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The State of Older People in Africa -2007

Regional review and appraisal of the Madrid International Plan of Action on Ageing

Economic Commission for Africa
African Centre for Gender and Social Development
Human and Social Development Section

Contents

Acronyms

ACGS	African Center for Gender and Social Development
AUC	African Union Commission
AUPFPA	African Union Policy Framework and Plan of Action
CSD	Commission on Social Development
ECA	Economic Commission for Africa
ECOSOC	Economic and Social Council
EGM	Expert Group Meeting
HAI	HelpAge International
ICPD	International Conference on Population and Development
ILO	International Labor Organization
MDG	Millennium Development Goals
MIPAA	Madrid International Plan of Action on Aging
NEPAD	New Partnership for Africa's Development Programme
NGO	Non-governmental Organizations
PRSP	Poverty Reduction Strategy Paper
REC	Regional Economic Community
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
UNFPA	United Nation Population Fund for Africa

Preface

Africa is faced with the simultaneous challenge of sustaining high economic growth and achieving social development. While overall economic growth remained strong during the last few years[1], there is still no clear evidence that such growth has created jobs for Africa's rapidly growing working age population, or reduced poverty. Inequality is rapidly increasing on income distribution, accessibility to resources and assets, and on accessibility to services such as health and education. Older persons, among other people, continued to be the most marginalized and vulnerable groups in Africa. As long as the depth and breadth of social inequalities continue, achieving inclusive development will remain a challenge for Africa.

Social development, as globally echoed during the Social Development Summit in 1994 in Copenhagen, requires not only economic growth, but also social justice, social inclusion and social cohesion. These principles are enshrined in national constitutions, and are indispensable for realizing the UN charter, which calls for achieving peace, security and development. Therefore, economic policies must be matched with social development policies and actions for an inclusive development process.

This special report on the ***State of Older People in Africa - 2007*** reflects the need for synchronization of economic and social polices for inclusive development. The old persons aged 60 or more in Africa are rapidly growing. They are estimated at 50.5 million in 2007 and expected to reach 64.5 million in 2015; the year for achieving the MDGs. They will exceed 103 million in 2030 and 205 million in 2050. With these rapidly increasing numbers, older persons in Africa will grow at annual rate of 3.1 per cent between 2007 and 2015, and 3.3 per cent between 2015 and 2050; which is faster than the growth of the general population.

The high growth and rapidly increasing numbers of older persons reflects the urgency for policy actions, as ageing is occurring at a much shorter period compared to Europe, for example. In addition to this timing constraint, policy actions on ageing in Africa are further complicated by rapidly changing environment in which older persons live. The great majority of the older persons live in rural areas where social infrastructure is scanty. The traditional support system and the family institution continued to break down as a result of increasing migration and urbanization, and political instability. While older persons lost much of the traditional social support, they found themselves having to play the role of caregivers for HIV/AIDS orphans.

These constraints notwithstanding, the review and appraisal of the implementation of the MIPAA conducted by the ECA show encouraging progress on policies and actions in the continent, particularly in the area of ageing and development. The great majority of the countries affirmed that ageing is a development challenge, and many of them included ageing in their national social development policies. Therefore, the platform for further action has been laid. However, progress during the last 5 years has been uneven. Social protection received more attention, as many countries have introduced or expanded their social security programs. Most of the contributory social security schemes only cover civil servants and formal sector employees. Agriculture and informal sector workers continue to be socially excluded. Therefore, the major

[1]According to the ECA Economic Report on Africa 2008, the continent achieved a 5.8 per cent growth rate in 2007, up from 5.5 per cent in 2006 and 5.3 per cent in 2005.

challenge for the social security programs is to scale-up the coverage and address the issue of social exclusion.

Countries are also confronted with the challenge of strengthening familial and informal social protection systems. Among the best practices identified in Africa in dealing with the challenge of ageing, are the Republic of South Africa, Mauritius and Tunisia. The Republic of South Africa has commendable old age grant provided monthly to its elderly citizens without other means of regular income support. Other countries with similar grants are Botswana, Lesotho, Mauritius and Namibia. In all these countries the grants were found to substantially reduce poverty rates among older persons.

Most of the countries need to improve their health systems, and to reorient health care and personnel towards meeting the needs of rapidly increasing numbers of older persons. The special care and health needs of older persons have been compromised by rapid spread of HIV/AIDS in the continent. Though the number of older people living with HIV/AIDS is increasing, they remain excluded from routine surveillance programs. Also, very little prevention, education and treatment targeted older persons. Moreover, older persons are bearing the burden of caring for AIDS orphans whose numbers are expected to increase from 12 million in 2006 to 16 million by 2010. Therefore policy actions are needed to incorporate older persons in the surveillance and HIV/AIDS intervention programs and strategies. Also, inclusive social development requires an enabling environment that supports older persons in terms of housing, strengthen their role as caregivers, eliminate neglect and violence against them, and to enhance the public image on ageing.

The review and appraisal of MIPAA show that increasing number of older persons in Africa requires partnership and collaboration among public, civil society and private sector to effectively integrate them in the development process. The countries identified several priorities for future actions. Most important is to strengthen institutional capacities for managing the multiple challenges of ageing; support public-private partnership for intensifying interventions; collect more data and conduct research and analyses to inform policy and program formulation and implementation. In addition to supporting these areas, UNECA will continue to help the countries to formulate and implement policies and program on ageing and development in the continent, and to document best practices and lessons of experience, and share knowledge with regional and like-minded institutions. The ECA will continue to identify areas where less progress has been made, particularly the areas related to poverty and the achievement of the MDGs.

The recommendation of this report will be valuable for the policy makers, officials, researchers and development planners at all levels, in their efforts to achieve inclusive social and economic development in Africa.

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[2] Amson Sibanda Joined UNDESA in 2007 while Israel Sembajwe retired in October 2007.

Executive Summary

This report contributes to the regional five year review of the implementation of the Madrid International Plan of Action on Ageing (2002) in Africa.

Population ageing is a global phenomenon. Mortality and fertility rates are declining worldwide and older people constitute increasingly higher proportions of the total world population. In 2007 people aged 60 and over represented 11% of the world's population and this is projected to rise to 21% by 2050 (United Nations Department for Economic and Social Affairs (UNDESA 2007). As long as the mortality rate among people aged 60 and over continues to decline and the population fertility rate remains low, the proportion of older people will continue to increase. The trend of population ageing is predicted to endure.

Ageing populations present a challenge to all regions of the world. However, the challenge is greatest in Africa which will experience the fastest rate of population ageing than any other region in projections to 2050. For the continent as a whole, the percentage of people aged 60 and over is predicted rise from 5.1% in 2000 to 10.4% by 2050 (UNDESA 2007). The rate of change has significant implications for socio-economic conditions within African countries and the challenge is heightened by the concurrent issues of the highest global levels of poverty and the HIV/AIDS pandemic, which affect the quality of life of millions of individuals and particularly impact upon older people.

Part One of this report examines the policy environment for tackling the challenge of ageing populations. The two key policy instruments, which guide country level responses, comprise:

- the Madrid International Plan of Action on Ageing (MIPAA), the global policy framework adopted by the United Nations General Assembly in 2002
  and
- the African Union Policy Framework and Plan of Action (2002) (AU PFPA) which represents the regional level policy instrument.

These complementary plans call for a range of recommended actions to achieve the common goal of improved wellbeing for Africa's older people. The key call for action is the mainstreaming of ageing and concerns of older people into national development frameworks, Poverty Reduction Strategies and Plans (PRSPs) and Millennium Development Goal (MDG) processes. Specific recommendations address older people's rights, inclusion in the development process, health and wellbeing, and a range of factors, which affect the social and economic situation of older people. Both the UN and AU have introduced five-year follow-ups to review progress on the plans and have mobilised agencies at the international, regional and sub-regional levels to encourage country level action and participation in the review. These agencies include the Economic Commission for Africa (ECA), the New Economic Partnership for Africa's Development (NEPAD) and the Regional Economic Communities (RECs).

National level responses to MIPAA and AU PFPA across Africa to date have been uneven, with varying levels of mainstreaming and policy development within countries. While African governments generally acknowledge the challenge of population ageing, the degree of

engagement is influenced by country-specific ageing circumstances, competing priorities for budgetary allocation and the capacity of institutions at the national, regional and community levels to respond effectively. To encourage engagement, clarity is required on the link between population ageing and development agendas, and the influence of international aid modality on PRSPs, where focus on poverty and younger age groups may be interpreted as reducing the commitment to social exclusion issues.

Part Two addresses four key factors, which affect the situation of older people:

1. Changing population age structure. Rates and patterns of age structure change vary in different regions in Africa. Northern and Southern Africa will experience the fastest rate of population ageing, with older people reaching up to nearly 20 % of the population in Northern Africa by 2050. The populations of Eastern, Middle and Western Africa are projected to age much more slowly. Nonetheless, the proportion of older people is increasing in all African regions and this creates demand for public policy intervention to deliver adequate health services, income security and protection from poverty. A number of commentators note the time-limited opportunity for African governments to take advantage of the current favourable dependency ratio, where the younger and potentially economically active out-number people 60 and over and under 20. There is an urgent need for international cooperation to support African governments to promote employment and economic growth and put measures in place to prepare for the increasing proportion of older people in the population.

2. Social and economic situation. The social and economic situation of older people in Africa is deteriorating. Processes of modernisation including individualism, urbanisation and migration, and the parallel process of the impact of HIV/AIDS have eroded traditional systems of intergenerational family and community support where many people living with HIV/AIDS (PLWHA) become dependent on their parents for care rather than supporting them in older age. These factors have combined to undermine not only older people's financial security but also traditional levels of respect and valuing. Many older people, particularly women, suffer stigmatisation, abuse and violence. Policy action is required to revitalise a sense of family responsibility in society and strengthen traditional community forms of support.

3. Health issues of older people and the impact of HIV/AIDS. In older age health issues change; there is a shift away from the incidence of communicable diseases to non-communicable diseases, typically chronic, degenerative and mental illness. This is accompanied by a higher incidence of disability. There are considerable implications for health service provision. The existing widespread lack of specialist services and personnel to serve the health needs of the growing numbers of older people needs to be addressed. Maintaining good health and improving access to existing services and treatment are major issues. Increasing numbers of poor older people, particularly women, need help at the fundamental level of improving the nutritional value of their diets and paying for services and essential medicines to treat their existing conditions. Free health services and medication for poor older people remain a goal.

The indirect and direct impact of HIV/AIDS is a further area of concern. Older people typically care for their adult children and/or grandchildren affected by the pandemic and this indirectly affects their health. Care-giving, paying for medicines and living expenses, foregoing economic

activity and the loss of current and future support, cause a slide into poverty and deplete the health of many older people through poor nutrition, fatigue and worry. The lack of comprehensive free health services for PLWHA and financial and social support for older people, commonly women, caring for PLWHA are areas for policy focus.

HIV/AIDS directly impacts upon older people when the virus infects them. Awareness raising of risk of infection and preventative measures targeted at older people is necessary. The needs of older people in HIV/AIDS treatment and intervention programmes are neglected in most African countries.

4. Social protection systems. Informal systems of social protection in the form of cash and kind from both extended family and community sources have suffered a decline in recent decades because of falling commitment to traditional systems of support. Their effectiveness has been further eroded by the HIV/AIDS pandemic reducing the numbers of younger people able to contribute. Traditionally informal social protection has been effective in reaching the poorest and most vulnerable in rural as well as urban areas. The potential for strengthening the characteristically weak resource bases of these systems and the re-energising of commitment to family and community responsibilities are areas for action on ageing.

In the majority of African countries formal systems of social protection capable of absorbing the increasing numbers of older people do not exist. Former civil servants and formal sector employees may receive pensions from contributory social security schemes, but the vast majority of the older population across Africa involved in informal sector activities do not receive financial support. Evidence of lower levels of poverty among older people and their households in countries where universal or means-tested non-contributory pension schemes operate, suggests knock-on benefits for the community as well as recipients. Despite global and regional policy aims of the introduction of non-contributory pensions for older people, there is no clear cut solution to improving and extending coverage of formal social protection systems in Africa given the state of most African economies. At this stage funding support from the international community is required to strengthen country level research into a) social security system options and b) potential linkages and synergy between formal and informal sector interventions.

Part Three presents examples of national progress on the implementation of MIPAA and AU PFPA. These are drawn from the Expert Group Meeting on Ageing in Ethiopia (2007), a review activity arranged in partnership between UNECA, DESA, the African Union and HelpAge International. Summaries of country presentations by national delegates from Ethiopia, Ghana, Mauritius, Republic of South Africa, Tanzania and Uganda, capture up-to-date statements of national responses to action on older people's concerns. The variation in response reflects differences in resource bases, institutional capacities and competing priorities within each country context.

Under **Policy Recommendations and the Way Forward** the report proposes 44 specific policy actions. These are drawn from each part of the report and identify areas for government intervention while at the same time encouraging the involvement of other key actors. While the recommendations are specific in nature, the overarching aim is the formulation and

implementation of national policies and plans to address ageing issues. The recommendations are also characterised by a number of themes of key relevance to progress:

- the need for evidence-based research to guide the formulation of policy and justify bids for budgetary allocation;
- the promotion of participatory dialogue and decision-making processes involving all stakeholders, including older people, to improve the relevance of policies and plans;
- the investigation of cross-sectoral cooperation and coordination between public and private sectors and civil society organisations to strengthen and scale-up effective interventions;
- the need for capacity strengthening to enable public institutions and civil sector organisations to implement plans effectively;
- the call for the engagement of international cooperation to support action on ageing.

The way forward therefore relies on a partnership approach between the actors involved at each level: global, regional, national and within each country, to take timely and effective action on ageing. The first step is for partners to engage actively in the five year review process.

Part 1

The policy environment

Africa will experience a faster growth in the number of older people in the population to 2050 than other regions of the world. The number of people aged 60 and over in Africa is projected to increase from the 2007 figures of 50.5 million to 64.5 million in 2015, and reach 205 million by 2050 (UNDESA 2007) . This represents a rate of increase of double the annual population growth, with the number of older people in the population increasing at an annual rate of 3.1% between 2001 and 2015, and 3.3% between 2015 and 2050. Ageing populations present a challenge to all regions of the world. However, the challenge is particularly significant in Africa, heightened by the concurrent issues of the highest global levels of poverty and the HIV/AIDS pandemic, which affect the quality of life of millions of individuals and particularly impact upon older people.

Africa as a region and national governments within the continent have recognised the global call for action. A range of international and regional policy instruments guide and support national policies and programmes to address the needs of people aged 60 and over. The following represent the key frameworks in the policy environment.

1. The Madrid International Plan of Action on Ageing

In 2002 delegates representing more than 160 governments attended the United Nations Second World Assembly on Ageing to revise the Vienna Plan on Ageing (1982) and establish a long term strategy for tackling ageing world populations. The meeting resulted in the adoption of the Madrid International Plan of Action on Ageing (MIPAA) and its call to action to 'build a society for all ages':

"People as they age, should enjoy a life of fulfilment, health, security and active participation in the economic, social, cultural and political life of their societies. We are determined to enhance the recognition of the dignity of older people and to eliminate all forms of neglect abuse and violence".

The Plan sets out 33 objectives and 117 recommendations, which are grouped around three priority areas:

- Including older people in development
- Advancing health and wellbeing into old age
- Ensuring enabling and supportive environments.

Among a range of aims and recommendations there is one firm target: to halve the number of older people living in extreme poverty by 2015 in line with the Millennium Development Goal on Poverty Reduction.

MIPAA constitutes the global policy framework:

- It is an international agreement which commits governments morally and politically to include ageing in all social and economic development policies, including poverty reduction strategies;
- It aims to ensure that people everywhere can age with security and dignity, and continue to participate in their society as citizens with full rights;
- It emphasises the right and potential of older people to participate actively in economic and social development.

The Plan calls for governments to integrate the rights and needs of people aged 60 and over into national development policies:

'Governments have the primary responsibility for implementing the broad recommendations of the International Plan of Action, 2002. A necessary first step in the successful implementation of the Plan is to. Programme innovation, mobilization of financial resources and the development of necessary human resources will be undertaken simultaneously. Accordingly, progress in the implementation of the Plan should be contingent upon effective partnership between Governments, all parts of civil society and the private sector as well as an enabling environment based, inter alia, on democracy, the rule of law, respect for all human rights, fundamental freedoms and good governance at all levels, including national and international levels.' MIPAA, Recommendation 116.

In order to guide national efforts, the Plan contains a section on implementation and follow-up. It is intended that the Plan is used as a practical tool to help policy makers focus on the key priorities associated with individual and population ageing. A number of supports have been put in place to strengthen implementation. This includes the designation of the Commission on Social Development (CSD) as lead organisation to support the implementation of MIPAA, by the UN General Assembly and the UN Economic and Social Council (ECOSOC). Accordingly, in 2003, CSD introduced a 'bottom-up' participatory assessment process for MIPAA, which promotes links between local and national ageing initiatives and regional intergovernmental and global levels of review.

In 2004 CSD introduced a five year cycle of review and appraisal for MIPAA. Thus in 2007, five years after MIPAA was adopted, a review period has been set in motion phased over two years (2007-08). This means that government reports may not be completed in detail before the end of 2008. The bottom-up approach leaves ownership of MIPAA in the hands of national governments, which is also explicit in MIPAA Recommendation 116, above. Take up of MIPAA has been uneven across Africa resulting in varying levels of prioritisation of ageing issues in national plans, and the MIPAA+5 review period therefore provides an opportunity for a range of stakeholders originally envisaged as playing key roles, to reflect on their input. The review also gives advocacy groups the opportunity to make their voices heard to influence policy directions and to call for the involvement of all stakeholders.

2. African Union Policy Framework and Plan of Action on Ageing

The African Union Policy Framework and Plan of Action on Ageing (PFPA) represents the regional response to tackling the challenge of ageing populations. Developed in a partnership between the AU, African governments and Help Age International from an initial focus of the Organisation for African Unity, (now the African Union (AU)), Session of the Labour and Social Affairs Commission in Namibia 1999, the policy was approved at the 38th Ordinary session of the Assembly of Heads of State and Government in South Africa, 2002. The PFPA states that it has been formulated to:

'guide AU Member States as they design, implement, monitor and evaluate appropriate integrated national policies and programmes to meet the individual and collective needs of older people.'

The PFPA commits all AU member countries to develop policies on ageing:

'Government has responsibility to provide leadership on the development of National Policies and to challenge discriminatory practices.'

At the same time it recognises the resource implications and recommends that

'*The rights and needs of older people should be included in national budgets and Governments should advocate the allocation of resources for programmes to address ageing issues from the international donor community.'*

The PFPA sets out the pressing issues and actions to be taken in 13 key areas connected with ageing and make 29 recommendations. It is possible to group the 13 areas of concern for people aged 60 and over in to four broad categories:

- Rights
- Poverty and income security
- Health, social welfare and role of the family
- Information and coordination of policy development.

Within these priority areas PFPA highlights the importance of factors with particular resonance in Africa including the depth of poverty, the impact of HIV/AIDS, the impact of migration, gender disparity, and the effect of crises, emergencies and epidemics. In this sense the PFPA is an instrument for government action that is geared to the specific circumstances and priorities of the continent.

The PFPA also emphasises coordination of efforts between stakeholders including the private sector, non-governmental organisations, religious bodies, the general public and media alongside national and local government bodies, to avoid duplication of input and mobilise resources efficiently. The coordination of plans and actions is encouraged beyond national boundaries; partnerships are promoted at sub-regional, regional and international levels, while the roles of the international community in providing funding and the concomitant national responsibility to seek funding for ageing are emphasised. In the same vein of inter-country cooperation, the PFPA

specifically identifies the need for research into ageing to be undertaken so that information on the scope and nature of ageing issues across Africa can be communicated to national and regional organisations responsible for policy implementation.

The PFPA contains indicators for monitoring progress against recommended actions. These include the development of a national policy and plan of action on ageing, ministerial or national department responsibility for ageing issues, constitutional changes to protect the rights of older people, national level allocation of dedicated budgets, a mechanism for reporting annually to the AU and importantly a system for older people to participate in national and other committees.

Following the launch of PFPA, the AU established the Economic Social and Cultural Council (ECOSOCC) in 2005 to support the building of strong partnerships between governments and the range African civil society stakeholders. As part of ECOSOCC, one of the ten committees set up to inform AU policies and programmes has the remit of social affairs and health; it is responsible for ageing among a range of other social issues. Thus the AU aims to work in partnership with regional and sub-regional bodies including the ECA, the African Development Bank, the New Economic Partnership for Africa's Development (NEPAD), and the regional economic communities (RECs) to advocate for the inclusion of social issues, such as ageing, into policies and development strategies at country level.

3. National policies on ageing in Africa

National responses have varied in terms of mainstreaming ageing issues and developing national policies and plans of action as called for by MIPAA and the AU PFPA, with some countries making more progress than others. Both MIPAA and the AU PFPA anticipated that individual country policy development would depend upon the political will, competing priorities, country-specific ageing circumstances and capacity of institutions at national, district and community level to engage:

'We commit ourselves to the task of effectively incorporating ageing within social and economic strategies, policies and action while recognizing that specific policies will vary according to conditions within each country.' MIPAA, Article 8.

Soon after the launch of both MIPAA and AU PFPA, the ICPD+10 Global Survey conducted by UNFPA in 2003 generated encouraging results: 12 African countries identified a major initiative in response to a question on the existence of policy and/or programmatic initiatives on meeting the needs of older people. This represented an improvement on the past when only Mauritius and the Seychelles included issues of older people in their policies or programme initiatives.

In addition, the ICPD+10 Survey for Africa conducted by UNECA in 2003 found that 32 out of 41 countries (78%) recognised ageing as a development challenge. In a UN analysis of population policies and population dynamics for 35 African countries, findings indicated that 17 countries (49%) considered ageing to be a major concern. These results suggest that ageing had been recognised as part of the development agenda and the foundation had been laid for action on ageing.

More specifically the UNECA ICPD+10 survey revealed that 13 countries (42%) cited policy development as their main measure in response to ageing issues, while 11countries (35%) developed provision of institutional care; and 7 countries (23%) identified provision of social security/pension schemes as the primary response (Table 1). In addition to the main measure indicated, 13 (42%) out 31 countries also cited a second measure: provision of institutional care by Benin, Morocco, Niger and Senegal, provision of social security/pension scheme by Cameroon, Seychelles, Togo; promotion of policy development by Algeria, Côte d'Ivoire, Ghana, Guinea, Mali and Tunisia. Togo went further and also identified policy development as a third measure.

Table 1: Main measures taken by countries to address the needs of older people

Measures	Number	%	Countries
Provision of institutional care	11	35	Nigeria, Cameroon, Burundi, Cape Verde, Côte d'Ivoire, Guinea, Mali, Seychelles, South Africa, Togo, Tunisia
Provision of Social Security/ Pension scheme	7	23	Botswana, Ghana, Lesotho, Sierra Leone, Gambia, Zambia, Zimbabwe
Policy Development	13	42	Angola, Benin, Central Africa Republic, Ethiopia, Madagascar, Mauritius, Morocco, Niger, Nigeria, Rwanda, Senegal, Sudan, Uganda
Total	31	100	All countries promoting a measures

Between 2003 and 2004 two sub-regional workshops were held in Africa to clarify the situation of national responses to action on ageing. In the first meeting held in 2003 in East Africa by the United Republic of Tanzania, UNDESA and Help Age International, a range of policy issues were raised including the pertinent challenges of:

- accepting older people as partners in development and as positive agents of change
- constructing the evidence base to enable governments to justify budgetary allocations to older people
- building the political will to integrate older people into development strategies linking ageing to existing policies and programmes
- linking older people with civil society groups active in poverty reduction and
- forging partnerships between stakeholders including older people.

In the second sub-regional meeting (West Africa 2004), held in Accra by HelpAge International, a number of encouraging policy developments were reported in 2004:

- Kenya's draft Policy on Ageing was awaiting presentation to Cabinet for approval;
- Mozambique had adopted a Policy on Ageing on 13 November 2004;
- Ghana's draft Policy on Ageing was presented in March 2003 and awaited approval;
- Zimbabwe's draft Policy on Ageing was expected to be tabled in Parliament by December 2004;
- Tanzania had adopted a National Ageing Policy in 2003;
- South Africa was in the preparation phase of a National Policy on Ageing;
- Cameroon's draft Policy on Ageing was being prepared.

In all these processes, HelpAge International was noted as an important international partner in providing technical and advisory support.

The task of capturing a comprehensive picture of the current state of progress towards MIPAA and AU PFPA at national level across the region presents a challenge because of uneven availability of information and differing country approaches to action on ageing. Nonetheless, the UNECA Expert Group Meeting on Ageing in Africa, convened in Ethiopia in November 2007, provides some valuable information. Presentations from Ethiopia, Ghana, Mauritius, South Africa, Tanzania and Uganda informed the meeting of progress on policy instruments:

- Ethiopia aims to introduce a National Plan of Action on Ageing and devise implementation manuals with stakeholders. A draft plan is at the consultation stage.
- Ghana's draft National Policy on Ageing continues to await adoption. There are aims to establish a National Coordinating Institution on Ageing to guide implementation of plans once the policy has been approved.
- Mauritius, as a welfare state, described a range of well-established legislative frameworks and welfare policies, which it is reviewing to address the challenges of an ageing population. No national policy on ageing was communicated.
- South Africa has developed a draft National Plan of Action on Ageing; it has reached the consultation and lobbying for funding stages.
- Tanzania's National Ageing Policy was approved in 2003; this awaits translation into national budgetary allocation to fund dedicated initiatives on ageing issues.
- Uganda has a range of overarching national policy frameworks to address poverty and the needs of vulnerable members of society including older people. Responsibility for ageing issues lies with the Ministry of Gender, Labour and Social Development and is the remit of the Minister of State for Elderly and Disability Affairs.

These country updates are helpful because they underline how intentions in many countries have not yet translated into mainstreaming and focus of practical action on

population ageing. They offer a reflection of the reality of policy development in the continent, where existing national institutional structures, influences of international aid modality and national priorities combine to result in differing actions, rates of response and levels of prioritisation on ageing in comparison with other development issues.

4. The significance of review and appraisal activity

The current MIPAA+5 bottom-up review and appraisal period to assess progress provides an opportunity to galvanise intent and identify obstacles that stand in the way of action on ageing. CSD has designated UNECA, in parallel with other United Nations regional commissions in other parts of the world, to work in partnership with UNDESA to initiate the UN review process in Africa. Towards the end of this exercise in 2008 more detailed and comprehensive information will have been gathered about the region's progress in implementing MIPAA. The review takes the shape of regional activities in which DESA and other commissions will be invited by the host commission to exchange knowledge and identify lessons learned. DESA recommends two areas for international cooperation:

- training activities on how to organise and coordinate a nationwide review and appraisal incorporating participatory methods of data collection and analysis;
- regional review and appraisal events (meetings/conferences) to evaluate the national experience in the region and identify future priorities for implementing the MIPAA.

