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WOMEN, AGEING AND HEALTH

Achieving health across the life span

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for the
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WOMEN'S HEALTH**

under the guidance of the
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authors.

“ Health is a fundamental human right.

*Our goal should not be solely
to extend lives in the physical sense,
but to ensure that the added years are worth living
with diminishing handicaps and disabilities, and
with a greater degree of health security.”*

Hiroshi Nakajima, MD, PhD
Director-General
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1

INTRODUCTION: SETTING THE AGENDA

1.1 Building on past initiatives

While the social position and health status of women have advanced in many areas since the United Nations Decade for Women was launched at the First International Conference of Women in Mexico in 1975, the report of the Conference made only a brief mention of older women. Since then, women's issues have been placed on the agenda of the international community and the special needs of ageing populations have been raised at a number of major international meetings, but none have provided an adequate basis or conceptual framework for addressing issues of ageing women in a lifespan perspective. A time line of these key events is set out in Box 1.

BOX 1: Key events, 1975-1999

1975	United Nations Decade of Women launched, Mexico
1982	International Plan of Action on Ageing, Vienna
1983	World Program of Action Concerning Disabled Persons
1985	The Forward-looking Strategies adopted, Nairobi
1986	United Nations Commission on the Status of Women
1991	United Nations Principles for Older Persons
1993	World Conference on Human Rights, Vienna Assembly
1994	United Nations International Conference on Population and Development, Cairo
1995	United Nations Social Development Conference, Copenhagen
1995	Fourth World Conference on Women, Beijing
1997	Fourth International Conference on Health Promotion, Delhi
1999	United Nations International Year of the Older Person

The earlier plans and agreements gave some general guides for policy and long term planning, but these were not widely taken up at national level. The Vienna International Plan of Action on Ageing agreed at Vienna Assembly identified particular areas of concern for ageing women and provided a starting point for approaching the subject in a systematic manner by recognising the multiple dimensions of ageing¹. In the Forward-looking Strategies adopted in 1985 at the culmination of the United Nations Decade for Women, ageing as a process was mentioned for the first time in an international statement on women, but only one paragraph was devoted to elderly women.

The Fourth World Conference on Women, held in Beijing in September 1995, was a major opportunity to raise awareness of the status of ageing women and their health. It provided the opportunity for the Global Commission on Women's Health to advocate on behalf of ageing women. Looking to the future, two events offer further opportunities. First, at the fourth International Conference on Health Promotion to be held in 1997 in New Delhi, ageing and women's health are both key areas for discussion. Second, the UN International Year of the Older Person in 1999 will provide an important subsequent opportunity to monitor progress and to ensure that continuing attention is given to the health of ageing women.

1.2 The Global Commission on Women's Health

The Global Commission on Women's Health was established to promote the adoption and implementation of effective actions related to women, to ensure that women's health is firmly established on national and international agendas, and to advocate on behalf of women's health concerns at an international level.

Health issues of ageing women were raised in the initial Issues Paper "*Women's Health: Towards a Better World*", presented at the first meeting of the Global Commission on Women's Health in April, 1994. The paper noted:

As life expectancy increases in most countries, it is estimated that the number of women over the age of 65 will increase from 330 million in 1990 to 600 million in 2015. Many of these elderly women will have experienced poor nutrition, reproductive ill-health, dangerous working conditions, violence and life style related diseases, all of which exacerbate the post-menopausal phenomena of increased likelihood of breast and cervical cancers and osteoporosis. Poverty, loneliness and alienation are common. Little data exists on the health conditions of the elderly female population except in industrialized countries from which extrapolation is made².

In subsequent discussions, the Global Commission determined that a background paper on ageing and health should be prepared, covering:

- C major health issues facing ageing and postmenopausal women;
- C social, cultural, political and economic determinants of the health of ageing and post-menopausal women;
- C specific needs of ageing women for health care; and
- C future action plans.

This report is one of a number of documents being prepared for the members of the Commission and, as such, is not a stand alone document. These discussion documents all adopt a lifespan approach to women's health and take up six key themes identified at the Commission's first meeting as having major impacts on women's health. These themes are:

- C nutrition;
- C reproductive health;
- C health consequences of violence;
- C lifestyle related conditions; and
- C the work environment.

1.3 The WHO Ageing and Health Programme

The preparation of this report coincided with the re-activation of the WHO Ageing and Health Programme, which followed on from the previous Health of the Elderly Programme as summarised in Box 2.

BOX 2: History of the WHO Ageing and Health Programme

1974	Publication of Report of Expert Committee on Health of the Elderly
1979	World Health Assembly adoption of Resolution on health care of the elderly, leading to the establishment of the Global Programme for Health of the Elderly (HEE)
1982	Incorporation of International Plan of Action on Ageing into HEE activities
1987	Research agenda established under HEE to investigate determinants of healthy ageing, osteoporosis, age-related dementias, and age-related changes in immune function
1989	WHO Expert Committee Meeting
1992-94	WHO Divisions, Geneva, and Regional Office collaboration on HEE - inter-regional meetings in Alexandria and New Delhi
1995	Reorientation of the programme adopting the new title >Ageing and Health=

Earlier work on ageing at WHO has provided a number of key sources for the present report. These include: the 1984 report on *The Uses of Epidemiology in the Study of the Elderly*³; the report of the 1989 Expert Committee, *Health of the Elderly; Improving the Health of Older People: A World View*, published in 1990⁴; and *Family Support for the Elderly: The International Experience*, published in 1992⁵.

