Ageing in sub-Saharan Africa in the context of Global Development: The Multiple Indicator Survey project (MISA)

Michael Murphy,

London School of Economics and Political Science

October 2018

Contents

I Setting the stage

1. Ageing in the framework of global development

1.1 Sustainable Development Goals (SDGs) – leave no one behind – how does ageing and how do older people fit in?

The Sustainable Development Goals (SDGs) programme was initiated at the United Nations Conference on Sustainable Development in Rio de Janeiro in 2012. The objective was to identify a set of goals to address major global social, economic, political and environmental challenges. The SDGs replaced the 2000 Millennium Development Goals (MDGs), which were particularly centred on reducing extreme poverty and hunger, preventing deadly diseases, and expanding primary education to all children.

While the MDG areas remain at the heart of the 2030 sustainability agenda, it was recognised that a more comprehensive framework was required for the achievement of such goals that would include both fundamental human rights as well as sustainability of the underlying determinants such as reducing climate change, access to clean water and reductions in air pollution, together with the ability to identify and monitor progress in these key areas.

The United Nations in conjunction with member states developed 17 Sustainable Development Goals with 169 targets that were agreed in September 2015 (United Nations General Assembly 2015a). The Goals and 232 related indicators as of early 2018 are given in Sustainable Development Goals (2018). The Goals focussing on infrastructure include: water (Goal 6), energy (Goal 7), industrialization (Goal 9), consumption and production (Goal 12), climate change (Goal 13), marine resources (Goal 14), forests etc. (Goal 15) and economic growth and employment (Goal 8). Socio-economic condition Goals include: poverty (Goal 1), hunger (Goal 2), good health (Goal 3) and education (Goal 4). Social relationship Goals are gender equality (Goal 5), inequality within and among countries (Goal 10) and peaceful and inclusive societies (Goal 16). Goal 17 is concerned with international co-operation and strengthening the data base.

While they include general goals that apply to all members of every society including "ending poverty, in all its forms, everywhere" and "reducing inequality", there is particular emphasis on tackling the marginalisation of specific groups such as children, women and girls, people with disabilities and older people in order to reduce their well-recognised disadvantages. These disadvantages are manifested across a number of dimensions, including poor socio-economic conditions, discrimination, worse access to services, violence and human rights abuses. Fundamental to the new Sustainable Development Goal (SDG) agenda is the central requirement to "leaving no one behind".

To be meaningful, targets need to be measured using sources that can provide data of sufficiently high quality to monitor progress to achievement of the 169 targets identified. Some SDG targets, such as ending poverty in all its forms everywhere, are absolute in that they relate to complete population coverage so that data sources that measure overall progress would appear to be sufficient. However, "leaving no one behind" has more

stringent requirements by requiring that all sub-groups must achieve a target such as a poverty line or some other standard. In addition, "leave no one behind" means not only that all groups must progress so that gaps between marginalised groups and everyone else does not widen, but also that existing gaps should be reduced. The Resolution adopted by the General Assembly on 25 September 2015 made this explicit:

> "As we embark on this great collective journey, we pledge that no one will be left behind. Recognizing that the dignity of the human person is fundamental, we wish to see the Goals and targets met for all nations and peoples and for all segments of society. And we will endeavour to reach the furthest behind first" (United Nations General Assembly 2015a, p. 3)

National-level statistics that only show aggregate improvements in areas such as poverty reduction or access to clean water may conceal slower progress (or even decline) for the most vulnerable. Leave no one behind puts emphasis on who benefits as well as on what has been delivered, so the focus is about inclusion as well as delivery of a service or benefit (German & Randel 2017). Appropriately disaggregated data are required to measure the rate of progress of these groups.

Monitoring SDG progress needs to be able to assess the conditions of the most vulnerable—women, youth, older people, migrants and rural populations among other disadvantaged groups—in relation to the wider population and between these groups to ensure that no group is left behind. Detailed, reliable and relevant disaggregated data are required to underpin the commitment to "leave no one behind." The United Nations' Inter-Agency and Expert Group on Sustainable Development Goal Indicators (2016) suggested that further disaggregation of additional SDG indicators by a range of characteristics such as income, sex, age, race, ethnicity, migratory status, disability and geographic location may be required. Therefore any collection system should be sufficiently flexible to respond to emerging needs.

Availability of suitable data for assessing SDG progress differs substantially between the identified special attention groups. In some cases, there are UN agencies concerned with particular sub-groups, such as UNICEF (children), ILO (workers) and UNESCO (education), which produce data to monitor the state of that particular group. In addition, there are long-standing and wide-ranging programmes such as Demographic and Health Surveys (DHS) centred on women of reproductive age and child health with over 300 surveys conducted in 90 countries with repeated surveys in most of these countries. However, there is no agency or co-ordinated data collection programme that covers the socio-economic and health conditions of older people. Comprehensive statistics of older people are rarely available especially outside High-income Countries (HICs) and a few Medium-income Countries (MICs). There are sets of co-ordinated surveys in a subset of countries; in Europe the Survey of Health and Retirement in Europe (SHARE), in North America the Health and Retirement Survey (HRS), in Asia the China Health, Ageing and Retirement Longitudinal Survey (CHARLS), as well as other harmonized ageing studies such as the WHO Study on Global Ageing and Adult Health (SAGE) and the Longitudinal Studies of INDEPTH communities in Africa (HAALSI). Many other general population surveys such as the Malawi Longitudinal Study of Families and Health (MLSFH), Botswana Core Welfare Indicators Surveys 2009/10 and Living Standards Measurement Studies (LSMS) contain sufficient numbers of older people to provide valuable information. These questionnaires and survey

organisation practices used in these surveys, together with survey guidelines developed by the UN Department of Economic and Social Affairs Division for Inclusive Social Development were used to inform development of the Multiple Indicator for sub-Saharan Ageing (MISA) project pilot survey that was designed to address these gaps, which is discussed later.

Those Sustainable Development Goals especially relevant to older people are Target 1.3 to implement nationally appropriate social protection systems and measures for all, including coverage of the poor and vulnerable; Target 2.2 to end all forms of malnutrition, including stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons; Target 3.8 to achieve universal health coverage, including financial risk protection, and access to health-care services and medicines and vaccines for all. Goal 17's specific target (17.18) is to "enhancing capacity-building support to developing countries … to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts" (Sustainable Development Goals 2018).

Many indicators are not broken down by age. If they are disaggregated, the great majority are concerned with children and young adults: for example, Goal 3. ensure healthy lives and promote well-being for all at all ages includes indicators such as maternal, under-5 and neonatal mortality and a number of reproductive health indicators. The need for more disaggregation of data has been recognised from the inception of the SDG programme, and developments to address this issue are taking place.

SDG Objective 3.5 notes that high-quality, accessible, timely, reliable and disaggregated data by all characteristics relevant in national contexts are needed to ensure that no one is left behind and includes key actions to improve the production of, and in particular to promote the expansion of data collection programmes to ensure the coverage of all age groups. The inaugural UN World Data Forum launched the Cape Town Global Action Plan for Sustainable Development Data that includes a number of actions around data disaggregation:

> "Quality and timely data are vital for enabling governments, international organisations, civil society, private sector and the general public to make informed decisions and to ensure the accountability of representative bodies. Effective planning, follow-up and review of the implementation of the 2030 Agenda for Sustainable Development requires the collection, processing, analysis and dissemination of an unprecedented amount of data and statistics at local, national, regional and global levels and by multiple stakeholders." (High-level Group for Partnership, Coordination and Capacity-Building for statistics for the 2030 Agenda for Sustainable Development 2016, p. 1)

The indicators required for monitoring a particular goal may differ between population sub-groups. For example, violence against children, young women and older people has different forms, perpetrators and consequences. The instruments necessary to uncover such violence are therefore likely to be very different for different groups.

At present, the number of targets and corresponding appropriate indicators for older people is very limited. While they are important in identifying the need for intervention and for evaluating the success of interventions, they are not designed to identify the pathways

involved, for which more detailed analysis is required. The main framework for evidence-based policy development for older people is the Madrid International Plan of Action on Ageing (MIPAA), which will now be considered.

1.2 Madrid International Plan of Action on Ageing (MIPAA)

The SDGs provide a comprehensive and verifiable framework for sustainable social, political and economic systems, going well beyond the outcomes for populations including areas such as climate change, sustainability of financial systems etc. Older people are one among a number of population sub-groups identified for special attention, but the principal framework concerned specifically for older people remains the Madrid International Plan of Action on Ageing (MIPAA) adopted at the Second World Assembly on Ageing in 2002 (United Nations 2002). The MIPAA Plan is a comprehensive policymaking framework for governments, non-governmental organizations and others to ensure that older citizens are able to age with security and dignity, continue to participate as citizens with full rights and receive appropriate care if required.

The 2002 Madrid International Plan of Action on Ageing (MIPAA) has three priority areas:

1. *Older persons and development:* The Plan recommends that older persons should be full participants in the development process and also share in its benefits. The themes are centred on active participation in society and development such as: including older people in the labour force; ensuring access to education and training; eradication of poverty; promoting income security, social protection/social security and poverty prevention; encouraging intergenerational solidarity; and recognising the need for special attention to rural development, migration, urbanization and emergency situations.

2. *Advancing health and well-being into old age:* The shift in disease patterns from predominance of infectious and parasitic diseases to one of chronic and degenerative disorders has major implication for the health needs of older people. Key areas identified under this heading include: life-time health promotion; universal and equal access to healthcare services; training of care and health staff; and the particular importance for older people of health and care issues related to HIV/AIDS, mental health and disabilities.

3. *Ensuring enabling and supportive environment:* Policies are needed to empower older persons, support their contribution to society, enhance lifelong development and independence and strengthen social institutions. Governments should formulate and implement policies that foster such an enabling environment, in conjunction with civil society and older persons themselves in the following areas: improving housing and the living environment; ensuring care and support for caregivers; tackling neglect, abuse and violence; and promoting positive images of ageing.

These three priority directions are broken down to 239 recommendations for action.

It remains a pathbreaking statement on how the world should respond to the challenges of building a society for all ages that links ageing to other frameworks for social and economic development and human rights. However, Zaidi (2018) draws a clear distinction between

the objectives and achievements of MIPAA:

> "The MIPAA experience so far offers one major lesson: its monitoring lacked a comprehensive global approach. This was partly because of lack of age-disaggregated data in many countries, but mainly because the MIPAA monitoring toolkit was not properly developed.
>
> While there has been progress in implementing the MIPAA, there is no one approach towards its monitoring. This in turn has led to too much anecdotal, descriptive and self-defined information, with little evaluation of the relationship between outputs and policy impact, and a difficulty in comparing countries."

To address such acknowledged deficiencies, attention has been focussed on the issue of improving the information base for effective policy-making and implementations, a topic we now turn to.

1.3 Renewed efforts to support age-disaggregated data and data collection on older persons

The rapid pace of population ageing reinforced the need to develop targeted policies and programmes, but lack of ageing-related statistics hampered the possibility of introducing appropriate policies to meet the challenges of ageing societies. The Open-Ended Working Group on Ageing was established by the General Assembly (resolution 65/182 on 21 December 2010) to consider the existing international framework of the human rights of older persons and identify possible gaps and how best to address them, including the feasibility of developing further instruments and measures (Martin, Rodríguez-Pinzón & Brown 2015, see also http://social.un.org/ageing-working-group/). The Group called for expanded data availability on ageing issues in areas such as healthcare, social pensions and age-inclusive policies and programmes. It concluded that data on some crucial ageing-related priority areas would require new initiatives to provide better sex and age-disaggregated data and standards for the presentation of such data.

The challenges and some of the opportunities related to data collection on older persons were discussed in the Expert Group Meeting on Global ageing and the data revolution – the way forward in the post-2015 environment in 2015 (United Nations, Department of Economic and Social Affairs, Division for Social Policy and Development 2015). The meeting considered the capacity of existing and new data sources to monitor and report on older persons and to ensure that ageing issues will be adequately reflected in the SDG indicators. It included a number of suggestions to include indicators particularly relevant to ageing issues in the SDGs.

Zaidi (2018) argued that greater national capacity is needed in many countries: both to design policies for the older population and to assess progress. Investment in data collection would have significant impact on the success of MIPAA.

One consequence of the recognition of the need for disaggregated data, and more specifically the need for more age-disaggregated data was the establishment of a new city group. The Titchfield Group was set up in 2017 and held its first full meeting in June 2018 (United Nations Economic and Social Council 2017; Titchfield Group Secretariat 2018). This Group is reviewing and extending existing work on ageing-related statistics and age-

disaggregated data, drawing on the expertise the international, academic and non-profit sectors from various countries. While this will include assessment of new emerging data sources including big data, these are likely to be complementary rather than replacements for existing data sources, especially sample surveys and censuses.

We now consider developments in Africa in the light of the consensus that more effort is required on research and availability of data on older people as a requirement for evidence-based policy-making.

2. Ageing at the African regional level

2.1 African Union and others

African governments formally adopted the United Nations Madrid International Plan of Action on Ageing (MIPAA) and the African Union Policy Framework and Plan of Action on Ageing (AU Plan) in 2002 (HelpAge International 2002). The AU plan, largely based on MIPAA, committed the signatory African member states to develop and implement policies on ageing as part of national development and poverty reduction policies and to ensure that people can age with security and dignity and to continue to participate in their societies as citizens with full rights. The framework recommended that: Member States recognise the fundamental rights of older persons and commit themselves to abolish all forms of discrimination based on age; and undertake steps to ensure that the rights of older people are protected by appropriate legislation, including the right to organise themselves in groups and to representation in order to advance their interests. In addition Member States should undertake all the necessary measures to ensure that older people can access all their rights.

The framework covered areas such as income, heath, education, elder abuse, with a particular focus on gender, recognising the particular vulnerabilities of older women. This comprehensive agenda included amending, where appropriate, national constitutions to ensure the rights of older people and establishing a legal requirement that children should be financially responsible for their aged parents.

Both action plans call for a comprehensive evidence base to support appropriate policy formulation, monitoring and evaluation while promoting participatory and inclusive approaches. The AU Plan recommended that Member States standardise the definition of older people as those aged 60 years and above; that national censuses and other data sources should include issues specific to the needs of older people; and that data should be collected and reported disaggregated by age (without upper age limits), gender and other socio-economic variables where appropriate (Aboderin 2007).

A relatively small number of countries set up National Ageing Councils, evidence to date suggesting that implementation is lacking. Between 2002 and 2011, National Policies on Ageing were adopted in Ghana, Kenya, Mozambique, South Africa, Uganda and Tanzania in sub-Saharan Africa in the period 2002-11.

The African Regional Conference on Population and Development in 2013 passed a resolution that members should promote a culture of respect, support, and active and

healthy ageing for older persons (United Nations Economic Commission for Africa, African Union Commission 2013). To achieve this, it is necessary to ensure that they receive health and long-term care if required, equitable access to social services, and protection against violence, abuse and social discrimination. It recognised the important social, economic and political consequences of population ageing (para. 209). It also emphasized the importance of collecting data on older persons for planning and research, to take into account their specific needs in implementing policies and programmes (para. 75).

