



RESEARCH

Toward a Fit-for-purpose Policy Architecture on Long-term Care in Sub-Saharan Africa: Impasse and a Research Agenda to Overcome it

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Context: Perspectives from sub-Saharan Africa (SSA) have featured little in the expanding global debate on long-term care (LTC) policy thus far – despite SSA countries' embrace of global commitments on the development of equitable and sustainable LTC systems.

Objective: Building on insights derived from ongoing analyses of relevant literature and policy frameworks, stakeholder engagement, as well as personal experience, this commentary examines the lack of a fit-for-purpose policy architecture on LTC in SSA at both regional and national levels.

Method: The analysis assesses the nature and drivers of this policy impasse and pinpoints an agenda for research to help overcome it.

Findings: LTC in SSA is provided overwhelmingly by families, with available evidence pointing to inequitably distributed deficits in the quality of such care and negative impacts on unpaid family carers. Governments have forged a spectrum of frameworks that speak to questions of LTC. Yet fit-for-purpose provisions that consider a need for expanded organized care and support provision to reduce quality deficits and costs on carers are widely lacking. The impasse may be rooted in a lack of awareness of relevant evidence, as well as in political views that resist organized care provision as an imposed western model that counters African values and as a distraction from priority child-, youth- and gender-focused development agendas. A concerted research effort that examines the compatibility of organized LTC provision with African family norms and its relevance for broader social and economic development in SSA is required to address the policy impasse.

Limitations: This overview is an exploration of the agenda, leading to suggestions for ways forward, and not an empirical research report.

Keywords: Long-term care; sub-Saharan Africa; policy architecture; action constraints; resources; family life; demographic dividend

Introduction

Sub-Saharan Africa (SSA) has featured little in the global discourse on long-term care (LTC) policy thus far – a gap brought to the fore at the 5th International Conference on Evidence-based Policy in Long-term Care in Vienna. With few exceptions, the tremendous breadth and depth of scientific content centred exclusively on Organisation for Economic Co-operation and Development (OECD) countries. Only two contributions focused on SSA, including my own plenary address (Aboderin, 2018), upon which this commentary is based.

Virtually all conference deliberations, moreover, concerned, in one form or another, the what, where and how of organized LTC provision: what LTC services are

needed and appropriate where, how may they be forged or improved upon and, the crucial question, who is to bear their costs. More fundamental questions about the why – why LTC services are required in the first place – appeared not to merit much discussion. A need for such services *per se* seemed broadly accepted in both OECD public and policy domains: it went without saying.

These conference parameters crystallized what is, arguably, the major challenge facing LTC policy in sub-Saharan Africa: a virtual lack of robust debate and policy architectures on the what, where and how of organized LTC provision, because the why has not yet been resolved.

My aim in this commentary is to reflect on this impasse and its key drivers and to propose a set of required research approaches to overcome it. In so doing, I attempt to construct an argument for SSA as a whole, albeit a cautious one, as it does not capture the immense diversity in economic, geographical and social contexts that exists among the region's 51 states. Nonetheless, I consider an SSA-wide assessment justified for two key reasons:

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First is an assumption, by African states themselves, that they share a common history, destiny and cultural identity. This assumption underlies the principles of Pan Africanism and an African Renaissance and underpins the very function of the African Union itself (Falola and Essien, 2013; AU, 2015).

A second reason is the broadly comparable demographic and development challenges facing SSA countries. All societies in the region are youthful, with large populations of children and young adults. The median age in SSA as a whole is 18.5 years, with 63% of the region's populace aged below 25 years and only 4.9% aged 60 years and above (UNDESA-PD, 2017a). Most states, moreover, are poor – albeit to varying degrees. Of SSA's 48 main countries, 41 are low- or lower-middle income countries (LMICs); only six are upper-middle and one is a high-income economy (World Bank, 2018).

Within this context, the basic constellations of LTC provision and receipt are largely similar across SSA countries, with the exceptions of Mauritius and the Seychelles. In these two small island states, which are among SSA's richest nations, both LTC policy and organized service provision are relatively advanced and merit a separate discussion (Epping-Jordan and Aboderin, 2017). These two countries are not included, therefore, in the argument developed below.