The AU has also undertaken a five year review process of African countries' progress on their regional instrument of action on ageing, the PFPA. The Expert Group Meeting on Ageing in Ethiopia in 2007, a review activity arranged in partnership between UNECA, DESA, the African Union and HelpAge International denotes cooperation and complementarities between the organisations to achieve the common goal of improved quality of life for Africa's ageing populations, and gathering information on the rate of progress as part of that process.

A number of presentations (Ferreira 2007; Nhongo 2007; Schoenmaeckers 2007) at the Expert Group Meeting 2007, noted the pressing nature of the phenomenon of ageing in Africa. Alongside the implications for societies in the future, there is recognition that the reality of the current situation of older people in African countries remains a matter of great concern, despite regional and global efforts to put in place frameworks and supports to encourage governments to take action. There are a number of factors that interplay to influence governments' focus on issues other than ageing. These include national priorities influenced by international aid modality, for example where PRSP focus on poverty reduction may be interpreted as reducing the commitment to social exclusion (Booth and Curran 2005). The PRSPs tend to encourage focus on the concerns of the younger sections of society in terms of reducing poverty and funding education to increase their employment opportunities and economic potential. This overlooks the economic potential of older people among whom many remain able and willing to contribute long after 60 but lack opportunity. Consequently, older people are often left out of the mainstream of government policy because their needs are not always

recognised as a development issue. This is exacerbated by the lack of voice of this largely vulnerable and marginalised group, where despite exemplary efforts (HAI 2007) to redress this situation, advocacy instruments are relatively underdeveloped and representation is low in comparison with competing interest groups. These and other factors combine to create a policy environment at individual country level where government interventions tend to prioritise other development issues rather than action on ageing in highly competitive funding environments.

This situation means it is essential for stakeholders to engage in the global and regional review processes for the following reasons. Firstly the review process will raise awareness about the importance of action on ageing. This in turn will help to encourage the commitment of governments to implement the AU PFPA and MIPAA. The majority of countries in Africa do not currently have active policies on ageing. These two ageing policy instruments provide clear guidelines for designing policies and programmes as well as allocating budgets. The bottom-up design of the review will also enable older people and their representatives to be heard and feed into the decision-making process. This makes a vital contribution to raising awareness of older people's issues and hearing firsthand accounts of the poverty, lack of access to healthcare and disempowerment, which they experience.

Secondly, this process of raising awareness may instil in policymakers the urgency of the situation. While it is natural in some ways for policymakers to be used to looking towards the short/medium term, the trend of ageing is a challenge that requires immediate attention even though it does not seem to be an immediate issue. The fact that the number of younger people in populations is growing attracts policy focus, deflecting attention away from the fact that their relative share of the population is decreasing. The ageing issue will not resolve itself. It will deepen. Some commentators argue a window of opportunity exists within which ageing issues may be satisfactorily addressed (Schoenmaeckers 2007, Bloom *et al* 2003). The window occurs when economically active members of society outnumber the young and the old, in other words the dependency ratio is favourable. To take advantage of this theoretical opportunity, supportive economic and institutional structures need to be in place to benefit from the favourable demographic structure. However the window is time-limited: those economically active people will age and will not be replaced at a sufficient rate resulting in the decrease of the proportion of economically active in the population. It is projected that the window of opportunity for African countries extends between 1990 and 2060. On the one hand in many countries the economic institutional structures are not sufficiently strengthened to benefit from a favourable dependency ratio. On the other hand a significant proportion of this period has passed and currently most governments lack appropriate national policy instruments to address the needs of an ageing population either in the present or in preparation for future increases in the proportion of older people in the population. It is therefore essential to put policies and programmes in place in the immediate future to deal with the situation before ageing becomes an overwhelming challenge.

5. Facilitating engagement with the MIPAA and AU PFPA review

In reporting environments where review activities are required on MDGs, PRSPs and various partnerships agreements in international cooperation, the issues of prioritisation, capacity and resource allocation for action on ageing are relevant at country level.

National responses to MIPAA and AU PFPA appear so far to have been influenced by the lack of clarity on the link between population ageing and development agendas (Ferreira 2007). Low prioritisation of policy action on ageing in many countries needs to tackled by examining assumptions about older people and gathering concrete information, for example, on the decline of family care for older people, the role of older people in caring for those affected by HIV/AIDS and the efficacy of social protection in reaching older people. The relevance of ageing to mainstream development needs to be clearly communicated. Existing evidence indicates that reduction of older age poverty could contribute to the reduction of poverty in other groups and broadly foster economic growth and development. Such findings needs to be effectively communicated and more research conducted in this vital area to provide governments with evidence-based arguments to influence resource allocation and participation in the review of activities, which in turn will guide future action on integrating older people into the development agenda (Ferreira 2007; African Union and HelpAge International 2006).

The capacity of government institutions to participate in MIPAA and AUPFPA implementation and review processes is a key factor. Both plans have compatible directions and objectives and the possibility of coordination and rationalisation of review and appraisal activities has been raised (Expert Group Meeting 2007). Convergence between activities may make the review process more accessible and achievable at national and local levels and encourage participation. There is also potential for regional and sub-regional cooperation, where countries with similar circumstances can cooperate and share information, good practice and knowhow and plan future activities collaboratively.

It is important to recognise that successful and lasting implementation of plans requires participation of all stakeholders, particularly older people themselves. Thus at country level governments are encouraged to include relevant participants in the review process and decision-making by involving national and local government bodies, non-governmental organisations, civil society organisations, older people, the private sector, the media and research institutes. At the regional and international liaison levels relevant UN agencies and the AU offer mechanisms for coordinating efforts for facilitating review and appraisal of national responses, for example through NEPAD and RECs.

Just as implementation of plans of action on ageing has resource implications, review activities will require budgetary allocation. Additionally, the emphasis on bottom-up review will require particular skills and inputs. There is a need for funding from the international community to support these activities, which have the direct potential of raising awareness at all levels and promoting action on ageing in Africa.

6. Conclusion

At both global and regional levels comprehensive policy instruments exist (MIPAA and AU PFPA) to guide action on ageing in Africa at country level. The current five year cycle of review of both MIPAA and AU PFPA to establish progress at country level offers the opportunity of raising awareness of ageing concerns and examining the obstacles that stand in the way of prioritising policy development and implementation. Commentators propose that interpretation of, for example, PRSPs as focusing on issues other than concerns of older people influences lack of prioritisation. The role of the international community in supporting both the action on ageing plans and the review procedures should be encouraged. A parallel objective is to establish coordinated efforts between all stakeholders, thereby recognising MIPAA's original statement that implementation of plans on ageing issues '*should be contingent upon effective partnership between governments and all parts of civil society and the private sector.*' (Recommendation 16.)

Part 2

Factors affecting the situation of older people in Africa

The rate of ageing in developing countries is faster than the rate experienced in developed countries (DESA, 2007). This means that developing countries will have less time to adjust to the consequences of ageing. This fact has significant implications for the socio-economic conditions within countries in Africa and the pressure placed on governments to respond through public policy. Part 2 of this report provides an overview of the trends and determinants of ageing and examines areas of key importance for policy action:

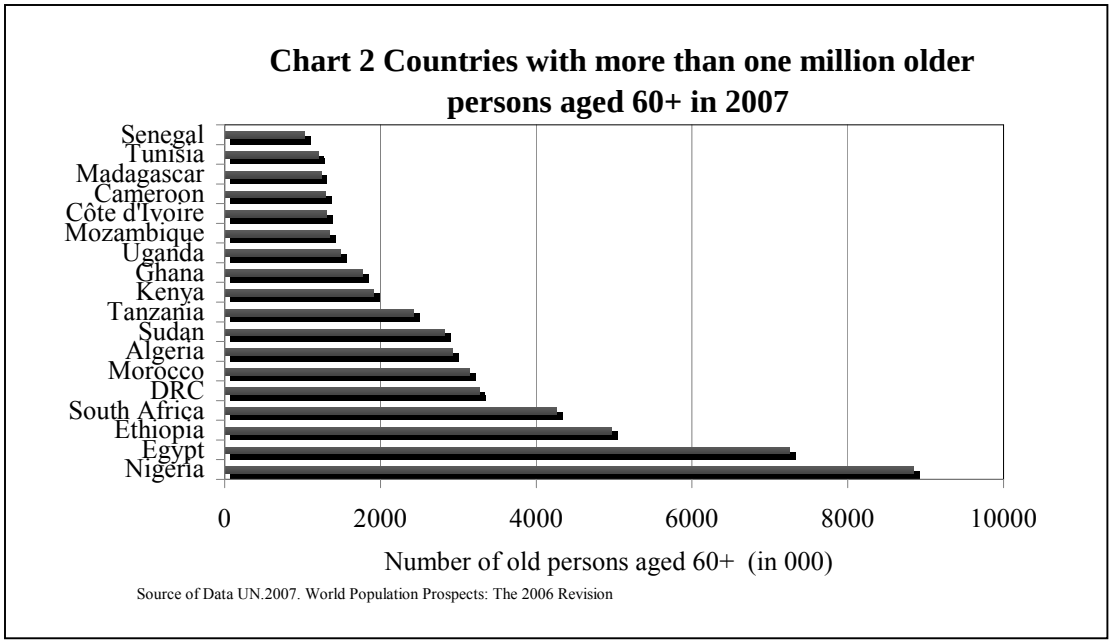
1. The changing population age structure
2. The socio-economic situation of older people
3. Health issues of older people and the impact of HIV/AIDS
4. Social protection systems and ageing.

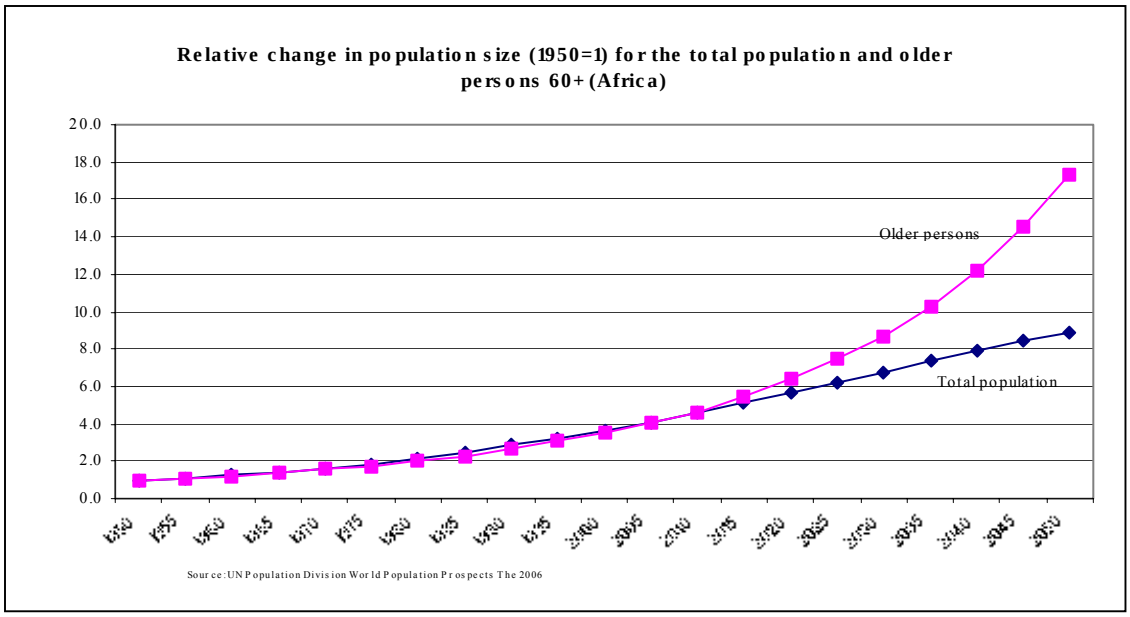
It is significant that the impact of the HIV/AIDS pandemic cuts across all these areas of focus.

1. The changing population age structure in Africa

Africa is often referred to as the youngest continent in terms of age structure. This description may contribute to the current relatively low prioritisation of ageing issues in national policies. However the age structure of Africa is changing dramatically and the continent will experience the fastest rate of growth of numbers of older people in the population than any other continent in projections to 2050. The following figures highlight the rapid rate of change and the need for immediate policy action. In 1950 the number of people aged 60 or over numbered approximately 12 million in Africa. By 2007 this number had increased to about 50.5 million people. The World Population Prospects 2006 Revision indicates that people aged 60 and over in Africa will reach 64.5 million by 2015, which is also the target date for achieving MDGs. By 2030 there will be 103 million older people and the number of older people is projected to rise to 205 million by 2050. The figures represent an increase in the numbers of older people across Africa in the next 40 years of 155 million (See charts 1 and 2).

These statistics therefore indicate an exponential rate of increase. In terms of proportion of the total population, the percentage of people aged 60 and over increased from 4.9% to 5.3% between 1950 and 2005. This proportion will increase to 5.6% by 2015, 6.8% by 2030 and rise to 10.4% by 2050. The reality is that older people will make up an increasingly significant share of the population in Africa (World Population Prospects: The 2006 Revision).





When the summary figures for the whole of Africa are disaggregated they reveal demographic variations between countries and sub-regions (Annex 3 provides a range of detailed statistics). Firstly, the majority of older people in Africa live in Northern Africa, Eastern Africa and Western Africa, which are the most populated regions in the continent. In contrast, only a small proportion of older people live in Middle Africa and Southern Africa. Secondly, the rate of increase differs between regions. Northern Africa and Southern Africa are the most rapidly ageing regions in the continent. In 2007 older

people made up 7% and 6.9% of the population of these two regions respectively. Projections indicate that older people in Northern Africa will increase rapidly to 8.2% by 2015, 11.9% by 2030 and 19.6% of the population by 2050. Southern Africa is also projected to experience a relatively rapid increase but at a slower rate. The remaining three regions of Eastern Africa, Middle Africa, and Western Africa follow a similar pattern of slow increase in older people as a proportion of the total population. By 2015 older people will represent between 4.3% and 5.1% of the total population in these three regions. This will increase slightly to between 4.6% and 6.0% by 2030, and the proportions are projected to rise to between 6.7% and 9.3% by 2050.

At the country level there are also considerable variations in rates of population ageing in Africa. The population is ageing rapidly in Mauritius, Tunisia, Algeria, Egypt, Morocco and Libya. In 2005 older people population aged 60 and over constituted 8.7% in Tunisia and 10% of the population in Mauritius. These percentages are forecast to increase to 10.4% and 13.3% respectively by 2015, and rise to 16.8% and 20.9% respectively, by 2030. At the same time these countries are experiencing a rapid decline in fertility and increasing survival rates across all age groups.

In Sub-Saharan Africa other countries experiencing rapid rates of ageing include Gabon, Djibouti, Cape Verde, Gambia, Ghana, Mauritania, Togo, and Senegal. The remaining countries have slow rates of increase in the percentage of older people in the total population.

Another distinct population ageing pattern is evident in those countries hardest hit by the HIV/AIDS pandemic (Botswana, Namibia, Lesotho, South Africa, Swaziland, Zimbabwe and Zambia). These countries are experiencing high death rates as a result of HIV/AIDS particularly among the sexually active age groups and a concurrent decline in fertility rates. The mortality rate is therefore a major factor in these countries impacting on the age structure of their populations.

1.1. The importance of changes in age structure

The three dynamic demographic components of fertility, mortality and migration rates combine to determine population ageing and its rate. Research into population and development tends to focus on how change in these three components impacts upon economic growth, rather than how these components affect the age structure of a country. In recent years the lack of research on how changes in age structure influence the development process and the need for improved information on policy implications, have received more attention. For example, recent literature on the demographic dividend refers to changing age structures and how greater numbers of potentially economically active people offer the possibility of boosting Gross Domestic Product (GDP) and economic growth (Bloom et al 2003), importantly in contexts where the strength and capacity of economic and institutional structures allow it.

The phenomenon of an ageing population is highly relevant to development because:

- it results from and signifies changes in fertility and reproductive heath, mortality and rates of survival from diseases such as HIV/AIDs, malaria, and tuberculosis, plus rates of migration which is often associated with young people;
- it therefore has key implications for a wide range of public policy issues including, for example, employment, labour force participation, provision of health and education services, changing family structures and social exclusion, and food security.

These two areas are given closer examination below.

1.2. Changing age structure and population dynamics

Demographic research conducted in developed and developing countries indicates that current and past levels and trends of fertility, mortality and migration rates, determine the age structure of any population. Therefore, at a given point in time, the age structure of a population is both an outcome and a summary index of its fertility, mortality and migration history. These components of population dynamics are influenced, directly and indirectly, by a range of reproductive health and socio-economic factors which are the domain of public policies, such as the level of nutrition, use of contraceptive methods, education and the level of income.

Fertility, mortality and migration rates influence the age structure of a population in the following ways. Firstly, the level and rate of fertility, which is usually expressed in terms of the Total Fertility Rate (TFR) and the age specific fertility rate may differ greatly between countries. Fertility rates affect the age structure of the population through a direct impact on the number of births. Thus persistence of fertility rates at high levels, which characterises the experience of most of the countries in Africa, will produce a broad-based age structure. When fertility starts to decline the broad-based age structure will begin to narrow as fewer babies are born in the population.

Secondly the mortality rate impacts upon the age structure by affecting the population at different points on the age scale. Death rates in relative terms are usually high in infancy, low during adulthood and high again at ages 65 and over. This pattern is generally reflected worldwide whether a country is developed or developing. Thus the shape of the curve for the age pattern of mortality is similar for countries globally. Countries differ only in terms of the level of mortality. This is very clearly demonstrated in comparisons between the age specific death rates and the differences in life expectancy at birth between various countries in the world. In countries where the general level of health in the population is satisfactory, the death rate tends to be low and life expectancy is high. The opposite is true in those countries, which are still aiming for a generally satisfactory level of health in the population. Therefore, mortality measures can be used as indicators of the extent of success/failure of public health policies. In recent decades the age pattern of mortality in Africa has been distorted by deaths resulting from AIDS, particularly in sub-Saharan Africa.

Thirdly, migration influences the age pattern of a population. How migration affects the age structure of a country depends on whether the country experiences out-migration or in-migration. For example, the movement of younger people to live in places of perceived opportunity leaving older people behind is well documented for both internal and international migration in Africa. The pull-factors for younger people include the prospect of employment and better living standards, and the push-factors incorporate unemployment and poor healthcare, to general lack of opportunity. When a country experiences out-migration and internal migration, typically from rural to urban areas this commonly results in the breakdown of inter-generational traditions of care for older people and the isolation of older people coping alone, particularly in rural areas.

The momentum of population growth is an age-related phenomenon. When an age structure is characterised by a relatively high proportion of younger people, combined with high fertility rates and improving health, these factors will generate high population growth rates. This is currently the case in many countries in Africa. For those countries in Africa, which, at present, experience this combination of factors, the population will continue to grow at relatively high rates for some years into the future. The impact of recent declines in fertility will not fully affect the age structures of the populations of these countries for a number of years. The ageing challenge facing African countries is further disguised by the impact of AIDS deaths on the age structure of the population.

In order to highlight the significance of trends in population change it is important to focus on the relative share of the population between young and older people and examine how these are predicted to change in the future. Thus the very real issue of ageing in Africa has been masked by the immediacy of higher absolute numbers of younger people, which will continue to outnumber older people. However the most significant component in the current population figures is the fact that the relative share of young people (0-19) in the population will decline from 54% in 2000 to 38% in 2050 in comparison with older people (60+), which rises from 5% in 2000 to 10% in 2050 (Schoenmaeckers 2007). Perhaps this information has not been communicated effectively enough or perhaps policy makers do not accept the implications of the statistics. In either case, the projections indicate that by 2050 almost half of the population in Africa will be dependent on the economically active population with growth rate of the older people in the population outstripping the growth rate of younger people.

1.3. Changing age structure and public policy

Changes in population structure and ageing increase pressure on public policy responses. For example, children aged less than five have special nutritional needs to help them survive through infancy and early childhood. When they pass early childhood, they need access to education, and as they mature past school age they need jobs. Therefore, it is important to identify the size and needs of various population groups, for example, children, young adults, older people, males, females, the girl child, to alleviate pressure on public services. How a government decides the allocation of the national budget between the competing demands of different sectors of the economy, public services, interest groups and the vulnerable and marginalised groups including older people

through policy and programme activities, depends upon a multitude of factors. One of the factors, which can influence budget allocation, is concrete data on population groups and socio-economic statistics. Clearly explained disaggregated statistics, which highlight the implications of population trends and relevance to public policy, are therefore required on a country by country basis to influence decision-makers to act on ageing

In order to influence policy it is necessary for stakeholders to understand the mechanism of government administration within a particular country framework. Consideration is required of at least the following four aspects of public policy and administration:

- distribution mechanisms relating income, wealth and natural resources. These are usually addressed through public policies relating to wages, salaries, subsidies, etc.;
- national allocation/distribution of public goods and services, particularly education and health services;
- the factors of production (labour force, capital, etc.) and their deployment among the various sectors of the economy;
- other public policies relating to governance, administrative and regulatory procedures, social order, planning, policies and decision-making.

A general understanding in almost all countries in Africa is that it is the responsibility of each government to provide basic rights to the population. In addition to keeping law and order, governments are responsible, for example, for providing a level of healthcare and education, providing employment opportunities, alleviating poverty, meeting the needs of the most vulnerable and marginalised often but not exclusively located in rural areas, and delivering national relief responses to natural disasters and conflict. Historically, public policy-making has been the exclusive responsibility of governments. In recent years a more participatory approach to public policy-making has developed, with citizens becoming more aware of their potential role in governance, planning and decision-making and seeking involvement often through the emergence of civil society organisations. In addition, international and local NGOs, the range of civil society organisations and private sector institutions have started to play a more positive role in addressing public welfare and environmental issues. With a more participatory approach including the involvement of key stakeholders it is more likely that policies and implementation plans will be based on relevant information and meet expressed needs of the intended beneficiaries. In addition improved policy dialogue within ministries and between ministries would lead to improved cooperation and coordination overcoming duplication of effort and neglect of overlooked groups. In some countries public policies disregard the need for social institutions to support the wellbeing of the population and citizens' human rights. Where the wellbeing of population is disregarded this may often lead to civil unrest and instability.

1.4. Linking public policy actions with population age structure

Population age structure takes a long time to change, and when change occurs it is difficult to reverse. Currently most public policies across Africa not adequately

acknowledge or respond to these facts. The time horizon of public policies is usually short and most of them are reversible. While public policies are designed to promote the wellbeing of the population and the age of target groups is implicit, the broader relevance of demography to policy goes largely unrecognised.

The interactions and linkages between population age structure and public policy need to be made more explicit. The example of education provides an illustration of the links between issues connected with a specific age bands and the implications for policy action. The influence of educational levels on the rates of fertility, mortality and migration is well documented. For part of their lives individuals experience a parallel process of ageing, or moving up the age scale, and moving up the education ladder. In this way education momentum is linked to the population age structure and momentum. The education attainment of the population will change as the younger and more educated generations move up the age scale.

This connection between education and age structure of population has several important implications. The demand for education services will be high when the age structure of the population is young. The gender gap in education is also likely to be high. Educational attainment will vary considerably by age; younger generations are more likely to be better educated than the older ones. The reproductive behaviour of young women (15-24) is likely to be very different from that of the older women (35 and above). Thus a variety of links may be identified between population age structure and education.

This dynamic link between age and education is evident in younger-age populations, particularly in Africa. The proportion of the population in different age bands therefore has implications for public policy and the linkages require further investigation and research to inform and guide policy. Other examples could be drawn from areas such as distribution of income and wealth and the relationship with unemployment and poverty, or the use of factors of production and natural resources, and their allocation among the various sectors of the economy.

The persistence of younger-age-skewed populations coupled with the rapidly increasing size of successive generations has determined the agenda of public policy in Africa. For this reason, public policy in African countries since independence has been service oriented: the emphasis has been on providing health, education and food, and establishing infrastructure particularly in rapidly growing cities. In practice, many governments in Africa have not managed to meet the high demand for food and services, generated by young-age population structure and high population growth rates. As these pressures continue it is difficult for governments to change their policies to promote economic growth or give more development focus to marginalised groups. Evidence indicates failure of public policies in Africa is a main cause of political instability and social unrest.

The implications of population age structure for public policy should, therefore, be addressed from multidisciplinary perspectives to reflect their multidimensional impacts

and repercussions. This would support governments to implement social and economic policies that address current pressing issues and plan for future change. Approaches and concepts should be developed to examine the issues and questions at a range of geographical, administrative and sector levels, recognising that approaches may need to be adapted to fit the circumstances at these different levels.

1.5. Conclusion

While demography is a defined discipline with established methods for measuring the characteristics of populations, public policy is broad and its domain and nature varies from country to country and by regions and economic blocs. It is therefore necessary to examine different approaches to public policy and establish how the relevance and implications of changing population age structures may be directly linked with different country contexts to increase understanding and guide decision-making at national level.

2. Social and economic situation of older people in Africa

One of a range of regional initiatives to focus attention on the need for action on ageing in Africa took the shape of a 2004 conference in Johannesburg organised by the Union for African Population Studies (UAPS) in collaboration with the South African Department of Social Affairs and the Human Sciences Research Council (HSRC). The conference aimed to identify resources to help tackle the phenomenon of ageing in Africa and to develop a plan of action to assist African countries to respond to international resolutions on ageing. Approximately 250 participants attended the conference, drawn from selected member States, as well as experts from the continent, India, USA, UNHQ, UNECA, UNFPA, Age in Action and HelpAge International (UAPS, 2004: 6-7). Among many outcomes the conference served to raise awareness of the social and economic situation of older people in Africa covering the following issues:

- the changing role of older people in African households and the impact of ageing on African family structures;
- ageing in the era of HIV/AIDS;
- ageing and pension schemes in Africa;
- care and quality of life of older people in Africa;
- ageing and poverty in Africa;
- lessons that sub-Saharan Africa can learn from ageing experiences from other regions;
- existing support for older people from both private (formal and informal) and public sectors.

Participants gained an improved level of recognition of the future implications and social and economic consequences of ageing. The key social and economic issues which affect the day to day experience of older people are highlighted here alongside myths about older people which influence their treatment by society.

2.1. The social context of older people in Africa

Traditionally, African societies have been characterised by cultural systems, which gave high status to older people. In the past there was recognition and appreciation of the experience and knowledge that older people offered, which contributed to a sense of integration in the community. In addition the extended family system provided for the social and economic needs of older people. However, there has been an increasing trend since colonisation to focus on change and modernisation, which has resulted in the higher valuing of the younger generations and looking towards the future, at the expense of maintaining regard for older people, learning from the past and valuing traditions. Over time this has led to the undermining of the roles, status and the welfare of older people who are increasingly becoming socially isolated and psychologically depleted.