A background document on Ageing and Health released in January 1995 details the reorientation of the WHO programme. Significantly, it includes specific mention of a gender perspective and points out that research and programmes in ageing which do not recognise gender differences will not be effective. The higher morbidity and disability rates experienced by older women is pointed out, as is their major role as carers. The key components of the Ageing and Health Programme provide the framework in which strategies for advancing the health of ageing women have been proposed in this report.

1.4 Defining health and ageing

The definition of health adopted in this report follows the broad WHO definition of health as a state of complete physical, mental, and social well-being. In applying this definition to ageing women, a first requirement is to recognise that ageing is a continuing process. Since the health of a woman in earlier periods of her life forms the basis of her health in later stages of her life, it is essential to consider the health of ageing women within a *life course* perspective; the strategic implication for promoting the health of ageing women is that both primary and secondary prevention initiatives must be taken during the later life span.

Another requirement is that older women throughout the world be given opportunities to advocate on the health issues of concern to them and to participate in developing programmes to address the problems they identify. It is only through such approaches to defining health that the value placed on different aspects of health by ageing women will be given due recognition.

There are major differences in the life course of ageing women in countries at different levels of development, and transitions across the life course vary accordingly. In societies where life expectancy is short, "older" may be defined at an age which other societies would define as "young". Some societies regard menopause as the start of "old age" for women; in others, women achieve old age with the birth of their first grandchild. Retirement from the work force based on chronological age is also used to denote entry to the later stage of life, although this definition is of limited applicability to older women. Although participation of ageing women in the paid work force is relatively low even in the developed countries, the majority of women keep working, unpaid, until they die.

When defining "old" for the general population, demographers and others have made distinctions between "mid-life", "young old" and "old old". Paradoxically, the age set for defining old age for women has commonly been five years or so younger than for men, notwithstanding women's greater life expectancy. The use of an arbitrary cut-off point of 55 or 60 years to denote the older segment of the female population, and 60 or 65 for men, masks tremendous diversity in the two to three decades which follow. Such chronological definitions have little biological, social or cultural meaning.

One event that carries a unique meaning in women's life course compared to men's is the menopause. The menopause is a universal event, or more correctly a universal process, that occurs at around 50 years in both developed and developing countries. While development brings major changes in life course events that occur before menopause, notably the narrowing of the span of child bearing years and major extension of the life cycle stages following menopause, the age of menopause itself remains relatively constant. The age of menopause thus provides a useful defining point for this paper, but at the same time it is recognised that menopause carries a wide variety of cultural and social meanings.

In developed countries the majority of women are in good health at this age. Yet it is in these countries that menopause itself is increasingly being depicted as an illness, or oestrogen deficiency "disease", to justify increasing medical intervention. In many developing countries, by the time a woman reaches menopause, her health may already have been undermined, not by her hormonal state, but by the aftermath of health problems in reproductive years and the social and environmental conditions under which she lives.

This report will cover the life course from age 50, covering stages labelled as "mid-life", the "young old" and the "old old". An extended later life is as yet the experience of a minority of women in developing countries, but it is becoming a more common experience. More women will reach old age in future in these countries and this stage of their life span will also be increased.

For the majority of women in the developed regions of the world, the experience of ageing lasts for many decades. With the expectation that the life course will run to an extended period of ageing and old age now a reality for women world wide, the life course perspective offers the potential for addressing the promoting of health in preparation for and throughout the later lifespan.

1.5 Scope and aims of the report

There is enormous diversity among older women. Some live extended lives and others have their lives shortened. Some live in abject poverty, others with vast wealth. Some expand their roles with increasing age, others face reduced status. Some are in excellent health even at advanced ages, and others have to rely on formal assistance for their everyday personal care. Whatever their situation, ageing women deserve much more attention if their health is to be advanced and lasting improvements in the quality of their lives are to be achieved.

While health issues of ageing has been identified as a policy concern in many developed countries, greater attention needs to be given to cohort differences of factors affecting the health of ageing women.

The health of women who are ageing now is in many ways different to that of those who are already older. Ageing has not yet been defined as an issue in many developing countries, but already two thirds of the net annual increase in the number of older women in the world is occurring in less developed countries.

Three considerations impel the greater recognition of health of ageing women as a major concern:

- C** the numbers of ageing women are increasing worldwide;
- C** women's life course beyond 50 now extends for a significant period and is increasing; and
- C** there is very significant scope for improving the health of ageing women.

Taking action to improve the health of ageing women is imperative if these women are to achieve an acceptable quality of life in the extended period of old age that will be their experience and if all societies are to avoid the consequences that will otherwise ensue. With a view to the future returns from investing in health, the scope of this report encompasses the coming generation of older women (those now in their 50s and 60s) as well those already in older age groups.

This report aims to propose a framework for action on health for ageing women within the Health for All context, a goal which encompasses WHO's aspirations for the elderly people of the world. It is not possible to present a comprehensive framework that addresses the health needs of all ageing women, in all countries. Rather, in recognition of the diversity of older women and their health, the framework aims to set directions and give some examples of actions that can be taken.

The report begins with a brief account of the particular features of demographic ageing of relevance to

the life course of ageing women. The social, cultural and economic determinants of health of ageing women are reviewed next. Attention then turns to priority health issues for ageing women and several common strategies are identified for addressing a number of major preventable conditions, chronic disabling conditions and mental health problems. The framework proposed in the final section draws together these and other strategies identified in each section of the report. In line with the key components of the WHO Ageing and Health Programme, strategies for action are grouped in five areas: policy development; advocacy; community-based programmes, including the support of carers; and training and research.