The analysis builds, eclectically, on a number of sources. These are: first, findings of an ongoing scoping review of literature on LTC in SSA and content analysis of regional and national frameworks on ageing (Aboderin, 2017); second, perspectives arising in exchange and dialogue on issues of LTC with African policy, civil society and practice actors at regional, national and sub-national levels (Epping-Jordan and Aboderin, 2017; Aboderin, 2017; Hoffman, Aboderin and Pot, 2018); and third, personal experiences of my family in Nigeria.

Points of departure

A central point of departure in any consideration of LTC in SSA settings are current demographic trends and prospects for global ageing. Across all regions, societies are ageing due to progressive rises in the share of older adults (aged 60 years and above) in their populations. This share is presently highest in high-income countries, having gradually risen over the past century to reach on average 25%. While the population proportion of older people in LMICs is still smaller, the pace of its increase is typically much more rapid than in the rich world. In South Asia and Latin America, for example, the population proportion of older people, currently around 10%, is expected to reach 20% or more by mid-century and to be on par with high-income countries, at 30% or more, by its end (UNDESA-PD, 2017b).

Within this context, SSA's profile is unique. Given persistent high fertility and mortality rates, the region is and will remain the youngest globally, with population ageing only in its infancy. The share of older people in SSA's population, presently 4.9%, will rise to only 7.6% by 2050

and 18.7% by 2100 (UNDESA-PD, 2017). A narrow focus on proportions, however, masks the absolute scope of ageing in the region. The number of older adults alive in SSA, already 54 million, is set to grow more sharply than in any other world region to 166 million by 2050 – more than in Northern, Southern and Western Europe combined and 43 million more than in North America (Aboderin, 2017; UNDESA-PD, 2017). The sheer size of SSA's growing older population alone constitutes a rationale for action to respond to evolving challenges in this group. But so too does the incipient nature of the region's population ageing. It implies a unique opportunity to begin to forge, and hone over time, the very systems and institutions that SSA will require to harness its mature populations in decades to come (Suzman, 2010).

A further point of departure in African discourses on LTC where they exist are key international accords on ageing or development which African Member States have endorsed (Aboderin, 2017) and which – in various forms and to varying degrees – address the care of older people. Such key frameworks include: the Madrid International Plan of Action on Ageing that ensued from the 2nd World Assembly on Ageing (UN, 2002); the 2015 United Nations Agenda 2030, which speaks to issues of care, especially in sustainable development goals (SDG) 3 and 5 (UN, 2015); and, most recently, the World Health Organization Global Strategy and Plan of Action on Ageing and Health (WHO, 2016).

Aligned with the SDG and the earlier instruments, the WHO Strategy articulates a clear set of directions on the ends that national LTC policies, in SSA and elsewhere, must seek to achieve (WHO, 2016). Highlighting governments' obligation to steer the development of equitable and sustainable systems of LTC provision (in homes, communities and institutions and not by families alone), the strategy distils four rights-based imperatives that such systems must fulfill:

- quality care that is person-centered, protects care recipients' dignity and autonomy and promotes self care to help preserve their intrinsic capacity and functional ability;
- effective integration of LTC with requisite health service provision;
- equal access to quality, integrated LTC for all who need it; and
- fair, decent conditions, support and opportunities for paid and unpaid carers to; ensure the burden and costs of care are shared equitably.

Realities of LTC in SSA

In many senses, these imperatives address what are understood to be major challenges in the provision and receipt of LTC in SSA (Epping Jordan and Aboderin, 2017; Essuman, Agyemang and Mate-Kole, 2018). Robust evidence on LTC in the region remains extremely patchy and much more research, both large-scale and in-depth, is needed. Nonetheless, the body of available evidence is sufficient to point to eight salient realities in the lived experiences of LTC across SSA settings.

A first such reality is an already considerable need for care in SSA's older population. Multiple surveys document

a significant prevalence of functional impairment among older adults at levels that are on par with or even exceed those found in other regions (**Table 1**). Rates of such disability are likely to rise in coming decades amid an expanding burden of chronic non-communicable diseases, including musculo-skeletal conditions (de Graft Aikins and Agyemang, 2015; GBD 2017; Disease and Injury Incidence and Prevalence Collaborators, 2018).

A second reality is that the largest part of LTC in SSA is unorganized, provided by families. Only a negligible share of care provision occurs through organized services. While family carers include men, a clear majority are women, particularly daughters and daughters-in-law, as well as spouses. Other, more extended kin, including grandchildren, also play a role (Epping-Jordan and Aboderin, 2017; Nortey et al., 2017).

