The plight of older women: from understanding to response

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Abstract

Population ageing is a global reality, and accompanying this is the feminization of ageing. To respond to this, countries face two major constraints – the paucity of information on the plight of the elderly, and poor integration of related services. Older women can be perceived as being the victim of the “triple jeopardy” of sexism, disempowerment and ageism. Thus, health care of older people has important gender dimensions. To address the wide-ranging needs resulting from the interaction between sex, gender and ageing, the health sector needs to see these in a linked and coherent manner, and this can be achieved by integration and mainstreaming. Integration increases efficiency, enhances client satisfaction and reduces the problem of lack of information. Integration calls for an understanding of the implications of ageing, gender and women’s health on each other. Integration does not merely connote a “sharing” of concepts, values and actions. It should identify priorities, determine how things are structured and work done, and effectively share information. While integrating women’s health, gender and ageing horizontally, it is critical that vertical integration between the levels of care also takes place. In this regard, primary health care (PHC) deserves special attention. There are several opportunities for integration of women’s health, gender and ageing. There are also challenges such as negative perceptions on both ageing and sexual and reproductive health, weak capacity of health systems, and possible conflict of stakeholders’ interest.

Introduction

Population ageing is a global reality, and is especially challenging for developing countries that are “becoming old before they become rich” compared with developed countries that “became rich before they became old”. In 2009, the percentage of the world population over age 60 was 11% globally, with marked variation among the WHO regions, the highest being in the European (19%), American (13%) and the Western Pacific (13%) regions, and significantly lower in the South-East Asia (8%), Eastern Mediterranean (6%) and African (5%) regions. While countries of the South-East Asia (SEA) Region have begun to respond to population ageing, they face two major constraints. The first is paucity of data and information on the profile of the elderly, which are needed to understand the “plight” of older persons, and which in turn are needed to formulate evidence-based policies, programmes and services; and related to this is the additional problem of lack of gender disaggregated data that can reveal the difference, if any, in the “plight” of older men and older women. The second constraint is insufficient integration with little attempts made to mainstream ageing into services for women’s health, of which sexual and reproductive health is a major component. These two constraints are interrelated; an understanding of the plight of older women will facilitate integration, and an integrated approach will lead to improved information and understanding of the problem.

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Population ageing and women
In almost all countries of the world, women live longer than men. Globally, the number of women aged 65 and above in 1990 was estimated to be 189 million; in 2015 this is expected to be 335 million. This sex differential is reflected in the higher ratio of women versus men in older age groups. In 2002, in Europe, there were 678 men for every 1000 women aged 60 and older; in less developed countries, there were 879 men for 1000 women. To further illustrate the influence of socioeconomic development, in Europe, on the average, women outlive men by eight years, while in Africa, this difference is only three years. From this socioeconomic perspective, two scenarios emerge. Most women who enjoy healthy older years are in industrialized countries, and they tend to have completed at least basic education, have had few children and access to health care, good nutrition, and minimal exposure to work-related stress and injury. Their old age concerns focus on issues such as hormone replacement therapy and degenerative conditions such as osteoporosis and arthritis. On the other hand, many older women in developing countries suffer from chronic health problems caused by years of neglect, discrimination and hardship. Their health reflects inadequate access to basic services and the hardships of childbearing and physical labour. The “feminization of ageing” coupled with the tendency for women to marry men older than themselves result in a disproportionate number of widows compared to widowers.

The plight of older women – the triple jeopardy
Because women live to a very old age, they are more likely than men to experience disabilities and multiple health problems associated with old age. Women are also more likely than men to experience domestic violence and discrimination in access to education, income, food, meaningful work, social security and political power. These cumulative disadvantages over the lifecourse place women, in particular vulnerability in old age. Added to these complexities is the economical vulnerability of women, especially older women. Therefore, the plight of older women can be portrayed by vulnerabilities arising from the following three social trends:

- “Sexism”: A woman, based on her sex (a biological construct) and her gender (a social construct), has unique health needs, especially sexual and reproductive needs, and due to the negative phenomenon of “sexism”, these needs are often not met.
- “Disempowerment”: Also resulting from the social construct of gender, a woman is socially disempowered, leading to inequality that places women at a severe disadvantage; this economic differential has led to the “feminization of poverty”.
- “Ageism”: As aged or elderly persons, both men and women are vulnerable to discrimination and exclusion, but the implications and burden on women are different and more serious than those for men.

Understanding the plight of older women
The “plight” of older women in the SEA Region is not well understood, as there is paucity of data and information. Health and ill-health are elusive concepts that are difficult to measure. The assessment of health status among the elderly is essentially limited to the use of mortality data since universally this is the only source available. Understandably this is inadequate and inappropriate for many conditions. Other sources of information on the health of populations come from various sources - respondents’ reports of signs and symptoms, diagnosed conditions, perceived health status or ability to perform specified
activities. All of these, if available can be used to measure and understand the “plight” of older women.

