Background Note
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Old age, disability and mental health: data issues for a post-2015 framework

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Efforts to include inequality in a post-2015 agreement are gaining momentum, with one strand of advocacy urging consideration of the inequalities associated with particular social groups. The Millennium Development Goals (MDGs) included gender-based inequality, with MDG 3 aiming 'to promote gender equality and empower women' while the official list of MDG indicators specifies that 'all indicators should be disaggregated by sex and urban/rural as far as possible'. Issues pertaining to infants and children featured strongly, but the MDGs overlooked, for the most part, other group-based differences.

This Background Note focuses on inequalities associated with old age, disability and mental health. It argues that these should be considered salient sources of group-based difference, given the numbers of people affected, their marginalisation and vulnerability, and their relative neglect in international agreements to date.

This note identifies a lack of data as a particular concern, but one that can be addressed through revisions to standard household surveys. To this end, the paper discusses the available data and their limitations, constraints to better data collection and efforts needed to adjust key international survey instruments – the World Bank's Core Welfare Indicator Questionnaire (CWIQ) and Living Standards and Measurement Survey (LSMS), Macro International's Demographic and Health Survey (DHS) and the UNICEF Multiple Indicator Cluster Survey (MICS) – to collect reliable data on these issues. It sets out technical adjustments that would enable these surveys to broaden their coverage, collect richer information and improve their identification of these three groups. It concludes by commenting on how measures to address the inequalities that affect these groups could be incorporated within a new post-2015 framework agreement.

Why this matters

Inequalities take many forms, some of which have received greater policy attention than others. Those associated with old age, disability and mental health issues did not feature in the MDGs and have been often neglected in international agreements to date. This Background Note argues for their inclusion in a post-2015 framework agreement.

Obviously, old age, disability and mental health issues are global in their scale, with salient effects on large numbers of people. But they also have close links to vulnerability and a lack of fulfilment of human rights. The discrimination experienced by those who fall into any one of these three groups is important to address in itself and is likely to have constrained progress towards certain MDGs. For example, in developing countries:

- older people may be more susceptible to fatal forms of malaria as a result of age-associated loss of immune function (Gavazzi et al., 2004)
- Over one-third of school aged children remaining out of school have a disability (Peters, 2003)
- Mental health issues and poor physical health can be mutually reinforcing, with one increasing the likelihood of the other (Das et al., 2007). However, we examine mental health issues

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separately as they are not always disabling and because the discourse on disabilities often neglects people with mental health issues.

A post-2015 development agreement that is truly concerned with inequality in its many forms should take these issues into account. One clear obstacle is the widespread lack of nationally-representative and internationally-comparable data – a challenge arising from definitional or technical issues (what to measure and/or how), operational issues (e.g., resource or capacity constraints), attitudinal issues (relating to stigma) and/or lack of demand from data users. A greater understanding is needed of these constraints and how they might be overcome. Our focus here is on the former.

Size, vulnerability and the international focus to date on old age, disability and mental health

The marginalisation of older people and those with disabilities or mental health issues is fuelled by prevailing attitudes, stigma, environmental barriers,[1] difficulties in accessing social services, and lack of voice and participation, all of which combine to render these groups 'invisible' (Cain, 2012). They are disadvantaged in many contexts, particularly where relevant policies and safety nets are absent, and their disadvantages tend to overlap in distinct ways, as well as with more often-studied sources of inequality such as gender and place of residence. We review the evidence on the size and vulnerability of each group and their treatment to date in international accords, before outlining ways in which the inequalities they face appear to overlap.

Older people

The global population is ageing. People aged 60 years and above – the international definition of older people used by the UN (UNDESA, 2004) – account for 11% of the global population. This share is expected to double to 22%, or 2 billion people, by 2050 (UNDESA statistics, cited in UNFPA and HelpAge International, 2012). Globally, there are already more older people than children under the age of five and they are expected to out-strip the number of youth aged 15 years and under by 2050. The fastest growth is happening in developing countries, with profound implications not only for older people themselves, but also for their households, their social and community infrastructure, and for social policy.

Recent studies in developing countries have found that households with older heads or members tend to be poorer than other households (Masset and White, 2004; Kakwani and Subbarao, 2007). Ageing may mean that people become less able to work and have fewer opportunities to do so, while policies and programmes designed to enhance livelihoods often exclude older people from activities that require high levels of labour capacity and mobility.