A third reality is the existence of wide deficits in the availability of family care, with many care-dependent older adults lacking a caregiver for periods of time or altogether. A representative study in Southwest Nigeria, for example, found the latter to be the case for almost 20% of

care dependent older adults surveyed (Gureje et al., 2006). Within the context of HIV/AIDS, potentially large numbers of older people have lost family support due to the selective mortality of their younger-generation kin (Kautz et al., 2010).

A fourth reality is major inadequacies in the quality of care provided by families. Studies point to experiences of inconsistent or poorly-timed care activities, a lack of access to required health services, instances of physical neglect and abuse, and a lack of consideration of the spectrum of needs and wishes of those receiving care (Epping-Jordan and Aboderin, 2017).

To illustrate elements of, and ambivalences around the gaps in person-centred care, I reflect with unease on the experiences of my grandmother who lived in Nigeria and died a decade ago at the age of 97. At age 88, she became dependent on care from others, and a decision was made – no doubt for cogent reasons – that she would move to her son's house in the same city. My grandmother had desired to stay in her own home and in the neighbourhood where she had lived for decades, but her wishes could not be, or

Table 1: Prevalence of functional limitations among older adults in SSA: selected studies.

Country	Sample age-range (years)	Rate	Measure	Reference
Ghana	65–74	52%	Need for assistance with at least 1 of 5 basic activities of daily living (ADL) (eating, bathing, dressing, getting in and out of bed, using the toilet)	WHO, 2015
	75 and over	68%		
Malawi (rural) 2010	45 and over	66.4%	Self reported moderate or severe limitation in one or more moderate or strenuous activities	Payne et al., 2013
Nigeria (rural)	60 and over	22.5%	Less than maximum performance score on gait or balance using the Tinetti Performance oriented mobility assessment tool (TPOMAT)	Abdulraheem et al., 2011
Nigeria (Yoruba-speaking areas)	65 and over	9.2%	Inability to perform or inability to perform without assistance at least one activity of daily living (ADL) or instrumental activity of daily living (IADL) (assessed through Katz Index; Nagi Scale)	Gureje et al., 2006
South Africa	65–74	38%	Need for assistance with at least 1 of 5 basic ADL (eating, bathing, dressing, getting in and out of bed, using the toilet)	WHO, 2015
	75 and over	49%		
Uganda	50 and over	33%	Inability to perform, or severe difficulty in performing one or more of six ADL/IADL (seeing, hearing, walking/climbing steps, remembering/concentrating, self care, communicating), or some difficulty in performing at least two activities	Wandera et al., 2014
France	65–74	10%	Need for assistance with at least 1 of 5 basic ADL (eating, bathing, dressing, getting in and out of bed, using the toilet)	WHO, 2015
	75 and over	26%		
Germany	65–74	11%	Need for assistance with at least 1 of 5 basic ADL (eating, bathing, dressing, getting in and out of bed, using the toilet)	WHO, 2015
	75 and over	30%		
China	65–74	20%	Need for assistance with at least 1 of 5 basic ADL (eating, bathing, dressing, getting in and out of bed, using the toilet)	WHO, 2015
	75 and over	37%		
Mexico	65–74	43%	Need for assistance with at least 1 of 5 basic ADL (eating, bathing, dressing, getting in and out of bed, using the toilet)	WHO, 2015
	75 and over	60%		

were not, entertained. Several months or so later, a proposition was made, again based on plausible and well-intentioned rationales, to relocate my grandmother to stay with her youngest daughter in Lagos. My grandmother protested: she wanted, absolutely, to stay in her hometown. The matter was dropped but some time later, on the occasion of paying a visit to the Lagos-based daughter, she was simply left there. My grandmother had no way of returning to her town and no option but to accept her move and new home. There, without a doubt, she was made comfortable and received the necessary basic care – meals, bathing, hygiene. Yet she was alone much or most of the time in her room with the door closed. Visitors, including myself, would drop in from time-to-time but mostly to deliver more or less hasty greetings and leave amid her complaints that she missed seeing and being with people. My grandmother was cared for by her family, but she certainly did not receive elements of care she'd wished for or in the place she'd wanted to be.

