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Information Needs for Research, Policy and Action on Ageing and Older Adults

A report of the follow-up meeting to the 2000 Harare MDS Workshop

Indicators for the Minimum Data Set Project on Ageing: A Critical Review in sub-Saharan Africa

21 and 22 June 2001
Dar es Salaam, United Republic of Tanzania

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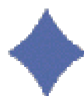 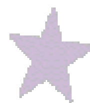 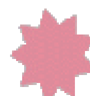

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This report contains the collective views of an international group of experts, and does not necessarily represent the decisions or the stated policy of the World Health Organization.

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List of Terms

FAO	Food and Agriculture Organization of the United Nations
HAI	HelpAge International
INDEPTH	An International Network of fieldsites with continuous Demographic Evaluation of Populations and Their Health in developing countries
MDS	Minimum Data Set
NIA	United States National Institute on Aging
OAU	Organization for African Unity
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive Summary

Fifteen collaborators and co-ordinators of the Minimum Data Set (MDS) Project met in Dar es Salaam, United Republic of Tanzania on 21 and 22 June 2001 to review the draft list of indicators with a view to approving a finalised list for the MDS.

Each country group (Ghana, South Africa, United Republic of Tanzania and Zimbabwe) presented a short progress report for the MDS Project in their respective countries. In some cases, difficulties had been encountered with challenges arising in terms of communication between those with a policy interest and those with a research focus. Despite these setbacks, progress is being made overall and efforts to bridge the divide between policy and research will be increased. The report from Zimbabwe was exceptional and one of the reasons for the success appeared to be the collaboration forged between the different stakeholders – with strong input from government offices and NGOs as well as universities and research institutions.

The review of the draft indicators started by reclassifying them to make the groupings more logical and, where relevant, bring them in line with classifications often used in census and other data collection processes. In addition, a category of indicators that will include all age groups (that is category A. "Summary Measures"), was added to give a general overview of the country situation and a point of comparison for a number of indicators.

Participants agreed that 50 years of age should be used for the MDS Project as the lower threshold for data collection related to ageing and older persons. It was felt that this age (instead of the previously agreed on age of 60 years) was a more realistic reflection of ageing for many people in Africa and, furthermore, will help provide data that will indicate emerging trends that might affect policy and planning. The subsequent change in the accepted definition is important because the consequences for data collection and impact on ageing policies are significant while at the same time it indicates a belief in the need to monitor some trends (e.g. diseases, risk factors, poverty) starting at younger ages.

Whilst it was possible to finalise most of the indicators, some remain unfinished – with need for further consultation and research. For example, participants agreed that there was need to collect data about rights violations (within the category F. Social Well-being indicators) there was no consensus about how, realistically, this could be done. Section VI of this report outlines some of the key debates that took place and lists the working groups that were established to promote further discussion on issues that could not be resolved during the meeting.

This report describes the process, methods and discussions at this meeting to create Version 3.0 of the MDS Indicators as part of a continuing effort to create a comprehensive MDS on ageing and older adults. These indicators can then be followed over time, leading to analyses of trends that will contribute to efforts to improve the situation of older persons. The Dar es Salaam Meeting served to highlight the enormous interest in the MDS Project among the stakeholders, it also underlined the challenges that need to be resolved in order to provide relevant and timely information on ageing to inform both policy and practice.

I. Meeting Aims

- To review the project structure and plan of work.
- To agree upon a process and criteria for selecting a finalised list of indicators.
- To identify problem and/or priority indicators and how to address them.
- To approve a finalised working list of indicators.
- To determine project needs and direction over the next two years.

II. Introduction

The World Health Organization (WHO) and HelpAge International (HAI), along with colleagues in Ghana, South Africa, the United Republic of Tanzania and Zimbabwe, as well as a wider group of national, regional and international collaborators, initiated the Minimum Data Set (MDS) Project in 1999. A major goal for the project was to create a set of valid, reliable and timely data that illustrated the overall situation of the older population in sub-Saharan Africa. These data would be grouped into indicators linked to research and policy needs.

The process of developing these indicators, establishing the methods and identifying available data began at a workshop held in Harare, Zimbabwe in January 2000. A report of the workshop proceedings are available online[a] and will be referred to as the 2000 Harare MDS Workshop Report in this document[1]. These indicators are not an end point, but instead, will be a source of data to build an evidence base and to inform policy and decision makers.

Information about the status and situation of older persons can be used to support actions that are needed to support their efforts to maintain independence, while at the same time, to continue contributing to their families and communities. Recent activities by the United Nations (UN) and the Organization for African Unity (OAU) related to ageing policy frameworks and plans of action are very positive actions for ageing and older populations on international and regional levels. National level interest in older adult populations and related ageing policies in countries of sub-Saharan Africa is also increasing. However, the continuing problems researchers and policy makers face in these countries are lack of quality data and how to present available information in a timely useable format. A number of initiatives have begun to address these issues. One in particular, INDEPTH[b], is a global network of fieldsites working at a local level in many countries in sub-Saharan Africa. They have created a research network to provide high quality data, standardised methods and working groups for specific issues like adult health. Links to these types of data collection efforts may provide a basis for longitudinal follow-up on a number of issues relevant to older adults.

While the data from these indicators will provide a source of valid, reliable and timely information for policy makers and programme planners, the MDS Project also recognises the importance of the proper presentation of this information to key stakeholders. In the current situation in Africa, the challenge is to tackle the difficult technical task of assembling the available data, filling the data gaps, and planning strategies to validate and update these data over time, while also disseminating and sharing the information in a digestible and easily understandable manner.

