Women, Ageing and Health: A Framework for Action

Focus on Gender

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United Nations Population Fund (UNFPA)
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This report summarizes the evidence about women, ageing and health from a gender perspective and provides a framework for developing action plans to improve the health and well-being of ageing women. It serves as a complement to a longer publication entitled Women, Ageing and Health: A Review. Focus on Gender.

This publication was developed by WHO's Ageing and Life Course Programme under the direction of Dr. Alexandre Kalache and Irene Hoskins, with the support of the Population and Development Branch of the United Nations Population Fund (UNFPA) and in collaboration with the Department of Gender, Women and Health of the World Health Organization (WHO). It was drafted by Peggy Edwards, a health promotion consultant from Ottawa Canada.

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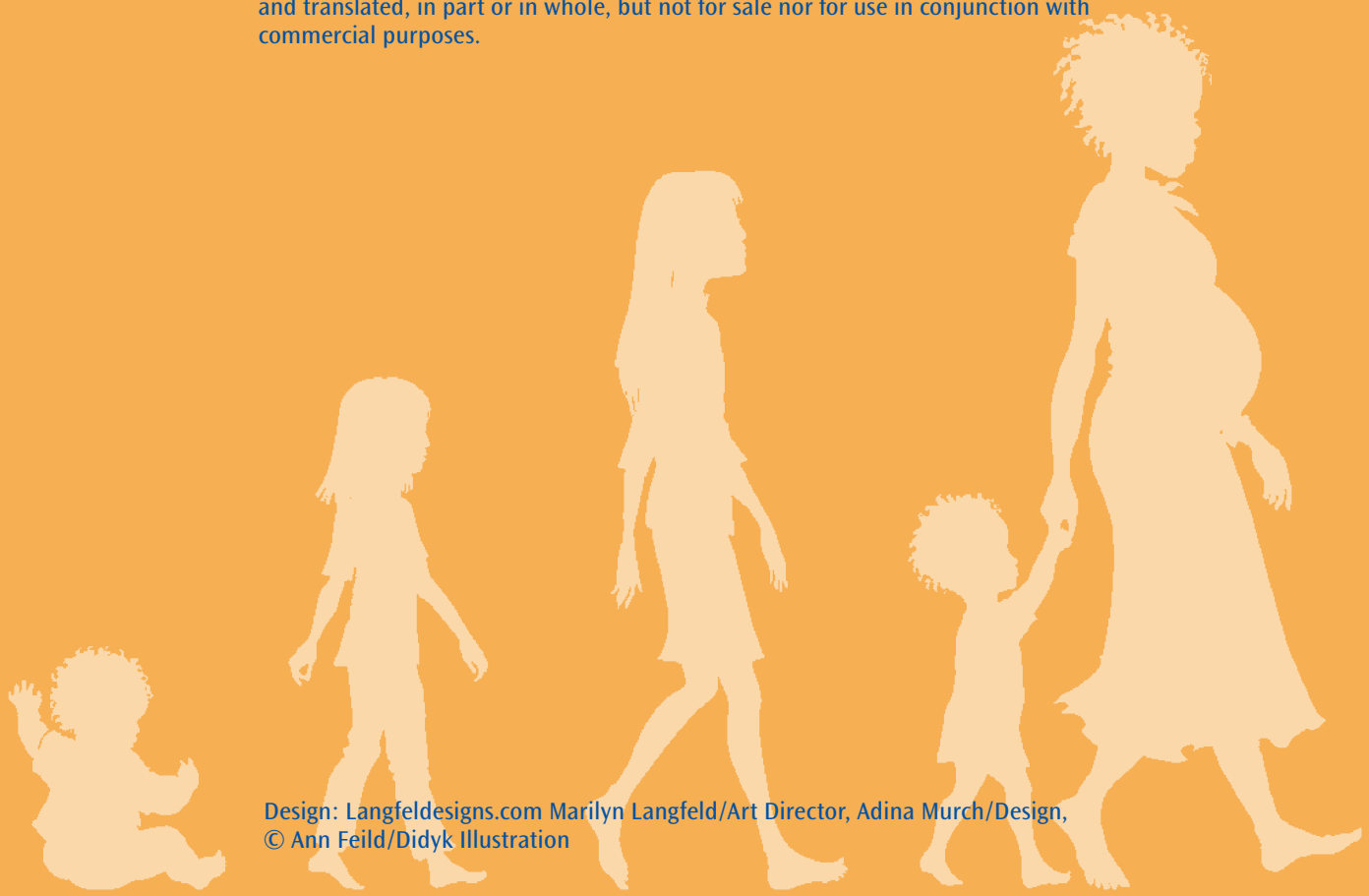