Of course, she was lucky in many ways. Located in the narrow middle class stratum, her adult children had the necessary resources to cater to her material and health-care needs. Her daughter had sufficient time-to-allocate to her care, not having to engage each day in a relentless search for income. Moreover, with a qualified nurse as a sibling, she could access information on essential care principles and practices.

In her carer role, her daughter was fortunate in other respects: besides time, she had relatively better access to basic amenities, infrastructure and space that rendered domestic chores and care activities, such as bathing my grandmother, washing bed-linen or cooking food, manageable, if not easy.

The same may not be said for the majority of care givers and recipients at the base of the socio-economic pyramid. Qualitative evidence points to such family carers' lack of even elementary knowledge about appropriate care practices and an essential dilemma facing them. This dilemma sees carers caught between the alternatives of opportunities for work and earnings or caring for their children, curtailing the care provided to their older kin or risking their own depletion (Aboderin, 2017). Such challenges are a central focus of global care policy debates and agendas (Folbre, 2018; UNRISD, 2016; UN Women, 2018).

A fifth reality – partly engendered by such care dilemmas – is the major costs that LTC constellations can impose on the well-being and prospects of both caregivers and recipients. Among the latter, studies point to experienced losses of dignity and autonomy, as well as stress, depression, declining function and hastened death. Among caregivers, evidence shows not only direct financial costs of care provision, lost opportunities for paid work, enterprise or education, but also stress and diminished mental and physical health (Epping-Jordan and Aboderin, 2017).

A related sixth reality concerns the inequitable distribution of exposures to deficits in the availability or quality of family care and to the costs of care. All indications are that such exposure is greater among the poor and among those living, or caring for kin, with dementia (Epping-Jordan and Aboderin, 2017).

Arising from the above is a seventh reality in current experiences of LTC in SSA. This is an apparent rising need and demand for access to organized LTC services to help mitigate deficits in and costs of family care provision. An organic, uncoordinated expansion of LTC services, particularly in urban areas, is emerging as a result. Such services fall mainly within one of two tiers: on one level, charitable (or publicly provided welfare) services for the most destitute; and on a second level, private for-profit services for those able to pay (Coe, 2016; Epping-Jordan and Aboderin, 2017; Owii and Aboderin, 2018).

The lack of access to such organized LTC provision for the poor majority and those living with dementia, as well as pronounced quality gaps in the services that do exist, constitute an eighth and final reality of LTC in SSA (Epping-Jordan and Aboderin, 2017).

Policy impasse

Despite evidence of the above realities, and despite commitments made by SSA countries to global rights-based accords on LTC, no robust policy debate, let alone policy architecture, so far exists in the region to guide an expansion of organized LTC services and support.

Neither is there a policy vacuum. Over the past 15 years, SSA governments individually and collectively have forged a spectrum of frameworks that speak, directly or indirectly, to issues of LTC. Key regional frames include the African Union (AU) Plan of Action on Ageing and the AU Protocol to the Charter on Human and People's Rights on the Rights of Older Persons, adopted in 2016 (AU/HelpAge, 2003; AU, 2016). Various country-level instruments encompass national policies on ageing: older person-focused stipulations in sectoral policies or constitutions, dedicated bills on older adults or, as in Tanzania or Zimbabwe, national strategies on healthy ageing.

This architecture offers an important foundation for Africa's response to the challenges and opportunities of its growing older population. Yet three thrusts in both regional and national frames suggest that they are not fit for purpose to steer required action on LTC.

One thrust is a lack of reference to existing quality deficits in or costs of family LTC provision on caregivers and recipients or to an expanding need or demand for access to organized care services within SSA contexts. A further hallmark is a clear emphasis on buttressing the centrality of family and traditional family care systems in the provision of LTC to older people. Examples are recommendations of the AU Plan of Action on Ageing, which oblige Member States to

Enact legal provisions that promote and strengthen the role of the family and the community in the care of its older members

and to

Learn from traditional values and norms to inform legislation about family values and the care of older persons (Section 4.7, Recommendation I).

A similar, country-specific exemplar a stipulation in Kenya's draft 'Older Persons of Society Bill' (2018):

The Older members of society shall be provided for mainly by their families, and their family members shall care for and look after them irrespective of their marital status (Article 29).

By the same token, the bill recognizes a duty of the state only in terms of providing a universal cash transfer to older adults. It specifies no obligation at all in relation to the provision of LTC (Article 30).