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[a] World Health Organization, WHOSIS, 2001. http://www.who.int/whosis/. MDS Project at : http://www.who.int/whosis/mds

[b] INDEPTH: International Network of field sites with continuous Demographic Evaluation of Populations and Their Health in developing countries. See www.indepth-network.net

III. Project Structure, Plan of Work and Needs

3.1. MDS Project structure

Each country has established a National MDS Secretariat through which all project activities are directed and approved. The Secretariats in Ghana (GhaMDS), South Africa (SAMDS Task Team) and Zimbabwe (ZimMDS) have created working groups:

1) the Research Working Groups will organise the collation and collection of data and methods to establish an evidence-base and to inform policy; and
2) the Policy Working Groups will outline the policy information needs and prepare to translate data into timely and useable information.

WHO and HAI have provided overall project oversight and organisation, including conceptualisation and development, technical advice, communications and coordination of fund-raising. At a future date, a regional secretariat will be created to help to coordinate cross-national research efforts while reviewing issues of data maintenance, linkages, comparability and standards (i.e. harmonisation).

3.2. General plan of work

A plan of work with three interrelated areas was approved during the 2000 Harare Workshop and briefly outlined below. The tasks include:

- creating a Directory of Ageing Research in Africa;
- creating an MDS to inform policy and estimate the burden of disease in older adult populations; and
- developing and implementing a comprehensive ageing survey on the health, mental, social, economic and general well-being of older persons in Africa.

The latter may include a baseline survey as a stand-alone effort or linked to ongoing data collection efforts. This may include surveillance/field sites, research networks and/or other surveys that facilitate a longitudinal study on ageing.

These areas of work are linked to distinct products; however, the project has also been developing methodological strategies and building a research network while providing support to enhance national research capacity. A substantial amount of attention, planning and work will be needed to ensure that the resulting information is presented in a format that is used by and accessible to researchers and policy-makers as well as relevant to the needs of older adults in Africa.

3.3. Progress Reports

Each country briefly presented an update on progress, output and activities. Progress and barriers to progress were presented. A discussion about similarities and differences in each country followed. The organization and working relationships within the ZimMDS has resulted in high output levels and significant progress in Zimbabwe.

IV. Definition of “old”

Before discussing the indicators, a working definition of “old” or lower age limit was needed. Workshop participants at the 2000 Harare MDS Workshop agreed to use the chronological age of 60 years and older as a guide for the working definition of old. The definition conformed with an UN endorsement (UN General Assembly resolution 35/129). However, this was revisited during the 2001 Dar es Salaam MDS Meeting. The meeting participants agreed that using this age cutoff did not take into account the real situation of older persons in developing countries, specifically in sub-Saharan Africa.

Participants acknowledged that while there are commonly used definitions of old age, there is no general agreement on the age at which a person becomes old. As the text box below (Defining Old) illustrates, old age in many developing countries is defined in terms not commonly used in developed countries. Despite this, it is not uncommon for the retirement age set by governments to be used. Considering that a majority of older persons in sub-Saharan Africa live in rural areas and work outside the formal sector, and thus expect no formal retirement or retirement benefits, this imported logic is unsuitable. One also needs to take into account the comparatively lower life expectancies in the continent and the smaller proportion of the older adults in the population when deciding upon a definition.

It was acknowledged that the use of 50 years of age is also somewhat arbitrary and introduces another set of issues, yet it was believed to be a better representation of a realistic working definition in Africa. Therefore, the participants agreed that the MDS Project should use 50 years of age as the lower age threshold for consideration. The participants endorsed using 50 years of age and older as the working definition of “older” or “old” for the purposes of this project. A full description is beyond the scope of this report, but will instead be presented in a discussion paper.

Defining Old

“The ageing process is, of course, a biological reality which has its own dynamic, largely beyond human control. However, it is also subject to the constructions by which each society makes sense of old age.

In the developed world, chronological time plays a paramount role. The age of 60 or 65 years, roughly equivalent to retirement ages in most developed countries, is said to be the beginning of old age.

In many parts of the developing world, chronological time has little or no importance in the meaning of old age. Other socially constructed meanings of age are more significant, such as the roles assigned to older people; in some cases it is the loss of roles accompanying physical decline which are significant in defining old age. Thus, in contrast to the chronological milestones which mark life stages in the developed world, old age in many developing countries is seen to begin at the point when active contribution is no longer possible.”

From Reference #8: Gorman M. Development and the rights of older people. In: Randel J, et al., eds. *The ageing and development report: poverty, independence and the world’s older people.* London. Earthscan Publications Ltd..1999:3-21.

V. Indicators

In an effort to describe the overall situation of the older population in sub-Saharan Africa, the MDS Project has developed a list of indicators specific to the older adult population. A primary goal for this meeting was to revise the latest version of the list of MDS Indicators (MDS Version 2.0). A description of this process follows.

5.1. Guiding principles

Since these indicators will be action- and use-oriented (for example, to assist with policy development and to develop/monitor, amongst other things, programmes and services), the data should be useful at all levels: national, sub-national (provincial or district) and local. An additional benefit of standardised data and a core MDS will be comparability across districts/provinces, countries and regions. These indicators may be used to:

- measure progress towards established objectives, targets and goals;
- monitor service performance and coverage;
- monitor trends and changes over time;
- monitor differences between population sub-groups; and
- provide timely response to policy and /or programme information needs.