The African Union *Africa Common Position on the Rights of Older People* (African Union 2012), adopted in 2013, recommended the rights-based approach of the United Nations Convention on the Human Rights of Older Persons for defending and promoting the human rights of older persons. Other recommendations include the creation of national programmes to promote societal awareness of the rights of older persons and their inclusion within SDGs. The Twenty Sixth Ordinary Session of the AU Assembly in Addis Ababa on 31 January 2016 adopted the framework that included a wide-ranging set of measures to ensure the rights of older people and ensure they would receive support where appropriate (African Union 2014a).

The African Union *Common African position on the post-2015 development agenda* adopted by AU Member States explicitly recognised ageing as a key demographic trend that will impact on the continent and that requires urgent responses. Older people are not identified as a group for particular attention, but are recognised as a group that would benefit from development in general (African Union 2014b).

In 2013 and early 2018, the UN Commission for Social Development reviewed progress on MIPAA across world regions including regional reports for Africa (United Nations Economic Commission for Africa 2011). While MIPAA was a landmark, widely-endorsed international policy framework on older people, implementation has been problematic, especially in Africa. The 2013 monitoring Report concluded:

> "More progress needs to be made in terms of policy implementation targeting the ageing population in Africa. The regional report mentioned other areas that deserved consideration, including the promotion of comprehensive data collection, analysis and research on the issue of ageing in order to address barriers, exclusion, inaccurate myths, negative attitude s from communities and the lack of empowerment of older persons, as well as laying the groundwork for policymaking and strategies." (United Nations Economic and Social Council 2012).

The latest UN review of MIPAA (Nzabona 2017) shows that despite progress, its implementation continues to remains uneven across both countries and the three priority areas. 33 out of 54 African Member States participated in the Review. 31 of these indicated having national programmes on older persons, including Kenya, Malawi and Uganda, which are the principal focus of the MISA programme discussed later. The report also reviewed ageing research across the continent and concluded that most research was concerned with health, while there was little ageing research in areas such as eradication of poverty, rural development, mental health, disability and housing/living environments.

There has been substantial progress on recognition of the importance of including older people into wider social developments, and for the need to improving their security and

dignity. However, major constraints remain including lack of resources, political will and data, the last especially in the African case. The Commission for Social Development in its 56th session, held a high-level panel discussion on the Madrid International Plan of Action on Ageing (MIPAA) on 31 January 2018 (https://www.un.org/development/desa/ageing/news/2018/02/csocd56-mipaa/). This confirmed that data disaggregated by age and sex are limited and available only in a few countries in Africa and the amount of research on ageing is very low. In such circumstances, while most governments have policies and programmes to promote health and wellbeing, the implementation and sustainability of relevant measures continues to remain a challenge. There is a particular lack of policies and programmes to ensure universal and equal access to healthcare for older persons, especially those with disabilities, in most African countries.

There is limited data related on older persons' concerns. While some progress has taken place in Africa, there is still a long way to go (Bennett & Zaidi 2018; Faye & Andrade 2018; Padmadas et al 2018). More research effort is needed in order to have quality data required for tracking MIPAA implementation.

3. *Empirical evidence on ageing in Africa*

3.1 Estimates and projections – demographic overview

African population ageing in global contest
With half of the world's population now living in countries with below replacement level fertility, and very rapid population ageing occurring in parts of world such as East Asia, sub-Saharan Africa (SSA) stands out as compared with much of the rest of the world by having both particularly low proportions of older people and much lower trends of population ageing as conventionally measured (Table 1). Because the MISA project was undertaken in Kenya, Malawi and Uganda, these countries are also presented.

It is therefore tempting to assume that population ageing is not a substantial issue in SSA. Even by 2050, the proportion of people aged 60 and over in SSA is likely to be lower than was the case in many European countries in 1900. Moreover, when compared with other regions, the pace of population ageing is much slower, apparently providing the opportunity to plan for the future in a more considered way than would otherwise be possible. This would be misleading for a number of reasons.

Numbers of older people

Issues related to ageing in SSA are substantially concerned with the social and economic situation of older people, not with the population distribution – i.e. the relative numbers of younger and older people. While much of the discussion in other parts of the world around population ageing is concerned with the relative position of younger and older people, the absolute numbers of these population subgroups are ultimately more important. In sub-Saharan Africa population size and the numbers of older people are both growing rapidly and implications of this will need to be considered, especially since this is a long-term continuing trend (Table 2).

Table 1. Proportion of population aged 60 and over (percent), actual and projected, selected World areas 1980-2050

Year	WORLD	sub-Saharan Africa	Kenya	Malawi	Uganda	High-income countries
1980	9	5	5	4	4	15
2015	*12*	*5*	*4*	*4*	*3*	*23*
2050	21	8	11	8	6	33

Source: United Nations, Department of Economic and Social Affairs, 2017 Revision of World Population Prospects available at https://esa.un.org/unpd/wpp/

Table 2. Population aged 60 and over (000s), actual and projected, selected World areas 1980-2050

Year	WORLD	sub-Saharan Africa	Kenya	Malawi	Uganda	High-income countries
1980	382,496	18,066	747	259	540	141,068
2015	906,002	46,268	1,943	757	1,344	269,741
2050	2,080,459	165,473	10,134	3,221	6,172	423,139

Source: United Nations, Department of Economic and Social Affairs, 2017 Revision of World Population Prospects available at https://esa.un.org/unpd/wpp/

Pace of ageing

Globally, the total number of older people is likely to increase from just under one billion in 2015, to just over two billion by 2050. World population aged 60 and over grew by about 140% in the 35 years to 2015 – roughly the length of a generation. The growth in High-income countries was lower than the global figure, just under 100%, and slightly higher, 160%, in SSA. In the next 35 years, the global population of older people is expected to grow by a similar amount of about 130%, but with much lower growth in High-income countries of 60%, compared with 260% in SSA, and 420% in the case of Kenya. In fact, of countries with expected population size of 50 million or more in 2050, Kenya has the highest expected growth in the world of people aged 60 and over in period since 2015, and Uganda has the third highest growth. The low level of population ageing in Africa using conventional indicators such as those of Table 1 does not show, for example, that the increase in numbers of people aged 60 and over in Kenya in the 5-year period 2045-50 is expected to be larger than the total number of this age group alive in 2015, so additional capacity equal to the total current volume of infrastructure, such as health care facilities and professionals, will need to added every five years even to maintain the current low levels of provision.

It took France 160 years for the proportion of people aged 60 and over to grow as much as is expected in the next 35 years in Kenya. Growth in numbers of older people in the developed world generally happened at a much slower pace with more resources available — both time and financial — than in the least developed world where this transition is happening much faster while the countries still face the challenges of rapid population growth and increased economic, social and environmental pressures on the scarce resource base.

Table 3. Growth of Population aged 60 and over, actual and projected, selected World areas 1980-2050: Index 2015=100

Year	WORLD	sub-Saharan Africa	Kenya	Malawi	Uganda	High-income countries
1980	42	39	38	34	40	52
2015	*100*	*100*	*100*	*100*	*100*	*100*
2050	230	358	522	425	459	157

Source: United Nations, Department of Economic and Social Affairs, 2017 Revision of World Population Prospects available at https://esa.un.org/unpd/wpp/

Relative size of population age-groups

The growth in number of older people is likely to increase sharply in years to come, although the numbers will remain below the number of children under age five in Malawi (Figure 1).

However, these trends will also lead to changes in the needs among different groups. With improving mortality, the numbers of infant and child deaths have been declining, while the number of deaths to older people is increasing – around 1980, there were five times as many deaths under age five as at age 60 and above, whereas by 2050 there are likely to be twice as many deaths among the older than the younger age group (Figure 2). At the same time, with the epidemiological transition there is a shift from communicable to non-communicable causes of death. Since health and social care needs increase rapidly in the years before death and older people are likely to have multiple complex non-communicable diseases, this will require a refocusing of heath service activities.

Figure 1 Population (000s) ages 0-4 and 60 & over, actual and projected 1980-2050, Malawi
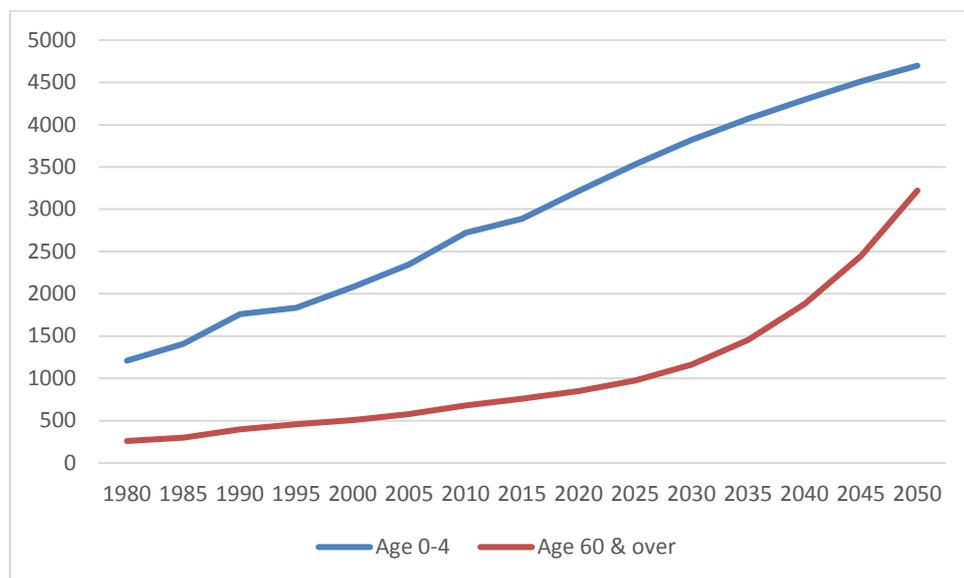
Source: United Nations, Department of Economic and Social Affairs, 2017 Revision of World Population Prospects available at https://esa.un.org/unpd/wpp/

**Figure 2. Deaths per quinquennium (000s), ages 0-4 and 60 & over, actual and projected 1980-2050, Malawi**
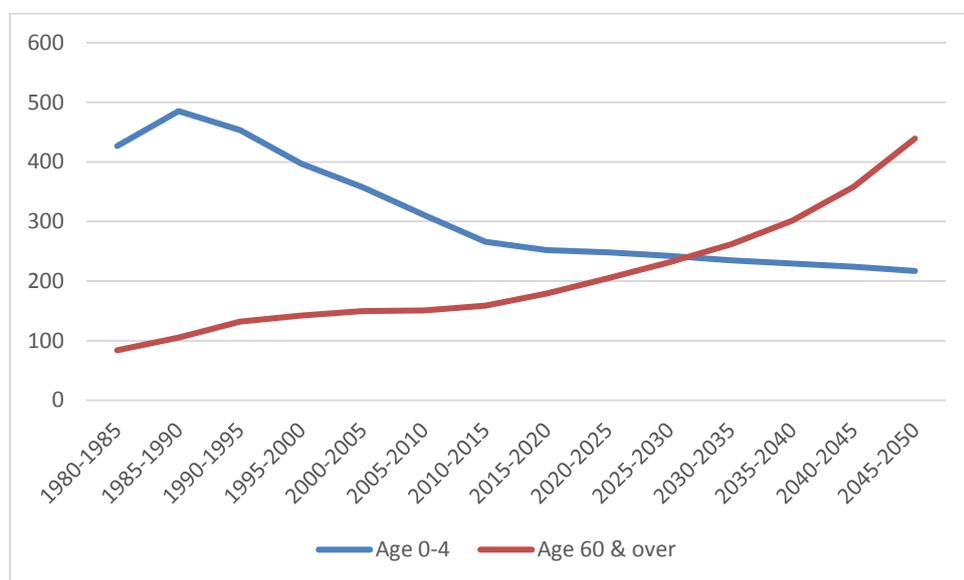
Source: United Nations, Department of Economic and Social Affairs, 2017 Revision of World Population Prospects available at https://esa.un.org/unpd/wpp/

Gender composition of the older population

Within the older population, there are likely to be changes with profound implications for the well-being of this group. For example, globally, the proportion of older people who are female is falling steadily as mortality generally improves. There were 130 women for every 100 men aged 60 and over in 1980, but the excess is expected to halve to under 120 by 2050. Whereas world and, in particular, high-income country femininity ratios are declining substantially as mortality differentials between men and women are also decreasing, sub-Saharan Africa presents a different trend, with the femininity ratio expected to remain constant over the period 1980-2050. Indeed, large increase in femininity ratios are expected in the three MISA study countries, especially in Malawi where the ratio is expected to reach 160 around 2025, before returning to more typical values around 2050 (Figure 3). These values, which largely arise due to earlier higher male HIV/AIDS mortality, have substantial implications for the situation of older people in years to come. The relative scarcity of older men will result in higher numbers of older widows, and poverty among older people is disproportionately concentrated among women especially those without a partner.

While the numbers of older people are increasing rapidly in sub-Saharan Africa, and especially in the three MISA study countries, there is not a corresponding increase in conventional indicators of population ageing such a proportion of older people, or median population age as younger age groups are also increasing. There are concerns in many other parts of the World relating to the sustainability of generous pensions, social assistance and health and social care systems and/or to the ability of society and economy to respond to an unprecedented pace of population ageing. However, in sub-Saharan Africa continuing high rates of population growth and consequent additional requirements from other groups, such as infants, means that there is only limited possibility of reallocating scarce resources to older people. To that extent, low levels of population ageing will not necessarily be to the benefit of older people in situations of rapidly increasing numbers, but African countries need to plan for a time in the not-too-distant future when their populations will be considerably older than they are today.