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Taking Action for Older Women and Men

As they age, women and men share the basic needs and concerns related to the enjoyment of human rights such as shelter, food, access to health services, dignity, independence and freedom from abuse. The evidence shows however, that when judged in terms of the likelihood of being poor, vulnerable and lacking in access to affordable health care, older women merit special attention. While this publication focuses on the vulnerabilities and strengths of women at older ages, it is often difficult and sometimes undesirable to formulate recommendations that apply exclusively to women. Clearly many of the suggestions for action in this report apply to older men as well.

1. Introduction

> *"Gender is a 'lens' through which to consider the appropriateness of various policy options and how they will affect the well being of both women and men."*
> … Active Ageing: A Policy Framework[1]
> World Health Organization, 2002

This Framework for Action addresses the health status and factors that influence women's health at midlife and older ages with a focus on gender. It provides guidance on how policy-makers, practitioners, nongovernmental organizations and civil society can improve the health and well-being of ageing women by simultaneously applying both a gender and an ageing lens in their policies, programmes and practices, as well as in research. A full review of the evidence is available in a longer complementary document entitled Women, Ageing and Health: A Review. Focus on Gender. It is available in hard copy and online at **www.who.int/hpr/ageing**.

About This Report

The concepts and principles in this document build on the World Health Organization's active ageing policy framework, which calls on policy-makers, practitioners, nongovernmental organizations and civil society to optimize opportunities for health, participation and security in order to enhance quality of life for people as they age.[1] This requires a comprehensive approach that takes into account the gendered nature of the life course.

This report endeavors to provide information on ageing women in both developing and developed countries; however, data is often scant in many areas of the developing world. Some implications and directions for policy and practice based on the evidence and known best practices are included in this report. These are intended to stimulate discussion and lead to specific recommendations and action plans. The report provides an overall framework for taking action that is useful in all settings (Chapter 2). Specific responses in policy, practice and research is undoubtedly best left to policy-makers, experts and older people in individual countries and regions, since they best understand the political, economic and social context within which decisions must be made.

This publication and the complementary longer Review are designed to contribute to the global review of progress since the Fourth World Conference on Women (Beijing, 1995),[2] the Madrid International Plan of Action on Ageing (2002),[3] and the implementation of the Millennium Development Goals.[4] While some progress has been made as a result of these United Nations initiatives and new policy directions have been adopted at the country level, the rights and contributions of older women remain largely invisible in most

settings. This lack of visibility is especially problematic for ageing women who face multiple sources of disadvantage, including those who are poor, divorced or widowed; immigrants and refugees; and members of ethnic minorities.

Key Concepts and Terms in this Report

Sex and Gender. **Sex** refers to biology whereas **gender** refers to the social and economic roles and responsibilities that society and families assign to women and men. Both sex and gender influence health risks, health-seeking behaviour, and health outcomes for men and women, thus influencing their access to health care systems and the response of those systems.[5]

Older women refers to women age 50 and older. **Ageing women** refers to the same chronological group but emphasizes that ageing is a process that occurs at very different rates among various individuals and groups. Privileged women may remain free of the health concerns that often accompany ageing until well into their 70s and 80s. Others who endure a lifetime of poverty, malnutrition and heavy labour may be chronologically young but functionally "old" at age 40. Decision-makers need to consider the contextual differences in how the process of ageing is experienced in their specific environment, when designing gender-responsive policies and programmes for ageing women.

Ageing is also both a biological and social construct. Physiological changes such as a reduction in bone density and visual acuity are a normal part of the ageing process. At the same time, socioeconomic factors such as living arrangements, income and access to health care greatly affect how individuals and populations experience ageing.