Indicators should be relevant to national needs and whenever possible measured with data from routine data collection processes. While the MDS Project will facilitate the task of creating a core MDS, it remains the responsibility of each country to determine the essential indicators for monitoring its population's health and socioeconomic status and system performance.

5.2. Rationale

Indicators are generally defined as variables that help to directly or indirectly measure changes in the situation/well-being and to assess the extent to which the objectives and targets of a programme are being attained[2]. Indicators are more general markers each composed of a number of data elements, and are defined to enable the monitoring and evaluation of objectives and targets.

> Health (and social) indicators summarise data which have been collected to answer questions relevant to the planning and management of health (and social) programmes. They can be useful tools for assessing needs, monitoring and evaluating programme implementation and impact.
>
> *From Reference #3:* World Health Organization. Selecting reproductive health indicators: a guide for district managers. (WHO/RHT/HRP/97.25) World Health Organization, Geneva. 1997.

Many examples of indicators and their application at country level are available in published and grey literature [4-7]. A multitude of indicators at the international level are available from a variety of sources; notable examples are listed in Section 5.3 below.

Practical and financial realities will compel project collaborators to select indicators that are already being collected as part of national and/or global monitoring and goals, and could easily extend data collection to include this population.

5.3. MDS Project Indicators

The MDS Indicators have been developed using the principles and rationale described above. The initial list of indicators under consideration for the MDS was a comprehensive list pooled from a number of sources (various national indicators; WHO's Basic Health Indicators[9] and Health for All 2010[10] indicators; World Bank's Social Indicators for Development and World Development Indicators[11]; UNDP's Human Development Indicators[12]; FAO's Anthropometric, Health and Demographic Indicators in Assessing Nutritional Status and Food Consumption[13]; UNAIDS Prevention Indicators[14]; UNICEF's State of the World Children Indicators[15]; and indicators for sustainable development[16], amongst others).

This initial list (Version 1.0) included 117 indicators divided into eight categories. Version 1.0 was reviewed during the 2000 Harare MDS Workshop and subsequently shortened to a core list of 24 indicators, each with multiple components, divided into the following five categories: 1) population and social; 2) socioeconomic status; 3) health status; 4) health risks and behaviours; and 5) social service and health care. This revised short-list of indicators (Version 2.0) was used as the basis for critical review during the 2001 Dar es Salaam MDS Meeting. The criteria and process for selecting the indicators are described below.

5.4. Indicator selection criteria

Since the MDS has been defined as the least amount of necessary information, it is not a comprehensive list of *all* possible indicators on ageing and older populations. In addition, objective criteria were needed to evaluate the merit of each indicator. These criteria may be used to establish the baseline indicators and can be re-applied when revising and updating the indicators over time. The core list of indicators can then be compared to national policy and research needs. Table 1 contains the list of objective criteria and steps proposed to meeting participants for evaluating the indicators in MDS Version 2.0.

5.5. Indicator selection process

Each participant contributed to the detailed review and revision of each indicator category and indicator. The ensuing debate about the indicators resulted in majority agreement or consensus on each item. Where consensus was not reached after lengthy discussions, a working group was established to follow-up and report back to the group.

In addition to the individual contributions of meeting participants, the group also used the Organisation for African Unity's Policy Framework and Plan of Action on Ageing (see the Report of the Expert Meeting on Developing an OAU Policy Framework and Plan of Action on Ageing, held in Kampala, Uganda (CAD/WGD/30/9.01)) and the UN International Plan of Action on Ageing (http://www.un.org/esa/socdev/ageing/ageipaa1.htm) as guides to revise and establish the list of indicators. The upcoming 2002 World Assembly on Ageing may be an opportunity to utilise and apply the MDS on ageing (http://www.un.org/esa/socdev/ageing/waa/).

Table 1. Proposed general criteria and steps for selecting indicators [c]

Step 1: Identification of existing lists of proposed indicators

Step 2: Aggregation of the proposed lists with identification of commonalities, overlaps and gaps

Step 3: Production of a preliminary short-list by prioritization of the selected indicators, avoiding overlaps

Step 4: Evaluation of each indicator using objective selection criteria in the following box

> ***practical:*** easy to collect, interpret and use;
> ***useful:*** can effectively measure change, progress or performance, either directly or indirectly;
> ***representative:*** adequately encompasses all the expressed/expected issues, sub-population and population groups;
> ***understandable:*** simple to define and easy to interpret and apply/use;
> ***ethical***: generated from data collected and sources chosen which do not conflict with accepted ethical values of a given society; and
> ***accessible:*** data are readily available and/or will be obtained through validated methods.

Step 5: Identification of the strong indicators - by a process of elimination

In addition to being scientifically robust (see box above), these indicators should be:

> * A reflection of the scientific qualities for any indicator is that it meets the following criteria:
> ***robust:*** it measures what it is supposed to measure;
> ***valid:*** it is a true expression of the phenomena it is measuring;
> ***reliable:*** it results in the same value given similar measurement conditions;
> ***objective:*** it is able to provide the same result if measured by different people under similar circumstances;
> ***sensitive:*** it is capable of reflecting changes in the phenomena of interest; and
> ***specific:*** it reflects changes in only the specific phenomena of interest.

Not all indicators will meet each of the criteria from steps 4 and 5, but these can then assist with developing strong and 'weak' indicators.