Figure 3. Femininity Ratio Population aged 60 & over, selected World areas 1980-2050
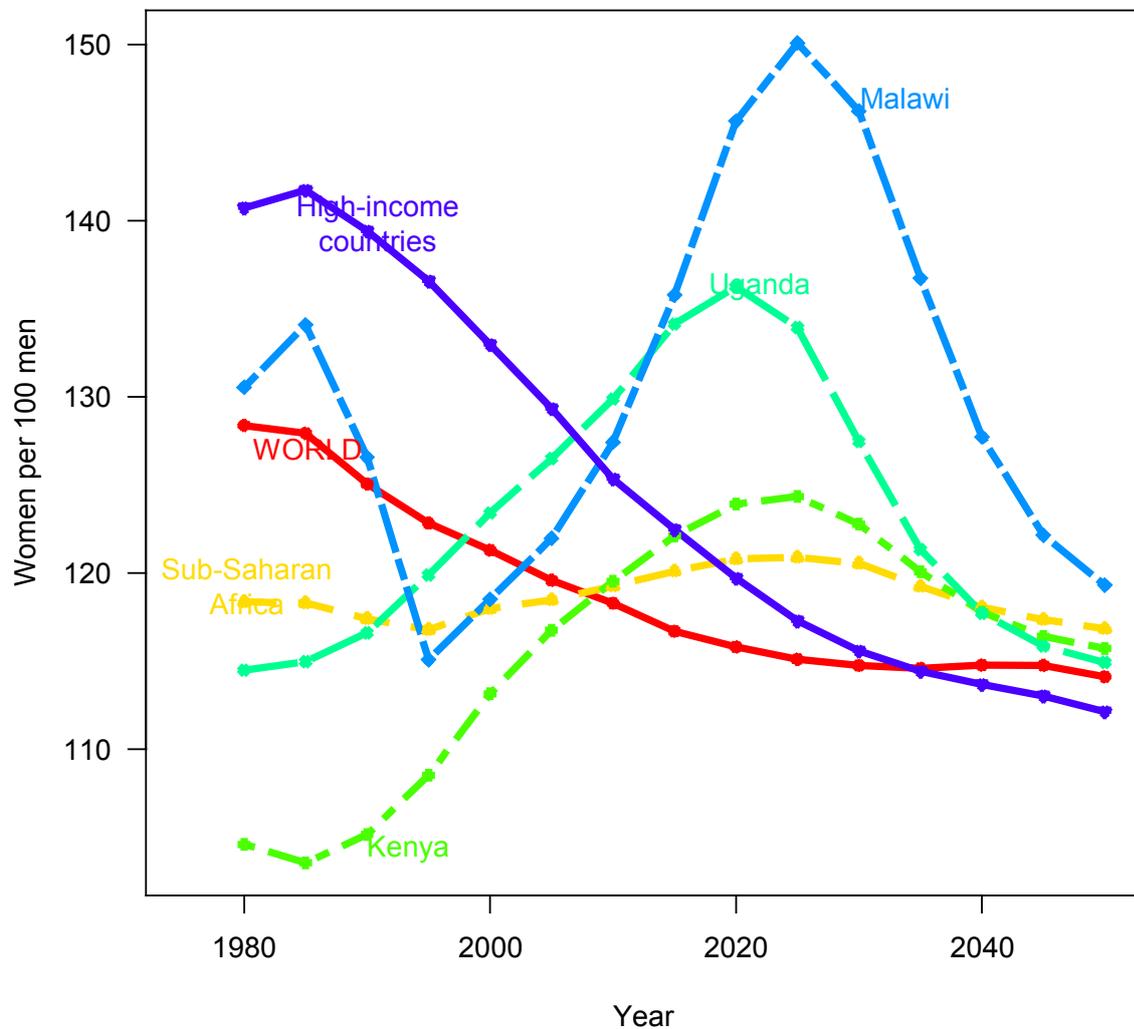
Source: United Nations, Department of Economic and Social Affairs, 2017 Revision of World Population Prospects available at https://esa.un.org/unpd/wpp/

3.2 Other research and selected data on ageing in Africa

There are a number of studies of ageing in Africa summarised in United Nations Department of Economic and Social Affairs, Population Division (2015). These were categorised according to how the research results addressed the policy directions of the Madrid International Plan of Action on Ageing (MIPAA), and the research methods that have been applied. While there is a growing body of research into ageing across Africa, high-priority areas of research remain under-investigated. There has been only limited ageing research in areas such as emergency situations, eradication of poverty, training of care providers and health professionals, rural development, mental health, disability and housing/living

environments. Most studies used quantitative approaches, mainly centred on health, including functional capacity (64 per cent) and the prevalence or epidemiology of a particular disease, circumstance, or event in an older population (32 per cent).

There are a number of sources for examining ageing in Africa, and some examples of the types of data that may be used to inform decision-making on ageing issues in Africa will be summarised briefly.

World Health Organisation Study on Global AGEing and Adult Health (WHO SAGE)

WHO's SAGE is a longitudinal study collecting data on adults aged 50 years and older, plus a smaller comparison sample of adults aged 18–49 years, from nationally representative samples in two African countries, Ghana and South Africa, together with China, India, Mexico and the Russian Federation. Household and individual level micro- and meta-data, and survey materials, are available at http://www.who.int/healthinfo/sage/cohorts/en/. Descriptive results from SAGE Wave 1 are available in He et al. (2012), and background information on SAGE in Kowal et al. (2012).

SAGE-INDEPTH

A short version of the SAGE questionnaire, focusing on health and well-being, was implemented in 2007 as part of the SAGE-INDEPTH collaboration. These data include the SAGE health state descriptions, WHO Disability Assessment Schedule and the WHO Quality of Life instrument, linked to selected socio-demographic data from Health and Demographic Surveillance System (HDSS) field sites in four African countries (Ghana, Kenya, South Africa and Tanzania). Further information is available at http://www.who.int/healthinfo/sage/indepth/en/ . See also Global Health Action (2010), which is devoted to this source.

SAGE-WOPS (HIV study)

Two waves of the SAGE Well-being of Older People Study (WOPS) HIV study has been conducted in South Africa and Uganda providing data on the effects of HIV/AIDS among older people infected or affected by HIV. The aim of this study was to describe the health status, well-being and functional status among older people either infected with HIV themselves, or affected by HIV/AIDS in their families. The impacts of caregiving and Antiretroviral Therapy (ART) were also examined. Further information is available at http://www.who.int/healthinfo/sage/hiv_studies/en/

The Malawi Longitudinal Study of Families and Health (MLSFH)

The Malawi Longitudinal Study of Families and Health (MLSFH) is one of very few longstanding, publicly available longitudinal sub-Saharan African cohort studies. The MLSFH was initially established in three districts in 1998 to study social network influences on fertility behaviours and HIV risk perceptions, but over time the focus of the study expanded to include health, sexual behaviours, intergenerational relations and family/household dynamics. A sample of parents of the original MLSFH respondents was added to the MLSFH to increase the suitability of the MLSFH for studying intergenerational aspects and the

health of older individuals in Malawi and the 2012 MLSFH round was restricted to those aged 45 and over.

Fuller information is available in Kohler et al. (2012) The MLSFH public use data can be requested on the project website: http://www.malawi.pop.upenn.edu/.

There are other available sources of data relevant to ageing and SDGs in Africa, which will be briefly described.

IHME information on Sustainable Development Goal indicators

The Institute for Health Metrics and Evaluation (IHME) at the University of Washington in collaboration with the Bill and Melinda Gates Foundation has published findings on the health-related Sustainable Development Goals in scientific papers and reports, together with a data visualization tool at https://vizhub.healthdata.org/sdg/. For more information see www.healthdata.org/globalgoals, Human Development Network the World Bank; Institute for Health Metrics and Evaluation Univ. (2013) and GBD 2016 SDG Collaborators (2017).

World Health Statistics

The World Health Statistics 2018 Report concentrated on monitoring health for the Sustainable Development Goals (World Health Organization 2018). While there are a large number of health-related SDG indicators available, the main focus is on comparable national-level health indicators that are not necessarily disaggregated by age and rarely provide information on vulnerable social groups.

Integrated Public Use Microdata Series (IPUMS)

The Integrated Public Use Microdata Series (IPUMS) database (https://international.ipums.org/international/), housed at the Minnesota Population Center, contains a wide range of census microdata. The records are converted into a consistent format and made available to researchers through a web-based data dissemination system. Registered users can run tabulations on-line or download datasets for additional analysis. In the three countries that participated in the MISA project, multiple censuses are available so permitting trend analysis (Table 4).

Table 4. Census data available at IPUMS by decade

Country	2000s	1990s	1980s	1970s	1960s
Kenya	2009	1999	1989	1979	1969
Malawi	2008	1998	1987	-	-
Uganda	2002	1991		-	-

Since, for example, age is coded in single years of age, researchers have the possibility to analyse data in any classification that they want (Table 4).

Malawi Integrated Household Survey

This survey is one example of multipurpose general population surveys that are common across Africa. The Malawi Integrated Household Survey is a nationally representative sample survey designed to provide information on the various aspects of household welfare in Malawi. The fourth round, IHS4, was in 2016-7. The survey collected information from a sample of 12,480 households statistically designed to be representative at both national, district, urban and rural levels enabling the provision of reliable estimates for these levels. Starting with the IHS4 the upcoming IHS rounds will be fielded every three, as opposed to five years. Full information is available at http://microdata.worldbank.org/index.php/catalog/2936

II Summary of the project

1. *Rationale: evidence-based policy making and capacity building focus of all activities*

A number of studies have concluded that there are substantial gaps data for socio-economic development in sub-Saharan Africa. The need for such information is particularly pressing, given the emphasis on the need for appropriate data to underpin the SDG goals, targets and indicators and to live up to the pledge that 'nobody will be left behind'. This is particularly the case for statistics on older people. While both MIPAA and subsequent frameworks on the rights and status of older people have been adopted in Africa, the consensus is that the evidence necessary to evaluate the progress of such initiatives has not been available, at a time when the rapid increase in the numbers of older people will considerably increase the need for effective policies. The General Assembly has continued to call for the international community and the UN system to support national efforts to provide funding for research and data collection initiative on ageing (United Nations General Assembly 2015b, p 6). Therefore, the MISA project (Multiple Indicator for Sub-Saharan Ageing) was started in 2105. The project was led by the Department of Economic Affairs under the leadership of the Division for Inclusive Social Development (United Nations Department of Economic and Social Affairs, Division for Inclusive Social Development 2015).[1]

The project's objective was to provide a comprehensive framework to address the major gaps on information on the conditions of older persons in the context of the very rapid increase in the number of older people in the region and of the 2030 development agenda. This included not only development of an instrument to collect the required data, but also to identify the ways that such data can be used to help formulate and monitor policies for older people across the region. Data are required for the whole older population to identify their particular needs, so a specialized ageing survey that includes the whole older population was the appropriate method to collect the data needed. While such information will need to be supplemented by additional sources, such as service use data, a broadly-based stocktaking of the social and economic conditions is a pre-requisite for effective interpretation and application of a range of additional data sources.

While comprehensive ageing studies have been undertaken in some HICs and MICs, and specialised health surveys, such as WHO SAGE, have been undertaken in Africa, no comprehensive ageing survey instrument had been developed for use in sub-Saharan Africa. Three countries—Kenya, Malawi and Uganda—took part in the project. These countries have high rates of growth in their older populations, and their national governments have identified ageing as an important policy priority and have requested UN support to improve their age-related data.

The immediate objective was to establish the feasibility and logistics of undertaking such a survey including: questionnaire development, both question construction and data capture;

---

[1] This section draws heavily on working documents produced during the project and the primary role of their authors is acknowledged. These are not yet in a form suitable for wider dissemination, but final versions will be available together with the survey microdata in the near future. These are given in the Additional documents section of the References.

sampling issues; and presentation of results. The survey was developed in close collaboration between national and regional policy makers, statisticians and experts dealing with issues related to older persons in Africa, together with international researchers and academics. The survey instrument was developed and piloted in four selected areas of Malawi.

The project also included an in-depth review/mapping of available data on older persons at the national level to identify gaps in data required for evidence-based policy on older persons in Kenya, Malawi and Uganda.

The ultimate project objective was to develop a survey instrument for African countries to enhance the capacity of government officials, scholars and civil society in sub-Saharan Africa to formulate, monitor and implement evidence-based policies on ageing.

The key objectives were:

- develop a standard methodology to produce, analyze and deliver a database of harmonized indicators about older persons in Africa to identify key areas for policy intervention and to monitor the performance of such policies
- promote a joint inter-Divisional capacity building intervention to develop a survey instrument to collect data on older persons in SSA
- support the collection and analysis of the most relevant data on the status of older persons within the framework of the International Statistical System
- assist Member States in the formulation and implementation of evidence-based policies on ageing
- contribute to the sustainable development agenda.

2. Activities

2.1 Mapping of data and statistics on older persons in three countries

The first part of the project to be completed was an assessment of empirical evidence on older persons in Kenya, Malawi and Uganda. Findings were discussed at national workshops in period February to May 2016. These assessments were to ascertain, assess and report on: existing national data and statistics on older people; policy and evidence use of such data; and evidence needs and data gaps that must be addressed as a priority to enable evidence-based policy and action.

2.2 National workshops

National workshop: Data collection methodology and tools for supporting the formulation of evidence-based policies in response to the challenge of population ageing in Kenya

The Kenyan national workshop took place in Nairobi on May 2016 with experts and officials from UN agencies, government, academe and civil society to assess the status of empirical data for evidence-based policy formulation on ageing in Kenya. The workshop provided important input into the development of the survey instrument on ageing for Africa that was piloted in Malawi in 2017.

The main input to the workshop was the analysis conducted by the national consultant of available data at the national level and the identification of gaps in data required for evidence-based policy on older persons (Aboderin & Owii 2016).

The following items were discussed:

- overview of national policies, programs and initiatives on ageing in Kenya
- feedback from the experts regarding the work of the project, particularly in relation to the MISA survey instrument
- identification of data gaps and recommendations for data needs for Kenya, including those that could be collected via the MISA survey instrument, especially those relevant to key priorities for national policy making, monitoring and evaluation initiatives for older people.

National workshop: Data collection methodology and tools for supporting the formulation of evidence-based policies in response to the challenge of population ageing in Malawi

A national workshop was organized in Malawi (Lilongwe) in May 2016, again with experts and officials from UN agencies, government, the African Development Bank, academia and civil society, particularly the Malawi Network of Older Peoples' Organizations (MANEPO) and HelpAge International Regional Offices (Southern Africa including the Mozambique Office and East, West Central Africa including the Tanzania Office).

The objectives were to assess the status of empirical data for evidence-based policy formulation on ageing in Malawi and to identify the knowledge-gaps, especially those that could be filled through the MISA survey instrument. As with the Kenyan workshop, this workshop also included an in-depth discussion on the critical importance of sound empirical evidence for policy implementation, and participants of the workshop provided input into the development of the MISA survey instrument.

The workshop also reviewed a universal pension feasibility study undertaken for Malawi by a national consultant (supported by HelpAge International). Experiences with the development of two national universal pension schemes (Mozambique and Tanzania) and implementation (Zanzibar) were presented. The analysis presented, and the outcomes discussed provide the foundation for the development of further steps to be undertaken to introduce a universal pension system in Malawi.

2.3 Regional workshop

A regional workshop to share findings and methodology with the wider SSA region in was held at Malawi 19-21 July 2016. The meeting included policy makers, data producers (NSOs), and data users (researchers, civil societies). The workshop started with assessment of empirical data for evidence-based policy formulation on ageing, identifying the knowledge-gap in Kenya, Malawi and Uganda. While all countries had adopted national policy frameworks covering the rights and socio-economic conditions of older populations, none had a comprehensive instrument to measure the needs of older people, or for monitoring and evaluating the national programmes. The contrast between a well-developed policy

framework but a lack of suitable data that was inhibiting policy formulation and implementation was noted.

The workshop included presentations of overviews of national policies, programs and initiatives on ageing in Mozambique and Tanzania, and on the implementation of the AFFORD Programme (Accountability and Fulfilment for Older People to Raise their Dignity) in Mozambique, Uganda, Tanzania, and South Africa (see http://www.un.org/en/development/desa/population/events/other/15/index.shtml).

The proposed MISA survey instruments, including questionnaires, interviewer and sampling manual and sampling costs were discussed including survey design and trade-offs between comparability with other ageing surveys such as SAGE and the set of HRS-linked studies while tailoring the instruments to the African context. Availability of relevant cross-national comparable data increase the possibility to understand the effects of various policies, and therefore data collection efforts should be harmonized, as far as practicable. Some minor revisions were made to the survey instruments to adjust for the sub-Saharan African context, especially the Malawian context.

III Overview of survey methodology

1. Introduction

Three countries, Kenya, Malawi and Uganda, participated in the project by mapping of data and statistics on older persons in these three countries. These confirmed that there was a lack of information directly relevant to the situation and needs of older people in all cases.

