline in fertility rates around the world are leading to an increasing proportion of older people. Although this process has taken place in socioeconomic contexts that differ from one region of the world to another, and in different stages of development of the welfare states, it has specific characteristics in LAC: the ageing process occurs in different ways in the region's countries, how fast it occurs, the differences in economic development can mark deep inequalities in situation of older persons, or the differences in the regional, national and subnational political frameworks built to protect older people's rights (Huenchuan, 2013; United Nations, 2002).

Since 2003, successive regional and intergovernmental meetings were organized to systematize action on public policy in the region. Results are reflected in several declarations: Regional Strategy for the Implementation in Latin America and the Caribbean of the MIPAA, Santiago de Chile (Chile), 2003; Brasilia (Brazil), 2007; San José (Costa Rica), 2012 and Asunción (Paraguay), 2017. In a complementary manner, Civil Society Organizations[6] of older

[6] The participation of Non-Governmental Organizations (NGOs) in the LAC Regional Conferences has its antecedent in the regional Conference organized by the United Nations Organization in Cairo in 1994. 179 government representatives and 1,254 non-governmental organizations attended this meeting, which emphasized the importance of individual rights, the incorporation of the gender dimension, the reproductive health as a fundamental axis to be considered in population policies and the importance of NGO participation in regional conferences (Peláez, n/d). Although this conference was not exclusive for the elderly, the participation of NGO there then set up.

persons have held meetings in Latin American countries to yield several declarations: Santiago de Chile, 2003; Brasilia, 2007; Tres Ríos (Costa Rica), 2012; and Ypacaraí (Paraguay), 2017. Just as important are the meetings of the Montevideo Consensus on Population and Development (MCPD) (2013) and the Organization of American States (OEA in Spanish) on the Inter-American Convention for the Protection of the Rights of the older persons (IACPHROP) are important (2015) (Figure 1).

**Figure 1. International and/or regional meetings and documents relevant to ageing in LAC region, 2002-2017**




*Source*: prepared by authors analysing United Nations (2002); CEPAL (2013); OEA (2015); CEPAL (2004); CEPAL-UNFPA (2011); CEPAL (2012); CEPAL (2017); Civil Society Declaration, Santiago 2003; Brasilia Declaration 2007; Tres Ríos Declaration, Costa Rica 2012; Ypacaraí Declaration 2017.

The 2002 MIPAA focused on the following priority issues: the economic situation of older persons and development; their health and well-being; and the physical and favourable environments in which the older population lives (CEPAL, 2004; Paredes et al., 2010). The United Nations introduced a change on policies towards older persons, through the Montevideo Consensus, 2013, – not only aimed at older persons but at the different population groups, paying special attention to the indigenous and Afro-descendant peoples of LAC. The Caribbean have a special issue in the region for the rapid ageing, migration, disasters and welfare policies (Quashie *et al.*, 2018). The other is the Organization of American States (OAS), which in June 2015 approved a binding instrument on human rights in the region, the Inter-American Convention on Protecting the Human Rights of Older Persons. This document, a point of reference for the world, represented a substantive shift in the understanding of political actions for the old age, because it recognized the older persons as subjects of rights and generated an instrument through which these rights must be recognized and protected by the States that ratify this commitment. To date five LAC countries (Argentina, Bolivia, Chile, Costa Rica and Uruguay) have ratified it. Finally, the Fourth Regional

Intergovernmental Conference on Ageing and the Rights of Older Persons, 2017, has ratified this change in its Asunción Declaration.

There now follows a review of the different positions discussed in the declarations of the intergovernmental and CSO meetings on population ageing, as well as in the Montevideo Consensus and the Inter-American Convention. All of this will be considered in terms of the areas identified as priorities in MIPAA 2002, so that changes and/or permanence in the lines of action can be accounted for.

*Older persons and development*

From the SWAA, older person's social and economic security, as well as their plural, participative and participatory access in the developing countries was included in this action. The guidelines for action lay in a paradigm of active ageing, promoting participation in employment, in social life in general, access to knowledge, education and training, security in income and the eradication of poverty. Different government and CSOs meetings in LAC have recognized the need to respect older persons' human rights, which include a diversity of dimensions, such as the right to non-discrimination and non-violence.

Economic security is assessed through the receipt of both contributory and non-contributory pensions, and is considered both in the 2002 MIPAA and in some declarations of the intergovernmental meetings in LAC (Santiago 2003, Brasilia 2007 and San José 2012). However, it was only discussed by the CSOs in the 2012 Tres Ríos Declaration, which mentioned the importance of universality in pensions for older persons. If economic security is observed from the generation of income through employment, it is clearly seen to be very important both at intergovernmental and CSO meetings, which highlighted the concern not only that older people should be able to find jobs, but also in decent conditions. Eradicating poverty, present in the 2002 MIPAA, is less visible in the different intergovernmental meetings but not so in the CSO declarations, because it matters so much to older people's quality of life that they do not want it to be ignored. Some analysis show that the rapid ageing in the LAC region after MIPAA and the policies to mitigate the socio-economic challenges (Salazar & Jenkins, 2018). One predominant aspect at the different meetings is how important it is for older persons to participate in civil society organizations as well as in social and cultural life. In all cases, emphasis is placed on the importance of them taking part in drafting programmes and policies geared towards the older population, as well as in monitoring them. Some issues, such as older persons' access to education or care and the prevention of natural disasters, were conveniently incorporated into the 2002 MIPAA, and have been reinforced in the Montevideo Consensus and the Inter-American Convention. However, they attracted less interest at the different meetings, with the exception of the Declaration of San José and Tres Ríos, which stressed how much these issues matter for ensuring that older persons maintain an adequate quality of life, related with the improvement of training capabilities and the development of safe residential environments (Table 1).

**Table 1: Coverage of MIPAA priority direction 'older persons and development' in the documents analysed**

| Official documents/ Priority directions | MIPAA 2002 | Montevideo Consensus 2013 | Inter-American Convention 2015 | INTER-GOVERNMENT MEETINGS DOCUMENTS | | | | CSO DOCUMENTS | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Santiago 2003 | Brasilia 2007 | San José 2012 | Asunción 2017 | Santiago 2003 | Brasilia 2007 | Tres Ríos 2012 | Ypacaraí 2017 |
| Older Persons and Development | Older persons rights | Human rights | Art 6. Life and elderly dignity rights<br>Art 7. Independence and autonomy rights | Human rights | Human rights | Human rights | Human rights | | Human rights | Human rights | Human rights |
| | Personal liberty<br>Freedom of expression and opinion, access to information<br>Right to nationality and freedom of movement | | Art 13. Personal liberty<br>Art 14. Freedom of expression and opinion, access to information<br>Art 15. Right to nationality and freedom of movement | | | Elderly personal liberty<br><br>Access to information and rights dissemination | | | | | |
| | Equality and non-discrimination for reasons of age or gender | Gender perspective and elderly discriminati on' eradication | Art 5. Equality and non-discrimination for reasons of age or gender | | Gender perspective in elderly public policies | Eradication of all types of discrimination | Gender and inter-generational relations inequalities<br>Fostering non-discriminant dignity and freedom among the elderly | | Ageing without age, gender, ethnicity, religion and nationality discrimination | Gender, ethnic and inter-generational perspective | |
| | Economic security | | | Pensions coverage enlargement | Pensions for all | Pensions sustainability | | | | Pensions for all | |
| | Accessibility to jobs | Decent jobs | Art 18. Rights to work | Decent jobs | Dignified jobs for the elderly | Accessibility to jobs | Accessibility to jobs | | Setting-up income for the elderly | Formal jobs to access the Social Security | Working conditions improvement |
| | Social, economic and political roles of the elderly<br><br>Elderly participation in their own decision-making processes | Elderly participation in programs and public policies design | Art 8. Right to participation and community integration<br>Art 27. Political rights<br>Art 28. Freedom of association and assembly<br>Art 21. Right to culture | Elderly social participation | | Elderly participation in civil society organizations<br>Social and political participation of elderly | Elderly participation in civil society organization<br>Social and political participation of elderly | Fostering elderly participation in civil society organizations<br>Fostering economic and social development by the elderly participation | Elderly participation in civil society organizations | Social, political, economic and cultural participation of elderly | Not hindering political, social and cultural participation of the elderly |
| | Poverty removal | | | | | | Elderly poverty removal | Elderly free of poverty by improving life conditions | | Elderly poverty | Elderly poverty |
| | Knowledge, education and training accessibility | | Art 20. Right to education | | | Right to education | | | | Removal of illiteracy on reading, writing and ICTs accessibility | |
| | Attention to natural disasters and emergency situations | Facing disasters plans | Art 29. Situations of risk and humanitarian emergencies | | | Helping the elderly in disasters | | | | Helping the elderly in emergency situations | |

*Source*: prepared by authors analysing United Nations (2002); CEPAL (2013); OEA (2015); CEPAL (2004); CEPAL-UNFPA (2011); CEPAL (2012); CEPAL (2017); Civil Society Declaration, Santiago 2003; Brasilia Declaration 2007; Tres Ríos Declaration, Costa Rica 2012; Ypacaraí Declaration 2017.

**Advancing health and wellbeing in old age**

The 2002 MIPAA was a significant advance when opted for a comprehensive perspective of physical, mental and emotional well-being and not only the absence of diseases, following the WHO guidelines. Certain aspects of this were the promotion of health and well-being throughout life, universal and equitable access to health care services, the training of health service providers and health professionals in specific geriatric and gerontological areas, mental health-related needs and disability of older persons. These last two respond to new problems triggered by increased longevity and ageing of the octogenarian population. Similarly, targeting older people with HIV/AIDS also highlights a reality that affects minority and particularly vulnerable groups where policies show a bias towards younger population groups and their sexual and reproductive health, while the role of post-reproductive sexual health derived from ageing has been neglected to date. At the meetings held over the last 15 years, some issues have clearly remained a priority on government and civil society agendas in the region. This is the case of universal social security and the progressive extension of coverage in medical services for older persons, given the very different private and public systems, because the latter are not universal throughout LAC. It is worth mentioning that the Asunción Declaration 2017 omitted its relevance.

The 2002 MIPAA has underscored the importance of addressing older persons' different needs in terms of their illnesses arising from the changes in the epidemiological transition and causes of death. This subject was reinforced in the Montevideo Consensus, in the Inter-American Convention and in the different intergovernmental meetings (not in the 2007 Brasilia Declaration). Yet it failed to arouse the same interest in the CSO's declarations, except in the last Tres Ríos and Ypacaraí meetings, where the importance of accessing health services and treatments was underlined once again. One aspect not considered in the 2002 MIPAA was the protection of the rights of older persons who require long-term care, but it did arise in the 2003 Santiago Regional Strategy, and was maintained in the 2007 Brasilia and 2012 San José Declarations. CSO forums have also stressed how much this aspect matters for older persons' life in the last two declarations (Tres Ríos & Ypacaraí). Its importance is borne out when it was incorporated into the Inter-American Convention as a fundamental right of the old age. It is worth mentioning that concern about the care given in ageing and the people who give that care resurfaced in Ypacaraí and Asunción.

A collateral yet essential aspect for ensuring respect for individual rights, and that appears in MIPAA, is training personnel in gerontology and geriatrics so as to comprehensively tackle ageing. This training aroused interest among the governments that took up this action again in the intergovernmental declarations of Santiago, 2003, Brasilia, 2007 and San José, 2012, while the CSOs only emphasize it as a human right in the last declarations of Tres Ríos (2012) and Ypacaraí (2017). Finally, also worth noting is that older person's nutrition was not taken up at any LAC meeting, despite having been announced in MIPAA (Table 2).

**Table 2: Coverage of MIPAA priority direction 'advancing health and wellbeing into old age' in the documents analysed**

| Official documents/ Priority directions | MIPAA 2002 | Montevideo Consensus 2013 | Inter-American Convention 2015 | INTER-GOVERNMENT MEETINGS DOCUMENTS | | | | CSO DOCUMENTS | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Santiago 2003 | Brasilia 2007 | San José 2012 | Asunción 2017 | Santiago 2003 | Brasilia 2007 | Tres Ríos 2012 | Ypacaraí 2017 |
| Advancing health and well-being into old age | General coverage of social security and health benefits | Social and health benefits | Art 17. Right to social security | General coverage of health services | Social and health benefits | Universalization of social security | | Universalization of social security | Universalization of social security | Health services accessibility | Exclusion of the elderly regarding social security |
| | Comprehensive health care and palliative care<br><br>Reducing factors that increase the risk of diseases | Adequating health policies to changes in the epidemiological process<br><br>Promoting the development and access to palliative care | Art 11. Right to give free and informed consent on health matters<br><br>Art 19. Right to health | Access to comprehensive health services adapted to the elderly needs | | Comprehensive care models<br><br>Access to medicines, equipment and rehabilitation services | Comprehensive care model, social protection services | | | Health services considering the elderly needs | Access to health care, treatments and medications |
| | | | Art 12. Rights of older persons receiving long-term care | Legal frameworks to guarantee the rights protection of people who receive long-term care | Challenges to address disability and dependency | Informed consent for medical interventions by the elderly<br><br>Supervision of elderly living in institutions | | | | Institutionalization of older people violates their rights | Violation of the elderly rights living in long-term nursing homes |
| | Training of health personnel to meet the elderly different needs | | | Training for gerontologists and geriatricians | Training programs for gerontologists and geriatricians | Promoting training for gerontologists and geriatricians | | | | Training on ageing considering a gender and human rights perspectives | Promotion capacities on the elderly human rights |
| | Access to adequate nutrition | | | | | | | | | | |

*Source*: prepared by authors analysing United Nations (2002); CEPAL (2013); OEA (2015); CEPAL (2004); CEPAL-UNFPA (2011); CEPAL (2012); CEPAL (2017); Civil Society Declaration, Santiago 2003; Brasilia Declaration 2007; Tres Ríos Declaration, Costa Rica 2012; Ypacaraí Declaration 2017.