2 LIFE COURSE AND DEMOGRAPHIC TRANSITIONS

"An ageing society is evolving, which, for the most part, is female." ⁶

The health outcomes of demographic ageing in terms of improved survival and changing patterns of morbidity are the product of changes in underlying economic, social and cultural determinants of health. Demographic ageing not only brings about major changes in the duration of life course stages, but also in the social experience of these stages. Of all these changes, the increase in women's life course after age 50 is the most obvious; it is also the change that presents most challenges in achieving quality of life for ageing women over these years.

This section begins with an account of later life course stages as now experienced in developing and developed countries and then presents a brief analysis of the demographic processes underlying population ageing, focusing on the differential ageing of the female population in developing and developed regions of the world.

2.1 Population ageing and lifespan transitions

As seen in Table 2.1, the later lifespan of women in developed and developing countries appears markedly different when life expectancies at birth are compared. Female life expectancy at birth ranges from just over 50 years in the least developed countries through the 60s and 70s in those undergoing rapid development. In developed countries, female life expectancy at birth of 80 years and more is now becoming the norm. These differences are accounted for not only by high infant mortality but also high maternal mortality.

Life expectancies at birth however disguise the duration of later life in developing countries. For women in developing countries who survive the early lifespan stages to reach middle age, life expectancy approaches that of women in developed countries. Life expectancies at age 65 show much greater similarity between developing and developed countries, at around 15 and 19 years respectively. At age 65, women in developing countries now have about three quarters of the remaining life expectancy of their counterparts in developed countries, and the gap will narrow in future as mortality declines not only at younger ages but also at later ages.

It is the likelihood of reaching older age rather than the total duration of life in old age that differs most markedly between countries at different levels of development. The smaller proportion of the population reaching old age makes it a less individual and social experience in developing countries than in developed countries. At the same time, the already considerable duration of this life stage for those who do reach it explains why there are some very old individuals in countries with low average life expectancies.

The life course transitions indicated by these demographic data bring major restructuring of family relationships and social roles of ageing women. In developed countries, these roles are well established but are undergoing change. Even more so in developing countries, traditional roles of older women are being overtaken and new norms have yet to emerge. The economic, social, cultural and political factors which will affect the health of ageing women as these social transformations proceed and which will have a major impact on the quality of life of women as they age, are taken up in Section 4. As these impacts will be felt increasingly in the future, particular attention needs to be paid to the next cohorts of ageing women - that is, those now aged from 50 to 60 years.

2.2 The gender transition

The theory of demographic transition has been widely used in analysing population ageing. Within it, a gender transition emerges. Three phases of population ageing can usefully be identified on the basis of changing patterns of survival of women relative to men and the associated gender balance of the older population. Data on selected countries presented in Table 2.1 illustrate these three stages.

In the *early stages* of the transition, life expectancy at birth for men and women is similarly low, as seen in Mozambique, Nigeria and India. Female life expectancy is still limited by high maternal mortality and is close to that of males.

*"The neglect of women's health and nutrition is so serious in some countries, particularly in Asia, that it even outweighs women's ... tendency to live longer than men."*⁷

In some developing countries, particularly in South Asia, women's life expectancy at birth is lower than or only equal to that of men, and has improved only marginally more than has men's life expectancy over the last 20 years. Further, it has been estimated that early deaths and the alleged infanticide of girl babies in these countries have caused up to 100 million women to be "missing" from the statistics⁸.

The *second stage* of the gender transition reflects two trends in mortality which are well established in more developed countries and are becoming evident in many developing countries. By far the major factor is reduced maternal mortality which ensures the survival of a larger proportion of women to middle age. This decline is due to reduced exposure to childbirth and improved standards of living; the decline in birth rates that also occurs in this phase contributes to the ageing of the population as the growth of younger cohorts decreases. Second, improvements in mid- and later life mortality lead to the survival of higher proportions of middle age cohorts into old age and to advanced old age. Life expectancy at birth

and at age 65 both increase, and it is the combined effects of improved female survival to middle age, followed by improved survival at older ages, that leads to the marked shift in the gender balance in the older population.

The contrast between the rapidly developing Asian and Latin American countries and Eastern European countries illustrates these differential trends. The Eastern European countries are exceptional in the lack of improvement in life expectancy over the last 20 years; improvements in infant and maternal mortality that achieved increases in life expectancy at birth in the first two post-war decades have not been followed by improvements in life expectancies in later years. It is this failure to increase life expectancy at age 65 that has kept overall life expectancies in Eastern Europe below those of established market economies.

Populations in the second stage of the gender transition are characterised by increasing proportions of older females. A high proportion of these women live alone; many are widows while others may never have married. This process, which has been described as the "feminisation of ageing", is the current experience of many developed countries and also of many rapidly industrialising countries such as Thailand and the Republic of Korea. In some developed countries, for example Sweden, there are two elderly women for every elderly man; the ratio widens considerably with increasing age⁹. The pronounced gender imbalance of the Eastern European countries resulting from the Second World War will reduce as those cohorts pass. In the developing countries where female life expectancy at 65 already exceeds that of men, the increasing proportion of women reaching this age and then surviving longer is set to make ageing at least, if not more, feminised than it has been in the developed countries.

The main social effect of the extension of later life for women at this stage of the gender transition is an extended period of widowhood. Widowhood occurs at a later age in developed countries (close to 70 years) but the greater differential life expectancy of women compared to men at age 65 in these countries means that it extends for a longer period. To the extent that trends in life expectancy at older ages in developing countries follow the pattern of women's life expectancy improving ahead of that of men, similarly protracted periods of widowhood can be expected. The markedly lower status of women at earlier stages of the life span in many of these societies stands to be compounded.