Related to the previous two thrusts is a further feature of existing policy frames on LTC. This is what may be described as a distinct and, one may speculate, deliberate ambivalence regarding the expansion of organized care provision. Several frameworks do mention the possibility of developing LTC services or recognize a residual role of organized care for older people without families. None, however, call explicitly for a broad expansion of access to organized LTC provision: statements of intent in this regard remain at best equivocal. At an Africa-wide level, for example, the AU Protocol on the Rights of Older Persons (2016) stipulates

State Parties shall:

'Enact or review legislation that ensures that residential care is optional for Older Persons' (Article 14) and 'Identify, promote and strengthen traditional support systems, including medical home based care, to enhance the ability of families and communities to care for older family members' (Article 12).

In a similar fashion, Kenya's national draft Older Members of Society Bill directs only that

The Cabinet Secretary may, in collaboration with any relevant Cabinet Secretary or the Executive Committee Member in a county ... develop ... home-based care (Article 32).

'Drivers of resistance' to policy progress

The present absence in SSA's existing policy architecture on LTC of an unequivocal focus on expanding access to organized LTC provision begs the question of what underpins the impasse.

One possible reason may simply be a lack of awareness among policy or decision makers of the deficits in and costs to the family of LTC provision as evidence-informed policy debate on LTC in SSA has remained patchy at best (Epping-Jordan and Aboderin, 2017). Yet such a knowledge gap may not be a principal driver given narratives about an erosion of traditional African family care systems not only dominate public and policy discourses on ageing but also are enshrined – directly or indirectly – in regional and national policy frameworks themselves, including in the AU Plan of Action. Indeed, assumptions of declining old age family support and care mechanisms were a major *raison d'être* for the pursuit of research and policy on SSA's older populations (Aboderin and Hoffman, 2015).

A further plausible and perhaps more obvious reason for the policy impasse, as the broader global debate on unpaid care highlights (Folbre, 2018; Razavi, 2016; UN Women, 2018), are the resource constraints faced by LMICs. Driven by fiscal concerns, SSA governments or donors may view an expansion of care service access or spending on older populations as an unaffordable luxury. At the same time, entrenched gender norms that see caring for kin as a woman's natural role may militate against state engagement with LTC provision in private spheres (Folbre, 2018; UN Women, 2018).

Such financial and normative perspectives undoubtedly play a role in restraining SSA's LTC policy architecture. However, their impact may not be dominant. A growing number of SSA countries are investing in an expansion of care services, albeit for young children (Esquivel and Kaufmann, 2017) while at the same time ever more states and their development partners are demonstrating a readiness to allocate budgets to targeted programmes for older adults, in particular non-contributory pensions and other social protection schemes (Aboderin, 2017; ILO, 2019).

There is a need, then, to consider other potential factors that might hinder SSA's pursuit of policy agendas that promote an expansion of access to organized LTC provision. To do so, one may usefully draw on the 'thinking and working politically (TWP)' approach (Dasandi, Marquette and Robinson, 2016), which has gained traction in international development (Laws and Marquette, 2018) and which underscores the critical importance of understanding and addressing the drivers of resistance to policy change. Recognizing development as fundamentally political process – and poor policy as a function of the interests and influence of actors who oppose change – the TWP approach calls for active engagement with such actors and the grounds for their opposition (Dasandi, Marquette and Robinson, 2016).

Applied to LTC, this implies a need to identify key regional, national and local level actors who reject an extension of organized LTC service access in SSA and to examine their rationales, motives and cases against such action.

No such systematic analysis exists thus far. Indications from relevant literature, policy and practice engagements, however, suggest that resistance to expanding organized LTC provision is salient among parliamentarians, finance and planning ministries, as well as religious and cultural leaders (Aboderin et al., 2015; Epping-Jordan and Aboderin, 2017) and that these actors' basic objections are two-fold.

One set of concerns, especially in central ministries, sees action on organized LTC provision as extraneous to the paramount population and development agenda that SSA countries must pursue: namely, to harness the region's bulge of young people to achieve a 'demographic dividend' of accelerated economic growth (AU, 2017; UNECA/AUC/AfDB, 2013). To trigger such a dividend, governments must make investments to promote broad-based fertility declines and quality human capital among Africa's youth, expand decent employment and enterprise

opportunities for them and foster their meaningful participation in governance processes (AUC/ECA/AfDB, 2013; AU, 2017). Amid such priorities, policy action to expand LTC service access is deemed at best as irrelevant, at worst a distraction.