*Ensuring enabling and supportive environments*

This area is divided into two groups of actions. The first are geared to physical environments, such as the adaptability of infrastructures that older persons require, and ranging from inside the home to the outside, transportation, the neighbourhood and the city. The second refers to social environments for assessing older people's relationships with their social, family and community support networks. They are defined in MIPAA as inclusive policies for integrating older people into the development process, both through access to services and their participation in drawing up and applying policies. Access to decent housing as appropriate for the older persons' needs is fundamental for analysing the old age environments, which was first established in MIPAA and culminated in the Inter-American Convention. In the Brasilia and San José Declarations it is also considered a topic of interest within the environments, while the Asunción Declaration only mentions the importance of access to housing. For the CSOs and tangentially, only the Tres Ríos Declaration refers broadly to the generation of legal frameworks for protecting older persons' assets. There are other environment-related aspects that vary in the different documents. For example, MIPAA specifically mentioned improving transport to make it accessible for older persons, while the Inter-American Convention focuses on more general aspects, such as the right to a healthy environment and the right to accessibility and personal mobility. Meanwhile, the 2003 Santiago and the 2017 Asunción Declarations refer to the adaptation and importance of physical environments, in general, an aspect that is not taken into consideration by CSO forums, except in the 2007 Brasilia Declaration, which mentioned the importance of having favourable conditions in various aspects, including housing and public services.

The MIPAA mentioned the importance of the right to personal freedom, freedom of expression and opinion, as well as of movement. These rights were readdressed in the 2012 Declaration of San José and the 2015 Inter-American Convention. It also applies to the eradication of gender and age-based discrimination, which has been taken up again in the 2013 Montevideo Consensus and the 2015 Inter-American Convention. All the intergovernmental meetings, except for the 2003 Santiago Declaration, highlighted the importance of promoting non-discrimination based on gender and age. By contrast, this discourse is only present in the CSO forums held in Brasilia, 2007, Tres Ríos, 2012 and Ypacaraí, 2017. From a rights recognition perspective, older person's self-image is the subject of outstanding attention. In MIPAA, it was considered relevant to promote recognition of older persons' knowledge and contributions in order to generate respect for this population. This approach did not prosper at the different meetings in LAC, with the exception of the 2003 Santiago Regional Strategy, where the importance of considering a positive image of old age was declared to include in the mass media. It was only in the 2007 Brasilia Declaration that CSOs raised the need to promote the vision of an active, participatory and healthy old age. Another environment-related action refers to the importance of offering assistance to older persons' carers, particularly women, as already established in MIPAA, yet its continuity was only maintained in the intergovernmental meetings of Brasilia, 2007 and San José, 2012, and its inclusion was not considered until the documents drafted at the last two CSO meetings (Tres Ríos, 2012; Ypacaraí, 2017) (Table 3).

**Older persons' scientific research and policies**

Research plays a key role in identifying scientific evidence, which is recognized by the political documents analysed. The Santiago Regional Strategy for implementing MIPAA in LAC (CEPAL, 2004) recognizes the need to promote national and regional ageing research when designing the political agenda, the funding measures and the development of cooperation structures. The 2007 Brasilia Declaration directs this commitment "at academic centres, scientific societies and ageing cooperation networks". With a similar emphasis, CSOs consider the role of research in allowing states to detect priorities for protecting older persons' rights (Coordinación, 2013). Finally, the Inter-American Convention, in 2015, recognizes that States will foster research and the provision of statistical data as an aid for devising policies for the protection of rights, essentially in the field of health, highlighting that research helps to train people in general and professionals in particular (OEA, 2015).

Research has already received institutional recognition for its role of "providing decision-making criteria" (Huenchuan, 2016) through the analysis of information sources, methodologies, use of techniques and intervention. This role can be recognized in some of the institutions that lead the older people-oriented policies in Latin America, such as the National Institute for Older Adults (Inmayores) in Uruguay, the Mexico City Care Centre for the Elderly (IAAM) or the National Directorate of Policies for Older Adults (DINAPAM) in Argentina. These organizations promote research, by providing data necessary for analysis, completing projects in liaison with universities and research centres, performing on-demand studies for regional organizations such as CEPAL or the Ibero-American Office of Social Security, OISS (Huenchuan, 2016; UNFPA, 2017), or reinforcing professionals' training (CEPAL, 2017). Special attention have the Caribbean research and intervention with life course perspective and not only with cross-sectional analysis (Quashie et al., 2018). Regional political agencies promote research projects. The Latin American Demographic Centre (CELADE) is the driving force behind research in this field, first in data provision and database maintenance, at a regional and national level, as established in the 2003 Santiago Regional Strategy. Second, external researchers and the CELADE itself engage in providing technical support, training, research and advice on ageing in the region, as the focal point on ageing in CEPAL for monitoring the United Nations' actions. The result, thirdly, is the wide range of ageing publications produced by CELADE or by Latin American social researchers, using multidimensional perspectives of ageing (demography, social protection, households, health, pensions, etc.). The 'institutionality' of research in Latin America is also recognized in the role that regional academic networks and research centres play, in accordance with each country's scientific capacities and its degree of development. For example, *research groups* could be identified (like in Brazil, through Curriculo Lattes, with countless scientific approaches), as well as *thematic networks* (like the Ageing, Health and Social Development Network in Mexico), *academic centres* (like the Interdisciplinary Center for Ageing (CIEn in Spanish), in Uruguay, or the Center for Research and Studies on Culture and Society (CIECS in Spanish), in Argentina, *government institutes* (like the National Institute of Geriatrics in Mexico, more oriented to health issues), or *multi-academic and multidisciplinary institutes* (like the Interdisciplinary University Seminar on Ageing, SUIEV, in Mexico).

**Table 3: Coverage of MIPAA priority direction 'ensuring enabling and supportive environments' in the documents analysed**

| Official documents/ Priority directions | MIPAA 2002 | Montevideo Consensus 2013 | Inter-American Convention 2015 | INTER-GOVERNMENT MEETINGS DOCUMENTS | | | | CSO DOCUMENTS | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Santiago 2003 | Brasilia 2007 | San José 2012 | Asunción 2017 | Santiago 2003 | Brasilia 2007 | Tres Ríos 2012 | Ypacaraí 2017 |
| Ensuring enabling and supportive environment | Elimination of all forms of violence, abuse and mistreatment towards the elderly | Elimination of violence towards the elderly | Art 9. Right to safety and a life free of violence of any kind | Elimination of all forms of discrimination and mistreatment towards the elderly | Elimination of discrimination and violence towards the elderly | Elimination of all forms of mistreatment towards the elderly | Eradication discrimination, mistreatment and violence towards the elderly | | | | Mistreatment towards the elderly persists |
| | Consider housing preferences for the elderly regarding suitability and location | | Art 23. Right to property Art 24. Right to housing | | Accessibility to public spaces and housing adaptation for the elderly, according their needs | Improving housing and environmental conditions | Housing accesibility | | | Safeguarding the elderly patrimony | |
| | Transportation improvement | | Art 25.Right to a healthy environment Art 26. Right to accessibility and personal mobility | Physical environment adaptation the characteristics and needs of the elderly | | | Healthy, accessible and suitable environments | | Setting up suitable conditions on health, housing, food, education and public services for the elderly | | |
| | Public acknowledgment of the elderly mastery and social contributions | | | Promoting a positive image of the old age | | | | | Promoting an active, participative and healthy image of the elderly | Removing the negative image of the elderly | |
| | Supporting people who help or assist the elderly, mainly the old women | | | | Support to care families, mainly women | Generate measures for families, mainly those taking care of the elderly Developing home care Social services to take care of the elderly | | | | Women taking care of the elderly Home care programs for the elderly | Women taking care of the elderly |

*Source*: prepared by authors analysing United Nations (2002); CEPAL (2013); OEA (2015); CEPAL (2004); CEPAL-UNFPA (2011); CEPAL (2012); CEPAL (2017); Civil Society Declaration, Santiago 2003; Brasilia Declaration 2007; Tres Ríos Declaration, Costa Rica 2012; Ypacaraí Declaration 2017.

Finally, other, more flexible institutional structures are also important due to their role in organizing activities and events in which ageing plays a prominent role, such as the Ageing Network of the Latin American Population Association (ALAP in Spanish), the Brazilian Association of Population Studies (ABEP in Portuguese), the Mexican Society of Demography (SOMEDE in Spanish) and the Association of Population Studies of Argentina (AEPA in Spanish) or the Latin American Research Network on Ageing, of the Oxford Institute of Ageing (LARNA in English), oriented to the analysis of demographic change and its consequences for society, or the Interdisciplinary Network of Psychogerontology (RediP in Spanish), oriented to the psychosocial sphere, or the Latin American Gerontology Network, which fosters interaction among stakeholders interested in ageing and practices in local environments.

Ageing projects leaders increasingly use mixed methodologies and advanced techniques to analyse socio-demographic situations in a multi-thematic manner. Their results are published in different dissemination channels, conditioned by two essential factors. One is the personal and institutional ties to international organizations such as CELADE. In this case, studies are often published, such as Population Notes, aligned with the institution's goals, which are multidisciplinary, not only oriented to the older population. A similar approach is taken with regard to academic networks that bring together ageing research, such as the ALAP Research Series or Latin American Population Review. Another important factor is the proximity to national or regional, disciplinary or interdisciplinary journals (health, economics, demography, psychology, etc.), which make it easier to publish in Spanish, with important national and regional repercussions, and which are indexed in regional platforms (e.g. Redalyc, Scielo, Dialnet or Latindex). Their international impact is more limited, especially in platforms based on citations and impact indexes: for example, Scimago only indexes five Latin American demographic journals, all in Q3 and Q4. A similar situation is to be found in the journals indexed in Scopus. All these magazines publish in Spanish or Portuguese, admitting some articles in English. This fact leads to another: hardly any papers of Latin American researchers are considered in successful bibliographical reviews on active or successful ageing in English. Menichetti *et al.*. (2016) and Cosco *et al.*. (2013) only quote one Brazilian study among the 20 and 26 analysed. Cosco (*et al.*., 2014) and Annear *et al.*. (2014), in their review of 103 and 83 articles, only include two (Mexico and Brazil, and Colombia and Brazil). However, when the review is specific to Latin America, a sufficient number of articles is included, most of them in English, but also in Spanish and Portuguese (Da Mata *et al.*., 2016). Capacity of Latin American research on ageing is verifiable when appropriate tools are used for its detection and analysis. The role of research acknowledged by public policy documents in LAC is only fulfilled when the focus is placed on its impact within LAC, where the research capabilities, its scientific structures and its production in Spanish and Portuguese ensure its social function.

**Final considerations**

The diversity of the demographic transition process places different LAC countries in particular situations regarding population ageing, in the integration of human rights in old age policies and in their political development. Even so, the continent is already experiencing

changes in the social, institutional and family organization derived from the substantial increase of older persons. The 2002 MIPAA and its follow-up in regional meetings have been central as a regional experience in three areas: economic situation and development, health and well-being, and physical and social environments. Several regional organizations have committed the different governments and CSOs to move forward in the implementation of public policies towards old age. The central axis that has changed this orientation is defined by the perspective of rights where older persons take part in the design, monitoring and evaluation of public policies. The supreme example of this approach may be found in the Inter-American Convention on the Protection of the Rights of Older Persons, as the first binding document for LAC countries. Essentially it acknowledges older person's right to non-discrimination and lists their specific rights to be protected. Scientific production has contributed to the design of policies by generating research on older persons' situation and often proposing concrete inputs for action. Undoubtedly, academic bodies are participating more and more actively in the regional and CSO meetings. The path that has been followed over these fifteen years – from the Madrid Assembly in 2002 – has been varied and covered several public policy priorities, and, despite the differences between each LAC government's commitment and implementation of actions, the region has made substantial progress in elderly-oriented policies. The recognition that the older persons are subjects with rights, fully integrated into the development of societies; the comprehensive, multidisciplinary health and well-being approach that must be addressed in these stages of life, as well as the adaptation of physical environments, have continued to structure the action. Social environments, support networks, abuse and mistreatment, as well as the discrimination experienced in old age, have also remained key issues on the agenda. The path of recognising older people as subjects with rights is what guarantees their inclusion in an integrated society. A set of measures to gain international visibility for the ageing policies is needed, such as a legally binding convention, the assessment toolkits (Sidorenko & Zaidi, 2018).

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# The Madrid International Plan of Action on Ageing: Where do we stand fifteen years later? Experience and lessons from selected countries in West and Central Africa

**Ousmane Faye[1] and Gilena Andrade[2]**

***Abstract.*** Africa has the fastest growing older population in all regions of the world. This unprecedented increase in the number of older people reflects successes in public health, education and economic well-being across the continent. Nevertheless, it poses new challenges as to how African countries should respond to the needs of their older populations. MIPAA provides a basis for coherent policies and practices to address these concerns. This study documents the various efforts made to implement this plan in the West and Central African region fifteen years after its adoption. The analysis is based on the most recent and reliable data available on ageing issues. The results suggest that, despite the commitment of countries in the region to implement MIPAA, ageing issues remain a neglected or non-priority issue in the region. The dynamics of ageing are not accompanied by innovative policies to provide older persons with the necessary economic, financial and medical resources. In most countries, older persons are hardly identified as a specific group to be targeted in development plans. Furthermore, there is practically no readable and adequate information on the elderly population. Countries in the region are unique in that they do not collect comprehensive information on older persons.