The traditional family institution, with its notions of intergenerational commitments, used to care for all family members, including older people. This familial sense of responsibility has been eroded by forces including migration of younger people particularly from rural to urban areas, urbanisation, social and political instability and the impact of the HIV/AIDS pandemic. HIV/AIDS has had a significant social impact upon older people, particularly women. Generally older people can no longer expect to be recipients of family care. The incidence of death among the middle generation has multiple impacts upon older people. Alongside bereavement, they lose people who might have once been a possible source of external financial support in their old age, and the ongoing income-generation responsibility is often coupled with active care responsibilities for adult children and grandchildren, which heighten the financial burden.

Box 1. Older people and poverty
Discrimination, limited policies and legislation on ageing, the impact of HIV and AIDS and ongoing conflicts and emergencies mean that many older people in Africa live in poverty and are denied access to basic rights and services. This is particularly true of older women and widows who are often discriminated against in issues of inheritance and land ownership. Households headed by older women are likely to be the most impoverished and are twice as likely as other households to be caring for orphaned and vulnerable children. Older women and men are increasingly the primary care-givers of children made vulnerable by HIV/AIDS, war and migration.
Source: International Action Against Child Poverty, 2006:5

Box 2. The burden on older people – the Uganda situation
In most cases, the unusually high numbers of deaths among adults and the burden of sickness places heavy demands on old people and stretches the formal and informal support systems of affected societies. Increasing numbers of older men and women in Uganda are therefore struggling to absorb the multiple impacts of HIV/AIDS on their families, households and communities. Many older men and women are facing the task of providing for themselves, their sick adult children as well as their orphaned grandchildren just at the time when their incomes are decreasing.
Source: Kakooza, 2004:30)

With the widespread development focus in national policies and plans on younger people, and competing demands for resources from marginalised and vulnerable stakeholder

groups, there will be those that are heard and those whose voices are not strong enough. The groups most likely to lose out are children, older people and women. Among women, older women are the most disadvantaged because they are no longer able to bear children, they are generally unmarriageable and although they may have the potential to be economically active they are not usually able to undertake physically challenging tasks. The examples from Zimbabwe (Box 3) demonstrate the care responsibilities older people take on while simultaneously experiencing stigmatisation, in the absence of organised social security systems.

Box 3. Perceptions from a survey of older people in Zimbabwe
The survey findings showed that the caregivers perceived their main role to be the provision of food, medical care, psychological support and daily physical care to their charges. Barriers to the caregivers' ability to render optimal care to both PWAs and orphans included: financial constraints; a lack of food and basic necessities; burn-out; stigma; violence; fear of contracting the disease; and frustrations inherent in the performance of daily chores (e.g. cleansing, feeding, washing). The caregivers were found to experience financial, physical and emotional stress due to their care giving responsibilities. A high level of verbal abuse (or anger) directed to the caregivers by their charges and in their communities, including accusations of witchcraft and stigmatisation, was documented.
Source: Ferreira, 2004: 70

2.2. Policy focus on the wellbeing of older women

The international community, regional and sub-regional groups and national organisations have actively given more attention to the issues facing women, including older women. Issues including degree of access to education, combating all types of discrimination against women, as well as harmful traditional practices such as female genital cutting, have all gained widespread attention over the past two decades.

Low levels of educational attainment and illiteracy are significant because they affect the ability of older people, particularly women, to generate income. In every country, except for Botswana and Lesotho where cultural practices dictate that girls attend school more than boys, illiteracy rates are higher for females than males, and the rates and gap increase with age.

The fact that women tend to live longer than men influences calls for particular focus on the socio-economic situation of women and associated policies and plans to improve their wellbeing. Projections of ageing to 2050 identify that there are higher proportions of women in comparison with men at each age band (60+, 65+ and 80+) among people 60 and over. However surviving older women are at a socio-economic disadvantage. As they become widowed, widowhood commonly imposes social restrictions that have negative effects on their well-being. In many cases women have no inheritance rights, which lead to them spending their later years in poverty, loneliness and isolation.

2.3. Improving the social support for older people

Commentators including Zuberi (2006) and others have noted the mismatch between the increasing social responsibilities of older people in Africa and available support to help them to cope with these extra burdens. They call for the development of organisations in African countries to represent older people and lobby for improvement to their social conditions and protection of their rights and freedoms as they contribute to society by shouldering increasing responsibilities of care. As the numbers of older people increase, there is a growing argument for developing a partnership approach to supporting people aged 60 and over. This would involve considering appropriate ways to revive traditional social welfare systems once nurtured by the extended family system, alongside introducing and strengthening modern social security policies and systems to complement the traditional ones.

Where supports have been introduced, particularly in the form of social pensions, positive changes are being recorded not only for older people but also for entire populations. For example, DFID (2005:13) records that in South Africa, having a recipient of the social pension in a household has been correlated with a three-to-four centimetre increase in height among children; and social pensions have been connected with 50 % increases in the income of the poorest 5%. Annex 1 provides more detail on the impact of non-contributory social pensions on poverty. Public and universal pension schemes are now seen by many as a means for reducing poverty, and there have been calls for a global old age pension to protect older people and support their livelihood endeavours (Blackburn 2007).

2.4. Social myths about ageing

Myth 1: Older people are witches.

In a world where beauty and youth are increasingly celebrated the ageing process and changing physical appearance may lead to stigmatisation, assault and in the most extreme cases may result in accusations of being a witch. Stigmatisation of older people is found worldwide but it is more pronounced in some parts of the world than in others.

Myth 2: Women deserve lower social status than men.

Women continue to be accorded lower social status than men worldwide despite international declarations of equality of rights. While it is clear that women already undertake vital and responsible roles in society, in many countries there is a gap between policy and practice on equal opportunities and rights. The development of policy instruments and importantly the implementation of social inclusion plans and programmes are essential to provide the opportunity to all individuals both women and men to fulfil their potential.

Box 4. Women accused of witchcraft

1. Janet

Eighty year old Janet Abra Wuo from Ghana's northeastern Volta region filed a law case against her brother, the Regent of her hometown, and to others for falsely accusing her of witchcraft and punishing her. The Regent had pronounced her guilty and forced her to "pay" her alleged victims with four bottles of gin. Wuo was also ostracised socially and currently lives the life of a recluse. One of Wuo's alleged victims, a school teacher named Devin Kwami Dzah, accused her of using sorcery to empty his bank account, render him impotent and damage his property.

2. Esther

Esther Asempa, a 75 year old, suffered a vicious attack from her nephew who chopped off her hands with a cutlass. The incident was made public by one of her relatives who reported it to the police. The nephew defended his actions by saying he had been informed that the aunt was responsible for his prolonged unemployment.

3. Kofi

Kofi Sarpong, a 35 year old university graduate, who had drinking problems and had lost several jobs, was told by a traditional priest that his ageing mother and grandmother were the cause of his troubles. Sarpong attacked both women with a machete. The grandmother died; the mother suffered mutilation but survived.

Source: Daily Mail & Guardian, Ghana, 16 April 2001.

2.5. The economic situation of older people in Africa

In developing countries, the majority of the people who are economically active work in the informal sector, typically in agriculture, trading or service activities. In these sectors, it is evident that older women and men continue to work until advanced ages. Many older women struggle to balance food production activities with care responsibilities as noted above, for husbands, children and grandchildren. These roles are often performed in conditions of poverty, where there are very limited opportunities to participate in income generating activities (WHO, 2000).

Over time, many developing countries have experienced a decline in the proportion of economically active people in the population employed by the formal sector, because of the stagnation or shrinking of national economies, particularly in Africa. This trend has led to the laying-off formal sector workers for indefinite periods and/or compulsory early retirement. In many countries in Africa, those fortunate enough to maintain a formal sector job to the official retirement age, often face retirement at 50 or soon after. With the increasing longevity of older people, life after retirement may be long with either a meagre or no pension.

Thus the circumstances that face the majority of older people in Africa are characterised by lack of support. The fragmentation of families, and poverty and health problems, combine to prevent younger generations from providing traditional support roles. At the same time limited coverage or lack of social security systems mean that in most African countries the state institutional framework is not currently in place to protect older people in their vulnerability.

For those older people whose physical health allows them to pursue income generation activities there is often the obstacle of lack of opportunity. It is in the interest of governments to consider what potential exists to create employment opportunities or support sustainable livelihoods for older people.

Box 5. The economic challenge of ageing
In order to avoid major fiscal crises caused by unsustainable numbers of older citizens receiving pensions and social security payments, governments will need to inspire change from both employers and individuals toward getting the ageing population employed for a longer working life. Some governments are already making progress in this area, and demonstrating that it is, indeed, possible to find win-win solutions to the ageing workforce conundrum.
Source: Manpower Inc., 2007: 2

2.6. Economic myths about ageing

Myth 1: Older people are an economic burden on society. It is often assumed that older people have nothing to contribute to society and are viewed as an economic burden, despite evidence to the contrary.

Box 6. Prejudice against older people
Age prejudice continues to prevent older people from fully participating in the development of their societies. Myths and misconceptions create the image of older people as unproductive, helpless, weak or disabled, forgetful and unable to learn new skills or absorb new information.
Source: Kisselly, 2002: 17

It is widely assumed that the fall in numbers of older people in waged employment is connected with a decline in functional capacity associated with ageing. Where this idea is linked with an assumption that only paid occupations have status, this promotes the myth that older people have nothing to contribute. The significant contributions made by work in the following areas are largely discounted:

- in agriculture by older people particularly women and often into late old age
- in the wider informal sector
- in voluntary roles in community organisations,
- as teachers and
- as community leaders

Many economies benefit from these contributions although they are seldom included in the assessment of national economic activities.

Myth 2: A person needs less income to live on in old age than in earlier years.
The amount of income required to live at any stage of life depends on individual goals and lifestyle. It is determined by such factors as work, travel, hobbies, and geographical location. A large proportion of older people live on very low incomes. The challenge for many is not a choice about how to spend disposable income but a choice between basic requirements such as food or covering increasing personal and dependant healthcare costs. Consequently the myth needs to be challenged in terms of raising awareness of the poverty in older age alongside the fact that living costs do not fall once healthcare, dependants and other issues are factored in.

Myth 3: Older people do not need to save for the future.
Life after retirement may last 30 years or more. Without secure employment or sustainable livelihoods, financial insecurity is a key issue for older people. Many live in poverty and have no access to investments or opportunity to save, the basic cost of living presents an ongoing challenge.

Myth 4: The rate of income tax will be lower in retirement
For former formal sector employees who receive a pension, the rate of tax might be as high as in retirement as in employment. Therefore ways to protect income after retirement should be considered including savings and investment options.

2.7. Civil society initiatives

It is clear that the erosion of family support structures and the adoption of unexpected care-giving roles in old age place older people in vulnerable socio-economic situations. Civil society organisations play an important role in supporting older people in poverty. There is increasing scope for civil society organisations to work in partnership with the public and private sectors to help meet the needs of older people. In an example from Ghana, the government supports various NGOs working for older people (Mba, 2004: 146-147). They include HelpAge Ghana and Christian Action on Ageing in Africa. Among a range of initiatives they have taken on advocacy roles for older people and raised national awareness of ageing issues. Such organisations are few and tend to concentrate their activities in the urban areas.

There are many examples of civil society organisations working in this way throughout Africa. However, because of organisational capacity and limited geographical spread many older people fall through the net of this support system. This lack of coverage underlines the need for cross-sectoral collaboration to scale up interventions so that older people have more equitable access to support in each country.

Box 7. Civil society initiatives to support older people
Kenya
Mawego is a remote village in Nyanza Province. The Mawego Mission supports older people whose families have migrated. The Mission looked for ways to engage the skills and energies of the more active older people instead of giving cash grants. In a participatory approach seniors proposed their own ideas for income generation after examining local needs. A local demand for kerosene was identified; it was used for heating, lighting and cooking but it was hard to obtain. A small project to sell kerosene was started and entirely managed by a group of older people. This sustainable initiative has contributed to improving to local wellbeing, while also allowing a development grant fund to be established to expand the venture. Older people now enjoy an assured regular income.

South Africa
Older members of a church centre realized that discarded plastic bags were a valuable raw material. In collaboration with a nearby school meals kitchen, they asked children to bring an old plastic bag in payment for a week's meals. Plastic threads from the plastic bags were used to durable weave mats with coloured designs suitable for kitchen mats. Being sold at low prices, the mats became useful and popular to poor households. To the older workers, the mats become a regular source of regular income.
Source: United Nations, 2003

2.8. Conclusion

There is an urgent need for national policies on ageing to address the socio-economic rights of older people to improve their wellbeing. In order to develop relevant plans, research information needs to be generated to inform decision-makers on the numbers of people affected, their living conditions and the problems of exclusion they face. Particular reference should be given to older women who are often widowed and living in situations where their access to resources is limited by social and cultural factors, leading to increased marginalisation (Agyarko, *et al*, 2000; Sembajwe, 2002).

If the quality of life of older people is to be improved, changes are needed in access to education and livelihood opportunities, plus the introduction of improvements in social protection systems as well as initiatives to strengthen family support systems. Raising awareness of the actual and potential contributions that older people make to society coupled with zero tolerance of abuse will help to change society's attitudes and rekindle respect towards older people. The possibility of collaboration between the government, the private sector and civil society organisations should be fully investigated as cross-sector partnership appears to offer considerable potential for the future.

3. Health issues of older people and the impact of HIV/AIDS

The dominant causes of sickness and death change as people age. Worldwide there is a shift away from the incidence of infectious and nutritional disorders to non-communicable diseases in older people, broadly characterised by chronic, degenerative and mental illnesses (Mujahid, 2006: 34). With increasing age, rises in the incidence of external causes of injury have also been observed, including traffic accidents, self-inflicted injuries and violence, (United Nations, 2007a: 116-117; United Nations, 2007b: 30-31). Additionally, in an ageing world, growth in the numbers of disabled older people has been identified. Together these factors increase the pressure on healthcare systems particularly in developing countries where commonly the health issues of older people are not prioritised and the institutional infrastructure to care for disabled people is lacking. The impact of the HIV/AIDS pandemic is a further factor impacting upon the health and wellbeing of older people in Africa.

Focus is given here to the key changing health issues associated with age and the impact of HIV/AIDS upon older people. Possible policy interventions and practical supports are also identified to help improve the situation. Areas of discussion are aligned to concerns and actions identified in the Madrid International Plan of Action on Ageing (MIPAA).

3.1. Health issues of older people in Africa

Ageing in Africa presents significant health challenges (Aboderin 2005). Older people living in poverty commonly lack the income to either sustain a healthy lifestyle or enable adequate access to health services. This set of circumstances leaves the growing number of older people vulnerable to the specific health conditions which commonly affect people 60 and over. WHO (1999) identifies the following health issues:

- alcohol use
- cardiovascular disease
- hearing loss
- nutrition
- osteoporosis
- physical activity
- tobacco use
- visual disability.

In an environment of limited healthcare choices, older people in Africa tend to face the negative impact of most of these conditions. There is evidence (United Nations 2007a: 123) that developing countries show a high prevalence of risk factors for chronic health conditions associated with smoking, alcohol, diet and weight.

In contexts of limited access to healthcare for older people a number of myths exist about older peoples' health issues which negatively affect society's attitudes as well as influencing the healthcare behaviour of older people themselves in terms of preparedness for the future and preventative action.

3.2. Health myths about older people

In most African countries there is limited access to free healthcare for older people. A number of myths exist about older people's health issues which negatively affect society's attitudes as well as influencing the healthcare behaviour of older people themselves, in terms of preparedness for the future and taking preventative action.

Myth 1: There is no need for long-term healthcare and government programmes will take care of health issues in older age, if they arise

People are living longer. They may live for many years beyond the age of 60. Even where government health programmes are provided for older people, it is very likely that the family will be responsible for paying at least one third of the expenses. Where there is sufficient income healthcare insurance would provide increased security.

Myth 2: Older people are frail

With a healthy life style, the majority of older people may maintain physical fitness well into later life. While some disease risk factors are inherited others are not and can be modified to prevent or delay onset of disease. The decline of physical fitness is largely determined by external factors relating to adult life style, such as smoking, alcohol consumption, diet and income. Frailty is therefore not an automatic characteristic of old age. For large numbers of older people in poverty however, maintaining an adequate diet to reduce physical vulnerability is the key challenge.

3.3. Erosion of a supportive environment in older age

A range of factors combine to undermine the physical and emotional wellbeing of older people. These include the already noted breakdown of familial support in terms of financial contributions to maintain adequate shelter, buy food for a healthy diet and medication to treat illnesses. As family members disperse or neglect family care

responsibilities this has a negative effect not only on the physical care of older people but also reduces their social interaction and emotional wellbeing as links within the local community decline. In the absence of adequate social protection and other forms of support older people become increasingly disadvantaged and vulnerable to illness.

Without the security of close family some older people may also become exposed to abuse; the examples above of older women accused of witchcraft illustrate the violence and exclusion some individuals may experience. The strengthening of intergenerational commitment to family care and society's rejection of violence is vital to protect vulnerable older people (WHO, 2002).

Health services are an important component of the supportive environment for older people. In many countries however available healthcare services do not match the particular health and medical needs of older people. Health personnel are generally not trained to provide the health needs of older people. In the common context of restricted budgets, shortage of both health workers and medical supplies, little emphasis is given in plans for service development to making specific provisions for the health needs of older people. Such provisions include targeted facilities, geriatric wards or the training and employment staff specialising in care and treatment of older people. Again older women experience particular problems because local health services rarely have specific healthcare provisions for menopausal conditions. Reproductive health services often overlook the needs of older people with the result that sexually active older people may be vulnerable to HIV infection. The current challenges will deepen as the numbers of older people increase in African countries and the demand for specific healthcare requirements puts increasing pressure on existing health services.

3.4. Ageing, health and gender

Throughout the world women tend to live longer than men. Table 2 presents life expectancy statistics for men and women in regions of Africa. In circumstances of social and economic disadvantage and where women and particularly girl children are discriminated against women's typically greater longevity may be reduced or even reversed. Although in general terms most women live longer they do not necessarily experience a good quality of life in their later years. Research indicates that older women suffer from disability more than men in the same age bands (Mather 2004). Table 3 illustrates that women experience more years living with disability than men in developing countries. There is therefore a need for sustained improvement to service infrastructure and community responses to support older disabled people with particular emphasis upon the needs of older women.

Table 2: Life expectancy by sex and selected old ages for Africa and Sub-regions

Total		Total				Female				Male			
Region		**Birth**	**60**	**65**	**80**	**Birth**	**60**	**65**	**80**	**Birth**	**60**	**65**	**80**
Africa	2000-2005	51.3	16.2	13.1	5.8	52.1	17.0	13.7	6 .1	50.5	13.3	12.4	5.5
	2045-2050	69.5	20.2	16.4	7.3	71.2	21.4	17.4	7.9	67.9	18.9	15.3	6.6
East Africa	2000-2005	45.4	15.6	12.7	5.7	46.0	16.3	13.3	5.9	44.8	14.8	12.2	5.4
	2045-2050	67.2	19.7	16.0	7.1	68.7	20.6	16.7	7.4	65.8	18.7	15.2	6.7
Middle Africa	2000-2005	50.0	16.0	12.9	5.7	51.1	16.7	13.4	5.9	48.8	15.3	12.4	5.4
	2045-2050	69.0	19.7	16.0	7.0	70.4	20.5	16.6	7.3	67.6	18.9	15.3	6.7
Northern Africa	2000-2005	66.4	17.1	13.6	5.6	68.0	17.9	14.3	5.9	64.8	16.1	12.8	5.3
	2045-2050	77.0	21.0	17.0	7.5	79.3	22.7	18.5	8.4	74.7	19.2	15.3	6.5
Southern Africa	20002005	46.4	15.6	13.0	6.3	47.1	17.6	14.6	6.8	45.6	13.2	11.0	5.3
	2045-2050	66.2	20.6	17.1	8.4	67.2	23.1	19.2	9.3	65.1	18.1	14.7	6.8
Western Africa	2000-2005	51.3	16.3	13.2	6.1	51.8	16.9	13.6	6.3	50.7	15.7	12.7	5.8
	2045-2050	69.0	19.9	16.1	7.1	70.4	20.7	16.8	7.4	67.7	19.0	15.4	6.8

Source: UN.2007. World Population Prospects: The 2006 Revision

Table 3: Leading causes of disability, years lived with disability (YLD) by cause as a % of YLD from all causes, developing countries 2002.

Cause group	% of total YLD	F to M ratio
I. **Communicable, Maternal, Prenatal and nutritional conditions**	23.4	1.36
Infectious and parasitic diseases	10.9	0.95
Maternal conditions	3.8	-
Perinatal conditions	3.1	0.98
Nutritional deficiencies	4.4	1.08
II. **Noncommunicable diseases**	64.9	1.03
Malignant neoplasms	0.3	2.02
Diabetesmellitus	1.1	1.11
Neuropsychiatric conditions	29.4	1.09
Unipolar depressive disorders	11.1	1.47
Bipolar disorder	2.5	0.98
Schizophrenia	2.9	0.97
Alcohol use disorders	2.5	0.15
Alzheimer and other dementias	1.0	1.40
Drug use disorders	0.8	0.28
Other neuropsychiatric disorders	8.6	1.37
Sense organ diseases	13.0	1.13
Vision disorders	8.7	1.26
Hearing loss, odult onset	4.3	0.92
Cardiovascular diseases	3.3	0.82
Respiratory diseases	4.2	0.72
Musculoskeketal diseases	4.6	1.18
Other non-communicable diseases	8.9	0.90
III. Injuries	11.7	0.66
Unintentional injuries	9.7	0.75
Intentional injuries	2.0	0.32

Source: Mather 2004:5

3.5. Links between health education and prolonging wellbeing

Research findings from USA and other countries indicate that improving the health of older people requires collaboration between sectors and interest groups at national, district and community levels (CDC and Merck Company Foundation, 2007). Individuals, healthcare providers, government agencies and community groups all have active roles to play in the design, implementation and evaluation of innovative strategies to reduce health challenges facing people 60 and over. An important intervention is improving health education to help people understand behaviours that are linked with disease and poor health. As noted previously smoking, poor diet, and physical inactivity are identified as some of the main underlying causes of poor health, and provide the foundation for some of the major causes of morbidity and death in old age like heart disease, cancer, stroke and diabetes (CDC and Merck Company Foundation, 2007). Annex 2 provides a detailed list of issues which affect wellbeing in older age). Before death, suffering from chronic diseases my cause extended years of pain, disability, and loss of function and independence.

Investment in health education can on the one hand promote healthy living to reduce the risk of disease in older age, and on the other hand guides older people to relieve symptoms and improve physical wellbeing in the present. Nonetheless, for most vulnerable older people smoking, drinking and exercise are not the issues and they need support for example, to improve the nutritional value of their diet and buy medicines in order to improve their health. In all these circumstances collaboration between the public and private sectors and civil society has the potential to make effective interventions in improving the health of older people.

3.6. HIV/AIDS

The indirect impact of HIV/AIDS on older people

The scale of the problem HIV/AIDS pandemic is daunting. In 2006 UNAIDS 2006 estimated that 2.8 million adults and children became infected with HIV and an additional 2.1 million died as a result of AIDS in sub-Saharan Africa alone. In countries most affected by HIV/AIDS such as Botswana, it is estimated that by 2025, more than half of those aged 35-59 years and one third of those aged less than 15 years will have been lost to HIV/AIDS. The high prevalence of HIV/AIDS among adult females has led to projections of deaths among adult women aged 15-49 exceeding deaths among men in the same age group and losses of 6 years in life expectancy compared with men (UN 2003). In most cases, most of these adults will leave behind an infected surviving spouse and children who will need to be cared for by other members of the family or community. A large proportion of AIDS victims also leave behind one or two surviving parents who are often in their 50s, 60s and 70s (Wachter *et al.* 2002).

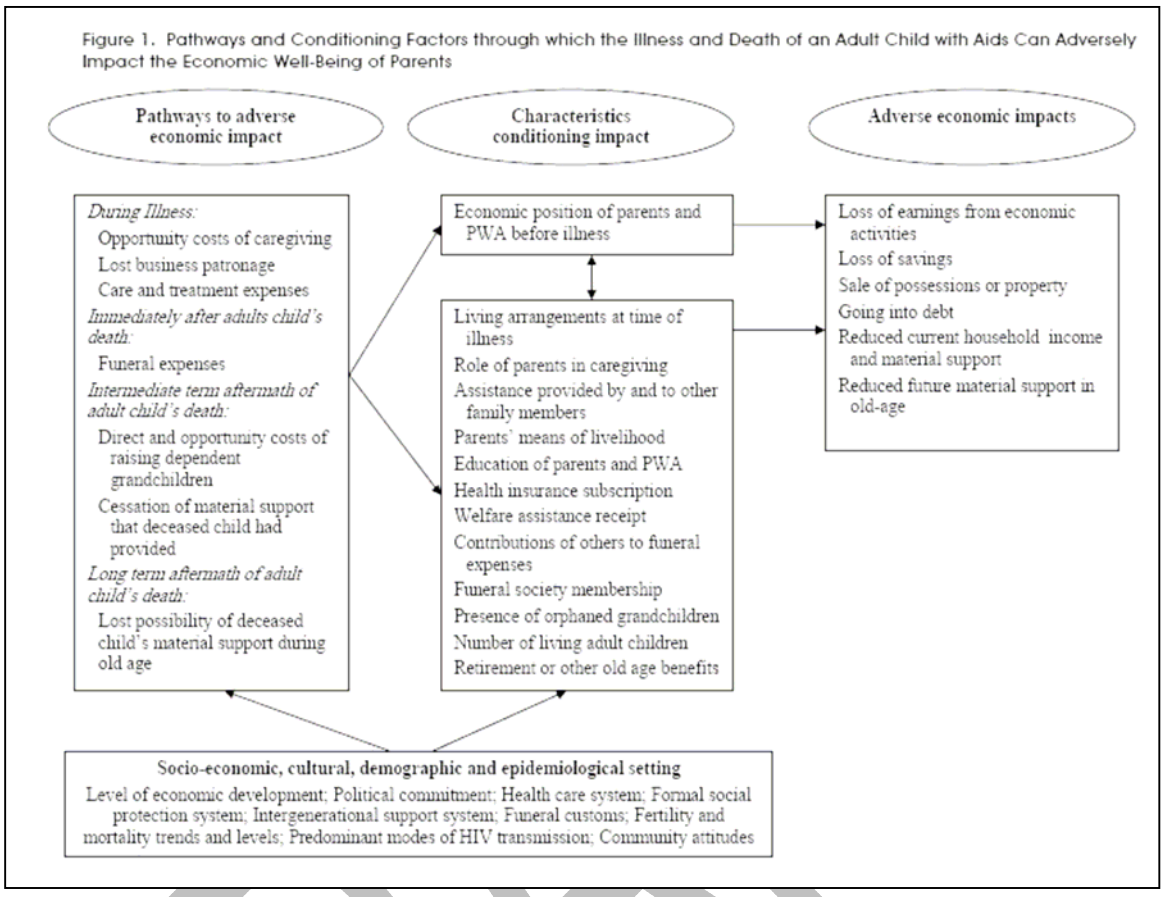
These massive morbidity and mortality numbers have an indirect impact upon the health of older people. Africa's older people are now increasingly dealing with the emotional, economic, social, and physical burdens of older age dependency. The lives of parents who lose an adult child to AIDS are impacted in many ways, including through 'caregiving during illness, paying for medical and living expenses, reduced or foregone economic activity, funeral expenses, loss of current and future support from the AIDS infected adult child, and fostering orphaned grandchildren" (Knodel

2006:3). They also have to cope with community stigmatization and isolation that is often associated with caring for an AIDS-affected family member (Belsey 2005). Figure 1 provides the many potential pathways through which the illness or death of adult children, as a result of HIV/AIDS, can impact the lives of surviving parents. According to Knodel *et al* (2002:4) 'how much these potential impacts actually occur remains largely for systematic empirical research to determine. They are all likely to be context sensitive and thus to vary across different settings.' While comprehensive statistical data surrounding these phenomena do not currently exist, case study material, anecdotal information and local fact-finding activities suggest that significant numbers of older people currently deal with these diverse impacts at a time when they themselves are expecting to receive old age support. In circumstances of existing poverty and age-related health issues, the extra burdens particularly the financial impact and diversion of activities away from food production can deplete the health of older people though poor nutrition, fatigue and worry.

