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REVIEW

Public and health policy for the aged in Africa to the South of Saara

Política pública e de saúde para o idoso na África ao Sul do Saara
Política pública y de salud para el anciano en África del Sur del Sahara.

Marta Regina Soares de Assunção[I]
ORCID: 0000-0002-7537-4109

Susana Isabel Mendes Pinto[I]
ORCID: 0000-0003-3778-9335

Helena Maria Guerreiro José[I]
ORCID: 0000-0002-2626-8561

[I] *Universidade Católica Portuguesa. Instituto de Ciências da Saúde. Porto, Portugal.*

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Corresponding author:
Marta Regina Soares de Assunção
E-mail: martaassuncao@icloud.com

EDITOR IN CHIEF: Antonio José de Almeida Filho
ASSOCIATE EDITOR: Dalvani Marques

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ABSTRACT

Objective: to know the social and health responses for the elderly in sub-Saharan Africa. **Methods**: An integrative literature review. **Results:** There is a lack of specialized health care to meet the real needs of the elderly, and the shortage of health professionals does not contribute favorably to this situation. There is a small number of facilities for the elderly and most of them are inadequate. Although there are models of care as well as social and health support policies for the elderly, there are still inequities/inequalities in access to these policies, especially for the most disadvantaged populations. **Conclusion:** Social and health policies for the elderly in Sub-Saharan Africa are below standard and appropriate economic, political and social intervention is required.
Descriptors: Aged; Health Services for the Aged; Public Policy; Old Age Assistance; Africa South of the Sahara

RESUMO

Objetivo: Conhecer as respostas sociais e de saúde para os idosos na África Subsaariana. **Métodos**: Revisão integrativa da literatura. **Resultados:** Há falta de cuidados de saúde especializados e direcionados às reais necessidades dos idosos, sendo que a escassez de profissionais de saúde não contribui favoravelmente para essa situação. Verifica-se baixa oferta de instalações destinadas aos idosos, e a maioria delas são básicas. Apesar de existirem modelos de cuidados para os idosos e políticas de apoio social e de saúde, ainda há iniquidades/desigualdades no acesso a elas, sobretudo para as populações mais desfavorecidas. **Conclusão:** As políticas sociais e de saúde para os idosos na África Subsaariana estão aquém das necessidades, sendo preciso garantir uma intervenção econômica, política e social adequada.
Descritores: Idoso; Serviços de Saúde para Idosos; Política Pública; Assistência a Idosos; África ao Sul do Saara.

RESUMEN

Objetivo: conocer las respuestas sociales y de salud para los ancianos en África subsahariana. **Métodos:** repaso integrador de la literatura. **Resultados:** hay falta de cuidados de salud especializados y enfocados a las reales necesidades de los ancianos, siendo que la escasez de profesionales de salud no contribuye favorablemente para esta situación. Se observa baja oferta de infraestructura destinadas a los ancianos y la mayoría de ellas son de bajo nivel. Aunque haya modelos de atención, así como políticas de apoyo social y de salud para las personas mayores, aún hay iniquidades/desigualdades en el acceso a ellas, sobre todo para las poblaciones más desfavorecidas. **Conclusión:** las políticas sociales y de salud para las personas mayores en el África subsahariana están por debajo de sus necesidades, siendo necesario garantizar una intervención económica, política y social adecuada**.**
Descriptores: Anciano, Servicios de Salud para Ancianos; Política Pública; Asistencia a los Ancianos, África del Sur del Sahara

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INTRODUCTION

By 2050, the world's population aged 60 and older is expected to reach 2 billion, and there is also a tendency for the number of people over 80 to increase. This age group is expected to grow from the current 125 million to 434 million worldwide[1]. Such demographic changes imply the need to provide tailored responses.

In Sub-Saharan Africa, as we look at the population pyramid (Figure 1), we find that although the emphasis on the young population is noteworthy, there is a variation at the top of the pyramid, which indicates an increase in the elderly population and reflects the growth of this phenomenon.