Despite their more limited opportunities for work, only one-fifth of older people worldwide have pensions and coverage is even lower in developing countries (UNFPA and HelpAge International, 2012), although studies point to their feasibility in even low-income settings (Hagemejer and Behrendt, 2009). At present, some 340 million older people are living without any secure income and, if current trends continue, this number will rise to 1.2 billion by 2050 (Meissner, 2010).

A recent study in Bulgaria, Ghana, Nicaragua, Viet Nam and the state of Andhra Pradesh in India reported that between 15% and 30% of older people lived alone or with no adult of working age (Masset and White, 2004). And in many countries where children have been orphaned by HIV and AIDS or conflict, or where parents have migrated, older people are taking on a heavy burden of caring for children (Kakwani and Subbarao, 2005). As with other forms of the 'care economy', this is not monitored (let alone rewarded) systematically.

No international convention exists as yet on the rights of older peoples although there are growing calls for such a convention, given the extent and prevalence of age discrimination and a recognised gap in protection. The 2002 Madrid International Plan on Ageing was the first to make explicit connections between ageing, development aims and human rights. It remains the only global agreement that commits governments to integrate issues related to ageing into economic and social development policies and into meeting the MDGs. However, the MDGs 'completely ignore the ageing of societies and poverty in old age' (UNFPA and HelpAge International, 2012).

Disability

Disability is not a rare event. Leading estimates from the World Health Organization's World Health Survey (WHO, 2011a) and Global Burden of Disease report (WHO, 2008), both using 2002-2004 data, suggest that between 15% and 20% of the population worldwide live with some form of disability, including those resulting from mental health issues, and that 2% to 4% of people have a severe disability.

On balance, disability is linked to a higher probability of being poor (Groce et al., 2011).[2] In many settings, people with a disability are less likely to obtain an education – a result of constraints to access, as well as stigma and a lack of support – and face reduced employment opportunities and earnings. Other household members may have to give up their jobs to care for them. Typically, people with disabilities have higher health-care costs, and may also face social and political marginalisation (Groce et al., 2011).

The poor, in turn, are more likely to be malnourished, in low-quality employment, subject to difficult living conditions and to be exposed to environmental hazards, all of which increase the likelihood of disability. Several meta-studies and individual country studies support this relationship.

- An analysis of 15 developing countries found that, in the majority, 'people with disabilities, on average, experience multiple deprivations at higher rates and in higher breadth, depth and severity than people without disabilities' (Mitra et al., 2013).
- In 13 developing countries, school-age children with disabilities were less likely to be enrolled in school (Filmer, 2008).
- Households with a member with a disability were 20% more likely to be poor in Tanzania (Masset and White, 2004) and 38% more likely to be poor in Uganda (Hoogeveen, 2005).
- In India, children with disabilities were over five times more likely to be out of school, while employment rates for people with disabilities were some 60% lower, on average (World Bank, 2007).

At a national level, the relationship between disability and poverty varies greatly according to the availability of health care, nutrition programmes, disability benefits and accessible schooling, highlighting the importance of policy (Mitra et al., 2013).

The 2006 *Convention on the Rights of Persons with Disabilities* marked an advance in the recognition of the rights of those with disabilities, but United Nations Member States need to do more to implement its commitments by adopting measures to ensure equality before the law, as well as non-discrimination in access to economic and social rights. UN General Assembly Resolutions in 2008 and 2010 have reinforced the need for a stronger focus on disability and have highlighted the way in which those with disabilities are invisible in statistics. People with disabilities are not included explicitly in any of the MDG targets and indicators. The 2010 and 2011 MDG Reports acknowledged the needs of this specific group, but they were was missing from the MDG Report for 2012.

Mental health

Mental health disorders account for 13% of the world's Global Burden of Disease (WHO, 2008), affecting some 450 million people, or more than six in every 100 people. Severe depression affects around 99 million people; the share of affected people has risen since 1990 and WHO predicts that it will affect more people than any other health problem by 2030 (WHO, 2008). In some countries, mental health issues are becoming increasingly important, relative to traditional health concerns. In Nepal, for example, suicide is now the leading single cause of death among women of reproductive age (accounting for 16% of deaths), while causes related to pregnancy and childbirth have fallen to third place (Suvedi et al., 2009).

