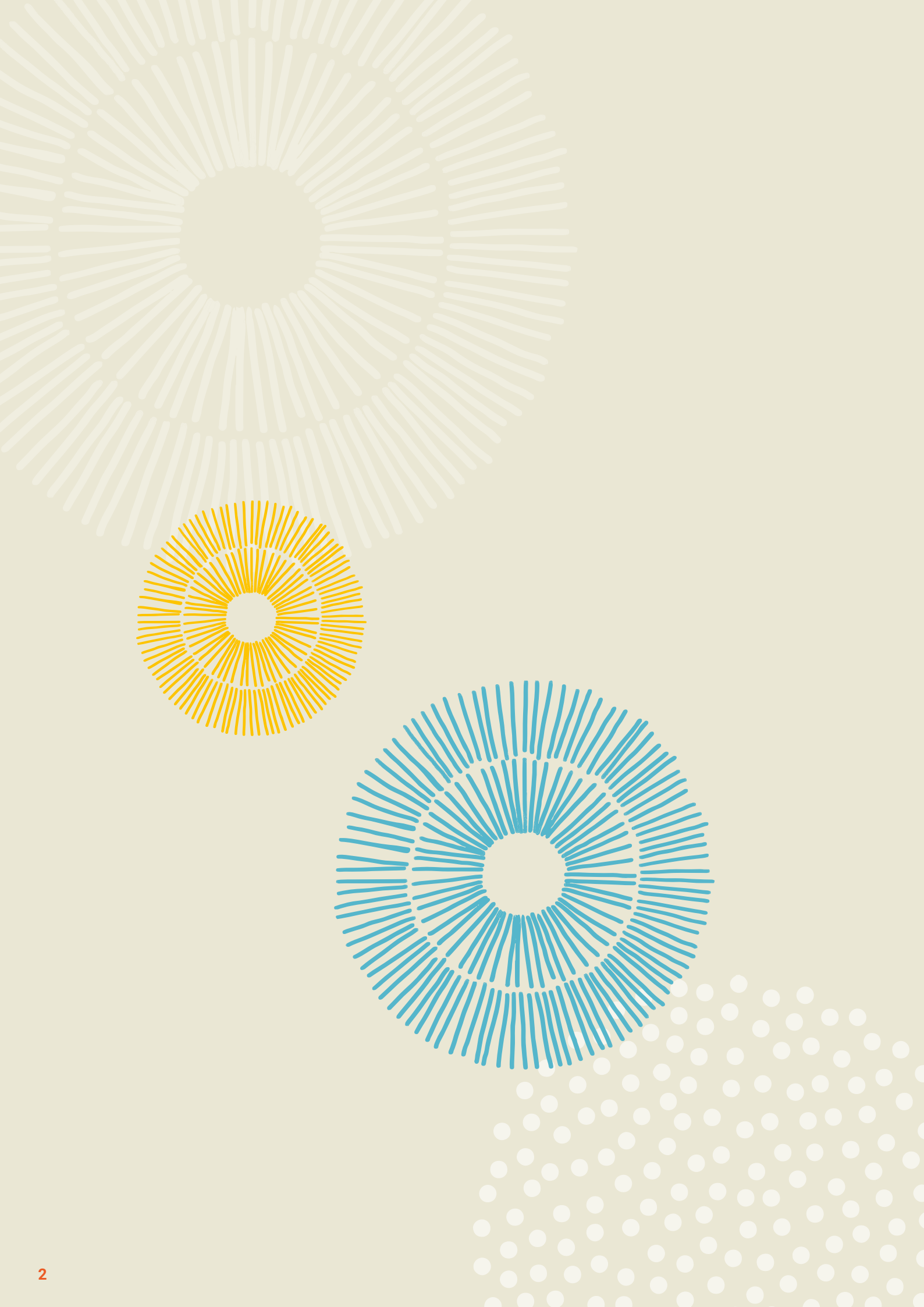
Rapid Review of **Healthy Ageing and Long-Term Care Systems** in East and Southern Africa



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Acronyms

ADCAP	Age and Disability Capacity Programme
ADL	Activities of daily living
AIDS	Acquired immunodeficiency virus
APC	Adult Primary Care
ART	Antiretroviral therapy
ARV	Antiretroviral
BRP	Basic Retirement Pension
CBHI	Community-Based Health Insurance
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CGP	Child Grants Programme
CHE	Current health expenditure
CRP	Contributory Retirement Pension
CSG	Contribution sociale généralisée
CSO	Civil society organization
D-GGHE	Domestic General Government Health Expenditure
DALYs	Disability-adjusted life years
DRC	Democratic Republic of the Congo
DSD	Department of Social Development
EAC	East Africa Community
ECA	Economic Commission for Africa
EEPNA	Ethiopian Elderly and Pensioners National Association
ESA	East and Southern Africa
ESARO	East and Southern Regional Office
GBV	Gender-based violence
GDP	Gross domestic product
GGE	General Government Expenditure
GSAP	Global Strategy and Action Plan on Ageing
GTP	Growth and Transformation Plan
HALE	Healthy life expectancy
HIV	Human immunodeficiency virus
IADL	Instrumental activities of daily living
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICOPE	Integrated Care of Older People
ICSM	Integrated Clinical Services Model
IDP	Internally displaced people
IHR	International Health Regulations
ILO	International Labour Organization

IMF	International Monetary Fund
LENASO	Lesotho Network for AIDS Service Organizations
LMICs	Low- and middle-income countries
LVC	Lay Volunteer Counsellor
MIPAA	Madrid International Plan of Action on Ageing
MOLSA	Ministry of Labour and Social Affairs
MoSD	Ministry of Social Development
MoU	Memorandum of Understanding
NCD	Non-communicable disease
NCPD	National Council for Population and Development
NDoH	National Department of Health
NEPAD	New Partnership for Africa's Development
NGO	Non-governmental organization
NGOCOA-NY	NGO Committee on Ageing at the United Nations Headquarters in New York
NHIF	National Hospital Insurance Fund
NHRI	National Human Rights Institution
NSDP	National Strategic Development Plan
OEWG	Open-Ended Working Group on the Human Rights of Older Persons
OHCHR	Office of the High Commissioner for Human Rights
OPCT	Cash Transfer Programme for Older Persons
PLHIV	People living with HIV
PWDs	Persons with disabilities
RCM-Africa	Regional Coordination Mechanism for Africa
RPSNP	Rural Productive Safety Net Programme
SADC	Southern African Development Community
SCC	Senior Citizen's Council
SCI	Service coverage index
SDG	Sustainable Development Goal
SGA	Stakeholder Group on Ageing
SPAR	State Party Self-Assessment Annual Report
SRH	Sexual and reproductive health
SSA	Sub-Saharan Africa
STI	Sexually transmitted infection
STRiDE	Strengthening responses to dementia in developing countries project
TB	Tuberculosis
UHC	Universal Health Coverage
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNDESA	United Nations Department of Economic and Social Affairs
UNHCR	United Nations High Commissioner for Refugees
UPSNP	Urban Productive Safety Net Programme
VUP	Vision 2020 Umurenge
WGA	Whole-of-Government Approach
WHO	World Health Organization

Foreword

While sub-Saharan Africa is recognized as having a large youthful population accounting for 70 per cent of its population, the rate of increase in the proportion of older persons is significant. The population of older persons is projected to increase from 64 million in 2015 to 107 million in 2030, representing a five-fold increase. As older people will constitute a greater share of national populations, the demand for tailored social, health, housing, and economic services will equally increase, and responsive interventions will be required to ensure a healthy and dignified ageing. Issues of gender inequality and ageism further exacerbate exclusion of older persons, while evidence shows that older people are less able to cope in fragile or emergency settings, including during the COVID-19 pandemic. While this poses new challenges for governments around the continent, the right set of policies and systems can make healthy ageing a reality for all. It requires a whole-of-society approach in incorporating an equally important focus on ageing, ranging from ensuring the absence of disease, to enabling older people to realize their full potential by participating in economic and social activities. The integrated approach across the life cycle will ensure the needs of current and future older populations are met, and that in turn,, societies will benefit from the valuable contributions of both the youthful population and older persons.

In particular, evidence underscores that older people can make significant contributions to social and economic sectors as workers, volunteers, consumers, and taxpayers, as well as providers of a range of unpaid and unseen services to families and communities. Increasing Healthy Life Expectancy makes women live longer, though with disproportionate impact from inequalities, discrimination and violence.

In the 2020-2030 Decade of Action for Sustainable Development, accelerated actions are required to ensure Healthy Ageing is prioritized, and to support the realization of the Agenda 2030, since the United Nations General Assembly proclaimed 2021-2030 the United Nations Decade for Healthy Ageing. It is a call for multisectoral action and a life-course approach to fulfil the needs of people at critical life stages. In a collective effort, the world can, within this decade, accelerate efforts to combat ageism and secure long-term and integrated care for all.

In consideration of these facts, UNFPA's East and Southern Africa Regional Office commissioned a review of Healthy Ageing and Old Age Care in the East and Southern Africa region. The review focused on the readiness and responsiveness of health, social welfare and long-term care systems in the 23 countries in East and Southern Africa to population ageing and the needs of older people in the region, including the sexual and reproductive health and rights of older women.

This review indicates that countries in the region have made great strides in increasing the longevity of their population and made progress in developing legal and policy frameworks on population ageing. It also finds that populations who live into old age have not been well provided for by most governments and are excluded in human capital, economic development, humanitarian emergency, and peace efforts.

The review also highlights critical gaps in the national preparedness to respond to the needs of older people. To ensure actions, the review puts forward policy and programme options on how the gaps can be addressed, while providing new insights on a more holistic approach to ageing. These findings will guide UNFPA in its future efforts on population ageing, and contribute to ongoing policy dialogue by actors on the continent to improve the well-being and quality of life of older people. UNFPA calls on all governments and partners to take bold and targeted steps to invest in both youthful and older population groups to ensure inclusive socio-economic transformation in line with the Sustainable Development Goals and aspirations of Agenda 2063.

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EXPERT REVIEWERS

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UNFPA EAST AND SOUTHERN AFRICA REGIONAL OFFICE (ESARO) PROJECT TEAM

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Executive Summary

This report provides an overview of population ageing and health trends in 23 countries in East and Southern Africa (ESA), and assesses the readiness and responsiveness of health, social welfare and long-term care systems to ageing and the needs of older people in the region. It assesses the state of regional, sub-regional and national frameworks and structures in place to support healthy ageing in six focal countries (Ethiopia, Kenya, Lesotho, Mauritius, Rwanda, and South Africa) and provides a set of recommendations to inform policy development and strategic interventions going forward.

KEY FINDINGS FROM SITUATIONAL ANALYSIS

- Countries in the ESA region are ageing rapidly, and 95.2 million people aged 60+ will reside in the ESA region by 2050. The impact of this trend and the needs of growing populations of older people are still not sufficiently considered in national and internationally driven development initiatives, putting older people at risk of being left behind.
- Women have longer life expectancies than men in the region (and corresponding higher representation of women in older populations in the region), and are particularly vulnerable to poverty, social exclusion and abuse in older age.
- Older people are vulnerable to poverty and struggle more than younger populations to exit poverty, yet social protection for older people in the ESA region remains limited. However, more progress has been made in this regard than elsewhere in sub-Saharan Africa (SSA), with a growing number of countries introducing non-contributory pensions or other cash transfer programmes that are inclusive of older people. For those living in poverty, poor living conditions are especially difficult to cope with in older age, and environmental conditions exacerbate ageing and make it more difficult to function.
- Levels of education are lower among older people than the general population, and older women are most likely to have little to no education, which impacts economic and social participation.
- Ageism is a major challenge in the region, particularly where it intersects with other forms of discrimination and disadvantage such as sexism or ethnic/racial discrimination.

95.2 million people aged **60+ years** will reside in the ESA region by 2050

- While people are living longer in the ESA region, they are not necessarily living in better health or with lower levels of disability, and there is a growing burden of non-communicable diseases (NCDs) and HIV among this population. Despite a growing population of older people, health systems of countries in the region are poorly geared to deal with older people's health needs, and older people struggle to access appropriate health-care services due to costs, physical access and the responsiveness of health systems and health-care staff to their needs.
- The sexual and reproductive health (SRH) of older people is particularly neglected, and older people struggle to, or are afraid to, seek appropriate advice or care, contributing to the growing burden of sexually transmitted infections (STIs) and HIV and AIDS in this group.
- Long-term care for older people is largely provided by the family in the ESA region, and gaps in capacity and quality of care require the development of culturally appropriate systems to provide external services to older people and families, and to support family-based long-term care and including the women who tend to become responsible for providing this care (both young and old).
- Older people are impacted heavily by disaster and humanitarian situations, and are poorly included in planning or carrying out responses. The COVID-19 pandemic has shown up gaps in health system preparedness for, and response to, emergencies in the region, and disruptions in essential health services have had a particular impact on older people with chronic conditions who need ongoing care.

KEY FINDINGS ON REGIONAL AND COUNTRY-LEVEL RESPONSES TO AGEING

Most countries in the region have developed national legislation/policies in response to the Madrid International Plan on Ageing and Health (MIPAA) and the Global Strategy and Action Plan on Ageing (GSAP), and are developing healthy ageing strategies in response to the United Nations Decade for Healthy Ageing 2021-2030. However, there is weak planning, coordination, implementation and management of ageing programmes, and a lack of financial resources for implementation. There has also been little progress on global action plans for dementia and NCDs. In terms of regional frameworks, the African Union Protocol to the African Charter on Human and People's Rights on the Rights of Older Persons in Africa has only been ratified by Lesotho, Ethiopia, Kenya, and Benin,

and the protocol is therefore not in effect. Other African Union frameworks and position statement related to older persons are in place (e.g. long-term care), but action on these frameworks at national level is unclear and likely limited.

There is significant variation in terms of policy development, implementation and programming for older people in the six countries included in this study. Mauritius, with its significantly older population is focusing on ageing as a critical issue for the health and competitiveness of its society and its economy, which provides a good example of a comprehensive and multi-sectoral framework to maximize quality of life for older people. South Africa has a well-established set of policies and programmes for older people across various sectors, but weaker implementation. Kenya has ratified the African Union Protocol on the Rights of Older Persons and developed a rich policy architecture on older persons' issues, but this is not matched by implementation, few programmes are in full operation and inter-sectoral collaboration is weak. Ethiopia has ratified the African Union Protocol on the Rights of Older Persons and has taken steps to develop policies and programmes on ageing, including expanding social protection for older people, but the National Action Plan on Older Persons remains unbudgeted and poorly implemented. Lesotho introduced a universal pension in 2004, showing that lower-income countries can provide social protection to older people, and was the first country to ratify the African Union Protocol, but capacity for implementation needs to be significantly strengthened. Rwanda recently developed a National Older Persons' Policy, but is still in the early stages of developing programmes for older people and social protection provisioning is particularly weak.

KEY RECOMMENDATIONS AND AREAS FOR ACTION

- Develop policies, systems and structures that promote the inclusion of older people and coordinate the ageing response at country level.
- Mobilize resources for older people and apply inclusive budgeting practices across sectors.
- Improve social protection for, and economic inclusion of, older people in the region.
- Strengthen older people's access to essential health services (including SRH services) and culturally-appropriate long-term care.
- Strengthen the inclusion of older people in disaster and health system emergency planning.
- Promote data collection across the lifespan with age and gender disaggregation of data.
- Address issues related to ageism and abuse of older people.

Introduction

Africa is a youthful continent in terms of population structure, but there is a large and rapidly growing population of older people in the region. By 2050, the population of older people (people aged 60+ years) in sub-Saharan Africa (SSA) is expected to increase from 52.1 million to 157.5 million (United Nations Department of Economic and Social Affairs, 2019). Two-thirds of older people in SSA live in East and Southern Africa (ESA)[1], the sub-region which is the focus of this study, and which is ageing particularly rapidly with some countries in Southern Africa (e.g. Mauritius, Seychelles, South Africa, Botswana and Lesotho) having significantly higher proportions of their population over the age of 60 years than elsewhere in SSA.

Despite increasing attention paid to these demographic shifts, development efforts by government and development partners remain largely focused on younger populations, overlooking older people's needs and vulnerabilities, as well their potential to contribute to the social and economic development in the region (Aboderin et al., 2020). There is a significant heterogeneity among older people in terms of their capabilities and corresponding ability to function and participate in economic and social life, nevertheless, all older people are more likely to be left behind in economic and social development. Older people are less likely to be able to exit poverty than other groups, and may experience challenges in accessing health, care and social protection services, and may face labour market exclusion, or abuse, violence and neglect, all of which have been exacerbated by the COVID-19 pandemic (World Health Organization, 2021). The intersection of gender inequality, age-based discrimination and ageist attitudes disadvantage women more than men. Women are more likely to live into old age, but are also more likely to have low quality of life in their later years (Aboderin et al., 2020). Older people are also less able to cope in fragile or emergency settings and given the risk of both natural disaster and conflict situations in the region, many older people in the ESA are exposed to very difficult conditions that considerably diminish their well-being (UNHCR 2021; HelpAge International, 2021).

By 2050, the population of older people in sub-Saharan Africa is expected to increase from **52.1 million** to **157.5 million**

1 In this report East and Southern Africa (ESA) is defined as the 23 countries falling under the purview of the UNFPA East and Southern African Regional Office (ESARO): Angola, Botswana, Burundi, Comoros, Democratic Republic of Congo, Eritrea, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

Several international and regional frameworks have been developed in response to population ageing, including: the Madrid International Plan of Action on Ageing (MIPAA), the United Nations Decade for Healthy Ageing (2021-2030), the Protocol to the African Charter on Human and People's Rights on the Rights of Older Persons, and the African Union Framework and Plan of Action on Ageing, but progress in developing and implementing policy and programmatic responses has been slow.

In the context of rapid ageing and the need to honour commitments to achieving the goals of MIPAA, the United Nations Agenda 2030 and the goals of the United Nations Decade for Healthy Ageing, UNFPA commissioned a rapid assessment of healthy ageing and old age care systems in 23 countries in the ESA region. This rapid assessment describes the patterns and implications of ageing in the ESA region, takes stock of the status of older people in the region (defined by the United Nations as people aged 60+ years), and assesses the state of regional, sub-regional and national frameworks and structures in place to support healthy ageing in six focal countries: Ethiopia, Kenya, Lesotho, Mauritius, Rwanda, and South Africa. Particular attention is paid to the UNFPA's mandate – sexual and reproductive health, HIV and AIDS, human rights, and gender equality – with a view to identifying areas for priority action for the East and Southern African Regional Office (ESARO) as it plans its response to ageing and the needs of older people in the ESA region.

PURPOSE AND SCOPE OF THE STUDY

The study aims to address the following key questions/objectives outlined in the terms of reference via a rapid assessment of the readiness and responsiveness of health, social welfare and long-term care systems in the 23 countries in the ESA region to population ageing and the needs of older people in the region:

1. Population ageing in Africa and in the ESA region — what are the implications for sustainable development.
2. How is the old age care system supporting older people in the ESA region organized, delivered and financed?
    a. In the context of Universal Health Coverage (UHC) and inclusive social protection systems, are health-care systems and complementary protection services able to provide the elderly with accessible, quality and age-appropriate integrated care and support needed to ensure quality of life and well-being?
    b. How are older women cared for in the ESA region? Are the reproductive and sexual health needs of older people met in the ESA region? (i.e., the HIV population needs old-age care, menopause, older persons living with disability, etc.) within integrated approaches?
    c. What are the measures in place to ensure continuity of care and protection services in emergencies (technology, innovation, etc.)?
    d. What is the multi-sectorial coordination mechanism at regional and national levels that ensures appropriate interventions are in place to ensure the dignity, well-being and quality of life for older persons in the ESA region?
3. What are the (preliminary) suggested policy options — institutional, community and family (towards 2030 and beyond)?

RAPID ASSESSMENT DESCRIPTION

This assessment of healthy ageing and old age care systems in the ESA region has been informed by comparative synthesis of existing data and evidence from official global and regional databases and repositories, scientific and grey literature, a review of existing legal and policy frameworks and continental reporting mechanisms, as well as direct stakeholder consultation with regional-level organizations.

Based on these sources of information, the report synthesizes evidence on:

1. The spectrum of relevant policy and advocacy actors in the African region and ESA, and their work on issues related to older persons.
2. Demographic, healthy life expectancy (HALE), disease, and disability profiles for the region using the United Nations Department of Economic and Social Affairs (UNDESA) 2019 data (based on 2020) projections and the World Health Organization (WHO) Global Health Observatory data.