**Keywords:** Ageing, West and Central Africa, policy, wellbeing.

## Introduction

Although older people make up a small proportion of the population in sub-Saharan Africa (SSA) and their proportions are projected to grow quite slowly relative to other areas in the world, population ageing is becoming a major social and policy issue in the region. The absolute number of older persons is rising more sharply in SSA than in any other region, almost quadrupling from 40 million in 2010 to 165 million by 2050 (United Nations, 2017). Life expectancy at age 60 in SSA is already 16 years for women and 14 years for men, signifying

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that a long old age is an increasing reality in the region. Within a context of continued, widespread poverty but also substantial growth and societal transformation in the region – and given older people's critical intergenerational and economic roles – the situation of SSA's rapidly growing older population will have far reaching consequences for policy in SSA. Above all, the health profile of SSA's older population, hugely exposed to chronic disease and impaired function, will pose major challenges and opportunities for formal and informal health and care systems, labour markets, overall productivity, human capital formation, demand and consumption patterns and, thus, development broadly. Understanding and anticipating challenges of population ageing is critical, therefore, for forging coherent mid- and long-term policy and practice responses across health, social and economic sectors in SSA. International debate on the challenges of population aging has intensified and focuses on concerns about the vulnerability of elderly persons to poverty, social exclusion, and limited access to healthcare. Major policy instruments, including the 2002 UN Madrid International Plan of Action on Aging (MIPAA), urge governments to develop responses to address the needs of older populations. As signatories to this plan, SSA states have expressed a commitment to its implementation.

Fifteen years after its adoption, the question is where do the MIPAA signatory countries stand? The aim of this paper is to provide a comprehensive assessment of how countries in Western and Central Africa[3] have implemented the Plan and to highlight the key problems. The MIPAA puts emphasis on the need to consider older persons in development planning, stressing that older persons should be able: *i)* to participate in and benefit equitably from the fruits of development; *ii)* to advance their health and well-being; *iii)* and that societies should provide enabling environments for them to do so. Such assessment is timely needed in a context of near-absence of ageing in mainstream policy and debate in the continent. Unlike children, youth, and women who are given a high profile in the various national and international development agenda (SDG, Agenda 2063, etc.), older persons in SSA tend not to be targeted as a specific group. Yet, there is a critical need to take full account of the ageing phenomenon in the continent. The growing number of older people is likely to put additional strains on families' and communities' resources, compromising thus all efforts made for poverty reduction in the region. Therefore, as the number of the older population is growing, it is crucial for African countries to implement innovative policies and public services designed purposely for this age group in order to cater for their specific needs in terms of housing, employment, health care, infrastructure and social protection.

This paper is organised into the following sections. Section 1 sets the context and explains the rationale of the study. Section 2 provides a detailed description of the data and sources that were used and identifies crucial data gaps. Session 3 highlights policies and legislation passed since 2002 in countries in the region to implement the MIPAA. Section 4 focuses on older persons' development capacities and resources. Section 5 discusses health issues and access to health services in older ages. Section 6 looks at the environment and conditions of ageing

[3] Benin; Burkina Faso; Cameroon; Cabo Verde; Central African Republic; Chad; Congo, Republic of; Cote d'Ivoire; Equatorial Guinea; Gabon; Gambia, The Republic of; Ghana; Guinea; Guinea-Bissau; Liberia; Mali; Mauritania; Niger; Nigeria; Sao Tome and Principe; Senegal; Sierra Leone; and Togo.

in the region and the living circumstances and social relations of older people in the various countries. Finally, section 7 concludes on the keys messages and recommendations for improving the quality of life for older persons in the region.

**Data**

A major constraint in providing the statistical groundwork needed to prepare this paper is the dearth of relevant, detailed and comparable data. In most countries in the region, existing data does not yet cover all problems relating to the older persons' plights. Often, information collected on demographic and health problems in these countries focus essentially on issues of concern to people who are not yet old: infant, child and maternal health; nutrition; HIV/AIDS; etc. Furthermore, population estimates and projections for many sub-Saharan African countries are based on limited data. Few countries in sub-Saharan Africa have data from a recent census. Very few countries in sub-Saharan Africa have viable vital statistical systems that produce usable data on fertility and mortality. This systematic lack of vital registration data makes it necessary to derive estimates of mortality using indirect demographic techniques based on survey and census data. The most readily available data that can be used to estimate fertility and mortality come from Demographic and Health Surveys (DHS). Therefore, the demographic data in this paper should be interpreted with caution.

This paper uses the most recent and reliable data available on ageing-related issues in some selected countries in the West and Central Africa region to assess the situation of the older persons. This section provides a detailed description of these data and their sources and highlights the crucial data gaps that need to be addressed in order to improve the ability to track progress in mainstreaming ageing in public policies and programs in Africa. The demographic data used are based on population estimates and projections prepared by the US Census Bureau and the World Population Prospect 2017 revision. Data on individuals' and households' socioeconomic and demographic characteristics used in this come from the household component of the most recent Demographic and Health Surveys (DHS) conducted in the various countries in West and Central Africa between 2002 and 2016. DHS are nationally representative samples, which the main objective is to collect information on the reproductive and health behavior of women aged 15–49. DHS household rosters include information on every person usually living in the household at the time of interview (de jure household members) or who slept in the household the night before the interview (de facto members). The household member file includes age, sex, relationship to head, and education level. For children ages 17 years and younger, the file also provides information on whether the member's biological mother and biological father were still alive.

Following Zimmer and Dayton (2007), we assess household composition and older persons living arrangements, focusing on de jure household members (that is, persons who lived in the household at the time of the survey). Indeed, the de jure approach is more consistent with selection probabilities based on censuses. We then use the information provided on members' age, sex, and relationship to head to identify with whom the older persons live together or not (alone, partners, children, grandchildren, siblings, and/or other relatives). DHS data contain

also a wealth index, which is a composite measure of a household's cumulative living standard. It is calculated using observable or easy-to-collect items (assets, services, amenities) that are specific to urban and rural areas. For each area of residence, predicted wealth scores are calculated and these scores are joined to make the combined wealth score at the national level. Quintiles for urban and rural areas and the country as a whole are then calculated using the de jure household populations of the two residential areas, to produce urban, rural and combined wealth indexes, respectively. Rutstein (2008) provides additional details on DHS procedures for calculating urban, rural, and total wealth indexes.

**Policies and legislation passed since 2002 specifically related to older persons**

This assessment of progress made towards the implementation of the MIPAA's guideline in the West and Central Africa region is based on information gathered from national offices and desk research. States that have acceded to MIPAA are bound to put its provisions into practice, but most countries in the region have yet to introduce relevant policy changes. Only a handful of countries have made significant efforts towards mainstreaming ageing issues into their national policies (Côte d'Ivoire, Ghana, Nigeria, Senegal and Togo). In what follows, a brief overview of what has been done in each country.

*Côte d'Ivoire.* The Directorate of Social Protection in charge of the elderly advocates with local authorities- regional councils for the integration of the elderly issues into their local development plan and policy. The government approved the bill on tax exemption for pensions and increased the latter by 8 percent in 2014.

*Ghana*. Initiatives to improve the quality of life of older persons are being implemented by government and partners: *i)* Introduction of the Eban Card for Old people (*Eban is an old Akan symbol which stands for love, safety and security*) with more than 20 thousand members registered in August 2016; *ii)* Formulation of gender policy on ageing women, which seeks to redress inequity in customary laws rooted in male inheritance of land and other productive resources that put women at a disadvantage, especially in their old age ; *iii)* Introduction of free medical services for people 70 and older; *iv)* Establishment of an Advisory Committee on ageing, responsible for preparing the bill on ageing; *v)* Ghana National Social Protection policy launched in December 2015, which contains: **a)** access to basic essential care for all; **b)** minimum income security for older persons that are supported in terms of programmes that affords them a meaningful livelihood and **c)** preparation of Bill on the Aged that is currently in review by the General Attorney. It is envisaged that the process will be completed in 2017. Further actions to be taken include:

- Establishment of the Ageing Fund; aged bill accelerated; fund established
- Implementation of the national gender policy (NGP) provision on access to productive resources by women is expected to be implemented expeditiously.
- Prioritize healthcare for the elderly by training geriatric doctors, nurses, and caregivers.
- Speed up the approval processes for the passage of the Aged bill which is currently with the Attorney General's office for reviewing and drafting. Most of the provisions of the ageing policy can only be operationalized when the law is in place.

*Nigeria*. Fragmented interventions on ageing are being addressed sectorally under the 2004 National Policy on Population and Sustainable Development (NPPSD) by the National Population Commission, National Health Policy, Federal Ministry of Health (FMOH) and the National Gender Policy through the Federal Ministry of Women Affairs and Social Development (FMWA&SD). Following the establishment of the Pension Reform (2004), about 7.8 million older persons receive a contributory pension, which is aimed exclusively at the formal sector, which, according to recent estimates, make up only 10% of the workforce and only 1.2% of the Nigeria workforce. The Non-Contributory Pension has been adopted in four States: Ekiti, Osun, Anambra and Cross Rivers. Four out of 36 states have introduced State Social Welfare Scheme for the elderly. In October 2014, the federal government announced plans to launch a National Policy on Ageing in the country to provide a suitable national framework for care of older persons. So far, two Geriatric centres have been opened. Two draft national and state-level policies awaiting enactment: i) 2014 draft National Social Protection Policy and ii) draft Cross Rivers State Social Protection Policy. The 2014 draft National Social Protection Policy accommodates the provisions of the 2003 draft National Policy on the Care and Welfare of the Aged and Older Persons.

*Senegal***.** Innovative policy options have been taken for the benefit of the elderly: i) the family grant programme; ii) the program of universal health coverage; and iii) the SESAME plan for free medical care. Senegal intends to invest in a Social Protection strategy which aims to guarantee better access to basic services and social transfers for the poorest and most vulnerable, in articulation with the national strategy of Social Protection, which includes: (i) strengthening social security for workers and retirees, through the institutional and legal social security framework reform, increasing the level of income of certain categories of workers, improving and extending social services; (ii) improving the socio-economic conditions of vulnerable groups, by strengthening the social reintegration of vulnerable groups and the expansion of the social transfers mechanisms; (iii) extending social protection to the informal sector and vulnerable groups by implementing a universal health coverage and the establishment of a system of information and monitoring. It is expected that in 2017, the health insurance coverage will increase from 20 to 75% with a focus on the older persons.

*Togo***.** Several actions have been towards integration of ageing issues into the: (i) national population policy (1998), (ii) Poverty Reduction Strategy (2008-2012); (iii) social protection policy in 2012; (iv) the strategy for accelerated growth and Promotion of employment (2013 - 2017). Other initiatives include: (i) celebration each year the international day of older persons (1st October): awareness of decision makers, technical and financial partners and the communities on the protection of the elderly and the inclusion of elderly needs in social development efforts; (ii) national policy for the protection of the elderly and its action plan integrated into the social protection policy (2009-2011); (iii) development of a documentary on the importance of the elderly within families and communities (2016); (iv) establishment of the structures of the National Advisory Council of the elderly at national and subnational level (2006). Furthermore, various studies on ageing issues have produced and the findings used for advocacy to promote actions in favour of old people: Healthy ageing produced (2008); retirement guide (2009); qualitative study on the opinions and attitudes of young people and adults in preparing for old age (2010); study on senior volunteerism and the final

report and database on the expertise of the elderly was validated in 2015 and a study on the protection of elderly to identify the most vulnerable is ongoing based in 2010 census data.

**Older persons and development in West and Central Africa**

Older people's situations vary considerably in terms of economic and financial autonomy. Many seniors are financially independent and manage to live off their own income and savings. Some may even help others, including some who remain active in the labour force. However, for large segments of the population, old age is associated with growing dependency and economic insecurity due to declining income or health and a growing need for care and support. The vulnerability of older persons is greater when there is no reliable source of income support, for example through social protection mechanisms, which may take the form of pensions, disability insurance or benefits care for the elderly. Retirement pensions or similar schemes with income support at an advanced age are essential to the social protection of the elderly.