Although evidence on the relationship between mental health issues and poverty is less consistent (Das et al., 2007), it has strong links to certain factors that heighten the probability of being socially excluded, such as lack of education, food insecurity, poor housing, low socio-economic status and financial stress (Lund et al., 2010). Changes in life circumstances brought on by, for example, illness, ageing, being widowed or in poor health and other adverse events, such as war, may also contribute (Das et al., 2007; Do and Iyer, 2009).

Mental health 'remains a largely ignored issue in global health, and its complete absence from the MDGs reinforces the position that mental health has little role to play in major development-related health agendas' (Miranda and Patel, 2005). There is vast and unmet need for mental health treatment, particularly in developing countries. In Colombia, Lebanon and Mexico, an estimated 76% to 85% of people with severe mental health issues do not receive treatment. Even in high-income countries, unmet need is estimated at between 35% and 50% of people with severe conditions (WHO World Mental Health Survey Consortium, 2004). Resources are part of the problem: one-third of the world's countries do not have any health-budget allocation at all for mental health, while in one-fifth of the countries that do, the allocation is less than 1% of the total health budget (Mental Health and Poverty Project, 2010).

The extent to which these and other sources of inequality overlap and reinforce one another may heighten exclusion and disadvantage. For example, older people are much more likely to experience disability – indeed, 38% of older people worldwide have a disability (Groce et al., 2011; WHO, 2011a), and older people with disabilities are more likely to be multi-dimensionally poor (Filmer, 2008). Dementia is projected to rise as populations age, and will affect an estimated 115.4 million people by 2050 (WHO, 2012). Women – who often face discrimination and other forms of inequality – are more likely to experience disability and some mental health issues than men (Das, et al., 2007; WHO, 2011a). Disability is also more evident in rural areas, which tend to be more deprived, than in urban areas (WHO, 2011a).

Physical and mental health conditions are often linked. For example, depressive disorders have been associated with a higher prevalence of cardiovascular disease and of diabetes, while schizophrenia has been linked to high mortality rates as a result of suicide but also infectious disease (Sartorius, 2007).

Despite the enormous size of these groups and their clear vulnerability, they are often neglected in international initiatives to combat inequality, as well as in domestic policy-making in many countries. Greater efforts are needed to uphold their rights and to ensure policies that foster their inclusion.

Major international survey instruments – existing data and gaps

A lack of data and monitoring mechanisms means that the situation of older people, people with disabilities and those with mental health issues is often invisible, making it more difficult to document and dismantle entrenched patterns of discrimination. There are limited or no data on these groups from the nationally-representative household surveys used to monitor MDG targets that would permit a multi-dimensional perspective on how they are faring, the circumstances of their households and their access to services. Such data would allow better monitoring of the distributional impact of policies and budget allocations.

The most efficient way to elicit relevant information in a global context is through internationally-comparable household surveys, such as those administered by World Bank, Macro International and UNICEF.

The World Bank regularly conducts several types of surveys, among them the Core Welfare Indicator Questionnaire (CWIQ)[3] and Living Standards and Measurement Surveys (LSMS).[4] The CWIQ, a concise questionnaire that fits on eight pages, is designed to monitor social indicators in Africa. It aims to obtain a quick snapshot of the communities it covers in terms of access, usage and satisfaction with public services.

In contrast, the LSMS is an in-depth household survey that aims to develop a rich multi-dimensional profile of countries. Tanzania's 2010/2011 National Panel Survey (NPS), for instance, is 48 pages long.[5] It is, therefore, more suitable for ascertaining whether individuals are living with a disability or mental health issue, and for linking information on age, disability status and mental health to other dimensions of well-being.

Demographic and Health Surveys (DHS), conducted by Macro International, are carried out in a range of developing countries every five years on average, and target women of reproductive age (usually 15 to 49 years old) and children under the age of five. The surveys consist of a household questionnaire and separate interviews for 'eligible' women within the household and, in most countries, men aged 15-59 years.[6]

UNICEF's Multiple Indicator Cluster Survey (MICS) has been conducted in more than 100 countries since 1995. Today, the survey is focused on providing MDG tracking data. The representativeness and structure of the survey are similar to the DHS surveys and the two data sources are comparable.

Several technical adjustments would enable these surveys to broaden their coverage, collect richer information and to improve identification of these three groups.