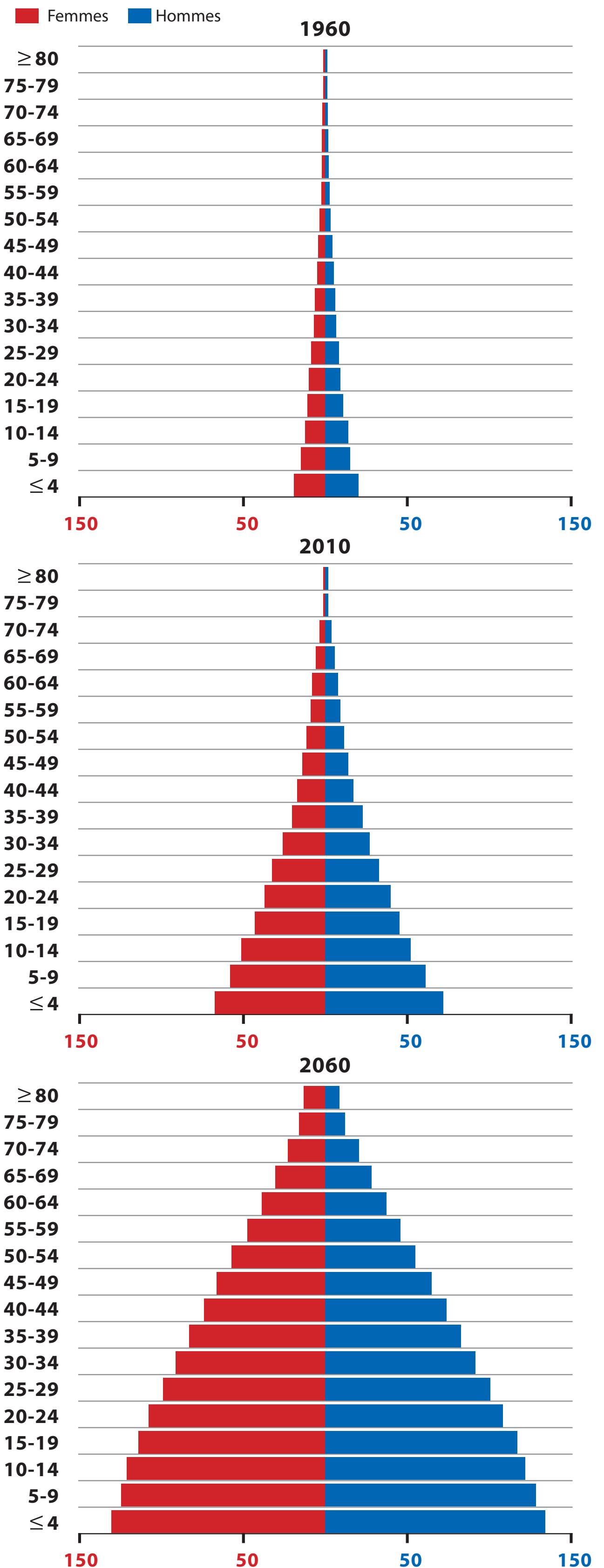
Of the 42 main countries in sub-Saharan Africa, only 4 are high- and middle-income economies and 6 are low- and middle-income countries. Regardless of economic status, the impact of the HIV / AIDS epidemic is still visible in the population pyramid of the region. Notwithstanding these aspects, many areas of Africa are growing steadily as life expectancy increases and fertility declines. It is estimated that by 2050, most African countries will double the aging population[2].

In developing countries, the population is aging very rapidly, leaving government authorities little time to react to the aging phenomenon and to implement political social and economic strategies in this area. While high-income countries such as Japan and European countries, notably France, have had time to adjust to demographic change because it has been progressive, developing countries are not expected to do so, given the rapid pace of this transition. By the year 2050, it is estimated that around 80% of all older people will belong to low- and middle-income countries[2].

In this sense, the future is somewhat predictable, and, unlike most changes societies will experience over the next 50 years, we know that the demographic transition to older populations will occur, and we can plan to make the most of this transition. Indeed, most people today can expect to live to be 60 or older. In low- and middle-income countries, this is mostly the result of great reductions in maternal and child mortality and the slowdown in infectious disease deaths. In contrast, in high-income countries, continuing increases in life expectancy were mainly due to the declining mortality among older people[2].

Increasing average life expectancy means increasing opportunities for older people, families, and societies, but its effective development depends on one determining factor, which is health. In this regard, there seems to be little evidence that older people are currently living healthier than their ancestors because although rates of severe disability have been reduced, there have been no significant changes in mild and moderate disability. In this sense, the focus will be on promoting "healthy" life in this population and enabling them to live in a healthy environment that increases their ability to remain active[2].

Several factors that influence aging from the beginning were identified, meaning there is influence from conception to death. These factors can be genetic, environmental (physical and social), and personal (gender, ethnicity, socioeconomic status)[1-2]. Disability in this age group, in both high-income and middle- and low-income countries, often results in impaired mobility, visual and hearing impairment, and non-communicable diseases such as heart disease, chronic respiratory disease, cancer, and dementia[1-2].



Note: The 2060 pyramid is estimated according to the average United Nations scenario.