Step 6: Identification of gaps in the coverage by the strong indicators and identification of the least problematic of the 'weak' indicators proposed for these programme areas

Step 7: Review of short list by expert panel and generation of final selection

In addition to the desirable scientific characteristics, there are additional elements that are relevant to the use of an indicator and the methodology employed to collect the data. These are that data required for the indicator:

a) are useful for taking action in the community by those who originally recorded the data, or the service unit from which the data originated; and
b) can be used to establish thresholds for action and/or contribute to attaining objectives and targets[a]; and
c) that these data should be generated, as far as possible, through routine service processes or through easily and rapidly executable surveys.

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[c] Adapted from Reference 3 (WHO Document WHO/RHT/HRP/97.26).
[d] Objectives are statements regarding desired population goals (for example health improvement or disease reduction) expressed quantitatively within a given time frame. Targets are usually expressions of desired system or service performance (for example, output or coverage) desired to be achieved at some time in the future.[17, 18, 19]

VI. Discussion

6.1. Project structure

The participants agreed with the project structure but acknowledged that more effort will be needed to bring policy and research together. The corresponding need for frequent communication and open dialogue amongst the project collaborators and with a broader group of interested stakeholder was identified as crucial to success.

6.2. Project needs: hardware, software and training

National project coordinators have expressed the need for additional support to extend their capacity and to expand ongoing work that contributes to the MDS Project. Computers, data management and analysis software and training are needed.

One goal of the MDS Project is to have a common data platform that will facilitate data entry, collation, cleaning, management, analysis and sharing. A sustainable data management process and/or system is being developed. Data transfer and sharing has been through exchange of Microsoft Access and Excel files. The project is currently developing the online database capacity within the MDS Project webpages (http://www.who.int/whosis/mds). As much as possible, standard data submission formats will be encouraged by providing Access and Excel spreadsheets with the MDS Indicators to national coordinators. Direct data entry via the internet may become a possibility. Data will also be geo-coded to be used in mapping software, such as WHO's HealthMapper (http://www.who.int/emc/healthmap/healthmap.html), as a means for both data management and information dissemination.

Especially in the situation of online communication and data sets, adequate hardware is necessary. Project computers and software have been distributed from WHO, when possible and where needed, as a means of improving the immediate computing capacity and online links for project coordinators and collaborators.

For longer term research needs, training courses on the technical, policy and data management aspects related to or directly linked to the MDS Project will be encouraged (see HAI Training Courses and MDS Project Newsletters Issues 1-5). At a future date, the MDS Project may consider developing a specific and regularly offered training course, to be hosted in conjunction with all the project partners as well as interested universities, institutes and stakeholders.

6.3. Discussions about the Indicators

Table 2 summarises discussions about data and specific issues for each category of indicators. In many cases, data for these indicators are not readily available or are of poor quality. A more detailed discussion on this issue is available in the 2000 Harare MDS Workshop Report, but basically, problems with available data were grouped into two categories:

- the insufficient use of available data; and
- the inadequate quality, completeness and timeliness of data produced through routine and non-routine mechanisms.[17,18]

Strategies to address these problems are outlined in Tables 2 and 3.

Table 2. Summary of Discussions by Indicator Category

Indicator Categories & Indicators	Discussion Summary
General issues	1. Reviewed definitions of urban and rural. Definition of rural is different for each country and includes, population totals per area (e.g. Ghana < 5,000; Zimbabwe < 20,000) or area type and service provision (e.g. South Africa = non-metropolitan area; and Tanzania = those area not designated as cities, municipalities, town and township councils as well as designated planning (trading centre) areas). Comparisons will need to take into consideration these differences. 2. Discussed data issues: level of data (i.e. macro vs. micro); terminology that include rates and patterns need to be well defined.
A. Summary Measures	1. For comparative purposes, need to include selected population data on all age groups. Despite some objections, it was accepted that including a wider range of ages would not affect the "minimum" in MDS. ACTION: add indicator category A. Summary Measures. 2. Discussed terminology of health systems indicators (A006): coverage to include eligible population, access, availability, satisfaction and outcomes. ACTION: coordinate terminology with that used at WHO (EIP/OSD).
B. Older Adult Population	1. Starting with this category of indicators, only data included from the population aged 50 years and above. 2. Discussed the definition of old age. Brief summary in Section IV. ACTION: discussion paper to be written. 3. Discussed mortality rate data: life tables available from WHO and countries (e.g. see Dr Marindo at the University of Zimbabwe). ACTION: compare life tables from different sources.
C. Socioeconomic Status	1. Discussed education status (C001): past education; continued lifelong education; and literacy. Categorisations used for the MDS Project should reflect the educational system at the time older persons were of primary/secondary school age. Mass media (C00104) will be used as gauge for public health efforts and as surrogate measure of education/income, however, it will be defined as utilisation of the given medium, not just access. It was felt that this information will be more useful for interventions. Primary occupation over working life would assist with both educational status and income indicators. ACTION: use education categories that reflect historical changes and compare across countries, add primary occupation over working life (C00105) as component of indicator C001. 2. Discussed poverty & basic needs (C002): poverty levels need to be defined at national level, but acknowledged the subsequent problems of comparability. The project will use internationally established levels to complement the national levels, yet with some reservation: comparability and availability as positive, applicability and accuracy as negative. ACTION: working group created. 3. Discussed income (C003 & C004): accurate income assessments and totals are very difficult to obtain. Income data are of notoriously poor quality, so it was agreed to focus more on expenditure data as a surrogate measure of income. Felt it is important to create a system to identify informal sources of income and pensions (where applicable). Labour-force participation rates were removed because of the poor quality and validity of the available data, especially in older populations.