A *third stage* of the gender transition is now emerging in advanced industrial societies. At this stage, very high life expectancies for women mean that there is limited scope for further improvement, while recent improvements in male life expectancy at older ages are starting to narrow the gap between males and females. If these trends strengthen, the gender balance of the older population will shift, but only slowly, towards a more even balance. Of those who are still married on reaching old age, more will experience a longer period of old age with their partner.

Table 2.1: Life expectancy of women and men, 1991, and improvements 1970-91^{9,10,11}

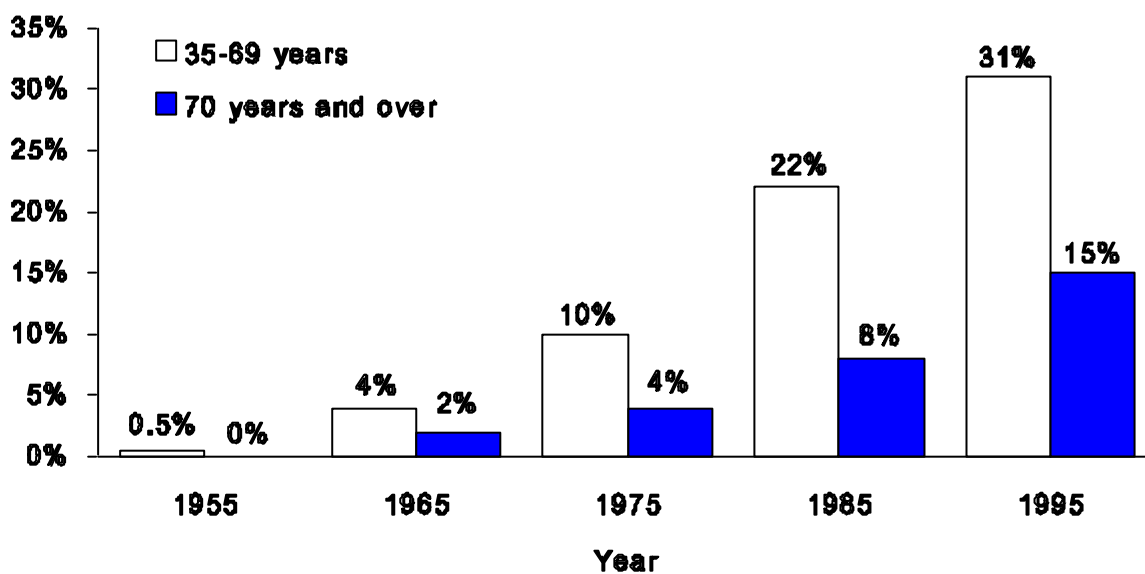
Country	Life expectancy at birth, 1991		Increase in life expectancy 1970-91		Life expectancy at age 65, 1991	
	Female	Male	Female	Male	Female	Male
<i>Sub-Saharan Africa</i>						
Mozambique	48	45	6	6	n.a.	n.a.
Nigeria	53	50	10	10	n.a.	n.a.
South Africa	66	59	10	9	n.a.	n.a.
<i>India</i>	60	60	11	10	n.a.	n.a.
<i>China</i>	71	67	8	6	16	14
<i>Other Asia and Islands</i>						
Bangladesh	52	53	8	7	n.a.	n.a.
Philippines	67	63	8	7	14	12
Malaysia	73	68	10	8	15	3
Korea	73	67	11	9	15	13
<i>Middle Eastern Crescent</i>						
Egypt	62	60	10	10	13	12
Turkey	70	64	11	..9	n.a.	n.a.
Tunisia	68	67	13	13	14	13
<i>Latin America</i>						
Brazil	69	63	8	6	n.a.	n.a.
Mexico	73	67	9	7	17	15
Argentina	75	68	5	4	17	14
<i>Former Socialist Economies of Europe</i>						
Romania	73	67	2	0	15	13
Poland	75	67	1	0	16	12
Hungary	74	66	1	-1	16	12
<i>Established Market Economies</i>						
United States	79	72	4	5	19	15
Spain	80	74	5	4	18	15
Australia	80	73	5	5	19	15
France	81	73	5	5	20	15
Japan	82	76	7	7	20	16

n.a.: not available

As well as the positive improvements in male mortality contributing to these trends, there are some emerging negative trends in female mortality at mature ages. A large part of the gap between life expectancy of men and women is due to differences in alcohol and tobacco consumption as well as accidents, suicide and chronic diseases. However, the impact of increased smoking rates among women

is now becoming more evident. Death rates from smoking-related diseases have plateaued in men whereas they are increasing in women at older years. The example of Denmark, presented in Figure 2.1, shows the increase in smoking-related deaths among the large cohorts of women who took up smoking at young ages and who are now reaching old age¹⁰. Cigarette smoking by women has not yet become widespread in developing countries, and there is still time to take global action to protect the health of older women by halting the spread of these toxic substances in these countries.

Figure 2.1
Percentage of total deaths in women attributed to smoking, Denmark (1955-1995)



2.3 Diversity within global ageing

2.3.1 Where are the world's ageing women

Most of the world's ageing women are living in developing regions of the world. Already, more than half of the world's women aged 60 years and over live in developing regions; 148 million compared to 121 million in developed regions. It is only at age 70 years and over that the number of women in the developed regions exceeds the number in the developing regions, but even at this age, the margin is small (60 million compared to 58 million).