Source: A. Chevalier, M: Le Goff, Panorama du CEPII, Nº2014-A-03-July 2014. Available from: http://www.cepii.fr/PDF_PUB/panorama/pa2014-03.pdf

Figure 1– Sub-Saharan Africa Population Pyramid (population by age group of 5, in millions of people)

Maintaining healthy behaviors throughout life, such as eating properly, doing regular physical activity, and avoiding harmful substances, can contribute to the reduction of non-communicable diseases and the improvement of mental, cognitive, and physical abilities, which delay care dependence and minimize frailty[1-2].

Evidence shows the relevance of supportive settings for the elderly with some type of disability, as these settings empower them to perform fundamental activities. Therefore, it is recommended having safe public options, physical structures, transportation, as well as accessible structures, which means access without barriers to people with disabilities[2].

OBJECTIVE

To research health and social policies for the aged in sub-Saharan Africa.

METHOD

The methodology used was an integrative literature review in scientific databases, namely CINAHL, Cochrane via EBSCO, and Medline via PubMed.

Research Protocol

The survey was conducted in August and September 2018 by combining Boolean operators with the terms *MeSh*: *health services for the elderly* OR *social support* AND *aged* AND *Africa*. Also by combining the keywords or natural keys: *elderly people* OR *older people* AND *Africa*.

Inclusion Criteria

Respond directly or indirectly to the study objective; have access to the full text; have been published in the last 5 years (from 2013 to 2018); include older people; have been written in English, French, Portuguese or Spanish. Articles were not excluded by the type of methodology used in the investigation.

Exclusion Criteria

The articles that do not involve the elderly population; do not refer to the population of sub-Saharan Africa; are related to specific pathologies such as HIV, asthma, tuberculosis, cancers; related to pharmacological interventions and therapeutic response to medications.

By searching with the terms *MeSh*, we obtained 47 articles, and with keywords or natural keys 137. A total of 184 articles were found. After excluding articles by title and for being repeated, 73 articles were selected. Then the abstracts were read and 23 articles were selected for a full reading. After that, one article was excluded, and 22 articles were selected for the analysis (Figure 2).

	EBSCO	PubMed	Total
MeSH terms	16	31	47
Key terms	49	88	137
Total	65	119	**184**
After exclusion by title/ repeated articles	37	36	73
After exclusion by abstract			23
After exclusion by reading whole text			**22**

Figure 2 – Articles selection

RESULTS

Of the 22 articles: 1 article was published in 2013; 8 in 2014; 6 in 2015; 3 in 2016; 3 in 2017; and 1 in 2018 (Chart 1). The articles focus on research conducted in 9 sub-Saharan African countries: South Africa (4 articles), Uganda (4 articles), Nigeria (2 articles), Malawi (1 article), Ghana (2 articles), Senegal (1 article), Kenya (1 article), Tanzania (2 articles) and Burkina Faso (2 articles). One study was jointly developed in Ghana and Senegal (1 article); one article corresponds to multicenter research (China, Ghana, India, Mexico, Russia, South Africa); and another, to a literature review.

Chart 1– Results

	Title	Year Country	Delineation/ participants number	Interventions	Outcomes
1	Disability Transitions and Health Expectations among Adults 45 Years and Older in Malawi: The Cohort-Based Model	2013 Malawi	Longitudinal n = 1.075 (2006) n = 1.665 (2008) n = 1.317 (2010)	Application of the SF-12 questionnaire to elderly people in a rural area in Malawi. The questionnaire consists of self-reported health and disability issues), and it is a health measurement research tool that has been validated in sub-Saharan Africa and globally.	Disabilities related to functional limitations proved having a negative effect on individuals' work activities and are negatively related to subjective well-being.
2	*"My Legs Affect Me a Lot. ...I Can No Longer Walk to the Forest to Fetch Firewood": Challenges Related to Health and the Performance of Daily Tasks for Older Women in a High HIV Context*	2014 South Africa	Qualitative n=30	Qualitative interviews with women over 50 (sociocultural context: South Africa, rural area and endemic HIV) about the relationship between health and daily activities, paying attention to the fulfillment of social roles.	The endemic context of HIV creates stressful situations (e.g., trying to survive, caring for sick adult children in a stigmatizing environment, raising grandchildren and losing those who should be their own caregivers in old age) that intervene in the health of individuals and their ability to participate in daily activities. Older women make links between compromised health and the (lack of) ability to perform the daily activities normally expected of them.