3. Available data on country-level progress in improving systems for the quality of life of older people.
4. Existing policy architectures, programming and institutional arrangements for the six focal countries, as well as at the continental level and in the ESA region.
5. Lived experiences of, and access to, services as described in the literature.

The synthesis of evidence is structured around the three priority areas of the MIPAA (2002): (1) advancing health and well-being into old age; (2) older persons and development; and (3) ensuring enabling and supportive environments. It also incorporates the focus areas of the United Nations Decade for Healthy Ageing 2021-2030, as well as the 2030 Agenda and related Sustainable Development Goals (SDGs).

Data related to relevant SDG indicators, as well as the information on the achievement for 10 indicators for the United Nations Decade for Healthy Ageing (2021-2030) have also been included in the situational analysis, and the evaluation of policy and programmes around health ageing and old age care systems in the region.

The following regional organizations were consulted for this review: WHO African Regional Office, Office of the High Commissioner for Human Rights Southern African Office, African Union Department of Social Affairs African Commission on Human and People's Rights, and HelpAge International. At a national level, input on focal countries was gathered via presentations and personal engagements with government representatives from Kenya, Lesotho and South Africa, and an older persons' organization in Rwanda (Nsindagiza).

FOCAL COUNTRY SELECTION

Six focal countries were selected for the rapid assessment based on the following broad criteria:

1. Capturing of a spectrum of upper middle-, lower middle- and low-income economies based on the World Bank country classifications of 2020.
2. Equal number of member countries of the respective regional economic communities in the East Africa Community (EAC) and Southern African Development Community (SADC).
3. A spectrum of countries with relatively advanced, emerging and nascent country-level policy responses on ageing[2].
4. Inclusion of a country facing a humanitarian emergency (Ethiopia).
5. Inclusion of a small island developing state (Mauritius).

Table 1 shows the six countries selected and their classification in terms of income group, regional economic community and level of ageing response.

2 The classification of countries into advanced, emerging and nascent is based on prior knowledge of country's existing policies and programmes around ageing in the region.

TABLE 1
CLASSIFICATION AND SELECTION OF SIX FOCAL COUNTRIES

Regional Economic Community	World Bank Classification 2021-2022 by income group			
	High-income	*Upper-middle income*	*Lower-middle income*	*Low-income*
EAC	--	--	Kenya	Ethiopia Rwanda
SADC	--	South Africa Mauritius	Lesotho	

Ageing responses: Advanced, Emerging, Nascent

Source: World Bank, 2021

LIMITATIONS OF THE ASSESSMENT

Given the rapid nature of the study, an in-depth analysis of only a quarter (six) of the countries in the region was possible. While focal countries have been selected to maximize variation in terms of context and responses to ageing, the assessment may not fully capture the diversity of responses to ageing in the region. Consultations with stakeholders and key informant interviews have mostly been limited to the regional level and already established contacts of the consultants, meaning mapping of policy and programmatic interventions to support older people at the national level is in some country cases limited to publicly available information. A lack of quality age-disaggregated data or data relevant to ageing, as well as quality peer-reviewed studies on older people in the region also limits the analysis, but is an important finding as it highlights existing limitations in developing evidence-based responses to ageing in the region. The COVID-19 context has changed priorities in relation to ageing, which are discussed but may not be captured fully in this report. While this report draws on literature on other regions on the African continent, it makes few direct comparisons between the ESA region and other regions; and outside of making comparisons regarding demographic data, this report has not engaged with the global literature on ageing outside of what is contained in global reports.

OUTLINE OF THE REPORT

The first section of the report presents a situational analysis of ageing and older people in the region, including: (1) an overview of trends in population ageing and the implications for development; (2) the social and economic position of older people; (3) the health and disability status of older people in the region; and (4) a review of the capacity, responsiveness and suitability of health systems, including long-term care provision, for older people in the region. Section 2 includes an overview of international, continental and regional responses and coordination mechanisms around ageing issues.

Chapter 1: Situational Analysis

1.1 Trends in population ageing in East and Southern Africa and implications for development

While ESA is a youthful region in terms of its population structure, it has a large and growing number of older people. In 2020, there were around 30.5 million people over the age of 60 years living in ESA, representing around 4.9 per cent of the total population in the region. Table 2 summarizes population statistics in the region, comparing with SSA and globally.

TABLE 2

SUMMARY OF POPULATION STATISTICS IN THE EAST AND SOUTHERN AFRICAN REGION, SUB-SAHARAN AFRICA AND GLOBALLY IN 2020 AND 2050

REGION	ESA REGION 2020	ESA REGION 2050	SSA 2020	SSA 2050	GLOBAL 2020	GLOBAL 2050
% Population > 60 years	4.9%	8.1%	4.8%	7.4%	13.5%	21.4%
% Population > 70 years	1.8%	3.1%	1.7%	2.8%	5.9%	11.3%

Source: United Nations Department of Economic and Social Affairs, 2019

The population of older people (people age 60+ years) comprises 4.9 per cent of the total population in the ESA region, which is significantly lower than globally (13.5 per cent), driving perceptions that ageing and older people are not a key concern in the region. This perception overlooks the large absolute number of older people in the region and rapid pace at which ageing is occurring - increased life expectancy is driving population ageing at a faster pace in low- and middle-income countries (LMICs) than has occurred in high income countries, which have had a relatively long lead time to plan for the demographic shift (World Health Organization, 2015).

While older persons' needs and concerns have long been neglected in favour of other development issues (Aboderin et al., 2020), countries in Africa are realising the importance of paying attention to demographic trends and seizing opportunities to invest in policies and systems that can harness Africa's demographic dividend, secure economies against population ageing in the longer-term, and ensure that older people are not left behind in development and that their human rights are protected and promoted. A potential demographic dividend emerges as fertility and mortality rates decline and a greater proportion of the population is of working age, reducing youth dependency, and theoretically increasing opportunities for economic growth (Eastwood and Lipton, 2012). This dividend could be supported and prolonged by investing in health and education systems and encouraging current generations to invest in retirement savings, which could be used to promote growth and reduce the impact on social protection systems as population ageing accelerates.

According to the United Nations World Population Prospects 2019 projections, despite having populations of older people comprising only 4-5 per cent of the population, highly populated countries in the regions have large populations of older people – in 2020 Ethiopia was projected to have 6.1 million older people (29th highest in the world), while the Democratic Republic of the Congo (DRC) had 4.2 million (38th), Tanzania had 2.5 million (52nd), and Kenya had 2.2 million elderly (58th), with these figures increasing significantly as the proportion of older people increases over time (see Figure 1). South Africa, which currently has a higher proportion of older people (estimated to be around 9 per cent) also has a large older population of 5.5 million people, which is expected to increase to around 12 million people by 2050 (United Nations Department of Economic and Social Affairs, 2019).

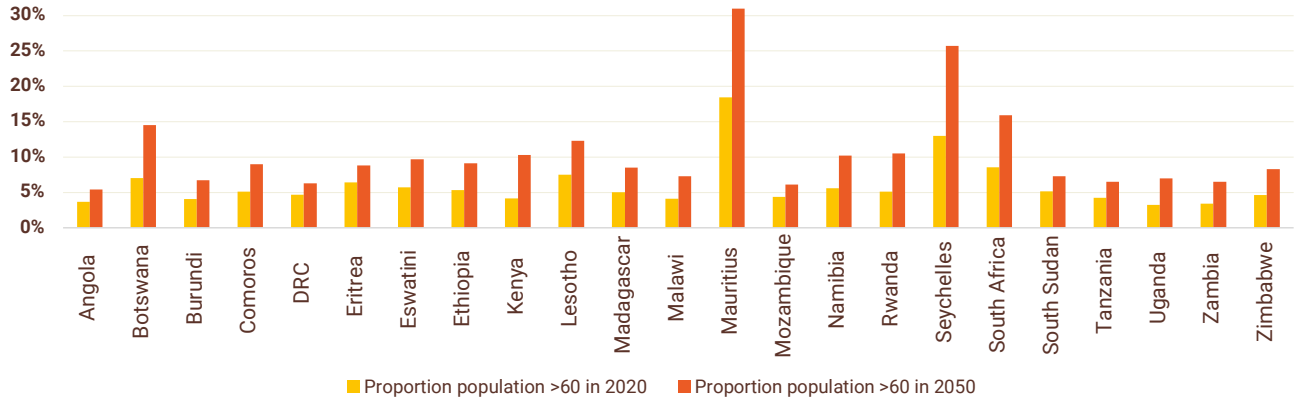
The population of older people in ESA is projected to increase to **95.2 million** by 2050, while the population of older people in SSA will increase from **52.1 million to 157.5 million** by 2050

The population of older people in ESA is projected to increase to 95.2 million by 2050, while the population of older people in SSA will increase from 52.1 million to 157.5 million by 2050, with 60 per cent of the older population in SSA residing in the ESA region. As is shown in Figure 1, the proportion of older people in the populations of Zambia, Seychelles, Rwanda, Botswana, Uganda and Kenya will likely double or more than double between 2020 and 2050. While older people will only represent 8 per cent of the population in 2050 the region (vs. 35 per cent predicted in Europe), this will mean that one of the world's least developed regions — which has made made relatively little provision for the needs of older people — will have the world's third-largest population of older people.

Figure 1 also shows notable variations within the ESA region in terms of population structure with countries such as Mauritius, Seychelles and South Africa having significantly higher proportions of populations over 60 years than countries such as Uganda, Zambia and Angola where less than 4 per cent of the population is over the age of 60 years.

FIGURE 1

PROPORTION OF OLDER PERSONS OF THE TOTAL POPULATION IN EAST AND SOUTHERN AFRICAN COUNTRIES IN 2020 AND 2050

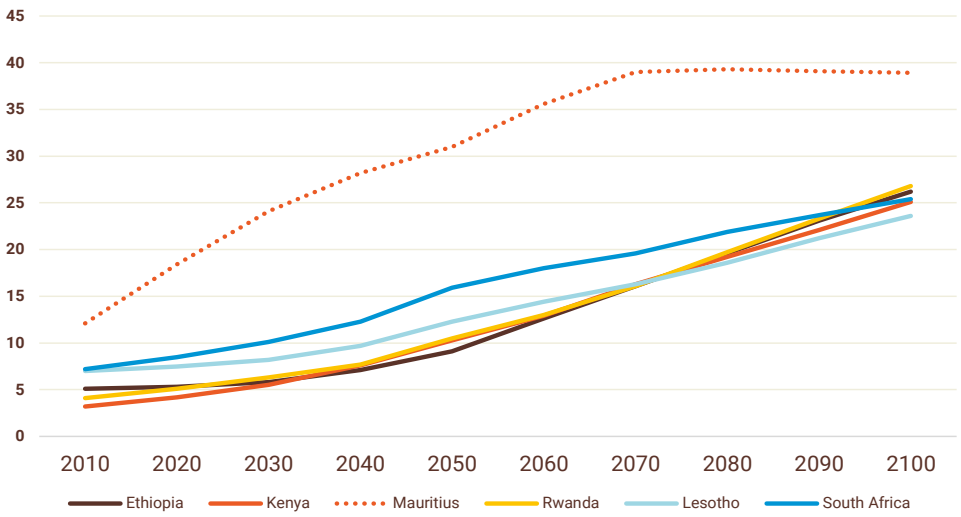


Source: United Nations Department of Economic and Social Affairs, 2019

Figure 2 further emphasizes how rapidly population ageing is occurring in the six focal countries included in this study. This trend is particularly notable in Mauritius where population ageing is at a more advanced stage, and in the next 50 years approximately 40 per cent of the population will be over the age of 60 years. The proportion of older people in the population of South Africa is predicted to increase from just under 10 per cent to 20 per cent over the same period. The proportion of older people in the Kenyan population, which had one of the youngest populations in the region in 2020, with only 4.2 per cent of the population over 60 years, will quadruple to over 16 per cent in the next 50 years, and will have the 39th largest population of older people globally in terms of absolute numbers.

FIGURE 2

AGEING TRENDS OVER TIME IN SIX FOCAL COUNTRIES: PERCENTAGE OF POPULATION > 60 YEARS (BOTH SEXES)



1.1.1 DRIVERS OF POPULATION AGEING

Population ageing worldwide is driven by increases in life expectancy coupled with reductions in fertility rates (World Health Organization, 2015). In the ESA region, population ageing is driven primarily by increases in life expectancy due to reductions in child mortality and mortality from communicable diseases rather than fertility rates. As Table 3 shows, fertility rates in the SSA have not declined as significantly as in other regions – in 2020 the fertility rate in SSA was projected to be 4.6, which is almost double the world fertility rate of 2.5, and only dropped below five children per women for the first time in the 2015-2020 period (United Nations Department of Economic and Social Affairs, 2019).

TABLE 3

SUMMARY OF KEY DEMOGRAPHIC INDICATORS IN THE EAST AND SOUTHERN AFRICAN REGION, SUB-SAHARAN AFRICA AND GLOBALLY

REGION	ESA REGION 2020	ESA REGION 2050	SSA 2020	SSA 2050	GLOBAL 2020	GLOBAL 2050
Median Age[3]	19.5	26.1	18.7	23.9	30.9	36.2
Fertility rate	-*	-*	4.6	3	2.5	2.18
Life expectancy birth	64	71	60.5	68.1	72.3	76.7
Life expectancy 60	17	18.7	16.4	17.8	20.7	23
Old age dependency ratio	5.7	8.4	5.5	7.7	14.3	25.3

Source: United Nations Department of Economic and Social Affairs, 2019

*Cannot calculate for ESA region countries

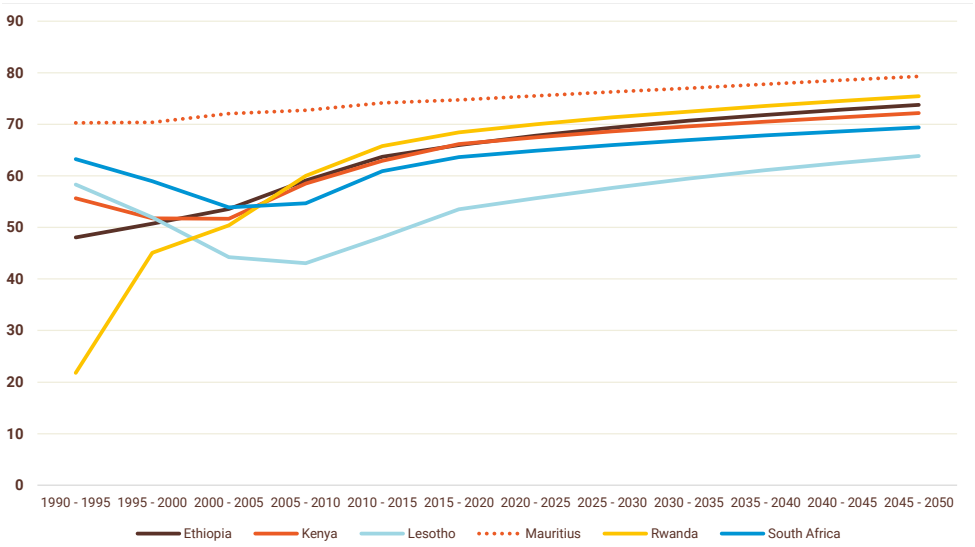
Women tend to live longer than men globally, and the ESA region is no exception – on average, women can expect to live to age 68 years at birth, while men can only expect to live to age 63 years. Average life expectancies at birth for both men and women are expected to increase significantly for both sexes over time (see Table 4). In Mauritius, which has the longest life expectancy in the region, women can expect to live to 79 years (at birth), while men can expect to live to 72 years. In Lesotho, which has the lowest life expectancy at birth in the region, men can expect to live to only 52 years, while women can expect to live to 59 years.

3 The ESA region median age calculated as median of median ages and average of life expectancies of each country. Others are calculated from scratch.

While life expectancy at birth in ESA is much lower than globally due to higher risk of mortality in earlier life, those who live to 60 years can expect to live 17 additional years in old age (18.2 for women and 15.15 for men). Figure 3 shows how life expectancy in the six focal countries has increased over the past 30 years. The significant dips in life expectancy in Lesotho and South Africa can be attributed to the HIV epidemic which hit Southern Africa particularly hard, but which has recovered since antiretroviral therapy (ART) became widely available. Not included in Figure 3 is the short-term impact of the COVID-19 pandemic on life expectancy and population structure given high COVID-19 mortality rates among older people. For example, based on national estimates in South Africa, life expectancy at birth among males dropped from 62.4 to 59.3 between 2020 and 2021, and from 68.44 to 64.6 for females over the same period (Statistics South Africa, 2021). Life expectancy in the country in the absence of COVID-19 or HIV and AIDS is predicted to be 71 (Statistics South Africa, 2021).

FIGURE 3

LIFE EXPECTANCY OVER TIME IN FOCAL COUNTRIES



Source: United Nations Department of Economic and Social Affairs, 2019

Greater longevity among women means that a larger proportion of the 60+ years population in the region is female than male, particularly among older age groups (70+ and 80+ years) (United Nations Department of Economic and Social Affairs, 2019). The feminization of the older population, combined with population ageing more generally, makes it important to pay specific consideration to older women's health, well-being and quality of life, and to address gender inequalities accumulated over the life course that leave older women more vulnerable to poverty, violence and abuse in older age (UN Women, 2017, 2015).

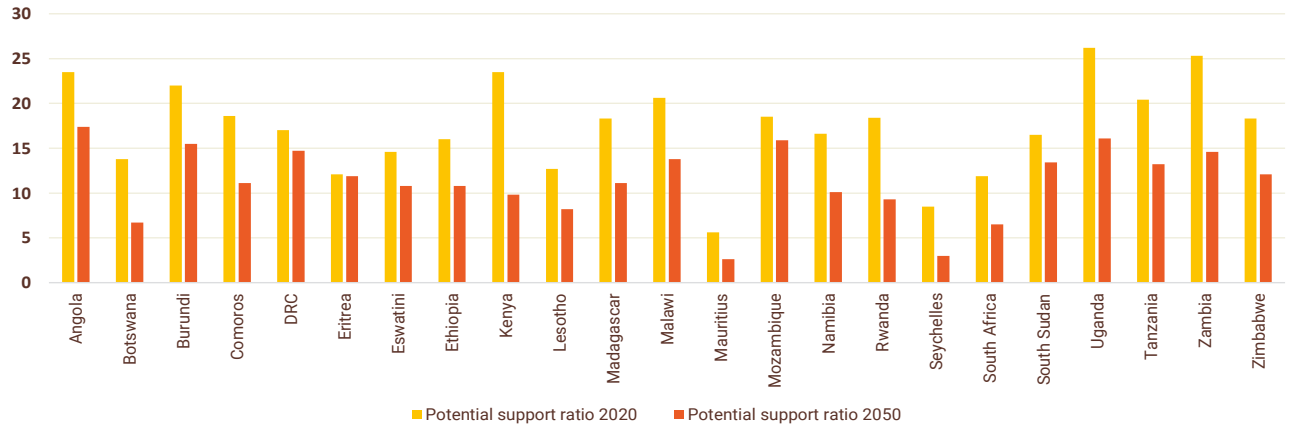
Given persistently high birth rates, the region will still have a significantly larger proportion of children and working-aged people relative to older age groups, or a youth "bulge". Currently younger people present a heavier burden on society than older people and old age dependency ratios are very low compared to globally, with only 5.7 people age 65+ years for every 100 people between 15 and 64 years. By contrast, child dependency ratios are the highest in the world, and there are 74.1 children aged 0 to 14 years for every 100 people aged 15 to 64 years. This explains the current focus on, and prioritization of, young people

in the region. Child dependency ratios in Angola, Uganda and DRC are between 85 and 90 where the global ratio is 39 and as low as 28 in Europe. In this context, older people, and particularly women, make valuable societal contributions via supporting or being primary providers of childcare to grandchildren.

While still comprising a relatively small portion of the population, as Figure 4 shows, by 2050 the potential support ratio (the number of working-age people [aged 15 to 64 years] per person aged 65+ years) will decrease for all countries in ESA between 2020 and 2050. A decrease in the potential support ratio has implications for social welfare and health systems as the number of working age persons supporting older people through taxation, contributions to pension and health schemes and direct transfers falls, which needs to be considered and planned for in terms of the sustainability of pension and health systems, particularly given limited tax bases in most countries.