Ageing may also constitute a **continuum of independence, dependence and interdependence** that ranges from older women who are essentially independent and coping well with daily life, to those who require some assistance in their day-to-day lives, and to those who are dependent on others for support and care. These groups are heterogeneous, reflecting diverse values, health status, educational levels and socioeconomic status.

The health of older men

This report does not address men's health issues. It recognizes, however, that ageing men—like ageing women— have health concerns based on gender. For example, the gender-related concept of "masculinity" can exacerbate men's risk-taking and health problems as well as limit men's access to health care. The report also acknowledges that men of all ages can play a critical role in supporting the health of women throughout the life course. Readers who want to learn more about male ageing and health are referred to the WHO document entitled *Men, Ageing and Health: Achieving Health Across the Life Span 2001* (*WHO, 2001, available online at* **www.who.int/hpr/ageing**).

A Global Profile of Ageing Women

For multiple reasons the feminization of ageing has important policy implications for all countries:

- Ageing women make up a significant proportion of the world's population and their numbers are growing. The number of women age 60 and over will increase from about 336 million in 2000 to just over 1 billion in 2050. Women outnumber men in older age groups and this imbalance increases with age. Worldwide, there are some 123 women for every 100 men aged 60 and over.[6]
- While the highest proportions of older women are in developed countries, the majority live in developing countries, where population ageing is occurring at a rapid pace.
- The fastest growing group within ageing women is the oldest-old (age 80-plus). Worldwide, by age 80 and over, there are 189 women for every 100 men. By age 100 and over, the gap reaches 385 women for every 100 men.[6] While most ageing women remain relatively healthy and independent until late in life, the very old most often require chronic care and help with day-to-day activities.
- Older women are a highly diverse group. Life at age 60 is obviously very different from life at age 85. Although cohorts of older women may experience some common situations, such as a shared political environment, exposure to war and the arrival of new technologies, their longevity has given them more time to develop unique biographies based on a lifetime of experiences.

Equity in health means addressing the differences between and among different groups of older women, as well as those between women and men.

The Knowledge Gap

When it comes to research and knowledge development, older women face double jeopardy—exclusion related to both sexism and ageism. Current information concerning ways in which gender and sex differences between women and men influence health in older age is inadequate. While gender-inclusive guidelines have been implemented in some countries, there is still a tendency for clinical studies to focus on men and exclude women. Surveillance data that include sex and age-disaggregated data are also limited. For example, most international studies on health issues – such as violence and HIV/AIDS – fail to compile statistics on people over the age of 50. Lastly, there is a paucity of research on gender differences in the social determinants of health. A recent study mapping existing research and knowledge gaps concerning the situation of older women in Europe found a lack of research related to women aged 50 to 60 in particular.[7] While there were numerous longitudinal studies on ageing, these studies had little or no gender analysis of the different impacts of health conditions and the social determinants of health on ageing women and men. In this report, some key issues for dissemination of research and information are described in each chapter.

2. A Framework for Action

This chapter describes a gender- and age-responsive framework for action based on the following components:

- A life-course approach
- A determinants of health approach
- Three pillars for action
- A gender- and age-responsive lens

A Life-Course Approach

Ageing is a life-long process, which begins before we are born and continues throughout life. The functional capacity of our biological systems (e.g. muscular strength, cardiovascular performance, respiratory capacity, etc.) increases during the first years of life, reaches its peak in early adulthood and naturally declines thereafter. The slope of decline is largely determined by external factors throughout the life course. The natural decline in cardiac or respiratory function, for example, can be accelerated by factors such as smoking and air pollution,

This implies that individuals can influence how they age by practising healthier lifestyles and by adapting to age-associated changes. However, some life course factors may not be modifiable at the individual level. For instance, an individual may have little or no control over economic disadvantages and environmental threats that directly affect the ageing process and often predispose to disease in later life.

Growing evidence supports the concept of critical periods of growth and development in utero and during early infancy and childhood when environmental insults may have lasting effects on disease risk in later life. For example, evidence suggests that poor growth *in utero* leads to a variety of chronic disorders such as cardiovascular disease, non-insulin dependent diabetes, and hypertension.[9] Exposures in later life may still influence disease risk in a simple additive way but it is argued that fetal exposures permanently alter anatomical structures and a variety of metabolic systems.[10] This means that girls who are born into societ-