*Financial security and old-age pension coverage*

Income insecurity

Old age is seen to be a time of losses - declining health, failing functionality, frailty, and shrinking networks. Therefore, the main risk when one reaches old age is poverty or income insecurity due to the loss of one's ability to earn income, partially or totally. In almost every country in the region, the main source of income for the elderly is labour income; particularly revenue in-kind from self-employment activities in the urban informal sector or subsistence agriculture. As a result, many people continue to work until they are no longer able to do so (Ezeh et al., 2006). The elderly may also benefit from transfers of close or extended family members, including transfers in kind through co-residence with the children (Aboderin, 2006.) Membership of cooperative groups such as self-help groups, credit associations and cultural groups is also another source of income for older persons in many countries. As well, in some countries, older people may also receive incomes from non-governmental aid organizations, including charitable and non-profit organizations and religious groups (HelpAge International & Cordaid, 2011). However, as extended family ties weaken due to urbanization, migration and widespread poverty, concerns are rising about the economic insecurity of older people in the region. Many are uncertain about their income and may encounter difficulties in meeting their needs. This concerns those who have never had children, those whose children or spouses have died or been displaced, and those whose children do not earn enough to support them. It also applies to those who no longer work or have declining participation due to reduced work opportunities or health-related difficulties. This is now happening in many African countries the region (Aboderin, 2006). In addition, the old age economic insecurity in West and Central Africa is compounded by market failures. Insurance and financial markets are clearly incomplete in all countries in the region. An incomplete market is one in which consumers would be willing to pay more than the cost of a good or service, but it is not provided. In the current state of capital markets in the region, many are denied participation in these markets, although some might be willing to pay a fair

premium. In almost every country in the region, Savings by individuals and households are constrained by income and access to formal financial services. Indeed, individuals and households in these countries do save, but do so outside of the formal financial system. Informal saving clubs are more common than formal savings accounts. Overall, countries in West and Central Africa are lagging behind in terms of financial inclusion. Countries in the region have the lowest proportions of adults with a bank account in a formal financial institution in the world: 11.8% in the central region and 12.6% in the West African Economic and Monetary Union (WAEMU), some distance from the average in sub-Saharan Africa 34%. Most savers in the region only make informal savings (European Investment Bank, 2016).

Old-age pension coverage

A pension plan is a formal arrangement whereby individuals earn income (regular periodic payments) when they reach a certain age and no longer receive regular income. Pensions play thus an important role in securing and improving the livelihoods of older people and reducing poverty. Evidence suggests that poverty among older people is low in countries where there exists a generous pension or safety net coverage for the elderly, such as in Brazil, Chile or South Africa. In contrast, in countries where old-age pension systems are non-existent or target a few numbers of people, older people are over-represented among the poor (Barrientos, 2003; Barrientos *et al.*, 2003; Bertrand *et al.*, 2003; Bourguignon *et al.*, 2004; Duflo, 2003). However, despite such a role, most the elderly in the region are not covered by a pension scheme. Virtually no country in the Western and Central Africa has focused on expanding coverage of the pension system or on setting up a social protection program for the older persons. Formal pension programs in the region are so far been limited in their coverage, include few incentives for workers to participate. As well, they often encounter administrative and governance difficulties, and in many cases, are not financially sustainable. In the region, the social security system generally provides retirement income only to high-income urban workers. Typically, levels of coverage in the rural and informal sector or for women are low. Tables 1 and 2 show the extent of old pension coverage in the various countries. Incomplete coverage is a widespread phenomenon the region. In most cases, fewer than 15 percent of all those in the labour force or in employment contribute to a pension scheme. The worst situation is in Chad, Cote d'Ivoire, Equatorial Guinea, Gambia, Mauritania, Niger and Nigeria, where the old-age pension covers fewer than 5 percent of the working-age population. The highest coverage is in Togo and Sierra Leone (58 percent), followed by Central Africa Republic (54 percent), Ghana (51), Burkina Faso (45), and Cabo Verde (44 percent). On another hand, a significant gender gap is worth to be mentioned: in nearly all countries in the region, women are covered to a much lesser extent than men, except for Central Africa Republic, Togo, Sierra Leone, Liberia, and Ghana. This suggests more economic insecurity among the aged women. In fact, for women, the chances of widowhood are high, given the fact that they have higher survival rates and that they tend to marry men who are much older than them.

**Table 1: Old-age pensions in West and Central Africa: Key features of main social security programmes**

| Country | Statutory pensionable age | | Estimate of legal coverage for old age as a percentage of the working-age population | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Total | | Mandatory | | Voluntary | |
| | Men | Women | Total | Women | Total | Women | Total | Women |
| Benin | 60 | 60 | 4.3 | 2.3 | 4.3 | 2.3 | 0.0 | 0.0 |
| Burkina Faso | 56 | 56 | 45.2 | 18.3 | 5.8 | 2.8 | 39.4 | 15.5 |
| Cameroon | 60 | 60 | 13.6 | 6.2 | 13.6 | 6.2 | 0.0 | 0.0 |
| Cabo Verde | 65 | 60 | 43.5 | 35.7 | 43.5 | 35.7 | 0.0 | 0.0 |
| Central African Republic | 60 | 60 | 54.1 | 60.3 | 14.7 | 13.4 | 39.4 | 21.5 |
| Chad | 60 | 60 | 3.6 | 0.5 | 3.6 | 0.5 | 0.0 | 0.0 |
| Congo | 60 | 60 | 10.2 | 5.9 | 10.2 | 5.9 | 0.0 | 0.0 |
| Côte d'Ivoire | 60 | 60 | 10.0 | 4.9 | 10.0 | 4.9 | 0.0 | 0.0 |
| Equatorial Guinea | 60 | 60 | 13.0 | 2.4 | 13.0 | 2.4 | 0.0 | 0.0 |
| Gabon | 55 | 55 | 11.6 | 9.5 | 11.6 | 9.5 | 0.0 | 0.0 |
| Gambia | 60 | 60 | 4.0 | 2.5 | 4.0 | 2.5 | 0.0 | 0.0 |
| Ghana | 60 | 60 | 51.0 | 45.0 | 11.7 | 5.8 | 39.4 | 39.2 |
| Guinea | 55-65 | 55-65 | 10.6 | 7.0 | 10.6 | 7.0 | 0.0 | 0.0 |
| Liberia | 60 | 60 | 50.2 | 50.4 | 9.1 | 4.4 | 33.0 | 36.0 |
| Mali | 58 | 58 | 38.3 | 29.4 | 6.1 | 3.7 | 32.2 | 25.7 |
| Mauritania | 60 | 55 | 4.7 | 1.3 | 4.7 | 1.3 | 0.0 | 0.0 |
| Niger | 60 | 60 | 3.4 | 1.6 | 3.4 | 1.6 | 0.0 | 0.0 |
| Nigeria | 50 | 50 | 3.7 | 1.9 | 3.7 | 1.9 | 0.0 | 0.0 |
| Sao Tome and Principe | 62 | 57 | 29.6 | 27.0 | 18.3 | 17.6 | 11.3 | 9.4 |
| Senegal | 55 | 55 | 11.9 | 6.6 | 11.9 | 6.6 | 0.0 | 0.0 |
| Sierra Leone | 60 | 60 | 57.9 | 52.3 | 5.3 | 2.4 | 52.5 | 49.8 |
| Togo | 60 | 60 | 57.7 | 57.1 | 57.7 | 57.1 | 0.0 | 0.0 |
| Africa | | | 26.9 | 16.2 | 20.3 | 11.5 | 6.6 | 4.7 |
| *North Africa* | | | *36.1* | *12.7* | *36.1* | *12.7* | *0.0* | *0.0* |
| *Sub-Saharan Africa* | | | *25.0* | *16.9* | *17.1* | *11.3* | *7.9* | *5.6* |

*Source:* http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=43197.

Figures show very limited development of pension coverage in the region. The West and Central African region has one of the world's lowest proportions of old age pension beneficiaries; less than 10% in most countries, far below the average in Africa (21.5%). Disparities within West Africa itself show that there are different levels of development. Cabo Verde has the best performance, both for men (60%) and women (53%). Gabon and Sao Tome and Principe, as well, have some relatively high proportion old pension beneficiaries (39% and 42%, respectively) whereas Chad's and Sierra Leone's old age pension beneficiaries rate is only 1.6% and 0.9%, respectively.

**Table 2: Old-age effective coverage in West and Central Africa: Old age pension beneficiaries: Proportion of older women and men (above statutory pensionable age) receiving an old-age pension**

| | Proportion by sex (%) | | | Proportion by type of program (contributory or not), (%) | |
|---|---|---|---|---|---|
| **Region or country** | **Total** | **Male** | **Female** | **Contributory** | **Non-contributory** |
| **Estimates (weighted by total population)** | | | | | |
| Africa | 21.5 | … | … | | |
| Middle East | 29.5 | … | … | | |
| Latin America and the Caribbean | 56.1 | 62.3 | 52.4 | | |
| Asia and the Pacific | 47.0 | … | … | | |
| Central and Eastern Europe | 94.3 | 97.2 | 93.8 | | |
| North America | 93.0 | … | … | | |
| Western Europe | 92.4 | 99.2 | 86.5 | | |
| **World** | 51.5 | … | … | | |
| Benin | 9.7 | ... | ... | 9.7 | … |
| Burkina Faso | 3.2 | 7.1 | 0.5 | 3.2 | … |
| Cameroon | 12.5 | 20.2 | 5.9 | 12.5 | … |
| Cabo Verde | 55.7 | 59.8 | 52.8 | 18.2 | 37.5 |
| Chad | 1.6 | ... | ... | 1.6 | … |
| Congo | 22.1 | 42.4 | 4.7 | 22.1 | … |
| Côte d'Ivoire | 7.7 | ... | ... | 7.7 | … |
| Gabon | 38.8 | ... | ... | 38.8 | … |
| Gambia | 10.8 | ... | ... | 10.8 | … |
| Ghana | 7.6 | ... | ... | 7.6 | … |
| Guinea | 8.8 | ... | ... | 8.8 | … |
| Guinea-Bissau | 6.2 | ... | ... | 6.2 | … |
| Mali | 5.7 | 8.5 | 3.7 | 5.7 | … |
| Mauritania | 9.3 | ... | ... | 9.3 | … |
| Niger | 6.1 | ... | ... | 6.1 | … |
| Nigeria | ... | ... | ... | … | 0.4 |
| Sao Tome and Principe | 41.8 | ... | ... | 41.8 | … |
| Senegal | 23.5 | ... | ... | 23.5 | … |
| Sierra Leone | 0.9 | ... | ... | 0.9 | … |
| Togo | 10.9 | ... | ... | 10.9 | … |

*Source*: http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=37897

*Formal pension systems*

National pension schemes in the region are mostly mandatory-contributory defined benefit (DB) schemes, financed on a pay-as- you-go (PAYG) basis. Only Gambia has a provident funds; while Nigeria has a funded defined-contribution (DC) scheme; and Ghana has a hybrid of DB and DC scheme. Meanwhile, only Cabo Verde has a nationwide means-tested non-contributory old-age assistance scheme. In Nigeria, as well, there exists a non-contributory old-age assistance schemes but at a state level, namely in Ekiti State. Launched in October 2011, the Ekiti State social pension scheme is pension-tested providing cash benefice to all

residents of the state who are over 65 years of age who do not receive any other pension and have a low income. All countries in the region have civil servant schemes, mostly separated from the national contributory schemes. As well, almost all civil servant schemes are PAYG defined-benefit schemes, except for Ghana where the scheme is a combination of DB and DC mechanisms, and for Nigeria where the scheme is a fully funded defined-benefice. Gambia is unique in the region in having a non-contributory scheme for civil servants and pay benefits out of general revenues. Because of their colonial basis, social security systems in West and Central Africa differ between the two main colonial blocs, the Francophone countries and the Anglophone countries. Differences are found in design, legislation, benefits and administration. The legislative framework of most Francophone systems excludes the participation of self-employed workers and those in the informal sector. An employee's membership in a plan is acquired through an employer. On the other hand, many social security schemes in English-speaking Africa allow the voluntary participation of self-employed and informal workers. In practice, both systems have a high density in the formal sector because of the design compatibility of people with an employment relationship. The eligibility criteria for pension benefits also vary between Francophone and Anglophone schemes. Unlike Francophone schemes, many English-speaking plans do not require complete retirement from work to be eligible for pension. In addition, Francophone social security systems are regulated by a centralized body called CIPRES, which groups together 14 French-speaking African countries (Benin, Burkina Faso, Cameroon, Central African Republic, Comoros, Niger, Senegal, Chad and Togo). There is no regulatory body to coordinate social security schemes on the English-speaking side.

*Poverty in old age*

Pensions schemes have multiple objectives, which include: to reduce poverty, prevent poverty, reduce income inequality, and provide income replacement of lost or reduced income due to various life contingencies, thus "smoothing" consumption of individuals and their families over the life cycle. Given the fact that almost all the pension schemes are mandatory contributory schemes on an earnings-related basis, most of the elderly in the region are obliged to continue working, mainly in the informal economy, because they are not entitled to pensions or the pension benefits are too low. Since most of these people work in the informal economy or in rural areas, they have not contributed to pension schemes during their working lives. Moreover, they cannot benefit from non-contributory social assistance or universal pensions that can lift them out of poverty when they reach retirement because such instruments do not exist in most countries, except Cabo Verde. Thus, most older persons in the region rely on their own income and/or support from their families to sustain their livelihood. To study poverty among the older persons in the region, we adopt Deaton and Paxson's (1995) approach. We classify sample households by living arrangements; in particular, we distinguish between two groups of sample households: households with and without older people aged 60 and above. We use the Demographic and Health Survey (DHS) wealth index as an indicator of standard of living that is widely used in the literature. We compare the quintiles distribution for households with and without elderly members and in this respect, highlight the similarities/differences in the wealth quintile among households living with or without older people. Results show how households are distributed by

household's wealth quintile following households' living arrangements. Remarkably, in almost every country, households with older persons are rather overrepresented in the two bottom quintiles, the poorer and the poorest.