To be continued

Chart 1

	Title	Year Country	Delineation/ participants number	Interventions	Outcomes
3	*Culturally diverse care for older people: what do we expect of caregivers?*	2014 South Africa	Qualitative	Interviews on *focus group* about nurses' expectations regarding caregiver training programs to ensure culturally diverse care. Data were collected from residential care homes within the boundaries of the Johannesburg metropolitan area.	Nurses' expectations were grouped into subthemes: communication and aspects that promote communication (highlighting the need for knowledge of culture and cultural differences between caregivers and caregivers); expectations regarding educational sessions and planning (importance of having in-service education programs that focus on cultural issues and sensitivity); expectations of how an understanding of different cultures could be promoted and facilitated (notably through family cooperation); expectations regarding knowledge sharing by different cultural groups (knowledge of cultural practices and different religions); concerns and challenges that influence expectations (such as institution involvement).
4	*Existing and evolving in two minds: beliefs in relation to health and illness expressed by older south Africans*	2014 South Africa	Ethnographic n=16	In-depth group and individual interviews as well as observation of participants, older people from a rural area, north of Pretoria, to clarify beliefs about health and disease.	The understanding of the world in which body and mind are inseparable emerges and relationships provide the basis for improving and maintaining health and promoting the cure of disease. The transition experienced by older people in South Africa influences beliefs about health and disease, noting the need to adapt to existing parallel health systems, Western biomedicine and traditional African medicine. There is a need to tailor care for the elderly to their unique needs to minimize the risk of developing stereotypes, cultural misunderstandings, prejudice and discrimination.
5	*Enrollment of older people in social health protection programs in West Africa and Does social exclusion play a part?*	2014 Ghana and Senegal	Quantitative Cross-sectional n = 435 (Ghana) n = 2,933 (Senegal)	Household cross-sectional surveys conducted in Ghana and Senegal to study whether older people are aware of and enroll in existing insurance programs in these two countries (Senegal's *Sesame* Plan and Ghana's National Health Insurance - NHIS) and to explore if economic indicators and social exclusion determine the enrollment of the elderly in these programs.	Older people, vulnerable to social exclusion, are less likely to enroll in the *Sesame Plan*, and politically vulnerable older people are less likely to enroll in NHIS. Additional efforts need to be made to specifically enroll older people in rural areas, ethnic minorities, women and isolated people due to lack of social support. The importance of modifying program resources, notably by eliminating the NHIS registration fee for seniors and setting up ID card administration offices in remote communities in Senegal.
6	*Perceptions and experiences of access to public health by people with disabilities and older people in Uganda*	2014 Uganda	Qualitative 2 *focus group*	Focus group discussions and interviews with key informants with older people in the Kamwenge district of Uganda; and with people with disabilities from the Gulu region. The interviews were conducted in local language by trained interviewers.	Older people and those living with disabilities express feelings of marginalization, including political marginalization, discrimination and unequal access to health services, which are the factors responsible for their poor health. At the same time, existing clinical services appear to be of poor quality, with little or no access to facilities, trained professionals and medicines, and no rehabilitation and mental health services available.
7	Prevalence and correlates of disability among older Ugandans: evidence from the Uganda National Household Survey	2014 Uganda	Quantitative Cross-sectional n = 2.382	Secondary analysis to data from a sample of older adults from the Uganda National Household Survey, focusing on prevalence and disability reporting.	Factors associated with disability were: advancing age, rural residence, living alone, divorced / separated / widowed marital status, dependence on monetary support, health problems and non-communicable diseases. The need to implement strategies that promote the health and functionality of the elderly is stressed.
8	Prevalence and patterns of multimorbidity among the elderly in Burkina Faso: cross-sectional study	2014 Burkina Faso	Quantitative Cross-sectional n = 389	Interviews, clinical examination and medical record review for persons aged 60 and over in Bobo-Dioulasso in an urban area.	The prevalence of multimorbidity among participants was 65%. The most emerging chronic diseases were hypertension (82%), malnutrition (39%), visual deficits (28%) and diabetes *mellitus* (27%). In people aged 70 years and over, malnutrition and osteoarthritis were more evident.