FIGURE 4

POTENTIAL SUPPORT RATIOS IN THE EAST AND SOUTHERN AFRICAN REGION IN 2020 AND 2050



Source: United Nations Department of Economic and Social Affairs, 2019

1.2 Social and economic status of older people in the East and Southern African region

Older people make valuable contributions to economic, family and community life in ESA, acting as carers, custodians of culture and history, mediators of disputes, farmers and traders — and have been respected for their wisdom, guidance and perceived connection with the ancestors (Alambo and Yimam, 2019; Rademeyer and Maharaj, 2020). However, in the context of rapid urbanization, societal change and poor economic conditions, there is evidence demonstrating that older people's social positioning and family-based support for older people have diminished (Rademeyer and Maharaj, 2020). Without adequate policies, systems and structures in place to protect and promote the rights of older people, older people in the region are highly vulnerable to poverty (Aboderin et al., 2020) and social and economic exclusion and abuse (World Health Organization, 2021).

1.2.1 LEVELS OF POVERTY AMONG AND LIVING CONDITIONS OF OLDER PEOPLE IN THE EAST AND SOUTHERN AFRICAN REGION

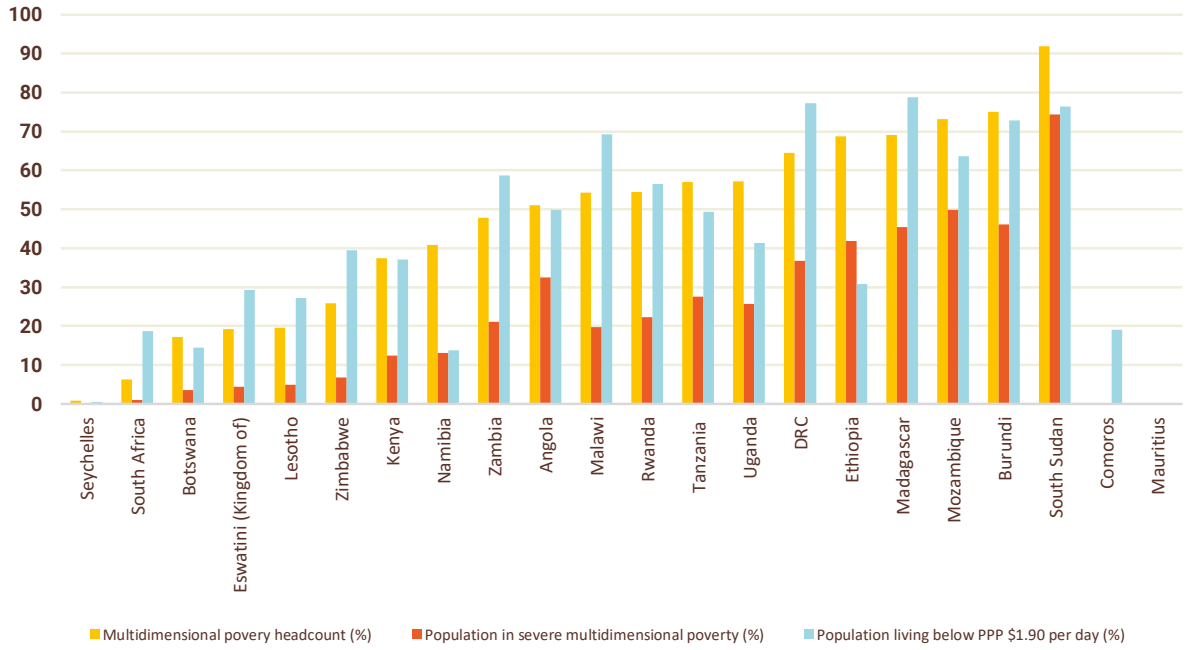
Despite this valuable contribution, poverty rates among older people in the region are high as most have lived a life of poverty working in low-paying informal sector jobs and continue work into old age in difficult, insecure, and often discriminatory conditions, to survive or to support their families (HelpAge International, 2010). As people's capacity or ability to participate in the workforce or earn adequate incomes diminishes with age and decreasing physical capacity, people with insufficient savings and assets are vulnerable to economic insecurity and poverty as they age, and globally about 8.2 per cent of multidimensionally poor people (105 million) are age 60 years or older (United Nations Development Programme and Oxford Poverty and Human Development Initiative, 2021). This effect is even more prominent in poor countries where participation in informal, low-paid labour over the life-course is more common in the working population, and limited social protection systems or other opportunities to exit poverty exist (Aboderin and Ferreira, 2008; Age International, 2015).

> ***"Where poverty is endemic, persons who survive a lifetime of poverty often face an old age of deepening poverty"*** *– Madrid International Plan of Action on Ageing, 2002, paragraph 45 (United Nations, 2002).*

As Figure 5 demonstrates, high rates of extreme poverty exist among the general population in the region. Prior to the COVID-19 pandemic, several countries in the region (e.g. Kenya, Ethiopia and Rwanda) had made great strides in reducing poverty and improving living standards over the past decade, but much of this growth has been concentrated in urban areas rather than in the rural areas where most of the population live. For example, Kenya and Ethiopia have growing digital economies, but both countries have very low levels of urbanization (around 78 per cent of the Ethiopian population and 72 per cent of Kenyans lives in rural areas) and poverty rates in rural areas remain persistently high.

FIGURE 5

PERCENTAGE OF PEOPLE LIVING IN MULTIDIMENSIONAL POVERTY AND EXTREME INCOME POVERTY LINE (SDG 1.1.1)



Source: Alkire et al., 2021 (Data from 2020 for MPI and 2019 for SDG 1.1.1)

There is little age-disaggregated data on poverty rates among older people in the ESA region. However, given low rates of social protection coverage, low levels of education and high rates of lifelong employment in the informal economy (Aboderin, 2010), many older people live in poverty in the region, working for as long as is physically possible in the informal labour market or agriculture, and becoming increasingly reliant on informal social support systems in older age. Global evidence shows that the risk of poverty is higher among older age cohorts as the "oldest-old" are more likely to have depleted their savings and are less likely to be able to participate in income generating activities (United Nations Department of Economic and Social Affairs Programme on Ageing, n.d.)

Data compiled by Aboderin et al. (2020) from Democratic and Health Surveys demonstrates that in the countries where data is available, almost half of older people fall into the bottom two wealth quintiles, with poverty concentrated mainly among rural populations (where older people tend to live) and where levels of poverty and precarity are particularly high due to the vulnerability to climatic shocks and related food insecurity. Poor infrastructural development, particularly in rural areas results in poor living conditions which are particularly challenging for older people. Older people in countries where social (non-contributory) pensions are widely or universally available are, in principle, less vulnerable to poverty, and disparities in poverty levels between age groups are less marked in Southern Africa than in other parts of Africa where there are lower rates of pension coverage (Lloyd-Sherlock and Amoakoh-Coleman, 2020).

Older women are particularly vulnerable to poverty due to lower levels of labour market participation over their adult life, levels of education and land ownership relative to men, as well as inequalities in inheritance practises. However, women may also have closer ties to younger-kin than older men, and may receive more resources and care from family in reciprocation for care provided, implying that gender differences in economic status may not be as clear-cut as is often assumed (Aboderin et al., 2020; Knodel and Ofstedal, 2003; Sabates-Wheeler et al., 2020).

Access to social protection and levels of financial inclusion

One of the contributing factors to high rates of poverty among older persons is the lack of access to pensions, particularly in a context where informal social protection systems are weakening (HelpAge International Tanzania, 2019). While globally, pensions are the most widespread form of social protection with 78 per cent of older people receiving pensions globally, only 20 per cent of people above statutory retirement age in countries SSA are currently receiving an old age pension (International Labour Organization, 2021). Except for countries in Southern Africa (where only 40.2 per cent of employment is in the informal sector), the vast majority (89.2 per cent) of employment SSA is in the informal sector (International Labour Organization, 2018), putting contributory pension programmes in reach of only a select few (usually public sector employees).

More women participate in the informal than the formal labour market than men in the region (92.1 per cent vs. 86.4 per cent) and are therefore less likely to contribute to contributory pension programmes than men (International Labour Organization, 2018). Furthermore, a very small portion of the current working age population (6 per cent), many of whom are unemployed or working in the informal labour market, are active contributors to formal contributory schemes (International Labour Organization, 2021), meaning that unless universal or means-tested non-contributory pensions are introduced more widely, the exclusion of older persons from social protection is likely to persist into the future.

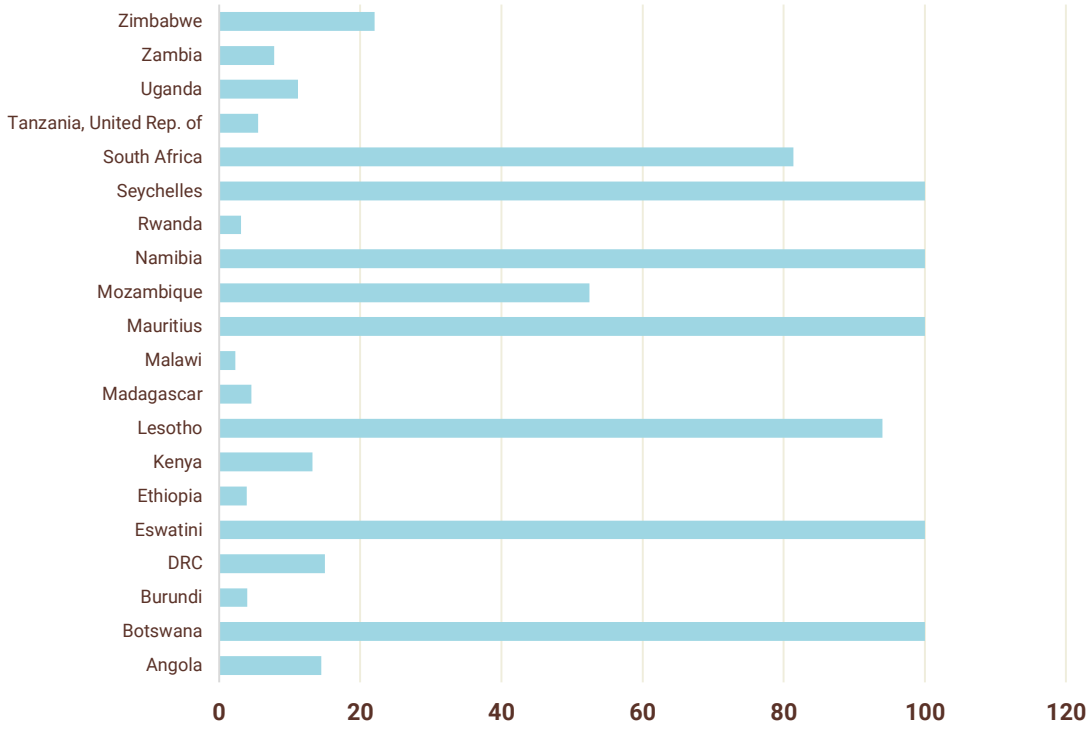
Effective social protection coverage for older people is one of the contributors to SDG Indicator 1.3.1 (proportion of population covered by social protection floors/system) and Figure 6 shows this coverage across the region as of 2020 (International Labour Organization, 2021). Southern Africa has the highest coverage in SSA, due to the availability of non-contributory old age pensions in Seychelles, South Africa, Mauritius, Botswana, Eswatini, Namibia, and Lesotho. These programmes are nationally funded, indicating their institutionalization and likely permanence with governments spending a significant portion of their social protection budgets on older people.

Social protection provision in most of Eastern Africa is limited to contributory or civil servant schemes, and national governments have lagged behind in terms of introducing social assistance for older people. However, Kenya, Uganda, and the Tanzanian archipelago of Zanzibar have recently introduced universal old age pensions, albeit with a high age of eligibility (80 years in Uganda and 70 years in Zanzibar and Kenya).

While globally, pensions are the most widespread form of social protection with **78 per cent** of older people receiving pensions globally, only **20 per cent** of people above statutory retirement age in countries SSA are currently receiving an old age pension *(International Labour Organization, 2021).*

FIGURE 6

EFFECTIVE COVERAGE (%) OF OLD AGE PENSIONS IN EAST AND SOUTHERN AFRICA



Source: International Labour Organization, 2021

While non-contributory pensions and cash transfers including older people as a targeted group are increasing in the region, the funds older people receive through these programmes are often too small to lift older people out of poverty or to even survive on (HelpAge International, 2019b), particularly where pensions are a primary source of household income. In the context of high rates of working poverty and unemployment among younger groups in the ESA region (International Labour Organization Regional Office for Africa, 2020), older persons are often financially supporting multiple youth dependents in multi-generational households (Burns et al., 2005; Kimuna and Makiwane, 2007; Lloyd-Sherlock et al., 2018a; Schatz and Ogunmefun, 2007; Tanga, 2008). Although pension sharing may reduce the impact of social protection programmes on alleviating poverty among older people as individuals, research has shown that it still has a significant impact on perceived quality of life among older people and improves the status and decision-making capacity of older people within households (Ralston et al., 2019; Tanga, 2008), and may make it easier for older people to negotiate access to care and support in intergenerational relationships (Button and Ncapai, 2019).

While there is a strong need to increase social protection coverage for older people in the other 11 countries in the ESA region, non-contributory pension systems in countries with well-established systems need to be carefully managed to be sustainable in the face of growing populations of older people. In Lesotho and Eswatini, universal pensions are the main social protection schemes available, and social protection spending is heavily concentrated on this single category of people to the exclusion of other vulnerable groups. This has generated criticism about targeting inefficiencies and the crowding out of social protection programmes for other groups as the number of older people grows (Schubert, 2020). In addition, in Mauritius and Seychelles where population ageing is at a more advanced stage (older people comprised 18 per cent and 13 per cent of these respective populations in 2020), the sustainability of pension systems may need to be revisited. In response to population ageing, Seychelles (which has the longest life expectancy in SSA) will increase the mandatory pension contribution from April 2022 and retirement age will be pushed back from 63 to 65 years in 2023.

1.2.2 LEVELS OF EDUCATION AMONG OLDER PEOPLE IN THE EAST AND SOUTHERN AFRICAN REGION

Given historically poor access to education among people in SSA, older people tend to have lower levels of educational attainment than the younger population (Aboderin et al., 2020). While this has improved over time, levels of educational attainment remain persistently lower in some parts of the region than others. For instance, in Ethiopia 86.5 per cent of older people have had no education. Even where education among the older population has improved, educational attainment is mainly limited to primary school – for example, in South Africa only 40 per cent of older people have achieved secondary school education (Aboderin et al., 2020). Older women also have lower levels of education than men, including in countries with higher overall levels of education (Aboderin et al., 2020). Low levels of education contribute to limited income earning opportunities to inability to access the formal labour market, resulting in a lack of opportunities to contribute to formal pension schemes or other forms of savings, and making it more likely that older people will rely on non-contributory pensions or cash transfers for financial support in old age. There is also a significant association between levels of education and poverty and health in old age (Carmel, 2019; Ross and Wu, 1995).

For instance, in Ethiopia **86.5 per cent** of older people have had no education.

In an increasingly digitalized world, low levels of education limit access to information, resources and opportunities, and deepen the "digital divide" between younger and older generations who have lower use of internet use and technological engagement than younger age groups due to skills deficits (AARP International, 2017). Older people are often regarded as less profitable or deserving beneficiaries for educational or vocational training, and are therefore less likely to be afforded opportunities for learning and skills development than younger groups (HelpAge International, 2010), making it difficult to bridge these gaps and making it more difficult for older people to participate in economic and social life. Low levels of financial and digital literacy are among the factors contributing to the exclusion of older people from financial services (Demirguc-Kunt and Klapper, 2012).

1.2.3 AGEISM AS A BARRIER TO SOCIAL INCLUSION

Ageism refers to the "stereotypes, prejudice and discrimination directed towards others or oneself based on age and includes stereotypes, prejudice and discrimination that are manifested at the institutional level, in interpersonal dynamics or self-directed" (World Health Organization, 2021). Ageism may intersect with, and reinforce, other forms of discrimination and patterns of disadvantage, the effects of which are exacerbated in old age. For example, in South Africa, the legacy of apartheid has created significant racially structured inequality in socio-economic status among older people. While older white people tend to be relatively wealthy and have private pension savings and access to private health care, black people (whose educational and employment opportunities were severely constrained by the apartheid system) were unable to save for old age and are now dependent on state pensions and an under-resourced health system (Lehohla, 2014). The Report of the Independent Expert on the enjoyment of human rights by older persons on her mission to Mauritius (A/HRC/30/43/Add.3) noted that certain communities and ethnic groups, such as the Creoles, remain significantly disadvantaged in the enjoyment of economic, social and cultural rights, in spite of the implementation of a range of measures benefiting the most disadvantaged segments of the population. Women across the region are also particularly vulnerable to social and economic exclusion given their unequal access to education, employment and resources over the life course and a corresponding lack of savings and assets, as well as being subject to physical, financial and verbal abuse and gender-based violence (GBV) (UN Women, 2015).

In the ESA region, resource constrained contexts with large youth populations, such as LMICs, the prevalence and effects of ageism are highly visible, with effects on the social and economic inclusion of older people, as well as their access to health. Labour market discrimination in the form of mandatory retirement ages or hiring practices are common in the region, with the justification being the opening of opportunities for younger people. In Kenya, Lesotho, Ethiopia, and Rwanda there is mandatory age-based retirement in place to ensure that younger people have access to employment opportunities, and in Rwanda there have been recent calls to lower retirement age to 55 years, terming the current age of 60 years as "unfair to fresh graduates" (Mbaraga, 2018).

A study on ageist attitudes using World Values Survey data, shows that of the six African countries included in this study, 85 per cent of respondents held moderately or highly ageist attitudes (Officer et al., 2020; World Health Organization, 2021). While there are no other studies that focus on the prevalence of ageism in the ESA region, there are a few studies that highlight ageism in health-care settings and document abuse and neglect of older people, which are discussed in Section 1.4.2.

1.3 Health and disability status of older persons in the East and Southern African region

While people in ESA are living longer, they are not necessarily living out their old age in better health. An epidemiological transition is occurring concurrently to the demographic transition in SSA and is characterized by an increasing burden of non-communicable diseases (NCDs), particularly among older people (Bigna and Noubiap, 2019; Mudie et al., 2019). Health in older age is strongly tied to social and economic status over the life course, as well as the environment, with poor health leading to lower quality of life and level of well-being together with higher levels of disability amongst older people (Pillay and Maharaj, 2013; World Health Organization, 2015).

Further, older people commonly suffer from multiple health conditions, particularly those who are socioeconomically disadvantaged (Barnett et al., 2012; Marengoni et al., 2011) as poverty and poor living and working conditions conditions through the life course accumulate and significantly exacerbate the degenerative effects of ageing (Pillay and Maharaj, 2013), leading to higher levels of depression and anxiety and lower self-rated health (Kelly et al., 2020; Phaswana-Mafuya et al., 2013). Rural residence is associated with lower quality of life and shorter life expectancy with high proportions of older people experiencing poor nutrition, resulting in poor energy levels, as well as mental distress and suicidal ideation (Legesse et al., 2019; Sweetland et al., 2019; Zelalem et al., 2020).

While older age does not imply dependence, there is a strong link between a high prevalence of chronic disease, disability and ageing, and an increase in the care burden, which has significant implications for economic, health and social systems (Chatterji et al., 2015).

Table 4 illustrates the differences between life expectancy and HALE at age 60 years in the ESA region compared to elsewhere in SSA, as well as globally. Given that life expectancy at 60 years is 18.2 for women and 15.5 for men in the ESA region, women will live on average five years of their remaining years after age 60 years in ill-health, while men will live fewer years but only four years in ill-health, equating to around a quarter of years lived after 60 years for both genders. While the proportion of years lived in ill-health in the region is not significantly higher than globally, it has significant implications for under-resourced and overburdened health systems in the region as the older population and the need for health and social care grow in tandem.

TABLE 4

LIFE SPENT IN ILL-HEALTH AFTER 60 YEARS, CALCULATED BASED ON HEALTHY LIFE EXPECTANCY AND LIFE EXPECTANCY AT AGE 60

REGION	UNFPA ESA REGION[4]		WHO AFRICA REGION		WHO GLOBAL REGION	
	Male	Female	Male	Female	Male	Female
Life expectancy age 60	15.5	18.6	16.7	19.0	19.5	22.7
HALE age 60	11.5	13.7	12.6	13.9	15.8	16.6
Life spent after age 60 in less than full health	4	4.9	4.1	5.1	3.7	6.1

Source: World Health Organization, n.d. (Global Health Observatory - Data from 2019)

Table 5 shows data for HALE and years spent in ill-health for focal countries in this study. Except for Lesotho, which has the lowest life expectancy and HALE in SSA, figures for other focal countries are above the ESA region average.