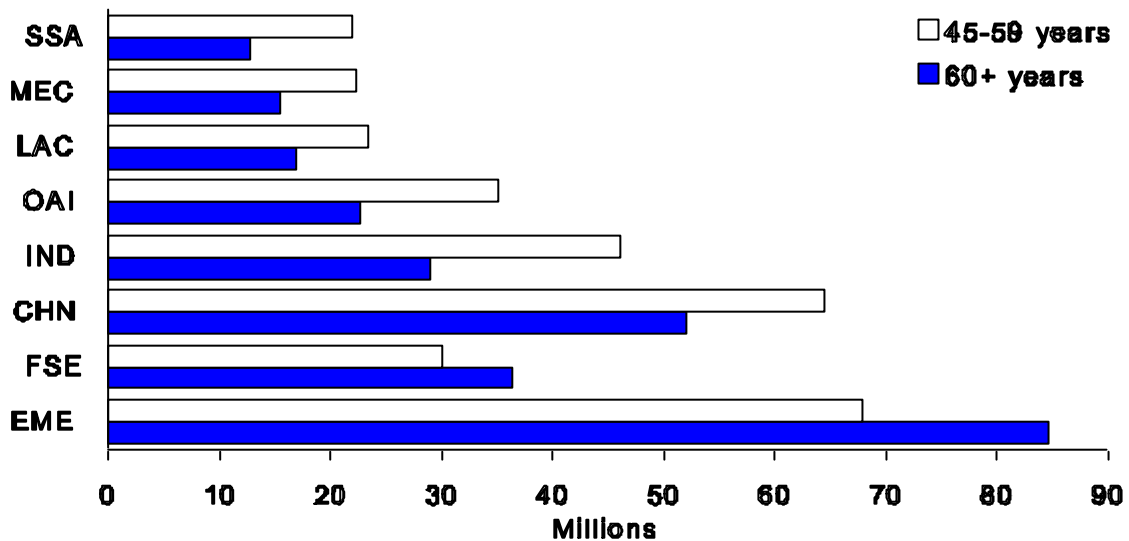
The future growth in the numbers and proportion of ageing women in developing countries is foreshadowed in the distribution of those now aged 45 to 59 years. Two thirds of the women in this age group (213 million) live in developing countries and one third (98 million) live in developed countries. The distribution of the world's ageing women for the eight World Bank regions¹¹ is shown in Figure 2.2. The imminent large increase of older women in the developing world contrasts with the age structures of the established market economies and former socialist economies of Europe, where the cohorts aged 45 to 59 are smaller than those now aged 60 years and over.

2.3.2 Differences in life expectancy

Population ageing is accompanied by a greater life expectancy at birth and at older ages for women than for men, although the gap is closing at older ages. In developed countries, women live on average about six years longer than men¹².

Differences in life expectancy between women in countries at different levels of development have received less attention.

Figure 2.2
Geographical distribution of the worlds aging women



EME: Established market economies; CHN: China; FSE: Former socialist economies of Europe; IND: India; OAI: Other Asian and islands; LAC: Latin America and the Caribbean; MEC: Middle Eastern crescent; SSA: Sub-Saharan Africa

Life expectancy at birth for women in developed countries exceeds that of women in middle income developing countries by 15 years and as much as 30 years for women in the poorest countries⁷. The disparity in life expectancy at birth of women in rich and poor countries has improved only a little over the past 20 years, and these differences in women's life expectancies represent major inequities that must be addressed.

While less pronounced, differences in life expectancy at age 65 between rich and poor countries are nonetheless evident. That later life expectancies in many developing countries are already approaching those of developed countries can be taken as an indicator of what can be achieved with improved health over the lifespan. Further narrowing of this gap will be an indicator of improved life expectancy at birth and at older ages in developing countries. The extended lifespan already experienced by older women in both developing and developed countries calls attention to issues of quality of life in these years.

There are also major differences in life expectancy and the quality of life of ageing women within countries, largely associated with class differences. Strategies to address these differences mean that health interventions must take into account quality of life as well as quantity of life.

2.3.3 Differences over the age range

There are not only differences in the proportions of older men and women in national populations, but also shifts in the age structure of the population. Notwithstanding their dominance on a global scale, ageing women in developing countries remain a smaller proportion of the population than in developed countries.

Whereas women aged 60 years and older account for around 20% of the female population in the developed regions, they account for only some 7% of women in developing countries. The equivalent proportions for men 60 years and over are nearly 15% in developed regions and 6% in developing regions.

The main trend in ageing in developed countries is the increase in the "oldest old", that is, those 85 years or older. The great majority in this age group are women, and this trend will continue in the foreseeable future. It is largely this group which will require access to a range of health and long term care services.

It is, however, important that the small absolute size of these very old cohorts be recognised so that the demographic aspects of the rapid increases projected for the oldest old in developed countries do not overwhelm other considerations. The oldest old constitute only a small fraction of the total population in the developed countries; Sweden has the highest proportion of "oldest old", 4.4%. In the least developed countries, less than 1% of the population is in the "oldest old" cohort; in countries such as Bangladesh and Indonesia, the proportion is as low as 0.2%, although the absolute numbers are substantial.

2.3.4 Cohort differences

Future cohorts of older women will be very different to those of the current generation. A cohort approach which follows each particular generation or age group over time is essential for developing social and health policies for women as they age. Encouraging each cohort to consider its own future

health is an important means of stimulating policies for health promotion that will address the different problems and potentials of each group.

An example is Latin America where it is projected that 60% of women who were aged 45-49 years in 1990 will survive to age 75-79. The health that these survivors can expect in their old age will depend on the social and physical environments in which they live over the next 30 years. Monitoring such environments and their influence on the health of these ageing women through cohort studies would be instrumental for policy makers.