To be continued

Chart 1

	Title	Year Country	Delineation/ participants number	Interventions	Outcomes
9	*The key actors keeping elders in functional autonomy in Bobo-Dioulasso (Burkina Faso)*	2014 Burkina Faso	Longitudinal Descriptive n = 351	Evaluation of the functional status of elderly (60 years and over) of Bobo-Dioulasso through the Functional Autonomy Measurement System (SMAF -).	In general, the elderly participants have good functional capacity or mild disability (68%), 32% have moderate to severe disabilities. The fact that older people die before (3%) or during (14%) moderate to severe disability reflects the poor quality of medical and / or social care to promote their functional autonomy. Maintaining the functional autonomy of the elderly is the responsibility of two groups: the elderly themselves and their families. There are no community, private or public structures to keep the elderly functionally autonomous. There are major gaps in the contribution of the social system to keeping older people in functional autonomy. Faced with functional disability at home, the elderly tend to die.
10	*Health and age in Nairobi's informal settlements- evidence from the International Network for the Demographic Evaluation of Populations and Their Health (INDEPTH): a cross sectional study*	2015 Kenya	Quantitative Cross-sectional n = 1.878	Data from the International Network for Demographic Assessment of Populations and their Health (INDEPTH) and the WHO Study on Global Aging and Adult Health (SAGE *Wave* 1) were analyzed.	With regard to quality of life and functional limitations, women reported worse quality of life and greater limitations than men in all domains, except self-care.
11	*Informing evidence-based policies for age and health in Ghana*	2015 Ghana	Knowledge translation process (health policy production for Ghana)	Definition of priority problems and responses to health problems (epidemiological data, policy review, local visits and key element interviews); evidence of interventions in low and middle income countries; discussion of policies as well as elaboration and presentation in health services.	Knowledge translation may be useful in middle-income countries, but needs adaptation to local environments. The lack of research on health interventions in this context is a barrier to the implementation of appropriate strategies, so flexible methods are needed.
12	Does Health Insurance Premium Exemption Policy for Older People Increase Access to Health Care? Evidence from Ghana	2015 Ghana	Qualitative/ Quantitative n=461 *focus group* n = 4.124 (quantitative study)	Individual and *focus group interviews*; visits and interviews with families living within 10 km of primary care facilities about their family, economic and health insurance-related conditions.	People over 60 are more likely to enroll in free health insurance than younger people. Non-registration is related to the lack of knowledge about insurance and its exemption. Social exclusion is a determining factor regarding the enrollment of the elderly in social programs. Exemption from the health insurance premium is a determining factor in health care.
13	Late-life depression: Burden, severity and relationship with social support dimensions in a West African community	2015 Nigeria	Quantitative Cross-sectional n = 350	Assessment of social support and depression (for persons aged 60 and over) through the Multidimensional Perceived Social Support Scale (MSPSS) and the Geriatric Depression Scale (GDS)	The low level of social support is associated with depression, especially social support from family and significant others. The severity of depression correlates negatively with the availability of social support. Perceived social support is assumed to be a significant determinant of depression in these older people. There is a need for intervention in the area of preventive mental health for depression.
14	*Depression in elderly people living in rural Nigeria and its association with perceived health, poverty, and social network*	2015 Nigeria	Quantitative n = 458	Initial application of the Mini-Mental and Geriatric Depression Scale (GDS-30) to people aged 65 and over for at least 6 months in 2 rural areas in Nigeria. When the score on GDS-30 was higher than 11, the Geriatric Mental State Program (GMSS) was used.	Late depression is associated with socioeconomic factors (such as poor social network and poverty) and health. However, economic difficulties are significant predictors of late depression. The social network and perceived health were related factors, but without significance. There was a higher prevalence of late depression compared to studies conducted in other developing countries.