TABLE 5

HEALTHY LIFE EXPECTANCY AND YEARS SPENT IN ILL-HEALTH IN SIX FOCAL COUNTRIES

COUNTRY	LIFE EXPECTANCY AGE 60 YEARS		HEALTHY LIFE EXPECTANCY AGE 60 YEARS		YEARS SPENT AFTER 60 YEARS IN LESS THAN FULL HEALTH	
	Male	Female	Male	Female	Male	Female
Ethiopia	17.4	19.4	13.3	14.4	4.1	5.0
Kenya	16.0	19.1	12	14	4.0	5.1
Lesotho	11.2	15.2	8.3	11	2.9	4.2
Mauritius	18.5	22.0	13.3	15.6	5.2	6.4
Rwanda	16.7	19.2	12.7	14.4	4.0	4.8
South Africa	17.3	20.5	12.7	14.8	4.6	5.7

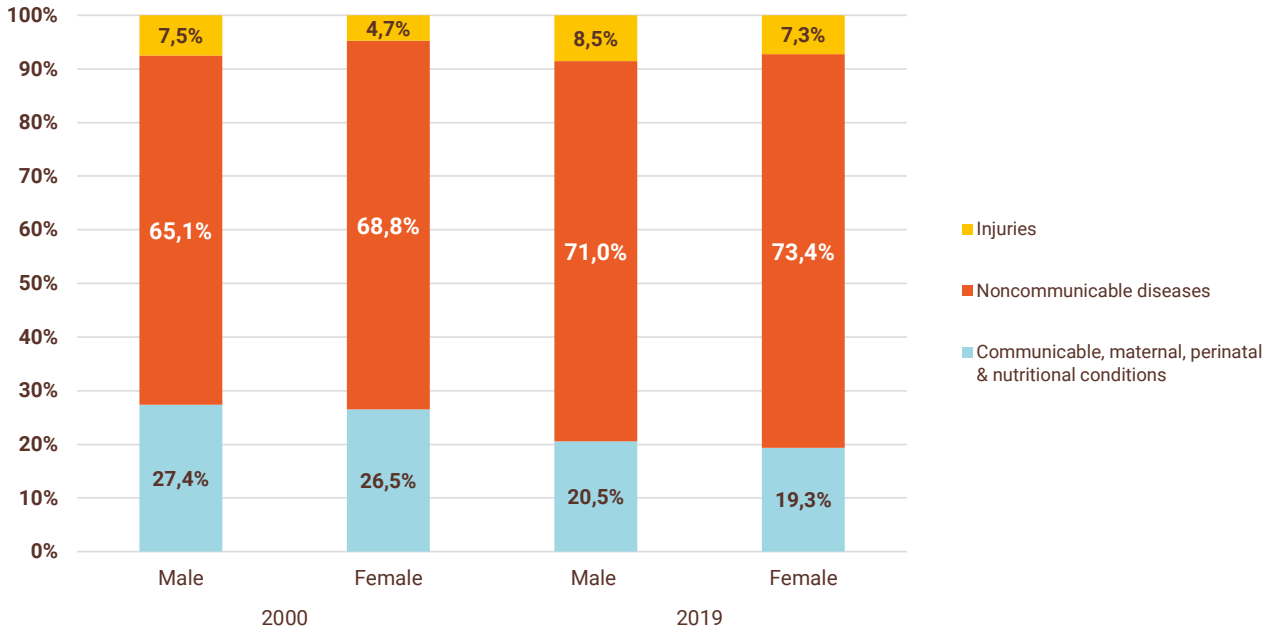
Source: World Health Organization, n.d. (Global Health Observatory - Data from 2019)

Alongside a demographic transition, the region is experiencing an epidemiological transition with NCDs becoming an increasing driver of death and disability, driven primarily by dietary risks, physical inactivity, high blood pressure, and smoking (Langer et al., 2015). As Figure 7 indicates, NCDs are becoming an increasing contributor to Disability Adjusted Life Years (DALYs), particularly among women. Older people comprise, a significantly higher proportion of the disease burden in terms of DALYs and NCDs have increased as a proportion of DALYs over the past 20 years (Mudie et al., 2019).

4 *ESA region calculated as average

FIGURE 7

DISABILITY-ADJUSTED LIFE YEARS IN THE EAST AND SOUTHERN AFRICA REGION IN 2000 AND 2019



Source: World Health Organization, 2020a (Global Health Estimates)

Existing international data estimates that globally around 46 per cent of people over 60 years live with one or more disabling conditions (Ageing and disability | United Nations Enable, n.d.), although the impact of these conditions on independence and function is difficult to establish from either subjective or objective measures, and will vary by context and from person to person. Data on disability prevalence and needs across all age groups is sparse and inaccurate in the African region, due to complexities and varying approaches in measuring disability in censuses and surveys. However, it is clear across multiple studies (including in the ESA region) and using multiple instruments to measure disability, that disability increases with age and is more prevalent among poor people (World Health Organization and World Bank, 2011; Day et al., 2020; Mwanyangala et al., 2010).

National studies on living conditions of people with disabilities in Namibia, Zambia, Malawi, and Zimbabwe have shown large gaps in service provision for people with disabilities (World Health Organization and World Bank, 2021). The high rates of disability among older groups in low-income settings, combined with poor service provision, low awareness of health-related conditions, absence of health seeking behaviour (e.g. avoidance of formal health facilities) and poor access to assistive devices (which can improve functional capacity and ability to participate in economic and social life), has considerable implications for older persons' ability to participate effectively in social and economic life and to access services and information in the region.

As populations age in the region, there is also likely to be a growing burden of Alzheimer's and other forms of dementia, but very little data on dementia prevalence is available. One systematic review, which modelled dementia prevalence rates in Africa based on existing studies estimated that around 2.4

Existing international data estimates that globally around **46 per cent of people over 60 years** live with one or more disabling conditions

(Ageing and disability | United Nations Enable, n.d.)

per cent of people over 50 years had dementia, with prevalence increasing in older age groups up to around 13 per cent in the 80+ years age group and higher rates among women than men (George-Carey et al., 2012). It is estimated that globally 75 per cent of people with dementia are undiagnosed, with many of these people living in LMICs (Akinyemi and Oguntiloye, 2021). Low awareness, stigma and barriers to services interfere with diagnosis and care, and results in the ostracising of older people or even accusations of witchcraft resulting in violence against women in some communities in the ESA region. Some studies have found that some health-care workers also believe in supernatural causation of mental health disorders and dementia (Alzheimer's Disease International, 2019; Brooke and Ojo, 2020; Kamoga et al., 2019; Musoke et al., 2021; Spittel et al., 2019). Poor training of health-care workers on dementia results in hesitancy to make diagnoses and fatalistic attitudes towards managing cognitive decline (Akinyemi and Oguntiloye, 2021; Musyimi et al., 2021). People living with dementia require significant care and support, which can be stressful and difficult for caregivers (Gurayah, 2015). A lack of government and community support or adequate facility-based care for families and caregivers of people with dementia exacerbates or adequate facility-based care, exacerbates an already significant caregiver burden and may result in poor quality care, neglect or abuse (Kakongi et al., 2020; Musyimi et al., 2021). Women experience a double burden: they are at higher risk of dementia as they grow older (a three-fold risk compared to men) and are also likely to be the main caregivers for people with dementia as partners, daughters and daughters-in-law (particularly in developing countries) (Erol et al., 2015). See Box 1 for a discussion of other gender inequalities in health and disability status.

BOX 1

GENDER INEQUALITIES AND HEALTH AND DISABILITY STATUS

Although longevity is higher among women, they are likely to spend more years in poor health and disability with lower quality of life and higher levels of dependence (Carmel, 2019). Various studies confirm that women suffer more than men from limitations in physical functioning in old age, such as reduced capacity to perform Activities of Daily Living (ADL) and Instrumental ADL (IADL), and frailty (WHO, 2015) (Langer et al., 2015). Women are more likely to report higher levels of disability and lower self-rated health and quality of life (Gómez-Olivé et al., 2010; Mwanyangala et al., 2010; Kyobutungi et al., 2010), while a higher level of education is associated with higher quality of life and better health status (Gómez-Olivé et al., 2010; Mwanyangala et al., 2010). Women are more likely to outlive their partners and live alone or experience loneliness than men, leading to inequalities in health status, including higher levels of depression and anxiety among women (World Health Organization, 2015).

Older women have been much more affected by the HIV and AIDS epidemic than men, both in terms of rates of HIV infection, which are higher among women than men (Kyobutungi et al., 2009) and because of the care responsibilities older women have had to assume in the face of the epidemic (Kyobutungi et al., 2009).

The impact of both cumulative and intersecting forms of discrimination leave older women in a position of social and economic disadvantage relative to men (HelpAge International, 2017b). Globally, older women do not have the same access to health care as men or younger women due to lower financial status, lower levels of access to health security schemes and low levels of literacy (World Health Oorganization, 2007). In Ethiopia, for example, gender disparities are clear from routine health information system data which show that women tend to receive health services less frequently than their male counterparts, possibly compromising their quality of life (Ministry of Health Ethiopia, 2021). Possible reasons for poor service utilization are most likely related to women's limited decision-making power in a highly patriarchal society. For example, women may need permission to visit a health facility, obtain money for treatment or be unwilling to (or not allowed to) travel to or visit a facility alone (Ministry of Health Ethiopia, 2021). The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)'s general recommendation no. 27 on Older Women and Protection of their Human Rights notes the following with regards to inequalities regarding older women's access to health care:

> *Older women's right to self-determination and consent with regard to health care are not always respected. Social services, including long-term care, for older women might be disproportionately reduced when public expenditure is cut. Post-menopausal, post-reproductive and other age-related and gender-specific physical and mental health conditions and diseases tend to be overlooked by research, academic studies, public policy and service provision. Information on sexual health and HIV/AIDS is rarely provided in a form that is acceptable, accessible and appropriate for older women. Many older women do not have private health insurance, or are excluded from State-funded schemes because they did not contribute to a scheme during their working life in the informal sector or providing unpaid care. (Convention on the Elimination of All Forms of Discrimination Against Women, 2010)*

1.4 The capacity, responsiveness and suitability of health systems for older persons

All people have the right to health, and national governments have the responsibility to offer safe, accessible, affordable, and quality health care, including assistive and palliative care, for all people, without discrimination. Given the increased risk of multiple chronic conditions, along with increased disability and frailty, an ageing population is likely to bring an increasing number of people who need health and long-term care. This is generally associated with rising demands on health and long-term care systems, making it important to focus on promoting healthy ageing to avoid growing costs (World Health Organization, 2020b).

1.1.1 UNIVERSAL HEALTH CARE COVERAGE AND HEALTH SPENDING

To preserve health and functional capacity and reduce the risk of disability in older age, access to primary care services is important and therefore a central component of the Global Strategy and Action Plan on Ageing (GSAP) 2016-2020 and the United Nations Decade for Healthy Ageing 2020-2030 strategy. However, access to health services is poor among many countries in the region and older people face particular challenges in accessing the services they need.

UHC is one of the key SDG targets for health (Target 3.8) and is defined as:

> ***"Ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship."***

UHC is measured in terms of coverage of essential health services (SDG Indicator 3.8.1) and the coverage of financial protection for health which is measured by the incidence of catastrophic health spending at >10 per cent or >25 per cent of household income (SDG Indicator 3.8.2).

In terms of the country-level service coverage index (SCI), countries in the region perform poorly with 48 per cent providing levels of service coverage of below 50 per cent, with Seychelles having the highest score of 70 per cent. However, there has been significant progress in terms of increasing UHC in all countries in the region over the past 20 years, and Table 6 provides the SCI scores since 2000 for the six focal countries included in this study.

TABLE 6

SERVICE COVERAGE INDEX SCORES FOR SIX FOCAL COUNTRIES

COUNTRY	2019	2017	2015	2010	2005	2000
Ethiopia	38	37	37	31	20	16
Kenya	56	54	52	47	37	30
Lesotho	48	48	46	43	33	27
Mauritius	65	64	63	57	52	43
Rwanda	54	55	53	45	31	23
South Africa	67	66	64	58	47	36

Source: World Health Organization, n.d. (Global Health Observatory - Data from 2000-2019)

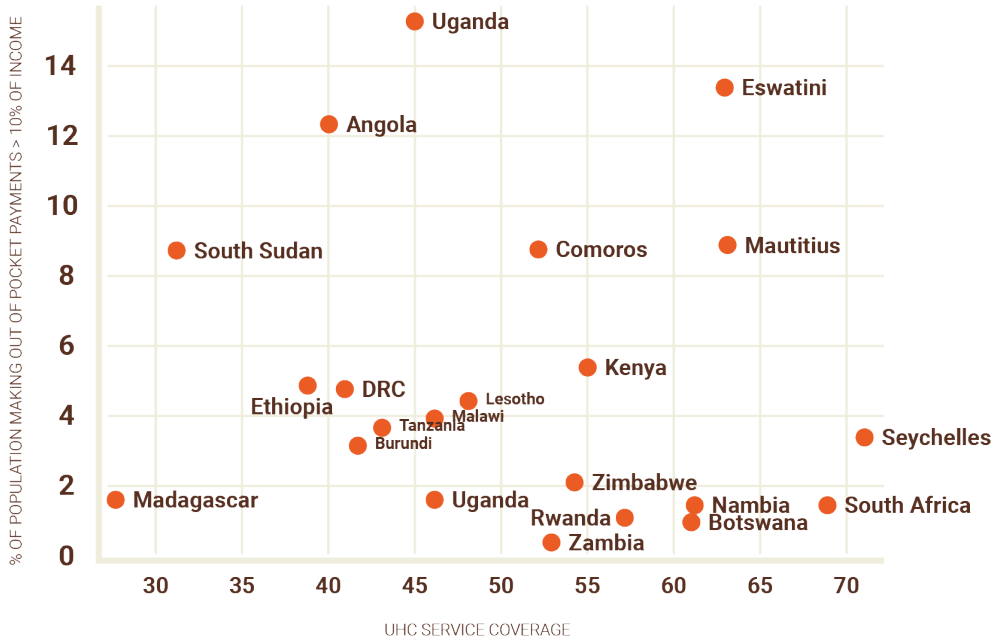
Private and government health insurance coverage among older persons is low in SSA. Catastrophic health spending is a major poverty risk, and given the increased risk of morbidity in old age, high out-of-pocket costs are particularly relevant to older people. Globally, people living in older households or households with higher old-age dependency ratio face the highest incidence of catastrophic health spending, as tracked by SDG Indicator 3.8.2 at the 10 per cent threshold across all income groups and United Nations regions (World Health Organization and World Bank, 2021). In the WHO African region, older households have the highest rate of catastrophic health spending (more than 10 per cent of income) among household types at 12.9 per cent (World Health Organization and World Bank, 2021).

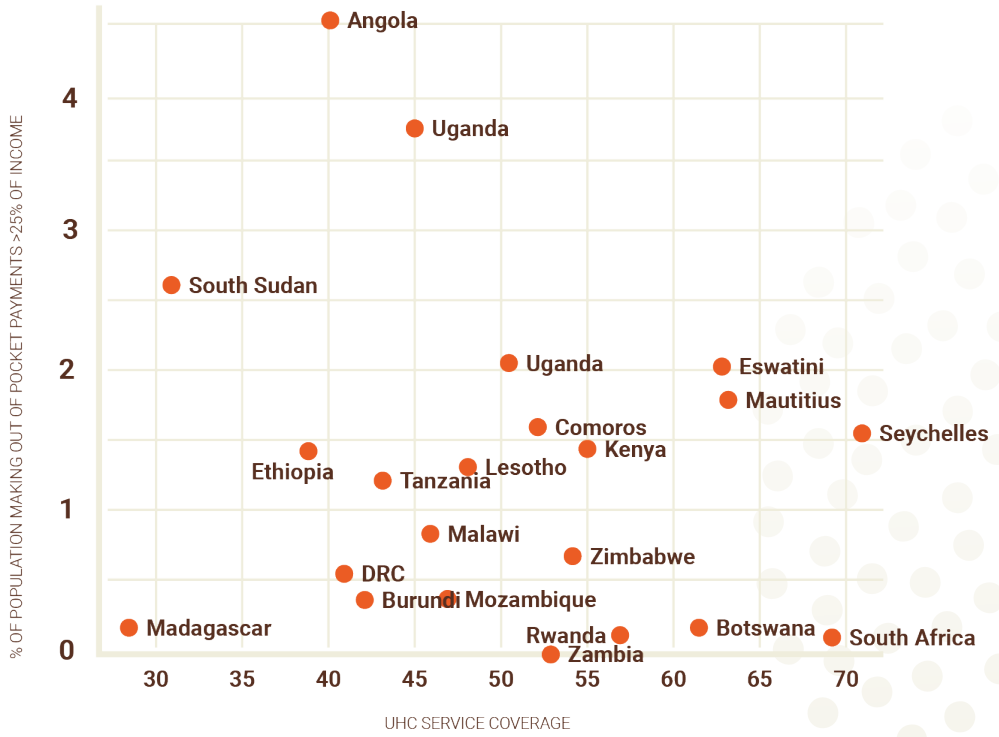
Incidences of catastrophic health spending are relatively low in the WHO African region compared with regions globally. This does not necessarily reflect better financial protection in countries where service coverage is also low (rather, it is a reflection of very poor access to services) (World Health Organization and World Bank, 2021).

Figure 8 maps UHC SCI against the proportion of households spending >10 per cent or greater than 25 per cent of their incomes on health in the ESA region based on 2017 data. Eswatini, Angola, South Sudan, and Uganda (15 per cent) stand out as having particularly high percentages of people spending more than 10 per cent of their incomes on health-care costs, and this situation has worsened over time in Angola and South Sudan, where levels of service coverage are also particularly low (World Health Organization and World Bank, 2021).

FIGURE 8

UNIVERSAL HEALTH COVERAGE SERVICE COVERAGE INDEX AND HEALTH SPENDING AS A PROPORTION OF INCOME IN THE EAST AND SOUTHERN AFRICAN REGION





Source: World Health Organization, n.d. (Global Health Observatory - 2017 SCI data and 2017 or latest available data on catastrophic health spending)

According to the International Labour Organization (ILO) World Social Protection Report, only 15.7 per cent of people are covered by a social health scheme in SSA compared with 66 per cent across the world, and below the 16.7 per cent average in low-income countries (International Labour Organization, 2021).

Several countries in the region have made provision for free or reduced costs for older people or via initiatives such as community-based health insurance. Ethiopia and Rwanda have made considerable progress in UHC through solidarity-based community-based health insurance, with contributions based on household income as identified by community-based committees. Older people in community health insurance programmes, while included in the Kenyan older persons' cash transfer programme, are eligible for national hospital insurance. However, in practice, older people may either be excluded from targeting, may struggle to contribute to these schemes, or must pay separately for the medication they need. Despite policies to reduce costs of care to older people, out of pocket expenditure on health remains high (due to lack of compliance by providers and lack of availability of supplies, equipment and medication) and is a barrier to access. In one study, older people in Mozambique, Tanzania, Ethiopia, and Zimbabwe were less likely to seek health services because of competing financial priorities and even where health-care services were free, transportation costs and the cost of medication were major deterrents to seeking health care even where health-care services were free (Stefanoni et al., 2017). One study in Tanzania reported that older people are not able to access free health services provided for in the Tanzanian National Ageing Policy because they are unable to prove their age, aggravated by the limited availability of health services, equipment and expertize (Mwanyangala et al., 2010). In South Africa, Lesotho and Mauritius older people receive free health-care services, but in the case of South Africa and Lesotho the responsiveness of these systems to older people's particular needs in a context of high demand for services from the general population is limited (Dhemba and Dhemba, 2015; Kelly et al., 2019; Knight et al., 2018).

Domestic health funding in the region is weak and spending in SSA is among the lowest globally (Kaneda and Ashford, 2020). In 2001, African Member States signed the Abuja Declaration, committing to a target of allocating at least 15 per cent of General Government Expenditure (GGE) to health (Domestic General Government Health Expenditure – D-GGHE). However, as 2019 data from the Global Health Expenditure Database, only South Africa (15.3 per cent) meets this target in terms of prioritising health spending, with Botswana close to achieving it at 14.3 per cent (see Table 1 in Annex A for health expenditure data on all countries). Domestic spending on health is less of a priority in South Sudan, Eritrea and Uganda (3 per cent or less). Per capita health expenditure is closely aligned with gross domestic product (GDP) per capita, with Seychelles spending $840 per capita and Madagascar, Burundi and DRC spending around $20 per capita.