Coverage

The first gap concerns **coverage**. Here, two adjustments to sampling would increase the ability to obtain a representative picture of society. The first is to *extend survey coverage to individuals who do not live in traditional household units*. Typical household surveys exclude people living on the streets, in residential-care facilities, long-stay hospitals or orphanages, etc. Extending coverage would provide a more accurate picture of how societies are faring, and is particularly important for our three groups, who are more likely than other groups to be living in institutions, and, in the case of those with disabilities and mental health issues, on the streets.

The second adjustment – which pertains to the DHS and MICS only – would involve *sampling households regardless of the age composition of their members*. The CWIQ questionnaire already puts all questions to all members of the household aged up to 99 years, except those questions that are only relevant at the household level, and the LSMS elicits a full roster of all household members and their ages up front. At present, however, DHS and MICS are not designed to capture issues relating to old age, not least because they sample only those households with a woman of reproductive age.

Richer information

The second gap concerns the need to collect **richer information** about the experiences of these groups. Here, two types of adjustments are recommended:

first, asking already-included questions of all household members; and second, asking questions on issues that may affect our three groups in particular.

Asking already-included questions of all household members is important to account for the intra-household distribution of resources and to obtain information that is as accurate as possible. Following the unitary model of the household, above all in assessing income and consumption, each member of the household is typically assigned a per-capita value equivalent to the total value divided by the number of household members, sometimes adjusted for age and household size. But this method does not give any insights into the actual allocation of resources within the household.

Asking for the data *directly* of the household member concerned (rather than asking a household head or other nominated person to answer on his or her behalf) tends to yield more accurate data. A recent experiment compared answers to household-survey questions on employment obtained from proxy reporting and self-reporting (Bardasi et al., 2010). Response by proxy yielded lower male labour-force participation, lower female working hours and lower employment in agriculture for men – and the evidence suggested information imperfections within the household, especially in relation to a distance in age between respondent and subject.

Finally, household surveys should *address issues that may affect particular groups such as older people (and women) in particular*, such as the care economy and domestic violence. Collecting data on care-taking requires time-use surveys that are time-consuming and that require painstaking effort. Questions on domestic violence are not always addressed to women over 50 years old, despite evidence that the problem may be sizeable not only among young women, but also among other groups in the population. In Europe, for example, an estimated four million older people experience physical abuse (WHO, 2011b), and in Mozambique, Tanzania and Zambia, older people are often the targets of witchcraft accusations, robbery, land and housing seizures and emotional abuse (HelpAge International, 2012).

In DHS and MICS, domestic violence questions are asked to one selected woman of reproductive age in each household.[7] CWIQ does not address domestic violence and just three LSMSs have asked pertinent questions: India (Bihar/Uttar Pradesh), 1997-1998; Malawi, 2004; and Tanzania, 2008-2009.[8] The India and Tanzania surveys ask their questions on 'violence against women' only of women of reproductive age – the former, of one woman in the household aged 15-49, and the latter, of all women in the household aged 15-50. The Malawi questionnaire asks its questions of all family members, but in a general module on safety and insecurity. It asks each household member if they have experienced physical violence and then asks who was the perpetrator. 'Household member' is a possible response, but household power relations are likely to lead to under-reporting. Inquiring about domestic violence through specially-designed questions is recommended, though these are sensitive issues to raise and require careful enumerator training. But there is little justification for asking such questions only of women in a certain age range.

Identification

The final gap concerns the **identification** of people who are older, who have disabilities and who have mental health issues. To highlight the circumstances of particular and smaller numbers of people, such as those of advanced old age among older people, it may be necessary to *over-sample particular groups to obtain representative data*. But a key issue is to *ask questions that identify people accurately, particularly those who have a disability or mental health issue*. Earlier work on disability and mental health (as well as on older age) has highlighted physical limitations, while more recent models emphasise how physical conditions interact with societal structures to enable or hamper activities, participation and exclusion. With this conceptual model in mind, we examine how surveys have tried to identify two groups of people – those with disabilities and those with mental health issues – highlighting examples of best practice.

Disability

Household surveys have three main ways to identify disability. The first is self-report or past clinical diagnosis. For instance, the 2006 Iraq LSMS asks respondents *'Do you suffer from any disability?'*, then asks about the nature of that disability, its cause and when it started. CWIQ asks one self-reporting question of disability: *'Is [NAME] physically or mentally handicapped or disabled?* – a question that also contains the qualification 'Include person only if handicap prevents him or her from maintaining a significant activity or schooling'. Such questions are problematic because they rely on perceptions of what constitutes 'disabling', which may differ across individuals, and are rooted in a physical model of disability. Such questions yield underestimates of prevalence, particularly where access to health services is low, or where stigma toward disability conditions responses, and are likely to identify only those people with more severe disabilities (Mont, 2007).