The direct impact of HIV/AIDS on older people

Although HIV/AIDS predominantly has an indirect impact on older people, there are also people aged 60 and over living with HIV/AIDS in Africa. Most HIV/AIDS treatment and intervention programmes focus on the needs of young and middle-aged adults and children and African societies therefore face a unique challenge in delivering services geared towards the needs and circumstances of older people (Knodel et al. 2002).

There are indications that the HIV infection rate is increasing among older people in African countries. Although almost two thirds of the estimated HIV/AIDS sufferers live in sub-Saharan Africa, little is known about the proportion and status of older people living with the disease on the continent (WHO 2002). Given the overall poor access to healthcare in Africa, it is highly likely that older people living with HIV/AIDS have very limited access to effective medical treatment. The lack of reliable information impedes appropriate advocacy on behalf of older people and targeted policy responses.



The impact of HIV/AIDS on the family

The pandemic has impacted upon the composition and structure of African families and households. Families normally carry the responsibility for caring for people living with HIV/AIDS (PLWHA) and in countries across Africa that group is highly exposed to the risk of being infected. Usually the sexually active young adult members of the household first contract the disease; if they are also the main income-earner and primary producer of food their illness and death has a particularly severe impact. People living with HIV/AIIDS remain alive for long periods of time with severe and cumulative financial and social consequences at the personal and household levels and also at community and national levels. In many instances, family resources become depleted, family relationships are strained and the resiliency of family itself is seriously tested (Belsey 2005).

The emerging trend in the change of household structure with increases in female-headed households and orphans cared for by grandparents (UNICEF 2006), implies higher dependency ratios, and a poor human and financial resource base. This increases the likelihood of rural and urban households plunging into extreme poverty with healthcare consequences.

Older age and caring for PLWHA

The lack of comprehensive health insurance and commonly inadequate healthcare facilities in African countries is compounded by a similar lack financial assistance for families caring for PWLHA. Across Africa many people live on less than US$1.00 a

day, for instance 75.8 per cent of people in Zambia and 72.3 per cent in Mali (UNDP 2007). The task of care giving exerts so much pressure on survivors that HIV/AIDS sufferers often receive inadequate medical treatment and diets. The lack of guidance given to older people caring for PLWHA also limits their capacity to provide appropriate care. Box 8 provides an example of an HIV/AIDS treatment programme that offers outreach services to PLWHA in their own homes. This illustrates the type of health service interventions that could be developed to support older people caring for PLWHA.

Box 8. A public health intervention in Mozambique

Day hospital with home assistance

'Antiretroviral therapy is administered to the population through day hospital and home assistance activities. In this way, lacking specialised facilities spread throughout the territory, the program is allowed to be in direct contact with the population, thereby guaranteeing the necessary control over the therapy. When the people to be treated cannot come closer to the possibility for therapy, it is DREAM that brings them closer.

However, AIDS cannot be combated exclusively with anti-retroviral drugs. It requires a more wide-ranging intervention taking into account the person's overall needs. The package of services ordinarily offered to the patient on a stable basis is comprised of voluntary counselling and testing, lab tests (biochemical, haemochrome, CD4+, and viral load), antiretroviral therapy, treatment of opportunistic infections and sexually transmitted diseases, nutritional support, basic health education, and social support.'

Leonardo International. 2003:19

Although coverage is sporadic, community-based organisation including church organisations also play an important part in providing services in the absence of public healthcare options for PLWHA. Such responses are particularly valuable in Southern Africa where the incidence of HIV/AIDS is highest and where frequent droughts have threatened food security for many including older people caring for PLWHA. Besides directly offering support to PLWHA, these organisations have also improved the assistance they give to families caring for PLWHA. Such interventions have reduced the distress of sale of productive and household assets such as livestock and land that often occur as families try to cover expenditures incurred due to either illness or death.

Old age and caring for orphans

UNICEF (2006) estimated 12 million of the 48 million orphans in sub-Saharan Africa had lost one or both parents to AIDS. By 2010, the figure is projected to rise to nearly 16 million AIDS orphans. In particular areas the burden is intense for older carers. For instance, the percentage of double and single orphans aged 0 to 14 that were being cared for by their grandparents was as high as 60% in Zimbabwe and Namibia (UNICEF 2006). Caring for orphaned children presents special challenges to the limited resources of older carers. They struggle to ensure that the orphans attend school, are well fed and are not marginalised and discriminated against. And because of their age, many grandparents die before the children reach the age of 18 which results in further separation, loss and uncertainty for the children.

3.7. Community-based responses to mitigate the impacts of HIV/AIDS

At the community and household levels there are a range of small scale effective practices and interventions that relieve the impact of HIV/AIDS in isolated areas. Although poorly documented they deserve more attention because they offer governments and other stakeholders the possibility practice-based evidence of effectiveness and the opportunity to strengthen existing programmes and scale up successful strategies (Binswanger 2000; Mutangadura *et al*. 1999). The following activities represent the types of effective interventions that could be scaled up countrywide.

Treatment interventions that support older people

In the short-term, the most concrete intervention is to promote access to treatment and to institute welfare programmes targeting AIDS patients as well as their families. If people are treated, this may keep them economically active for longer which eases the care burden for older parents. Therefore providing free medical care for the poor is a key intervention. When PLWHA are too ill to work NGOs currently offer valuable services in home-based care. The scaling-up of effective NGO programmes should be encouraged because they relieve the suffering of the sick and reduce the care burden for older people.

Interventions such as establishing community kitchens where children can eat, or providing the caregiver with seeds and other necessary inputs for growing food, are often beneficial and should be implemented more widely.

Agricultural production responses

A large majority of HIV/AIDS affected households in rural Africa continue to earn their livelihoods from farming. Some family coping mechanisms to overcome HIV/AIDS induced labour shortages have negative impacts. These include taking girl children out of school when agricultural activity peaks, to help in the fields and at home. Conversely there is an observable shift away from agricultural production as young children and adult males and females engage in off-farm activities such as petty trade to supplement household income.

There are various support strategies that rural households have employed to address food insecurity among household affected by HIV/AIDS. These include labour pooling, intra-household reallocation of labour and responsibilities, reconfiguration of time-use patterns, promotion of non-labour intensive crops, and promotion of crops and farming systems that reduce vulnerability to ecological and social factors. At the same time labour shortages have led to neglect of farms with repercussions beyond the affected household in terms of spread of pests and diseases. Rural policy responses organised at the community level have therefore been directed at preserving agricultural lands, water resources as well as pest control. Specific support projects include:

- Junior field schools in Eastern and Southern Africa targeting HIV/AIDS affected households (FAO 2004).
- In Zimbabwe, AIDS widows are being trained how to grow cotton by experienced farmers through farmer field schools (White and Robinson 2000).

- In Malawi, junior farmer field schools for AIDS orphans and vulnerable children are also targeting fishing communities (FAO 2004).
- In other parts of Southern Africa, HIV/AIDS issues have also been incorporated into agricultural services provision through integrated pest management training programmes (Haddad and Gillespie 2001).
- Subsistence crop to diversification to low maintenance alternatives including cassava, sorghum and millet. This mitigation measure has been recorded in Zimbabwe (FASAZ 2003) and Cote D'Ivoire (Black-Michaud 1997).

Such programmes offer scope for scaling up, however the advantages and disadvantages of each need careful consideration as some prioritise food security and others prioritise income generation.

Food Aid and Micronutrient Supplementation Programmes

The HIV/AIDS pandemic has worsened pre-existing food and nutrition insecurities across rural Africa. Responses to this challenge which help relieve the burden on carers including older people include:

- Food and nutrition assistance programmes, for example in Uganda and Zambia, run by both foreign and/or local food aid agencies
- In Malawi, communities are experimenting with community food banks to help minimize the financial consequences of an HIV/AIDS related death (Connolly 2004).

Again the reach and impact of these responses need to be assessed. For example, the most disadvantaged households may not be able to participate in community food banks and in these and other instances there is need for communities to devise strategies that protect the poorest as well as the poor. The roles of church and community-based organisations need to be fully explored.

Community safety nets

Further HIV/AIDS mitigation measures include the provision of community safety nets and help groups that target vulnerable women, children and orphans (Box 9). In addition to the responses listed above options include:

- community based social support and care of HIV/AIDS sufferers
- training survivors and other households members new skills such as carpentry, tailoring and poultry farming (Mutangadura et al. 1999; FAO 2004).

Box 9 Community support initiative Kashenye- Kiziba Ward, Bukoba Rural District, Tanzania
Village members and the NGO (Partage) work in partnership to provide integrated support to orphans using existing village and household structures. A day centre run by volunteers who receive a small allowance from the village, provides care for under-school age children. The children are given food, clothing, and medical care, playing and learning facilities. School age going orphans are assisted with school fees, uniforms and books. The grandparents and other family members who care for the orphans are given seed money to start income generation activities. Village leaders in collaboration with the NGO manages and monitors the activities of these programs (Ijumba 2005).

3.8. Conclusion

Two main influences affect the health and wellbeing of older people in Africa. Firstly older people face the range of non-communicable diseases and conditions characteristic of ageing worldwide. In order to improve the situation the emphasis should be on prevention through health education, and, importantly, provision of support for the poor older people to maintain healthy diets and relieve poverty. Both measures would contribute to prolonging wellbeing. Coupled with this, improvements to treatment and health services which target the health needs of older people are needed plus free access to health services and medication for poor older people. Secondly the HIV/AIDS pandemic has undermined the food and income security of older people as well as adding the burden of care of PLWHA and their children. These changes negatively impact upon the health of older people.

For the mitigation of both influences on the health of older people, dialogue and partnership between government agencies which decide health policy and deliver public services, other healthcare providers including NGOS both national and international, and community-based organisations are required to orient health systems and personnel to the specific needs of an ageing population, which are also impacted upon by the HIV/AIDS pandemic. Older people themselves are key stakeholders, on the one hand they have individual responsibility to maintain their health as long as possible, on the other hand their voices should be heard by decision-makers at all levels to influence policies and plans that will affect them.

There is also a need to strengthen and sustain traditional institutions and networks to support older people and include them in the affairs of family and society to increase respect and valuing.

4. Social protection systems and ageing in Africa

Despite clear indications of the growing numbers of older people in Africa and projections that the proportion of older people in the population is also increasing (as described in Part 1), formal systems of social protection targeted at this group are largely inadequate. The vast majority of poor older people rely on informal family and community-based social protection systems to survive. The relative lack of national policy responses is influenced by the absence, to date, of:

- a major crisis related to ageing which has put significant pressure on existing social protection systems
- clear evidence that ageing has negatively impacted upon the rate of economic growth.

While the lack of an acute problem in the present might be interpreted by decision-makers to mean that there is no need for concern, it is imperative that concerted efforts should be made to develop comprehensive national social protection capacities to prepare for forthcoming changes in population age structure that cannot be avoided. Africa needs to take advantage of the current theoretically favourable dependency ratio between the proportion of economically active and the burden of younger and older people, to improve coverage of formal social protection systems to relieve current suffering and prepare for the future.

Social protection systems can be defined as a set of public actions that address risk, vulnerability and chronic poverty. There three main forms are presented in Box 10.

The obvious challenge is how to enable governments to introduce social protection systems in contexts where very few people can afford to make the necessary contributions. Nonetheless, the World Bank (1994) and others (Barrientos and Lloyd-Sherlock 2002) argue the way forward for African countries is to aim to establish a basic social protection system that is non-contributory but guarantees some minimum income for people aged 60 and over to shield them from poverty.

Box 10
Definitions of social protection
Social protection can be divided into three operational components:
• **Social insurance** which involves individuals pooling resources by paying contributions to the state or a private provider so that, if they suffer a shock or a permanent change in their circumstances, they are able to receive financial support (for example, unemployment insurance, contributory pensions and health insurance). Social insurance is, in general, more appropriate for better-off individuals, although it can have an important role in preventing them from dropping into poverty.
• **Social assistance** which involves non-contributory transfers to those deemed eligible by society on the basis of their vulnerability or poverty. Examples include social transfers (non-contributory pensions, child welfare grants, food vouchers) and other initiatives such as school feeding or fee waivers for education or health.
• **Standards** which refer to the setting and enforcing of minimum standards to protect citizens within the workplace (though this is difficult to achieve within the informal economy).
Cash transfers are a form of social assistance including
• cash given to individual households, as distinct from communities or governments;
• cash grants, cash for work and voucher programmes rather than interventions such as monetisation, microfinance, insurance, budget support and fee waivers;
• cash as an alternative to in-kind transfers such as agricultural inputs, shelter and non-food items, as well as an alternative to food aid distribution.
Sources: Based on Harvey (2005) and DFID (2005).

4.1. Older age poverty in Africa and determinants

Although the modest economic progress in Africa recorded in recent years has led to improvements in the quality of life enjoyed by some African citizens, in general, the incidence of poverty among older people remains disproportionately high compared with other age groups. Poverty is higher among older women, particularly among those who are living alone, in advanced old age and who are often disabled (Mugambe 2006; Najjumba-Mulindwa 2003-04). These higher levels of poverty in older age are linked to women's low socio-economic status earlier in life. The low participation levels of women in the formal labour market has resulted in a significant

proportion of Africa's population not receiving the opportunity to contribute effectively to old age pension schemes. The widespread lack of gender sensitive social protection systems has compounded their situation in old age.

More broadly factors beyond gender, such as marital status, education level, employment status, health, ethnicity/race, living arrangements, and place of residence are all determinants of poverty in older age. For example, low levels of human capital formation (particularly education and skills), working in subsistence agriculture and the informal sector, as well as low levels of savings and property ownership are also associated with older age poverty. In most African countries a large proportion of older people relied, when economically active, or still depend on agriculture for their livelihood and their life experience is characterised by many of the components listed above. The likelihood of rural populations living in poverty is heightened by the additional factor that existing national social security measures rarely reach them.

4.2. Types of social protection systems in Africa

The two main types of social protection systems in Africa comprise informal support systems including family support and formal social support systems (typically taking the forms shown in Box 11 below).

Familial and other informal support systems

Familial and informal support networks provide social protection for most older people in Africa. The transfer of resources in cash and in kind from children to ageing parents has been a mainstay of traditional social protection systems. The transfer of these resources has prevented large numbers of older people from sliding into destitution (Barrientos and Lloyd-Sherlock 2002). In return, older people across most African communities perform care roles and pass on cultural knowledge to younger generations in their families and communities. Several studies in the past recorded that younger generations across Africa expected to support older generations (Caldwell 1976; De Lancey 1990). Other investigations have shown that where older people receive social pensions, children in the household also benefit from increased household income. (Case and Deaton 1998; Duflo 2000).

Informal support systems go beyond the extended family and also include benefits in cash and kind from membership of traditional solidarity networks, co-operative or social associations such as burial societies, self-help groups and rotating savings and credit clubs, as well as from cultural associations (Olivier et al 2004). In some cases older people also receive benefits from non-governmental sources such as local, national and international non-governmental organisations and churches.

However the effectiveness of these informal social protection systems is undermined by weak resource bases. They may therefore fail to adequately protect large numbers of older people from poverty. In addition, as noted throughout this report the strength of familial and informal support systems has been diminishing across many countries for reasons associated with modernisation already cited. Therefore, supplementing intra-family and community support with public social protection programmes is essential if Africa's older population is to be protected from poverty.

Formal social protection systems

In many African countries universal social protection systems capable of absorbing the increasing numbers of older people do not exist. Most of the contributory social security schemes on the continent only benefit civil servants and formal sector employees. Currently, less than 10 percent of Africa's workforce is covered by social security programmes (Turner 2001). Therefore, informal sector workers and those working in subsistence farming continue to be socio-economically excluded; consequently, they face increased chances of living in poverty. However, in those countries where non-contributory social protection systems exist, (Table 4 provide examples), poverty levels among older people and their households are much lower in comparison with countries where older people do not receive any form of older age benefits.

Box 11. Non-contributory old-age pension schemes in selected countries

A universal scheme - Namibia

Old-age pension schemes in Namibia were inherited from the colonial South African regime at the time of independence in 1990. The National Pension Scheme (NPS) also known as the Universal Pension Scheme, is a social pension, which provides a flat-rate, non-contributory and non-taxable benefit. During the apartheid years, the system was characterised by extreme inequalities. White Namibians received substantially higher social pension payments than black Namibians. After the country's transition to democracy in the 1990s, the Government brought about harmony and alleviated racial discriminatory practices. Currently, everyone who is a Namibian citizen residing in Namibia and is above the age of 60 years is entitled to the old-age pension. This entitlement is regardless of any assets, income and other pensions from derived contribution schemes. According to studies, the social pension benefits its recipients, their families and local communities in a variety of ways including contribution to household incomes, poverty reduction, food security, and education of grandchildren.

A means-tested scheme - South Africa

The pension is a means-tested benefit, granted to women from age 60 and men from age 65. The programme began in the early 1900s as a means of providing a basic income in retirement for 'whites and coloureds' who lacked an occupational pension (van der Berg, 2001). Subsequently, the programme was extended to black South Africans, but with more stringent conditions for entitlement and lower benefit levels. After the fall of apartheid, parity in the provision of the social pension was instituted, at a lower level than that previously enjoyed by the white South Africans. Black South Africans are now the main beneficiaries. The scheme is funded through general taxation and pays relatively generous pensions (around $3 per day). Benefit entitlements are means-tested on the income of the individual beneficiary, and his/her partner if married, but not on the income of other household members. The benefit produces a significant redistribution of income in a country where, on average, the incomes of white citizens remain ten times that of Africans.

Source: Sigg 2006:172

Although formal social protection schemes are few in number, a variety of alternative approaches exist across Africa (Turner 2001). The North Africa sub-region boasts the oldest and most comprehensive social protection programmes in the region. The process of institutionalising these programmes began in the 1950s in Algeria, Egypt, Libya, Morocco and Tunisia. The Tunisian programme includes agricultural workers by charging them lower contribution rates than urban workers. And in Egypt, the programme reaches the self-employed by encouraging them to declare their earnings (Turner 2001).

In West Africa, most Francophone countries were members of the West African Retirement Pensions Fund, a voluntary plan that was established during the colonial era. However, most countries began to introduce compulsory programmes in the early 1960s. Today, countries like Mali and Cote D'Ivoire have introduced programmes that are based on defined benefits.

In Anglophone countries, the history of social protection programmes is quite different from systems in French-speaking countries. More modest provident funds were established in countries like the Gambia, Ghana, Kenya, Nigeria, Tanzania, Uganda and Zambia. However, from the 1980s onwards, a majority of these countries began to switch from provident funds to defined benefit social security systems largely because of the inability of provident funds to provide comprehensive benefits.

In Southern Africa a variety of social security systems were introduced in the 1950s and 1960s (Olivier 2004). However, most of these programmes excluded large numbers of people. The move towards universal social protection only began after most Southern African countries gained independence (Table 4).

Table 4: Older age non-contributory pensions in Africa

Country	Type of pension programme	Retirement age	Monthly benefits in US$	Number of beneficiaries
Botswana	Universal	65	23	71,000
Mauritius	Universal	60	55	109,000
Namibia	Universal	60	26	82,000
South Africa	Means tested	65 (males) 60 (females)	80	1,800,000

Lastly, there are a number of countries that have not yet introduced social protection programmes. These include Eritrea, Ethiopia, Democratic Republic of Congo, Lesotho, Sierra Leone and Somalia. Most of these countries have recently emerged from conflict situations and this has hindered efforts to introduce social protection initiatives (Turner 2001).

4.3. Challenges to social protection systems in Africa

In countries where social security programmes exist, the major challenges are how to scale up or extend coverage to address the issue of social exclusion. The situation is worsened by PAYG systems in Africa are already experiencing difficulties because of the increasing numbers of older beneficiaries.

Scaling up coverage in Africa is not straightforward given the structure of African economies. Over 75 percent of the workforce is involved in agriculture, while the share of the informal economy in non-agricultural employment is 78 percent (Xaba et

al. 2002). On the one hand as long as large numbers of informal sector workers, subsistence farmers and other disadvantaged groups struggle to cover their day-to-day living costs it is unrealistic to expect them make contributions into a social security plan. This is compounded by a general lack of confidence in existing contributory pension schemes. It is difficult to ask people in subsistence agriculture and other informal sector livelihoods, whether in poverty or more financially secure to make contributions to social security systems in the absence of transparency and well-functioning public institutions.

The HIV/AIDS epidemic also complicates the financing of social protection programmes in sub-Saharan Africa. The disease predominantly affects the continent's the age range expected to be economically active, as well as reducing life expectancy in this age band. This undermines the economic base that is essential to building and sustaining social security programmes (Turner 2001). At the same time there are early indications that people are less motivated to save for retirement in those age bands where life expectancy is declining. Migration of large numbers of skilled and unskilled workers beyond Africa also negatively impacts upon the dependency ratio and reduces the tax revenue and social security funds in African countries (ECA 2006).

4.4. Policy responses

There is no clear cut solution to improving and extending coverage of social protection systems in Africa given the state of African economies. However, African countries need not repeat the mistakes made by the developed countries by introducing expensive social protection systems that have been shown to be unsustainable (World Bank 1994).

Experience of formal social protection programmes is fairly recent in Africa, particularly in sub-Saharan Africa. There are a range of options for governments to assess including:

- mandatory pay-as-you-go systems where both workers and employers contribute a percentage of funds to the financing of social security alongside a universal non-contributory social pension. A study by Kakwani and Subbarao (2005) on ageing and poverty in 15 low income African countries showed that the fiscal cost of providing such a combined social pension programme would be 2 to 3 percent of GDP. This is much higher than the total levels of public expenditure on healthcare in some low income African countries. Kakwani and Subbarao (2005:28) therefore contend that *'from the perspective of maximum poverty reduction, there appears to be a need for a non-contributory pension program restricting the eligibility to the poor among the elderly. Considerations of affordability and fiscal sustainability suggest that it is best to limit the benefit level to about one-third of the poverty threshold, eligibility age threshold to be 65+, and explore alternative non-income based methods of targeting to restrict the pension only to the poor among the eligible elderly (i.e., 65+).'* A major weakness of such a strategy is poor poverty targeting in addition to the usual criticisms of lack of transparency, corruption and paternalism.

- the establishment of individual accounts. In this system governments would need to set minimum retirement ages and qualifying conditions for retirement benefits, such as the minimum number of years workers are required to make contributions to the national social security scheme.
- a basic pension programme as recommended by MIPAA to extend coverage of social protection systems to workers in atypical employment and the informal sector (Sigg 2006). Basic coverage should also cover the rural elderly who are the most vulnerable to economic shocks.
- linking strengthened familial and informal social protection systems to formal social protection systems. The two systems share the common goal of protection of older people from destitution. According to Olivier et al. (2004:16): *'The objective of linking informal social security systems with formal social security systems is to strengthen informal social security systems and to help them assume some of the characteristics of conventional social security. Thus the idea is to provide support to informal social security and this support can be both financial and technical. Financial support can be directed at providing start-up capital for informal social security schemes or can be used to provide subsidies designed to enable informal social security schemes to meet their administrative costs and to provide better benefits. Technical support, on the other hand, would encompass imparting skills in core areas such as bookkeeping, record keeping, determining contributions rates and benefit structures and how to access capital markets. The stakeholders which can provide this support include government, nongovernmental organisations and the private sector.'* For many African countries, this would be a major challenge given the progress in scaling-up the limited social protection programmes that exist. Therefore any attempts to absorb informal systems should be done gradually and with a clear understanding of how these informal social protection programmes work (Von Benda-Beckmann 1997). Box 12 provides an example from Kenya of the challenge of integrating the two systems.

Each of these options has advantages and disadvantages. Support from the international community is required to enhance the gathering of basic data to establish the scale and parameters of the challenge, as well as strengthen institutional capacity. Both actions will contribute to effective decision-making and implementation of initial plans. At the same time in line with ILO's decent work agenda there are calls for plans and programmes to aim for full employment and decent work opportunities for African citizens, to promote economic growth. Improving employment rates will boost the sustainability of pension programmes and other social protection schemes through for example contributory schemes and tax contributions. It will also help to protecting more workers from unstable or part-time employment often associated with low wages. The decent work agenda should also offer employment opportunities to those older people who still want to work, particularly older workers who are close to retirement.

Box 12. Integrating Indigenous and Statutory Social Security Systems: The Case of Kenya

The Challenge

Only a minority of the 30 million Kenyans command enough resources of their own to make sufficient individual provisions for older age. The majority of Kenyans, however, have to seek social protection through a combination of individual arrangements based on their own economic activities and support extended by solidarity networks (e.g. family, kinship, friends and community). Approximately 12% of the total labour force is at least partially covered by formal private or public social security arrangements, usually based on employment-related contributions to social security schemes. Kenya's social protection system:

- Compared with the total size of the working population (approximately 12 million people), only 1.5 million are assured access though employment either to contributory schemes such as government social insurance schemes and private provident funds or to non-contributory schemes for civil servants and members of the armed forces.
- The vast majority of people depend on support in older age from informal systems including the family and the community to which they belong or from which they originate, which include the traditional village community, their ethnic group of origin, and/or the new neighbourhood group in the shanty town to which they have moved.