	ACTION: a broader list of income sources was created for C003 to be included in data collection; economically-active population will be used in C003 on a conditional basis and will be reviewed.
D. Housing & Living Arrangements	1. Discussed living arrangements (D001): types and uses of rooms in a household were deemed as important as the number of rooms. ACTION: add two items, D00106 (Number of rooms per dwelling) and D00107 (Number of rooms used for sleeping per dwelling). 2. Discussed definition of household (D002): agreed that a household would be defined to include only those who eat out of same pot +/- time factor (i.e. > 1 month per year). ACTION: describe and define time factor for D002. 3. Discussed definition of household head (D00201): the figurative and literal household head may not be the same person. A person who runs the household, the decision-maker, or the primary breadwinner may or may not be the head. It was agreed that designation of the head would be based on household self-reports (i.e. who is generally recognised within a household as the head). ACTION: add one item, D00202 (primary household breadwinner). 4. Discussed institutional care (D003): few formal facilities exist and the majority of these are geared for minority and wealthy population groups. Need to include formal and informal care in the home setting. ACTION: review terminology for care-giving and receiving.
E. Health Status, Risks & Behaviours	1. Discussed disability (E003): need to review literature, WHO work and country data. Assessment tools needed. ACTION: working group to review disability surveys and WHO work. 2. Functional status and mobility(E004): again, no widely used/validated assessment tools for adult populations. ACTION: working group. 3. Tobacco, alcohol and drug abuse (E005): briefly discussed smoking prevalence vs. smoking impact ratio (WHO). Alcohol intake to include local and home concoctions. ACTION: use smoking prevalence until smoking impact ratio is validated. 4. Nutrition (E006): assessment tools needed, see work at HAI and MDS Project funded work at University of Cape Town. ACTION: food security issues moved to C02 (Poverty and Basic Needs) indicators. Working group created.
F. Social Well-Being	This entire category of indicators is very important. Agreed that it needs considerably more attention and development. HAI has done a lot of work in these areas and will take the lead. Quality of life measures from WHO and Prof. Møller at Rhodes University. ACTION: working group created.
G. Impact of HIV/AIDS	Needs wider consultation even after reworking the structure and wording of the indicators. ACTION: working group created – WHO action needed.

6.3.1. Working groups

It was agreed that nine indicators and one whole category of indicators needed more discussion and wider consultation. Table 3 indicates the issues and persons who agreed to provide feedback and advice on how to structure and develop the indicators in these areas. It was agreed that a wider group of colleagues and expertise was needed and would be consulted.

Table 3. Working Groups and Issues by Indicator

Indicators	Working group facilitator (s)
C.02. Poverty and basic needs (including food security)	Dr Biritwum, Dr Nsowah-Nuamah
E.03. Disability	WHO
E.04. Functional status and mobility	Ms Broderick, Dr Ferreira, Dr Kalula, Ms Kanyowa, Dr Madzingira
E.06. Nutrition	Dr Biritwum, Prof Charlton, WHO
F.01. Social integration	HAI
F.02. Contributions	HAI
F.03. Rights	HAI, Dr Ferreira
F.04. Subjective well-being and quality of life	Dr Ferreira, Prof Møller
F.05. Attitudes towards older people	HAI
G.01-04. Impact of HIV/AIDS	WHO

VII. Conclusion

Version 2.0 of the MDS Indicators was critically evaluated by meeting participants during the 2001 Dar es Salaam MDS Meeting held on 21 and 22 June 2001. The resulting Version 3.0 includes 31 indicators in seven categories. This latest draft includes 31 indicators grouped into seven categories: 1) summary measures; 2) older adult population; 3) socioeconomic status; 4) housing and living arrangements; 5) health status, risks and behaviours; 6) social well-being; and 7) impact of HIV/AIDS (see Appendix 2). All indicators will be adjusted for age, sex and urban/rural setting where applicable. Another consideration was to include geo-referenced data where available and to include this in future data collection efforts. A graduated MDS with a core and expanded set of indicators needs to be developed.

Both qualitative and quantitative data will be incorporated into the MDS. It is believed that this will provide a richer context and deeper understanding of the data. Data sources and detailed definitions for each indicator, as well as strategies to fill data gaps, are available in separate MDS Project documents.

The MDS Project coordinators and collaborators acknowledge the need for a regular and systematic process of indicator review and revision. This would provide a system to assess and reassess the situation of the older population. While it was acknowledged that an annual or bi-annual review of indicators will be needed, the process and criteria to accomplish this task were established at the meeting. Forging and strengthening linkages to other activities related to ageing research and ageing policy development, at the national, regional (OAU's Framework and Plan of Action on Ageing) and international (UN International Plan of Action on Ageing and) levels was encouraged.

The following products were generated during the meeting:

- A list of indicators in seven categories: 1) summary measures; 2) population; 3) socioeconomic status; 4) housing and living arrangements; 5) health status, risks and behaviours; 6) social well-being; and 7) impact of HIV/AIDS (see Appendix 2);
- A process and set of criteria for evaluation and re-evaluation of the indicators;
- A list of problem/priority areas, including current data difficulties and needs for improvement; and
- A number of working groups to address each of the problem/priority areas.