In 2001, African Member States signed the Abuja Declaration, committing to a target of allocating at least **15 per cent** of General Government Expenditure (GGE) to health *(Domestic General Government Health Expenditure – D-GGHE).*

High private health insurance and out-of-pocket costs pose challenges for older people with limited incomes, even where pensions are available and older people may be forced to make financial trade-offs, neglecting health needs in relation to other household expenses, including care for grandchildren (Stefanoni et al., 2017). However, one study did show that older people were more likely to seek health care and were better linked to health awareness activities if these were provided (e.g. in Ethiopia health promotion activities were linked to pay points for one donor-supported cash transfer programme) and were more likely to be able to afford transport costs and medication (Stefanoni et al., 2017).

Also shown in Table 1 in Annex A is the proportion of CHE funded from external sources via development assistance. More than half of countries in the region rely heavily on external funding, with external health expenditure accounting for more than a third of CHE in 47 per cent of the countries in the region (and more

than half in South Sudan and Mozambique). The international development agenda therefore shapes how health-care resources are allocated in countries where there is high reliance on foreign aid for health service delivery. Most development assistance for health is focused on younger age groups (34 per cent on children under five years despite only being 19 per cent of the health burden in LMICs), while only 9 per cent of development assistance for health targets people aged 60+ years despite them accounting for 26 per cent of total health burden in LMICs (Dieleman et al., 2020). The WHO data on external health expenditure disaggregated by disease and conditions (available on 16 countries in the region) shows that funding for NCDs (which particularly impact older people) forms only a tiny percentage of externally funded expenditure, except in Mauritius and Seychelles where funding is slightly higher at 13 per cent, with the vast majority of external funding being focused on infectious and parasitic diseases in all countries where data is available.

Preventing and managing NCDs is crucial to preserving the health and capacity of older people. Despite a growing burden of NCDs on the continent, particularly among older people, health services for NCD prevention and management are limited and poorly integrated. Funding levels for NCDs by both government and international donors are weak and implementation of the "Best Buys" and other recommendations from the WHO Global Action Plan for the Prevention and Control of NCDs (2013-2030) have been low (Allen et al., 2020; Devermont and Harris, 2020; World Health Organization, 2017a) (See Table 5 in Annex A).

Weak health spending makes for under-resourced health systems, which has a big impact on availability of health services. As part of the goal of achieving UHC, SDG Target 3c tracks health worker density, using thresholds of 30 physicians, 100 nurses and midwives, and five pharmacists employed in the public sector, per 10,000 uninsured population. According to WHO Health Worker Density data, no countries in the ESA region met the thresholds of physicians or nurses when data was last captured; 86 per cent of the countries in the region have less than 40 nurses/midwives and 90 per cent have less than 10 physicians (with 40 per cent having less than one doctor and 10 nurses per 10,000). Low-income countries in the region have considerably fewer human resources for health. Malawi, for instance, has the lowest number of physicians globally (0.36) and only 4.4 nurses per 10,000 people. It is also important to note that there is often a skewed distribution of health workers across urban and rural areas, with rural facilities having even fewer staff than the national average. These shortages in human resources for health have important implications for older people in terms of availability and quality of health-care services, and shows the immediate value of community-level responses to meeting older people's needs.

Malawi, for instance, has the lowest number of physicians globally **(0.36)** and only 4.4 nurses per 10,000 people.

1.1.2 ACCESS TO SERVICES AND RESPONSIVENESS OF THE HEALTH SYSTEM TO OLDER PEOPLE

Access to health care is shaped by individual patient characteristics such as financial position, social capital, level of education, and physical and cognitive capacity, as well as supply-side factors in the health-care system. Supply-side factors include: the availability of equipment, medicine and skilled human resources, as well as facilities, policies, structures, and processes (Ameh et al., 2014; Kelly et al., 2019). Given potential limitations in older persons' individual capacity to access health care, supply-side factors become particularly important in security access to health care, and appropriate health services for older people need considerable strengthening in the ESA region.

Research on older people's perception of health and use or experiences of health-care services in countries in the region is limited and indicates significant barriers to access, high levels of dissatisfaction and low levels of quality in care in both rural and urban settings (Gómez-Olivé et al., 2013; Govender, 2012; Kiplagat et al., 2019; Lopes Ibanez-Gonzalez and Tollman, 2015; Roos and Malan, 2012; Wairiuko et al., 2017; Wandera et al., 2015). Access challenges, costs and negative experiences of health-care services, make older people distrustful or reluctant to seek health care except in humanitarian emergencies, resulting in a lost opportunity to prevent or manage declines in health, functional capacity and quality of life. Studies in Ethiopia and Kenya show low demand for services among older people, especially among rural dwellers, socioeconomically deprived groups such as pastoralist communities, and those without formal education due to poor satisfaction, low levels of trust, difficulties in access, low system literacy and sociocultural beliefs (Alene et al., 2019; Ministry of Health Ethiopia, 2021).

Physical access

Older people with mobility and sensory impairments and those in rural areas struggle with accessing facilities due to long distances to facilities, lack of or cost of transportation, difficulties in recruiting someone to accompany them to the facility, and infrastructure that does not take into account the needs of people with disabilities (Peltzer, 2009; Wandera et al., 2015; Western Cape Department of Health in collaboration with the National Institute for Communicable Diseases, 2020). People in rural areas are also more likely to incur catastrophic health costs (Harris et al., 2011). A recent geolocation study in SSA showed that 16 per cent of people aged 60 years and older lived more than two hours from any health facility, with around 10 per cent not having a hospital within a travel time of six hours (Geldsetzer et al., 2020). Although there is national and sub-national variation in access across SSA, most countries in the ESA region contain areas where adults over 60 years face these or longer travel times. In two related reports by HelpAge International on social protection and action to health care in Ethiopia, Mozambique, Tanzania, and Zimbabwe, authors showed that all countries had limited availability of health-care services with people walking 30-45 minutes to reach services. Many study participants were unable to walk and then were forced to pay for transport if it was available as public transport can be challenging with bicycles being the most common mode of transport. According to the Rwandan Household Survey data from 2019-2020, the mean time in minutes on foot to a health centre is similar – around 47.3 minutes (similar distance to a food market/shop). These studies clearly paint a more positive light

A recent geolocation study in SSA showed that **16 per cent** of people aged 60 years and older lived more than two hours to any health facility, with around 10 per cent not having a hospital within a travel time of six hours

(Geldsetzer et al., 2020).

in terms of access, but it is important to note that access to health care among older people is completely unstudied in some countries in the region such as Burundi, Madagascar and South Sudan.

Older people that are able to reach facilities often have negative experiences of health facilities because of poor infrastructure and physical environment and lack of age-friendliness in terms of physical accessibility (e.g. lack of ramps) and limited seating. Older people have access to health-care services in general clinics with everyone else and health services are not necessarily well integrated or focused on NCDs, which disproportionately affect older persons. High demand for services and weak health-care management systems, resulting in issues such as long queues or weak referral systems can be significant barriers to access for older people who may struggle to navigate the health system or attend multiple appointments due to costs and transport issues (Kelly et al., 2019; Naidoo and Van Wyk, 2019). Only a few countries in the region have health-care services targeted at older people (e.g. South Africa and Mauritius), but even then, such services are available only at secondary or tertiary hospitals in urban centres.

Systems responsiveness

In addition to the general lack of human resources for health, older people are disadvantaged by the lack of skills and training on caring for older persons, low awareness of age-related conditions such as frailty and dementia, low capacity for dealing with multi-morbidity and inability to communicate effectively with older people (Dotchin et al., 2013; Frost et al., 2015; Peltzer and Phaswana-Mafuya, 2012). There are very health workers in the region with specialized knowledge of older people's health, such as geriatric nurses, geriatricians, psychogeriatricians and family physicians with an interest in geriatrics (Dotchin et al., 2013) and there is limited undergraduate focus on geriatric issues in medical training (Booysen et al., 2017). With the exception of Kenya and South Africa, no other governments in the region offer support to institutions for offering geriatric training (Saka et al., 2019a).

Given time and resource constraints, fee structures and the typical nature of doctor-patient interactions, many health-care professionals are also not in a position to provide care to older people, who may more take time to assess and treat with adequate care (Jacinto et al., 2011; Kalula and Petros, 2011; Rougé Bugat et al., 2012).

Poor access to health-care services such as NCD screening can lead to later diagnosis, resulting in poorer health outcomes. The Kenyan Stepwise National NCD Survey showed that 56 per cent of Kenyans had never had their blood pressure measured, 98 per cent had never had their cholesterol tested and that 88 per cent had never been tested for high blood sugar (and of those who were diagnosed with

high blood sugar, only 40 per cent were taking medication) (Kenya National Bureau of Statistics, Ministry of Health and World Health Organization, 2015).

Ageism in health services

Several studies report that health workers negative attitudes towards older people and manageable health issues are often overlooked or attributed to the ageing process, resulting in low levels of functioning, poorer health outcomes and diminished quality of life (Clarke et al., 2014; Stefanoni et al., 2017; Werfalli et al., 2019).

Older people may also be overtly excluded from accessing certain treatments or services. Older age is not a homogeneous state, and older people have varying levels of intrinsic capacity (a composite of all the physical and mental attributes on which an individual can draw), nevertheless, health care rationing on the basis of age (rather than intrinsic capacity or functional capacity) is widespread (World Health Organization, 2021). Trade-offs around the provision of limited health resources are particularly likely in resource constrained settings such as humanitarian emergencies or under-resourced health systems in LMICs where older people are more likely to be de-prioritized in the provision of care (Wareham, 2015). Globally, age discrimination in health services been made particularly visible by the COVID-19 pandemic, and has also been observed in countries in the ESA region, including South Africa, Rwanda and DRC where older people were, in some cases, denied access to COVID-19 critical care services (World Health Organization, 2021).

Ageism also shapes data collection, and this is visible in the lack of disaggregated data or total exclusion of older people in health surveys and datasets (e.g. Demographic and Health Surveys which typically exclude women over age 50 and men age 55/60 years) and the resultant lack of data to inform policy responses to older people is a significant challenge on the African continent (HelpAge International, 2017a, 2020).

1.1.3 SEXUAL AND REPRODUCTIVE HEALTH SERVICES

The sexual and reproductive health (SRH) of older women and men is often overlooked based on the assumption that they are not sexually active and is generally a “taboo subject” in many societies and remains a “blind spot” on the development agenda. As a result, there is little research and data on the issue available nor much progress in terms of policy development or programming vis-a-vis older persons’ SRH needs (Aboderin, 2014; Banke-Thomas et al., 2020; Heidari, 2016). At the *International Conference on Population and Development’s Beyond 2014: International Conference on Human Rights*, older people were explicitly recognized as one of four key population groups that have been marginalized and excluded in their access to SRH services and rights.

In the ESA region, the SADC Regional Strategy on Sexual and Reproductive Health and Rights (2019-2030) makes no mention of older people in terms of HIV or any age-related SRH issue. One of the many reasons for the EAC Sexual and Reproductive Health Rights Bill was withdrawn by the East African Legislative Assembly in 2021 was the failure to include the SRH needs of people over 55 years, and the Bill is currently being redrafted.

Health systems are not well geared to meet older persons' SRH needs and they often face prejudice and discrimination when seeking services related to sexual health. Health care workers may believe that older person's sexual health needs are outside their scope or practice, and ageism may bias the kind of information they seek from or share with older patients, for instance sexually transmitted infection (STI) prevention information, resulting in later detection of STIs and HIV among this group (Kearney et al., 2010; Kiplagat et al., 2019; Rauf and Rauf, 2010). The decline in reproductive hormones in the menopause process can, among other things, affect sexual function in women and declining testosterone can also impact men. But because of ageist assumptions about their sexuality, older people (particularly women) may feel that they are not able to seek support and guidance from health professionals. Ageing and having had a larger number of children in earlier life can result in pelvic floor disorders, incontinence and pelvic organ prolapse, which can have a significant impact on quality of life and can lead to social isolation and mental health problems which can be overlooked among older women in the absence of appropriate services (Langer et al., 2015). Women with low economic status tend to begin menopause at earlier ages than wealthier women (Langer et al., 2015), increasing risk of osteoporosis, genital tract infections and cardiovascular disease later on in life, which reduces quality of life, and in the case of osteoporosis, significantly increase the risk of disability and frailty (Langer et al., 2015). Mortality rates from breast and cervical cancer are high among older women in the SSA, which also point to a lack of screening and treatment programmes (Jedy-Agba et al., 2020; Teshome and Chavez-MacGregor, 2021).

The "greying" of the HIV pandemic and its implications for older people and health systems

The neglect of SRH in older age groups is especially problematic given that epidemiological data shows that rates of STIs and HIV are increasing in older people (Minichiello et al., 2012). ESA has been deeply affected by the HIV and AIDS epidemic, and despite significant strides taken in managing the disease, HIV continues to have a significant impact on older people in the region. The important role that older people, particularly grandmothers, have played in caring for orphaned and vulnerable children or in caring for the sick has been well-documented (Aboderin and Hoffman, 2017; Dayton and Ainsworth, 2004; Kuo et al., 2013; Ogunmefun and Schatz, 2009; Schatz and Seeley, 2015). This literature shows that the physical and emotional labour and stress of palliative caregiving and the financial and other related stresses of caring for orphaned and vulnerable children have negatively impacted the health and well-being of older women (de Klerk, 2011; Ssengonzi, 2007).

Largely absent in the discourse around the impact of and response to HIV and AIDS in the region is the growing proportion of the HIV positive population that is older than 60 years. The now widespread availability of ART for HIV in ESA means that many people with HIV are now living into old age. According to one estimate, the total number of adults living with HIV aged 50 years or older in SSA will nearly triple from about 3.1 million in 2011 to 9.1 million in 2040. Based on the application of the same microsimulation model to the South African context, which has the largest number of people living with HIV (PLHIV) in the world, prevalence among the 50+ age group is expected to increase to around 26 per cent in 2040 (from 9 per cent in 2011). Despite this trend, reporting on HIV and

According to one estimate, the total number of adults living with HIV aged **50 years** or older in SSA will nearly triple from about **3.1 million** in 2011 to **9.1 million i**n 2040.

AIDS in older people is very weak, with little data available for people aged 50+ years globally, and little research conducted on HIV and its impact in this age cohort until quite recently.

HIV is now treated as a manageable chronic disease, however, the growing number of HIV positive older people has considerable implications for health service provision as older people living with HIV tend to have worse health, higher rates of disability, more complex health needs and higher risk of mortality than HIV negative people (Mugisha Okello et al., 2020; Negin et al., 2012). Older people are more susceptible to infection with HIV and are more susceptible to acquiring NCDs a result of 1) side-effects from ART, 2) persistent HIV-inflammation, which causes accelerated ageing and enhanced risk of NCD co-morbidities in older age, or 3) NCD risk behavior is indecipherable (Ciccacci et al., 2019; Kiplagat et al., 2019; Negin et al., 2014, 2012; Vollmer et al., 2017). Managing co-morbidities alongside HIV is challenging for clinicians and expensive for PLHIV, particularly where integrated, patient-centred care or UHC is absent (Kiplagat et al., 2019; Knight et al., 2018). Older people are less responsive to, and are more susceptible to, the side-effects of ART and polypharmacy, and drug-interactions can make clinical management and adherence more difficult (Harris et al., 2018). Stigma around HIV, combined with age discrimination also makes it difficult for older people to access the health and social services they need and results in social isolation and loneliness (Kiplagat et al., 2019).

Using data from demographic and health surveys, Vollmer et al. (2017) found that HIV prevalence is increasing in older age groups, while it has decreased in younger ones. The limited number of empirical estimates of HIV incidence in adults over 50 years of age in SSA that do exist show substantial risk of HIV acquisition in this age group, underlining erroneous assumptions about decreasing sexual activity among older people (Mojola et al., 2015; Vollmer et al., 2017; Wallrauch et al., 2010; Majola et al., 2015) One South African study found that older men tend to have multiple partners over the age of 60 years, but that both older men and women were hesitant to disclose their HIV positive status or request condom use, indicating that behaviour change interventions targeted at older people are necessary (Lekalakala-Mokgele, 2016).

Given this growing challenge, policy and programmatic responses to population ageing need to include HIV as a key issue and some have called healthy ageing among PLHIV the “4th 90” in the 90:90:90 campaign targets set for ending the HIV epidemic (Harris et al., 2018). There is, however, weak inclusion of older people’s vulnerability and needs in HIV strategic plans in the region.

1.1.4 LONG-TERM CARE FOR OLDER PEOPLE IN THE EAST AND SOUTHERN AFRICAN REGION

Long-term care for older people in the region is primarily provided by families, and public programmes and systems to provide paid care to older persons or support family-based care are scarce on the continent (World Health Organization, 2017b). Only South Africa, Mauritius and Seychelles have long-term care frameworks in place, and there appears to be an impasse in the development of long-term care policies, strategies and programmes in SSA, at least partially created by idealized conceptions of norms and values around care in Africa (Aboderin, 2019, 2010).

While the proportion of people over 70 years who are more likely to need care is very small in most countries in the ESA region, the need and demand for long-term care services is, in fact, growing rapidly. While empirical data on family care *for* older persons in the region are quite limited (Aboderin and Hoffman, 2017) there are indications that the availability and quality of care provided to older people has been eroded by changing family structures brought about by migration, the HIV and AIDS epidemic and high rates of poverty and unemployment, as well as changing norms and ideas around filial and community commitment to older people, weakening intergenerational solidarity (Cattell, 2008; Makoni, 2008; Nzima and Maharaj, 2020; Schatz and Seeley, 2015; Aboderin, 2019; Hoffman, 2016). Older people, particularly those in rural areas where younger populations are moving to urban areas to find work, are increasingly left with very limited family support (Eboiyehi, 2015; Maripe, 2010; Zelalem et al., 2021), and in some contexts may move to urban areas to seek livelihoods via begging, contributing to a growing population of homeless adults, some of whom may enter care facilities run by charitable organizations (Gebeyaw et al., 2021).

Care work, which is mainly performed by women with little societal recognition, has negative financial and psychological implications for caregivers, and impacts women's labour market participation and educational attainment in cases where children are designated as caregivers (Schatz and Seeley, 2015; WHO, 2017). Caregivers often lack the training and skills needed to manage the complex conditions of old age or to deal with palliative care issues (Nzima and Maharaj, 2020). The financial, physical and emotional commitments and pressures of caring for older people are exacerbated by poor access to health and support services (Aboderin, 2019; Hoffman, 2016, 2014). Caring for people with dementia is particularly challenging and caregivers of those with dementia report substantial emotional, financial and physical difficulties, even in high resourced settings (Brodaty and Donkin, 2009), which can lead to abandonment and abuse of older people (Schatz and Seeley, 2015). Often neglected is the important role that older people play in caring for other older persons in the absence of intergenerational support, which is particularly common in Rwanda where the genocide has left many older people with little family for support (Sadruddin, 2020; van Eeuwijk et al., 2016).

While private facilities or in-home nursing services are available in most countries, their cost is prohibitive for most of the population, and public services and those provided by charitable organizations are poorly funded and are heavily reliant on private donations (World Health Organization, 2017b). Given the preference for family care, long-term care facilities are stigmatized and seen as a last resort for those who are destitute with no family support (Aboderin, 2019; Hungwe, 2010; Nzima and Maharaj, 2020; Teka and Adamek, 2014). Furthermore, there is limited regulation of the sector, which can result in limited and low-quality care (World Health Organization, 2017b).

Despite the clear normative preference for family- and community-based long-term care, government efforts to support this care are quite limited and much of the support is provided by older persons organizations or initiatives of organizations such as HelpAge International (Nzima and Maharaj, 2020; World Health Organization, 2017b). Community health worker programmes are present in many communities, but are not usually focused on older people, and their resources, skills and capacity to provide support to older people and their caregivers are quite limited (Nzima and Maharaj, 2020). In contrast to the rest

of the ESA region, South Africa and Mauritius make some provision to support home-based care of older people (see Annex B for more details on long-term care provisioning in both South Africa and Mauritius).