The formal statutory and the informal social security systems still operate as institutionally unlinked subsystems. Somewhere in between, social security islands are emerging in the form of self-organised, group-based social insurance schemes operated by trade unions, savings and credit co-operative societies, welfare associations and self-help groups.

In order to satisfy the social protection needs of the majority of Kenyans in a context where both the formal and informal social protection systems are under pressure, the formal social security institutions need to be prepared for institutional links with the social security initiatives of the informal sector. This will not only increase the numbers of people involved in preparing for the retirement, but will at the same time enhance the capacity for solidarity and cross-subsidisation.

Source: Gsanger 2001.

4.5. Conclusion

Government responses to the phenomenon of ageing populations in most African countries have not translated into comprehensive formal social protection systems targeted at older people. The majority of older people rely on informal systems of family and community support, which though traditionally robust are now being undermined by modernisation, individualism, migration and the impact of HIV/AIDS.

International policy frameworks call for the introduction of non-contributory pensions for older people. The performance of African economies and competing demands for public investment from other sectors of the economy as well as strong lobbies from a range of disadvantaged groups make this a difficult decision for governments. Yet action now will relieve the suffering of many poor and destitute older people in countries across Africa, with the aim of establishing effective systems to cope with their growing numbers year on year.

The support of the international aid community and the potential for developing links between formal and informal sector interventions, to scale up effective community initiatives, offer ways forward. Nonetheless, all options require governments to mainstream ageing issues and introduce a supportive policy and institutional framework that prioritises older people rather than overlooking them.

Part 3

The situation of older people in selected countries

The following are examples of progress on the implementation of MIPAA in selected countries. Some of these example were presented by country delegates at the Expert Group Meeting on Ageing in Addis Ababa, Ethiopia, 19-21 November 2007. The meeting was arranged in partnership between DESA, UNECA, the AU and HelpAge International and it formed one of the components of the regional review process planned for Africa. The event responded to the:

- CSD resolution on the review and appraisal of MIPAA
- the DESA recommendation on international cooperation specifically relating to regional events and appraisal activities to evaluate the national experience in the region and identify future priorities for implementing action on ageing
- complementary AU PFPA five year review process.

Relevant findings and directions of the meeting are reflected in Parts 1 and 2 of this report. The summaries of country level action included here highlight the variability in response to action on ageing. This is determined by differences in resource bases, institutional capacities and competing demands for budgetary allocation and corresponding level of prioritisation given to the concerns of older people within each country context. Nonetheless, there were clear indications among the delegates at the Expert Group Meeting that there is raised awareness of the pressing need for action on ageing and the rights of older people to be included in the development process.

While it is possible to gather information on country level policies and plans that respond to older people's issues, there is a widespread lack of data on the social and economic situation of people 60 and over. This is significant because the current absence of information based on systematic research into older people's day-to-day circumstances, food and income security, access to health care and medicines, care responsibilities and the levels of discrimination and isolation they experience hinders prioritisation of their issues and translation in to effective policy action.

Overviews of national policy development and action on ageing are presented for Burkina Faso, Cameroon Ethiopia, Ghana, Mauritius, Republic of South Africa, Tanzania and Uganda.

Burkina Faso

Burkina Faso has a current estimated population approaching 14 million. A national census was carried out in 2006; however, the results have not yet been published. The information used in this report is therefore based on the most recent firm figures, which come from the 1996 census. According to the 1996 census, there were 791,128 older people (defined here as 55 years and over) of which 52% were women and 48% men. This number represents an 8% rise in growth from the 1985 census of 678, 250 older people.

Most older people (88.83%) live in rural areas and are predominantly involved in agriculture, in crop and livestock production (67.47%). The literacy level among this group is very low with nearly 98% being illiterate. Married couples account for 67% of older people, while widowers and widows account for 27%.

Older people's concerns

Older people represent a considerable proportion of the population and they face many difficulties. Findings from a 1995 survey on the situation of older people in urban areas and a 1996 report on older citizens, highlight primary healthcare issues, food, transport, housing, access to recreation, the lack of income and social exclusion as the key problems identified by older people themselves..

Social exclusion constitutes a major problem for older people in Burkina Faso. A particular problem facing older women is the accusation of sorcery and witchcraft. This has forced thousands of older women to flee from their communities and remain socially excluded. These women have been accommodated in four major centers located in Ouagadougou, Tèma, Bokin and Dédougou.

Generally there is inadequate information on the situation of older people in Burkina Faso because of the lack of systematic research. The few studies available including the ones cited above do not take into account critical issues, for example, the living conditions of the older people in rural areas, the impact of the HIV/AIDS pandemic, the abuse of rights and lack of legal protection for older people, among others. The lack of reliable data stands in the way of analysing the situation of older people and guiding the formulation of strategies and policies.

Recent studies of the situation of older people

Through the support of HelpAge International, a study on the phenomenon of social exclusion among older people accused of sorcery was undertaken in seven of the most affected provinces of Bazega, Kadiogo, Kossi, Kourwéogo, Oubritenga, Passoré and Zondwéogo. The results indicated that those targeted were mainly women. The study also identified socio-cultural, economic and health problems as consequences of social exclusion. These findings were disseminated in a national workshop and in provinces of Yako and Manga in 2006. Representatives of provincial authorities and local NGOS, as well as public administrators and chiefs attended the meetings.

A separate study on social exclusion was carried out by ADRA. ADRA's other activities concerning the issues of older people include public campaigns during the

International Day of the Elderly on 1st October and debates on the role and the place of older people in the community. ADRA has also supported the construction of centres for older people accused of witchcraft at a cost of approximately CFA 170 million.

The policy environment

In recent years there has been increasing awareness of older people's concerns at Government levels. The Ministry of Social Action and National Solidarity (MSANS) is the lead department for the wellbeing of older people, being responsible for services and programmes including psychosocial assistance, income-generation activities and food relief. The Government allocates an estimated twenty million Francs (CFA 20 000.000) annually to support the homeless and people living in temporary structures with material and food assistance; these include many older people. Older women accused of witchcraft make up part of this group and MSANS has played a key role in raising awareness of social exclusion and relocating affected women to rehabilitation centres to accommodate them. The media also gives regular reports on violations of the rights of older people accused of witchcraft.

In addition, 60 million Francs (CFA 60,000,000) is allocated from the national budget to support the activities of older people's organisations. MSANS, through its Department of the Elderly, has also been instrumental in setting up a National Council of Elderly (CNPA) in 2002. CNPA receives 10 million Francs (CFA 10,000, 000) to strengthen its capacities to work on older people's issues.

A National Plan of Action for older people was developed and takes into account older age concerns from all classes of society, and particularly those affecting women. The Plan was endorsed during a national seminar in 2006 and is currently under review before being presented for funding. Funding is also being sought for a more comprehensive national study of the situation of older people.

The role of older people's associations

CNPA plays a key role in coordinating the activities of older people's associations and enabling them to participate in decision-making dialogue. The CNPA is the leading organisation representing the interests of older people in the country. The National Executive consists of 19 members including 3 women. Its main roles cover:-

- coordinating and directing the actions of older people's organisations
- supporting the decisions and actions of the Government for the implementation of MIPAA and any plans for older people
- ensuring the participation of older people in decision-making on issues affecting them
- promoting better intergenerational understanding and solidarity.

In addition to the existing National Association of Retirees and the Delegation of War Veterans and Former Servicemen, which have groups in all the provinces of Burkina Faso, a range of older people's associations have been formed specifically to promote the status and protect the rights of people 60 and over, and are guided by CNPA.

The main challenge facing the CNPA and older people's organisations is the difficulty of decentralising and forming a network of associations that have countrywide coverage.

Conclusion

Two challenges to action on ageing stand out. Firstly, the lack of recent statistical data and research on the situation of older people stands in the way of formulating and implementing interventions which are matched closely with older people's key concerns. Up-to-date information would also contribute to increasing the relevance of national policy development. Secondly, the absence of laws which protect the rights of older people is a major concern and needs urgent action.

Cameroon

The MIPAA marked turning point in how the world addresses the key challenge of "building a society for all age". It focuses on three priority areas: older persons and development; advancing health and well-being into old age; and ensuring enabling and supportive environment. Based on a human rights approach, this report will put emphasis on what is done or is in the pipeline regarding two major aspects:

- The protection of older persons;
- The promotion of the image and the participation of older persons

Prior to that, this is a brief overview of the situation of ageing in Cameroon.
Overview of ageing issues in Cameroon:

- In Cameroon, like in other African Countries, ageing is an emerging issue due to the erosion of the traditional family and cultural system
- In order to properly address the issue of protection and promotion of older persons, we need to know how many are they? Where and how do they leave (in urban and rural area)? Which problem are they facing? What are they capable of? What do they think about themselves, the younger generations, the future of their society
- For all those preoccupations, we need to specify and update information and statistics (quantitative and qualitative) that are not available based on the UN ratio of 6% of the global population, we can say that in Cameroon older persons are considered to be 960,000 (nine hundred and sixty thousand).
- That is why, out of the general population census conducted this year and which results are still to be published, and the Government is in the process to carry out a special data collection on the elderly and the retired people. The data collection form is available and we are now looking for funding. We are working with the UNDESA within their support programme to the countries in the implementation of the MIPAA. We received a UN exploratory mission in Cameroon from the 15 – 25 October 2007 led by Rosemary LANE to evaluate the needs concerning the protection and the promotion of older persons. That will help to assess national ageing situations, identify local, regional and national priorities so as to put in place appropriate policies, programmes and projects.
- But, while waiting to that needs assessment, there are many actions been done by various actors

Some major actions; listing few of them:

Awareness raising:

- Participation to the second World Assembly on Ageing and other Regional meetings;
- Cameroon hosted the biennial Help Age International Africa Regional Workshop from 11 – 13 September 2006 attended by representatives of

Governments and organisations from 14 countries (Cameroon, South Africa, Uganda, Ethiopia, Ghana, Tanzania, Lesotho, Swaziland, Mozambique, Sudan, Zimbabwe and the UK);

- Advocacy and consultations between the Ministry of Social Affairs and the other ministries and stakeholders (recommendation of the 1st forum of National Solidarity held in June 2005);
- Edition and distribution of pamphlet on ageing;
- Celebration of international day of the older persons;
- Mainstreaming ageing through: Cross – Government working team;
- There is now cross-Government working group on social development with a draft social development strategy paper;
- Within the present review of our poverty reduction strategy paper (new generation), issues to ageing have been considered in the draft

Some protective actions:

- New department within the Ministry of Social Affairs in charge of social protection of disabled and older persons;
- Creation of geriatric units in the regional hospitals;
- Facilitation of procedures for the processing of pensions;
- Special grants to poor and abandoned older persons;
- Financial support to NGOs, Association of older persons and organizations caring for them;
- Orphans and other vulnerable children programme by which families that are grandfathers and grandmothers are given nutrition, health education and legal support to care for their kids

In general, the protection of older persons is still a big challenge in developing countries. However, older persons should not be considered only as those in need or a burden of the economy but also resourceful persons who can bring solution to different problems and foster development.

Ethiopia

Ethiopia has a population of 75 million made up of more than 80 distinct ethnic and linguistic groups. It experiences a population growth rate of 3%. The economy depends heavily on the agricultural sector and among the population approximately 50% cannot afford to supply their minimum nutritional requirements and 44% are estimated to live below the national poverty line. Only 45% of people have access to health facilities and like most other African countries HIV/AIDS is a major health issue.

Based on 2006 figures, there are 3.3 million older people in Ethiopia. Financial security is a challenge in older age as the Social Security system remains limited in coverage and supports. About 500,000 older people are eligible for pensions after retirement; these are workers in civil, military and government formal sector employment. The remainder of older people who work in the informal sector, mainly in agriculture, or who are employed in the private sector and do not participate in contributory pension schemes, are not covered by formal social security schemes and rely on their families and the community for support in older age.

In recent years there has been a decline in traditional systems of family support for older people; however there is motivation at community levels to reinforce commitment to intergenerational responsibilities and strengthen relationships. At the same time there is strong political will to care for older people and the Government is engaging in a range of relevant activities. Along with government and family support other bodies involved in caring for older people include:

- NGO's - both international and local
- religious organisations
- civil society organisations.

The policy environment

At the national level the constitution of Ethiopia states;
'*The state shall, with available means, allocate resources to provide rehabilitation and assistance to the physically and mentally disabled, the aged, and to children who are left without parents or guardian…*'

The Ministry of Labour and Social Affairs (MOLSA) is the Government department responsible for improving the standard of living of older people among a range of other disadvantaged groups including people with disabilities, vulnerable children youth, women and the family.

In terms of policies that affect older people, the Government has formulated a Developmental and Social Welfare Policy which has three main types of intervention:

- developmental
- preventive
- rehabilitative.

This policy aims to promote the delivery of basic social welfare services to all Ethiopians. It specifically targets:

- children and youth in difficult circumstances
- women suffering from severe economic and social deprivations
- older people in need of care and support
- people who are victims of social problems.

Other national policies, which aim to address the concerns of older people alongside other groups, include policy instruments in the areas of population, HIV/AIDS and health issues and the Poverty Reduction Strategy.

Ethiopia's response to ageing issues at the international and regional level

Ethiopia has participated in reviewing and commenting on the both the first and second UN international plans on ageing. This has involved in-country consultation with stakeholders including both representatives of, and older people themselves to make relevant contributions to the MIPAA amendment process, which are rooted in the opinions of people 60 and over.

At the regional level Ethiopia participated in the expert meeting to develop the OAU Policy Framework and Plan of Action on ageing in the two sessions held in Addis Ababa and Kampala. And as a member of the African Union, Ethiopia approved the AU PFPA in Durban, South Africa.

Ethiopia's response to ageing issues at the national level

MIPAA urges member states to take national actions to mainstream ageing in their national development programmes. In response, firstly, Ethiopia has translated the full MIPAA document into Amharic (the official language) to raise awareness of the plan. Secondly the Government has developed a draft National Plan of Action on Ageing (NPA) in Amharic and English. The formulation process involved the participation of stakeholders. The same consultative process has been used to develop implementation manuals for the NPA.

The development of the NPA was also guided by MIPAA and AUPFPA, two baseline surveys in north and south Ethiopia and relevant existing national policies and development plans, particularly poverty reduction strategies and the main Developmental and Social Welfare Policy. The initial draft plan was prepared by MOLSA and followed by consultative meetings with all relevant stakeholders including age-care organisations and older people's associations and individuals. The draft was revised taking into account these inputs and launched. In the same way, the implementation manual was prepared and revised following consultation with relevant stakeholders: parliamentarians, government ministries and agencies, regional labour and social affair bureaus and older people and pensioners national associations

The draft NPA has two components: humanitarian and developmental and its target beneficiaries are:

- rural and urban older people
- older women

- highlanders and nomadic older people
- displaced, disabled, poor and HIV/AIDs affected older people
- households supported by older people (intergenerational solidarity).

Progress on implementing MIPAA and the AUPFPA therefore takes the shape of the draft NPA which awaits ratification. In preparation for ratification forums at federal and regional level have been established and action committees are planned. In the meantime other national policy measures include older people's issues within their remit.

Conclusion

Ethiopia has made significant progress with the resources at its disposal. Stakeholders recognise that the approval and implementation of the NPA is faced with a number of hurdles. The most significant are challenges are connected with lack of recognition of the importance of placing ageing in the development agenda, capacity issues resulting from lack of trained personnel in this area and the fundamental lack of funding.

The Ethiopian Government therefore calls for international and regional support from organisations including the AU, HAI, UNDESA, UNFPA and ADB. These bodies are urged to make a commitment in their activities to supporting the Ethiopian Government in its efforts to implement the NPA programme.

Ghana

Ghana has a current estimated population of approximately 23 million people. The age for retirement is 60; most policies for older people are directed at people 65 and over. In the 2002 census, people 65 and over made up 5.3% of the population which represented a 32.5% increase between 1984 and 2000. As in most African countries the majority of people lives in rural areas and are economically active in the informal sector, particularly agriculture. More women than men are engaged in agriculture and they are responsible for 70% of agricultural output. Yet women face institutional discrimination in attempts to gain access to land ownership and credit, particularly in older age.

The policy environment

A range of policy instruments exist designed to promote and protect the wellbeing of all citizens:

- The fourth Constitution of the Republic of Ghana (1992) ratifies the legal protection and promotion of basic human rights for all, including the rights of older people, in the development process.

- The 1994 National Population Policy (NPP) calls for the enactment of laws to protect the rights of older people and raise awareness of their needs. It specifically states

'Deliberate measures shall be taken to alleviate the special problems of the aged and persons with disabilities with regard to low incomes and unemployment.'

In addition a variety of other national policies recognise the issues of older people including:

- the 2006-2009 Growth and Poverty Reduction Strategy (GPRS) within which strategies have been outlined to address older people's concerns under the Social Policy Framework for mainstreaming and the vulnerable.
- aspects of the National Social Protection Strategy 2006 in the form of the Livelihood Employment Against Poverty scheme and the Social Grants Scheme which allocates cash transfers to specific target groups.
- the National Disability Policy which stipulates free healthcare for people with total disability.
- The National Health Insurance Scheme which exempts older people from payment.

With specific reference to ageing issues, the Government formed a National Committee on Ageing in 1997 and in parallel with the MIPAA meeting developed a draft National Policy on Ageing by 2003. Since 2003 the Ministry of Employment and Social Welfare has taken steps to have the policy ratified by Parliament. Proposed actions targeting older people's issues in the draft policy include:

- the formation of a National Coordinating Institution on Ageing

- provision of comprehensive healthcare programmes
- promoting older age employment
- strengthening of community care facilities.

The draft Policy also aims to enable older people to participate fully in national development and social life. The draft is compatible with existing national frameworks, and MIPAA and AU frameworks and activities.

Current Government programmes that affect older people

Meanwhile a number of national programmes support action on a range of issues that affect older people's lives including the following:

Rural development, migration and urbanisation.

The Ministry of Women's and Children's Affairs has initiated interventions to improve the situation of disadvantaged older people, particularly women in rural communities. Initiatives include:

- assistance to abandoned and stigmatized older women
- micro-finance schemes for older women.

Health and wellbeing

Since 1998 people aged 70 and over receive free public medical services. When the National Health Insurance Scheme is implemented older people will benefit without making contributions. The Ministry of Health has introduced a range of health initiatives to promote healthy lifestyles, care and support for older people and the rights of older people. A particular challenge is the neglect of older people in HIV/Aids data and therefore their exclusion from targeted programmes and education.

Work force and ageing labour force

The Government in partnership with the private sector has introduced income-generating and employment initiatives for older people. Older people's issues are included in the work of the Ghana Labour Commission and the Fair Wages Commission. In addition, in order to promote active ageing, new flexibility on full and part-time employment in critical sectors enables some older people to return to work particularly in the education and health sectors. For example, encouraging full utilisation of potential and expertise, education professionals, doctors and nurses are engaged in work after retirement age often to train younger people.

Access to knowledge, education and training

Large numbers of people reach older age with minimal literacy and numeracy. In line with MIPAA recommendations, the Government has introduced opportunities for continuing training and retraining. One of the most relevant programmes is the work of the Non-Formal Education Division of the Government Education Service, which provides functional literacy education to adults especially women and the rural poor, including older people.

Governance and older people

The Government recognizes and promotes the role of older people in governance.

Intergenerational solidarity

Following Ghana's observance of International Year of Older Persons 1999, the Government, NGOs and civil society have acted to raise awareness of older people's rights and protection from abuse and neglect. The Government has designated July 1st (Republic Day) as Senior Citizens Day to acknowledge their contribution to society. Other initiatives include the introduction of Community Care Programmes, Family Welfare Services and Community Work Groups as well as developing Government/NGO partnerships to establish Day Centres for older people. Extending these initiatives to reach older people in rural areas remains a challenge.

Income security and social protection

Income security and social protection for older people is a Government priority. Two contributory pension schemes exist:

- a formal sector scheme for pensionable officers and African civil servants who joined the scheme after 1972
- a scheme introduced in 1972 for both formal and informal sector workers.

However, a non-contributory scheme does not exist and the Government recognises that the majority of older people do not receive social protection and that most of the people in the large and expanding informal sector will not be protected by a pension when they reach older age.

Eradication of poverty

Approximately one third of Ghanaians' live below the national poverty line. Most older people live in poverty, in rural areas and experience declining remittances from their families. New levels of urban poverty are now being identified. The Government is aware that economic and social structures are ill-equipped to meet the requirements of the older population. Currently the GPRS and the NPP are responsible for strategies to address the issues of older people among other vulnerable groups. The National Policy on Ageing with its specific role of mainstreaming ageing issues awaits ratification.

Conclusion

Ghana believes it has made modest progress in the implementation of MIPAA. However, three key challenges have been identified which need to be addressed to improve progress. Firstly, the draft National Policy on Ageing needs to be ratified and appropriate actions developed for its implementation. Secondly, the capacity of the Ministry of Manpower Youth and Employment (MMYE) needs to be strengthened and appropriately resourced alongside other institutions to effectively co-ordinate the implementation of the MIPAA. Thirdly, modernisation processes have impacted on traditional values. There is a need to enable older people to benefit from aspects of modernisation.

Mauritius

Mauritius has a population of about 1.2 million. An estimated 10% of the population is aged 60 and over. It is projected that by 2040 older people will account for about 20% of the total population. In absolute terms the number will triple from present levels to reach about 350,000 by that date. Declining fertility rates over the past few decades have affected the age structure of the population, with Mauritius' population pyramid now manifesting the characteristics of a typical developed country age structure. This gives rise to concern about future dependency ratios. The dependency ratio declined from 1028 in 1962 to 530 in 2000. This resulted from former high fertility rates producing large number of children who have now moved into the economically active age group. However, more recent falls in the fertility rate mean that in the years to 2050 the proportion of economically active people in the population will decline and there will be a simultaneous rise in the proportion of older people in the population resulting in an increased dependency ratio. In 1990 an average of 7.4 economically active people supported one pensioner; it is projected that with the growing number of older people there will be approximately three people only to support one pensioner by the year 2030. The Government has given serious attention to population changes and detailed projections into the future, which allows them to consider the various impacts of population ageing and future proportions of different age groups in the population. For example between 1990 and 2040 the number of older people to 1000 younger people (0-14) will increase from 286 to 944. This level of analysis facilitates responsive planning.

Policy Environment

Mauritius is a welfare state and this is reflected in Government expenditure where the main areas of public spending are the social services, accounting for about 50% of the recurrent budget expenditure. National health and education services are completely free in Mauritius. Future health service development will take into account the need for increased focus on older people's health issues. Improved gerontology services are already planned, while the additional training courses for geriatric staff have been initiated. The Government of Mauritius recognises the challenge of population ageing and has taken specific social security measures to the extent that social security alone absorbs about 15% of recurrent national expenditure. The Ministry of Social Security and National Solidarity is responsible for policy development and the current approach is being carefully evaluated to ensure its sustainability and that adequate support goes to older people. Priority is now being given to identify social security schemes that are most suitable for the Mauritian context.

At the national level a number of Government actions have been implemented to improve the wellbeing of older people. These include:

- the Protection of the Elderly Persons Act 2005 under which an Elderly Person's Protection Unit has been established to address cases of abuse.
- the 1995 revision of the Act governing the role of the Senior Citizens Council in its aim to improve the quality of life of Senior Citizens and promote activities and projects for their welfare, with emphasis on their rights to dignity and independence.

- the National Economic Development Council (NECD) initiative to protect the wellbeing of older people, resulting in recommendations to maintain the home-based care of people 60 and over for as long as possible.

A parallel area of focus to ensure a good level of support for older people takes the shape of ongoing efforts to establish a well-organised network to provide cost-effective care. This is expected to involve partnership between Government and NGOs in generating maximum levels of voluntary support, particularly encouraging the participation of older people themselves.

Current measures and benefits for older people

As a welfare state Mauritius' older people benefit from a wide range of interventions designed to allow them to age with dignity and respect while enjoying a reasonable standard of living. These measures include

Pensions – both non-contributory and contributory schemes are available:

- the Basic Retired Pension (BRP) – since 1950 this universal pension has been paid to people 60 and over, at a rate at the age of 60 equalling the minimum wage; this rate is tripled at the age of 90 and increased again at 100. In addition older people with significant health issues receive additional financial benefits.
- The Contributory Retirement Pension (CRP) – retired employees in the public and private sectors receive the CRP. The rate depends on the amount they contributed every month.

Social Aid Allowances - older people are entitled to a range of benefits including:

- a monthly rent allowance if living alone and paying rent
- generous travel allowances, free wheelchair, free blankets, free (means-tested) spectacles and hearing aid for people 60 and over
- free home-based health care visits for people 90 and over
- a lump-sum cash grant, a grant for purchase of medicines, a monthly medical check-up and free telephone apparatus for people 100 and over.

Housing and Family Support

As women enter the work force home-based care for older people is becoming increasingly difficult to maintain. The Government advocates the strengthening of family-based care and is promoting intergenerational solidarity through civic education campaigns. To delay the transfer of older people to residential homes a carer's allowance is available for people caring for a disabled older person. The Government is also taking measures to address the shortage of residential homes for older people and is in dialogue with the Senior Citizen's Council.

Health Needs

In addition to free health care older people are entitled to annual check-ups and those 75 and over can receive home-visits by doctors. The healthcare system is well developed with decentralised hospitals as well as specialised hospitals and geriatric services at all levels.

Day Care Centres

Day Care Centres have been set up throughout the islands and provide facilities for social, recreational and health needs. They are staffed by personnel trained in caring for older people. This service benefits older people while enabling family members to work or attend school.

Civil Society and Private Sector Interventions

These include community support groups which provide help to bedridden older people and liaise with other service providers, charitable institutions which care for older people who lack family support, and private residential homes which are monitored under the 2003 Residential Care Homes Act.

Conclusion

The Government of Mauritius has already initiated short, medium and long term planning to manage the concerns of older people and address the implications of the predicted changes in population age structure of the country. However, despite an enviable starting position compared with the majority of African countries, the national budget is limited and the Government anticipates future tax increases to pay for the care of older people.

Republic of South Africa

South Africa has a current population of approximately 47 million made up of four historically defined population groups: African, White, Coloured and Indian. African people account for approximately 80% of the population. There is considerable diversity in ageing patterns among these groups because of differences in their fertility and mortality rates and accessibility to resources. The 2001 census figures indicate that more than 3 million South Africans were older people, and in terms of percentage of total population, people 60 and over accounted for 7.3%, those aged 70 and over made up 3.2% and those aged 80 and over made up 1%. Overall the African population is younger compared with the other population groups. For example, there is an almost two-and-half times higher proportion of older whites who are age 80+ compared with the other population groups. However, the large majority of older people are African (around 2.257 million are African, 0.682 million White, 0.254 Coloured and 0.087 Indian). It is projected that by 2015 the proportion of older people in South Africa will increase to 9.5% and the number will increase to 4.24 million.