A second case against such expansion centres on views of organized LTC provision, which is typically conceived as implying institutional care, as a western, 'un-African' model that contravenes the continent's core cultural values of family cohesion and respect for elders (Aboderin and Hoffman, 2015; Epping-Jordan and Aboderin, 2017). The two quotes below from a Ghanaian bishop and from a parliamentarian in Kenya are exemplars of the sentiment:

We must desist from creating... such dead ends into Ghanaian life. For me, the day we adopt such a culturally humiliating system will be a gloomy one indeed. Let us continue to keep the aged in their homes with their children and grandchildren (Ghanaian Catholic bishop, quoted in Van der Geest, 2016).

We need to 'delete the idea of establishing small-scale residential homes... That is un-African and it goes against our culture. I cannot imagine myself sending away my old mother to a home to be taken care of. I cannot imagine that... The idea of homes has worked in the developed world and European countries and even in the USA but I do not think we have reached that stage as a country. It is a taboo in... our cultures (Parliament of Kenya, Senate Hansard, 20 March 2014, p. 28).

Such rejection of organized LTC on cultural grounds must be understood as part of a broader, African renaissance thinking-inspired political endeavor that rejects 'western-imposed' blueprints for Africa and, instead, seeks to safeguard and build on Africa's own systems and strengths in pursuit of 'homegrown' development in the continent (Aboderin and Hoffman, 2015; AU, 2015; Epping-Jordan and Aboderin, 2017). Crucially, as the quotes below illustrate, the centrality of the family in care provision for elders is seen as a distinct, if not defining, element of Africa's unique cultural identity vis-a-vis the global North:

In Africa... the centrality, uniqueness and indispensability of the family in society is unquestionable... Traditionally, Africa's development has been a result of the strength of the family... Building the capacity and resilience of the African family to avoid breakage will be all important... in the development of Africa (AU Plan of Action on the Family, 2004: 3).

It must be clearly understood that an African Renaissance does not mean imitating or blindly copying everything European. In this context let us consider some of the most distinctive aspects of Africa's identity and cultural glory. In countries like Britain, France and the US, for example, there are

certain aspects of behavior that are still repugnant to African people, such as neglect of, and lack of respect for, the elderly, parents in particular... In Africa... age is given great respect, and so too are parents (Okumu, 2002: 7).

Toward a cross-regional research agenda?

The above areas delineate what could be not only an important, but also a hugely exciting agenda for policy and scientifically relevant research on LTC in SSA. More than that, the agenda also speaks to unresolved challenges and questions of LTC in other LMICs, as well as, arguably, in high-income settings. A cross-regional research endeavor that builds on both South-South and South-North collaboration and exchange would be ideally placed to realise the agenda and, in so doing, to help advance a fit-for-purpose LTC policy architecture and debate in Africa and beyond.

Conclusion: Addressing the 'drivers of resistance'

A concerted effort to address the above concerns and engage the actors presently resisting an expansion of access to LTC services is vital if a fit-for-purpose policy architecture on LTC in SSA is to be established. Besides targeted and active stakeholder engagement, such an effort will need to comprise a programme of incisive inquiry in three key areas.

The first such area is a systematic mapping of relevant political actors at local, national and regional levels and a thorough analysis of political discourses on LTC in order to distil the spectrum, key thrusts and nuance of current lines of reasoning regarding the extension of organized LTC provision.

A second domain where research is needed is the generation of a robust evidence base, both large-scale representative and small-scale in-depth, that clarifies the case on where, how and to what extent an expansion of access to LTC services (i) is needed to fulfill rights-based needs and (ii) has the potential to advance the establishment of enabling conditions for a first demographic dividend. The latter requires a focus specifically on the possible relevance of an expanded LTC service sector for the creation of job and enterprise opportunities for Africa's young and the reduction of barriers to women's labour force participation (Aboderin and Gelfand, 2019).

A third, critical, realm for investigation is the intersection of organized LTC provision and customary values and normative expectations of family cohesion, care obligations and respect for elders. Research is needed to better understand not only the essential nature of such norms but also their application and interpretation within the context of concrete care arrangements and experiences. To what extent an expansion of LTC service access is compatible with customary values, and may even serve to strengthen family and intergenerational bonds, ought to be a core query to be considered in this regard.