The already tenuous sustainability of existing facility-based and community-based long-term care and other services for older people in the region have been threatened by COVID-19, due to increased expenses in terms of staffing and infection prevention control requirements, funding cuts, decreased demand and decreased ability of older people and their families to pay for services (Ashwell et al., 2020; Lee-Francke, 2021; World Health Organization Regional Office for Africa, 2021). The effects of COVID-19 among long-term care facility residents has been particularly devastating, both in terms of case fatality rates and the psychological impact of the pandemic (Ashwell et al., 2020; Kelly et al., 2021; World Health Organization Regional Office for Africa, 2021).

1.1.5 HEALTH SYSTEMS PREPAREDNESS FOR EMERGENCIES AND CONTINUITY OF CARE FOR OLDER PEOPLE

Disaster risk, both in terms of hazard and the human and economic costs of disasters due to human vulnerabilities, has increased globally and is likely to increase due to climate change and the growing frequency of weather-related disasters, and countries in SSA, including those in ESA, are at particular risk (Handicap International, 2017; United Nations High Commissioner for Refugees, 2021). Older people, people with disability and women are disproportionately affected by health emergencies, natural disasters and armed conflicts. Older internally displaced people (IDPs), refugees and stateless older people require additional support and protection because of increased risks due to ageing, including neglect, discrimination or abuse (United Nations High Commissioner for Refugees and HelpAge International, 2021).

Emergency situations negatively impact older people's traditional roles and social positions as communities, and support structures fall apart and make older people more dependent on others and more vulnerable to marginalization and exclusion, particularly where access to resources is scarce (Barbelet, 2018; Barbelet et al., 2018; United Nations High Commissioner for Refugees, 2000). Older people are also often the most reluctant to flee their homes or may find it more difficult to seek refuge, and are therefore more easily separated from family in exile, but are also highly unlikely remain in IDP camps if they do flee. For example, in Northern Uganda in 2009, 65 per cent of IDPs remaining in camps were over 60 years (HelpAge International and Internal Displacement Monitoring Centre, 2012).

The HelpAge International Disaster Risk and Age Index assigns scores to 192 countries based on: (1) hazard and exposure to natural and human created disasters; (2) vulnerability, based on socio-economic factors and the presence of vulnerable groups (including older people); and (3) coping capacity based on institutional and infrastructural factors. Several countries in the ESA region rank high in terms of overall risk, and almost half of the 23 countries in the region fall into the top 50 countries globally (See Table 2 in Annex A).

The African region has the most insecure health systems globally (Global Health Security Index, 2019). In most countries in the ESA region, health systems are unprepared to prevent or respond to health or other emergencies and the needs of older people in these situations, with critical gaps in the humanitarian context. In the ESA region, South Africa stands out as having the highest score, ranked 34 globally, with Kenya, Uganda and Ethiopia scoring above the global average. On the other hand, half of the countries in the region are classified as "least prepared", with Burundi, Eritrea and South Sudan having amongst the lowest scores globally (in the low 20s). A finding of the Global Health Security Index report in 2019 was that "Countries are not prepared for a globally catastrophic biological event" proved prophetic in 2020 with the emergence of the COVID-19 pandemic, however some countries with higher rankings have performed worse in terms of managing COVID-19 than would be expected. This lack of resilience posed a significant threat to fragile health systems in the face of COVID-19, and therefore ability of older people to access COVID-19 treatment and other forms of health care during the pandemic.

Health system preparedness is also measured by the International Health Regulations (IHR) capacity and health emergency preparedness, an indicator for SDG Target 3.d. (see Table 3 in Annex A). While some countries such as Ethiopia, South Africa, Rwanda, Uganda, and Mozambique score well above the global average of 65 per cent, some countries such as Lesotho, Madagascar, Malawi, and South Sudan are woefully unprepared with scores of 50 per cent or lower. Previous external evaluations of IHR conducted in the WHO African region also showed major IHR capacity gaps, including many in the area of "response" such as: emergency preparedness, emergency response operations and medical countermeasures and personnel deployment (Talisuna et al., 2019).

Overall gaps in health system preparedness for health emergencies in the region are a concern for all population groups, but older people are likely to be disproportionately affected by health system interruptions (see Box 2 for a discussion on health systems and COVID-19 in the region).

The African region has the **most insecure** health systems globally

(Global Health Security Index, 2019).

Lack of inclusion of older people in disaster planning and responses

Despite their vulnerability and potential contribution, groups such older people and persons with disabilities (PWDs) are often poorly targeted in humanitarian interventions by governments, the humanitarian community and funders. Later-life refugees are often overlooked because they may struggle to evacuate and constitute a relatively small percentage of displaced populations and are therefore less visible and are not included in planning efforts (HelpAge International, 2016). Older people are also insufficiently included in disaster risk reduction strategies or their development (HelpAge International, 2020). The findings of the 2016-2017 MIPAA review show that about three quarters of the countries reporting in Africa (23) had national emergency preparedness plans; but less than half of these indicated inclusion of issues of older people. The majority of African countries reported limited capacity of relief workers to care for older persons in emergency situations. When older people are included in humanitarian responses, they are often grouped together with other vulnerable populations (women, children, PWDs) which may have different needs or vulnerabilities. For example, the Ethiopian Humanitarian Response Plan makes several mentions of older people as being most affected by emergencies and includes older people in its list of vulnerable groups, but all indicators and targets are related to women and children (Government of Ethiopia and United Nations Office for the Coordination of Humanitarian Affairs, 2020).

Research conducted on the humanitarian response in displacement and drought settings in East Africa showed that humanitarian and development partner organizations may not sufficiently engage with older people or understand the complexity of issues around older people's social position and needs in these settings, making assumptions that the inclusion of older people in family and community support systems do not necessarily hold true in practice (Barbelet, 2018; Barbelet et al., 2018). Older people may, in fact, struggle to access information, food rations or adequate health services. Specific nutritional needs, treatment for chronic health disease and support for cognitive deficiencies may require further tailored assistance not usually included in packages provided to displaced populations (HelpAge International and Internal Displacement Monitoring Centre, 2012).

In its work in the region HelpAge International found that older people are the last to receive assistance at the place where the disaster has occurred, and are the last to be considered for assistance at the new place of settlement. In needs assessments of older people conducted by HelpAge International in the context of natural disasters, conflict, socioeconomic crises and COVID-19, older people's basic needs were often unmet in these contexts; needs overviews and humanitarian response plans tend to include older people as a "vulnerable" group with no concrete plans or suggestions for response and little to no age-disaggregated data available for planning (HelpAge International and Age International, 2020). Progress, is however, being made in recognizing the need to include older people in humanitarian responses and the United Nations High Commissioner for Refugees (UNHCR) has recently revised its vulnerability markers to be more sensitive to older persons, as well as its age, gender and diversity policy, which aims to increase participation and inclusion of older people (United Nations High Commissioner for Refugees, 2018).

BOX 2

COVID-19 RESPONSE AND OLDER PEOPLE

The COVID-19 pandemic has forcibly illustrated existing weaknesses within global health systems and has disrupted services for prevention and treatment, making people living with NCDs, who are already vulnerable to COVID-19, more at risk of becoming severely ill or dying of COVID-19.

Despite plans to strengthen capacity, health services in many African countries were interrupted or inaccessible and hospitals were unable to cater to and handle patient loads, with implications for acute, chronic and emergency care (PERC, n.d.; Bhalla, 2021; Devermont and Harris, 2020; Gyasi, 2020a; Hulland, 2020; Zhang et al., 2020). The intense focus on COVID-19 rather than other health issues may have also led to setbacks in managing malaria, HIV and AIDS, tuberculosis and other infectious diseases on the continent. NCD services, on which older people rely, were also heavily disrupted and two WHO surveys conducted to assess the impact of the COVID-19 pandemic on essential health services revealed disruptions of essential health services in nearly all countries in the African region, and more so in low-income countries. Chronic disease management relies heavily on treatment adherence for adequate therapeutic outcomes (Viswanathan et al., 2012) and health service interruptions during COVID-19 have serious implications for people with NCDs, many of which are older people (World Health Organization, 2021). Data from two WHO surveys tracking continuity of services during the pandemic showed widescale interruption of NCD services and long-term care, palliative and rehabilitation services, as well as mental health services (including dementia services) (WHO, 2020).

COVID-19 has also been a case in point of the exclusion of older people from disaster and health emergency management responses. Apart from vaccine prioritization policies for older people there has been poor inclusion of older people in national-level COVID-19 response planning and implementation by national governments (World Health Organization Regional Office for Africa, 2021). Limitations in older people's access to health care social protection and, the lack of age, gender and disability-disaggregated data has made it difficult to include older people in the COVID-19 response (World Health Organization, 2021).

Chapter 2: International, Regional and Selected Country-level Responses to Ageing and the Needs of Older People

This section outlines the legislative and policy frameworks and coordinating mechanisms in place to facilitate the inclusion of older people, as well as issues facing older people at international, regional (continental/ESA sub-region) and national level for the six focal countries included in this study (Ethiopia, Kenya, Lesotho, Mauritius, Rwanda and South Africa).

2.1 International frameworks and policies related to ageing and older people

There are several international and regional instruments and institutions in place to assist governments in the ESA region to develop and implement strategies to address ageing and the needs and rights of older people, and to recognize and further enable their contribution to society and development. These frameworks are outlined below.

MADRID PLAN OF ACTION ON AGEING

In 2002, The Madrid Plan of Action on Ageing and the Political Declaration adopted at the Second World Assembly on Ageing in April 2002[5], put ageing issues on the international agenda (United Nations, 2002). Signatories of the political declaration, committed to taking action to develop a society that meets the needs of older persons and to take action in three priority areas: (1) advancing health and well-being into old age, (2) older persons and development, and (3) ensuring enabling and supportive environments. This includes incorporating ageing into social and economic strategies, policies and action. The plan takes a life course approach to reducing the cumulative effects of factors that increase the risk of disease, functional ability and potential dependence in older age, and promotes universal and equal access to health-care services.

In response to MIPAA, South Africa, Mozambique, Uganda, Tanzania, Zimbabwe, Kenya, Ethiopia, Malawi, and Lesotho have all developed national legislation/ policies on ageing (Saka et al., 2019b). The MIPAA review of the submissions of the 31 African countries that participated in the review showed that three quarters (23) encountered significant challenges in implementing policies, and only half indicated a presence of budget allocation for policy implementation; political will, limited resources and weak coordination within government were cited as major challenges in this regard (Nzabona, 2017). An analysis of ageing-related issues included in national policies in the African region showed that the main focus of governments has been on poverty reduction, social services and abuse/neglect, while issues related to labour market inclusion and humanitarian/ conflict situations are mentioned least often (Nzabona, 2017).

5 A total of 159 states were represented at the assembly. All countries in the ESA region attended with the exception of Comoros, Swaziland, Lesotho and Seychelles. South Sudan was not yet an independent state in 2002, but Sudan was represented at the assembly.

AGENDA 2030 AND THE SUSTAINABLE DEVELOPMENT GOALS

The 2030 Agenda for Sustainable Development, adopted by all United Nations Member States in 2015, provides a shared global plan to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030. It includes 17 SDGs or Global Goals which must be implemented by every country in the world.

Of the 17 goals, nine were assessed by UNDESA as related to ageing and the protection and promotion of the rights of older persons:

1 **No Poverty**	10 **Reduced Inequalities**	11 **Sustainable Cities and Communities**
2 **Zero Hunger**	5 **Gender Equality**	16 **Peace, Justice and Strong Institutions**
4 **Quality Education**	8 **Decent Work and Economic Growth**	17 **Partnerships for the Goals**

UNITED NATIONS DECADE FOR HEALTHY AGEING 2021-2030

The United Nations Decade of Healthy Ageing (2021-2030) was proclaimed by the General Assembly in December 2020. Healthy Ageing is defined as developing and maintaining the functional ability that enables well-being in older age. The Decade of Healthy Ageing is the culmination of over four years of collaboration between the WHO and many stakeholders and partners across the world, and reflects the vision of the SDGs of leaving no one behind.

The Global Strategy and Action Plan on Ageing and Health (2016–2020) preceded and provides the rationale for the Decade for Healthy Ageing. Although the region has made modest progress in achieving the objectives of the Global Strategy and Action Plan (GSAP) (See Table 4 in Annex A), daunting challenges must still be overcome to contend with the inevitable and potentially overwhelming health and social consequences of rapid population ageing. While 15 of the 23 countries in the ESA region have put in place national strategies and plans, implementation has been weak. Progress has been weakest in terms of the availability of cross-sectional and longitudinal, nationally representative, individual-level data on older people, which limits the capacity of governments to plan and budget for developing policies and programmes related to ageing and older persons.

While **15 of the 23 countries** in the ESA region have put in place national strategies and plans, implementation has been weak.

According to the GSAP progress report for the African region (Regional Committee for Africa, 2020), challenges to implementing the GSAP include the lack of a national healthy ageing programme in about 50 per cent of Member States, and weak capacity to address the health and social needs of older people at the community level in an integrated manner through the primary health-care system. Other challenges include the lack of comprehensive long-term care systems for older people, low coverage of social protection schemes for older people and inadequate data for planning.

During consultations for this report, WHO AFRO regional office also highlighted the following challenges to policy implementation in a consultative interview:

- Limited capacity for planning, coordination and management of ageing programmes.
- A lack of financial resources and workforce skilled in the area of ageing.
- Weak health systems in terms of integrated care, long-term care, adequate medicine, health commodities and supplies and assistive technology for older people.
- Inadequate data and limited research initiatives on ageing in the region.

The United Nations Decade programme of work for 10 years takes a multidimensional approach, recognizing the contribution of physical, social, and economic environments to experiences of ageing. The Decade aims to foster healthy ageing and improve the lives of older people and their families and communities by addressing four areas for action:

1. Change how we think, feel and act towards age and ageing.
2. Ensure that communities foster the abilities of older people.
3. Deliver person-centred integrated care and primary health services responsive to older people.
4. Provide access to long-term care for older people who need it.

The African Regional Framework for the Decade prioritizes certain key areas for Member States to focus on: national health needs assessments; the development of costed health ageing plans; the development or strengthening of programmes to ensure care of older people, including social and physical environments that foster healthy ageing and functional ability; national mechanisms to report progress on national, regional and global progress indicators; and the development of research agenda to support the needs of the health ageing programme.

UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) is an international human rights instrument adopted in 2006 to protect the rights and dignity of persons with disabilities. All countries in the ESA region, except Eritrea, have signed and ratified the convention, with Botswana ratifying it most recently in August 2021 after many years of delay. Given the intersection between older age and disability, the UNCRPD has the potential of advancing the rights of older persons, and there are significant overlaps between the disability agenda and older persons' agenda, particularly around accessibility issues.

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

CEDAW was adopted in 1979 by the United Nations General Assembly and is often described as an international bill of rights for women. All countries in the ESA region have ratified the treaty. In 2010, concerned about the multiple forms of discrimination experienced by older women and that older women's rights are not systematically addressed in the reports of states parties, the Committee on the Elimination of Discrimination against Women adopted a new general recommendation on older women and the protection of their human rights. This recommendation compels state parties to address issues particular to older women such as access to education, social pensions and adequate housing, as well as consent in relation to health or the right to inheritance. Despite evidence highlighting the distinct challenges and forms of discrimination faced by older women, less than 3 per cent of concerns, observations and recommendations made in the last 20 years by the Committee on the Elimination of Discrimination against Women which monitors the implementation of the convention, were related to older persons.

INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS (ICESCR)

The International Covenant on Economic, Social and Cultural Rights (ICESCR) is a core human rights treaty which enshrines economic, social and cultural rights such as the rights to adequate food, adequate housing, education, health, social security, water and sanitation, and work. This covenant compels national governments to ensure that all people, including older persons enjoy access to these rights, which influence health and quality of life. All countries on the continent have ratified this instrument with the exception Botswana and Mozambique.

SENDAI FRAMEWORK FOR DISASTER RISK REDUCTION 2015-2030

The Sendai Framework was adopted at the Third United Nations World Conference on Disaster Risk Reduction in Sendai in 2015. It outlines clear targets and four priorities for action to prevent new, and reduce existing, disaster risks. The successful advocacy work of civil society actors has resulted in the Sendai Framework being inclusive of age, disability and gender, and older people are identified in the Sendai Framework as important stakeholders in disaster risk reduction: "Older persons have years of knowledge, skills and wisdom, which are invaluable assets to reduce disaster risk, and they should be included in the design of policies, plans and mechanisms, including for early warning." There has been considerable enthusiasm for adopting and implementing the Framework on the African Continent, and the African Union has developed an aligned Disaster Risk Reduction Strategic Plan and Plan of Action 2018-2030.

WORLD HEALTH ORGANIZATION GLOBAL ACTION PLAN FOR THE PREVENTION AND CONTROL OF NCDS 2013–2030

There has been slow progress in responding to the growing burden of NCDs in SSA, but countries in the ESA region countries have been making progress towards achieving their commitments to the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2030 via the development of policies and strategies and related targets in the region (See Table 5 in Annex A). Only 60 per cent of countries in the region have developed policies and strategies and 65 per cent have developed or partially developed national-level targets and indicators for NCDs. The mid-term review of the Global Action Plan for NCDs shows that while there is a statistically significant association between having an NCD policy, strategy or action plan and an adjusted implementation score, this association is not seen in low-income countries and any improvement may be short-lived.

Only **60 per cent** of countries in the region have developed policies and strategies and **65 per cent** have developed or partially developed national-level targets and indicators for NCDs.

WORLD HEALTH ORGANIZATION GLOBAL ACTION PLAN ON THE PUBLIC HEALTH RESPONSE TO DEMENTIA 2017–2025

This Global Action Plan aims to improve the lives of people with dementia, their caregivers and families, while decreasing the impact of dementia on communities and countries. Based on Global Dementia Observatory data from 2017, which monitors implementation of the action plan, the only countries in Africa that have reported on progress are Eswatini, Mauritius and South Africa, with Eswatini and South Africa reporting having no plans and Mauritius reporting having one under development, and none of the countries reporting having in place targets or budgets for addressing dementia at this stage. However, the STRiDE dementia project is supporting the development of these plans in South Africa and Kenya.

INTERNATIONAL COORDINATING MECHANISMS AND STAKEHOLDERS IN AGEING

United Nations programme and focal point on ageing

The United Nations Programme on Ageing is part of the Division for Inclusive Social Development under the United Nations Department of Economic and Social Affairs (UNDESA), and is focused on facilitating and promoting the three priority directions of MIPAA.

United Nations Open-Ended Working Group on the Human Rights of Older Persons (OEWG)

The OEWG on Ageing brings together Member States, National Human Rights Institutions (NHRIs), non-governmental organizations (NGOs) and United Nations agencies annually to discuss ways of strengthening the protection of the human rights of older people. The OEWG has been discussing the creation of *a new United Nations Convention to protect the rights of older people.* A United Nations convention would compel governments to fulfil their human rights obligations and responsibilities to older people and develop laws and policies to give effect to these rights. However, the participation of Member States (globally) and other stakeholders in these discussions remains low.

Stakeholder Group on Ageing

The Stakeholder Group on Ageing (SGA) is a member of the Major Groups and other Stakeholders mechanism involved in the implementation of the SDGs and brings together networks of organizations concerned with issues related to ageing. The SGA members are NGOs working in the field of ageing at the global, regional and national levels. The SGA enables the voice of older persons to be heard at the global level with respect to the 2030 Agenda and its implementation process, and has a regional focal point in Africa (SGA Africa).

NGO Committee on Ageing at the United Nations Headquarters in New York (NGOCOA-NY)

NGOCOA-NY represents international and national organizations and works to raise world awareness of the opportunities and challenges of global ageing, and is a member of the SGA.

2.2 Frameworks, policies and coordinating mechanisms related to older people in the African Union and in the East and Southern African region

Awareness, debate, research and action on ageing and issues affecting older people in SSA have intensified over the past fifteen or so years. This can be observed in the inclusion of older people as a vulnerable group in development strategies and the creation of regional and national policy frameworks to improve the welfare of older people. The African Union has developed several policy frameworks relevant to older people.