Sample surveys continue to be the main source of high-quality information. Surveys addressed to the general population are unlikely to provide either sufficient sample sizes of older people, given that they make a relatively small fraction of the population, or meet the specific data needs of this group. Administrative data usually provide information only on those in contact with the agency, collect only data relevant to the agency, and are likely to exclude those "left behind". The content of surveys is under the control of the survey organisers, the information collected can be disaggregated by key sub-groups, the precision of results can be estimated, and long-term consistency can be assured. Therefore, a new instrument that covered the whole range of policy-related issues was developed and tested in co-operation with African countries under the title Multiple Indicator Survey on Ageing (MISA).

There were a number of challenges in the design of MISA:

- Ability to cover a substantial fraction of the MIPAA priority directions and the SDGs goals – therefore requiring comprehensive nationally-representative data on the demographic, social, economic and health conditions of older people
- Design valid survey instruments that can be easily implemented in different SSA contexts, for both intra-country, e.g. suitable in rural and urban areas, and inter-country, e.g. for making comparisons across different SSA countries
- Whenever possible harmonize the study instruments with other ageing studies to allow comparisons with other ageing populations while simultaneously adapting study instruments so that they are culturally appropriate for the SSA context.

The target population is the household population aged 60 and over, the same as the UN definition of older people, which maximises the number of interviews with the population of older people with a fixed overall sample size. While a younger cut-off age such as 50 would permit the experiences as people transition to the older age range could be examined, the number of over-60s would be reduced.

The survey used face-to-face interviews with a standard clustered sample design; details of the survey are given in the following sections. The survey instrument consists of a set of manuals (interviewer, field supervisor, sampling and survey cost estimation manuals) and two questionnaires: a household questionnaire administered to a key informant (ideally the household head) to gather information on all members of the household, on household finances and living conditions and an individual questionnaire for information from each individual aged 60 and over in the household.

A pilot survey was undertaken to develop and test an instrument that, if successful, could be fine-tuned and used more widely across sub-Saharan Africa to address the common needs

of older people across the Region. The MISA survey was conducted by the Malawi National Statistical Office (NSO) at the request of the Ministry of Gender, Children, Disability and Social Welfare. The NSO had the responsibility for operational matters including planning, training of interviewers, conducting fieldwork and processing of collected data.

The total time for the survey was nine months (Table 5). The components of the programme will be discussed briefly.

Table 5. Timetable for Survey

Component of survey	Number of days
Preparation of the survey sample and finalization	Dec 2016 - Feb 2017
Translation of questionnaires into two local languages (Chichewa and Chitumbuka)	Feb 2017
Support Computer Assisted Personal Interview (CAPI) development and programming	Dec 2016-June 2017
Provide complete list of human resources required for the survey	March 15 2017
Organize and conduct training of household listing	1-3 May 2017 (3 days)
Conduct household listing	4-30 May 2017 (25 days)
Select sample of eligible household to interview	June 2017 (10 days)
Organize and conduct training interviewers training	3-14 July 2017 (10 days)
Conduct fieldwork on data collection	20 July-18 August 2017 (30 days)

2. Survey content: Household and individual questionnaires

The approach was a standard one with an initial sift in the selected clusters to identify eligible respondents. The household questionnaire identifies all age-eligible respondents in the household, those age 60 years and over, who are invited to participate in the second part of the study. An individual questionnaire was then used to collect information from each of these household members age 60 years and over. The household and individual questionnaires were designed by reviewing and taking into consideration several leading ageing studies already underway in other parts of the world, especially in Europe (the Survey of Health and Retirement in Europe (SHARE), the English Longitudinal Study of Ageing (ELSA), the Irish Longitudinal Study of Ageing (TILDA)); in North America the Health and Retirement Survey (HRS); in Latin America the Mexican Health and Aging Study (MHAS) and the Brazilian Longitudinal Study of Health, Ageing and Well Being (ELSI-Brazil)); in Asia the China Health, Ageing, and Retirement Longitudinal Survey (CHARLS) and the Longitudinal Ageing Study in India (LASI), as well as other harmonized ageing studies such as the WHO Study on Global Ageing and Adult Health (SAGE) and the Longitudinal Studies of INDEPTH communities in Africa (HAALSI). Many other questionnaires such as the Malawi Longitudinal Study of Families and Health (MLSFH), Botswana Core Welfare Indicators Surveys 2009/10, the Living Standards Measurement Study (LSMS) and survey guidelines developed by the UN Department of Economic and Social Affairs Division for Inclusive Social Development Technical Cooperation Unit were used to inform development of the Multiple Indicator for Sub-Saharan Ageing (MISA) project pilot survey.

After identification of eligible households one responsible adult, typically the head of household so not necessarily an older person, answered a household questionnaire (National Statistical Office 2017a). The household questionnaire had two main functions. The first was to identify eligible respondents in the household, who would be interviewed using the individual questionnaire. Since all members of the household aged 60 and over were interviewed individually — but no-one else —special attention was given to ensure to the accuracy of age reporting especially for those in their late 50s/early 60s, around the borderline for eligibility. If the respondent was not being able to provide the age of any household member, an event-sheet was provided to assist the respondent. If no eligible older person lived in the household, no further information was collected, but otherwise the household questionnaire collected additional information from the informant on key socio-demographic variables for <u>all</u> household members such as their marital status, educational level and health status. Although Computer Assisted Personal Interview (CAPI) software was used in the collection, the distribution of types of information collected may be obtained from the paper version as follows (Table 6).

Table 6. The household questionnaire

Topic	Start page
Introduction and screening for Eligibility	1
Section 1: Information on Household Questionnaire Respondent	6
Section 2: Household Listing	7
Section 3: Housing Environment	10
Section 4: Household Income	13
Section 5: Household Agricultural Income and Assets	17
Section 6: Household Financial and Non-Financial Assets	23
Section 7: Access to Social Programs and Benefits	26
Section 8: Overall household economic conditions	29
End of Interview	31

Questions on household-level conditions such as physical housing conditions, and levels and sources of income and assets of all types were specified in a way directly relevant to the population context being interviewed. In the pilot, attention was given to agricultural activities since the survey was conducted in rural areas, although would need to be adjusted for use in urban settings. Finally, information was collected on access to social programs and benefits by any member of the household, and the informant's perception of the household's economic situation.

At the next stage, all older people who were members of the sampled household were interviewed using the individual questionnaire (National Statistical Office 2017b) (Table 7).

Table 7. The individual questionnaire

The questionnaire includes information on socio-demographic characteristics (education, marital status, literacy etc.); children's situation (including numbers, survival status, co-residence and having current or past experience of having orphans living in the household). However, the main content is on health and financial conditions. A wide range of health indicators are collected including self-reported health, ability to undertake activities of daily living (ADLs) and whether s/he suffers from a range of health problems. Some conditions, such as stroke and cancer, questions were based on contact with health services, such as "Has a doctor or health professional ever told you that you have …" and "Are you currently taking any medications prescribed by a doctor or health professional to treat your … ". Care is needed in interpreting these responses as indicating prevalence of various health problems, since they are about contact with health services. In other cases, respondents were asked questions about their own perceptions such as "Do you sometimes have pain, stiffness, or swelling in your joints?". Taken in conjunction with other sources of population-level estimates of prevalence, such questions can provide information on areas such as unmet need and, in particular, constraints on access to health care. Mental health was measured by a question on ever-diagnosis of depression and a series of questions on

perceptions of own well-being using the Centre for Epidemiological Studies CESD-8 depression scale.

Apart from health care, the other main component of the individual questionnaire is concerned with provision and receipt of care both inside and outside the household. "Care" is disaggregated into the following categories: personal care; financial assistance; emotional help; help with household chores; HIV/AIDS related; disability, physical or mental health; or simply with "old age".

There were shorter sections on employment, pensions, benefits, elder abuse, and social interaction, including loneliness.

Context-Specific Components of the Survey

Some specific questions will need to be adjusted to the country's context to make them relevant for use, these include:

- All financial information(e.g. use of local currencies in questions; money categories chosen to ensure that the responses are distributed across all the values chosen)
- Educational levels for those finishing education more than 50 years ago that can differentiate respondents' level of education
- Occupation/current employment that relate to patterns experienced by those often working part-time and outside the formal sector
- Social programs and benefits, which are likely to be country-specific in levels and description.

Older people are less likely to be multilingual than younger members of the population and it will therefore be necessary to translate the questionnaires into appropriate local languages and to have interviewers fluent in these languages: in the Malawi pilot, versions were prepared in English, Chichewa and Chitumbuka. While this is a general problem, not just confined to older respondents, this is likely to more challenging because of the lower levels of literacy and linguistic fluency and possibly different languages used by older respondents, especially among the "old old", those aged 80 and over. While the language to be used in a particular interview may not be known in advance, with a CAPI system, alternative language questionnaires may be programmed into the electronic devices (laptops or tablets) so removing the need to have printed alternative language questionnaires available. Use of alternative languages needs careful testing to ensure accuracy of translation of concepts that may not be clearly or consistently defined across different languages, such as depression or loneliness or even phrases as "could not get going".

3. Survey organisation: Interviewer and field supervision

Interviewing procedures

Sample surveys are a well-validated method of obtaining information, and MISA draws on this experience. There are some challenges to be expected when interviewing older persons. Older persons are typically less educated than younger populations; they have less

experience of social surveys; they might experience problems concentrating over an extended period of time and/or may have other intellectual or physical impediments that make conducting an interview more demanding. Interviewers were therefore trained to treat all respondents with dignity and respect. When older respondents need to have a question repeated or they need more time to answer it, interviewer were instructed to adjust to the respondent's situation, even if this requires a somewhat longer time than when working with younger respondents. The interviewer's priority is to ensure high quality of the collected data (National Statistical Office 2017 c,d).

However, if a respondent was not able to participate in the survey because of physical and/or mental health reasons, the interview was not conducted. If the respondent has difficulties in participating in the interview, a family or household member may assist with the respondent's agreement. An assisted interview can be conducted if the respondent is also able to provide informed consent to participate in the interview, but proxy interviews were not permitted.

A section of the individual questionnaire focuses on abuse of older people. If an interviewer encounters a situation when s/he suspected that the respondent is abused, s/he was instructed to report this to the team supervisor who will then decide how to proceed.

Field force organisation

NSO recruited 40 survey personnel for the household listing and 40 for the main survey fieldwork who had experience of household listing and data collection using CAPI, and knowledge of the local language where the survey was conducted. One third of survey personnel were female.

The survey team consists of the survey manager, data manager, CAPI/data management consultant, IT support, six supervisors and eight field-teams consisting of one team-leader, four interviewers and a driver per team. The eight team leaders were permanent staff of NSO who was responsible for team logistics and welfare in the field. The specific duties of the team leader and the back-up are described in detail in the Team Leader, Supervisor and Editor Manuals (National Statistical Office 2017 c,d).

The team of supervisors/regional coordinators based at the central office was responsible for fieldwork teams and provided guidance and overview to the survey staff in the field. They monitored the progress of the field work, provided support and back-up as needed and reviewed data collected through CAPI (Computer-Assisted Personal Interviewing) and ensured the regular transfer of data (and questionnaires in case paper questionnaires need to be used) to the central office. Data entry staff and computer programmers were assigned to the project as needed.

Interviewer training

The main objective of the training was to provide guidance to personnel conducting interviews in the field. The last day of the training was dedicated to field practice.

Training of interviewers took two weeks. Training included both formal classroom and practical training. The classroom training focussed on different parts of both household and

individual questionnaires. The first part of the training focused on the paper-version of the questionnaire. The second part provided an introduction into Computer Assisted Personal Interviewing (CAPI). Interviewers were encouraged to share knowledge and best practices to benefit from individual experiences. One day was dedicated to CAPI application and testing

Household listing training took three days, and covered how to update the sampling frame and to conduct household listing, including how to contact local chiefs to inform them about the survey and to obtain their co-operation.

4 Data collection using CAPI (Computer Assisted Personal Interview)

The data collection was undertaken using CAPI (Computer Assisted Personal Interview) (Beckles 2017, a.b) rather than use of printed forms since it was anticipated that this would be more efficient for reasons including:

Improved accuracy of information collected e.g.
- skips automatically implemented reducing potential interviewer errors
- checks on validity of responses and internal consistency, permitting correction of earlier responses
- "personalisation" of responses, so, for example, actual names of household members are available when checks or probes are undertaken

Efficiency of procedures, e.g.
- no need to have printed questionnaires in multiple languages available in case needed
- more control by team supervisors
- electronic transfer of completed interviews
- control and monitoring of interviewing, e.g. timing of interviews
- additional functionality, e.g. automatic geo-coding and direct interface with GIS software
- automatic selection of sample households

However, moving from paper-based to CAPI needs additional training and organization, potential issues include:
- Training of interviewers and field force in use of new technologies
- Co-ordination of activities between the questionnaire developers and CAPI programmers
- Schedule of activities to allow for additional stage of programming CAPI software

Decisions are required about:
- choice of software for the application (in this case, the widely used CS-Pro free software developed by US AID was used)
- choice of technology, such as use of laptops or tablets and match between CAPI interface and data capture (e.g. smaller screens can show less information but may be less obtrusive and convenient for mobile field forces). Tablets that were already available for NSO staff were used for this application
- robustness of system, e.g. vulnerability of hardware to damage, theft, failure etc.
- level of internet connectivity for transfer of data to central location

- ability to use software requiring wide bandwidth (especially GIS applications) and fall-back in case of internet problems
- security and confidentially, e.g. should interviewers have internet connectivity or only local Bluetooth access to the team leader, who will have sole responsibility for data transfer.

The CAPI programming part of the project took a substantial amount of time by a highly proficient specialist programmer (Table 5), in part because the whole project was completely new. This work must be undertaken before the fieldwork phase and allowance for this will need to be built into the timetable. Although later users of the instrument will be able to build on this investment in programming the current questionnaires, the need for competent experienced staff to be involved with the project at the questionnaire design stage is necessary to ensure that questions can be efficiently programmed, since this can be more difficult to do at a later stage.

It is important to test the programs thoroughly in advance and it is also necessary to have access to programmers through the fieldwork phase since errors in the programs may result in the software ceasing to function. Since internet connectivity may be a problem, back-up including having pen and paper questionnaires available should also be considered.

5. Sampling procedures

The MISA sampling manual provides sampling guidelines for sub-Saharan Africa context (Megill 2016). The Malawi Pilot MISA was used as practical example for developing and implementing sample design and weighting procedures. The sampling design follows official UN guidelines for selecting representative samples of the target population for household surveys, in this case persons aged 60 years or over.

While the principal objective is to design an instrument for addressing needs of aging population in sub-Saharan Africa at the national level, the instrument is sufficiently flexible to be implemented at sub-national regional level if required (the pilot survey was conducted in four rural districts of Malawi).