To be continued

Chart 1

	Title	Year Country	Delineation/ participants number	Interventions	Outcomes
15	Levels of functional disability in elderly people in Tanzania with dementia, stroke and Parkinson's disease	2015 Tanzania	Quantitative Prevalence study n = 2.232	Assessment of functional capacity in three groups of people with neurological disease: dementia, cerebrovascular accident (CVA), and Parkinson's disease. Participants were people aged 70 or older from 12 villages in the Hai rural district of Tanzania. Barthel index and specific clinical assessment for each condition were used.	High levels of disability occur in people with dementia, stroke and Parkinson's disease. The people with the greatest disability (moderate or severe) were primarily those with stroke, followed by those diagnosed with Parkinson's and finally with dementia. The people with dementia identified in this study had not been previously diagnosed, and it is suggested that strategies be developed so that they can begin to be properly diagnosed and interventions that promote the reduction of dementia rates associated with SSA disability, due to the impact and weight it has both for people and for their families.
16	Health Care for Older Adults in Uganda Lessons for the Developing World	2016 Uganda	Case Study	Discussion of a situation based on: health care overview, socioeconomic and cultural contexts, and resources to overcome health service barriers and health policies, and international aid.	Description of the numerous challenges older people face in developing countries and recommendation of geriatric care programs that should result from partnership between government, community development agents and others. These should meet the needs of more contextualized policies and health care aimed at promoting dignified aging.
17	*Chronic disease, risk factors and disability in adults aged 50 and above living with and without HIV: findings from the Wellbeing of Older People Study in Uganda*	2016 Uganda	Quantitative Cross-sectional n = 471	Chronic diseases were diagnosed by self-report and disability was determined using the WHODAS (*World Health Organization Disability Assessment Schedule*). Participants were people 50 years of age and older living in three different locations in Uganda.	About half of the population was infected with HIV; In these people, chronic obstructive pulmonary disease as well as ophthalmic problems are more prevalent, being more expressive with advancing age. Diabetes is more prevalent in people without HIV. Chronic diseases are more prevalent in people aged 70 years or older. Sleep-related problems are associated with greater disability. There is an association between sociodemographic factors, chronic diseases and risk factors for disability.
18	*Prevalence of factors associated with frailty and disability in older adults from China, Ghana, India, Mexico, Russia and South Africa*	2016 China, Ghana, India, Mexico, Russia, South Africa	Quantitative Cross-sectional n = 34.123	Building a disability index and disability assessment using the WHODAS (*World Health Organization Disability Assessment Schedule*) for people over 50 in 6 countries: China, Ghana, India, Mexico, Russia, South Africa	Both frailty and disability are age-related problems in the context of low- and middle-income countries. With these elderly, it is possible to achieve results of lower disability and fragility, and education and income may be protective factors for disability and fragility in some contexts.
19	Removing user fees for health services: The multi-epistemological perspective on access inequities in Senegal	2016 Senegal	Qualitative n=34	Identification of the causes of inclusion or exclusion of people in a protective scheme for the elderly (Program *Sesame*) through semi-structured interviews and *focus group* to people aged 60 or older from 4 regions of Senegal.	The causes associated with exclusion in the *Sesame* Program fall into three categories: lack of information about the plan; not understanding the need to use the health services included in the plan; and inability to access health services. Social exclusion is a determining factor in this process.
20	*Predictors of health care use by adults 50 years and over in a rural South African setting*	2017 South Africa	Quantitative Cross-sectional n = 5.795	Questionnaire applied to persons aged 50 and over who live in a rural district of South Africa to describe people's health problems and determine predictive factors for health care use.	Chronic diseases (communicable and non-communicable) are the main predictors of health care utilization. Education of 6 years or older increases the possibility of the person to resort to health services.
21	Identifying Frailty and its Outcomes in Older People in Rural Tanzania	2017 Tanzania	Quantitative Cohort study n = 1.198 (1st phase) n = 296 (2nd phase)	Data collection by applying a 40-item frailty index to 70-year-olds living in 6 villages in the rural district of Hai. Data on mortality and dependence were collected over three years.	The highest frailty index score was significantly correlated with the variables: older age, never having studied, falls, mortality and dependence on activities of daily living. Functional disability and cognitive function are shown to be significant independent predictors of the "mortality or dependence" outcome. Assessing fragility seems to be a useful way to identify those who need support the most. The instrument built for fragility assessment seems to have good construct validity.

To be continued

Chart 1 (concluded)

	Title	Year Country	Delineation/ participants number	Interventions	Outcomes
22	Long-term Care for Older Adults in Africa Whither Now?	2018	Reflective literature review	Analysis of world and sub-Saharan African studies, including those developed by WHO, and analysis of the current situation in Ghana regarding existing initiatives for the care of older people.	There is a need for innovative policies and public services appropriate to the aging trend of this population. This innovation should include family involvement in caring (leveraging the workforce of African society), person-centered care, caregiver training, integration with health services, equity, favorable conditions for resource development and sustainability. Existing programs must be critically analyzed to be more appropriate, contextualized and thus more successful.

The themes that emerged from the articles included in this review were: *Major health / social problems of older people in specific communities in sub-Saharan Africa,* more specifically, chronic diseases (such as high blood pressure) and non-infectious diseases (such as depression), frailty, disability, isolation, exclusion, poor economic conditions; *Elderly support structures*, emphasis on family, formal limited and rudimentary support network and the existence of mostly free health insurance programs in countries such as Ghana and Senegal; and *Recommendations for the possible resolution of identified problems*, as well as for promoting healthier aging. The articles discuss the inefficiency of social policies to support the elderly and reflect particularities, namely the need to implement culturally sensitive care that prevents social marginalization and exclusion.

In general, the articles analyzed respond mainly indirectly to this research, in the sense that currently existing social support policies are scarce. Thus, it is subtly that they emerge.

DISCUSSION

Chronic diseases or conditions are common in the elderly, affecting their life. In a study conducted in Burkina Faso, to assess multimorbidity among the elderly, the most common chronic diseases identified were: hypertension (82%), malnutrition (39%), visual impairment (28%) and diabetes *mellitus* (27%). In some countries in sub-Saharan Africa, policymakers appear to does not meet the current health needs of the elderly[3-5].

Besides chronic diseases, the studies also analyze the occurrence of depression in the elderly, which is associated with socioeconomic factors (interactions between their social network, poverty) and health factors that deserve attention, particularly in developing countries where socio-economic deprivation and poor health are common[6-7]. It should be noted that in these countries there are unmet demands for depression diagnosis and treatment. That is, it is noticed that, either before or after diagnosis, often the elderly are not monitored by a health professional. In addition, in this context, health-seeking behavior can have an impact on treatment due to cultural factors[6-7].