The 2001 census also shows that a large proportion of older people have received no education. The figures reveal that 43% of people 60 and over have not had formal education and educational disadvantages are more prominent among African older people, with over half (58%) never attending school. This has implications for access to information and awareness of public messages.

Together these realities present significant challenges in terms of the scale of the increasing needs of the older population, and the practicalities of providing care, and services. With the expectation that the number and proportions of older people will increase in the future, the Government recognises the challenge of the situation and has paid special attention the concerns of this vulnerable segment of the population.

The policy environment

At the national level South Africa aims to implement MIPAA in an approach which incorporates the MIPAA statement that ageing is not simply an issue of social security and welfare but of overall development and economic policy. South Africa's action on ageing also takes into account MIPAA's statement that the primary responsibility for implementing the Madrid Plan of Action lies with the governments, but also that a partnership approach with civil society, the private sector and the older people themselves offers a way forward.

The South African Government efforts to develop legislation to mainstream ageing concerns into national development frameworks are therefore influenced by:

- MIPAA
- the South African Constitution and acknowledge
- the wisdom of older people
- the need to protect older people
- the need to promote active ageing.

The Older Person's Act reflects these directions and values. Initial work on specific legislation to address the concerns of older people began in the International Year of

Older People. The Older Person's Act was approved by the South African Parliament in March 2006. This legislation focuses on:

- Community based care and support services for older people
- The rights of older people
- The protection of Older People
- Residential care facilities.

The legislation is based on the additional principles that older people should be able to live independently functioning at their highest potential without fear of abuse, and that older people should be treated fairly and be valued independently of their economic status.

Practical action on ageing issues

The Older Person's Act promotes and guides the following interventions:

Development of community- based care and support services

These include:

- Programmes that provide physical care
- Supportive services, e.g. advice, information
- Education
- Day care
- Leisure activities
- Intergenerational programmes
- Economic empowerment programmes

Capacity-building for older people

This area covers:

- Multi-purpose facilities to provide for the intergenerational skills transfer programmes
- Technical and other skill development
- Home-based care
- Peer counselling skills

Training to service providers unable to access the INIA programme

Negotiations are underway with the International Institute on Ageing (INIA) to establish a satellite campus in South Africa to provide NGOs, CBOs, FBOs, older people and other grassroots' organisations certificated training on the following courses:

- Social Gerontology
- Geriatrics
- Economic and financial aspects of ageing
- Demographic aspects of population ageing and its implications for socio-economic development

This will ensure that older people and service providers are better equipped to deal with challenges and roles that they are expected to fulfill in the era of HIV/AIDS.

Active participation in society and development

Support will be given to strengthen older people's participation in voluntary programmes, legislation debates. Older people will also be able to access counselling on abuse on a national toll-free line.

Other areas of Government action

The following actions address older people's concerns connected with abuse and health issues.

Abuse

As part of a national strategy on protection from abuse of older people developed in collaboration with the Department of Health and other stakeholders, a number of initiatives have been devised in primary health care clinics, mental health care services and health education as well as active ageing programmes in service centre's

The newly developed Act for older people provides for the protection from abuse and the criminalisation of offenders. In addition South Africa has also embarked on the following programmes:

- Promoting the "restoration of the dignity of older people" through the development of community plans of action (Operation Dignity)
- The establishment of humane conditions at service points as one of the many plans developed at community level to restore the dignity and respect of older people
- Special efforts to ensure that older people remain within mainstream society
- The development of a national protocol on the management of abuse of older people
- The development and dissemination of information on Alzheimer's disease, the rights of older people, the new legislation (a user-friendly version for older people), and how to access to help in cases of abuse.

HIV/AIDS

With specific reference to the impact of the pandemic on older women South Africa has provided the following:

- Legislation aimed at a) giving support services to older people who care for their sick dependants and b)providing for material and social needs of dependants of the sick people
- Care for orphans
- Residential care policy and minimum standards have been developed and their appropriateness tested
- Extension of ages in child support has been increased to target orphaned children and their caregivers
- Outreach campaigns o ensure registration of all children and older people who are eligible for social assistance from the Government.

Creating an enabling and supportive environment for older people

The following programmes have been developed to promote independent living and the ability to function at the highest potential:

- Poverty reduction strategies which include older people's issues
- Social security provisions in terms of Government social assistance grants for all older people including those in the rural areas
- Income generation programmes
- Basic services including access to free water, a housing subsidy scheme and free primary healthcare.

Raising awareness of older people's issues

A national forum on ageing has been established in partnership with the South African Human Rights Commission, the private sector, NGOs and older people, where issues affecting older people are discussed. The forum aims to consult with other existing forums such as the AGES, Help-Age International and International Federation on Ageing (IFA). The purpose of the forum is to strengthen national awareness and action on supporting older people in need, so that older people remain within mainstream society and the physical and spiritual needs and contributions of older people are recognised. The forum would also be responsible for approving the Charter on the Rights of Older People. The draft charter is currently being consulted with provincial forums.

Developing a South African Plan of Action on Ageing

A draft South African Plan of Action on Ageing has been developed and is currently under consultation with national departments to lobby for funding to implement the South African Plan.

Conclusion

South Africa has implemented a range of actions to improve and protect the wellbeing of older people in line with MIPAA recommendations. The ratification and funding of the national Plan of Action on Ageing for older people is a key step in this development work. Without the endorsement of this coordinating document a challenge remains in ensuring the collaboration of all service providers to mainstream of older people's issues, and to carry that commitment through to the programme level and integration of services.

Tanzania

The 2002 census indicated Tanzania had a population of 34.4 million and experienced an annual growth rate of 2.9% between 1988 and 2002. At that time 4% of the population was aged 60 and over. Life expectancy at birth for both sexes increased from 51 years in 2002 to 57 years in 2025. Tanzania has a relatively young population and a relatively high fertility rate. International migration has not been a major factor of population change; however, internal migration in the form of rural to urban movements has affected the distribution of people with the urban population accounting for 23.1% of the total population in the 2002 census.

Most older people live in rural areas and the majority, particularly older women, live in poverty. Poverty of the elderly often goes beyond income, and includes physical weaknesses, isolation, powerlessness and low self-esteem. Where rights exist (over property and healthcare for example), older people often fail to claim their entitlements because of lack of information and appropriate structures. Few older people have any form of pension (estimated at less than 5% of those 60 and over) and a growing number are carers of HIV/AIDS sufferers and orphans. In addition, in the past, older people commanded respect and power; they controlled land and permanent crops, and played an important role in conflict resolution and were sources of information and knowledge. These roles are being eroded by changes in family structure, migration, and the dominance of a culture, which gives status to literacy and formal education.

Generally, the situation of older people in Tanzania is characterised by:

- Laws that do not protect older people, particularly women who are often denied property rights and suffer abuse
- Poverty
- Poor health and widespread inability to access to free medical services
- Isolation and lack of family support
- Weakening of traditional life and reduced role in the community.

The policy environment

The Constitution of Tanzania (1977) as amended in 1984 and 1995 recognises the human rights of all citizens, and these rights are enshrined in a range of legislative instruments, With specific reference to older people, Tanzania has responded to the United Nations Organisation Declaration No. 46 (1991) on older people's rights by formulating and approving the National Ageing Policy, (2003) which also reflects many of the recommendations of MIPAA and AUPFPA policy frameworks.

The main objective of the National Ageing Policy, 2003 is to ensure that older people are valued in society, provided with rights and services and accorded the opportunity to fully participate in the daily life of the community. The specific objectives include:

- To recognise older people as a resource
- To create a conducive environment for the provision of basic services to older people
- To allocate resources for older people's income generation activities

- To empower families for sustained support to older people
- To initiate and sustain programmes that provide older people with the opportunity to participate in economic development initiatives
- To prepare strategies and programmes geared towards elimination of negative attitudes and age discrimination
- To enact laws that promote and protect the welfare of older people
- To ensure that older people receive basic health services
- To initiate programmes that will provide an opportunity for older people to sustain good customs and traditions for the youth in the society

The Government also recognises that population ageing is a cross-cutting issue and that partnership between central government, local government authorities, voluntary agencies, families and villages are necessary, with each stakeholder contributing to the design and implementation of plans to ensure their effectiveness. However, despite this policy and statements within in it that aim to provide an implementation framework , setting out the inputs and mechanisms for delivery for each stakeholder group to facilitate action on ageing, necessary budgets have not been allocated and older people remain on the margins of the Poverty Reduction Strategy.

Priorities for action on ageing

Older people continue to experience the following problems which present a continuing challenge to the Government. Specific issues:

- Food shortage
- Lack of drinking water
- Problems in obtaining adequate clothing
- Difficulty in obtaining firewood
- Lack of financial means to pay for health services
- Lack of government assistance when medical treatment is needed
- Lack of local government support towards older people in terms of food and housing
- Lack of personal security resulting from accusations of witchcraft.

Broader issues associated with changing roles and position in society:

- Diminishing importance of the traditional role of older people within their communities
- The increasing need to stay economically active in order to survive
- Dealing with theft of money, crops and property by young people
- Care of HIV/AIDS infected children and the care for the orphaned grandchildren
- Lack of basic requirements, connected with a decline in traditional support systems
- Lack of willingness by medical staff to treat older people.

In order to deal with these pressing concerns, which affect the day-to-day quality of life of poor older people the following priorities have been identified for Government action:

- National budget allocation to safeguard the interests and rights of the older population
- Ensuring health providers are aware of exemptions of payment for the older Tanzanians and provide older people with good quality services and care
- Ensuring health budgets at local level include provision for exemptions and delivery of an essential drugs kit for the older poor
- Providing budget information in appropriate forms at local level on health budgets and their use
- Developing community-based mechanisms to revive adult learning, including the involvement of retired teachers as educators
- Requesting the Ministry of Water and Livestock Development to make improvements to ensure vulnerable groups have access to safe water and sanitation
- Ensuring that credit, legal and financial facilities are available to all people on clear terms, including older people.
- Ensuring information on entitlements and legal reform (such as the Land Act) is available in appropriate forms accessible to older people, and to work in partnership with NGO's active in this area.

Conclusion

A variety of challenges remain which stand in the way of the implementation of MIPAA in Tanzania. The primary constraint is lack of resources at the national level to fund dedicated action on ageing. At the same time there is the lack of appropriate mechanisms to incorporate the resolutions at all levels, as well as constraints relating to capacity of institutions and organisations to implement planned actions.

Therefore, there is a pressing need for support to prepare strategies and action plans, and mobilise funds in order to improve the life of older people.

Uganda

As in other developing countries the proportion of older people in the total population is increasing. According to the 1991 Uganda census, the population of older people was 686,260 (4.1%) of the total population of 16.67 million. The Uganda census results of 2002 indicate an increase to 1,101,039 representing 4.6% of the total population (UNHS). A more recent report (UNHS, 2005/06) estimated a population of older people of 1,200,000 of which 53% were female while 47% were male. This trend of increase in both absolute numbers and as a proportion of the population has profound consequences at individual, community and national level.

Older people in Uganda experience a range of factors, which affect their quality of life. A Government study conducted with the support of the World Health Organisation (WHO) revealed that among a mix of pressing problems including poverty and inadequate nutrition, older people prioritised poor health as their primary concern. Key obstacles to accessing healthcare services were inability to pay for consultations and medicines as well remoteness from services, lack of staff trained in older people's health issues and lack of relevant drugs. In addition, HIV/AIDS, indirectly affected older people's health in terms of losing family support, and burden of care for people living with and affected by HIV/AIDS.

The policy environment

The Constitution of Uganda recognises the rights of older people and provides the basis for the enactment of laws to address their rights and needs. Article 32 of the Constitution stipulates

'*Notwithstanding anything in this Constitution the state shall take affirmative action in favour of groups marginalized on the basis of gender, **age**, disability or any other reason created by history, tradition or custom, for the purpose of redressing imbalances which exist against them.'*

More specifically the National Objectives and Directive Principles of State Policy of the Constitution state

'The state shall make reasonable provision for the welfare and maintenance of the aged.'

In terms of participation of older people in decisions that affect them, the Local Government Act CAP 243 Section 10 (f) and 23 (6) provide for representation of two older people, male and female, elected by older people in Local Government Councils. At the same time the Equal Opportunities Commission Act (2007) provides for monitoring and evaluating policies, programmes, plans and activities to ensure that they are compliant with equal opportunities and affirmative action in favour of groups marginalised on the basis of sex, age, ethnic origin, religion, social and economic standing, gender.

The Ministry of Gender, Labour and Social Development (MGLSD) is the lead agency for action on ageing and implementing the recommendations of MIPAA. It

therefore leads the coordination of policy and because the Government recognises the issues of older people are multi-dimensional, implementation involves the participation of central Ministries, Local Governments, Faith-based Organisations, Non-Governmental Organisations, Community-based Organisations, the private sector, older people themselves and the community. The MGLSD works closely with Uganda Reach the Aged Association (URAA) and associations of older people from grassroot level to district level. A bottom-up approach is adopted, (which fits with MIPAA review approaches) in planning and implementation of programmes for older people. The Government recognises that participation of older people in these processes enhances ownership and sustainability of programmes.

The work of the MGLSD and is assisted by the Minister of State for Elderly and Disability Affairs, the political head of the Department for Disability and Elderly. The Department has specific responsibility for policy formulation and designing programmes for older people.

National policy responses to ageing issues

There are a range of overarching policies and plans, which include older people within their target beneficiaries. These include:

- Vision 2025 which is a long term national development framework and covers older people's concerns by generally improving access to basic services, infrastructure and other social amenities and aiming for 'a society where older people age with security and dignity'.
- The Poverty Eradication Action Plan (PEAP). This provides an overarching framework to guide public action to eradicate poverty. It identifies priority action areas and aims to support, mobilise and empower vulnerable groups to participate in the economic growth and social development process.
- The Social Development Sector Strategic Investment Plan. This was developed to implement the PEAP component on human development. It addresses major challenges of inequity, inequality, exclusion, unemployment and low productivity among the poor and the vulnerable. It articulates interventions for promoting their participation and ability to access basic services. I
- Other Sector Plans, which implement PEAP, include the Plan of Modernisation of Agriculture, Water and Environmental Sanitation, Education Sector Investment Plan and the Health Sector Strategic Plan among others. Concerns and needs of older people are being integrated during review of these planning frameworks.

Principles for guiding plan interventions for older people

The Department of Disability and Elderly provides a framework for responding to the issues, concerns and needs of older people. The guiding principles include:

- **A rights-based approach**
- **Independence** which promotes active ageing
- **Respect for older people** to protect them from abuse and reduce their vulnerability

- **Family and community-based care** which aims to strengthen familial responsibility for older people as the first line of support followed by the community
- **Partnerships.** This principle promotes partnership in service delivery and care for the older people I
- **Intergenerational linkages.** This principle emphasises engagement of older people in community activities to work towards creating a society for all.

Priority action

The Department of Disability and Elderly identifies the following areas for priority action to improve older people's quality of life:

- Economic empowerment of older people
- Strengthening formal and informal community support institutions
- Enhancing access to Social Services such as health, water and sanitation, food and nutrition, shelter, recreation, leisure and sports, education and training
- Psycho-Social Support
- Care and support of older people with disabilities
- Research and information dissemination.

The following examples provide information of interventions in two areas of fundamental importance to older people: health and financial security.

Health: Department recommendations in this area include integrating health services for older people into the general healthcare system. In this way services would become more responsive to the older people's health issues by providing trained staff, increasing availability of a recommended list of drugs to treat common conditions in older age, and including older people in HIV/AIDS programmes and food and nutrition programmes. The special health needs of older people should be integrated into plans and budgets at relevant levels of local government.

In response to the need to deliver training in older people's health needs, MGLSD in collaboration with HelpAge International and UNFPA have supported the training of staff in Gerontology at the University of Malta. The knowledge and skills attained have been used to develop a six week Certificate Course in Gerontology at Nsamizi Institute of Social Development. Participants are usually drawn from Government institutions and NGOs involved in implementing programmes for older people in Uganda.

Financial security: A specific initiative in this area coordinated by MGLSD, with funding support from DFID and HelpAge International, is the piloting of a cash transfer scheme targeting chronically poor households, including these headed by older people. It is recognised that lack of cash among people in chronic poverty makes it difficult for them to benefit from mainstream development programmes. The scheme will be piloted in six districts to assess the effectiveness of cash transfers. The lessons learned from the districts will be used to expand the project to more districts in a planned, controlled and systematic manner.

Conclusion

There are a number of key actions which need to be undertaken to strengthen focused action on ageing and respond to MIPAA and AUPFPA. Firstly, the sensitisation of local governments and stakeholders to integrate programmes for older people in sub-county and district plans is important. Secondly, the capacity of all stakeholder organisations needs to be strengthened to enhance delivery services for older people. Thirdly, research and dissemination of best practices and experiences in intervention needs to be improved to ensure relevant and effective initiatives in the future. Fourthly, effective coordination and mobilisation of resources to provide quality services for older people is required. But one action has been identified which will facilitate improvements in planning and implementation in all other areas. This is the creation of one national level coordinating body between Government departments, other service providers and older people to lead action on ageing.

Policy recommendations and the way forward

There is clear evidence of population ageing worldwide. Projections into the future indicate that the rate of ageing will present a serious challenge for governments throughout the world, but particularly in Africa. The African continent is experiencing the fastest increase in the proportion of older people in the population than any other continent. This is significant because African countries will have less time to adjust to the social and economic consequences of population ageing than other countries.

At the global and regional levels policy instruments exist, in the form of MIPAA and the AU PFPA, to guide national level policy action. However, the response to these calls for action has been uneven among governments in Africa, and though some have made valuable progress, most countries have not prioritised ageing issues. The five year review processes of both MIPAA and the AU PFPA are currently underway. The MIPAA +5 'bottom-up' review is time-tabled over two years until the end of 2008. This provides an opportunity to:

- establish progress
- raise awareness of older people's issues
- involve key stakeholders, particularly older people, in review dialogue to guide future formulation of relevant policies and plans
- understand what currently stands in the way of progress
- re-prioritise commitment to action among governments.

As part of the regional follow-up to MIPAA this report has examined the existing policy environment, the implications of the rate of population ageing in Africa and the socio-economic, health and social protection context of older people, as well as providing examples of national responses to ageing from a range of African countries. Drawing upon this information, the report proposes the following recommendations.

Policy environment recommendations:

1. International and regional efforts to be increased to raise awareness of the significance of ageing issues and the pressing need to engage in MIPAA and AU PFPA action on ageing at national level.
2. Support to be given to national governments to encourage engagement in the MIPAA and AU PFPA review processes including a) training activities on organising and coordinating bottom-up nationwide review and appraisal and b) regional review and appraisal events (meetings/conferences) to evaluate the national experience and identify future priorities for implementation.
3. Investigation of the possibility of convergence and synchronisation of MIPAA and AU PFPA review and reporting activities to streamline the required inputs at country level.
4. Clarification of the right of older people to be included in the development agenda so that PRSPs and action towards MDGs address their needs, as supported by the Millennium Declaration.
5. Ageing and the concerns of older people to be mainstreamed into national development frameworks and poverty eradication strategies.

6. National governments to prioritise action by formulating and approving a national policy on ageing.
7. National governments to support the implementation of policies and plans on ageing by allocating specific budgets for older people's concerns.
8. Research is urgently needed to build the evidence base on ageing and poverty to inform policymaking and planning on ageing concerns within country contexts. Research priorities, to enable the disaggregation of summary statistics and the gathering of empirical evidence to influence decision-makers, include a) the demographic situation and trends and variations b) effectiveness of current policies and programmes in reaching older people c) the socio-economic situation of older people d) the health issues of older people and the coverage of existing health services e) the impact of HIV/AIDS on older people f) the effectiveness of formal and informal social protection systems and older people's requirements. In each area the circumstances of women need to be specifically identified because of their heightened disadvantage and widespread invisibility in policies and plans.
9. International cooperation in the form of funding and targeted inputs is required to a) support research to guide relevant interventions b) strengthen institutional capacity and c) deliver interventions.
10. Governments to introduce mechanisms for all key stakeholders including older people, the full range of civil society organisations and the private sector, to engage in dialogue with the public sector to inform decision-making.
11. Governments to investigate the scope for cross-sectoral cooperation and support between the public and private sectors and civil society to address older people's concerns.

Recommendations relating to the changing age structures of African populations:

12. International and regional communication of the relevance of ageing concerns and the exponential rate of population ageing to current public policy action at country level, needs to be strengthened in messages to both the international cooperation community and to national governments.
13. The need for a multi-disciplinary approach to incorporating the multi-dimensional impacts of ageing in policy actions, at all levels, should be promoted.
14. Rates of population ageing, socio-economic conditions and institutional frameworks vary between countries in Africa. Interventions to address ageing issues should therefore be matched to country-specific circumstances.
15. The pressing need for country level action on ageing should be emphasised to promote a) relief of current suffering among poor older people b) the implementation of support systems to prepare for increasing numbers and proportion of older people in the population.

Recommendations relating to the social and economic situation of older people in Africa:

16. The erosion of traditional familial and community support structures caused by multi-dimensional modernisation processes and the impact of HIV/AIDS, requires country level responses to re-instil the notion of reciprocal responsibility at family and community levels.

17. At national level awareness needs to be raised that emphasis of policy support for the younger age bands and economically active has led to widespread neglect of the rights of older people, resulting in many living in poverty and isolation.
18. Policy focus is required on the concerns of older people, particularly older women, who in general experience higher levels of poverty and disadvantage than older men. Older women's particular vulnerability in widowhood is marked and government action is required on their protection and rights to inheritance.
19. The stigmatisation of older people in society is an increasing trend. The right to age with dignity and respect should be upheld and anti-discriminatory legislation introduced to address violence, abuse and accusations of witchcraft.
20. National campaigns are needed to raise awareness of the social and economic contributions older people make to society in order to improve older people's status and society's attitudes towards them. Public messages should communicate contributions in the form of a) continued economic activity over the age of 60 in agriculture and informal sector activities b) the social responsibility older people shoulder in caring for the sick and young at family and community levels which have positive indirect economic impacts.
21. The economic potential of older people needs to be supported through policy action to enable those older people willing to work to stay economically active for longer, in both formal and informal sectors
22. Awareness of the wider socio-economic benefits of social pensions needs to be raised among decision-makers. These include impacts of a) supporting individual livelihood endeavours which often have knock-on benefits in the community economy b) improving the health and nutrition of the family.
23. Governments should investigate the possibility of a partnership approach to social protection to build upon the complementarities of traditional social welfare systems and public policy approaches.
24. The role of civil society organisations and their interventions should be examined to assess the possibility of scaling-up.

Recommendations relating to health issues of older people and the impact of HIV/AIDS:

Health issues of older people.

25. There should be increased recognition of the implications for health services of the shift away from communicable diseases to non-communicable diseases (chronic, degenerative and mental illnesses) as well as an increase in incidence of disability in older age.
26. Greater emphasis should be given to the rights of older people to access healthcare, and the need to provide targeted public healthcare services for older people, particularly women who, on average, live longer than men. Action is needed on a) training personnel in the care and treatment of older people's health issues b) the provision of specialist services c) the improved availability of relevant medicines.
27. The institutional infrastructure and care options for older disabled people need public policy focus.
28. Health education campaigns are required to raise public awareness of a) ways to promote healthy living to contribute to prevention or delaying the onset of older age health issues b) self care advice to relieve low-level symptoms.

29. Government action is required on public education programmes to inform people about the likelihood of living longer, once they reach the age of 60, and the need, where financially possible, to save and invest in health insurance policies in order to protect themselves and relieve the burden on public health services.
30. Poor older people need support to maintain healthy diets, access health services and buy essential medicines. Existing traditional institutions and networks that support the healthcare needs of older people should be strengthened and sustained.
31. The possibility of partnership between government agencies which decide health policy and deliver public health services and other healthcare providers should be investigated. In particular government and civil sector cooperation in scaling up NGO and community initiatives to achieve consistent coverage in rural and urban areas should be given high priority.
32. Free healthcare should be introduced for poor older people.

The impact of HIV/AIDS on older people.

33. Older people commonly bear care responsibilities for adult children and grandchildren living with HIV/AIDS. Targeted health education is required to reduce older people's risk of infection with the virus.
34. Some older people are sexually active and their needs should be addressed in health education campaigns to prevent infection, and in health service provision.
35. The higher dependency ratio experienced by many older people caring for PWLHA pushes families into extreme poverty where inadequate diets increase susceptibility to illness and disease. Policy action is required to target and support these people.
36. Successful interventions at community and household level including a) community initiatives to improve diets and support food production to increase food security b) NGO projects providing home-based care for PWLHA relieve the burden placed upon older people and levels of poverty. These interventions need to be investigated to assess the potential for scaling up.
37. Free medical treatment for PLWHA is a required. Maintaining the health of AIDS patients allows them to remain economically active for longer which benefits their families including older people.
38. Training in new income generation activities is required for survivors of HIV/AIDS, including older people, to promote secure livelihoods.

Recommendations relating to social protection systems and population ageing:

39. Urgent action is needed to put in place mechanisms to improve the coverage of formal and informal systems of social protection, before the favourable dependency ratio between the economically active and the burden of young and older people declines.
40. Non-contributory social protection systems should be introduced to guarantee a minimum income for poor people aged 60 and over. Where the government does not provide non-contributory schemes, poor older people rely on family and informal social security systems. These systems generally suffer from weak resource bases and recipients are vulnerable to extreme poverty particularly in rural areas.

41. Social protection systems should be gender sensitive to respond to the higher levels of poverty and vulnerability experienced by older women.
42. In most African countries only 10% of the workforce receives a pension from contributory social security schemes. These schemes should be strengthened and their coverage widened.
43. Efforts should be strengthened to improve the employment rate, which would contribute to sustaining pension programmes and other social protection schemes.
44. Practical and funding support from the international community is required to strengthen investigations on a country-by-country basis into a) social security system options b) potential linkages and synergy between formal and informal sector interventions.

Throughout these recommendations the following themes naturally recur which signifies their importance:

- the need for evidence-based research in each area to provide information which decision-makers can use to guide the formulation of policy and justify bids for budgetary allocation;
- involving key stakeholders, including advocates for older people and older people themselves, in all levels of decision-making to increase the participatory nature of processes and improve the relevance of policies and plans;
- promoting cross-sectoral cooperation and coordination between public and private sectors and the full range of civil society organisations active in poverty reduction, to identify the scope for new partnership approaches and the strengthening and scaling-up of effective interventions;
- the need for capacity strengthening to address this relatively new area of policy focus. Key public institutions at national and lower levels and relevant civil society organisations require this support to enable them to implement plans effectively, mobilise resources appropriately and coordinate efforts to avoid duplication;
- the call for the support of the international community. In 2002, MIPAA's Article 4 emphasised that enhanced international cooperation was essential to complement national efforts. Given the uneven response on action on ageing in Africa in the subsequent five years, the role of the international community and aid modality appears to be critical in encouraging engagement and supporting progress.