Key principles for MISA survey design include:

- To maximise accuracy within a fixed overall cost, a stratified two-stage sample design was employed using an existing sampling frame. In this case the frame from the last Census in 2008 was used, using census enumeration areas (EAs) from that 2008 census as primary sampling units (PSUs) – This provided a stringent test, since the frame was constructed at the date almost the furthest from the survey date (the next Census is scheduled for 2018).
- The sample should be representative and cover 100% of the target population – in this case the household-based population aged 60 and over in the selected areas.
- The household sample is probability-based using an existing sampling frame and established sampling procedures to obtain unbiased estimation and to be able to calculate the sampling errors and other measures of precision.
- In the absence of closely-related ageing surveys, the decision on sample size was made by making comparisons with other multi-purpose surveys in SSA.

Considerations of the budget available and the accuracy with which key variables can be measured suggested a target sample size of approximately 2,000 respondents would be appropriate. Further analysis of the pilot results will permit the precision of outputs to be measured directly.

The enumeration areas (EAs) contained around 200 households on average in 2008, although there was considerable variation between and within districts. At the first stage a sample of 40 EAs were selected in each district with probability proportional to size (PPS). The sample domain, the area that the MISA pilot covered, was purposively chosen as four districts selected based on number of older persons, ethnicity, main language and other social economic conditions to test both the questionnaire and survey procedures. Within each of the four sampled districts of Mzimba, Lilongwe, Mangochi and Nsanje, 40 clusters were sampled.

Before the data were collected, a complete count of households in the 160 selected Clusters (enumeration areas) was conducted in June 2017 to update the sampling frame, an important correction procedure, especially when the sampling frame is out-of-date. It provides complete and recent information on the number of households for each selected cluster and ensures that the MISA sample is representative of the current population of the selected districts.

Household listing

Household listing was carried out as a separate operation by a field staff team before the interview past of the survey started. Using different teams for household listing and interviewing is more reliable because staff that were specifically trained and concentrated on listing were less likely to bias the sample by excluding households that were harder to reach. In addition, the random selection of households was done by a separate listing team from lists in a single central office using reliable and uniform procedures.

The listing teams used a CAPI screening questionnaire to identify persons age 60 or over. This information was used to sample households with eligible persons to interview during the second stage of sampling methodology. The CAPI listing also collected basic household information and GPS coordinates for each household listed; this information assisted teams to located households that were selected for interview during the main data collection phase.

Team leaders were given an introductory letter to the District Commissioner and the police informing them about the objective of the survey and that the data collection teams will be working in their districts for the months of July and August 2017 and requesting assistance for them teams if required. Each team member had a personalised letter of introduction requesting officials and general public to be of assistance to the NSO data collection teams whenever necessary.

Conduct of fieldwork

A field movement plan was developed to assist teams to reach selected households in the selected clusters. The list of selected clusters was arranged in such a way that each team

should move according to a predetermined cluster each day in order to minimize travel time and the problems of locating clusters and selected households.

Number of sample households per cluster

A key design decision for this two-stage sampling procedure is t*he* sample "take" per cluster, *th*at is, the number of households to be selected in each cluster. A lower number of sample households per enumeration area (EA) also results in higher costs, since additional sample EAs would need to be selected and listed. Since only a portion of the households in each EA will have an eligible member age 60 years or over, it is necessary to determine the average number of households per PSU with eligible elderly members that would be available for selection. Because more than one eligible individual aged 60 years or over may reside in a household, it would still be effective to select fewer households than the number of eligible respondents per EA.

Estimates of the number of individuals aged 60 years or over per household with at least one regular household member aged 60 years or over can be obtained from recent census or household survey data. The decision was to make an estimate of this figure by using the value for the same cohorts at the 2008 Census, i.e. the census population aged 52 and over. It was recognised that the value for this cohort 9 years later in 2017 would differ owing to mortality, changes in household structure and migration. Each eligible household contained an average of 1.5 individuals aged 52 or over in the 2008 census. In the event the average number of those 60 or over in 2017 was about 1.2. A fixed number of sample households per cluster was chosen since it is easier for survey management and implementation, but it requires sampling weights that vary by sample PSU within a stratum. On balance, the advantages of a fixed rather than a variable number of households per cluster are such that a variable number is only recommended in exceptional cases in such surveys.

If one of the objectives of the survey is to obtain reliable estimates for subnational domains, such as regions, a target sample size would have to be determined for each domain.

Since the weighting of the survey data is done automatically by the tabulation software, the need for a self-weighting sample is less important, although the design should try to avoid any extreme variability in the weights.

6. Lessons learnt from the pilot survey

The survey is a unique comprehensive source of information across the main areas that affect the living conditions of older people in the selected areas, including their demographic, social, economic, physical and psychological health characteristics, their well-being, incomes, living circumstances, social networks, HIV and AIDS experiences, lifestyles and health behaviours. It is intended to provide baseline information to inform future policy and strategy for older persons and overcome their relatively invisible status as compared with many other groups. Availability of such information should help to provide a level playing field for the development of policies and programmes affecting older persons. While the fieldwork, data collection and analysis went according to plan, nevertheless there are some lessons that may be learnt (National Statistical Office 2017e).

Consultation with Stakeholders

This is of paramount importance in the implementation of MISA. Two workshops were conducted in Malawi; the first one held in Lilongwe on 19-21 July 2016 included experts from several African Countries. This workshop reviewed and revised the draft survey tools, questionnaires, manuals and sampled design manual, for wider use in Sub Saharan Africa. The second training workshop which was held in Zomba on 8-10 February 2017 was to prepare the implementation of the Survey. The main objectives were to engage stakeholders in the implementation of the survey and pre-test the survey instruments, including computer assisted personal interview (CAPI). The outcome of the training identified NSO staff to be field supervisors for the main survey, and revised questionnaire and interviewers' manual.

Sample frame

Area sampling needs a current sampling frame to ensure representativeness of the sample. In this case, the frame was updated from the census in 2008, using a new listing exercise during the implementation of the survey in 2017; this was facilitated by the use of CAPI.

Community mobilization

There is need to meet with local authorities and explain to them the purpose of the survey to be accepted in their area. NSO prepared introductory letters to District Commissioners, Police and Traditional Authorities informing the about the Survey; NSO learnt that some Traditional Authorities needed a letter from the District Commissioner to make sure that the teams had gone through the District Commissioner's office to obtain approval for them to work in the sampled areas. Local authorities were cooperative and helpful in the interviewing component, in part because the household listing team had established a good rapport. Most households were aware of the survey.

Field movement plan

Use of base maps assisted teams in locating selected clusters. A base map printed on a large A0 size paper shows clearly all land marks, road, tracks, footpaths and other features on the map. All selected Traditional Authorities had a base map. By using base maps, a field movement plan was developed which assisted teams to move efficiently from one cluster to another and from one selected household to the next one. This reduced improved field supervision and reduced travel time and problems of locating clusters and selected households, so ensuring that the survey was completed within the planned period.

Use of CAPI

Use of CAPI reduced time for data processing since there was quicker final sample selection, real time of data capture, no need for separate data entry, and data cleaning is minimized. Data checks are embedded in the application. A CAPI application was developed to list all the households in the selected clusters and the sample of household was selected from the updated list. The selection of households for interview was faster, easier and more accurate than previous methods using paper listing forms. CAPI-based sample selection, data

collection and data capture are likely to become increasingly important in years to come and experience with such approaches is important for upgrading skills.

Field work on data collection and use CAPI

Comprehensive testing of CAPI application is required before the launch of field work. Some teams had problems CAPI application terminating or stopping working in the middle of the interview due to valid value sets not being included in the CAPI application. There is need to have support available to fix problems that are identified during fieldwork. The consultant was able to do this in most cases, although in two clusters paper questionnaire were used.

Use of CAPI application

Field work on data collection went according to plan. Data collection was conducted by using CAPI and most of data collection staff had used CAPI either during household listing or in an earlier survey. While it was found to be easy to train enumerator on using CAPI, it is preferable to recruit a mix of new and experienced users. However, interviewers were not given sufficient time to practice CAPI application due to short time that was dedicated to the development of the application. There is need to finish the application and provide the CAPI manual for interviewer training in good time.

Number of interviews per interviewer per days

On average, each interviewer undertook three household and four individual interviews per day. It took an interviewer three hours on average to complete all interviews per household, including both household survey and individual survey components.

Collection of GPS points

During household listing, a CAPI application was developed to take GPS points automatically. Teams found it difficult for the tablets to acquire the GPS points as it needed a clear sky view and a good terrain. Fortunately, the application was made in such a way that, the enumerator could bypass taking GPS points and proceed with household listing.

Hard to reach areas

Accessibility of some of the selected clusters proved a challenge. Some teams had to hire boats to cross the rivers or reach the other side of a bay which was inaccessible from the land. During survey planning, areas hard to reach were not factored in the budget. Locating selected households was not a problem. The major challenge was accessibility of some of the clusters.

Targeted government programs

During household listing, some households reported they had age eligible persons and were selected to be part of the sample, but during data collection field work the selected households was found to have no age-eligible persons. This was done deliberately by some of the household heads thinking they would be eligible for some kind of assistance after the interview, though the aims of the survey were clearly explained to them.

Locating households for interview

Although finding selected households by survey teams was not a major challenge as the household listing was done shortly before the interviews; there was a few difficulties in finding the names of the heads of the selected households. It would be preferable for the household listing and the actual data collection be done concurrently to avoid some cases of cheating on age and problems of finding the name of the selected household.

Call backs are inevitable

Call-backs were undertaken since some eligible individuals were not present during the visit of the interviewers. Most of the call backs were done the same day. In some cases, a vehicle would be sent to pick the individual from the place where he/she had gone if it is within the community.

Questions that require recall of more than 30 days and difficult sections

Interviewing older persons, especially those aged eighty years and above was a challenge. Particular concerns were on questions that required a recall period, especially those of more than 30 days. For example, some older people had difficulties in recalling how many times they went to market in the last week provide to them a challenge to recall. Such questions were included in the individual questionnaire sections on children, mental health, health care utilization, and in the household income section of household questionnaire.

Interpretation of questions

Some mental health issues like experience of stress/anxiety were difficult to explain clearly in local languages. Care is needed in translation to ensure that such responses are directly comparable when different languages are used.

Mapping using tablets sections

Maps which were loaded into the tablet assisted the teams in locating selected clusters and households that were selected for interviews.

Timing of survey

Weather conditions during the data collection period were good. If the survey had been undertaken in the rainy period, it would have required more time and resources, especially in areas that were hard to reach.

IV Other project activities

1. National-level data availability and policy frameworks

The major other component of the MISA project was an in-depth review of available data on older persons at the national level and to identify of gaps in data required for evidence-based policy on older persons in three African countries, Kenya, Malawi and Uganda. Three consultants assessed the situation in these countries as follows.

1.1 Kenya

The Kenya analysis was based on three major sources of data - namely stakeholder consultations, web-based searches and prior findings of an earlier scoping study 'Evidence revolution on ageing in Kenya' (Aboderin & Owii 2016).

<u>Legal framework</u>

The *New Constitution of Kenya (2010)* provides explicit rights, entitlements and privileges for older people with specific obligations to the state and family. The State is required to take measures to ensure older peoples' participation, personal development, dignity, respect and protection from abuse; and together with the family, the obligation to provide care and reasonable assistance to older people. This includes the State's obligation to protect older people and other vulnerable groups. Older people are explicitly safeguarded from age discrimination, and the constitution requires the State to provide appropriate social security to needy older people.

The *National Policy on Older Persons and Ageing (NPOPA)*, which builds explicitly on the United Nations Madrid International Plan of Action on Ageing (MIPAA) and the AU Plan was initially developed in 2009 and revised in 2014. The National Policy includes policy issues and objectives across areas including: poverty, health, Food security, infrastructure, education, employment, income security and social protection.

*T*he Government has established a dedicated *Division on Older Persons and Social Welfare (DOPSW)***,** within the now Ministry of Labour, and East African Affairs (MLEAA) - with the explicit mandate to promote and coordinate Government action on ageing across sectors. To fulfil its remit the DOPSW seeks to foster a multi-sectoral approach to mainstream and advance the rights and aspirations of older people and, to this end, pursues cooperation with key Government departments, civil society organizations and international development partners.

A *National Gender and Equality Commission (NGEC)* was established to spearhead efforts to reduce gender inequalities and the discrimination against marginalized groups including older people. Its functions include auditing, facilitation, monitoring and advisory functions to lay a foundation for state, private and non-state actors in Kenya for the integration of the principles of equality and inclusion in national and county policies, laws and administrative regulations

A *Health and Ageing Unit* within the Ministry of Health concerned with the unique health concerns of older people.

In June 2018, the *Inua Jamii 70 and Above* universal social pension was launched under which all Kenyans over 70 will receive 2,000 shillings (just under US$20) per month.

Data availability

While there exist a number of administrative data sources that cover older people and some specialised surveys such as the 2012/3 National Housing Survey contains information on older people, comprehensive data on this group are lacking and the main source remains the National Population and Housing Census (2009,1999, 1989) containing age- and sex disaggregated, cross-sectional and trend information on living conditions of older people in rural and urban areas, and the Kenya Integrated Household Budget Survey (2015/16, 2005/6) that contains additional information on socio-economic advantage/disadvantage of older people in rural and urban areas. The Kenya STEPwise Survey for non-communicable disease risk factors (2015) included only those aged 18-69.

The lack of specific policy and programmes on older people is due in part to the lack of relevant evidence that policy makers and planners would require. Although Kenya has a broad set of general and specific policy, legal and strategic provisions for older people that cover 16 of the 18 MIPAA key issues, this is not matched by commensurate levels of implementation. Only a few substantial programme initiatives have so far ensued, which are concentrated narrowly in three areas namely social protection, HIV/AIDS and long-term care.

Kenya's policy responses to ageing exhibit little systematic use of evidence to inform policy formulation, implementation, monitoring and evaluation of initiatives for older people. While existing data national data on older people could be better exploited, substantial gaps in the evidence base on the circumstances of older people would remain. Both Government and civil society stakeholders perceive the need for high-quality evidence to enable them to advance effective policy and action on older people in Kenya, it is clear that this will require new primary survey research.

Conclusions and Recommendations

The Kenya analysis identified four key recommendations to promote evidence-based policy on ageing in Kenya:

1. Establish of a Government-led stakeholder information-sharing group on action on ageing in Kenya across sectors

2. Undertake with partners a secondary analysis initiative to generate an evidence base on the state of Kenya's older population from existing survey, administrative, and other data sources.

3. Identify a set of current priority evidence needs of relevant policy stakeholders in Kenya that can be addressed through a primary data collection initiative, either as part of existing survey platforms and/or through a stand-alone survey on older people

1.2 Malawi

The review used information from searches in the University of Malawi library and on-line and relevant documents from relevant organizations in order to identify the policy context, available data and data gaps on older people in the country (Chintsanya 2016).

Legal framework

There are legal frameworks that make provision for the rights of older people, both as members of the wider society and as a specific group. The *Malawi Constitution* guarantees the right to development to all people, including older people. The Ministry of Gender, Children, Disability and Social Welfare (MGCDSW) has oversight on issues concerning older people.

The *National Policy for Older Persons* of October 2016, based on the UN Madrid Plan of Action on Ageing, seeks to ensure older people have access to affordable and appropriate health care, older people make full use of their skills and abilities, and discrimination against older people, especially widows, is prevented.