A list of data sources for each indicator was previously produced by the MDS Project and will be linked to this new list of indicators. The available data list will be updated and linked to MDS Indicators Version 3.0.

7.1. Problem/priority areas

A number of problem and priority issues were identified during the meeting. After discussing relevant data and issues, a number of options to address these issues were explored. The options included:

- Consulting a wider group;
- Consulting known experts in the respective field; and
- Establishing working groups.

Each option will be applied. The working groups will report back to WHO and HAI with updates and revisions until the problems with the particular indicators in question are resolved.

7.2. Follow-up actions

For the MDS Project to make practical contributions and improvements in the situation of older persons in each country, and to inform policy, a number of actions will be needed, including:

- Endorsing the indicators at the highest level;
- Providing clear definitions and meanings for these indicators;
- Creating objectives and targets for the indicators that are defined by key stakeholders;
- Specifying how the indicator data is to be obtained and used at each service level;
- Improving and standardizing data collection procedures as well as health assessment tools and recording;
- Developing a computerised database for maintaining, analyzing and disseminating the information;
- Addressing the problem/priority areas;
- Translating and disseminating the information to policy and decision makers;
- Linking indicators to national, regional and international policy efforts;
- Assessing and strengthening surveillance and monitoring procedures; and
- Linking to ongoing longitudinal research and routine data collection systems.

All project collaborators will need to include key stakeholders during each step of the project. This includes stakeholders at all levels (from local to international) to ensure the transfer of useable and timely information from bottom to top and top to bottom.

Participants agreed to improve/increase cross-national communications and to expand the diversity of disciplines contributing to and collaborating on the project.

7.2.1. Work area #1

Completion of the Directory of Ageing Research in Africa by early 2002 is desired. Extra efforts will be made by each national secretariat to finish this work in each country, while WHO and HAI will work to collect information in non-project countries in Africa.

7.2.2. Work area #2

WHO will provide copies of an draft version of the MDS to national project coordinators by early 2002. Data entry at both country level and at WHO, leading to the release of MDS Version 1.0, should be completed by mid-2002. Data gaps will then be identified and strategies to fill those gaps will be developed.

7.2.3. Work area #3

As a means to validate the baseline MDS Version 1.0, an ageing survey will be developed and implemented. The process of developing a questionnaire and timeline for the survey will be initiated in early 2002.

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APPENDIX 1. List of Participants

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APPENDIX 2. Minimum Data Set Project Indicators, Version 3.0

DRAFT

Note: Version 3.0 contains 31 indicators. Data for the indicators are to be adjusted for age, sex, and urban/rural setting. For this project, 50 years of age and older is used as the lower chronological age threshold (except where specified otherwise) for inclusion in the indicator categories except Category A. Category A will include data for all age groups, whereas, Categories B through G will be focus on the population aged 50 years and older.

A. SUMMARY MEASURES
- 01. General population
- 02. Migration rates & patterns
- 03. Population health status
- 04. Income & expenditures
- 05. Social security/welfare & services (WORKING GROUP)
- 06. Health systems

B. OLDER ADULT POPULATION
- 01. Number & percentages of older persons
- 02. Life expectancies at age 50, 60, 80 years
- 03. Mortality rates

C. SOCIOECONOMIC STATUS
- 01. Education
- 02. Poverty & basic needs (incl. food security) (WORKING GROUP)
- 03. Sources of income & transfers
- 04. Income & expenditure distribution

D. HOUSING & LIVING ARRANGEMENTS
- 01. Housing conditions
- 02. Household composition
- 03. Institutional care

E. HEALTH STATUS, RISKS & BEHAVIOURS
- 01. Causes of morbidity and mortality
- 02. Self-reported health status
- 03. Disability (physical/mental) (ACTION BY WHO)
- 04. Functional status (physical/mental) & mobility (ACTION BY WHO + working group)
- 05. Tobacco, alcohol & drug abuse
- 06. Nutrition

F. SOCIAL WELL-BEING
- 01. Social integration (WORKING GROUP)
- 02. Contributions (ACTION BY HAI)
- 03. Rights (abuse & violence, displacement, loss of property) (WORKING GROUP)
- 04. Subjective well-being & quality of life (WORKING GROUP)
- 05. Attitudes towards older people (ACTION BY HAI)

G. IMPACT OF HIV/AIDS
- 01. Demographic
- 02. Health
- 03. Social
- 04. Economic

Minimum Data Set Project Indicators by Categories A through G.
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A brief description of the composition of each **indicator** (in bold) is listed below. Complete definitions of each indicator and indicator components are included in separate document.

A. SUMMARY MEASURES

A001. General population (including population estimates and projections (1970-2050)).
- A00101. Total number of persons by 5-year age group, AIDS mortality included.
- A00102. Annual population growth rate, by 5-year age group.
- A00103. Sex ratio.
- A00104. Dependency ratio.
- A00105. Marital status.

A002. Migration rates and patterns.
- A00201. Internal migration rates (including internal displacement).
- A00202. International migration rates.
- A00203. Migration patterns.
- A00204. Number of refugees.

A003. Population health status.
- A00301. Life expectancy at birth, AIDS mortality included.
- A00302. DALE/HALE at birth.