**Table 3: DHS wealth index: quintile distribution by household type (based on de jure household members)**

*(0 = household without elderly; 1 = household with elderly)*

| Countries | Type of household | Poorest | Poorer | Middle | Richer | Richest |
|---|---|---|---|---|---|---|
| Benin | 0 | 17.03 | 18.14 | 18.84 | 21.62 | 24.37 |
| | 1 | 26.24 | 21.51 | 20.59 | 16.57 | 15.09 |
| Burkina Faso | 0 | 17.35 | 19.77 | 19.10 | 19.55 | 24.22 |
| | 1 | 25.46 | 21.30 | 19.87 | 18.11 | 15.26 |
| Cameroon | 0 | 15.85 | 17.03 | 18.29 | 22.87 | 25.96 |
| | 1 | 25.11 | 27.23 | 22.10 | 13.47 | 12.10 |
| Republic of Congo | 0 | 18.31 | 19.27 | 21.09 | 21.58 | 19.75 |
| | 1 | 32.09 | 24.33 | 17.10 | 11.72 | 14.76 |
| Cote d'Ivoire | 0 | 21.41 | 18.65 | 20.25 | 21.18 | 18.50 |
| | 1 | 21.41 | 18.65 | 20.25 | 21.18 | 18.50 |
| Gabon | 0 | 13.44 | 22.96 | 22.60 | 22.38 | 18.63 |
| | 1 | 47.66 | 13.54 | 12.97 | 10.99 | 14.84 |
| Ghana | 0 | 11.48 | 16.70 | 22.29 | 24.45 | 25.07 |
| | 1 | 20.51 | 25.46 | 22.61 | 16.70 | 14.73 |
| Guinea | 0 | 20.43 | 20.19 | 16.67 | 21.32 | 21.38 |
| | 1 | 22.87 | 20.75 | 22.79 | 18.52 | 15.07 |
| Liberia | 0 | 20.35 | 17.48 | 17.86 | 23.80 | 20.51 |
| | 1 | 25.61 | 24.88 | 21.30 | 14.40 | 13.81 |
| Mali | 0 | 14.88 | 17.34 | 18.22 | 22.95 | 26.61 |
| | 1 | 22.56 | 20.68 | 21.61 | 19.66 | 15.50 |
| Nigeria | 0 | 15.92 | 18.24 | 18.97 | 20.82 | 26.05 |
| | 1 | 16.98 | 18.72 | 26.45 | 23.48 | 14.37 |
| Sao Tome & Principe | 0 | 21.30 | 20.97 | 20.42 | 18.76 | 18.55 |
| | 1 | 32.26 | 21.24 | 19.41 | 14.17 | 12.91 |
| Senegal | 0 | 13.70 | 15.81 | 20.49 | 25.16 | 24.84 |
| | 1 | 19.64 | 21.49 | 18.73 | 19.65 | 20.49 |
| Chad | 0 | 23.64 | 21.15 | 18.73 | 16.99 | 19.48 |
| | 1 | 30.80 | 18.07 | 17.49 | 16.34 | 17.31 |
| Togo | 0 | 11.01 | 15.48 | 20.88 | 26.90 | 25.74 |
| | 1 | 17.62 | 22.74 | 28.99 | 17.35 | 13.30 |

*Source:* Data from the Demographic and health survey (DHS)

The extent of poverty among older people varies considerably from one profile to another. We do not have disaggregated data to be able to measure these differences. However, it can be assumed that those who do not have children, and those who get around by get around by themselves, tend to be poorer. Women tend also to be generally poorer than men, in part because they are generally less likely to accumulate savings because they are less likely to

have gainful employment and are also more likely to have left the labor market earlier. The oldest older, those aged 80 years and older, also tend to have more limited capacities and more complex needs than those between the ages of 60 and 79, which particularly exposes them to economic uncertainties.

*Educational profile of the older persons*

The education profile of older people shows that most older persons in West and Central Africa have no formal education. The proportion of those with no schooling more than 60 percent in almost every country. As well, a significant proportion of older person have not completed primary school (Table No 4).

**Table 4: Older persons' educational attainment (%)**

| Countries | No education | Incomplete primary | Complete primary | Incomplete secondary | Complete secondary | Higher |
|---|---|---|---|---|---|---|
| Benin | 84.08 | 6.66 | 3.61 | 3.57 | 0.63 | 1.46 |
| Burkina Faso | 96.02 | 2.16 | 0.77 | 0.75 | 0.06 | 0.22 |
| Cameroon | 58.93 | 19.70 | 12.37 | 6.63 | 0.95 | 1.42 |
| Chad | 90.02 | 4.58 | 2.37 | 2.01 | 0.36 | 0.66 |
| Congo (Brazzaville) | 57.88 | 23.82 | 6.83 | 8.66 | 0.95 | 1.86 |
| Cote d'Ivoire | 86.41 | 3.50 | 3.66 | 4.32 | 1.09 | 1.02 |
| Gabon | 57.69 | 24.59 | 7.16 | 8.75 | 0.38 | 1.44 |
| Ghana | 60.60 | 7.66 | 1.59 | 24.50 | 0.54 | 5.11 |
| Guinea | 87.26 | 3.52 | 1.29 | 2.68 | 1.17 | 4.07 |
| Liberia | 76.31 | 7.45 | 1.34 | 7.14 | 6.05 | 1.72 |
| Nigeria | 62.09 | 8.19 | 13.16 | 2.98 | 6.23 | 7.35 |
| Sao Tome & Principe | 44.90 | 51.93 | 1.09 | 1.98 | | 0.10 |
| Senegal | 90.36 | 3.98 | 1.24 | 2.96 | 0.53 | 0.94 |
| Togo | 74.62 | 11.52 | 5.51 | 6.07 | 0.50 | 1.78 |

*Source:* Data from the Demographic and health survey (DHS)

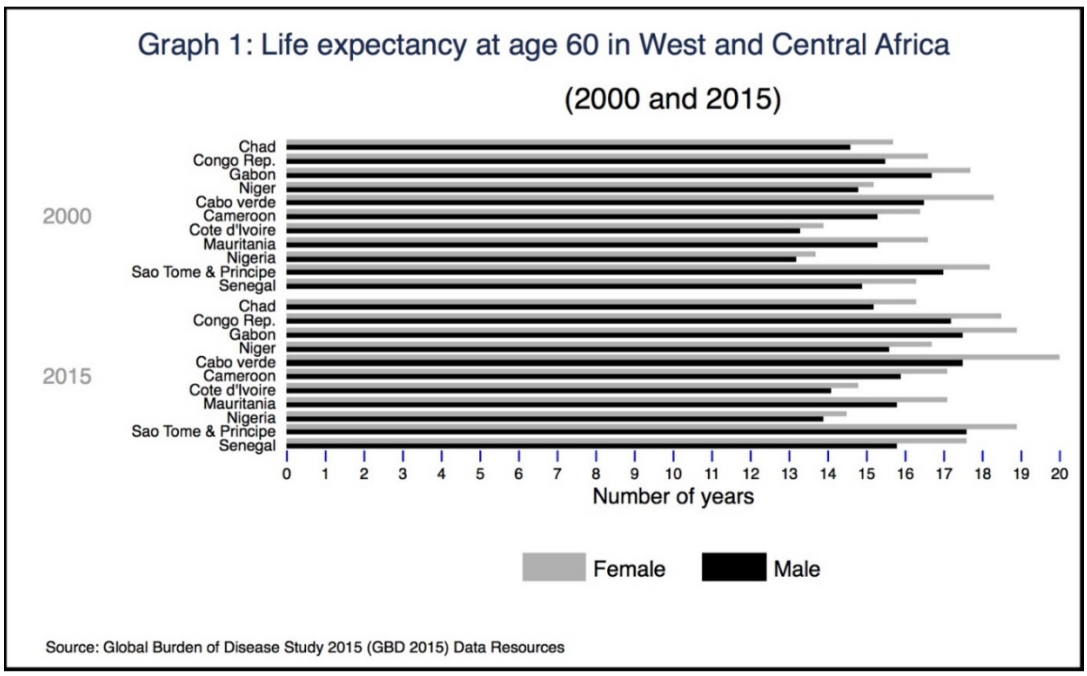
There is considerable disparity between countries in the proportion of elderly people who have completed primary school and has reached a higher level of education. In Ghana, a large number of older people who have completed primary school have not completed high school. Few have gone through high school and graduated. This contrasts with the profile in Nigeria, where much older people have graduated from high school and reached higher education. In addition, Ghana and Nigeria have the highest proportion of older persons with post-secondary education. The proportion of older people in these two countries who have attained a higher level of education is at least threefold that of older people in the other countries. Burkina Faso and Sao Tome and Principe have the lowest share of older people with higher education in the region. Formal education is a fundamental factor of successful ageing. Educational attainment is linked to many aspects of a person's development. Research has shown that higher levels of education usually translate into better health status, higher

incomes and consequently higher standards of living. People with higher educational levels may be less dependent on their families for financial assistance. In comparison, being low educated may expose to harder and low paid jobs. As well, it may lead to having poor self-perceived health and functional limitations (Crabtree, 1967; Zimmer et al.,1998; Kuate-Defo, 2006; Cosco et al., 2017). In the region, as educational opportunities were not well developed in the 1930s to 1950s, the current cohort of elderly people on average has a relatively low level of education. At that time, many countries in West and Central Africa were under colonial administration. The possibility of going to school was almost nil, especially for rural people and girls especially for the females from villages.

**Health**

*Health profiles of older persons*

To assess the health status of the older people in a country, it is useful to have information on indicators such as morbidity, mortality, use and access to health care, health risk factors for older persons, prevention and personal health expenses, etc. However, available health statistics in the different countries in the region still do not provide accurate and timely information on these indicators. As well, there is a dearth of data on disability among older people, including the presence of physical or mental impairments that limit a person's ability to perform an important activity and affect the use of or need for support, accommodation, or intervention to improve functioning. In this paper, we look at health profiles of the older people in the region using information on the expectation of life at age 60 published by WHO (2016). This gives the expected average number of years of life remaining at 60 years old. We use this measure as a proxy to capture the profile of the older populations' health, wellbeing and quality of life in the West and Central Africa region.




*Main causes of deaths*

Cause-of-death classification is a useful tool to illustrate the relative burden of cause-specific mortality. In fact, ranks indicate the most frequent causes of death among the causes that can be classified. The rankings do not illustrate the risk of mortality by cause, as shown by mortality rates. The rank of a specific cause (i.e., its mortality burden in relation to other causes) may decrease over time even if its mortality rate has not changed or its rank may remain the same over time, even if its mortality rate decreases. There are important variations in the leading causes of older persons' death are noted across countries and periods (tables 4).

**Table 5: Estimated deaths ('000) by cause, Population aged [60-69], 2015**

| | | Communicable, maternal, perinatal and nutritional conditions | | | Non-communicable diseases | | | | | | | Injuries | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Countries | All Causes | Infectious and parasitic diseases | Respiratory Infectious | Nutritional deficiencies | Malignant neoplasms | Diabetes mellitus | Neurological conditions | Cardiovascular diseases | Respiratory diseases | Digestive diseases | Genitourinary diseases | Unintentional injuries | Intentional injuries |
| **Benin** | 9.3 | 1.1 | 1.0 | 0.1 | 0.7 | 0.5 | 0.1 | 3.2 | 0.5 | 0.9 | 0.3 | 0.6 | 0.1 |
| **Burkina Faso** | 13.5 | 1.9 | 1.3 | 0.3 | 1.4 | 0.6 | 0.1 | 4.6 | 0.5 | 1.1 | 0.2 | 0.8 | 0.2 |
| **Cameroon** | 19.9 | 4.1 | 1.8 | 0.1 | 1.7 | 1.1 | 0.2 | 6.1 | 0.9 | 1.7 | 0.6 | 1.0 | 0.3 |
| **Cape Verde** | 0.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Central African Republic** | 5.1 | 1.2 | 0.4 | 0.1 | 0.5 | 0.2 | 0.0 | 1.6 | 0.3 | 0.3 | 0.1 | 0.2 | 0.1 |
| **Chad** | 10.9 | 2.2 | 1.1 | 0.1 | 1.0 | 0.5 | 0.1 | 3.2 | 0.5 | 1.0 | 0.2 | 0.6 | 0.1 |
| **Congo** | 3.5 | 0.9 | 0.2 | 0.0 | 0.4 | 0.2 | 0.0 | 1.0 | 0.2 | 0.2 | 0.0 | 0.1 | 0.0 |
| **Côte d'Ivoire** | 27.5 | 4.0 | 3.0 | 0.2 | 1.9 | 1.3 | 0.3 | 9.3 | 1.4 | 2.8 | 0.7 | 1.4 | 0.4 |
| **Equatorial Guinea** | 0.8 | 0.1 | 0.1 | 0.0 | 0.1 | 0.1 | 0.0 | 0.2 | 0.0 | 0.1 | 0.0 | 0.0 | 0.0 |
| **Gabon** | 1.4 | 0.3 | 0.1 | 0.0 | 0.2 | 0.1 | 0.0 | 0.4 | 0.1 | 0.1 | 0.0 | 0.1 | 0.0 |
| **Gambia** | 1.4 | 0.2 | 0.2 | 0.0 | 0.1 | 0.1 | 0.0 | 0.5 | 0.1 | 0.1 | 0.0 | 0.1 | 0.0 |
| **Ghana** | 25.4 | 3.8 | 2.7 | 0.1 | 2.5 | 1.5 | 0.2 | 8.6 | 0.9 | 2.1 | 0.6 | 1.5 | 0.3 |
| **Guinea** | 11.4 | 2.2 | 1.2 | 0.1 | 1.1 | 0.4 | 0.1 | 3.5 | 0.6 | 1.0 | 0.3 | 0.7 | 0.1 |
| **Guinea-Bissau** | 2.0 | 0.6 | 0.2 | 0.0 | 0.1 | 0.1 | 0.0 | 0.6 | 0.1 | 0.2 | 0.0 | 0.1 | 0.0 |
| **Liberia** | 3.9 | 1.2 | 0.3 | 0.0 | 0.3 | 0.2 | 0.0 | 1.0 | 0.1 | 0.3 | 0.1 | 0.3 | 0.0 |
| **Mali** | 12.5 | 1.8 | 0.5 | 0.2 | 1.6 | 0.5 | 0.1 | 4.1 | 1.3 | 1.1 | 0.3 | 0.7 | 0.1 |
| **Mauritania** | 3.3 | 0.5 | 0.4 | 0.0 | 0.3 | 0.2 | 0.0 | 1.0 | 0.1 | 0.3 | 0.1 | 0.2 | 0.0 |
| **Niger** | 14.9 | 2.6 | 1.8 | 0.2 | 1.1 | 0.5 | 0.1 | 4.5 | 0.8 | 1.5 | 0.4 | 1.0 | 0.2 |
| **Nigeria** | 202.2 | 62.7 | 24.8 | 1.2 | 15.4 | 9.1 | 1.7 | 48.5 | 6.9 | 14.7 | 3.4 | 8.1 | 2.2 |
| **Senegal** | 9.9 | 1.6 | 0.8 | 0.1 | 1.2 | 0.4 | 0.1 | 3.1 | 0.5 | 0.8 | 0.3 | 0.7 | 0.2 |
| **Togo** | 6.3 | 0.8 | 0.7 | 0.1 | 0.6 | 0.3 | 0.1 | 2.2 | 0.3 | 0.6 | 0.2 | 0.4 | 0.1 |

*Source*: Global Health Estimates 2015: Deaths by Cause, Age, Sex, by Country and by Region, 2000-2015. Geneva, World Health Organization; 2016.