While older men and women are afflicted by the same common chronic diseases, such as cardiovascular diseases, diabetes, musculoskeletal problems, incontinence; health care of older people has an important gender dimension. Rates and trends and types of diseases differ between men and women because of biological characteristics and socially determined roles. There are gender variations in perceptions of health and ill-health, health expectations and the ideas of appropriate behaviour. For example several studies have shown that elderly men are more likely than elderly women to say that they cannot cook a meal on their own. Even allowing for this and other potential biases, and in spite of the paucity of information, it is clear that the prevalence of health impairments and disabilities in later life is higher among women than among men. Household surveys to compute activities of daily living (ADL) show higher rates of disabilities among women in all elderly age groups. The reasons for these gender differentials are not fully understood. Biological differences can explain for some conditions such as osteoporosis. Selective survival is another possible explanation; as more men die at younger age, those who do survive to old age may have particularly favourable characteristics. In terms of health-seeking behaviour, more older women than older men seek health care— but older women’s “female” concerns are often trivialized.

“Men aren’t like women, women go in normally once a year and have blood tests and mammogram and off we go, but men don’t like doctors and that is understandable” (Older woman, Australia).

To address the wide-ranging needs resulting from the interaction between sex, gender and ageing, the health sector needs to see these in a linked manner, and this can be achieved by integrating and mainstreaming these at policy, programme and service delivery levels. Before the subject of integration and mainstreaming is discussed, it is pertinent to examine some basic concepts in the domains of women’s health (especially reproductive health), gender, and ageing.

Women’s health: sexual and reproductive health and gender

While women’s health has a broad scope, and women also suffer conditions that men suffer from, discussion will limit itself to sexual and reproductive health. The definitions of reproductive health and sexual health adopted by the International Conference on Population and Development in 1994 are useful. Inherent in these definitions is the centrality of rights, and the recognition that the attainment of health and sexual and reproductive health is a human right. This perspective underscores the importance of gender. The movement from the sex focus to the gender focus, which is essentially moving from the biological to the social aspects, means that the rights perspective has become even broader in scope and also more complex. The social disadvantages faced by women occur throughout the life course, and persist into old age, and indeed the plight of the elderly woman is the result of these accumulated disadvantages.

Ageing and women

The definition, concept and perception of “old age” varies among cultures and countries; while this applies to both men and women, it is more true for women. Cultural influences also define when one becomes “old”, especially women. The “fear” of ageing is more obvious in women than in men, and the reasons are mostly socio-cultural. Active ageing is defined as the process of optimizing opportunities for health, participation and security in order to enhance the quality of life as people age. The word “active” has positive connotations that
not only view healthy and productive lives in older years, but also for older people to continue to participate in society, and be respected as a resource for society. This definition also recognizes the life-course perspective, and that interventions must be available at every stage of life, not only after old age sets in. These basic concepts have particular relevance to women. Even more relevant is the fact that the two cross-cutting determinants of ageing are gender and culture, as shown in the figure above. These two cross-cutting determinants are themselves interrelated – in many cultures, girls and women are accorded a lower status. But in these same societies, old age is respected and venerated. Thus age has an influence on woman’s status in society.

**Putting them together**

To achieve integration it is useful to review the implications of ageing and gender on the overall health of women including sexual and reproductive health.

- There are diseases that are common to men and women when they age, as well disabling conditions (immobility, instability, incontinence, intellectual impairment), so women need to be given the same attention as men.
- There are conditions that are specific to women in older age, especially menopause, but also breast cancer and cancers of the reproductive system including cervical cancer.
- The sexual and reproductive health needs of older women can be perceived from several aspects – menopause, fertility control (it is a misconception that family planning needs cease for all older women), sexual difficulties.
- Some lifestyle-related diseases that are pertinent to both men and women, have specific impact on women - such as obesity and hazards of tobacco (women may not smoke but can be exposed to the hazards of...
passive smoking) and these can arise during or have residues in older age.

- Policies in the non-health sectors have impact on both men and women, but the impact on women and on older women, may be different – social and health services, housing, education, transport, employment, pension schemes, tax policies.
- The double burden that women have to bear by being the sufferers of the conditions of old age, and at the same time, they are often the custodians of health of others including of other older persons; this is a socially determined gender-based tradition.
- Women are often being targeted for and are more vulnerable to promotion and advertising related to "anti-ageing” modalities and products; cosmetic products and cosmetic surgery are the most promoted.
- Abuse and violence against older women can occur at any stage of their lives including in old age; indeed elderly abuse is a social ill that affects both men and women.