Cohort shifts can take place rapidly. For example, in Japan and Spain, shifts to separate living arrangements for older people have been occurring very quickly, as the desire to continue living an independent life becomes a preferred, and increasingly feasible, option. To sustain this trend, more options for housing for independent elderly women and care arrangements for those who become dependent will be required. Providing independent living options within a larger supportive environment will be an important means of ensuring appropriate social contact.

In both developed and developing countries, older women are the main carers for their partners, and many of the women who are carers for frail elderly parents are themselves ageing. In developing countries, changes in living arrangements associated with urbanisation suggest that even more of the care of older women will fall to other older women in the future.

2.4 Monitoring demographic trends and changes in health status and well-being

The marked difference in the health experiences of successive cohorts of ageing women and the differences between countries at different levels of development mean that aggregate data on total aged populations is inadequate for monitoring trends in health status. A simple but significant contribution could be made by the presentation of all relevant data by more detailed age and sex and economic status categories. A second important basic development is the use of age and sex specific life expectancies rather than only life expectancies at birth as indicators of changes in later life.

Improvements in demographic data are of direct importance in monitoring trends in the health status of ageing women. Further indicators, such as WHO recommended¹² indices of healthy life expectancy, need to be developed. This poses a number of technical problems, and must also take into account the differences in social and cultural meanings of disability and handicap. Methodological issues of this kind have begun to be addressed in the work of the REVES group and others¹³. Gender factors need continued attention and recognition.

As women live longer than men, the quality of their longer life becomes of central importance. Quality of life, measured in terms of older women's capacity to maintain physical, social and mental well-being notwithstanding varying levels of illness and disability, is of as much relevance as increased life expectancy and years of life free of disability. Measures of quality of life must reflect older women's experience and their expectations about acceptable levels of functioning in their daily lives.

Emerging measures such as Disability Adjusted Life Years (DALYs) or Quality Adjusted Life Years (QALYs) have yet to consider to these issues^{14,15}. Indeed, there is a risk that such measures of the burden of illness will give an overly negative account of the health of ageing women, in turn affecting the way in which these issues are recognised in policy. To avoid these consequences, indicators which more adequately reflect the health of ageing women need to be developed.

2.5 Longer lives - healthier lives

The changes in the life course of ageing women outlined in this section, and the diversity of experience of later life, have significant implications for the health of ageing women. Above all, the greater life expectancy for women in developed countries sets the basic goal for strategies for the health of ageing women globally, namely to reduce the inequities in life expectancy of women in developed and developing countries. These inequities are not measured simply in the number of years of life, but reflect underlying inequities in the determinants of health and the quality of life that must be addressed if life expectancies are to be improved.

The benefits of improvements in life expectancy free of disability as individuals age are obvious; not only would it reduce the cost of disability (to themselves, their families and society) but it would expand their roles and, in the process, improve the public image of older persons as active citizens. As yet there is no clear evidence that women's greater life expectancy has any significant advantage in terms of remaining years lived free of disability. If longer lives for women are to be years of quality, policies must then be directed to ensuring the best possible health for women as they age.

An important adjunct to these policies, and an area in which WHO has a key role, is the establishment of data sets for monitoring demographic trends and health outcomes. Strategies are needed to expand the range of indicators, in order to take into account functional status and well-being in terms relevant to the experience of ageing women.

Strategies proposed to these ends are:

- C** that Member States review national health goals and targets to ensure that the health of ageing women is fully addressed;
- C** that intersectoral policy initiatives be developed by Member States to reduce the differences between developing and developed countries in life expectancy of ageing women, and between groups of ageing women within countries at different levels of development;

- C that age- and sex-specific life expectancies be used in conjunction with life expectancies at birth as basic indicators for monitoring changes in the later life course; and
- C that appropriate and relevant indicators of the health of ageing women be developed, involving the critical analysis of current global measures of health status from the perspective of ageing women, taking into account the way in which ageing women perceive their quality of life and value their health.

3 HEALTH PRIORITIES FOR Ageing WOMEN

3.1 Defining health priorities for ageing women

Before discussing any health issue as a priority for ageing women, the basis on which priorities have been defined must be made explicit. The approach to defining priorities adopted here involved applying the WHO definition of health to the situation of ageing women, and the development of criteria by which various health problems could be assessed as priorities. The *criteria* adopted for defining a health issue as a priority for ageing women cover three dimensions:

(a) The *scale* of the problem means it is

- C of major significance in both developed and developing countries;
- C of high prevalence in women over age 50 compared with younger women; and
- C of greater impact in ageing women than men.

(b) The *nature* of the problem is such that it

- C has a progressive impact on women as they age, if not addressed;
- C has a major impact on functioning and independence as well as mortality;
- C is preventable, through primary prevention during the whole life course and secondary prevention at older ages; and
- C can be substantially addressed by primary health care measures, including selfcare management.

(c) The *presentation* of the problem is

- C overstated in some cases, under-rated in others, or generally under-researched;
- C often at risk of over-medicalisation or inappropriate interventions; and
- C already recognised in national health goals and targets in some countries, but requires a greater focus on ageing women.

When these criteria are applied to a wider range of health problems, a number of conditions are identified that can be grouped into three major areas:

- C *Major preventable causes of morbidity and mortality:* heart disease and stroke; cancer; and communicable diseases, especially in developing countries;
- C *Major chronic disabling conditions:* musculoskeletal; osteoporosis; and incontinence;
- C *Mental health:* depression and dementia.