A004. Income and expenditures.
- A00401. Real GDP, per capita.
- A00402. Real annual expenditures, per capita.
- A00403. Gini coefficient.
- A00404. Total expenditures, by sector and per capita.
- A00405. Social expenditures (pensions, social security, social welfare), by sector and per capita.
- A00406. Health expenditures, by sector, major expenditure categories, income distribution and per capita.

A005. Social security/welfare and services.
- A00501. Availability of resources, by region, sector and type.
  - A0050101. Social security/pensions: Number of eligible clients.
  - A0050102. Social security/pensions: Number of recipients.
- A00502. Access to social services: Average distance to nearest facility/support personnel.
- A00503. Use of social services (per year), by sector and type.

A006. Health systems.
- A00601. Availability of resources, by region, sector and facility type.
  - A0060101. Number of eligible clients.
  - A0060102. Number of health care facilities.
  - A0060103. Number of health care professionals, by type per facility.
  - A0060104. Number of traditional caregivers/healers/herbalists.
  - A0060105. Access to essential drugs.
- A00602. Access to health services/systems, by region, sector and facility type.
  - A0060201. Average distance to nearest government funded /private health care facility.
  - A0060202. Average distance to nearest traditional caregiver/healer/ herbalist.
  - A0060203. Average travel time to nearest government funded/private health care facility.
  - A0060204. Average travel time to nearest traditional caregiver/healer/herbalist.
- A00603. Use of health care services/systems, by region, sector and facility type.
  - A0060301. Number of patient visits (per year), by type of service and patient type (new or revisit).
  - A0060302. Number of times in last year used a facility or service provider.

A0060303. Number of times in last year used a traditional caregiver/healer/herbalist.

A0060304. Source of payment for services/treatment: formal or informal.

A00604. Percentage of patients rating overall satisfaction with health care services received as very good, good or fair on 5-point scale (very good, good, fair, poor, very poor).

A00605. Percentage of patient outcomes as a result of services provided, rated as: cured; improved; no change; worsened; death, by acute or chronic illness type.

B. OLDER POPULATION

B001. Total number of older persons (estimates and projections), AIDS mortality included.

B00101. Total number of persons age 50+, 60+ and 80+ years.

B00102. Percentage of the population 50+, 60+ and 80+ years.

B002. Life expectancies at age *x*.

B00201. Life expectancy at 50, 60 and 80 years.

B00202. DALE/HALE at age 50, 60 and 80 years.

B003. Mortality rates.

B00301. Crude death rate.

B00302. Mortality rate: total, all-cause, age-adjusted, age-specific, & cause-specific.

C. SOCIOECONOMIC STATUS

C001. Education.

C00101. Percentage of the population that is literate.

C00102. Number of years of education.

C00103. Highest grade of education completed.

C00104. Utilisation of mass media (newsprint, radio, television).

C00105. Primary occupation over working life.

C002. Poverty and basic needs

C00201. Percentage of population below the national poverty line.

C00202. Percentage of population below international poverty line (PPP $1/day).

C00203. Percentage of population below international poverty line (PPP $2/day).

C00204. Percentage of population with basic needs met.

C003. Sources of income and transfers (formal and informal work income plus pensions)

C00301. All sources of income (agricultural vs. non-agricultural).

C00302. Primary source of income.

C00303. Economically active population, in thousands.

C004. Income and expenditure distribution.

C00401. Total monthly household income.

C00402. Total monthly household expenditure.

C00403. Monthly household expenditure distribution (food vs. non-food).

D. HOUSING & LIVING ARRANGEMENTS

D001. Housing conditions

D00101. Number of households, by region and location.

D00102. Percentage of households with access to safe water.

D00103. Percentage of households with access to waste/excretia disposal and sanitation.

D00104. Percentage of households using *x* energy/fuel source for cooking/lighting.

D00105. Percentage of households with *x* roof, floor, and wall material types.

D00106. Type of dwelling.

D00107. Number of rooms per dwelling.

D00108. Number of rooms used for sleeping per dwelling.

D00109. Household location (i.e. % urban, peri-urban, squat, rural).

D002. Household composition[e]

D00201. Household heads: Percentage distribution by sex.
D00202. Primary household breadwinner.
D00203. Household population: Distribution of the *de-jure* members[f].
D00204. Household population: Relationships of the *de-jure* members to the household head.
D00205. Average household size, by household head, region and location.
D00206. Percentage distribution of urban and rural dwellings with 1+ person aged 50+ years by region.

Institutional care

D00207. Number of older people's homes, by type (i.e. source of operating funds) and region, in thousands.
D00208. Number of residents in older people's homes, by type and region, in thousands.
D00209. Numbers of older persons receiving formal (professional or semi-professional) home care services.

E. HEALTH STATUS, RISKS AND BEHAVIOURS

E001. Causes of morbidity and mortality

E00101. Leading causes of death.
E00102. Leading conditions for inpatient admissions (including iatrogenesis).
E00103. Leading reasons for outpatient visits.
E00104. Population with cognitive or mental impairment.
E00105. Average number of diagnosed conditions, as a percentage of categories (a) none, b) one, c) two to four; d) five or more).
E00106. Population with 1+ risk factor for NCDs.

Self-reported health status

E00107. Percentage of population indicating self-rated health as very good, good or fair on a 5-point scale (very good, good, fair, poor, very poor).
E00108. Leading self-reported health conditions, including mental illness.

E002. Disability (physical, mental, sensory).

E00201. Percentage of population with self-reported disability (sight, hearing, physical, mental, multiple, unspecified, total).
E00202. Population with diagnosed disability, as a percentage of all diagnosed disabilities based on ICF disability classification categories.