The priority areas are:

- promotion and protection of older people's rights

- promotion of access to health, water and sanitation services by older people

- promotion of food security

- provision of welfare support and income security

- provision of housing and shelter

- promotion of research, education and training on ageing.

Other policies/legislation/strategies relating to older people include the *Malawi Growth Development Strategy III* (MGDS III); the *National Social Support Policy* (NSSP, adopted in 2012), a policy that targets ultra-poor and vulnerable groups to enable them benefit from the country's economic development processes; the *Social Cash Transfer Programme*; the *Wills and Inheritance Act* and the *Public Works Programme* among others. A new mandatory *National Pension System* (NPS) was established in 2011 under the *National Pensions Act* (NPA) as mandated by the Pension Bill (2010) requiring both employee and employer contributions for individuals employed for at least 12 months that provide retirement and death benefits to members and beneficiaries. Under the Pension Bill employers are also required to purchase a life insurance policy for every employee with a payout value equivalent to the employee's annual pensionable income. Further, employers are required to pay severance allowance according to the Employment Act.

Data availability

Census data provide stock and socio-demographic information position of older people, including overall, age-based and sex-based death rates among older people (but not cause-specific mortality rates since such information is not collected using a census questionnaire). There are a number of nationally representative surveys which provide some information on

the demographic characteristics of older people including the Welfare Monitoring Surveys (WMS), Labour Force Survey (LFS) and Integrated Household Surveys (IHS). The IHS, a general population survey with size of 12,447 households and 53,885 individuals in the 2016-17 survey may be used for calculating poverty levels of households headed by older people. Although the proportion of older people is small, around 3,000 such individuals should be included in IHS. However, many surveys only cover younger age-groups and surveys and censuses conducted in Malawi that have included older people, usually present information on respondents aged 60 years and over as a single group, and such generalised findings do not provide sufficient details to inform policy makers on issues related to ageing.

There are other agencies that collect statistics including on older people, but for operational and administrative needs only but results are not broken down by age and do not provide useful information to inform policies and programmes for older people. For example, although the Ministry of Health collects cause-specific information about diseases from health clinics and district hospitals, summary statistics sent to headquarters are not disaggregated by age, again making it difficult to identify the number of older people suffering from a particular disease.

Limited consistency and continuity of questions is a further issue. For example, the 2008 Welfare and Monitoring Surveys (WMS), asked detailed questions on witchcraft experiences among older people, but the subsequent 2011 WMS survey contained only one question, making it difficult to monitor trends in the experiences of older people regarding accusation of witchcraft practice.

Conclusions and Recommendations

1. Current information on older people is insufficient to provide data that could be used to address the needs of older people in Malawi.

2. Addressing the gaps in data requires a collaborative effort involving various government and non-governmental organisations to conduct a survey to assess older people's needs, that could provide statistics to provide an evidence-base for establishing a legal and regulatory framework to provide an enabling environment for older people.

3. Malawi's *National Policy for Older Persons* should be informed and strengthened by evidence drawn from data and statistics of older people in the country.

4. There is a need to build capacity in departments that collect data on older people to enable them carry out analysis, dissemination and archiving of age-disaggregated data.

5. The key stakeholders should be involved as critical partners to establish a national forum with the mandate to coordinate activities relating to the condition of older people.

1.3 Uganda

Legal framework

The 1995 *Constitution of Uganda* stresses the rights, opportunities and access to services of all citizens irrespective of age and other social, cultural and demographic characteristics. The constitution provides explicitly for welfare of older people in Uganda. However, the question of the extent to which the constitution is adhered to remains unclear (Nzabona 2016).

The 2009 *National Policy for Older Persons of Uganda* (NPOP) was introduced to address issues relating to older people. The policy framework focuses on several priority areas that aim to improve the quality of life and the potential of older people such as promoting their economic empowerment by supporting entrepreneurship among older people and improving access to micro credit. Special attention is given to social inclusion and equity, including improving coverage of retirement benefits and grants schemes for chronically poor older people in the informal sector. The Policy calls for interventions aimed at improving the health of older people include re-orienting health workers, promoting special outreach health programmes and including drugs for treatment of later life illnesses on the essential drug list. Since the majority of older people live in poor accommodation, predominantly grass thatched, with mud walls and rammed earth floors, the policy calls for interventions to improve housing for older people. The policy calls for interventions that address the needs of older people and a case is made for educating planners and architects on the accessibility needs of older people, to encourage the provision of age-friendly buildings and infrastructure including pavements, public toilets and walkways.

The *National Council for Older Persons Act* (2012) set up a *National Council for Older Persons* that is the main national level channel through which needs, problems, concerns, potentials and abilities of older people can be communicated to government and its agencies and other service providers. The functions of *National Council for Older Persons*, which includes only people aged at least 60 years of age and at least one third women, include setting standards on the quality of services provided to older people and monitoring subsequent implementation; ensuring the conduct of free and fair elections to ensure that the rights and interests of older people; and provision for sub-councils for older people at every level of disaggregation including municipality, city division, town, sub-county, parish or ward and village.

Data availability

Uganda has conducted seven population censuses since between 1948 and 2014. The 2014 census published information on the population by single year of age, although the latest decennial census data becomes increasingly out of date and can hinder efficient planning.

Some information on the social, economic and health situation of older people can also be obtained from surveys, including Household Budget Surveys (1989 & 1990) and National Household Surveys (seven between 1993/94 and 2009/10) that include the whole adult population. However, there are no specific studies of older people and survey questions are limited to younger age groups in some cases.

There is a sound policy and regulatory framework in Uganda designed to ensure the rights of older people and for achieving MIPAA objectives on population ageing.

A substantial amount of data on older persons is available but not much of it has been analysed for policy purposes, and substantial gaps remain.

The *National Policy for Older Persons of Uganda* acknowledges that information on various aspects of older people's lives including community involvement, unpaid work, socio-cultural contributions of older people, diseases, especially HIV/AIDS, age-friendly facilities, ownership of dwellings, and on older persons' own views, reflections and experiences are lacking.

Recommendations

1. Relevant stakeholders should analyse existing census and survey data to increase understanding of the state of older persons and population ageing in the country.

2. The Government should consider running a national survey to provide a comprehensive picture of the state of older people in the country as part of addressing current gaps in research and documentation.

3. Modules targeting older persons should be routinely included in the regular national censuses and surveys.

V Ageing in Malawi – empirical evidence

1. Introduction

The MISA pilot survey was designed to test the feasibility of undertaking a survey on ageing in sub-Saharan Africa, to test the instruments developed and assess its suitability for use across the Region.

The survey is not nationally-representative but it is representative of the four regions chosen, nevertheless, they are likely to be indicative of the magnitude expected to be found in the country as a whole, and indicate the precision with which some of the key variables collected in the survey can be measured.

These preliminary analyses provide more up-to-date information about general socio-economic conditions of older people than the latest 2008 census. However, the survey also provides detailed information on topics such as income not collected in censuses. Such information is potentially available in general-purpose surveys such as the Malawi Integrated Household Survey, which has a larger sample of older people than this pilot survey and can provide both information on trends and relativities between older people and the remainder of the population. Such information would be important for determining priorities between competing groups and for monitoring progress. At present, there is only a single-round survey so the policy-relevant uses are limited but even such preliminary information is important to set the scene and to identify areas for particular attention.

In particular, a comprehensive source of information on a broad range of factors that are particularly relevant to the conditions and needs of older people has been almost entirely lacking. A comprehensive overview of the information collected in the MISA Malawi pilot survey is given in the report Aging in sub-Saharan Africa: Multiple Indicator Survey on Ageing (MISA) (Chintsanya 2018). However, a major benefit of surveys is to be able to bring different topics together, and this and therefore this section will give examples of the sorts of information that may be obtained from ageing surveys such as the MISA Malawi pilot survey. Two examples will be presented.

2. Witchcraft accusations

The first example is that of witchcraft. While this is globally and historically widespread, it has attracted considerable attention in contemporary Africa. There is a common view in both academic and popular publications that older people, especially older women, are particularly vulnerable to accusations of witchcraft (Machangu 2015; Mail and Guardian 2014; Mgbako and Glenn 2011; Schnoebelen 2009; The Guardian, 2008 2010 a,b). However, this issue remains under-investigated.

The MISA survey included a question on witchcraft accusation together with a range of other questions on elder abuse in the Elder Abuse Suspicion Index section, enabling witchcraft accusations to be compared with other aspects of abuse (Table 8).

Table 8. Questions on Elder Abuse, MISA Survey 2017

ELDER ABUSE SUSPICION INDEX © (EASI)			
Question	Proportions (percent) answering:		
	Yes	No	Did not answer
EA1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	18.6	80.7	0.7
EA2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?	5.0	94.7	0.3
EA3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	30.1	69.6	0.3
EA4. Has anyone tried to force you to sign papers or to use your money against your will?	4.7	95.1	0.2
EA5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	9.0	90.8	0.2
In the past 12 months, has anyone ever:			
EA6. Taken things away or threatened to take things away from you?	12.6	87.1	0.3
EA7. Abandoned or threatened to abandon you?	9.3	90.3	0.4
EA8. Harmed or threatened to harm someone or something close to you (kids, pets, etc.)?	10.3	89.5	0.2
EA9. Used non-verbal behaviour such as shaking a fist, pushing, poking, or slapping, to threaten or scare you?	10.9	89.0	0.2
EA10. Manipulated you by withholding affection and love?	18.6	80.6	0.8
EA11. Behaved in ways that frighten or intimidate you?	16.2	83.7	0.1
EA12. Confined you against your will?	5.1	94.3	0.6
EA13. Prevented you from contacting family, friends, or community resources?	7.4	92.3	0.3
EA14. Kept things from you or lied about things that you should know about?	14.1	85.5	0.3
EA15. Called you unkind names or put you down?	21.3	78.5	0.2
EA16. Accused you of being a witch or using witchcraft?	23.8	75.8	0.4
EA17. Felt entitled to use your money on themselves?	4.2	95.7	0.1

Notes: Estimates are values weighted using sample weights.
Table includes non-responders

Response rates were very high among the 2,238 respondents, over 99 percent in all cases.

Among the types of abuse included, the proportions saying that they had been accused of being a witch or using witchcraft was high, nearly one quarter and second only to the 30 percent of those who had been upset because someone talked in a way that made them feel shamed or threatened. The proportion accused of witchcraft was much higher than, for

example, those reporting financial abuse such as someone using or attempting to use the respondent's money, which was around five percent. The figure for witchcraft abuse indicates that around 200 thousand older people would be accused each year in Malawi as a whole if similar values held.

These data may be used to test the assumption that those accused of witchcraft are disproportionally old, female and living outside of a family unit. There is a small excess of women among those accused of witchcraft, 25 percent vs. 22 percent of men, indicating that the female stereotype may have be overemphasised (Table 9). However, the higher proportion of women than men in the older population means that about 50 percent more women than men would have been accused.

Table 9. Proportions accused of witchcraft by gender, MISA Survey 2017

Age group	Witchcraft accusation			
	Yes (Percent)	Sample size	No	Yes (Percent)
Male	22.3	189	77.7	711
Female	25.0	334	75.0	991
Total	23.9	523	76.1	1702

Notes: Estimates are values weighted using sample weights.
Table excludes non-responders (N=13 of total N= 2238)

However, the association with age is more substantial: while about 20% of those aged 60-69 had been accused, the figure was closer to 30% for those aged 70 or over (Table 10).

Table 10. Proportions accused of witchcraft by age, MISA Survey 2017

Age group	Witchcraft accusation			
	Yes (Percent)	Sample size	No (Percent)	Sample size
60-69	19.7	221	80.3	905
70-79	29.4	183	70.6	481
80 & over	26.8	119	73.2	316

Notes: Estimates are values weighted using sample weights.
Table excludes non-responders

Figure 4 shows the estimated proportions accused of witchcraft by age and gender. The proportions accused almost double between age 60 and 90 for both genders (although sample numbers are small at the upper age limit). While women appear to be at a disadvantage compared to men at every age, this is less than the differences between the "young old" and "old old".

Figure 4. Proportion accused of Witchcraft by age & gender, MISA Survey 2017
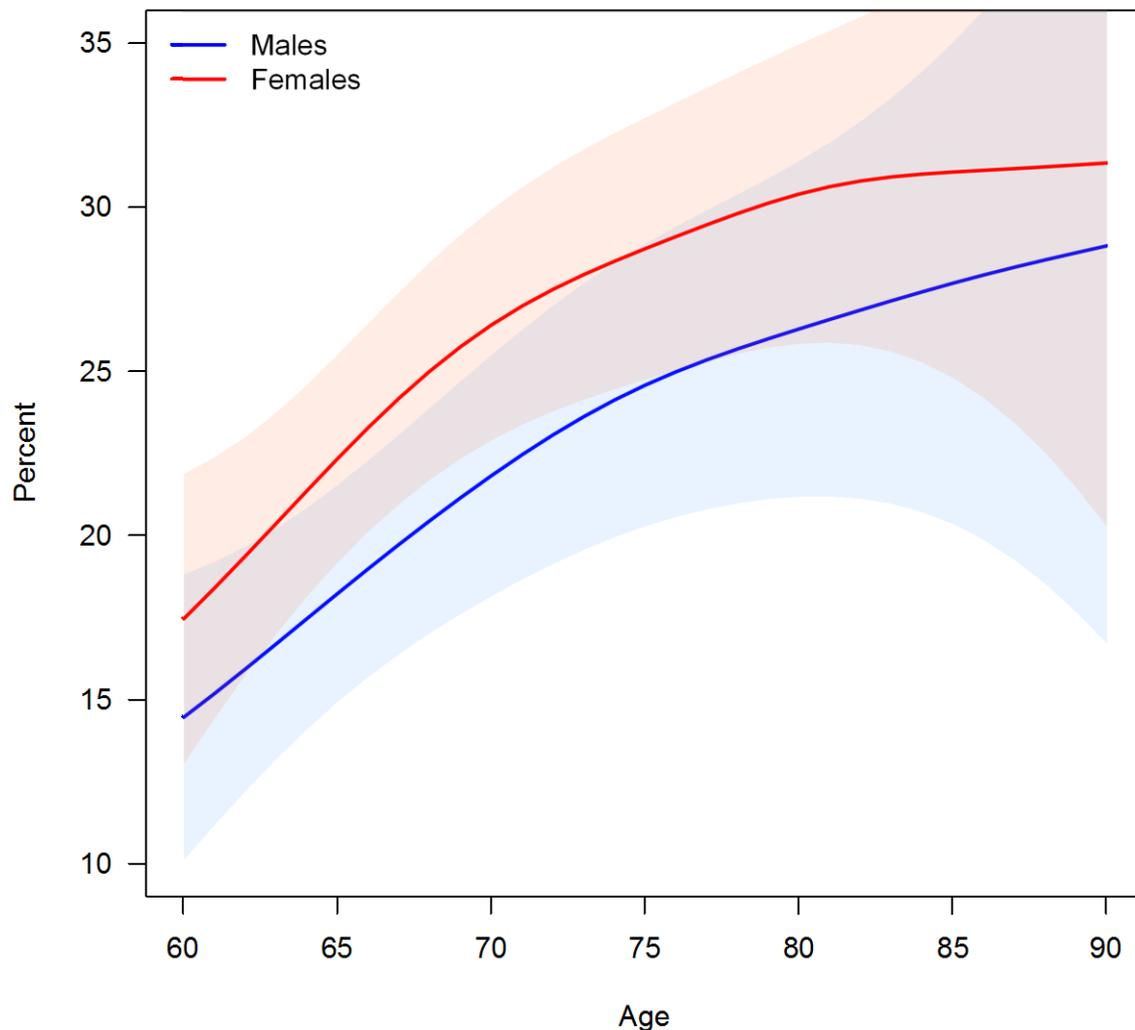
Source: 2017 MISA Malawi Pilot Survey. Shaded area gives +/- 2 s.e. values

Those who are partnered (married but also including a small proportion who are cohabiting) and the relatively small "other" group, comprising the never married, separated and divorced, have similar rates that are somewhat lower than the widowed group who stand out as having the highest values, although in part this is because they are older on average and more likely to be women, both of which place individuals at risk of being accused (Table 11).

