

Older people's health in sub-Saharan Africa



Awareness is growing that the world's population is rapidly ageing. Although much of the related policy debate is about the implications for high-income countries, attention is broadening to less developed settings.¹ Middle-income country populations, in particular, are generally ageing at a much faster rate than was the case for today's high-income countries, and the health of their older populations could be substantially worse.² However, little consideration has been given to issues of old age in sub-Saharan Africa, which remains the world's poorest and youngest region.³ Development and health agendas for that region, including those being discussed in relation to targets to succeed the Millennium Development Goals,⁴ understandably centre on how to increase the capacity of and opportunities for the region's young people. Yet strong arguments exist for why the health of older people (aged 60 years and older) should not be overlooked. Not least is the substantial size of these populations—already double the number of older adults in northern Europe—which is expected to grow faster than anywhere else, increasing from 46 million in 2015 to 157 million by 2050.⁵ Furthermore, life expectancy at age 60 years in sub-Saharan Africa is 16 years for women and 14 years for men, suggesting that, for those who survive early life, a long old age is already a reality.²

However, perhaps the most important reason to consider the older population in present plans for increased human and economic wellbeing in sub-Saharan Africa is that, contrary to common assumptions, older Africans play roles that are crucial to achievement of this wellbeing. Within families, older people are often carers or guardians of younger kin. They directly shape younger generations' access to health, education, and other capabilities, and thus their future human capital. The extent of older people's caregiving is increasingly recognised in the context of HIV/AIDS—more than 60% of orphaned children in Namibia and Zimbabwe, for example, are looked after by their grandmothers.⁵ This care function is also important in everyday settings of poverty or labour-related parental absence—in the urban slums of Nairobi, Kenya, for instance, more than 30% of older women and 20% of older men (aged 60 years or older) care for one or more non-biological child (African Population

and Health Research Center, Centre for Research on Ageing, University of Southampton, unpublished).

Beyond the family, older African people have key economic roles. In most sub-Saharan African countries, older people largely remain in the labour force,⁶ particularly in smallholder agriculture, which encompasses the bulk of food production and must be revitalised if nutrition security and sufficient job opportunities are to be ensured for younger generations. As a result of selective rural-urban outmigration, incapacity, or uninterest of younger adults in farming, older people constitute a substantial share of smallholders. In Kenya, for example, the average age of a farmer is estimated to be 60 years.⁷ Similarly, preliminary analyses of national survey data from Malawi and Kenya show close to 20% of decision makers on smallholder land use in both countries to be aged 60 years and older (African Population and Health Research Center, unpublished). The extent to which older African people can execute their social and economic functions effectively depends heavily on their physical and mental capacity.^{8,9} Conversely, if their health deteriorates to a point at which they themselves need care, the responsibility is likely to fall on female younger kin, whose own health, and employment and education opportunities, can be affected.¹⁰ Impaired health in older age in sub-Saharan Africa thus affects not only older individuals, but families, communities, and prospects for development more broadly.

Yet older African people face a large morbidity and disability burden, particularly from chronic disease. Our preliminary analysis of 2010 Global Burden of Disease data identifies cardiovascular and circulatory disease, nutritional deficiencies, cirrhosis of the liver, and diabetes as major causes of disability-adjusted life years in sub-Saharan Africa's older population. Moreover, representative surveys of older adults' health show high rates of hypertension,¹¹ musculoskeletal disease,¹² visual impairment,¹³ functional limitations,⁹ and depression.¹⁴ Additionally, infectious diseases continue to affect older Africans, underscored by a substantial prevalence of HIV infection and its exacerbating effect on several non-communicable diseases.¹⁵ At the same time, evidence of heterogeneity in health and function within older populations and the importance



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For the 2010 Global Burden of Disease data see <http://ghdx.healthdata.org>

For the WHO Study on Adult Health and Ageing see <http://www.who.int/healthinfo/sage/en>

of modifiable factors in shaping it underscore the importance of health-promoting interventions to enable successful ageing in the region.¹⁶ Yet a large proportion of, or even most, older Africans lack the requisite care—results of the WHO Study on Adult Health and Ageing¹¹ in Ghana, for example, showed 96% of those with hypertension to have no adequate treatment for the disorder.