In a community setting in West Africa (Nigeria), the severity of depression in the elderly correlated negatively with the availability of social and family support (including significant people), thus, there is a strong influence of these actors on elderly depression, so it is suggested to strengthen formal and informal social support for the elderly[6-7]. The importance of the family's role in aged care, especially those who are dependent, is reinforced by the lack of long-term care in the community. However, it appears that not all families perform this role, contrary to the existing stereotype about the Africa population. This difficulty in ensuring care, by family members, is related to the necessity to combine this long-term care for the elderly with other activities, including work activities. In this sense, it is reinforced the idea of the need for the creation of paid care (guaranteed by government entities) as an alternative to family care[8].

Age-related fragility and disability (functional and/or cognitive) are increasing concerns for the elderly population in low- and middle-income countries. Results in South Africa and Tanzania indicate that lower levels of frailty and disability can be achieved in older people, and studies highlight the need for preventive approaches and targeted support programs[9-11].

According to a study in Uganda, disability is associated with aging, rural residence, isolated housing, divorced or widowed marital status, dependency on income, general illness, and self-reported non communicable diseases. In this regard, the authors state that socioeconomic limitations are associated with disability among the elderly[9]. In Tanzania, the study of this relationship highlights the need to properly diagnose people and intervene to prevent disability, optimizing social responses, as this type of population most often depends exclusively on family care and has not enough income to cover expenses[10].

A study in Bobo-Dioulasso (Burkina Faso) shows that 68% of older people have good functional capacity or mild disability, and 32% have moderate to severe disability. Older people die before they recover (3%) or during recovery (14%) from moderate to severe deficits. This means that the quality of medical and social care does not maintain the functional autonomy of the elderly with disabilities of this nature. They also evidenced that those who contribute financially to the maintenance of functional autonomy are the elderly themselves and their families. Community structures (private or public) to keep the elderly in functional autonomy are nonexistent. Poor physical health results in functional limitations related to subjective well-being that restrain the daily activities of older people, particularly in rural areas (such as Malawi). This limits activities in key areas, such as survival, and leads to the recommendation of national and international policies for the rehabilitation of people with disabilities at this age group[12-13], as shown in previous studies.

The prevalence of self-reported quality of life (QOL) and difficulties in specific functions were estimated by age and gender

in Nairobi (particularly in the favela population), where women reported poorer QOL and greater functional difficulties than men in all groups domains except for self-care. Considering the eight functional domains that differently affect QOL, the researchers state that it is important to implement targeted interventions to improve affect, reduce physical pain, improve cognitive ability, and facilitate mobility. This implies assuming that investing in the health and quality of life of older people in sub-Saharan Africa is crucial to help the region achieve strategic development goals, improve health outcomes, and sustainable economic development[14].

Many older people, particularly in rural areas of sub-Saharan Africa, have activities that, generally, enable them to be self-reliant (e.g. cooking and cleaning), to care for their relatives (particularly those who are sick and infected with HIV), and to obtain some financial gains (e.g. by manually producing mats). These activities are influenced by a social environment in which well-being and health have been reported as inadequate or unsatisfactory by international authorities. There is a need to develop policies and programs aimed at improving the mental and physical health of older people to increase their well-being and their ability to contribute to their families' and communities' well-being[14]. The World Health Organization report also emphasizes the social contribution of the elderly in this context, especially the care of the young and sick relatives, as well as the development of agricultural activities[2].

Looking at the review, Senegal and Ghana have emerged as countries that provide social protection for the elderly, particularly through free access to health care programs for the elderly, such as the *National Health Insurance Scheme* and the *Sesame Plan*. Nevertheless, studies have shown that the elderly, at risk of social exclusion, are currently at a disadvantage in enrolling in such programs and that none of the plans has yet reached the goal of equity in access for the elderly. Despite attempts to minimize financial barriers to enrollment, economically vulnerable people still suffer from inequity. According to the authors of this study, it is useful to implement measures to identify the poorest to ensure they know and enroll more in these programs. Besides, it is emphasized the importance of being able to reach in remote areas older populations who belong to ethnic minorities, women, and isolated people due to the lack of social support. Recognizing and implementing measures to address the factors that prevent the enrollment of older people at risk of social exclusion can improve the prospect of achieving equity and universal coverage in older populations[15-17].

A study in Uganda shows that a sense of community marginalization is present in both the elderly and people with disabilities. These groups report the experience of political marginalization, discrimination, and unequal access to health services. These factors are identified as the main reason for their poor health. In this study, the authors found that there were poor quality clinical services, little or no access to the facilities, lack of trained personnel and medications, and no rehabilitation or mental health services available. On this basis, they recommend that measures must be taken to ensure healthcare equal rights for all citizens, by allocating resources to proactively support the most marginalized citizens[18].