The second approach, usually applied in conjunction with the first, aims to ascertain the degree of disability by asking questions that relate to particular functions. For example, the 2004 Bosnia and Herzegovina survey asked respondents whether they consider themself to be disabled, and then three follow-up questions.

- *Has your health activity limited your ability to perform vigorous activities such as lifting heavy objects, running, or participation in strenuous sports?*
- *Has your health limited your walking uphill?*
- *Has your health limited you from bending, lifting, or stooping?*

This is useful, but it is not comprehensive in the range of activities included.

The third approach undertakes a more systematic inquiry of the person's functioning across an agreed set of domains. The United Nation's Washington Group on Statistics (WG) has marked a major step forward in recommending a simple set of internationally-comparable questions to establish the prevalence and severity of disability (Box 1). These focus on the constraints that a person's physical condition has upon his or her ability to undertake a range of basic activities that are necessary to function in society – namely seeing, hearing, mobility, cognition, self-care, and communication. The WG questions have been posed in the World Health Survey and in the 2006 Ugandan DHS.

The measurement of disability in Uganda provides an example of how prevalence can vary even within the same country over roughly similar periods using these different approaches. Using the WG questionnaire, the 2006 DHS survey established a 20% disability rate for the population aged five years and above. This contrasts with the 3.5% rate captured in the country's 2002 Population and Housing Census and the 7% rate that emerged from the 2005-2006 Uganda National Household Survey (UBOS and Macro International Inc., 2007), both of which asked a single question to identify disability and specified that it must have lasted six months or more.[9]

An Annex[10] to accompany this Background Note gives examples of disability questions in different surveys. Disability does not form part of the DHS core survey but, nevertheless, some DHS include some disability-related questions. MICS have passed through four phases; the 2nd phase introduced an optional Ten Question Module that aims to identify children with congenital and developmental disabilities by asking about impairments, actual health conditions (such as epilepsy) and activity limitations (e.g., difficulties in walking or speaking) – though analysis of the resulting data suggests implementation issues, such as substantial variation in the survey process and questions asked, and the lack of follow up of children identified by their parents as disabled (Loiza and Cappa, 2005, p. 20).

Box 1: Washington Group recommended questions on disability

Because of a physical, mental, or emotional health condition…

1. Do you have difficulty seeing even if wearing glasses?
2. Do you have difficulty hearing even if using hearing aid/s or are you deaf?
3. Do you have difficulty walking or climbing stairs?
4. Do you have difficulty remembering or concentrating?
5. Do you have difficulty (with self-care such as) washing all over or dressing?
6. Do you have difficulty communicating (for example, understanding or being understood by others)?

Question response categories: No, Some, A lot, and Unable.

Source: http://bit.ly/BNESLR1

The 2010/2011 Tanzania NPS gives an example of best practice: all respondents aged 12 years and older are encouraged to reply for themselves and the enumerator is instructed to record whether or not the response is obtained directly or by proxy. The questions follow the WG model, asking additional questions on when each specified difficulty began, whether it reduced the amount of work the respondent could do (at home, work or school) and whether any measures had been taken in the previous 12 months to improve the respondent's performance of activities.

Mental health

Mental health issues have received short shrift in international survey instruments to date. The DHS core questionnaire does not address mental health at all. Countries are free to omit or add questions on specific topics as deemed necessary, but only the 2002 Uzbekistan survey included a module on mental health using screening questions. Similarly, no MICS addresses mental health issues. Customised for each country, of a total of 96 LSMSs conducted to date, only 17 surveys in seven countries – Albania, Bosnia Herzegovina, India, Jamaica, Kyrgyzstan, Nicaragua and Romania – contain relevant questions.

As with disability, three approaches can be used to elicit the prevalence of mental health issues. Again, the first is to ask the respondent to self-report a condition or to report a clinical diagnosis, as happens with CWIQ and most LSMS. Most of these questionnaires present mental health issues either as a possible answer to the question of whether the respondent has a chronic illness or injury/disease during a particular period (e.g., *Have you had any illness/ injury during the past four weeks?* Jamaica, 1999) or as a response category for the question on self-reported disability (e.g. *Do you suffer from a handicap? What type of Handicap?* Romania, 1994; *What type of disability or chronic disease did 'X' suffer?* Albania, 1996). The second approach, which features in some LSMSs, uses questions on mood and perceived psychological status. These questions can provide a general assessment of mental health, but do not permit the identification of specific disorders. Finally, screening questionnaires ask a few questions that aim to identify particular mental health issues. The Annex[10] that accompanies this Background Note also gives examples of mental health questions from different surveys.