For the 10/66 Dementia Research Group see <http://www.alz.co.uk/1066>

A crucial but often omitted perspective is a comparison with younger age groups. Illness and disability rates of older people substantially outstrip those of younger adults.^{17,18} This contrasts starkly with findings from high-income countries that show older age to be an increasingly unreliable predictor of greater morbidity or impaired function.¹⁹ Yet, despite having worse health than younger age groups, older people in sub-Saharan Africa have been observed to use health services substantially less than younger people do.^{17,18} This disparity points to possible age-based inequalities in access to health care that need attention in addition to the widely considered axes of inequities in health (ie, economic status, sex, ethnic origin, or rural or urban residence).

Barriers to health care faced by older African people include absence of an escort or high costs of transport to health providers, and private sector fees for medicines or treatment.^{18,20} Older patients use commercial providers because of the unavailability, perceived poor quality, or age insensitivity of services in government facilities.¹⁸ These providers, in a bid to achieve the health Millennium Development Goals, typically remain focused on services for infectious diseases, children, and reproductive age adults.^{18,20} The supply-side difficulties are exacerbated by important demand-side factors. Such obstacles include resource allocation norms within poor families, which can prioritise the needs of the young at the expense of the old, and older adults' often little appreciation of the value of, or need for, management of asymptomatic chronic disease.^{18,20}

For the Global Commission on Ageing in Developing Countries see <http://www.partners-popdev.org/ageing>

In view of the direct importance of older African people's physical and mental health for the achievement of core development goals, their burden of ill health and likely inequitable access to necessary care provide compelling economic and social grounds for action. These needs should be incorporated into emergent frameworks for attainment of universal health coverage in sub-Saharan Africa in the form of a commitment to maintenance of health and function across the entire

life course. Essential action on non-communicable diseases, in particular, will need to extend beyond a focus on prevention of early mortality from key diseases to include provision of chronic care for key non-fatal disorders that affect the function of older populations. However, such a commitment will need to be accompanied by concerted evidence generation if it is to be converted into practice. Such research will need to: better define health needs and care gaps for older Africans; identify feasible and effective models for adaptation of health systems in sub-Saharan Africa; and persuade decision makers to invest in these models.

Longitudinal studies such as the WHO Study on Adult Health and Ageing or 10/66 dementia research are starting to improve understanding of priority intervention needs in a small number of sub-Saharan African countries. However, further social and epidemiological investigations are needed in these and other national contexts. These studies will need to be complemented by assessments of effectiveness of the few existing health financing, human resource, essential medicine or technology, and service delivery approaches targeted at older people in sub-Saharan Africa, and by design and testing of new models.

Lastly, national evidence on possible age-based health inequities and economic effects of ill health in the older population is needed to help garner political will for action. Such information could be generated—as part of the called-for data revolution for the post-Millennium Development Goals agenda—through systematic expansions to sampling, data collection, or analysis protocols of routine surveys, such as Demographic and Health Surveys, regularly undertaken by countries in sub-Saharan Africa. The fact that developing-country governments have launched a joint Commission on Ageing in Developing Countries bodes well. This Commission should help promote the necessary research and operationalisation of emerging findings by policy makers and external drivers of health-system development in sub-Saharan Africa.

**Isabella A G Aboderin, John R Beard*
African Population and Health Research Center, PO Box 10787 – 00100 Nairobi, Kenya, and Centre for Research on Ageing, University of Southampton, Southampton, UK (IAGA); and Department of Ageing and Life Course, World Health Organization, Geneva, Switzerland (JRB)
iaboderin@aphrc.org

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