3.2 Major preventable causes of morbidity and mortality

It is because the major preventable causes of morbidity and mortality all take effect over extended time periods that a life course perspective on the health of ageing women is most appropriate. Primary prevention strategies will be most effective when initiated as early as possible. These strategies are also applicable to older women, and where problems are already apparent at older ages, secondary prevention and self care strategies are also relevant. Heart disease, stroke and lung cancer are the conditions which primary prevention needs to address, while secondary prevention strategies are applicable to the other cancers.

3.2.1 Heart disease and stroke

Heart disease and stroke are the major causes of death and disability in ageing women. The common view of heart disease and stroke as men's health problems has tended to overshadow the recognition of their significance for ageing women's health and there is a need to bring their importance into sharper focus.

In a typical developed country, heart disease and stroke are the major causes of death among older women, accounting for close to 60% of all adult female deaths. Cardiovascular diseases are also the major cause of death among women aged 50 years and over in developing countries, despite the incomplete control of communicable diseases. Half of all deaths of women over 50 in developing countries are due to these conditions; although communicable diseases are not fully controlled in these countries, they are no longer important causes of sickness and death in old age. As death from cardiovascular diseases is frequently preceded by a period of morbidity and disability, they also account for a high proportion of disability.

Trends in heart disease and stroke over the last two decades show the extent of improvement that can be achieved (Table 3.1). The control of stroke in Japan has resulted in a decline of 43% from 1970 to 1990, from a rate as high as that which now prevails in many developing countries, to a level commensurate with current rates in the United Kingdom, Germany and Australia. In the majority of

developed countries for which trend data are available, declines in death rates have been greater for women than men, but cardiovascular disease will continue to be the major health issue for older women, even if favourable trends in mortality rates are sustained. The exceptions are the Eastern European countries, where the lack of improvement in life expectancy shown in Table 2.1 is largely due to the lack of progress in controlling these conditions.

Table 3.1 shows that trends in developing countries are less positive. An analysis of the global burden of stroke¹⁶ has shown that age-specific mortality rates for stroke are higher at younger ages in developing countries and that improvements in mortality for women from 1970 to 1990 have been far less in many developing countries than in developed countries.

The patterns of morbidity and disability that accompany these mortality patterns indicate that developing countries carry a substantial part of the global burden of stroke. As increasing age is the main risk factor for stroke and cardiovascular disease more generally, this burden will increase as greater proportions of the population in developing countries reach older ages. There is a possibility that any decrease in the high rates due to low standards of living in these countries may be offset by an increasing adoption of western lifestyles without the benefits of economic development.

Further, since in developing countries the chances of surviving a stroke are currently less than in developed countries, improvements in survival rates could add to the burden of disability and see increased years of life being years with handicap.

Studies of both heart disease and stroke show that some aspects of health behaviour among younger and older women are similar. However, age can bring specific health management problems bearing in mind that signs and symptoms are assessed differently in men and women. Women also modify their perception of themselves and their abilities to cope with effects of illness in different ways to men. Information to empower older women to adopt self-care approaches to prevention of heart disease, stroke and other chronic diseases can also include assisting older women to cope with any caring needs that may arise as a result of these conditions.

Despite the importance of cardiovascular disease in ageing populations, few studies have specifically examined women in this age group. Most longitudinal studies have begun with a cohort of middle-aged men and, as the cohorts have aged, conclusions have been drawn about the significance of risk factors for cardiovascular disease in older age groups. However, even these data are limited and cardiovascular disease policy decisions - especially those relating to older women - have long been hampered by inadequate data¹⁷. The dearth of data is even greater for developing countries, yet the levels of morbidity and mortality indicated by what data are available show an even more pressing need for information.

Table 3.1: Stroke mortality for women in developing and developed countries¹⁹

	Age specific stroke mortality rate, 1990 (per 100,000)			% of deaths > 55 caused by stroke	
	55-64	65-74	75+	1990	Change 1970-1990
China	197.9	664.9	2408.2	n.a.	n.a.
Argentina	104.8	254.1	1118.8	12.6	- 13 %
Romania	177.4	572.0	2286.2	20.6	+ 2 %
Japan	- - -	262	- - -	17.4	- 43%
USA	42.2	126.9	778.5	9.1	- 41 %

Since heart disease and stroke are due to the prevalence of risk factors in the population, primarily cigarette smoking, raised blood pressure and raised cholesterol, there is great scope for primary prevention through reduction of smoking, promotion of exercise and improved diet¹⁸.

The two approaches to primary prevention for the whole population (including ageing women) are the *high risk strategy* and the *population strategy*¹⁹. The high risk strategy involves finding and treating individuals who are deemed at high risk of developing cardiovascular disease. This strategy is costly and limited, and does not offer a realistic solution, especially in developing countries.

In contrast, reducing the average risk of the population at all ages is likely to have the greatest impact and can be justified by the fact that most new cases of cardiovascular disease will occur in people who may be at only mildly raised levels of risk. For example, a comprehensive nutrition policy in Norway has been successful in reducing the consumption of fat²⁰. A reduction in the consumption of tobacco has also been achieved in many countries through a population strategy. A further major advantage of population-based approaches is that substantial benefits accrue for addressing other health disorders with the same contributing factors. Thus, the same population-based strategies for heart disease and stroke are applicable to the other priority areas taken up below.

BOX 3: Primordial prevention: lessons for developing countries

Primordial prevention is the avoidance of the emergence and establishment of the social, economic and cultural patterns of living that are known to contribute to an elevated risk of disease. In some developing countries, coronary heart disease is becoming increasingly common, particularly in urban populations, which have already acquired high risk behaviours. Cigarette smoking is increasing rapidly in developing countries while the overall consumption of cigarettes in many developed countries is dropping. It has been estimated that by the year 2010 there will be over two million deaths each year in China from smoking-related disease unless a major effort is made now to reduce smoking. The indirect impact on women will take the form of increased numbers of widows²¹.