Short screening instruments have been shown to be reliable in eliciting the prevalence of common mental health issues and can be incorporated successfully into large and nationally-representative standard household surveys (Das et al., 2007). This is the approach taken by the 2001, 2003 and 2004 Bosnia and Herzegovina LSMSs. Such questionnaires have been developed on the basis of the 'stem' and 'branch' structure of a detailed diagnostic questionnaire[11] in which the respondent is asked a small number of screening questions and, if they respond positively, they are asked additional questions about associated symptoms leading to a full diagnosis. Screening instruments use only the first set of core questions to assess the prevalence of the mental health issues of interest (Box 2).

Box 2: Screening instruments used to evaluate mental-health issues

- PRIME-MD Patient Health Questionnaire, focuses on depression
- Mini-International Neuropsychiatric Interview, focuses on 15 disorders
- General Health Questionnaire (GHQ), has 12 and 28 question versions
- K6 and K10, used in World Mental Health (WMH) surveys to identify serious mental health issues (anxiety, mood, behavioural and substance disorders)

Source:
http://bit.ly/BNESLR2; http://bit.ly/BNESLR3;
http://bit.ly/BNESLR4; http://bit.ly/BNESLR5

Information on mental health is not only important in itself, but would add insights to the information already covered in household surveys. For instance, in LSMS, it would enable identification of those characteristics associated with people who have mental health issues, to see the effects on multiple dimensions of their well-being and to obtain information about their access to treatment. Though the CWIQ is likely too short to identify specific mental health issues, obtaining general information on the presence of a mental health issue would show inequalities faced by these people in access to treatment and other public services. In the DHS, questions on conditions relating to reproductive health, such as sexual dysfunction and postpartum depression, could be particularly apt. And the early onset of many mental health issues (Kessler et al., 2007) suggests that MICS could be a valuable instrument to collect information on risk factors in childhood and adolescence.

Other constraints: resources, politics and attitudes

The previous section outlined definitional and technical issues involved in eliciting information on old age, disability and mental health issues in standard internationally-comparable household surveys. However, more inclusive data collection may also require greater resources and/or capacity, as well as political will and efforts to overcome the attitudinal or cultural constraints that preclude households and communities from revealing the existence of, and circumstances facing, people with disabilities or mental health issues.

Adding questions to surveys renders them more costly and time-consuming – both for enumerators and respondents. Survey fatigue can set in, which can compromise data quality (Rathod and LaBruna, 2005). The insufficient coverage of several MDG indicators in poorer countries attests to the difficulty in the collection of even a narrow set of indicators. At the same time, the size and vulnerability of these three groups – coupled with a lack of detailed information about their circumstances and a demonstrated ability to collect the needed data efficiently – makes a strong case for the recommended adjustments.

People in these three groups are often marginalised in political terms. For example, some people with mental health issues are denied the right to vote – the Thai Constitution denies the vote to anyone 'being of unsound mind or mental infirmity' (WHO 2009) and a majority of EU states deny the vote to those under guardianship (European Union Agency for Fundamental Rights, 2010). They may also be excluded from family decisions. People with disabilities and older people too may face challenges to full participation. It follows that elected representatives may not heed the needs and preferences of these groups, particularly in the light of a lack of data on their use of public services. The scant attention paid to these issues is evident in relatively small budget allocations in many countries.

The stigma that surrounds physical or mental health issues impedes the advancement of basic rights and has been identified as a barrier to revealing and seeking treatment for mental health issues in particular (Kessler, 2000). A survey of Nigerian high school children, for example, found that over 65% felt afraid to talk to someone with these conditions or would feel embarrassed if friends knew that someone in their family had mental health issues (Dogra et al., 2012). Such widely-held opinions can contribute to social distancing and feelings of isolation, and reduce the effectiveness of treatment (Perlick, 2001). Clearly, greater efforts are needed to generate awareness and sensitisation.