Competing Interests

The author has no competing interests to declare.

References

- Aboderin, I.** 2017. Towards long-term care systems for Africa: setting agendas. *A resource document*. Geneva: World Health Organization.
- Aboderin, I.** 2018. Toward 'fit-for-purpose' policy on long-term care in sub-Saharan Africa? Key challenges, approaches and opportunities. *Keynote address, 5th International Conference on Evidence based policy in long term care of the International Long Term Care Policy Network, 10–12 September, Vienna, Austria*.
- Aboderin, I** and **Hoffman, J.** 2015. Families, inter-generational bonds and ageing in sub-Saharan Africa. *Canadian Journal on Aging*, 34(Special issue 03): 282–289. DOI: <https://doi.org/10.1017/S0714980815000239>
- Aboderin, I, Mbaka, C, Egesa, C** and **Owii, H.** 2015. Residential Care and Human Rights in Kenya. In: Meenan, H, Rees, N and Doron, I (eds.), *Human Rights and Residential Care for Older Persons: International Perspectives on a Rights Culture*. London: Routledge. pp. 13–23.
- African Union (AU).** 2004. Plan of action on the family in Africa. Addis Ababa: Ethiopia.
- African Union (AU).** 2015. Agenda 2063. *The Africa we want*. Addis Ababa: African Union.
- African Union.** 2016. Protocol to the African Charter on Human and People's Rights on the Rights of Older Persons. Addis Ababa: African Union.
- African Union/HelpAge International (AU/HelpAge).** 2003. African Union policy framework and plan of action on ageing. Addis Ababa: African Union.
- Coe, C.** 2016. Not a Nurse, Not Househelp: The New Occupation of Elder Carer in Urban Ghana. *Ghana Studies*, 19(1): 46–72. DOI: <https://doi.org/10.1353/ghs.2016.0003>
- Dasandi, N, Marquette, H** and **Robinson, M.** 2016. *Thinking and working politically: From theory building to building an evidence base*. Birmingham: DLP.
- De Graft Aikins, A** and **Agyemang, C.** (eds.) 2015. *Chronic Non-communicable Disease in Low and Middle Income Countries*. Boston: CABI International. DOI: <https://doi.org/10.1079/9781780643328.0000>
- Epping-Jordan, J** and **Aboderin, I.** 2017. Toward long-term care systems in Africa. *World Health Organization Technical Series on Long-Term Care*. Geneva: WHO.
- Esquivel, V** and **Kaufmann, A.** 2017. Innovations in care. *New concepts, new actors, new policies*. Berlin: Friedrich Ebert Stiftung. Available at: <http://library.fes.de/pdf-files/iez/13282.pdf>.
- Essuman, A, Agyemang, FA** and **Mate-Kole, CC.** 2018. Long-term care for older adults in Africa: whither now? *Journal of the American Medical Directors Association*, 19: 728–730. DOI: <https://doi.org/10.1016/j.jamda.2018.07.012>
- Falola, T** and **Essien, K.** 2013. *Pan-Africanism and the Politics of African Citizenship and Identity*. London: Routledge. DOI: <https://doi.org/10.4324/9780203725030>
- Folbre, N.** 2018. Developing care. *Recent work on the care economy and economic development*. Ottawa: IDRC. Available at: <https://idl-bnc-idrc.dspacedirect.org/bitstream/handle/10625/57142/IDL-57142.pdf?sequence=2&isAllowed=y>.
- GBD 2017 Disease and Injury Incidence and Prevalence Collaborators.** 2018. Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. *Lancet*, 392(10159): 1789–1858. DOI: [https://doi.org/10.1016/S0140-6736\(18\)32279-7](https://doi.org/10.1016/S0140-6736(18)32279-7)
- Gureje, O, Ogunniyi, A, Kola, L** and **Afolabi, E.** 2006. Functional disability among elderly Nigerians: results from the Ibadan Study of Ageing. *Journal of the American Geriatrics Society*, 54(11): 1784–1789. DOI: <https://doi.org/10.1111/j.1532-5415.2006.00944.x>
- Hoffman, J, Aboderin, I** and **Pot, AM.** 2018. Developing the long-term care economy in Gauteng, South Africa: Expanding opportunities for work and equality. Strategy and action plan. *Co-convenor presentation in the research-policy-practice dialogue on 'Developing the long-term care economy in Gauteng, South Africa: Expanding opportunities for work and equality'; 5–6 March, Vanderbijlpark, South Africa*: North West University.
- International Labour Office (ILO).** 2019. World social protection report data 2017–2019. Geneva: ILO. Available at: <https://www.social-protection.org/gimi/gess/Wspr.action>.
- Kautz, T, Bendavid, E, Bhattacharya, J** and **Miller, G.** 2010. AIDS and declining support for dependent elderly people in Africa: retrospective analysis using demographic and health surveys. *BMJ*, 340: c2841. DOI: <https://doi.org/10.1136/bmj.c2841>
- Laws, E** and **Marquette, H.** 2018. Thinking and working politically: reviewing the evidence on the integration of politics into development practice over the past decade. *TWP community of practice*. Available at: <https://twppcommunity.org/wp-content/uploads/2018/04/Thinking-and-working-politically-reviewing-the-evidence.pdf>.
- Nortey, ST, Aryeetey, GC, Aikins, M, Amendah, D** and **Nonvignon, J.** 2017. Economic burden of family caregiving for elderly population in southern Ghana: the case of a peri-urban district. *International Journal of Equity in Health*, 16: 16. DOI: <https://doi.org/10.1186/s12939-016-0511-9>
- Okumu, WAJ.** 2002. *The African Renaissance. History, Significance and Strategy*. Trenton, NJ: Africa World Press.
- Owii, H** and **Aboderin, I.** 2018. Assessing the landscape of organized long-term care provision for older adults in Kenya: development and application of a classificatory framework and mapping tool. *Paper presented at the 5th International Conference on Evidence based policy in long term care of the International Long Term Care Policy Network, 10–12 September, Vienna, Austria*.