43

Table 11. Proportions accused of witchcraft by partnership status, MISA Survey 2017

| Marital status | Witchcraft accusation | | | |
	Yes (Percent)	Sample size	No (Percent)	Sample size
Currently partnered	21.7	251	78.3	923
Widowed	27.6	229	72.4	632
Other	21.2	43	78.8	147

Notes: Estimates are values weighted using sample weights.
Table excludes non-responders

While there are some differences in the probability of being accused between the sub-groups above, these are not large compared with the strong association of being accused of witchcraft and suffering other forms of abuse (Table 12). Half of those who has not been accused had suffered some other form of abuse, but seven out of eight of those who had been accused of witchcraft had suffered at least one other form of abuse. Sixty percent of those who had been accused had suffered at least three additional forms of abuse, whereas only about 20 percent of those who has not been accused of witchcraft had suffered three or more other forms of abuse. Data such as these do not, of course, establish whether being accused of witchcraft is a consequence or a cause of suffering other types of abuse.

Table 12. Proportions accused of witchcraft by number of additional elder abuse types, MISA Survey 2017

| Number of other abuses | Witchcraft accusation | | | |
	Yes (Percent)	Sample size	No (Percent)	Sample size
0	12.5	66	50.3	873
1 or 2	27.5	143	30.7	485
3 or more	60.0	304	19.0	295

Notes: Estimates are values weighted using sample weights.
Table excludes non-responders

Much of the discussion about witchcraft, especially in the media, has inevitably concentrated on topics such as violence against those accused of witchcraft and the experience of children accused of being witches. Information on the general prevalence of abuse associated with witchcraft is lacking. The estimates presented here suggest that this is a widespread phenomenon and while there are some differences between sub-populations, these are relatively small in most cases and therefore any policy responses should address the needs of the older population as a whole and not be concentrated only on specific sub-groups. The association of witchcraft accusations with a range of other forms of abuse suggests that it be tackled as part of a wider programme to reduce abuse – that it is important in its own right, but also as part of a wider syndrome.

3. Self-rated health

The second example is to identify the variables that are associated with people's self-rated health, a widely-used measure for both policy and analysis, including international comparisons. The 5-fold classification of levels collected ("Excellent", "Very good", "Good", "Fair", "Poor") was dichotomised into "Good to Excellent" and "Fair or Poor".

Table 13 shows the proportions in these two groups by a series of socio-demographic, and physical and mental health variables. Figure 5 shows estimated trends by age for men and women separately. There is an increase in reported poor health by age, a factor that is important since the numbers of older people in sub-Saharan Africa will increase rapidly in the next few decades. However, substantial proportions even of the oldest group shown say they have good health. As usually found, women generally report worse health than men do, and this is not simply because they live longer and are older on average. Women report worse health at every age, although differentials tend to decline with age, so that by the oldest ages shown, around age 90, values are similar, with about 70 per cent reporting that their health was less than good.

Other socio-demographic differentials also exist: those who are widowed report worse health than people in other partnership statuses, and those with more education report better health. In both cases, this is partially accounted for by the fact that widows tend to be older than average, and the better-educated younger than average. Those with poorer economic status, as indicated by going hungry or having insufficient food were also more likely to report worse health.

These results reinforce conclusions that health conditions remain socio-demographically patterned to the highest ages, with the less advantaged reporting poorer health than the more socially advantaged.

Table 13. Self-reported health status by selected Socio-demographic variables, MISA Survey 2017

Variable	Self-reported health status (percent)	
	Good to Excellent	Fair or Poor
Sex of respondent		
Male	63.3	36.7
Female	54.2	45.8
Current marital status		
Currently partnered	63.2	36.8
Widowed	50.3	49.7
Other	59.2	40.8
Age of respondent		
60-69	67.5	32.5
70-79	52.3	47.7
80 & over	38.9	61.1
Highest educational level		
Never attended school	54.7	45.3
Primary	59.3	40.7
Secondary or above	85.0	15.0
Ever gone hungry or eaten less than thought appropriate in past year		
Yes	55.8	44.2
No	64.7	35.3

Notes: Estimates are values weighted using sample weights.

Table excludes non-responders

The main determinant of people's reported health status is usually assumed to be their physical heath. As shown in Table 14, those who have difficulties with undertaking activities of daily living (ADLs), such as getting dressed by themselves or going to and using toilet are much more likely to report themselves as not being in good health. The more of these activities of daily living a person has difficulty with, the worse their reported health, so that while two thirds of those who have no difficulties are in good or excellent health, this figure is under 10 percent for those with six ADL conditions.

However, people's overall health status is affected by mental state as well as physical conditions. Those who sleep badly report worse health, and over twice as many of those who feel lonely often report health as not good as those who never feel lonely.

Table 14. Self-reported health status by selected physical and mental health variables, MISA Survey 2017

| Variable	Self-reported health status (percent)	
	Good to Excellent	Fair or Poor
Physical health		
Number of ADL conditions		
0	65.3	34.7
1	44.0	56.0
2	34.2	65.8
3	26.6	73.4
4	14.7	85.3
5	12.2	87.8
6	8.1	91.9
ADL: Difficulties with getting dressed		
Yes	15.2	84.8
No	59.3	40.7
ADL: Difficulties with getting to and using toilet		
Yes	20.3	79.7
No	59.4	40.6
Mental health		
Restless sleep in past week		
Rarely (less than 1 day)	62.7	37.3
Some or little of the time (1 to 2 days)	58.6	41.4
Occasionally or moderate amount of time (3 to 4 days)	50.8	49.2
All of the time (5 to 7 days)	44.8	55.2
How often feels lonely		
Never	67.4	32.6
Rarely	54.1	45.9
Sometimes	54.3	45.7
Often	33.5	66.5
Number of elder abuses suffered		
0	65.6	34.4
1 or 2	55.7	44.3
3 or more	49.1	50.9

Notes: Estimates are values weighted using sample weights.

Table excludes non-responders

Linking in with the discussion above, the larger the number of types of abuse suffered, the more likely an individual is to report her or himself as in poorer health.

In order for efficient use of resources to address the needs of older people, comparable high-quality information is required across a number of domains. While such information is a necessary requirement for evidence-based policy development (and for monitoring if continuing comparable data are available), it is also important to identify relationships within and between these domains. The challenges of providing care for some of the most rapidly increasing rates of numbers of older people in the world, in the context of a low-income country with large-scale rural to urban migration among younger generations and a distorted population age structure due to HIV/AIDS are substantial. On the other hand, successful initiatives in one area such as elder abuse may have benefits for the general health and well-being of the older population.

Figure 5. Self-reported health status by age & gender, MISA Survey 2017
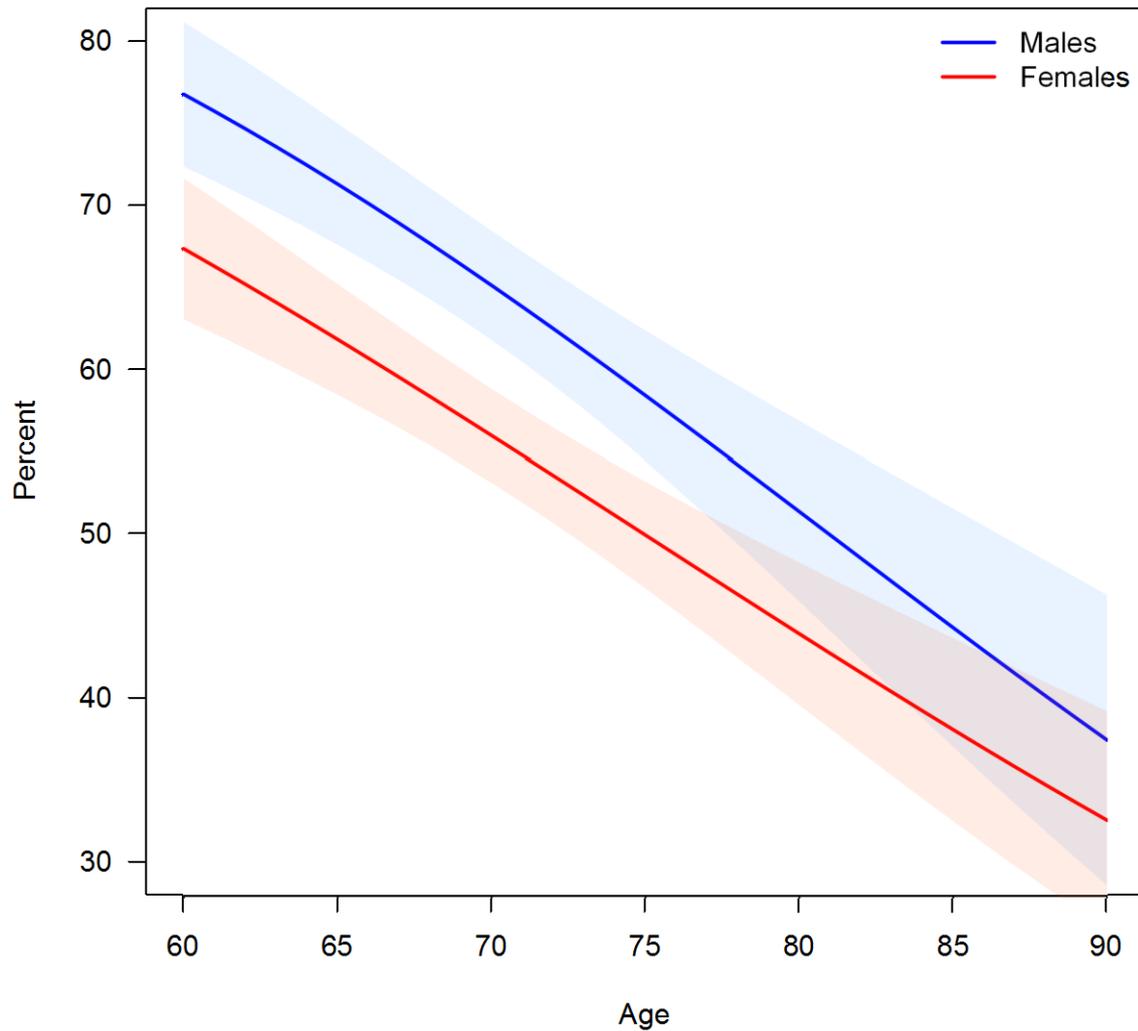
Source: 2017 MISA Malawi Pilot Survey. Shaded area gives +/- 2 s.e. values

VI Conclusion and Summary

Timely and accurate data are at the heart of effective policy identification, formulation, and implementation. The need for better information has been recognised frameworks from the early 2000s, both those centred on older people such as Madrid International Plan of Action on Ageing (MIPAA) and those that principally address the needs of other groups, such as the Millennium Goals (MDG). The more recent and comprehensive Sustainable Development Goals (SDG) framework emphasises that development needs to be inclusive, not only by ensuring everyone is included, but also that that relatively disadvantaged groups need to be given special attention if they are not to be left behind. The importance of human rights for all and the need for wider participation in decision-making by national governments, civil society and local communities have become more prominent. These developments were particularly important for the position of older people in society, not least because they were a rapidly-increasing group with implications for the simultaneously emerging principle, the need to incorporate sustainability as a key component of development initiatives. Globally, the largest growth of older people is likely to be found in sub-Saharan Africa, and especially in Eastern Africa (Tables 1 and 2), but it is in this Region that some of the most substantial gaps in data to underpin evidence-based policy have been identified.

Against this background, the MISA project was developed by the Division for Inclusive Social Development of the UN Department of Economic Affairs in conjunction with national governments of African countries, civil society, regional organisations and other stakeholders. The project commissioned reviews from national experts on ageing in Uganda, Kenya and Malawi, which covered the status of national policies on ageing, availability or otherwise of age-related data and their use in informing policies on ageing. While all three countries have comprehensive national policies on older persons, all reviews concluded that data on older people were indeed lacking, especially when compared with data on groups such as children aged under five years and women of reproductive age, available from sources such as Demographic and Health surveys (DHS). The reviews note that while there is possibility to exploit existing data further, evidence needed for domestic policy making on ageing, to underpin MIPAA, SDG and national policy frameworks, and for capacity building on ageing at the national level, would still be lacking. National workshops in each country were organised to consider the findings of the reviews and endorsed the conclusion that a national survey on ageing would be the appropriate method to provide the information needed in a number of different policy and planning areas.

In collaboration with national and regional policy makers, statisticians and experts dealing with issues related to older persons in Africa, the decision was to develop a specialised ageing survey instrument, the Multiple Indicator Survey on Ageing (MISA), that could meet a substantial fraction of the identified national data gaps in data on the situation of older persons. The survey should include multiple domains, on people's socio-demographic living conditions, economic situation including poverty, intergenerational relations, provision and receipt of care, well-being and physical and mental health. It would also include interactions with – and experiences of – government programmes such as health services, pensions and welfare. It should be able to be implemented across all African countries to provide a basis for the development of evidence-based policies and programmes in the region, provide

information for MIPAA and SDG goals, targets and indicators, as well as improved information on the conditions of older people for other stakeholders

Given the lack of prior experience of comprehensive ageing surveys in sub-Saharan Africa, it was necessary to assess the feasibility of undertaking such a survey; to test both the survey content; to identify issues that would be need to taken into account before such an instrument could be recommended for wider use; to test new capabilities such as CAPI; to build up capacity in NSOs; and to involve wider interest groups such as governments and NGOs to ensure that the needs and interests of these groups are included in further developments.

The pilot survey was successfully undertaken in 2017 in four rural areas of Malawi, with a sample of just over 2,000 respondents. Some preliminary results are available and examples are presented earlier. The investment in preparing survey materials (especially in programming and testing CAPI data collection, organisation and data capture), identification of issues especially relevant to ageing surveys in the region (such as treatment of different languages, context-specification of context-specific questions) etc. means that the survey instrument is available with minor modification for use in other sub-Saharan countries.