However, there are some strong trends common to all countries. In both periods and in all countries, the leading causes of death were infectious and parasitic diseases. Most deaths

recorded in the various countries are related to these diseases. Infectious diseases are widely spread in the region and are mostly related to malaria and TB. Cardiovascular diseases account for the second important cause of death in the region. Important increases in the number of deaths associated to these diseases are noted in all countries between 2000 and 2015. Cardiovascular diseases are becoming a very significant health problem across the region. Lifestyle choices associated with cardiovascular diseases, including sedentary lifestyle, smoking and poor diets, are now widely prevalent in the region. Another major cause of deaths for older persons in the region is the respiratory diseases, followed in rank order by digestive diseases; diabetes mellitus; injuries (intentional and unintentional); malignant neoplasms; etc.

*Health Care System*

Health-care workers and ageing in the region

Observed trends in ageing in the different countries in the region are expected to increase demand for health care services and for health care workers. Because people typically demand more health care services later in life, the demand for health care workers will likely grow faster than in the past. Older people tend to have chronic conditions that require special skills and special care, particularly geriatric care. Geriatrics is the branch of medicine concerned with health problems specific to aging and with the treatment, diagnosis, and prevention of disease in older persons. Additionally, an ageing population will result in many health workers retiring during the next years. Then the basic question is whether the current health care workforce is sufficiently trained to meet existing demands of older patients, let alone higher future demands. However, there are important data gaps on health-care staffing and training in almost every country in the region. This is a challenge for all countries and is a particular concern with regard to disaggregated data. Where data on health staff are available, there is rarely sufficient information to monitor levels of effective coverage for the older population.

Health insurance coverage

Data scarcity is also an issue with regard to health insurance coverage for older people. This is a particular problem, hampering the ability to monitor health-care financing and health-care seeking behavior for older equity in the West and Central Africa countries.

**Enabling Environment**

*Living arrangements*

The findings on the living arrangements of older people in households show that, in almost every country, older persons live in extended households. Co-residence with children is common for older adults in every country and living alone is rare. The dominance of elderly persons living in extended households reflects on the fundamental role family support continues to play in ensuring that the needs of the older persons are met. Country variations

show that older people living in extended household setups are more prevalent in Sahelian such as Senegal, Mali, and Burkina Faso, as well as in Guinea while nuclear households among the elderly are predominantly found in Sao Tome and Principe and Ghana. Despite these disparities, old person living alone is an exception in the region. The prevalence of living alone among older people in West and Central Africa, though varying widely across countries, is at lower levels than in the other regions of Africa, with the exception of Sao Tome and Principe, Ghana, and Gabon (10%, 6% and 5%, respectively).

**Table 6: Older persons' Living arrangements (based on de jure household members):**

| Countries | On average an older person co-resides with (number of) | | | | | Percentage of households composed only of older persons |
|---|---|---|---|---|---|---|
| | Children | Adults [16-24] | Adults [25-59] | Older persons | Household size | |
| Benin | 2.1 | 0.7 | 1.0 | 0.4 | 5.1 | 4.2 |
| Burkina | 2.8 | 0.9 | 1.5 | 0.5 | 6.7 | 1.89 |
| Cameroon | 2.5 | 0.9 | 1.3 | 0.4 | 6.2 | 3.92 |
| Congo | 1.6 | 0.7 | 1.1 | 0.4 | 4.8 | 3.33 |
| Cote d'Ivoire | 2.8 | 0.9 | 1.7 | 0.4 | 6.7 | 2.44 |
| Gabon | 1.7 | 0.7 | 1.1 | 0.5 | 5.0 | 5.1 |
| Ghana | 1.4 | 0.5 | 0.7 | 0.3 | 4.0 | 5.83 |
| Guinea | 3.3 | 1.1 | 1.8 | 0.5 | 7.6 | 1.26 |
| Liberia | 2.7 | 0.8 | 1.4 | 0.4 | 6.3 | 1.88 |
| Mali | 6.2 | 1.7 | 3.2 | 0.7 | 12.7 | 0.39 |
| Nigeria | 2.0 | 0.7 | 1.3 | 0.3 | 5.3 | 3.42 |
| Sao Tome and Principe | 0.9 | 0.5 | 0.5 | 0.3 | 3.2 | 10.37 |
| Senegal | 5.3 | 1.8 | 3.3 | 0.5 | 12.0 | 1.01 |
| Chad | 3.0 | 0.8 | 1.1 | 0.3 | 6.2 | 2.43 |
| Togo | 2.4 | 0.8 | 1.2 | 0.4 | 5.8 | 3.47 |

*Sources:* Data from the household roster component of recent Demographic and Health Surveys - DHS

**Table 7: Older persons' Living arrangements: Structure of households composed only of older persons (%)**

| Countries | Size (based on de jure household members) | | | |
|---|---|---|---|---|
| | 1 person | 2 persons | 3 persons | 4 persons and more |
| Benin | 78.15 | 19.95 | 1.63 | 0.27 |
| Burkina | 53.07 | 38.99 | 5.78 | 2.17 |
| Cameroon | 76.94 | 19.35 | 3.71 | 0.00 |
| Congo | 67.10 | 29.01 | 3.73 | 0.16 |
| Cote d'Ivoire | 72.08 | 24.15 | 3.77 | 0.00 |
| Gabon | 60.54 | 32.52 | 5.98 | 0.95 |
| Ghana | 78.09 | 21.03 | 0.59 | 0.30 |
| Guinea | 61.29 | 37.63 | 1.08 | 0.00 |
| Liberia | 64.74 | 34.21 | 1.05 | 0.00 |
| Mali | 41.18 | 52.94 | 5.88 | 0.00 |
| Nigeria | 73.44 | 26.17 | 0.39 | 0.00 |
| Sao Tome and Principe | 88.16 | 11.84 | 0.00 | 0.00 |
| Senegal | 79.55 | 15.91 | 4.55 | 0.00 |
| Chad | 77.40 | 21.39 | 0.96 | 0.24 |
| Togo | 79.14 | 19.54 | 0.99 | 0.33 |

*Sources:* Data from the household roster component of recent Demographic and Health Surveys - DHS

Analysis of household size, i.e. the number of people per household show noticeable differences in household size between households with and without older persons. Households with older persons are predominantly larger. For instance, in Mali and Senegal, the average size with older people is 15.9 and 15.5, respectively; meanwhile the average size of households without older persons is 9.8 and 9.9, respectively. The co-residence with the older people is just one element among many that are part of a package of transfers towards the older persons from family members. These transfers represent only a part of the total transfers to the older persons, which may include other formal income such as pensions, disability income, and other social transfers and allowances. Thus, the co-residence of older people with their children (or other relatives) is only one among many other transfer flows involving the older persons (Palloni, 2001). The observed prevalence of co-residence with children may be related to the weakness or non-existence of other forms of transfers in the region. It may also be related to low household incomes, as well as the health status and dependence of the elderly.

*Support for caregivers of older persons*

Older people need companionship and physical care and assistance. The observed trends of living arrangements in the region show that older people in the region rely more heavily on family members for care and survival. Data show that a significant proportion of older people in the different countries are married or live with a companion. The proportion of widowed, as well, is important. The remaining proportions of never married, divorced and separated

are very low, except for Sao Tome and Principe. When analysed by sex, older men tend to be more married and older women are more likely to be widowed in almost every country. As well, the share of widows among older women is higher than the share of widowers among older men. This is mainly because men were usually older than women at the time of marriage, together with the fact that women had longer life expectancy than men leading to the phenomenon that husbands usually died before their wives.

**Keys messages and recommendations**

Despite considerable increase in the aging population and governments' commitment to implement the MIPAA, ageing-related issues remain a neglected or de-prioritized topic in almost all countries in West and Central Africa. As signatories to the MIPAA, governments promised to develop responses to address the needs of the growing older populations. Fifteen years later, the pace of change has been slow and uneven. Overall, countries in the region accord low priority in their national development policies and programs to the aging populations. In many countries, older persons are barely identified as a specific group to be targeted in development plans. To ensure successful ageing in every county in the region, member States should fully implement the commitment to the older people contained in the MIPAA. To that end, they may wish to take the following actions:

- Increase the share of public expenditure allocated to basic social security to address vulnerabilities related to old age, ill health, disability and unemployment and other life crises;
- Develop and improve adequate, sustainable and responsive social protection schemes, including social insurance and pension schemes, that meet basic minimum needs throughout the life cycle;
- Ensure that social protection measures such as health insurance and information on those benefits, are accessible for all workers, including migrant workers and women in the informal sector;
- Review, strengthen and expand social protection to meet the needs of people living in poverty adequately, taking into account older persons' specific needs and priorities;
- Develop minimum pensions that are independent of years of contribution to ensure that basic minimum needs are met; and take innovative measures to extend basic health insurance coverage to all;
- Ensure universal access, based on equality between women and men, to appropriate, affordable and quality health care services for all throughout the life cycle;
- Remove any kind of barriers to health care access for the older persons by, particularly, advancing health service provision for older people. A great emphasis should be put on the training of geriatrists and gerontologists and the creation of geriatrics services in the health facilities.
- Adopt policies and support mechanisms that create an enabling environment for older people's organizations and networks, including self-help groups and workers' organizations and cooperatives, in particular groups which support the educational and employment opportunities of vulnerable groups such as migrants, and people with disabilities.

- Develop longitudinal surveys aimed at providing comprehensive and cross-nationally harmonized data resources for building scientific knowledge and informing policy development on ageing and related issues in SSA.

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

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***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

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## 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).

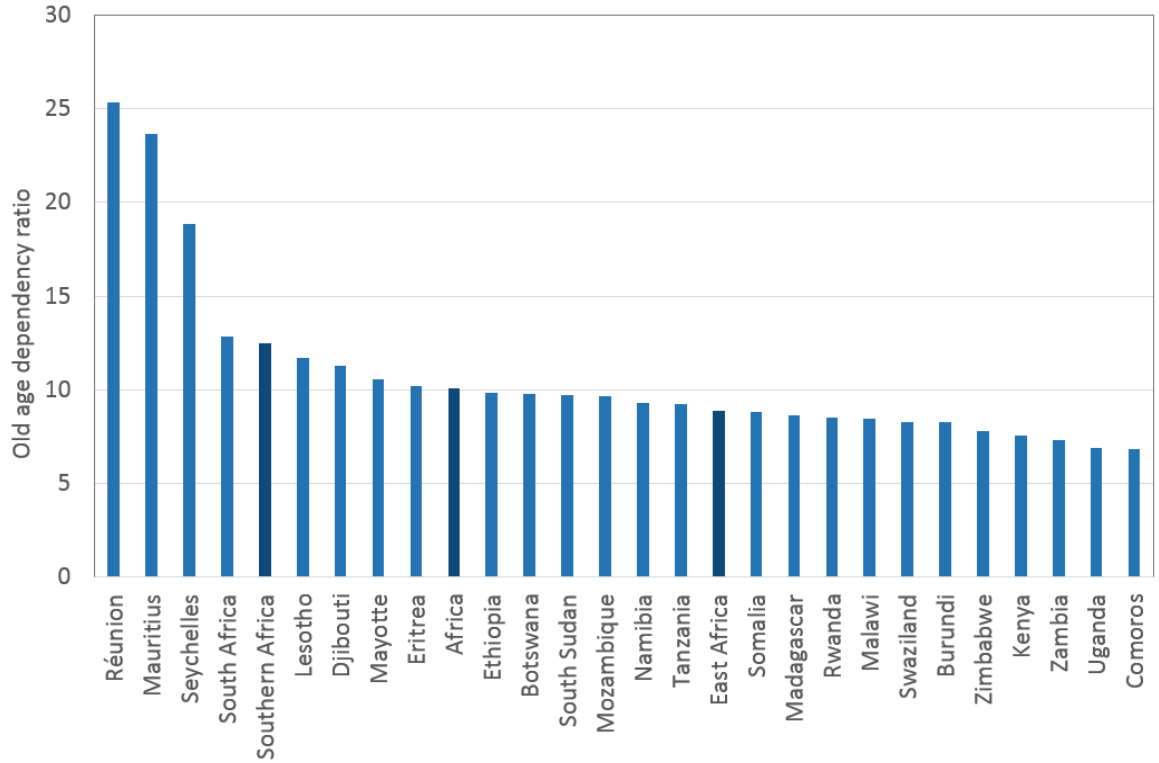
The pace of population ageing is also determined by the changes in fertility and child mortality rates. Between 2000 and 2015, under-five mortality rates declined by about a third in the whole of Africa and by two-fifth in the ESA region particularly in Rwanda, Ethiopia, Kenya, Botswana and Namibia. 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).