- Payne, CF, Mkandawire, J and Kohler, HP.** 2013. Disability transitions and health expectancies among adults 45 Years and older in Malawi: A cohort-based model. *PLoS Medicine*, 10(5): e1001435. DOI: <https://doi.org/10.1371/journal.pmed.1001435>
- Razavi, S.** 2016. Redistributing quality care and sustaining quality care services: a prerequisite for gender equality. *Policy Brief No. 5*, New York: UN Women.
- United Nations (UN).** 2002. Madrid International Plan of Action on Ageing. New York: United Nations.
- United Nations (UN).** 2015. Agenda 2030 for sustainable development. New York: United Nations.
- United Nations Department of Economic and Social Affairs – Population Division (UNDESA-PD).** 2017a. World population prospects. The 2017 revision. *Custom data acquired via website*. New York: UNDESA. Available at: <https://population.un.org/wpp/DataQuery/>.
- United Nations Department of Economic and Social Affairs – Population Division (UNDESA-PD).** 2017b. World population aging. *Highlights*. New York: UNDESA. Available at: http://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2017_Highlights.pdf.
- United Nations Economic Commission for Africa/African Union/African Development Bank (UNECA/AUC/AfDB).** 2013. Reaping and capitalizing on the demographic dividend for Africa. Addis Ababa: UNECA.
- United Nations Research Institute for Social Development (UNRISD).** 2016. Policy innovations for transformative change. Geneva: UNRISD.
- United Nation (UN) Women.** 2018. Turning promises into action. Gender equality in the 2030 Agenda for sustainable development. New York: UN Women. Available at: <http://www.unwomen.org/en/digital-library/publications/2018/2/gender-equality-in-the-2030-agenda-for-sustainable-development-2018>.
- Wandera, SO, Ntozi, J and Kwagala, B.** 2014. Prevalence and correlates of disability among older Ugandans: evidence from the Uganda National Household Survey. *Global Health Action*, 7: 25686. DOI: <https://doi.org/10.3402/gha.v7.25686>
- World Bank.** 2018. World Bank country and lending groups 2018. Washington: World Bank. Available at: <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups>.
- World Health Organization (WHO).** 2015. Global report on ageing and health. Geneva: WHO. Available at: <http://www.who.int/ageing/events/world-report-2015-launch/en/>.
- World Health Organization (WHO).** 2016. Multisectoral action for a life course approach to healthy ageing: global strategy and plan of action on ageing and health. Geneva: WHO.

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