References

Aboderin, Isabella (2007) Development and Ageing Policy in Sub-Saharan Africa: Approaches for Research and Advocacy. *Global Ageing: Issues & Action* 2007 4:3. Available at https://www.ifa-fiv.org/wp-content/uploads/global-ageing/4.3/4.3.full.pdf

African Union (2012) *Africa's Common Position on Human Rights of Older Persons in Africa. 3rd Session of The AU Conference of Ministers of Social Development (Camsd3) Addis Ababa, Ethiopia 26-30 November 2012, CAMSD/EXP/11(III)*. Available at https://social.un.org/ageing-working-group/documents/africa-older-persons2012.pdf

African Union (2014ab) *Protocol to The African Charter on Human and Peoples' Rights on The Rights of Older Persons in Africa. Adopted by The Twenty Sixth Ordinary Session of The Assembly, Held in Addis Ababa, Ethiopia 31 January 2016*. Available At Https://Au.Int/Sites/Default/Files/Pages/32900-File-Protocol_On_The_Rights_Of_Older_Persons_E.Pdf

African Union (2014ba) *Common Africa Position (CAP) on the Post 2015 Development Agenda. African Union March 2014*. Available at https://au.int/sites/default/files/documents/32848-doc-common_african_position.pdf

Bennett, and Asghar Zaidi (2018) Editorial: Three challenges in realising the MIPAA. International Journal on Ageing in Developing Countries 2(2):76-81. Available at https://www.inia.org.mt/journal/issue

Faye, Ousmane and Gilena Andrade (2018) The Madrid International Plan of Action on Ageing: Where do we stand fifteen years later. Experience and lessons from selected countries in West and Central Africa. *International Journal on Ageing in Developing Countries* 2(2):164-183. Available at https://www.inia.org.mt/journal/issue

GBD 2016 SDG Collaborators (2017) Measuring progress and projecting attainment on the basis of past trends of the health-related Sustainable Development Goals in 188 countries: an analysis from the Global Burden of Disease Study 2016. *The Lancet* Volume 390, ISSUE 10100, P1423-1459, September 16, 2017. Available at https://www.thelancet.com/journals/lancet/issue/vol390no10100/PIIS0140-6736(17)X0041-X

German, Tony and Judith Randel (2017) *Delivering Results to Leave No One Behind: A discussion paper for the Results Community OECD workshop What Results – Who Counts? Effective development co-operation for the 2030 Agenda. Prepared by Tony German and Judith Randel Strategic Advisers to Development Initiatives, 19 September 2017*. Available at https://www.oecd.org/dac/results-development/docs/leave-no-one-behind-results-workshop-oct-2017.pdf

Global Health Action (2010) *Volume 3, 2010 - Issue s2: Special Issue: Growing older in Africa and Asia: Multicentre study on ageing, health and well-being. An INDEPTH WHO-SAGE*

collaboration (Supplement 2). Available at
https://www.tandfonline.com/doi/abs/10.3402/gha.v3i0.5302@zgha20.2010.3.issue-s2

He, Wan, Mark N. Muenchrath, and Paul Kowal, U.S. Census Bureau (2012) *Shades of Gray: A Cross-Country Study of Health and Well-Being of the Older Populations in SAGE Countries, 2007–2010*, U.S. Government Printing Office, Washington, DC, 2012. Available at
https://www.census.gov/library/publications/2012/demo/p95-12-01.html

HelpAge International (2002) *AU Policy Framework and Plan of Action on Ageing (AU Plan)*. Available at
http://www.un.org/esa/socdev/ageing/documents/implementation/AUFrameworkBook.pdf

High-level Group for Partnership, Coordination and Capacity-Building for statistics for the 2030 Agenda for Sustainable Development (2016) *Cape Town Global Action Plan for Sustainable Development Data Prepared by the High-level Group for Partnership, Coordination and Capacity-Building for statistics for the 2030 Agenda for Sustainable Development (HLG-PCCB). Cape Town, South Africa, 15 January 2017*. Available at
https://undataforum.org/WorldDataForum/wp-content/uploads/2017/01/Cape-Town-Action-Plan-For-Data-Jan2017.pdf

Human Development Network the World Bank; Institute for Health Metrics and Evaluation Univ. (2013) *The global burden of disease: generating evidence, guiding policy - sub-Saharan Africa regional edition (English)*. Human Development Network. Washington DC: World Bank Group. Available at
http://documents.worldbank.org/curated/en/831161468191672519/The-global-burden-of-disease-generating-evidence-guiding-policy-sub-Saharan-Africa-regional-edition

Institute for Health Metrics and Evaluation, Human Development Network, The World Bank (2013) *The Global Burden of Disease: Generating Evidence, Guiding Policy — Sub-Saharan Africa Regional Edition. Seattle, WA: IHME, 2013*. Available at
http://www.healthdata.org/sites/default/files/files/data_for_download/2013/WorldBank_SubSaharanAfrica/IHME_GBD_WorldBank_SubSaharanAfrica_FullReport.pdf

Inter-agency and Expert Group on Sustainable Development Goal Indicators (2016) *Report of the Inter-agency and Expert Group on Sustainable Development Goal Indicators. United Nations Economic and Social Council E/CN.3/2017/2**. Available at
https://unstats.un.org/unsd/statcom/48th-session/documents/2017-2-IAEG-SDGs-E.pdf

Kohler, Hans-Peter , Susan C Watkins, Jere R Behrman, Philip Anglewicz, Iliana Kohler, Rebecca L Thornton, James Mkandawire, Hastings Honde, Augustine Hawara, Ben Chilima, Chiwoza Bandawe and Victor Mwapasa (2015) Cohort Profile: The Malawi Longitudinal Study of Families and Health (MLSFH). *International Journal of Epidemiology* 44(2): 394–404. doi: 10.1093/ije/dyu049. Available at
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4469793/

Kowal P, Chatterji S, Naidoo N, Biritwum R, Wu Fan, Lopez Ridaura R, Maximova T, Arokiasamy P, Phaswana-Mafuya N, Peltzer K, Williams S, Snodgrass JJ, Minicuci N, D'Este C, Boerma JT and the SAGE Collaborators. (2012) Data Resource Profile: The WHO Study on global AGEing and adult health (SAGE). *International Journal of Epidemiology* 41(6):1639-49.

doi: 10.1093/ije/dys210. Available at
https://watermark.silverchair.com/dys210.pdf?token=AQECAHi208BE49Ooan9kkhW_Ercy7
Dm3ZL_9Cf3qfKAc485ysgAAAZ4wggGaBgkqhkiG9w0BBwagggGLMIIBhwIBADCCAYAGCSqGSI
b3DQEHATAeBglghkgBZQMEAS4wEQQMVXu-
d7VXbiiEWogwAgEQgIIBURlT9XkidVEXmCe5QkxpKs5d15iSzI5MlBZRD8YELQkmlhHQ0qjoC77
FOZkOyekI4UjZOnXZ1N8HoKoCtMzNSS58JTNMtW_iY3SpsKnTDEncuyssBMMFEkdT-Og-
Vk2gLc-
tYCEtuQVJeYZ62OMoks86tLls_CrkOmhwj5WGDZM8JnwPNdagVCGBpNuA6iSFFpp6hnfKCZgF
VBwsGwgCvtspvUEzLXUWjGKFerU_DqRboj4rwHIBOhx1y9aFwGgZiu9QMY9ng4UzBg1pOr0F
Sboh_qnDatML6wzCjHQ9RT7VFfCf3qe3KsXTkoIi6q5eu9EWMALA0vzxuwjAJPAv1hWaaV9eG
XnreMLySFH2EkoPRmlXbiSss95y5HXmz2nADhZhqQ1M6cWmpVRfzAfH7gpzF6PukVGJHVb3J
EjT29Ro8bh7gJye_zLvEM1kBDYcQtI

Machangu, Hamisi Mathias (2015) Vulnerability of Elderly Women to Witchcraft Accusations among the Fipa of Sumbawanga, 1961-2010. *Journal of International Women's Studies* 16(2), 274-284. Available at: http://vc.bridgew.edu/jiws/vol16/iss2/17

Mail and Guardian (2014) *Seven accused of witchcraft burned alive in Tanzania*. Available at https://mg.co.za/article/2014-10-10-seven-accused-of-witchcraft-burned-alive-in-tanzania

Martin, Claudia, Diego Rodríguez-Pinzón and Bethany Brown (2015) The United Nations and Older Persons: A Global Approach with Multiple Dimensions. Pp. 9-124 in *Human Rights of Older People: Universal and Regional Legal Perspectives*. Dordrecht, Netherlands: Springer.

Mgbako, Chi and Glenn, Katherine (2011) Witchcraft Accusations and Human Rights: Case Studies from Malawi. George Washington International Law Review 43(3): 389-417. Available at http://docs.law.gwu.edu/stdg/gwilr/PDFs/43-3/1-%20Mcgako%20Glann.pdf

Nzabona, Adel (2017) *The Third Review and Appraisal Cycle of The Implementation of The Madrid International Plan of Action on Ageing in Africa for the Period 2012 – 2017. Final Report Submitted to United Nations Economic Commission for Africa - July, 2017*. Available at https://www.un.org/development/desa/ageing/wp-content/uploads/sites/24/2018/03/eca-report-mipaa2017.pdf

Padmadas, Sabu S., Richmond Tiemoko, Nyovani J. Madise Fiifi Amoako Johnson, Saseendran Pallikadavath and Asghar Zaidi (2018) Tracking progress towards the Madrid International Plan of Action on Ageing (MIPAA) in East and Southern Africa: milestones and challenges. *International Journal on Ageing in Developing Countries* 2(2):184-206. Available at https://www.inia.org.mt/journal/issue

Schnoebelen, Jill (2009) *New Issues in Refugee Research. Research Paper No. 169. Witchcraft allegations, refugee protection and human rights: a review of the evidence*. Available at http://www.unhcr.org/4981ca712.pdf

Sustainable Development Goals (2018) SGD Indicators Metadata. Available at https://unstats.un.org/sdgs/metadata/

The Guardian (2008) *No country for old women*. Available at https://www.theguardian.com/journalismcompetition/old-women

The Guardian (2010a) *Witchcraft used as excuse for violence against older women in Tanzania*. Available at https://www.theguardian.com/global-development/2012/oct/01/witchcraft-violence-older-women-tanzania

The Guardian (2010b) *Dozens jailed for witchcraft in Malawi*. Available at https://www.theguardian.com/world/2010/oct/14/dozens-jailed-witchcraft-malawi-women

Titchfield Group Secretariat (2018) *Report of the 1st Technical Meeting of the Titchfield City Group on Ageing and Age-disaggregated data. Chichester, UK, - 26-27 June 2018*. Available at https://gss.civilservice.gov.uk/wp-content/uploads/2018/07/Report-of-the-1st-Technical-

United Nations (2002) *United Nations Report of the Second World Assembly on Ageing Madrid, 8-12 April 2002. A/CONF.197/9*. Available at https://www.unece.org/fileadmin/DAM/pau/MIPAA.pdf

United Nations Economic and Social Council (2012) *Second review and appraisal of the Madrid International Plan of Action on Ageing, 2002. United Nations Economic and Social Council E/CN.5/2013/6 28 November 2012*. Available at http://undocs.org/E/CN.5/2013/6

United Nations Economic and Social Council (2017) *Report of the United Kingdom of Great Britain and Northern Ireland on ageing-related statistics and age-disaggregated data. United Nations Economic and Social Council E/CN.3/2018/19*. Available at https://www.un.org/development/desa/ageing/wp-content/uploads/sites/24/2018/03/Report-of-the-United-Kingdom-of-Great-Britain-and-Northern-Ireland-on-ageing-related-statistics-and-age-disaggregated-data.pdf

United Nations Economic Commission for Africa (2011) *African Centre for Gender and Social Development Report on Ageing - Africa Region*. Available at http://www.un.org/esa/socdev/ageing/documents/review_and_appraisal/ecareport.pdf

United Nations Economic Commission for Africa, African Union Commission (2013) *African Regional Conference on Population and Development Addis Ababa, Ethiopia 3 and 4 October 2013. United Nations Economic Commission for Africa ECA/ICPD/MIN/2013/4*. Available at http://www.un.org/en/development/desa/population/publications/pdf/policy/Compendium/Volume%20II/j_Chapter%205.pdf

United Nations General Assembly (2015a) *Resolution adopted by the General Assembly on 25 September 2015. 70/1. Transforming our world: the 2030 Agenda for Sustainable Development. United Nations A/RES/70/1*. Available at http://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_70_1_E.pdf

United Nations General Assembly (2015b) *Follow-up to the Second World Assembly on Ageing A/RES/69/146*. Available at http://undocs.org/A/RES/69/146

United Nations, Department of Economic and Social Affairs, Division for Social Policy and Development (2015) *Global Ageing and the data revolution – The way forward in the post-2015 environment. New York, 7 - 9 July 2015. Report of the Expert Group Meeting*. Available at http://www.un.org/esa/socdev/ageing/documents/egm/2015.pdf

United Nations, Department of Economic and Social Affairs, Population Division (2015). *Directory of Research on Ageing in Africa: 2004-2015 (ST/ESA/SER.A/391)*. Available at http://www.un.org/en/development/desa/population/publications/pdf/ageing/Dir_Research_Ageing_Africa_%202004-2015.pdf

World Health Organization (2018) *World health statistics 2018: monitoring health for the SDGs, sustainable development goals*. Geneva: World Health Organization. Available at http://apps.who.int/iris/bitstream/handle/10665/272596/9789241565585-eng.pdf?ua=1

Zaidi, Asghar (2018) *Implementing the Madrid Plan of Action on Ageing: What have we learned? And, where do we go from here? 29 January 2018 By Asghar Zaidi, Professor of International Social Policy, University of Southampton*. Available at http://hdr.undp.org/en/content/implementing-madrid-plan-action-ageing-what-have-we-learned-and-where-do-we-go-here

Additional documents

Aboderin, Isabella and Hilda Owii (2016). Data collection methodology and tools for supporting the formulation of evidence-based policies in response to the challenge of population ageing in Kenya. African Population and Health Research Center (APHRC) Nairobi.

Beckles, David (2017a) Survey on Aging in sub-Saharan Africa. Ageing Survey 2017 CAPI Documentation

Beckles, David (2017b) Survey on Aging in sub-Saharan Africa. CAPI Users' Manual

Chintsanya, Jesman (2016) Methodology and Tools for Supporting the Formulation of Evidence-based Policies in Response to the Challenge of Population Ageing in Malawi

Chintsanya, Jesman (2018). Aging in sub-Saharan Africa: Multiple Indicator Survey on Ageing (MISA) in Malawi.

Megill, David J. (2016) Study on Aging in Sub-Saharan Africa: Sampling Manual Final Version Prepared After the Workshop in Malawi, July 18-21 2016

National Statistical Office (2017a) Survey on Aging in sub-Saharan Africa. Household Questionnaire

National Statistical Office (2017b) Survey on Aging in sub-Saharan Africa. Individual Questionnaire

National Statistical Office (2017c) Multi-Indicator Survey on Aging (MISA) Population in Malawi. Report on Training of Field Workers and Data Collection: August 2017

National Statistical Office (2017c) Study on Aging in Sub-Saharan Africa: Interviewer's Manual

National Statistical Office (2017e) Study on Aging in Sub-Saharan Africa. Documentation of Lessons Learnt

Nzabona, Abel (2016) Data Assessment Study of Population Ageing In Uganda. Assessment Report Submitted To The United Nations Department For Economic And Social Affairs.

United Nations Division for Social Policy and Development (2015) Project Document. 9th tranche of development account.