AFRICAN UNION PROTOCOL TO THE AFRICAN CHARTER ON HUMAN AND PEOPLE'S RIGHTS ON THE RIGHTS OF OLDER PERSONS IN AFRICA (PROTOCOL ON THE RIGHTS OF OLDER PERSONS)

Member States of the African Union adopted the Protocol on the Rights of Older Persons on 31 January 2016. The Protocol aims to ensure respect and protection of the rights of older persons and accelerates the progressive advancement of older persons' rights across multiple dimensions, including access to social protection, health, care and support, residential and the right to protection and non-discrimination. The protocol also recognizes the specific protection needs of older women, the role that older people play in caring for vulnerable children and the need to adopt measures to support older people in this regard. The protocol is not yet in force as only 14 countries have signed it and only four have ratified it (Benin, Ethiopia, Lesotho, and Kenya), and 15 countries need to ratify the protocol for it to come into effect. Several countries, including South Africa, are in the advanced stages of the ratification process and Rwanda has ratified the protocol but has not yet deposited it.

AFRICAN UNION DRAFT POLICY FRAMEWORK AND PLAN OF ACTION ON AGEING

The draft policy and plan of action updates and builds on the African Union Framework and Plan of Action on Ageing (2002), which frames investments in older people as contributing to overall social and economic development objectives and considers changes and progress over the past 20 years, as well as current trends. The framework takes a cross-cutting and human-rights based approach that focuses on addressing inequities, by including older people in the development of responses to ageing, supporting families and communities, harnessing information and communication technologies as part of the ageing response, expanding social protection, and recognising and harnessing the intersection of ageing with other demographic, social and environmental trends. Key action areas include: (1) improving health care and health care access for older people; (2) developing long-term care systems; (3) investing older people/s intergenerational roles and eliminating elder abuse and age-based discrimination; (4) ensuring access to lifelong learning and fostering research and training on ageing and later life; and (5) preparing younger people for retirement and other aspects of later life.

AFRICAN UNION COMMON AFRICAN POSITION ON LONG-TERM CARE SYSTEMS FOR AFRICA

In 2017, the African Union Specialized Technical Committee on Social Development, Labour and Employment developed a position paper that makes recommendations for the African Union and Member States on long-term care provision in the region. This position document acknowledges the gaps in adequacy and sustainability of long-term care provision by families and the need for "well-coordinated, regulated and sound mechanisms that can strengthen, supplement or substitute for, and address the gaps in, family care" while retaining central family involvement. The paper also highlights the economic potential of developing a "care economy" which can lead to greater youth employment. Key to this work is gathering evidence on long-term care in the region, consolidating national policy architectures and designing and implementing long-term care policies and strategies.

OTHER RELEVANT DOCUMENTS:

- Protocol to the African Charter on Human and People's Rights on the Rights of Persons with Disabilities in Africa (Protocol on the Rights of Persons with Disabilities)
- African Union Disability Strategic Framework
- Agenda 2063: The Africa We Want
- African Union Draft Social Agenda 2063
- Plan of Action on the Family in Africa 2004
- Draft Protocol to the African Charter on Human and People's Rights on the Rights of Citizens to Social Protection and Social Security

2.3 Regional actors and coordinating mechanisms

UNITED NATIONS ECONOMIC COMMISSION FOR AFRICA

The Economic Commission for Africa (ECA) is one of the United Nations' five regional commissions which is mandated to promote the economic and social development of its Member States, foster intra-regional integration, and promote international cooperation for Africa's development. ECA is responsible for promoting and coordinating Member States' contributions to the United Nations 2030 Agenda and African Union Agenda 2063, as well as MIPAA.

AFRICAN UNION

- African Union Commission Department of Health, Humanitarian Affairs and Social Development, which attends to issues related to older people
- The Specialized Technical Committee of Social Development, Labour and Employment
- African Union/United Nations Regional Coordination Mechanism for Africa (RCM-Africa) – the Joint secretariat of the African Union Commission and ECA coordinates the work of United Nations agencies and the African Union on the continent, including the achievement of the 2030 Agenda and Agenda 2063 goals and to supports the New Partnership for Africa's Development (NEPAD) programme.
- African Commission on Human and Peoples' Rights Working Group on Rights of Older Persons and People with Disabilities. The African Commission is tasked with promoting and protecting human rights and interpreting the African Charter Provisions, and the working group developed the African Union Protocol on the Rights of Older Persons. The African Commission has limited resources and experiences challenges in terms of political will, responding to appeals, reporting and weak implementation.

SUB-REGIONAL BODIES RESPONSIBLE FOR AGEING AND OLDER PEOPLE

- Ministry of EAC, Labour and Social Protection, which is responsible for ageing and older people
- Social and Human Development Directorate of the SADC Secretariat

CIVIL SOCIETY ORGANIZATIONS OPERATING AT REGIONAL LEVEL

- HelpAge International plays an important coordinating and advocacy role around ageing issues in the region and provides technical support to governments around developing policies and programmes around ageing.
- The Stakeholder Group on Ageing (SGA Africa) – a regional coalition of civil society organizations, non-governmental and professional organizations in ageing, Human Rights Institutes and Institutes on Ageing, working on multi-levels as members of the United Nations ECA African Regional Mechanism for Major Groups and Other Stakeholders Group to achieve SDGs Agenda 2030 and African Union Agenda 2063.
- Centre for Human Rights, University of Pretoria works to advance human rights in Africa, and has been very active in campaigns to support the ratification of the African Union Protocols on the Rights of Older Persons and the Rights of Persons with Disabilities.

2.4 Summary of policy and programmatic responses to ageing in six focal countries

This section summarizes the response to ageing in the six focal countries included in this study: Ethiopia, Lesotho, Kenya, Mauritius, Rwanda and South Africa. Table 6 in Annex A summarizes the progress around policy and programme development using the MIPAA priority direction framework and more detailed tables providing specific details on legislation, policies and programmes implemented in each of the six countries are included in the country summary reports in Annex B.

Overall, these countries have made efforts over the past 10 years to include older people in human rights frameworks and are making progress towards developing policies and strategies around ageing. However, implementation is considerably weaker outside of Mauritius and South Africa, which have more developed structures and more resources.

- Mauritius, which has the most rapidly ageing population in SSA stands out among the six focal countries and is described by the AARP as "leading the African region in proactively identifying aging as a critical issue for the health and competitiveness of its society and its economy" (AARP International, 2018). It has put in place a comprehensive and multi-sectoral framework to maximize quality of life for older people, emphasizing what the National Strategy Paper and Action Plan on Ageing 2016-2020 calls "happy ageing", and even offers highly subsidized local leisure holidays for older people.
- South Africa also has a well-established set of policies and programmes for older people across various sectors, but the scale of inequality, absolute size of the older population (over 5.5 million) and challenges with governance result in much weaker implementation of programmes than in Mauritius.
- Kenya has ratified the African Union Protocol on the Rights of Older Persons and developed a rich policy architecture on older persons' issues. However, this is not yet matched by implementation – few programmes are in full operation and intersectoral collaboration is weak (Ministry of Public Service, Gender, Social Protection, Senior Citizens Affairs and Special Programmes, 2021).

- Ethiopia has ratified the African Union Protocol on the Rights of Older Persons and has taken steps to develop policies and programmes on ageing, including expanding social protection for older people (which is still quite limited), and has mainstreamed older persons issues in some sectoral development plans. However, the National Action Plan on Older Persons remains unbudgeted and poorly implemented (Stefanoni et al., 2017). Ongoing insecurity in the region may also disrupt both economic progress on addressing ageing issues, and put older people at significant risk.
- Lesotho has taken great strides by introducing universal pensions and becoming the first country to ratify the African Union Protocol on the Rights of Older Persons, but capacity for implementation needs to be significantly strengthened.
- Rwanda has very recently developed a National Older Persons' Policy, but is still in the early stages of developing programmes for older people.

SUMMARY OF COUNTRY PROGRESS IN TERMS OF THE THREE MIPAA FOCAL AREAS

Legal and policy frameworks

- Responsibility and coordination for policies and programming related to older persons exists within ministries responsible for social development and social protection in all six focal countries. The six countries also all have national focal points on ageing and health located in their ministries of health. These focal points are key for the effective coordination and promotion of ageing related activities and tasks at country level, and for fostering communication with the international community, and aligning country and international priorities. However, in practice these focal points in health ministries have limited budget and staff complements, meaning their capacity and influence is limited. Furthermore, intersectoral government collaboration is weak outside of Mauritius, which has a government coordinating mechanism which ensures that older people are included in all national and sectoral development plans (Senior Citizen's Council of Mauritius).
- Coordination between government and civil society around ageing issues is also weak in all countries except Mauritius. South Africa has several platforms for engagement on older people's issues, mainly at provincial level, but national coordination is relatively weak. Lesotho has a Lesotho Age Network which brings together various government ministries and civil society on a quarterly basis, but capacity is weak.
- All six focal countries have national policies in place around ageing, but levels of implementation vary, with Rwanda having only very recently introduced an ageing policy and South Africa and Mauritius having formal legislation in place focused on older persons.
- While all countries recognize the rights of older people in their constitutions, and Ethiopia and Lesotho have ratified the African Union protocol, only South Africa and Mauritius have specific national legislation in place related to older persons.

Social and economic inclusion

- All countries include civil society in consultative processes that include older persons' organizations and have made mention of older people in national development plans, but actual targets and budgetary commitments are lacking.
- In most countries, it is not clear to what extent older people's needs and inputs gathered through consultative processes are mainstreamed across sectors or plans outside those focused specifically on their needs, or how much emphasis is put on inclusion in sector plans where older people are mentioned.
- Older persons organizations are more active and influential in some countries than others. In Mauritius, the older persons' sector is influential and there are a very large number of senior citizens organizations. In South Africa there are also many older persons organizations, some umbrella organizations represent and coordinate older persons' organizations and various platforms facilitate input from older persons exist on paper (e.g. Older Persons Parliament). However, older persons organizations are relatively weak and underfunded, and actual capacity to undertake coordinated advocacy campaigns is weak. In Kenya and Ethiopia, there are numerous older person organizations, but their capacity and reach are weak (one survey showed that only 3.5 per cent of those surveyed had heard of the Inua Jamil pension programme – a key government programme – via older persons organizations). In Lesotho and Rwanda there is very little capacity in the older persons' NGO sector outside of one or two key organizations.
- The presence of HelpAge International country offices in Kenya and Ethiopia has significantly bolstered the visibility of older persons on the agenda in these countries as HelpAge International has been able to provide input on policy issues etc., HelpAge International network partners are also active in Lesotho, South Africa, Rwanda, and Mauritius.
- South Africa, Lesotho, Mauritius, and Kenya have made provision for non-contributory pensions with wide coverage, but Rwanda and Ethiopia, which include older people in other broader cash transfer programmes, still need to develop programmes to increase pension coverage among older people.
- Older people are only superficially included in disaster risk reduction policy and management plans and programmes along with other vulnerable groups, except for in Kenya and also South Africa which makes more provision in policy and legislation (although likely limited in practice).
- All six countries acknowledge and celebrate the International Day of Older Persons

Health systems

- Lesotho, South Africa and Mauritius have removed health user fees for older people, while Kenya, Rwanda and Ethiopia have included older people in health insurance schemes. Coverage of the community-based health insurance among older persons in Rwanda is high, but significant gaps still exist in the Ethiopian and Kenyan systems.
- No gender specific targets around healthy ageing exist in any of the countries.
- Data availability on older people and their needs, as well as the use of existing datasets is an issue in all countries and in SSA more generally.
- Support for long-term care is limited outside of Mauritius and South Africa. Mauritius has an advanced long-term care system catering to the needs of older people that covers family-based and facility-based care, as well as targeted primary health and tertiary health and rehabilitative services. South Africa has a relatively well-developed long-term care system, but it is poorly funded and regulated. A defunding of facilities in favour of community-based care interventions has not resulted in concomitant strengthening of community-based care – NGOs are active in providing services coverage with some government support, but coverage is patchy and services are poorly funded. Kenya and Lesotho are making some effort to regulate facilities but provide no funding or community-based services to support long-term care provision by family.
- All countries have acknowledged the need to invest in NCD prevention and management, but the extent of implementation of these programmes and their inclusivity of older people is less clear.
- In terms of efforts to strengthen health care access and responsiveness for older people, South Africa and Mauritius have the most well-developed systems. Efforts to improve access in these and the other four countries are mainly focused on integrated care and extending primary health-care service availability rather than specifically focused on older people, but are likely to benefit older people.
- Outside of Mauritius, countries do not make provision for special services for the elderly within primary care. Access to specialized geriatric care is extremely limited. Tertiary level hospitals in South Africa have specialized services, but access is limited to urban areas.
- HIV and AIDS is a neglected health issue among older people in all six countries. Older people are mentioned in HIV strategic plans for South Africa and Lesotho, and in the SRH plan of Kenya. In Lesotho the Policy for Older Persons acknowledges the need to support older people with HIV. However, across all countries there are very few programmes in place to deal with HIV in the older population outside of supporting them as caregivers of orphans and vulnerable children or sick people.
- Only Kenya and Mauritius have also included older people in their SRH plans. The Mauritius National Sexual and Reproductive Health Strategy is exceptional its inclusion of older people's specific SRH needs and is detailed further in the Mauritius country summary report.
- Reports from Lesotho and Ethiopia indicate that social protection has strengthened family-based care of older people.

- NCD policy in Rwanda covers older people and the policy includes the provision of NCD check-ups in the *Imihigo* (performance contracts) of local leaders, but the extent of implementation is unclear.

Enabling environments

- NHRIs play an important role in monitoring older persons' fundamental and socio-economic rights and responding to complaints of human rights violations. Kenya, Rwanda, Mauritius, Ethiopia, and South Africa all have A-status NHRIs, indicating they comply with the Paris Principles, and South Africa, Rwanda and Ethiopia have commissioners dedicated to older persons and persons with disabilities. Kenya has a National Gender and Equality Commission, which has a special interest group dedicated to older persons, and which has conducted an audit of long-term care facilities and monitors and promotes mainstreaming of issues of the elderly in governance structures. The South African Human Rights Commission has done some important monitoring work in long-term care facilities and conducted an investigative hearing on older persons' rights in 2015. Lesotho does not have an operational NHRI and is in the process of developing one with United Nations support.
- There has been considerably less progress in this area than in others and it was difficult to find plans or policies on improving environmental accessibility for older people or PWDs and none of the countries appear to be part of the Age Friendly Cities network. While South Africa has made efforts at housing, little work has been done in terms of making public spaces, including health-care facilities more accessible.
- While all six focal countries have made provisions for non-discrimination and against abuse or neglect of older people, systems for reporting and addressing elder abuse are limited or function poorly.
- Only South Africa and Mauritius make assistive devices freely available to people with disabilities (including older people with disabilities).

Summary and Conclusions

Countries in the ESA region have made great strides in increasing the longevity of their populations, but people who do live into old age have not been well provided for by most governments and are side-lined in human and economic development efforts. In the context of rapid demographic, social, epidemiological, and environmental change, it is critical for states in the region to pay attention to the needs of a growing older population, from both a human-rights and a development perspectives. Putting in place policies and programmes that promote healthy ageing not only improves the welfare of the current population of older people in the region, but also allows them to participate in economic and social life and other meaningful activities for longer. This will help to safeguard economies from the possible deleterious impacts of rapid ageing on health and economic systems and create opportunities to harness the contributions of older people to development. Supporting healthy ageing in populations in the region also requires taking a life course approach and putting in place interventions to support healthy ageing early in the life course, such as addressing NCD risk factors, supporting reproductive health and choices of younger women, and addressing the social determinants of health that accelerate ageing and functional decline.

The situational analysis highlighted a clear need for increased social protection in terms of pension and health financing coverage, as well as the importance of addressing the significant health care access barriers and issues around health system responsiveness. This includes addressing the current lack of pension contributions among younger generations. The neglect of the SRH needs of older people is visible in the growing prevalence of HIV and AIDS and STIs in this population and the add in complex health needs of the ageing HIV-positive adults.

The ageist assumptions underlying the neglect of this population in the health system need to receive more attention.

Despite their vulnerability in disaster situations, older people are not well included in disaster planning or responses. The family has been critical in supporting and providing care to older people, but given changing societal and economic structures and economic it is insufficient to continue to rely on the family as the locus of care without acknowledging the value of the work done by caregivers young and old and bolstering family support structures to improve care capacity and reduce the negative impacts of care on households and caregivers.

This report has shown that the ESA region has made progress in terms of developing legal and policy frameworks to address ageing, but weak budget allocation and implementation has meant that quite limited progress has been made thus far. In the last MIPAA review about three-quarters of the reporting countries indicated encountering challenges with the implementation of national strategies and programmes on ageing. Insufficient financial resources ranked as the main challenge affecting implementation, closely followed by insufficient political will, cooperation between ministries, information, and translation of research into practice (MIPAA +15 review). An additional barrier to implementation is the very little funding that is allocated to matters concerning older persons by the international community.

Older age does not need to imply the end of good health and quality of life and ensuring that people can live decent lives as they age need not be expensive and interventions to prevent or slow the functional decline of older people; provide support for those who become care dependent can be carried out at the community level by building on and supporting existing community structures and traditional models of providing care.

Policy Recommendations and Areas for Action

DEVELOP POLICIES, SYSTEMS AND STRUCTURES THAT PROMOTE THE INCLUSION OF OLDER PEOPLE

- Governments are urged to ratify international and regional frameworks on ageing and older people, specifically the African Union Protocol on the Rights of Older Persons, and to develop and implement national policies on ageing and older people.
- Governments need to develop consolidated action plans for advancing issues of older people, along with mechanisms for tracking and reporting progress. Deliberate efforts must be made by governments to implement a Whole-of-Government Approach (WGA) to mainstream age-friendly strategies and interventions into all sectors, ministries and departments.
- Governments need to take a life course approach to healthy ageing, taking action to ensure peak health and function earlier in the life course by addressing social determinants of health and preventing functional decline in later years through supporting active and healthy ageing.
- Governments need to develop or strengthen coordination mechanisms to promote collaboration on ageing issues across departments and between government and civil society.
- Older people themselves must be at the centre of all development and humanitarian initiatives focused on ageing and older persons' issues, and there is a need to shift from a growth-based approach to a human-rights based model of development.
- Build opportunities and platforms for older people to meaningfully engage with leaders and decision-makers at local and national levels and voice their needs and concerns. Financial and technical support should also be provided to umbrella bodies that coordinate advocacy efforts by older persons' organizations.
- Development partners should support the creation of monitoring systems at the national and subnational level by engaging and building capacity in civil society organizations to work in a coordinated manner and hold governments accountable for implementing policies. One component may be engaging older people to act as monitors of policy implementation and programme roll-outs. For example, HelpAge International has trained "Older Citizen Monitors" in Uganda, Kenya, Mozambique, and Zanzibar to monitor roll-out of pension programmes for older people.
- NHRIs could be better leveraged in all countries to encourage and coordinate and mainstream policy responses to ageing by government and ensure compliance with international agreements.

MOBILIZE RESOURCES FOR OLDER PERSONS AND APPLY INCLUSIVE BUDGETING PRACTICES ACROSS SECTORS

- Inclusive budgeting practices should be mainstreamed across all departments and programmes to ensure that budgets take inequalities driven by gender, age and disability into account in allocating resources.
- Countries should include a dedicated line item in the health budget dedicated to healthy ageing to ensure that resources are available to implement healthy ageing plans and programmes.
- International development partners need to increase financial and technical support to NGOs, community-based organizations and older persons' organizations that are providing critical support to older people and their caregivers living in community settings.

IMPROVE SOCIAL PROTECTION FOR AND ECONOMIC INCLUSION OF OLDER PEOPLE IN THE REGION

- With the technical and financial support of development partners, governments should develop and extend universal non-contributory social pension and health financing systems with the goal of ensuring access for all older people and achieving the goal of UHC in the region. At the same time, governments with existing social protection systems should consider funding models for pensions and social health insurance schemes to ensure that these systems remain sustainable in the context of rapidly ageing populations.
- Governments should introduce policies aimed at combatting age discrimination and exploitation in the labour market and remove existing discriminatory policies (such as mandatory retirement ages) and include older people in literacy and training opportunities.
- Government, together with development partners, should ensure the inclusion of older people in decent work programmes and programmes that support informal sector work, including access to microfinance and microcredit schemes that can support labour market participation.
- Governments should introduce or strengthen legislation to protect older women's land rights.
- The business community, NGOs, government and the international community should partner to develop programmes that promote digital literacy among older people to promote their inclusion in the context of rapid technological progress in the region and bridge the "digital divide" between generations. This could include intergenerational knowledge-sharing activities; providing older people with access to basic technology to facilitate better access to media communications; harnessing technology to develop innovations that can support older people, caregivers and communities on issues related to ageing.