Need for response — integration and mainstreaming

Many Member States of WHO-SEAR have begun to respond to the ageing of the population, and some may have taken into account the gender differential, but obviously this is not yet sufficient. WHO has recommended Member States to adopt specific strategies – policy formulation, advocacy, programme development, information, training and research. Integration and mainstreaing is essential to address the wide-ranging needs of these different situations, at policy, programme and service delivery levels. Integration increases efficiency by reducing duplication and overheads, and by bringing multiple services in a single visit; it also brings about a more client-centred approach to health care.

Integration of these will also reduce the current problem of lack of information. The information systems in the SRH and gender domain focus on women of reproductive age group, with relative neglect on the needs of older women; and likewise there is lack of information of the sexual and reproductive health (SRH) needs of older people, both men and women, in programmes on ageing. Hence there is very little knowledge on the "plight" of older women, which is needed to formulate evidence-based policies, programmes and services.

It is therefore the duty of the health policy-maker and service provider to ensure integration or mainstreaming of these three domains of women’s health, gender and ageing. Any two of these three domains can be integrated with or mainstreamed into the third one. It is generally true that in almost all countries, gender has been or at least has begun to be, integrated with women’s health and SRH. Thus, it is prudent that these two domains be mainstreamed into programmes and services related to ageing; or vice versa.
wherein the programmes and services for ageing are integrated or mainstreamed into the programmes and services for women’s health and gender. The end result will be the same with either approach.

With gender and culture as the two cross-cutting determinants of active ageing, there is no other way of effectively providing care to older people except using an integrated approach. What do integration and mainstreaming imply?

Opportunities and challenges in integration and mainstreaming

The opportunities for integrating women’s health/SRH, gender and ageing are many, including:

- As mentioned earlier, integration has been strongly advocated in reproductive health, and gender issues have become well integrated in RH; therefore extending this approach to other areas such as ageing is not embarking on the unfamiliar.
- The disenchantment of several programme managers with what used to be the trend in the past, that of an un-integrated, vertical, stand-alone approach.
- This current high level of interest and advocacy is also from governments and donors, with international conferences providing strong platforms such as the International Conference on Population and Development (ICPD 1994) for women and gender; and the First and Second World Assemblies on Ageing in 2000 and 2002 respectively for ageing. While these conferences specifically call for strengthening of the relevant area of concern (sexual and reproductive health and rights, gender; and ageing), they all, either explicitly or implicitly, call for integration.
- Following this, there are now several models and good practices for integration and mainstreaming, such as the experience in some countries in linking maternal and reproductive health services with HIV/STI services; and as mentioned earlier, gender mainstreaming has made a strong foothold in several health programmes.

Notwithstanding these opportunities there are challenges for integration and some of these are:

- Negative perceptions on ageing and SRH - one unfortunate negative trend is “ageism”, the mistaken perception that the elderly are a “problem” or a “tolerated burden”; which leads to the views of dependency and paternalism, and even to social discrimination and abuse. Similarly, SRH is viewed negatively because several components especially sexuality is a sensitive issue.
- Perceived difficulties for integration – there is often a fear surrounding integration because of inherent organizational difficulties, which can be ameliorated by “starting small” such as improving linkages and referrals. Integration does indeed call for changes to the system, but establishing a structure for service integration can facilitate, but does not guarantee implementation of services, especially due to complexity of service packages for both ageing and SRH; the existence of established vertical programmes, and weak administrative capacity in some countries. Changes are needed in referral system, medical support for an expanded service, updated guidelines, integration of records, delegation of activities, competence of personnel, supervision and evaluation.
Donor interests: Women’s health especially, sexual and reproductive health, depends on donor support in many low-resource countries. Effective donor collaboration greatly facilitates integration efforts. Different donor priorities may result in an unbalanced perception and evaluation of integrated services. Donors and recipients need to address issues of resource sharing, assuming joint responsibility for successes and failures, and balancing local priorities with agency interests.

National programme constituencies: Programmes are most likely to succeed if they include a wide range of constituencies, such as policy-makers, women’s advocacy groups, grass-roots organizations, service providers and client representatives.

The organization of government ministries/agencies: Personnel, resources, and policies are organized separately, which makes integration challenging.

Conclusion

Population ageing is a worldwide phenomenon. For developing countries such as those in the SEA Region, the challenge is huge because their health and welfare systems are generally not ready to meet the needs of an ageing population, unlike the developed countries. One of the challenges is to ensure that older women, who face the triple jeopardy of being a woman, an older person, and often a socially disadvantaged person, are provided with services to alleviate their plight. To address these adequately and coherently, the health sector has to ensure that information is made available to understand the plight of older women, and to design an appropriate response based on this understanding. An appropriate response is to integrate or mainstream the services related to women’s health, gender and ageing with one another.

References and bibliography


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