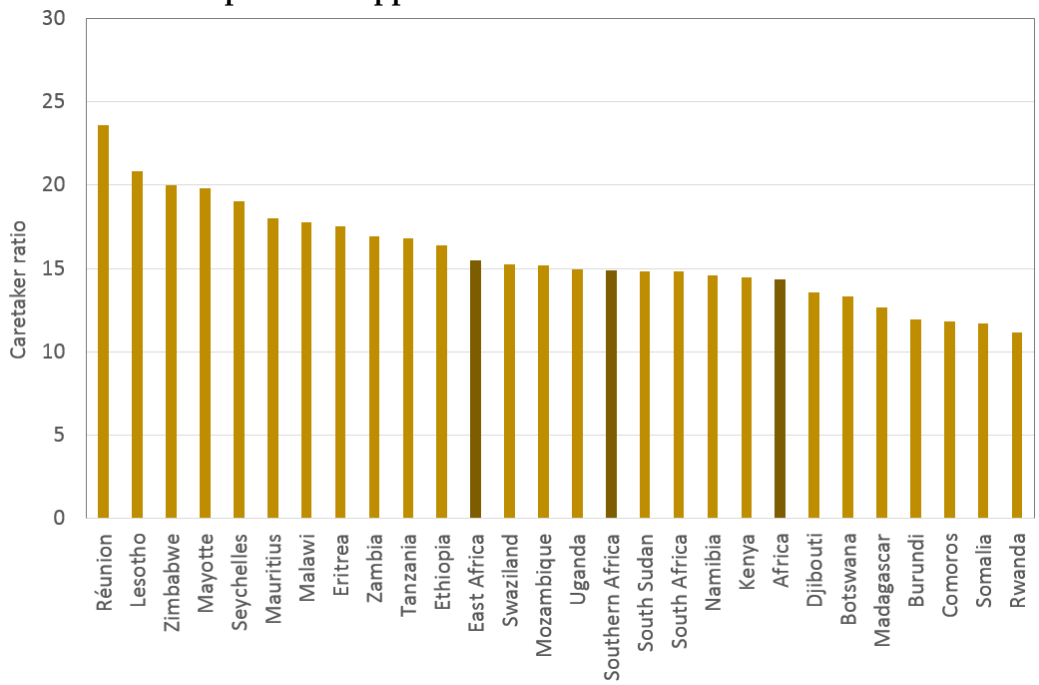
The observed changes in fertility and mortality rates over the last 15 years had impact on the population age structures especially in eastern Africa. Figure 1 illustrates the demographic old-age ratios of countries in the ESA region. The old-age dependency ratios or more appropriately the demographic 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 countries[7 1], 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**

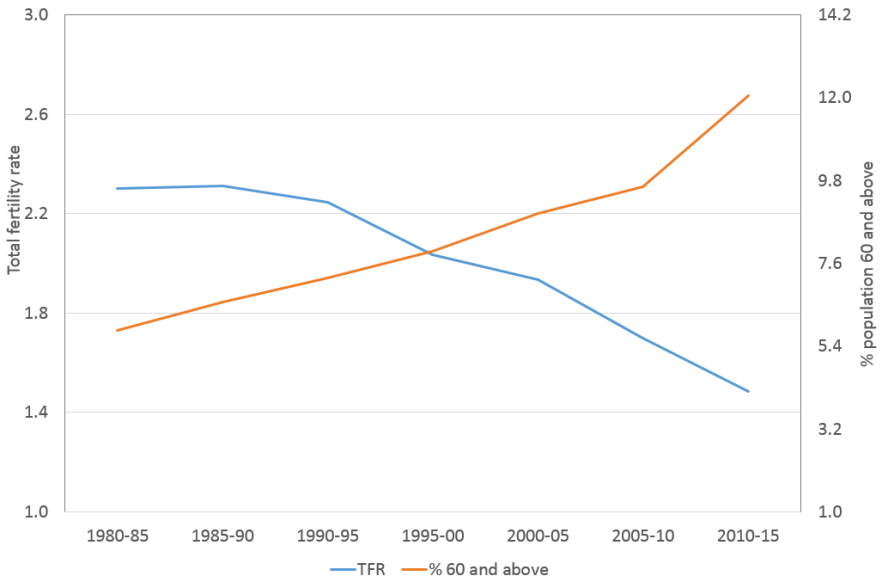
Population ageing has been gradually recognised in the national policy agenda of most African nations. The websites of government departments and international agencies including HelpAge International provide information of national ageing policies, highlighting the policy implementation, coordination, 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 people[8 2]. 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 Ezeh 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 countries[10 4]. 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 & Ranchchod, 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 (Ezeh 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** |
| **Population**[1] | | | | | | |
| 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 |
| **Economy**[2] | | | | | | |
| 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*: [1]United Nations (2017); [2]UNDP (2016); na: not applicable. [3]UNESCO 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 world[11]. 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 (Guven 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: [1]also known as Programa de Subsido 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.

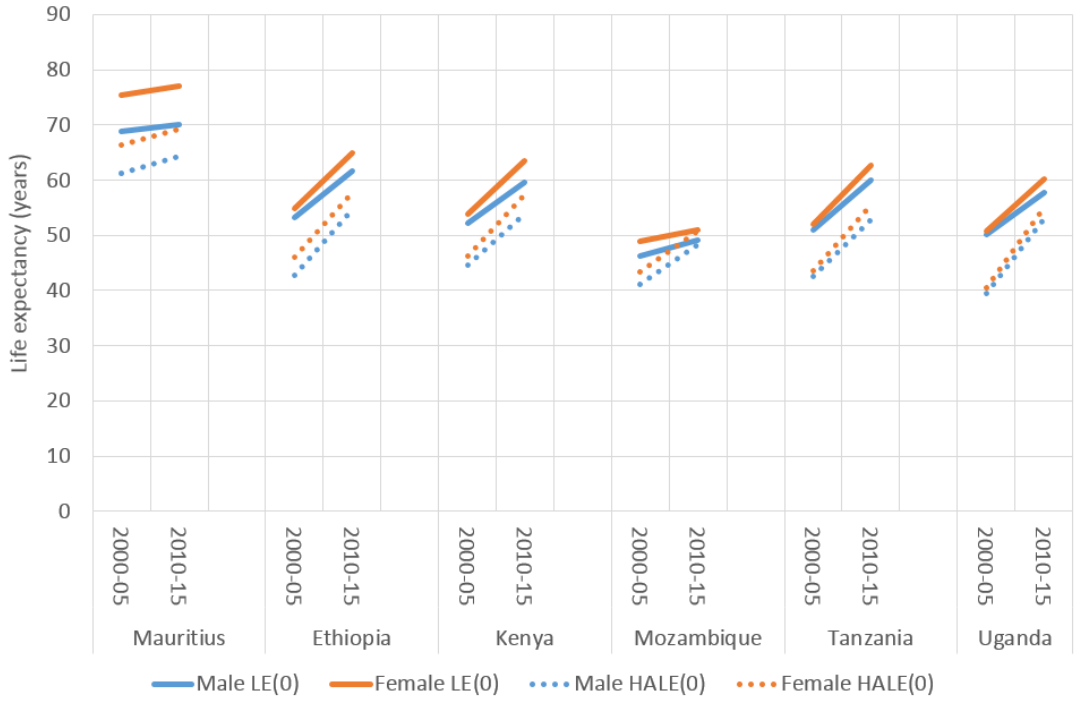
**Advancing health and wellbeing in older age**

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)

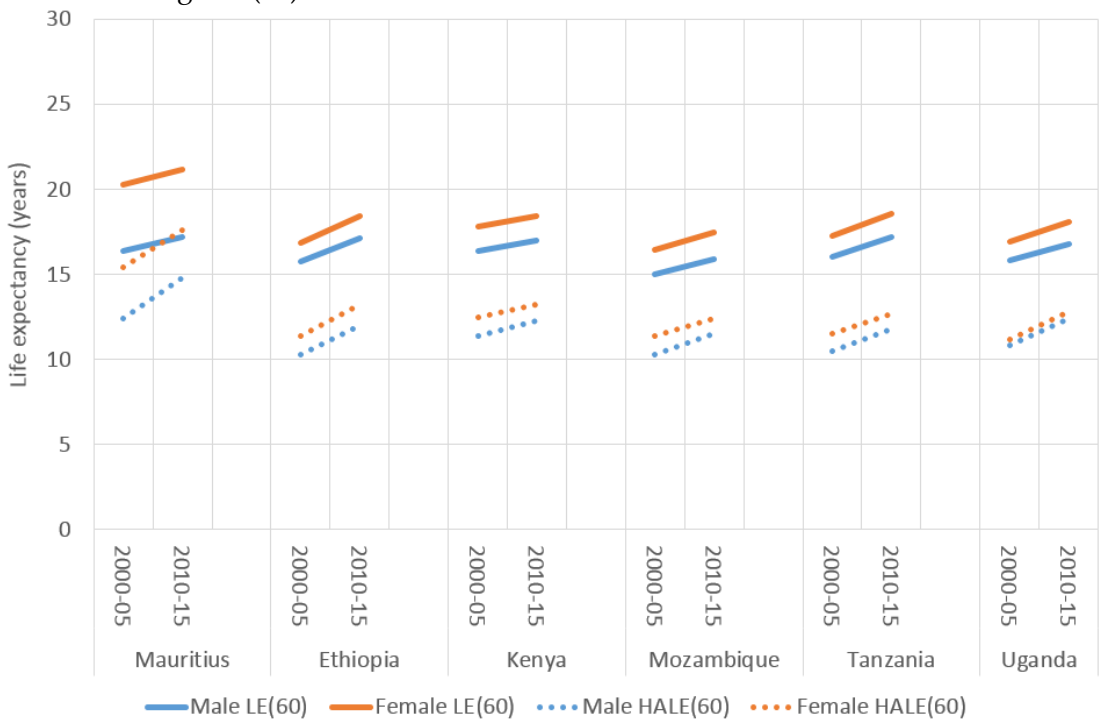
There has been a steady increase in life expectancy since 2000 in the ESA region, while trends in Mozambique have been mediated by gains in life expectancy prior to 2000 (Figure 3a). The increase in life expectancy is attributed to sustained reductions in under-five mortality along with gradual improvements 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).

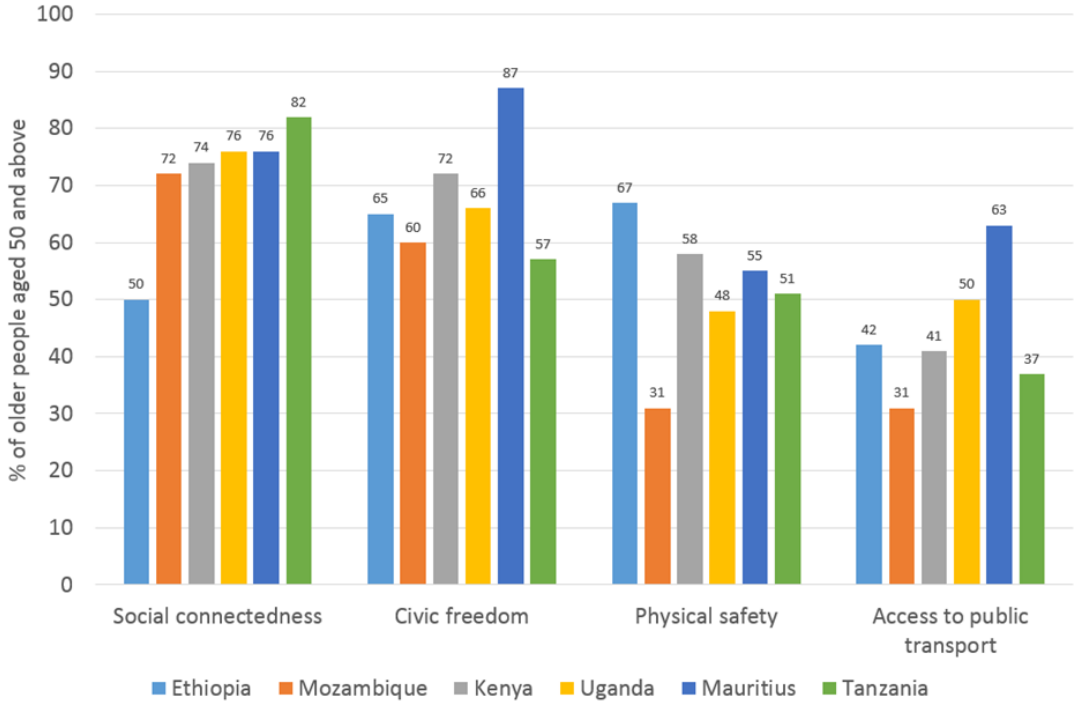
Figure 4 shows selected indicators of enabling environment for people aged 50 and above in ESA countries. The data for these subjective indicators are drawn from the Gallup World Poll Database[12]. The indicators focus on people's perceptions about social connectedness, physical safety, civic freedom 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 Ezeh, 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.