STRENGTHEN OLDER PEOPLE'S ACCESS TO ESSENTIAL HEALTH SERVICES AND CULTURALLY APPROPRIATE LONG-TERM CARE

- Training for health workers and community health workers on older persons' health and psychosocial needs, including SRH needs is essential for increasing responsiveness, trust and use of services by older people and reducing ageism in health services. This should be the dual responsibility of health ministries and national NGOs, supported by donor funding.
- The provision of NCD prevention and management services need to be prioritized at all levels of the health system and across the life course in the context of the rapidly growing burden of NCDs and the particularly high prevalence among older people. This requires increased funding for NCDs from both government budgets and development assistance.
- Older people need to be targeted in HIV and AIDS and STI prevention campaigns by national health ministries.
- Governments need to increase financial protection for health services to reduce large out-of-pocket spending among older people and poor older people need to be exempted from paying out-of-pocket when seeking care. Programmes also need to be put in place to reduce gaps in coverage of outpatient medicines.
- Civil society should empower older people on their health rights and support them to participate in public discussions around health and long-term care.
- Governments need to develop national policies, strategies and plans on long-term care to build long-term care systems and services and address the needs of older persons requiring care. National coordination mechanisms should be in place to ensure long-term care is integrated and coordinated within health and social systems and to manage partnerships between governments, civil society, faith-based organizations, community-based organizations, families, and volunteers.

STRENGTHEN THE INCLUSION OF OLDER PEOPLE IN DISASTER AND HEALTH SYSTEM EMERGENCY PLANNING

- Humanitarian organizations and development partners need to adopt age- and disability-sensitive policies and programming based on the Minimum Standards for Age and Disability Inclusion in Humanitarian Action a part of the Age and Disability Capacity Programme (ADCAP).
- Special attention should be given in contingency plans and strategies to address the amplified threats faced by older refugees or IDPs and provide access to health-care services in regions affected by conflict or other humanitarian emergencies. This is the responsibility of national governments with support from humanitarian and other development agencies.
- Emergency response plans need to include sections on older people that are based on consultations with older people and the organizations that represent them, as well as risk and vulnerability assessments to ensure that older people can be identified and their specific needs addressed in emergency contexts.
    - Older people's knowledge, skills and years of experience must be acknowledged and engaged by supporting older people to participate and have a voice in the development of disaster risk reduction strategies
    - Older people should also be included in the process of collecting data for risk assessments at the community level and government departments, and humanitarian agencies should collaborate with community networks and older persons' associations to support the identification and direct engagement of older people in planning and implementation of emergency responses.
    - Humanitarian agencies, other United Nations organizations and governments need to include older people in reporting on any emergency context.
- Humanitarian agencies and governments should specifically allocate separate resources to older people in programmatic responses to disasters and health emergencies. Taking a more homogenous approach to "vulnerable groups" risks older people being deprioritized in relation to other groups.
- Ministries of health should include alternative measures for providing older people continued access to essential health services, particularly for chronic conditions, during health emergencies. This can be achieved through community outreach programmes using local resources such as community health workers, community-based organizations, or transport services to deliver medications or provide door-to-door services. Funding should be allocated for these initiatives in emergency response planning.

PROMOTE DATA COLLECTION ACROSS THE LIFESPAN WITH AGE AND GENDER DISAGGREGATION OF DATA

- Governments and the international development community should invest in building data collection capacity in the region to improve the collection and analysis of ageing-related data and support African knowledge production.
- Put in place new demographic and health data collection models to allow African countries to plan for an ageing population. This should include the development of guidelines for standardized analysis and reporting of data across the region. Government statistical offices and researchers from the region should engage with the Titchfield City Group on Ageing (endorsed by the United Nations Statistical Commission) in their efforts improve age-disaggregated data and ageing-related statistics.
- All government statistical agencies, and the research community engaged in survey and census data collection, should ensure that data gathered and reported in surveys and health information systems and registers are disaggregated by age (in 5-year cohorts from 60 years upwards to capture the heterogeneity among the older population) and all surveys should include adequate samples to represent older people. Upper-age cut-offs in data collection (e.g. in Demographic Health Surveys) should also be removed.
- The research community, with funding from government and the donor community, should address information gaps on the health and well-being of older people by carrying out cross-sectional and longitudinal surveys and studies on ageing.

ADDRESS ISSUES RELATED TO AGEISM AND ABUSE OF OLDER PERSONS

- Governments need to modify or repeal any existing laws or policies that directly or indirectly discriminate against people based on their age.
- Government and civil society need to put in place enforcement mechanisms and monitoring bodies to enable the effective implementation of laws and policies addressing discrimination, human rights and inequality.
- Government and NGOs should roll-out communication campaigns, as well as educational and intergenerational activities across formal and informal education sectors to tackle ageism and break down societal assumptions about older people as weak and vulnerable that have been reinforced by the COVID-19 pandemic. In communication campaigns, there is a need to highlight the social and economic contributions people continue to make in old age, to reinforce their human rights and address ageism and stigma, including in relation to mental and cognitive health problems such as dementia.
- Humanitarian organizations should include violence prevention and response strategies in disaster preparedness and response plans and in risk mitigation communications to reduce and respond to violence against older people in emergency contexts.
- Government departments and NGOs should implement support programmes to support older people who have been abused, and inform the public about the availability of services to prevent and respond to violence and abuse.

Annexes

Annex A: Additional data tables

TABLE 1

COMPOSITION OF HEALTH-CARE SPENDING IN THE EAST AND SOUTHERN AFRICAN REGION

COUNTRY	CHE % GDP	CHE PER CAPITA IN US $	GGHE-D AS % OF GDP	GGHE-D AS % OF GGE	GGHE-D AS % CHE	EXTERNAL HEALTH EXP % OF CHE	OUT-OF-POCKET % OF CHE	VOLUNTARY HEALTH INSURANCE % CHE	OTHER PRIVATE HEALTH EXP % CHE
Angola	2.5	71.3	1.0	5.4	41.2	3.2	37.5	6.8	18.1
Botswana	6.0	481.5	4.7	14.3	78.5	6.1	3.1	8.9	12.2
Burundi	8.0	20.6	2.7	8.5	33.4	25.7	24.7	0.9	16.3
Comoros	5.2	72.3	0.8	4.1	16.1	17.6	61.8	3.1	4.5
DRC	3.5	20.6	0.6	4.4	15.8	38.8	38.5	3.1	6.9
Eritrea	4.5	25.3	0.8	2.4	17.6	39.2	43.2	-	0.0
Eswatini	6.8	264.1	3.4	10.0	50.7	26.1	10.6	10.9	12.6
Ethiopia	3.2	26.7	0.7	4.8	22.7	34.1	37.9	1	5.3
Kenya	4.6	83.4	2.1	8.3	46.0	18.5	24.3	9.8	11.2
Lesotho	11.3	124.2	4.9	8.8	43.5	42.3	13.8	-	0.4
Madagascar	3.7	19.8	1.2	8.0	32.2	28.2	32.5	3.5	7.1
Malawi	7.4	30.4	2.4	8.7	32.6	43.6	16.9	6.1	7.0
Mauritius	6.2	685.9	2.9	10.2	47.0	0.3	45.7	5.7	6.9
Mozambique	7.8	39.5	1.7	5.6	21.3	62.7	10.0	0.4	6.0
Namibia	8.5	427.3	4.0	10.7	46.9	4.7	8.2	39.9	40.2
Rwanda	6.4	51.4	2.6	8.9	39.9	33.8	11.7	2.3	14.6
Seychelles	5.2	839.8	3.8	10.2	72.7	0.0	25.2	0.7	2.0
South Africa	9.1	546.7	5.4	15.3	58.8	1.1	5.7	33.9	34.4
South Sudan	6.0	22.6	1.0	2.1	16.3	55.0	23.5	3.3	5.2
Uganda	3.8	32.4	0.6	3.1	15.1	42.0	38.3	3.8	4.6
Tanzania	3.8	40.3	1.6	9.6	40.9	36.1	22.2	0.8	0.8
Zambia	5.3	69.3	2.1	7.0	40.1	43.7	10.2	0.6	6.0
Zimbabwe	7.7	103.0	1.4	8.7	17.6	29.6	24.4	27.3	28.4

Source: World Health Organization, n.d. (Global Health Observatory - Data from 2019)

TABLE 2

THE HELPAGE INTERNATIONAL DISASTER RISK AND AGE INDEX

COUNTRY	HAZARD AND EXPOSURE	VULNERABILITY	LACK OF COPING CAPACITY	OVERALL RISK	RANK
(lowest-highest rank)	**(0-10)**	**(0-10)**	**(0-10)**	**(0-10)**	**(1-192)**
South Sudan	7.0	5.8	9.0	7.1	6
Congo DR	5.4	7.3	8.5	7.0	8
Kenya	5.8	6.6	7.6	6.6	12
Uganda	6.2	5.9	7.6	6.5	14
Mozambique	4.4	6.8	7.6	6.1	17
Ethiopia	5.3	4.8	7.8	5.9	21
Burundi	3.7	7.1	7.6	5.8	23
Tanzania	4.0	6.5	7.5	5.8	26
Zimbabwe	3.4	5.9	7.6	5.4	33
Madagascar	3.6	4.3	7.7	4.9	42
Eritrea	2.2	5.6	8.7	4.8	49
Rwanda	2.3	6.9	6.3	4.6	55
Malawi	1.9	6.4	7.4	4.5	62
Swaziland	2.1	5.8	7.5	4.5	63
Angola	3.5	3.4	7.5	4.5	64
Zambia	2.0	6.0	6.6	4.3	71
Lesotho	1.5	6.4	7.4	4.2	77
Namibia	1.9	5.8	6.2	4.1	81
South Africa	4.3	3.0	5.1	4.0	83
Comoros	1.0	5.7	7.8	3.6	99
Botswana	1.4	4.3	5.4	3.2	111
Mauritius	3.4	2.5	3.8	3.2	113
Seychelles	1.6	3.7	4.4	3.0	122

Source: HelpAge International, 2015

TABLE 3

INTERNATIONAL HEALTH REGULATIONS CAPACITY AND HEALTH EMERGENCY PREPAREDNESS

COUNTRY	COMPLIANCE WITH INTERNATIONAL HEALTH REGULATIONS (IHR) CORE CAPACITY SCORE (STATE PARTY SELF-ASSESSMENT ANNUAL REPORT 2020)	WHO STATE PARTY SELF-ASSESSMENT ANNUAL REPORT (SPAR) BENCHMARK CAPACITY LEVELS
Lesotho	40	2
Madagascar	36	
Malawi	39	
South Sudan	36	
Botswana	43	3
Burundi	53	
Comoros	41	
DRC	52	
Eritrea	57	
Eswatini	46	
Kenya	44	
Seychelles	56	
Tanzania	51	
Zambia	58	
Zimbabwe	52	
Angola	65	4
Ethiopia	67	
Mauritius	64	
Mozambique	70	
Namibia	61	
Rwanda	73	
South Africa	79	
Uganda	69	

Source: World Health Organization, n.d. (Global Health Observatory, Health Emergencies - Data from 2020)

TABLE 4

PROGRESS ON GLOBAL STRATEGY AND ACTION PLAN ON AGEING/UNITED NATIONS DECADE FOR HEALTHY AGEING INDICATORS IN THE EAST AND SOUTHERN AFRICAN REGION

Country	National Focal Point on ageing	National strategy / policy / plan on ageing	National multi-stake-holder forum / committee on ageing	National legislation and enforcement strategies against age-based discrim-ination	Legislation / regulations that provide older adults with access to assistive devices	National program Age-friendly Cities and Communities	National poli-cies for com-prehensive assessments of the health and social care needs of older people.	National long-term care policy plan / strategy/ framework	Cross-section-al nationally representative data on older persons	Longitudinal nationally representative surveys on older persons
Angola	?	?	?	?	?	?	?	?	?	?
Botswana	Yes	Yes	No	No	No	No	No	No	No	No
Comoros	No	No	No	No	No	No	No	No	No	No
Eritrea	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No	No
Eswatini	No	No	No	No	No	No	No	No	No	No
Ethiopia	Yes	Yes	?	Yes	No	No	No	No	No	No
Kenya	Yes	Yes	Yes	Yes	No	No	Yes	No	No	No
Lesotho	Yes	Yes	No	No	No	No	No	No	No	No
Madagascar	Yes	Yes	Yes	No	No	No	No	No	No	No
Malawi	No	No	No	No	No	No	No	No	No	No
Mauritius	Yes	Yes	Yes	Yes	Yes	?	Yes	Yes	Yes	?
Mozambique	?	Yes	?	?	?	?	?	?	?	?
Namibia	Yes	No (under discussion)	Yes	Yes	No	Yes	No	Yes	No	No
Rwanda	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No
Seychelles	No	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No
South Africa	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No
South Sudan	No	No	No	No	No	Yes	No	Yes	No	No
Uganda	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	Yes
Tanzania	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No
Zambia	?	Yes	?	?	?	?	?	?	?	?
Zimbabwe	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No
TOTAL	**13**	**15**	**9**	**10**	**4**	**7**	**7**	**10**	**2**	**1**

Source: World Health Organization, 2021 (and updated where more current information was available)

TABLE 5

COUNTRY PERFORMANCE ON GLOBAL ACTION PLAN ON NON-COMMUNICABLE DISEASES (2013-2030) IN THE EAST AND SOUTHERN AFRICAN REGION (AS AT 2020)

COUNTRY	TARGETS AND INDICATORS	POLICIES AND STRATEGIES	EDUCATION ON PHYSICAL ACTIVITY	GUIDELINES ON TREATMENT
Angola	No	No	No	No
Botswana	Yes	Yes	Yes	Yes
Burundi	Yes	Yes	No	Partially
Comoros	No	No	No	?
DRC	Partially	Yes	No	?
Eritrea	Yes	Yes	No	No
Eswatini	Partially	Yes	No	No
Ethiopia	Yes	Yes	Yes	Yes
Kenya	Yes	Yes	No	Yes
Lesotho	Yes	Yes	No	Yes
Madagascar	No	Yes	Partially	Yes
Malawi	No	No	No	Yes
Mauritius	Partially	No	Partially	Partially
Mozambique	Yes	Yes	No	Yes
Namibia	Yes	No	No	No
Rwanda	No	Yes	Yes	Yes
Seychelles	Yes	Yes	Yes	Partially
South Africa	Yes	Yes	Yes	Yes
South Sudan	Yes	No	No	No
Uganda	No	No	Yes	Yes
United Republic of Tanzania	Yes	Yes	No	Yes
Zambia	No	No	Yes	Yes
Zimbabwe	No	No	No	Partially

Source: World Health Organization, 2020c

TABLE 6

PROGRESS ON MADRID INTERNATIONAL PLAN OF ACTION ON AGEING IN SIX FOCAL COUNTRIES

OVERARCHING FRAMEWORKS AND COORDINATION AT NATIONAL LEVEL	ETHIOPIA	KENYA	LESOTHO	MAURITIUS	RWANDA	SOUTH AFRICA
National Focal Point on ageing	Yes	Yes	Yes	Yes	Yes	Yes
National strategy / policy / plan on ageing	Yes	Yes	Yes	Yes	Yes	Yes
National multi-stakeholder forum or committee on ageing and health	No	No	Yes	Yes	No	No
Representation and participation of older persons organizations in government policymaking processes at all levels	Yes, but limited capacity	Yes	No	Yes	Yes, but limited capacity	Yes
Recognition of the rights of older people in constitution and other legislation	Yes	Yes	Yes	Yes	Yes	Yes
Status of ratification of African Union Protocol on the Rights of Older People	Ratified	Ratified	Ratified	No (in process)	Signed and ratified, but not deposited	No (in process)
MIPAA PRIORITY DIRECTION 1: OLDER PERSONS AND DEVELOPMENT	**ETHIOPIA**	**KENYA**	**LESOTHO**	**MAURITIUS**	**RWANDA**	**SOUTH AFRICA**
Inclusion of issues of older persons relating to three priority areas of Madrid plan in national and sectoral development plans	Yes	Yes	Yes	Yes	Yes	Yes, but NDP has a youth focus
Existence of policies facilitating the education or employment of older persons	No	Yes	No	Yes	No	Yes, education
Availability and coverage of universal pension	No	Yes	Yes	Yes	No	No (means tested, although high coverage)
Availability, scope and coverage of legislation ensuring basic social protection for all ages	Yes, but limited coverage and low value	Yes	Limited mainly to old age and children	Yes	Very weak coverage	Yes
Inclusion of older people in all phases of humanitarian and disaster relief programmes (preparedness, relief and reconstruction) and decision-making	Yes, but not in detail	Yes, except for decision-making	No sufficiently included	Yes	Included in policy but not in plans	Yes

MIPAA PRIORITY DIRECTION 2: ADVANCING HEALTH INTO OLD AGE	ETHIOPIA	KENYA	LESOTHO	MAURITIUS	RWANDA	SOUTH AFRICA
Inclusion of financial protection for health for older people	Yes (but access limited)	Very limited	Yes	Yes	Yes	Yes
Inclusion of needs of older persons in national health plan	No	Yes	Yes	Yes	Partial	?
Availability, scope and coverage of gender-specific ageing targets	?	?	?	?	Yes	?
Availability, scope and coverage of programmes facilitating the use, accessibility and appropriateness of health-care services by older persons	Poor	Limited	?	Yes	None	Yes, but implementation varies
Inclusion of needs of older persons in national disability plan	?	No	No	Yes	Yes	Yes
Inclusion of older persons in HIV and AIDS statistics	No	No	No	No	No	No
Inclusion of older persons in HIV and AIDS programming and HIV caregiver support programmes	No	No	Yes	No	Yes, in policy, but unsure in practice	Yes
Inclusion of older persons programmes addressing the reproductive and sexual health needs of older people (aside from HIV)	No	Yes, but seems limited	No	Yes	None	?
Availability, scope and coverage of non-communicable disease prevention and management programmes (including mental health, vision, hearing and dental health), particularly at the primary health-care level	Weak	Yes, but coverage unclear	Weak	Yes, good coverage	Yes, but coverage unclear	Widespread, but more specialized services not available
Availability, scope and coverage of programmes promoting healthy and active ageing including reduction of behavioural risk factors and environmental risk factors at all ages, but with particular attention to persons over age 50	Limited	?	Limited	Yes, extensive	None	Yes
Existence of training programmes for professionals and para-professionals on the needs of older persons	?	Yes, but very limited	?	Yes	Yes (for CHWs)	Yes, but limited training in general curricula and not popular field
Existence of primary health-care services specifically designed for older persons	None?	None	None	Yes	None	None

Existence of mental health programmes and prevention programmes and services for older persons at all levels, particularly community level	None	Yes	Limited	Yes	None	Yes
Existence of guidelines and standards of health-care provision and rehabilitation services for older persons	Guidelines in place but not specific to older people	?		?	Yes (for CHWs)	Yes
National policies for comprehensive assessments of the health and social care needs of older people.	No	No	No	?	None	?
National long-term care policy / plan/ strategy/ framework	No	No (but standards in place)	No (but guidelines in place)	Yes	None	Yes
Availability, scope and coverage of programmes facilitating family, community and institutional long-term care for older persons	Limited	Yes, expanding efforts	Limited	Yes, extensive	Limited	Yes, but limited in rural areas and poorly funded
Cross-sectional or longitudinal nationally representative, anonymous individual level data on older persons and their health status and needs	No	Some	No	Yes	No	Yes
MIPAA PRIORITY DIRECTION 3: ENSURING ENABLING, SUPPORTIVE ENVIRONMENTS	ETHIOPIA	KENYA	LESOTHO	MAURITIUS	RWANDA	SOUTH AFRICA
Existence of a national policy and programmes to make transportation accessible, affordable and appropriate to older persons	No	No	No	Yes	No	Yes, but access varies
National legislation and enforcement strategies against age-based discrimination	?	Yes	Limited	Yes	Limited	Yes
Existence, scope and coverage of national legislation and programmes to combat elder abuse and provide services to older victims of neglect, abuse and violence and promote intergenerational solidarity	Yes, but limited	Yes	Yes	Yes	None	Yes
Legislation / regulations that provide older adults with access to assistive devices from the WHO priority assistive products lists	No	No	None	Yes	None	Yes
National programme to support the development of Age-friendly Cities and Communities.	No	No	No	Yes	Partial (related to disability rather than age)	No national programme, but other supporting programmes in place

Source: Summary of findings in this report

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