E003. Functional status (physical and cognitive/mental) and mobility.

E00301. Percentage of population with 1 or more ADL deficiency.
E00302. Percentage of population with 2 or more IADL deficiencies.
E00303. Percentage of population scoring less than 24 on (MMSE) (or validated test to be identified.)
E00304. Percentage of population with mobility impairment on a four point scale - independent, with help, only with aid, cannot/bed ridden.
E00305. Percentage of population reporting regular physical activity[g].

E004. Tobacco, alcohol and drug abuse rates.

E00401. Percentage of the population using a tobacco product daily/occasionally/never by frequency, amount and duration of use (past and present).

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[e] Working definition: household members eat out of the same pot +/- time factor (i.e. > 1 month per year).

[f] DE JURE - According to law; by right,; legitimate. DE FACTO - Common, but without strict legal authority. In this case, *du jure* meaning "usual resident/household member" (i.e. most months of the year or "eat out of same pot") contrasted with *de facto,* implying status households status as of the night prior to the interview (i.e. who slept in the dwelling the previous night).

[g] Generally accepted recommendation for physical activity beneficial for health: physical activity of moderate amount and intensity, accumulating to about 30 minutes duration, most days of the week. "Moderate amount" is roughly equivalent to physical activity that uses approximately 150 calories (kcal) of energy per day, or 1000 calories per week. (CDC and WHO)

E00402. Smoking prevalence (until smoking impact ratio developed further by WHO/EIP).

E00403. Percentage of the population that consume alcohol-containing beverages by amount (average volume) and frequency (patterns of drinking) (see WHO/EIP).

E00404. Substance/drug abuse prevalence (i.e. prescription and non-prescription/illicit drugs).

Nutrition[h]

E00405. Percentage of the population with < 67% of RDA energy intake.

E00406. Percentage of the population with < 67% of RDA protein intake.

E00407. Percentage composition of the macronutrient intake.

E00408. Percentage composition of the micronutrient intake.

E00409. Percentage of the population with MUAC <24 and/or BMI < 18.5 or > 25.

F. SOCIAL WELL BEING

F001. Social integration.

F00101. Percentage of the population living alone.

F00102. Percentage of the population with no remaining family

F00103. Percentage of the population with no regular contact with family/friends.

F00104. Percentage reporting loneliness.

F002. Contributions.

F00201. Percentage of households reporting a positive contribution by older persons to the household/community, by contribution type.

F003. Rights (abuse and violence).

F00301. Yearly reported abuse.

F00302. Yearly crime statistics.

F00303. Forms of reported/documented abuse ((as %) physical, emotional/verbal, financial, and/or sexual abuse, neglect, accusations of witchcraft, and systematic abuse).

Subjective wellbeing and quality of life

F00304. Average scores on summary measures (global happiness, life satisfaction index), by age and sex.

F004. Attitudes towards older persons

F00401. Perceptions of older persons, by age categories (19-35, 36-49) with scales of scoring

F00402. Respect standards (norms), calibration across cultures?

G. IMPACT OF HIV/AIDS

G001. Demographic impact of AIDS:

G00101. Total number of persons by 5-year age group, AIDS mortality NOT included.

G00102. Prevalence of HIV infection by age group, sex and region.

G00103. Number of AIDS deaths by age group, sex and region.

G00104. Percentage of older persons providing care for adult children with HIV/AIDS.

G00105. Percentage of older persons providing care for grandchildren with HIV/AIDS.

G00106. Percentage of older persons providing care for orphaned grandchildren.

G00107. Number of care-recipients per caregiver.

G002. Health impact of AIDS: (morbidity and mortality).

G00201. Life expectancy at birth, AIDS mortality NOT included.

G00202. Morbidity/mortality attributable to HIV/AIDS caregiving.

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[h] Macronutrient is equivalent to the total food energy intake. Recommended Dietary Allowances (RDA) from: Subcommittee on the Tenth Edition of the RDAs. *Recommended Dietary Allowances.* 10th ed. Food and Nutrition Board, Commission on Life Sciences, National Research Council. Washington DC, National Academy Press. 1989; 1-285. *See Charlton K, et al. Food habits, dietary intake and health of older coloured South Africans. University of Cape Town, 1995.*

G00203. Self-reported change in rate of health maintenance activities due to HIV/AIDS caregiving (increase, no change, decrease).

G00204. Self-reported worry/stress, grief, loneliness, lack of support, by caregiver type[i].

G00205. Percentage of older persons with adequate knowledge of preventive/caregiving practices, by caregiver type.

G003. Social impact of AIDS:

G00301. Total number of living children.

G00302. Number of children who have died, by AIDS attributable or non-attributable death.

G00303. Number of internally displaced households with 1+ older person, as a result of AIDS, by region.

G00304. Self-reported rates of stigma/abuse.

G004. Economic impact of AIDS:

G00401. Total household income or expenditures during caregiving.

G00402. Total household income or expenditures after AIDS death.

G00403. Percentage distribution of expenditures (including medical/funeral and burial costs and costs related to orphan care (i.e. school fees)).

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[i] Caregiving categories: not a caregiver, caregiving not related to non-HIV/AIDS, caring for HIV/AIDS adult child, caring for HIV/AIDS relative, caring for HIV/AIDS grandchild, caring for HIV/AIDS non-relative, caring for orphaned grandchild.