The way forward therefore relies on a partnership approach between the actors involved at each level: global, regional, national and within each country, as originally recommended in MIPAA (Recommendation 16).

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Annex 1

Selected parameters for, and impact on poverty of, non-contributory social pensions, selected countries								
Country	Age eligibility	Universal (U) or means-tested (M)	Amount paid monthly		Percentage of people over age 60 receiving a pension	Annual basic pension as percentage of income per capita (data year)	Percentage GDP cost of social pension (circa 2000-2002)	Impact on poverty, circa 2000-2006
Argentina	70+	M	US$ 88	273 pesos	6	22 (2000)	0.23	Incidence of poverty dropped 31 percent in households receiving tax-financed pension, while incidence of extreme poverty dropped 67 percent (1997 data)
Bangladesh	57+	M	US$ 2	165 taka	16	7 (2003-2004)	0.03	Increased expenditure on food, health and microinvestments (HelpAge International/Asia Pacific Regional Development Centre (2006))
Bolivia	65+	U	US$ 18	150 bolivianos	69	23 (2004)	1.3	Beneficiary households increased food consumption by 6..3 per cent, with positive effects in rural areas in food consumption, output increase, and children's schooling
Botswana	65+	U	US$ 27	166 pula	85	9 (1999/00)	0.4	
Brazil: *Beneficio de Prestaao Continuada*	67+	M	US$140	300 reais	5	33 (2003)	0.2	Reduced to18 per cent probability of poverty of household members and increased income of the poorest by 100 percent and

Selected parameters for, and impact on poverty of, non-contributory social pensions, selected countries								
								5 percent
Brazil: *Previdencia Rural*	60+ men 55+ women	M	US$140	300 reais	27	33 (2003	0.7	Increased school enrolment for girls aged 12-14
Costa Rica	65+	M	US$ 26	13 800 colones	20	10 (2000)	0.18	
India	65+	M	US$ 4	200 rupees	13	10 (1999)	0.01	
Lesotho	70+	U	US$ 21	150 maloti	53	--	1.43	Established in 2004 and data on impact not available yet; first evidence, however, indicates that 65 per cent of pension income was spent on children cared for by older people (Samson, 2006)
Mauritius	60+	U	US$ 60	1978 rupees	100	18 (1999/00)	2	Poverty rates for older people (single and couples) were reduced by over 40 per cent
Moldova	62+ men 57+ women	M	US$ 5	63 lei	12	23.3 (1996)	0.08	
Namibia	60+	M	US$ 28	200 dollars	87	17 (1999/00)	0.8	Increased expenditures on food, health, grandchildren's education, agricultural technology, livestock and microenterprises
Nepal	75+	U	US$2	150 rupees	12	10 (2001/02)	0.1	
Samoa	65+	U	US$ 33	100 tala	100	22 (2003)	1.4	
South Africa	65+ men 60+ women	M	US$ 109	780 rand	60	32 (2003)	1.4	Reduced the probability that a household member would become poor by 12.5 per cent; and increased by

Selected parameters for, and impact on poverty of, non-contributory social pensions, selected countries								
								50 per cent the income of the poorest 5 per cent; and improved children's nutrition, health, education, fostered expansion of microenterprises, and stimulated intergenerational living arrangements
Tajikistan	63+ men 58+ women	M	US$ 4	12 somoni	--	--	--	
Thailand	60+	M	US$ 8	300 baht	16	15	1..3	
Uruguay	70+	M	US$ 100	2499 pesos	10	24 (2001)	0.62	Incidence of poverty and extreme poverty among older people 70+ has been low owing to pension coverage of 75 percent of those in this age group
Viet Nam	60+	M	US$ 6	100 000 dong	2	5 (1998)	0.02	
Viet Nam	90+	U	US$ 6	100 000 dong	0.5	--	0.0005	

Source: United Nations, 2007a: 163-16

Annex 2. Selected health issues affecting well-being in old age

A. Ageing and Alcohol

Research suggests that sensitivity to the effects of alcohol increases with age. Older people achieve a higher blood alcohol concentration than younger people after consuming an equal amount of alcohol. While younger people are likely to develop tolerance to increasing amounts of alcohol, older people have a decreased ability to develop this tolerance. Moderation in alcohol consumption is, therefore, always advisable as the ageing process takes place.

B. Ageing and Cardiovascular Disease

Cardiovascular Disease (CVD) is one of the most common causes of death world wide in older age for both men and women. In the developing countries, deaths from CVD rank a close second behind lower respiratory infections, yet in absolute global terms, two-thirds of all CVD deaths occur in developing countries.

Although there are risk factors contributing to CVD that cannot be modified, such as family history of cardiac disease, many risk factors can be modified to prevent or delay its onset. In fact, the impact of lifestyle and diet on CVD may be greater than that of non-modifiable risk factors, thus underscoring the critical importance of promoting healthy behaviours throughout the entire life course.
Even in older age, the benefits of adopting and/or continuing a healthy lifestyle reap considerable benefits. Among the most important areas for CVD prevention are:

- Lowering high blood pressure;
- Prevention and/or cessation of tobacco use;
- Normalisation and control of blood glucose levels;
- Control of body weight;
- Promotion of a physically active lifestyle;
- Lowering high cholesterol levels; and
- Adoption and/or maintenance of health eating behaviours.

C. Ageing and Hearing loss

Hearing impairment leads to one of the most widespread disabilities, and is common in older people. It occurs in two main ways. The first is through obstruction to the passage of sound waves, and the second is through disease or damage to the hearing organ in the inner ear or to the nerve which carries the hearing information to the brain. In older age, hearing impairment is more commonly due to the second mechanism, and may have a particular cause, such as diabetes, high blood pressure, certain medications and exposure to loud noises over a long period of time. It may result in problems of communication by speech, and loss of background noise and warning sounds leading to frustration, social isolation, loneliness, low self esteem, withdrawal and depression.

Fortunately, hearing loss may be prevented by avoiding exposure to excessive noise, or use of potentially damaging drugs and by early treatment of diseases leading to hearing loss, such as middle ear infections.

D. Ageing and Nutrition

While the need for caloric intake decreases with age, the requirements for fluids, protein, most vitamins and minerals stay the same or even increase. A balanced diet with plenty of fluids, a high proportion of fibres, vegetables and fresh fruit, good dentition or well fitting dentures, regular meals, and medical supervision for those who take medication are important factors in preventing malnutrition in older people.

E. Ageing and Osteoporosis

Osteoporosis is the gradual decline in borne mass with age, leading to increased bone fragility and fractures. The majority of osteoporotic fractures occur in older women, due to a natural decline in borne density after the menopause. The most common fractures, associated with osteoporosis are fractures of the hip and the vertebrate. The risk to osteoporosis can be minimized by avoiding smoking, taking part in physical activity, avoiding excess alcohol consumption, and adequate calcium and vitamin D intake.

F. Ageing and Physical Activity

The majority of older people are able to remain physically active well into older age. Physical activity can be fun, and should ideally be conducted in a group setting or with friends, thus increasing social contacts and social integration. Physical activity in older age has been shown to increase muscle strength, balance, joint suppleness, and overall physical coordination. Physical activity and favourable effects on blood pressure and body weight, and reduces the risk of heart disease, osteoporosis, certain cancers, diabetes, and falls in older people. It enhances relaxation, reduces stress, anxiety and depression, and increases mental agility.

Walking is a safe and natural exercise in all life settings, does not require any special skills or equipment. Health gains from walking are particularly valuable for old people, as they improve muscle strength, balance and posture. Other practical examples of increasing physical activity include gardening, cycling, swimming, gymnastics, dancing, or housework and simply climbing the stairs instead of taking the lift.

G. Ageing and Tobacco Use

It is stated that tobacco use has been shown to cause about 25 life-threatening diseases; and that smoking is a major risk factor in 8 of the top 16 causes of death in people aged 65 years and older. Therefore, ceasing smoking is beneficial at all ages.

H. Ageing and Visual Disability

The major age-related cause of blindness and visual disability include cataract (nearly 50% of all blindness), glaucoma, macular degeneration and diabetic retinopathy. Cataract results from a change of transparency of the lens in the eye, which becomes opaque and impedes the light from entering the eye. The disease can be treated with a relatively simple operation to remove the opaque lens; this treatment is available in all countries.

Glaucoma refers to a group of diseases which cause irreversible blindness due to optic nerve damage. Although glaucoma as such cannot be prevented, its consequences if visual loss can be avoided if the disease is detected and treated early. Hence, the need for regular eye examinations.

Diabetic retinopathy results from diabetic damage to the blood vessels in the retina, resulting in loss of vision. It is the leading cause of blindness in adults in developed countries. Regular eye examinations and timely treatment can prevent loss of vision in diabetic retinopathy.

Muscular degeneration is the most common disorder in the group of non-avoidable causes of visual loss. It involves the progressive degeneration of a very light sensitive area of the retina. Resulting visual disability can be alleviated by means of optical devices, rehabilitation and counselling.

Source: WHO, 1999

Annex 3

Demographic Indicators of older persons in Africa

Source of data: United Nations Population Division, Department of Economic and Social Affairs World Population Prospects. The 2006 Revision (Medium variant) ST/ESA/SER.A/266

Table 1: Elderly population by age groups and sex (000) 2007

	Males						Females						Both Sexes					
	60-64	65-69	70-74	75-79	80+	Total	60-64	65-69	70-74	75-79	80+	Total	60-64	65-69	70-74	75-79	80+	Total
AFRICA	8 213	6 131	4 266	2 554	1 696	22 859	9 331	7 306	5 282	3 317	2 448	27 683	17 543	13 437	9 548	5 871	4 143	50 542
Eastern Africa	2 235	1 642	1 144	689	451	6 161	2 647	2 013	1 441	902	655	7 659	4 883	3 655	2 586	1 591	1 106	13 820
Burundi	48	35	24	14	10	131	70	53	38	24	18	203	118	88	61	38	28	334
Comoros	7	5	3	2	1	17	7	5	4	2	2	20	14	10	7	4	3	37
Djibouti	8	5	3	2	1	19	9	6	4	2	2	23	17	12	7	4	2	43
Eritrea	33	21	12	6	4	77	45	31	19	12	9	116	78	52	31	18	13	192
Ethiopia	679	489	324	184	112	1 788	748	560	383	228	156	2 076	1 427	1 050	706	412	268	3 863
Kenya	224	165	132	86	62	669	261	198	160	104	77	800	485	363	293	190	139	1 470
Madagascar	156	120	83	49	33	441	173	137	98	61	44	512	329	258	181	110	77	954
Malawi	102	78	56	33	20	289	121	94	67	43	29	354	223	172	123	76	49	643
Mauritius	19	13	9	7	6	54	22	17	13	10	11	73	41	30	22	16	17	127
Mozambique	164	122	84	50	31	450	212	165	117	72	49	615	375	287	201	122	80	1 065
Réunion	12	10	7	4	3	35	14	11	9	6	7	48	26	21	16	11	10	83
Rwanda	48	36	28	18	11	142	69	54	41	25	20	209	116	90	69	43	32	350
Somalia	63	46	30	17	10	166	71	55	36	20	13	195	134	101	66	37	23	361
Uganda	188	130	96	63	41	517	223	159	122	82	59	645	411	289	218	145	100	1 163
United Republic of Tanzania	309	226	154	91	59	839	374	281	196	120	86	1 057	683	507	350	211	145	1 896
Zambia	83	62	43	26	17	231	107	82	59	36	26	310	190	145	102	62	43	541
Zimbabwe	91	76	56	38	31	292	122	103	76	53	45	398	213	179	132	91	76	690
Middle Africa	874	644	427	243	146	2 334	1 038	797	555	336	231	2 957	1 912	1 440	982	578	377	5 291
Angola	112	82	53	29	15	292	133	100	68	39	24	364	245	183	121	68	39	656
Cameroon	161	123	86	52	35	457	181	142	103	65	49	541	342	265	189	117	85	998

Table 1: Elderly population by age groups and sex (000) 2007

	Males						Females						Both Sexes					
	60-64	65-69	70-74	75-79	80+	Total	60-64	65-69	70-74	75-79	80+	Total	60-64	65-69	70-74	75-79	80+	Total
Central African Republic	35	28	20	12	8	103	47	38	28	18	14	145	82	66	48	30	22	249
Chad	83	63	41	23	12	222	92	73	52	31	19	267	175	136	93	54	31	489
Congo	30	22	15	9	6	82	37	28	20	13	9	106	67	50	35	21	15	188
Democratic Republic of the Congo	432	311	201	111	63	1 119	528	398	271	160	107	1 463	961	709	472	270	170	2 582
Equatorial Guinea	5	4	3	2	1	14	6	5	3	2	2	17	11	8	6	4	3	31
Gabon	14	10	7	5	5	42	14	11	9	7	7	48	28	21	17	13	11	89
São Tomé and Príncipe	1	1	1	1	0	4	1	1	1	1	1	5	2	2	2	1	1	9
Northern Africa	2 166	1 675	1 249	770	485	6 347	2 306	1 905	1 485	973	688	7 357	4 473	3 581	2 734	1 743	1 173	13 704
Algeria	315	265	222	133	81	1 016	352	302	253	164	137	1 208	668	566	475	297	218	2 224
Egypt	917	685	489	297	185	2 574	972	772	616	399	267	3 026	1 889	1 457	1 106	696	451	5 599
Libyan Arab Jamahiriya	77	54	36	20	14	200	61	48	34	22	20	185	138	102	70	42	34	385
Morocco	355	289	225	149	91	1 109	377	349	258	183	115	1 283	732	638	483	331	206	2 391
Sudan	377	275	185	109	71	1 017	411	309	216	133	97	1 165	788	584	401	241	168	2 182
Tunisia	121	105	91	62	43	421	131	123	105	72	52	483	252	228	196	134	94	903
Western Sahara	4	3	2	1	1	10	3	2	1	1	1	8	6	5	3	2	2	18
Southern Africa	607	426	271	151	94	1 548	772	598	423	265	224	2 283	1 379	1 024	694	416	318	3 831
Botswana	14	11	7	4	3	39	18	16	12	7	6	59	33	27	19	11	9	98
Lesotho	16	14	12	7	5	54	24	20	16	11	9	81	40	34	28	19	14	135
Namibia	17	12	9	6	4	47	21	16	12	8	6	64	38	29	21	14	10	111
South Africa	551	381	238	131	80	1 382	697	538	377	235	201	2 046	1 248	919	615	366	281	3 429
Swaziland	9	7	5	3	2	25	11	9	6	4	3	33	20	16	11	7	5	58
Western Africa	2 330	1 745	1 174	701	519	6 469	2 566	1 992	1 378	841	650	7 427	4 896	3 737	2 552	1 541	1 169	13 896

Table 1: Elderly population by age groups and sex (000) 2007

	Males						Females						Both Sexes					
	60-64	65-69	70-74	75-79	80+	Total	60-64	65-69	70-74	75-79	80+	Total	60-64	65-69	70-74	75-79	80+	Total
Benin	65	46	30	17	9	167	82	61	42	25	15	224	147	107	72	41	25	391
Burkina Faso	77	64	45	32	43	261	107	94	68	46	55	370	184	158	113	77	98	631
Cape Verde	2	2	2	2	1	10	4	5	5	3	2	18	6	7	7	5	3	28
Côte d'Ivoire	195	146	95	50	25	510	174	136	93	52	29	484	370	281	187	102	54	994
Gambia	17	13	9	5	4	48	19	14	10	6	5	54	37	27	18	11	9	103
Ghana	238	173	119	72	49	651	246	185	131	82	61	704	485	358	249	153	111	1 356
Guinea	84	59	36	21	12	212	97	73	47	29	17	263	181	132	83	50	29	474
Guinea-Bissau	13	10	7	4	2	35	15	11	8	5	3	42	27	21	15	9	6	78
Liberia	24	17	11	6	3	60	28	20	13	8	5	73	52	37	24	13	8	134
Mali	62	58	47	36	46	248	95	84	63	46	59	347	157	142	110	81	104	595
Mauritania	20	18	14	9	8	70	29	24	17	11	11	92	49	42	31	21	19	162
Niger	120	84	61	45	56	366	113	83	55	35	37	322	233	167	116	80	92	689
Nigeria	1 186	881	578	328	197	3 170	1 311	1 008	687	408	277	3 692	2 498	1 889	1 265	736	474	6 862
Senegal	115	93	70	47	49	375	120	97	72	48	51	390	236	190	143	96	100	765
Sierra Leone	57	41	26	13	6	142	67	50	33	17	9	176	124	91	58	30	15	318
Togo	53	39	26	15	9	142	60	47	34	21	14	175	113	86	60	36	22	316

Table 2: Population aged 60 or more as a % of the total population

	Burundi	Comoros	Djibouti	Eritrea	Ethiopia	Kenya	Madagascar	Malawi	Mauritius	Mozambique	Rwanda	Somalia
1995	0.044	0.040	0.042	0.041	0.044	0.042	0.048	0.048	0.085	0.050	0.039	0.043
2000	0.042	0.041	0.045	0.039	0.045	0.041	0.048	0.047	0.090	0.050	0.039	0.042
2005	0.040	0.043	0.049	0.040	0.046	0.039	0.049	0.046	0.096	0.050	0.037	0.042
2010	0.039	0.046	0.054	0.040	0.047	0.040	0.049	0.046	0.110	0.050	0.035	0.042
2015	0.041	0.048	0.059	0.039	0.049	0.043	0.052	0.046	0.133	0.051	0.037	0.045
2020	0.043	0.053	0.064	0.039	0.052	0.047	0.057	0.046	0.159	0.052	0.041	0.048
2025	0.044	0.060	0.071	0.039	0.056	0.051	0.062	0.047	0.187	0.053	0.045	0.052
2030	0.044	0.069	0.080	0.043	0.060	0.056	0.067	0.047	0.209	0.054	0.047	0.056
2035	0.044	0.080	0.090	0.055	0.066	0.062	0.074	0.048	0.223	0.055	0.050	0.062
2040	0.047	0.093	0.101	0.073	0.074	0.071	0.082	0.053	0.245	0.057	0.057	0.070
	Uganda	**Tanzania**	**Zambia**	**Zimbabwe**	**Angola**	**Cameroon**	**Central African Republic**	**Chad**	**Congo**	**DRC**	**Equatorial Guinea**	**Gabon**
1995	0.043	0.044	0.045	0.047	0.040	0.054	0.060	0.051	0.050	0.044	0.065	0.074
2000	0.040	0.046	0.045	0.049	0.040	0.054	0.059	0.048	0.050	0.043	0.064	0.069
2005	0.038	0.046	0.045	0.052	0.039	0.054	0.058	0.046	0.050	0.042	0.062	0.067
2010	0.037	0.048	0.045	0.052	0.038	0.054	0.056	0.044	0.050	0.040	0.061	0.069
2015	0.036	0.049	0.045	0.055	0.039	0.055	0.057	0.045	0.051	0.039	0.062	0.075
2020	0.036	0.051	0.044	0.057	0.040	0.058	0.058	0.046	0.053	0.039	0.061	0.082
2025	0.036	0.053	0.043	0.059	0.042	0.061	0.058	0.046	0.057	0.039	0.062	0.091
2030	0.037	0.057	0.043	0.060	0.044	0.066	0.059	0.048	0.062	0.040	0.064	0.100
2035	0.040	0.062	0.045	0.063	0.046	0.072	0.061	0.051	0.068	0.043	0.067	0.110
2040	0.045	0.070	0.050	0.075	0.050	0.082	0.067	0.055	0.077	0.046	0.071	0.120

Table 2: Population aged 60 or more as a % of the total population

	São Tomé and Príncipe	Algeria	Egypt	Libya	Morocco	Sudan	Tunisia	Botswana	Lesotho	Namibia	South Africa	Swaziland
1995	0.065	0.058	0.065	0.047	0.066	0.050	0.080	0.044	0.069	0.050	0.055	0.044
2000	0.065	0.063	0.069	0.053	0.072	0.052	0.085	0.048	0.069	0.050	0.060	0.047
2005	0.058	0.065	0.072	0.060	0.075	0.055	0.087	0.051	0.067	0.052	0.067	0.050
2010	0.053	0.069	0.079	0.067	0.081	0.059	0.091	0.054	0.067	0.056	0.076	0.054
2015	0.053	0.080	0.089	0.076	0.092	0.062	0.104	0.062	0.068	0.060	0.085	0.058
2020	0.057	0.092	0.101	0.089	0.110	0.066	0.123	0.068	0.069	0.064	0.095	0.059
2025	0.062	0.111	0.112	0.104	0.126	0.072	0.144	0.071	0.068	0.070	0.102	0.059
2030	0.067	0.133	0.120	0.125	0.143	0.079	0.168	0.073	0.065	0.074	0.108	0.056
2035	0.074	0.157	0.133	0.152	0.161	0.088	0.194	0.075	0.064	0.078	0.113	0.052
2040	0.092	0.185	0.150	0.182	0.180	0.099	0.222	0.085	0.068	0.083	0.118	0.050
	Benin	**Burkina Faso**	**Cape Verde**	**Côte d'Ivoire**	**Gambia**	**Ghana**	**Guinea**	**Guinea-Bissau**	**Liberia**	**Mali**	**Mauritania**	**Niger**
1995	0.043	0.052	0.064	0.045	0.049	0.050	0.049	0.052	0.038	0.053	0.053	0.044
2000	0.043	0.048	0.063	0.048	0.053	0.053	0.048	0.050	0.037	0.053	0.053	0.045
2005	0.043	0.045	0.055	0.051	0.058	0.056	0.050	0.047	0.036	0.050	0.053	0.048
2010	0.045	0.040	0.049	0.053	0.063	0.060	0.051	0.044	0.035	0.045	0.052	0.049
2015	0.048	0.039	0.051	0.056	0.067	0.064	0.054	0.043	0.036	0.044	0.059	0.051
2020	0.052	0.040	0.059	0.059	0.072	0.069	0.057	0.041	0.036	0.043	0.066	0.053
2025	0.056	0.043	0.073	0.061	0.078	0.076	0.060	0.041	0.037	0.043	0.074	0.056
2030	0.060	0.048	0.088	0.064	0.085	0.084	0.064	0.041	0.037	0.045	0.083	0.055
2035	0.066	0.055	0.099	0.068	0.092	0.094	0.070	0.043	0.039	0.050	0.095	0.055
2040	0.073	0.064	0.117	0.077	0.098	0.107	0.077	0.045	0.041	0.056	0.108	0.057

Table 2: Population aged 60 or more as a % of the total population

	Nigeria	Senegal	Sierra Leone	Togo
1995	0.046	0.059	0.056	0.047
2000	0.046	0.061	0.055	0.047
2005	0.046	0.062	0.055	0.048
2010	0.047	0.062	0.054	0.049
2015	0.049	0.062	0.053	0.052
2020	0.051	0.064	0.052	0.056
2025	0.054	0.067	0.053	0.060
2030	0.058	0.073	0.055	0.066
2035	0.063	0.081	0.056	0.074
2040	0.069	0.092	0.059	0.084
2045	0.079	0.105	0.063	0.097

Table 3: Old-age dependency ratio (ratio of population aged 65+ per 100 population 15-64)													
	1990	1995	2000	2005	2010	2015	2020	2025	2030	2035	2040	2045	2050
AFRICA	6.0	6.0	6.1	6.1	6.2	6.3	6.7	7.1	7.5	7.9	8.5	9.4	10.6
Eastern Africa	5.5	5.5	5.5	5.5	5.5	5.5	5.6	5.8	6.0	6.3	6.7	7.5	8.5
Burundi	6.0	5.8	5.6	5.0	4.6	4.7	5.2	5.5	5.5	5.3	5.3	5.7	6.5
Comoros	4.8	4.8	4.8	4.8	5.0	5.3	5.5	6.0	6.7	7.8	9.1	10.6	12.7
Djibouti	4.5	4.6	4.8	5.1	5.4	5.9	6.3	6.8	7.6	8.6	9.6	10.8	12.4
Eritrea	5.1	5.0	4.6	4.3	4.4	4.6	4.5	4.3	4.1	4.6	6.1	8.2	9.7
Ethiopia	5.3	5.3	5.4	5.5	5.5	5.6	5.8	6.0	6.4	6.9	7.5	8.3	9.3
Kenya	5.5	5.2	5.2	4.9	4.7	4.8	5.2	5.6	5.9	6.4	7.1	8.1	9.5
Madagascar	5.8	5.8	5.9	5.9	5.9	5.8	6.2	6.7	7.2	7.8	8.4	9.3	10.2
Malawi	5.3	6.0	5.9	6.0	6.0	5.9	5.7	5.7	5.7	5.6	5.6	6.1	6.8
Mauritius	8.3	8.9	9.1	9.6	10.1	11.8	14.8	18.5	22.6	25.7	27.6	31.1	33.2
Mozambique	6.4	5.9	5.9	6.1	6.2	6.3	6.2	6.2	6.2	6.2	6.2	6.4	6.8
Réunion	8.7	9.0	9.5	10.4	11.3	12.7	14.9	17.6	22.1	26.0	27.8	28.3	29.4
Rwanda	5.4	5.3	5.1	4.6	4.1	4.1	4.4	4.9	5.2	5.2	5.4	6.2	8.1
Somalia	5.5	5.0	4.9	4.9	4.9	5.0	5.3	5.6	6.0	6.4	7.1	7.9	8.4
Uganda	5.4	5.5	5.7	5.2	4.9	4.7	4.6	4.5	4.4	4.4	4.7	5.3	6.0
United Republic of Tanzania	5.2	5.3	5.5	5.6	5.8	5.9	5.9	6.0	6.2	6.5	7.0	7.9	8.9
Zambia	5.4	5.4	5.6	5.7	5.7	5.6	5.4	5.1	4.9	4.8	5.0	5.6	6.3
Zimbabwe	5.7	5.8	6.0	6.1	6.2	6.0	6.4	6.6	6.6	6.6	6.9	8.3	10.8
Middle Africa	5.9	5.8	5.7	5.5	5.4	5.3	5.3	5.2	5.3	5.4	5.7	6.2	6.8
Angola	5.1	4.9	4.8	4.7	4.6	4.5	4.7	4.8	5.0	5.1	5.3	5.7	6.3