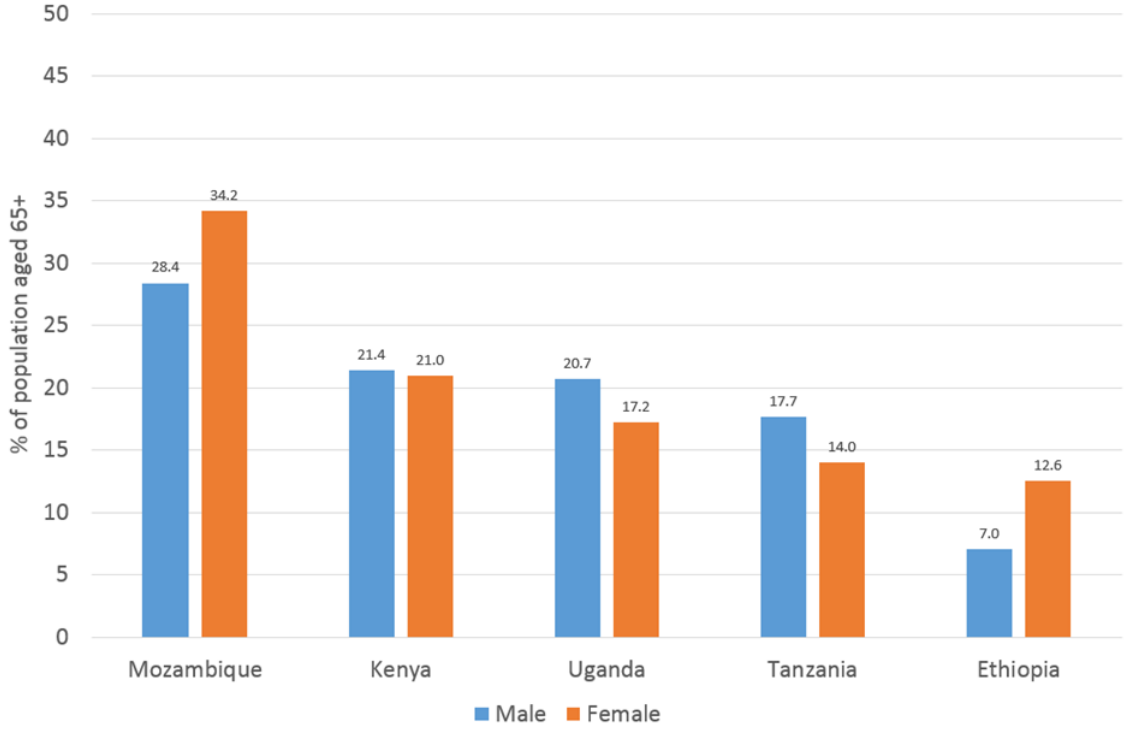
[12] http://worldview.gallup.com

**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 polices, 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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# Formosa, M. & Kutsal, Y.G. (2017) (Eds.). *Population ageing in Turkey: Social and health care services for older persons*. Malta: BDL Publishers. ISBN: 9789990945799

**Ozen Asut[1] and Songul Vaizoglu[2]**

*Population ageing in Turkey: Social and health care services for older persons*, addresses a contemporary problem of our century in a dynamic country - Turkey - which acts as a bridge between high-income countries and low-income countries. Turkey's population aged 65 and above has increased threefold in 50 years and life expectancy at birth has increased to 75 for men and 81 for women for the period between 2013-2015. In spite of the distinct increase of older population aged 65 years and above, systematic and integrated approaches for gerontological and geriatric services in Turkey are not sufficient. The present publication attracts attention to the prevailing problems of our day on the issue and the urgent need for additional government resources in this area, as well as addresses current approaches for specific subjects in the medical and social field.

The book addresses both preventive aspects and control measures for chronic conditions and diseases related to ageing. These include oral health and mental problems as well as health care services needed for an ageing population. Experts on specific subjects have worked on all the different aspects of ageing in a multi-disciplinary approach including medicine, pharmacy, psychology, nursing, dentistry, social aspects, nutrition and dietetics and research on the issue. The role of the multi-disciplinary approach has been emphasized under all the headings presented. Besides, the effects of cultural factors in dealing with the problems of older people have been discussed in the different sections of the book. Since ageing is also a social issue, various social factors have been taken into consideration throughout the sections, such as social class, gender, marital status, family size and living arrangements. In Turkey, gender differences need special attention since older women are especially vulnerable and dependent. General principles regarding the current global needs of an ageing population have been presented throughout the book.

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These are universal health coverage, equity, preventive and promotion measures and preserving the dignity of the older population. Moreover, specific issues on ageing in Turkey have been included in the relevant chapters of the book in more detail.

The book includes 13 chapters on the particular aspects of ageing, exemplified by the situation in Turkey. The chapters address major problems on ageing population concerning relevant disciplines and includes also research and other data of the country when available. Data from national research on ageing population in Turkey have also been presented. The separate chapters of the book document demographic trends, social and geriatric aspects of ageing in national and universal terms, and the available services for older population in Turkey. The themes of the 13 chapters include general approaches and organization in geriatrics and gerontology, health problems and specific chronic diseases related to ageing, nutritional approaches and physical activities for older people, geriatric rehabilitation, community care services, home care services and long-term health care services. Geriatric syndromes such as urinary incontinence, sleep disorders, pressure ulcers, frailty, malnutrition, polypharmacy are presented with reference to the country's conditions and needs.

The editors, Marvin Formosa and Yesim Gökce Kutsal, are themselves globally recognised authorities in geriatrics and gerontology. They have organized the material in a logical sequence to ensure coverage of the situation worldwide and in Turkey. Each chapter provides definitions of terms specific to the respective discipline to help specialists and also practitioners better understand the different subjects. Notably, the book provides resources for researchers, clinicians and students on particular areas regarding the problems of older populations. The book as a whole may be expected to be a current guideline and reference book for all the various practitioners working in the field of ageing, not only in Turkey but also in other countries. As a last comment, it should be emphasized, that the global healthcare society will certainly continue benefiting from the book by frequent updating of the information presented in the years ahead.

# Garrett, M.D. (2017). *Immortality with a lifetime guarantee: Aging as a human survival strategy*. United States of America: Createspace., 238 pp. ISBN-13: 978-1545288320

**Reviewed by Chin Nam Chia[1]**

The captivating title of the book '*Immortality with a lifetime guarantee'* immediately arouses the curiosity of avid readers, especially of non-fiction books, to browse through its pages. Eight well-researched chapters, organised to progressively build on the argument of each preceding chapter, beckon the readers to join the author on a journey to explore the immortality of humankind. The book climaxes in the final chapter where the readers are surprisingly confronted with the author's position *against* the idea of immortality but in favor of ageing as a human strategy for survival as a species. Consequently, the author suggests that death is not only the ultimate point, but also necessary for the human life course. Given that there are already countless books and sci-fi movies which suggest that science is bringing humanity closer to immortality, one wonders how many readers would agree with the author's proposition. The answer hinges immensely on how well Mario Garrett argues his case.

The synopses of the chapters may entice you to find out the answer for yourself. The first chapter, 'Immortality all around us', establishes the facts that immortality is a reality; whether we look at the genes in the human body, the bacteria thriving around us or even the creatures in the sea. Contrary to popular belief, science has yet to discover the solution to enable the human species to live forever. The second chapter, 'Why are we mortal', explores the reasons behind the need for us to grow old and die. It is apparent from scientific literature that aging is an integral part of our existence. Otherwise, the human race will become extinct. Being mortal enables humans, who are endowed with longevity through the presence of a bigger brain, to survive and thrive as a species by passing on the knowledge of our shared history and environment from generation to generation. The third chapter, 'Search for the switch', builds on the preceding chapter by debunking the fountain of youth narrative. The theories of biology of aging and genetics should inform us of our survival strategies in an ever-changing environment rather than mislead us into thinking there is a 'cure' for ageing. The fourth chapter, 'Survival package: balance', states that our life expectancy depends on how well we respond to the environment. In other words, the true story of the biology of immortality is in finding stability in this symbiotic relationship. The fifth chapter, 'Lessons from centenarians', tests out this argument by scrutinizing the lives of people who are one hundred years old and more. This exercise not only confirms the need to be in tune with our immediate environment but also surfaces many factors that facilitate or impede living longer.

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Nevertheless, more has to be done to investigate the intricacy of achieving longevity. The sixth chapter, 'Death fear' rationalizes the fear of death as an outcome of being endowed with a bigger brain and increased longevity. Scientific advancement may extend the human lifespan, but it does not lead to immortality. Immortality is a psychological crutch to help us deal with the fear of death. In fact, death plays a vital role in the development of the human species. The seventh chapter, 'Delusional life' cautions that the belief in immortality is a delusional trick to get us into thinking we can actually defeat death. The final chapter, Chapter Eight, 'Future of immortality', concludes that immortality is purely a psychological construct. It is a concept that goes against our strategy for survival as a species.

For general readers, this book might not be an easy read because of the many technical terms and jargon used by the author pertaining to the field of ecological biology, genetics, biology, neurology and anthropology. However, he makes the reading a lot easier by providing a conclusion for every chapter to bring home his main point. In this way, he ensures readers do not miss the crucial messages which are meant to substantiate his case. For the students of gerontology, this book is definitely a good read as the author provides a broad coverage of the issues associated with aging and supports his argument of aging as a positive development process based on scientific and empirical evidences from researchers and experts from the field.

There are two areas which may adversely affect the experience and knowledge imparted to readers who intend to use this book as a resource for gerontology. Firstly, it lacks a proper referencing of sources. Perhaps the author assumes readers are familiar with the authors, researches and books cited. This may not be the case given the broad coverage of the various topics across ecological biology, genetics, biology, neurology and anthropology. It would be expedient to have an additional section such as, "Notes on Sources", to facilitate the read, particularly for those who interested in gerontology. Secondly, the author's position with regards to religion may come across as controversial. It is presumptuous of him to state, "religion is dependent on the construct of immortality." Theologians and scholars of the major world religions will definitely refute his statement and even find it offensive. Moreover, in the third paragraph of Chapter One, he wrote that "we will revisit religion throughout the story of immortality" (2), which implies he would further address the issues of religion and immortality in the following chapters. Disappointingly, there was no more mention of religion after that singular statement.

To sum up, the author uses a wide coverage of many topics to disprove immortality as a lifetime guarantee and establish ageing as a fact of life.

# Mishra, S. (2017). *Remember me: You, me and dementia*. India: Suprija Print Art, 253 pp. ISBN: 978-93-85221-05-7

**Reviewed by Anupama Datta[1]**

The book by Sailesh Mishra, founder of Silver Innings Group, India is a pioneering attempt by a social entrepreneur and a sensitive individual to shed light on a very important yet overlooked topic in India - dementia. The author has made an attempt to inform the common people about the disease, its stages, impact on the person with dementia and other medical facts, in good detail. However, the main focus is on care which, as of now, is more important than information on cure. Therefore, the book is presented as a sagacious mix of information, which is comprehensive enough to make this book into a manual; at the same time it is interspersed with first person accounts of caregivers and family members. It conveys very effectively the trials and tribulations of caregivers, both in institutional settings and in the family, besides capturing the experience of the persons suffering from the disease. There are a few poems in the book that are poignant especially 'Who Am I?' by Rama Rangaswamy. However, in the emotional narrative of the care givers we can see a common thread that relates to a very important policy question, that is quality care for persons with dementia. Almost all the persons suffering from dementia are older people, mainly dependent on their ageing spouse for care. The book makes amply clear that care for someone living with dementia is a twenty-four by seven, three hundred and sixty-five days work. It is never ending and at times poses special risk and challenges due the aggressive and other behaviour anomalies of the person with dementia. As it is a progressive degenerative disease, conditions worsen with time.

The author has very intelligently included views of the experts on all aspects pertaining to dementia in the last segment, as the lay reader is by then familiar with the disease and the challenges it poses. The last chapter, which is written by the author himself about the way forward, makes a very significant point about social support for the families who have a loved-one suffering from dementia. It is not possible for a family to deal with the stress alone. In India, where we take pride in the fact that our communities are a source of strength for any individual member, we must make an attempt to increase information about this disease so that the persons with dementia and their families are not discriminated, but supported in the herculean task by sharing the burden.

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In a country like India that is ageing rapidly, this book will go a long way in spreading awareness about dementia and its impact on people; both the person with dementia and the caregivers. It will put dementia in the public purview. People can read and understand the nuances of the disease and also be like a ready reckoner. It is a reader friendly book written in a lucid style that gives comprehensive information about dementia covering clinical and social aspects very meticulously. The dilemmas and experiences of the family add human touch to the otherwise factual book. This book successfully raised very important yet neglected concerns of health, care, wellbeing and economic security of the growing population of aged in the country. However, one urgent area of concern, that is the affordability of quality care in old age, especially for chronic conditions that require sustained long-term intervention, have not found the place that it deserves in the book.