Implications

So far, inequalities related to old age, disability and mental health have been relatively neglected in international instruments. A post-2015 framework presents an invaluable opportunity to tackle inequalities at a global level and to advance commitment to the rights conventions pertaining to the inequalities that face these particular groups. Equally, it provides the opportunity to make these groups visible in national and international monitoring frameworks.

A two track approach is proposed. The first track would seek to 'mainstream' disability and older age by including these categories as 'cross-cutting' issues associated with disadvantage, in much the same way as gender has been included in the MDGs. Any targets that apply to individuals or households would, therefore, need to be monitored by disability status and age group. Various degrees of disaggregation are possible. A top level proposal would be to disaggregate tracking indicators by age bands (already collected) and disability status. But further disaggregation is possible. The 'Voices of the Marginalized' NGO consortium[12] recommends more detailed data collection:

'Following UNDESA recommendations,[13] disaggregation of data must be by both gender and by age group; by 0-5 years, 6-14 years, 15-24 years, 25-59 years and thereafter in 5 year bands until death; and by disability (where detail allows, using the Washington Group's short questionnaire).'

A second, complementary, approach would seek to establish particular targets related to these issues. Here numerous possibilities have been proposed.

- Disability could be included explicitly in targets on employment, education and health.
- A goal devoted to mental health treatment and awareness-raising could benefit several hundred million people.
- Age-inclusive goals could include an increase in healthy life-expectancy at birth.
- Goals aiming at health and income security by extending social protection floors would benefit all people affected by economic aspects of inequality.

Conclusion

This Background Note has shown that old age, disability and mental health issues are salient sources of group-based difference, given the size of the affected populations, their marginality and vulnerability, and their relative neglect in international instruments to date. More inclusive data collection may require greater resources and/or capacity, political will, and overcoming the attitudinal or cultural constraints faced by these groups. Our focus, however, has been on the technical adjustments to internationally-comparable household surveys that are used to gather MDG monitoring data that would broaden their coverage, collect richer information and improve the identification of people who fall within these three groups.

- *Broaden coverage:*
  - extend survey coverage to individuals who do not reside in traditional household units
  - sample households regardless of the age composition of their members.
- *Collect richer information:*
  - ask already-included questions of *all* household members
  - ask these three groups about issues that may affect them disproportionately, such as caretaking and domestic violence, in the case of older people.
- *Improve identification:*
  - implement the short Washington Group questionnaire to identify disability
  - incorporate a screening questionnaire that indicates the presence of mental health issues.

This Background Note has shown that it is feasible to collect data on these three sources of inequality in standard international household surveys and has identified examples of best practice. It enumerates two channels to incorporate these inequalities within a new framework agreement: one would monitor how people are faring, based on their disability status and age band, and another would establish targets that apply directly to the circumstances of these groups.

The MDGs do not address inequalities associated with age, disability and mental health; this has represented a lost opportunity to reduce these inequalities. A post-2015 framework should be sensitive to these issues, advancing the commitments specified in international human rights frameworks, and ensuring adequate measurement and monitoring.

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Endnotes

1. Such as inaccessible public buildings and a lack of information in accessible formats (Cain, 2012)
2. A recent meta review identified seven studies that found a positive link between disability and economic poverty and five that did not (Groce et al. 2011).
3. http://bit.ly/BNESLR21
4. Other key surveys are Integrated Surveys and Priority Surveys but as these are intended to monitor household reactions to the macroeconomic environment, we exclude them here.
5. http://bit.ly/BNESLR22
6. The age range varies in some countries, see: http://bit.ly/BNESLR23
7. http://bit.ly/BNESLR24
8. According to http://bit.ly/BNESLR25
9. The populations differed slightly: the latter two surveys considered all people, not just those aged 5 years and above. The question asked in the census and National Household Survey is: ‘Does (NAME) have any difficulty in moving, seeing, hearing, speaking or learning, which has lasted or is expected to last 6 months or more?’. See: http://bit.ly/BNESLR26 and http://bit.ly/BNESLR27
10. This annex is available at http://bit.ly/BNESLR6
11. WHO efforts to develop cross-country psychiatric surveys from the 1990s resulted in the Composite International Diagnostic Interview (CIDI), which from 1998 was expanded under the World Mental Health (WMH) Survey Consortium to cover severity, impairment and treatment.
12. ADD International, HelpAge International and Sightsavers work together to reduce the social, economic and political exclusion of older people, people with disabilities and people with mental health issues.
13. http://bit.ly/BNESLR28

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