Table 3: Old-age dependency ratio (ratio of population aged 65+ per 100 population 15-64)													
	1990	1995	2000	2005	2010	2015	2020	2025	2030	2035	2040	2045	2050
Cameroon	6.9	6.8	6.6	6.5	6.3	6.3	6.3	6.4	6.7	7.2	7.9	9.0	10.6
Central African Republic	7.6	7.3	7.3	7.2	6.9	6.6	6.7	6.7	6.6	6.6	6.8	7.4	8.4
Chad	6.7	6.4	6.1	5.8	5.6	5.3	5.4	5.5	5.5	5.6	5.8	6.3	7.0
Congo	6.1	5.9	5.9	5.8	5.9	5.9	5.8	5.9	6.2	6.8	7.5	8.5	9.6
Democratic Republic of the Congo	5.4	5.4	5.3	5.2	5.1	5.0	4.9	4.8	4.7	4.8	5.0	5.4	5.9
Equatorial Guinea	7.8	7.8	7.8	7.6	7.4	7.2	7.4	7.3	7.3	7.4	7.6	8.0	8.7
Gabon	10.5	9.7	8.8	7.9	7.5	7.6	8.5	9.3	10.3	11.3	12.4	13.6	15.3
São Tomé and Príncipe	8.9	8.6	8.2	8.1	6.9	6.0	5.8	6.3	7.0	7.5	8.2	10.5	13.6
Northern Africa	6.7	6.9	7.2	7.4	7.6	8.2	9.3	10.8	12.3	13.7	15.5	18.1	21.2
Algeria	6.8	6.6	6.8	6.9	6.8	7.3	8.7	10.3	12.6	15.3	18.4	22.4	27.5
Egypt	7.0	7.2	7.5	7.8	8.1	8.9	10.2	11.7	13.0	13.8	15.3	17.7	20.7
Libyan Arab Jamahiriya	4.6	4.8	5.2	5.8	6.7	7.5	8.6	10.0	11.7	14.1	17.8	22.4	28.0
Morocco	6.8	7.5	7.6	8.1	8.1	8.7	10.2	12.6	14.6	16.6	18.8	21.5	25.5
Sudan	5.7	5.8	6.1	6.3	6.6	6.9	7.1	7.5	8.1	8.9	9.9	11.2	12.7
Tunisia	7.9	8.8	9.1	9.3	9.0	9.5	11.3	13.8	16.7	19.9	23.5	27.9	33.1
Western Sahara	4.5	4.0	4.0	3.5	3.4	3.9	5.2	7.3	9.9	12.8	16.2	19.9	23.7
Southern Africa	5.6	5.7	6.0	6.7	7.5	8.4	9.4	10.4	11.1	11.6	12.0	12.5	13.6
Botswana	5.2	5.0	5.2	5.5	5.7	5.9	6.9	7.5	7.7	7.6	7.8	9.0	11.2
Lesotho	8.5	8.9	8.8	8.6	8.3	8.1	8.1	8.2	8.0	7.3	7.1	7.6	9.1
Namibia	6.4	6.3	6.2	6.0	6.0	6.3	6.8	7.3	7.9	8.3	8.6	9.2	10.3
South Africa	5.5	5.6	6.0	6.7	7.6	8.6	9.8	10.8	11.6	12.2	12.7	13.2	14.3
Swaziland	5.3	5.4	5.4	5.7	5.9	6.4	6.9	7.0	6.7	6.1	5.5	5.3	5.9
Western Africa	6.0	5.9	5.9	5.9	5.9	5.8	6.0	6.2	6.5	6.8	7.3	8.1	9.2

Table 3: Old-age dependency ratio (ratio of population aged 65+ per 100 population 15-64)													
	1990	1995	2000	2005	2010	2015	2020	2025	2030	2035	2040	2045	2050
Benin	5.7	5.4	5.2	5.1	5.1	5.3	5.8	6.2	6.5	6.9	7.5	8.3	9.7
Burkina Faso	8.3	7.5	6.8	6.1	5.6	4.9	4.8	4.8	5.1	5.7	6.5	7.4	8.3
Cape Verde	9.0	8.5	8.1	7.6	6.3	5.4	5.7	6.7	8.5	10.3	11.6	13.7	16.8
Côte d'Ivoire	5.1	5.2	5.5	5.7	5.9	6.0	6.3	6.5	6.7	6.8	7.3	8.4	10.1
Gambia	5.2	5.4	6.0	6.7	7.4	7.9	8.2	8.6	9.3	10.0	10.7	11.4	12.3
Ghana	5.8	5.9	6.1	6.3	6.6	7.0	7.3	7.8	8.5	9.4	10.6	12.1	14.1
Guinea	6.0	5.9	5.7	5.7	6.0	6.1	6.4	6.7	7.0	7.4	8.0	8.8	9.9
Guinea-Bissau	6.7	6.4	6.3	6.1	5.8	5.5	5.4	5.1	5.0	5.0	5.1	5.3	5.5
Liberia	4.8	4.6	4.4	4.3	4.3	4.3	4.3	4.3	4.3	4.4	4.5	4.7	5.1
Mali	7.7	7.7	7.8	7.4	6.9	6.0	5.7	5.5	5.4	5.5	6.0	6.7	7.6
Mauritania	6.3	6.4	6.5	6.4	6.3	6.1	6.9	7.7	8.6	9.6	11.0	12.5	14.1
Niger	5.5	5.8	6.1	6.4	6.7	6.9	7.1	7.3	7.5	7.3	7.2	7.2	7.3
Nigeria	5.7	5.7	5.6	5.5	5.5	5.5	5.6	5.8	6.1	6.4	6.9	7.6	8.8
Senegal	7.2	7.5	7.8	7.9	7.9	7.7	7.5	7.5	7.8	8.4	9.3	10.6	12.3
Sierra Leone	6.3	6.2	6.2	6.2	6.2	6.1	5.9	5.9	6.0	6.1	6.2	6.4	6.8
Togo	6.0	5.8	5.8	5.7	5.7	5.8	6.1	6.4	6.9	7.5	8.3	9.4	10.9

Table 4: Old-age dependency ratio (ratio of population aged 65+ per 100 population 20-64)													
	1990	1995	2000	2005	2010	2015	2020	2025	2030	2035	2040	2045	2050
AFRICA	7.5	7.5	7.6	7.7	7.6	7.8	8.1	8.6	9.0	9.4	10.1	11.0	12.4
Eastern Africa	6.9	6.9	7.0	7.0	6.9	6.9	7.0	7.2	7.4	7.6	8.0	8.9	10.0
Burundi	7.4	7.2	7.4	6.5	5.8	5.7	6.4	6.9	7.0	6.7	6.6	7.0	7.9
Comoros	6.1	6.1	6.1	6.0	6.2	6.5	6.7	7.1	7.9	9.1	10.5	12.2	14.5
Djibouti	5.6	5.7	6.0	6.3	6.7	7.1	7.4	8.0	8.8	9.9	11.1	12.3	14.1
Eritrea	6.7	6.8	5.9	5.4	5.5	5.6	5.5	5.3	5.0	5.4	7.1	9.5	11.2
Ethiopia	6.6	6.6	6.8	6.9	7.0	7.0	7.2	7.4	7.7	8.2	8.8	9.6	10.8
Kenya	7.1	6.8	6.7	6.3	5.8	5.9	6.5	6.9	7.2	7.6	8.4	9.5	11.1
Madagascar	7.3	7.3	7.4	7.4	7.4	7.3	7.6	8.1	8.6	9.2	9.9	10.8	11.8
Malawi	6.6	7.7	7.5	7.7	7.7	7.7	7.3	7.1	7.1	6.9	6.8	7.3	8.0
Mauritius	9.6	10.5	10.5	10.8	11.5	13.2	16.5	20.4	25.0	28.4	30.6	34.3	36.6
Mozambique	8.2	7.4	7.4	7.6	7.9	8.0	8.0	7.8	7.6	7.5	7.5	7.6	8.0
Réunion	10.3	10.5	11.0	11.9	12.9	14.3	16.9	19.8	24.8	29.1	31.1	31.5	32.6
Rwanda	6.7	6.7	6.9	6.2	5.2	5.0	5.3	6.1	6.4	6.3	6.4	7.3	9.4
Somalia	6.9	6.4	6.0	6.1	6.0	6.2	6.6	6.9	7.3	7.8	8.5	9.4	9.9
Uganda	6.9	7.1	7.3	6.7	6.4	6.0	5.9	5.7	5.5	5.5	5.8	6.4	7.2
United Republic of Tanzania	6.6	6.7	6.9	7.1	7.2	7.4	7.5	7.4	7.5	7.7	8.3	9.2	10.4
Zambia	6.8	6.9	7.1	7.3	7.3	7.2	6.8	6.4	6.1	5.9	6.1	6.7	7.4
Zimbabwe	7.3	7.5	7.8	7.9	7.8	7.4	7.7	7.9	7.9	7.7	8.0	9.6	12.3
Middle Africa	7.5	7.3	7.2	7.0	6.9	6.7	6.6	6.6	6.6	6.7	7.0	7.5	8.1
Angola	6.4	6.2	6.1	6.0	5.9	5.7	5.9	6.0	6.2	6.4	6.5	6.9	7.5

Table 4: Old-age dependency ratio (ratio of population aged 65+ per 100 population 20-64)													
	1990	1995	2000	2005	2010	2015	2020	2025	2030	2035	2040	2045	2050
Cameroon	8.7	8.5	8.4	8.1	7.9	7.7	7.7	7.7	8.0	8.4	9.2	10.4	12.2
Central African Republic	9.3	9.1	9.0	9.1	8.7	8.3	8.2	8.2	8.0	7.9	8.0	8.7	9.7
Chad	8.4	8.1	7.7	7.3	7.0	6.8	6.8	6.8	6.8	6.9	7.1	7.5	8.2
Congo	7.7	7.5	7.3	7.3	7.3	7.2	7.2	7.2	7.5	8.0	8.8	9.9	11.0
Democratic Republic of the Congo	6.9	6.8	6.7	6.6	6.5	6.4	6.2	6.1	6.0	6.0	6.3	6.6	7.1
Equatorial Guinea	9.5	9.5	9.6	9.5	9.2	8.9	9.1	9.0	8.9	8.9	9.1	9.5	10.1
Gabon	12.8	11.9	10.9	9.7	9.1	9.1	9.9	10.9	11.9	13.0	14.2	15.4	17.3
São Tomé and Príncipe	11.2	11.3	10.8	10.2	8.7	7.4	7.1	7.6	8.2	8.7	9.5	12.0	15.4
Northern Africa	8.3	8.6	8.9	9.0	9.0	9.5	10.8	12.4	14.1	15.6	17.5	20.2	23.8
Algeria	8.5	8.2	8.5	8.4	8.0	8.3	9.8	11.7	14.3	17.2	20.5	24.7	30.2
Egypt	8.6	8.9	9.3	9.5	9.5	10.4	11.8	13.5	14.9	15.7	17.2	19.8	23.2
Libyan Arab Jamahiriya	5.9	6.0	6.5	6.8	7.6	8.6	9.8	11.5	13.3	15.8	19.7	24.6	30.8
Morocco	8.4	9.2	9.3	9.7	9.5	10.0	11.6	14.4	16.6	18.7	21.1	23.9	28.3
Sudan	7.2	7.3	7.6	7.8	8.1	8.4	8.6	8.9	9.5	10.3	11.4	12.8	14.5
Tunisia	9.6	10.8	11.0	11.0	10.4	10.6	12.5	15.3	18.5	22.1	26.0	30.7	36.4
Western Sahara	5.4	4.8	4.8	4.1	4.0	4.4	5.8	8.2	11.1	14.5	18.2	22.1	26.2
Southern Africa	6.9	6.9	7.3	8.0	9.0	10.0	11.2	12.2	12.9	13.4	13.8	14.3	15.5
Botswana	6.5	6.3	6.6	6.9	6.9	7.1	8.1	8.8	9.0	8.8	8.9	10.2	12.7
Lesotho	10.9	11.5	11.5	11.2	10.6	10.3	10.1	10.1	9.7	8.8	8.4	9.0	10.6
Namibia	8.1	7.9	7.7	7.7	7.6	7.7	8.0	8.7	9.3	9.8	10.0	10.5	11.8
South Africa	6.7	6.7	7.1	7.9	9.1	10.2	11.5	12.7	13.5	14.1	14.6	15.1	16.2
Swaziland	6.8	6.9	7.1	7.4	7.6	8.0	8.4	8.6	8.2	7.4	6.6	6.2	7.0
Western Africa	7.5	7.5	7.5	7.4	7.4	7.3	7.4	7.6	7.8	8.2	8.7	9.5	10.7

Table 4: Old-age dependency ratio (ratio of population aged 65+ per 100 population 20-64)													
	1990	1995	2000	2005	2010	2015	2020	2025	2030	2035	2040	2045	2050
Benin	7.2	6.7	6.6	6.4	6.4	6.6	7.1	7.6	7.9	8.3	8.9	9.7	11.2
Burkina Faso	10.8	9.7	8.7	7.8	7.1	6.2	6.0	6.0	6.3	7.0	7.9	8.8	9.8
Cape Verde	11.3	11.0	10.6	9.8	7.8	6.5	6.8	7.9	10.0	11.9	13.2	15.6	19.0
Côte d'Ivoire	6.2	6.5	6.9	7.3	7.4	7.4	7.7	7.9	8.0	8.1	8.5	9.6	11.6
Gambia	6.3	6.6	7.3	8.2	9.0	9.7	9.9	10.4	11.1	11.8	12.5	13.2	14.1
Ghana	7.2	7.4	7.6	7.8	8.0	8.5	8.8	9.3	10.0	10.9	12.2	13.9	16.0
Guinea	7.5	7.3	7.2	7.1	7.5	7.6	8.0	8.2	8.5	8.9	9.5	10.3	11.4
Guinea-Bissau	8.3	8.1	7.9	7.7	7.4	7.1	6.8	6.5	6.3	6.3	6.4	6.5	6.7
Liberia	6.1	5.8	5.6	5.5	5.4	5.4	5.5	5.5	5.5	5.5	5.6	5.9	6.2
Mali	9.9	10.0	10.2	9.6	8.9	7.7	7.2	7.0	6.8	6.9	7.4	8.1	9.0
Mauritania	7.9	8.0	8.1	7.9	7.7	7.4	8.3	9.2	10.1	11.2	12.7	14.3	16.1
Niger	6.8	7.4	7.7	8.1	8.5	8.8	9.0	9.3	9.5	9.2	9.0	8.9	8.9
Nigeria	7.1	7.1	7.1	7.0	7.0	6.8	7.0	7.1	7.3	7.6	8.1	8.8	10.1
Senegal	9.0	9.5	9.9	10.0	9.8	9.5	9.2	9.1	9.3	9.9	10.8	12.2	14.0
Sierra Leone	7.7	7.6	7.6	7.6	7.6	7.5	7.4	7.3	7.4	7.5	7.5	7.7	8.1
Togo	7.5	7.4	7.3	7.2	7.2	7.2	7.4	7.8	8.2	8.8	9.6	10.9	12.5

Table 5: Life expectancy at age x (e(x)) for the elderly population 2005-2010																		
	Males						Females						**Both Sexes**					
	60	**65**	**70**	**75**	**80**	**85**	**60**	**65**	**70**	**75**	**80**	**85**	**60**	**65**	**70**	**75**	**80**	**85**
AFRICA	14.95	11.86	9.20	7.00	5.26	3.93	17.00	13.53	10.50	7.96	5.91	4.35	16.00	12.72	9.88	7.52	5.62	4.18
Eastern Africa	14.71	11.70	9.12	6.98	5.28	3.97	16.63	13.26	10.33	7.86	5.88	4.35	15.71	12.52	9.76	7.45	5.61	4.19
Burundi	14.52	11.48	8.88	6.74	5.06	3.78	16.15	12.85	9.99	7.60	5.69	4.23	15.46	12.28	9.54	7.26	5.45	4.06
Comoros	15.39	12.15	9.38	7.08	5.27	3.90	17.35	13.74	10.58	7.93	5.81	4.21	16.40	12.99	10.02	7.55	5.59	4.10
Djibouti	14.24	11.24	8.69	6.60	4.95	3.71	15.94	12.61	9.74	7.35	5.46	4.02	15.12	11.96	9.26	7.02	5.25	3.91
Eritrea	12.94	10.49	8.41	6.69	5.29	4.19	15.95	12.90	10.25	8.01	6.18	4.74	14.66	11.92	9.55	7.56	5.94	4.64
Ethiopia	15.05	11.92	9.23	7.01	5.25	3.92	16.52	13.16	10.23	7.78	5.81	4.31	15.81	12.56	9.76	7.42	5.56	4.14
Kenya	15.26	12.16	9.49	7.27	5.49	4.11	17.22	13.74	10.69	8.12	6.04	4.44	16.25	12.96	10.10	7.70	5.77	4.29
Madagascar	16.16	12.84	9.96	7.56	5.64	4.18	17.56	14.01	10.90	8.28	6.16	4.53	16.88	13.45	10.46	7.94	5.92	4.38
Malawi	13.50	10.51	7.99	5.95	4.36	3.18	16.39	12.74	9.57	6.95	4.91	3.41	14.89	11.58	8.75	6.43	4.63	3.30
Mauritius	16.82	13.71	10.98	8.67	6.75	5.21	20.80	17.08	13.73	10.80	8.32	6.29	18.92	15.54	12.53	9.92	7.73	5.95
Mozambique	13.20	10.52	8.25	6.37	4.88	3.72	15.67	12.47	9.70	7.39	5.54	4.12	14.47	11.52	9.00	6.90	5.23	3.94
Réunion	17.56	13.92	10.73	8.04	5.89	4.27	23.22	18.99	15.10	11.64	8.69	6.30	20.61	16.74	13.26	10.23	7.70	5.68
Rwanda	14.01	11.11	8.65	6.62	5.01	3.79	15.69	12.51	9.77	7.48	5.65	4.24	14.95	11.90	9.28	7.11	5.39	4.06
Somalia	14.06	11.05	8.50	6.41	4.79	3.57	15.42	12.23	9.49	7.22	5.41	4.04	14.77	11.67	9.02	6.85	5.13	3.83
Uganda	14.85	11.81	9.20	7.04	5.31	3.99	16.58	13.21	10.27	7.81	5.83	4.31	15.75	12.54	9.77	7.45	5.60	4.17

Table 5: Life expectancy at age x (e(x)) for the elderly population 2005-2010																		
	Males						Females						**Both Sexes**					
	60	**65**	**70**	**75**	**80**	**85**	**60**	**65**	**70**	**75**	**80**	**85**	**60**	**65**	**70**	**75**	**80**	**85**
United Republic of Tanzania	14.97	11.91	9.28	7.10	5.36	4.02	16.89	13.46	10.47	7.96	5.93	4.37	15.97	12.73	9.91	7.56	5.68	4.22
Zambia	13.20	10.54	8.27	6.40	4.91	3.75	15.57	12.39	9.64	7.34	5.51	4.10	14.42	11.49	8.98	6.90	5.23	3.95
Zimbabwe	13.28	10.75	8.57	6.75	5.27	4.09	16.13	12.85	9.99	7.59	5.66	4.16	14.77	11.84	9.32	7.20	5.49	4.15
Middle Africa	14.12	11.15	8.62	6.56	4.93	3.70	15.79	12.53	9.72	7.38	5.52	4.11	15.00	11.89	9.22	7.02	5.27	3.94
Angola	13.28	10.45	8.06	6.12	4.60	3.47	15.03	11.93	9.26	7.06	5.31	3.99	14.21	11.24	8.72	6.65	5.01	3.77
Cameroon	14.72	11.67	9.05	6.90	5.18	3.88	16.28	12.96	10.07	7.66	5.72	4.24	15.53	12.34	9.59	7.31	5.48	4.09
Central African Republic	13.48	10.71	8.36	6.42	4.89	3.71	15.90	12.65	9.84	7.49	5.62	4.17	14.79	11.77	9.18	7.03	5.32	4.00
Chad	14.02	10.85	8.18	6.03	4.38	3.19	15.96	12.41	9.34	6.83	4.89	3.49	14.99	11.64	8.78	6.45	4.66	3.36
Congo	14.19	11.23	8.71	6.63	5.00	3.75	16.30	12.89	9.94	7.48	5.52	4.04	15.29	12.11	9.37	7.11	5.31	3.94
Democratic Republic of the Congo	13.99	11.04	8.53	6.48	4.87	3.65	15.59	12.39	9.62	7.33	5.50	4.11	14.86	11.78	9.15	6.97	5.24	3.93
Equatorial Guinea	15.20	12.02	9.29	7.04	5.26	3.91	16.47	13.11	10.19	7.74	5.79	4.29	15.88	12.61	9.78	7.43	5.56	4.13
Gabon	16.13	12.87	10.03	7.66	5.75	4.27	17.90	14.29	11.10	8.41	6.22	4.54	16.99	13.57	10.57	8.04	6.00	4.43
São Tomé and Príncipe	16.27	12.67	9.55	6.99	4.99	3.53	18.45	14.48	10.95	7.98	5.63	3.90	17.44	13.63	10.30	7.52	5.34	3.74
Northern Africa	16.64	13.13	10.07	7.52	5.51	3.99	18.90	14.99	11.52	8.57	6.19	4.39	17.78	14.08	10.82	8.08	5.89	4.23
Algeria	17.45	13.69	10.39	7.64	5.47	3.86	19.69	15.79	12.29	9.29	6.83	4.92	18.66	14.84	11.45	8.58	6.25	4.49
Egypt	16.45	12.96	9.92	7.41	5.42	3.93	18.86	14.85	11.27	8.24	5.83	4.04	17.65	13.90	10.61	7.85	5.66	4.02
Libyan Arab Jamahiriya	17.41	14.10	11.20	8.73	6.71	5.10	21.43	17.57	14.07	11.00	8.40	6.28	19.23	15.73	12.61	9.91	7.66	5.83
Morocco	16.78	13.19	10.07	7.47	5.42	3.90	18.91	14.94	11.41	8.41	6.01	4.22	17.83	14.06	10.74	7.95	5.73	4.07
Sudan	16.02	12.73	9.88	7.51	5.61	4.16	17.51	13.97	10.87	8.25	6.14	4.51	16.78	13.37	10.40	7.91	5.90	4.36
Tunisia	17.27	13.64	10.46	7.80	5.69	4.10	20.01	15.88	12.16	8.97	6.38	4.43	18.61	14.73	11.30	8.38	6.04	4.28
Western Sahara	15.58	12.31	9.50	7.17	5.32	3.93	17.47	13.83	10.65	7.97	5.84	4.22	16.35	12.94	9.98	7.51	5.56	4.07
Southern Africa	12.75	10.41	8.41	6.74	5.38	4.28	17.18	13.92	11.05	8.61	6.60	5.00	15.10	12.35	9.96	7.93	6.25	4.89

Table 5: Life expectancy at age x (e(x)) for the elderly population 2005-2010																		
	Males						Females						**Both Sexes**					
	60	**65**	**70**	**75**	**80**	**85**	**60**	**65**	**70**	**75**	**80**	**85**	**60**	**65**	**70**	**75**	**80**	**85**
Botswana	13.36	10.65	8.34	6.43	4.91	3.74	16.22	12.81	9.84	7.37	5.40	3.91	14.80	11.73	9.09	6.91	5.16	3.83
Lesotho	11.99	9.61	7.60	5.94	4.61	3.57	15.28	12.05	9.26	6.95	5.12	3.74	13.77	10.93	8.50	6.50	4.91	3.69
Namibia	14.07	11.19	8.73	6.69	5.07	3.82	17.05	13.47	10.33	7.70	5.60	4.01	15.60	12.35	9.55	7.22	5.36	3.94
South Africa	12.74	10.43	8.46	6.80	5.44	4.35	17.35	14.11	11.25	8.81	6.79	5.17	15.20	12.48	10.11	8.09	6.42	5.05
Swaziland	11.95	9.64	7.68	6.06	4.75	3.72	15.17	11.94	9.16	6.86	5.04	3.67	13.64	10.87	8.51	6.55	4.99	3.78
Western Africa	14.60	11.51	8.88	6.72	5.02	3.75	16.01	12.64	9.73	7.32	5.41	3.97	15.31	12.09	9.32	7.04	5.23	3.87
Benin	14.94	11.60	8.74	6.42	4.63	3.33	16.80	13.09	9.86	7.20	5.12	3.61	15.94	12.40	9.36	6.85	4.91	3.50
Burkina Faso	12.78	10.10	7.85	6.03	4.62	3.56	14.83	11.67	8.98	6.78	5.06	3.78	13.90	10.96	8.48	6.46	4.88	3.70
Cape Verde	16.41	12.98	10.00	7.53	5.56	4.08	19.12	15.18	11.67	8.68	6.27	4.44	17.99	14.25	10.96	8.18	5.95	4.27
Côte d'Ivoire	13.62	10.56	7.97	5.89	4.30	3.14	15.76	12.24	9.21	6.72	4.80	3.41	14.56	11.30	8.52	6.27	4.54	3.28
Gambia	14.68	11.44	8.69	6.46	4.75	3.50	15.90	12.37	9.33	6.85	4.94	3.55	15.30	11.92	9.02	6.67	4.85	3.54
Ghana	16.55	13.18	10.25	7.79	5.82	4.31	17.77	14.19	11.04	8.37	6.22	4.56	17.16	13.69	10.65	8.09	6.03	4.45
Guinea	14.84	11.51	8.67	6.37	4.60	3.31	16.80	13.09	9.87	7.21	5.13	3.62	15.84	12.33	9.30	6.81	4.89	3.49
Guinea-Bissau	13.94	11.00	8.50	6.45	4.85	3.64	15.72	12.49	9.70	7.38	5.53	4.13	14.86	11.78	9.14	6.96	5.23	3.92
Liberia	13.12	10.38	8.06	6.18	4.70	3.58	14.66	11.60	8.99	6.84	5.14	3.86	13.92	11.02	8.56	6.55	4.96	3.75
Mali	15.29	12.17	9.49	7.27	5.51	4.16	17.73	14.13	10.97	8.31	6.16	4.52	16.71	13.32	10.37	7.90	5.93	4.41
Mauritania	14.57	11.20	8.35	6.07	4.36	3.15	16.02	12.23	8.97	6.34	4.37	3.03	15.37	11.77	8.69	6.22	4.37	3.09
Niger	18.18	14.57	11.38	8.68	6.48	4.78	17.06	13.53	10.46	7.88	5.83	4.28	17.70	14.14	11.01	8.38	6.25	4.61
Nigeria	14.16	11.18	8.65	6.57	4.94	3.70	15.59	12.38	9.62	7.32	5.50	4.10	14.90	11.81	9.17	6.98	5.25	3.93
Senegal	15.36	11.94	9.01	6.63	4.80	3.48	17.23	13.36	9.99	7.20	5.05	3.51	16.27	12.63	9.49	6.92	4.94	3.51
Sierra Leone	12.97	9.99	7.51	5.54	4.06	2.99	14.44	11.15	8.37	6.14	4.44	3.23	13.73	10.59	7.96	5.86	4.27	3.13
Togo	15.09	11.71	8.83	6.47	4.66	3.34	17.45	13.63	10.27	7.48	5.29	3.69	16.30	12.70	9.58	7.02	5.02	3.55