Older people's beliefs in South Africa regarding health and illness encompass the view that body and mind are inseparable, and spirituality and relationships are critical to improving and maintaining health. Older South Africans simultaneously believe in two healing systems (Western biomedicine and traditional African medicine), emphasizing the importance of contextualized care as well as the need to adapt to the ongoing transition, both in the personal and social spheres, giving careful attention to cultural generalizations. Failure to do so can lead to serious consequences, such as an apparent high risk of developing stereotypes, cultural misunderstandings, prejudice, and discrimination[19].

Regarding the understanding of what is expected from caregivers of the elderly, particularly in old people's homes, in one of the studies found, the authors report that in-service training programs do not address cultural diversity, which means that this diversity is neither understood nor respected. Proper initial assessment and registration are suggested when older people are admitted, to learn about their physical, emotional, psychological, religious, cultural, and social habits and practices, personalizing care[20].

A study based on a particular case in Uganda reinforces the importance of cultural care. Appropriate home care or institutionalization would have been helpful, especially because of the widespread care need and the multidimensional challenges faced. As a result of this study, recommendations emerge to create geriatric care programs focusing on culturally appropriate home care and training models for caregivers, in order to make the aging process healthier[21]. Given that often developing care models in developing countries follow those in developed countries, emphasizing the institutionalization of fragile older people in long-term care (such as retirement homes) may neglect the strength of the African social fabric[21]. We believe this situation could be surpassed when they implement the recommendations of the *Executive Council of the African Union* for long-term care[8].

Evidence also points to the lack of qualified and specialized medical care for older people in sub-Saharan Africa, which is ascribed not only to the lack of doctors but also of other health professionals. There is a low offer of elderly facilities such as retirement homes, day centers, and rehabilitation centers, most of which are basic and use rudimentary equipment. There are, however, models of elderly care, notably in Ghana, Kenya, South Africa, Tanzania, Mauritius, Seychelles, and South Africa, where long-term care is available. The expenses of this type of care in the context under consideration are diverse, from free to very expensive, varying by country[22].

This lack of health care may be justified by the large number of medical schools in sub-Saharan Africa that do not teach geriatrics. One study corroborates to this inadequacy of health services for this population, pointing to a gap in the teaching of this discipline, which is related to aspects such as the lack of specialized knowledge (72%), funding deficit (52%) and the absence of geriatrics studies in the national curricula(48%)[23].

Perceptions about older people in Africa, contrary to common sense, can sometimes be associated with negative attitudes. *Ageism* is predominant, especially against elderly women. It is common to hold the elderly responsible for family misfortunes and may even label them as wizards. This attitude is reinforced by superstitions, religious, and cultural beliefs found in most African countries. Some believe that the elderly and those with mental disabilities are possessed by evil spirits and should be exorcised[22].

Ghana has identified and worked on 5 primary aging and health issues that gave rise to the Recommended Aging and Health Interventions in Ghana, which can be transposed to other sub-Saharan African realities[24]. These interventions focus on community awareness to address the needs of the elderly, integrating elderly healthcare in community programs, training health professionals, creating more aged-friendly services, increasing insurance coverage, provision of support resources, specifically for hearing and visual impairments, creation, and training of community support group[24].

Contributions to the field

The publications systematization of studies on the elderly population in sub-Saharan Africa, specifically concerning social and health responses, allowed us to know this population's needs, existing social and health responses, main issues, and possible strategies to solve them, trying to enable older people of this geographical region to age healthier.

Study Limitations

There is a possibility that there are articles written in languages other than Portuguese (Spanish, French, and English) that were not accessed, which may have limited this study.

FINAL CONSIDERATIONS

The focus on population aging is mainly in developed countries. In comparison, there is less attention to the world's poorest region, sub-Saharan Africa, where children and adolescents still comprise a high proportion of the population. Despite this, nowadays, evidence suggests that aging is no longer an exception in Africa.

The 22 articles in this review include studies conducted in several sub-Saharan African countries, specifically South Africa, Uganda, Nigeria, Malawi, Ghana, Senegal, Kenya, Tanzania, and Burkina Faso. In this review, rather than clearly defining the existing social and health policies in sub-Saharan Africa, as there is still a void in this area, some of the needs of older people in such a context were highlighted, which allowed the authors, from different studies, making suggestions and recommendations. These should be the focus for policymakers to design policies that promote healthy aging based the community resources that meet their culture and empower them so that older people can enjoy the possible provided care.

In conclusion, aging is an increasing reality, and the number of aged people in the short term justifies policymakers to establish this theme as a priority in their agenda, ensuring adequate and fair economic, political, and social intervention. Policy measures aimed at equitable access and healthcare for the elderly (including free and adequate access to health) are desirable.

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