The scope for primordial prevention in developing countries is considerable (Box 3). Coronary heart disease occurs on a large scale only if the basic underlying cause is present, that is, a diet high in saturated fat. Where this cause is largely absent, as in China and Japan, coronary heart disease is less common than stroke. Any increase in the frequency of cigarette smoking will, however, result in an increase in cardiovascular disease; changes in traditional dietary habits will compound this increase.

Dissemination of information about the extent of cardiovascular disease in the older female population is essential to ensure that women do not become complacent about this condition which is too often seen as a male problem.

3.2.2 Cancer

It is the long latent period for most cancers that dictates the importance of early detection. Age is thus an important factor in preventative strategies, but the known benefits of these strategies vary. It is among women in mid-life rather than those who are younger that available interventions are likely to be most effective, yet applications at younger ages have been more common to date. There is a need to review the available evidence and develop guidelines to ensure the most clinically appropriate and cost-effective use of these interventions.

The major cancer in women in developing countries is *cervical cancer*, followed by *breast cancer*.

By contrast, in developed countries, *breast cancer* ranks first, followed by *lung cancer*. Because lung cancer is most amenable to primary prevention, it is discussed first.

Lung cancer

Lung cancer is the most preventable of all cancers; over 90% is attributable to cigarette smoking. The levels of morbidity and mortality among older women due to lung cancer are now similar in developed and developing countries¹⁴ and likely to grow worldwide, given that increasing numbers of women smoke.

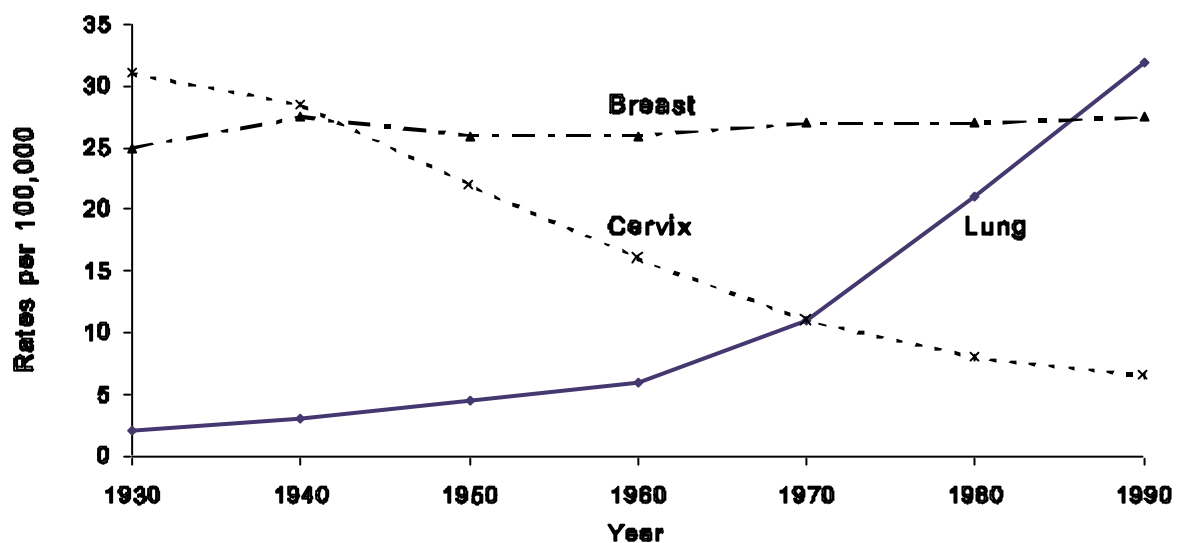
There is no cure for lung cancer. Prevention is not only the only option, but it is the most effective one. Strategies to promote giving up smoking will also yield major benefits in relation to other health problems.

Although lung cancer is not yet widespread in most of the developing world, the lessons from developed countries where women have now been regular smokers for some decades, are very clear. Lung cancer in women has increased fourfold over the past 30 years in many developed countries. As shown in Figure 3.1, it has overtaken breast cancer as the leading cause of cancer death in women in the United States who were the first women to take up cigarette smoking in large numbers. This pattern is being repeated elsewhere in developed countries where women have started smoking.

If current smoking patterns persist, or get worse, even higher costs associated with ill health and disability will occur. For example, in Spain few deaths in older women are attributed to smoking at present because only a very small proportion of 60 year old Spanish women have ever smoked.

However, the situation has changed recently; 50% of young women now smoke cigarettes. If most of them continue to smoke, it can be anticipated that there will be an epidemic of smoking-related deaths when these women reach middle and old age¹³.

Figure 3.1
Trends in mortality for cervix, breast and lung cancer in US women,
age adjusted to the US 1970 population



In most developed countries and Eastern European countries, between one quarter and one-third of women smoke; anti-smoking policies and health education strategies are aimed at containing these levels and especially at countering cigarette advertising targeted at young women. Even higher levels are to be found in many Latin American countries, where up to two-thirds of young women smoke. In most African and Asian countries levels are considerably lower (less than 10%). There are also a number of traditional societies where smoking has long been common practice among women. Everywhere, strategies are needed to counter the aggressive marketing policies in developing countries by the tobacco industry.

Cervical cancer

About 500,000 new cases of cervical cancer are diagnosed each year, mostly in developing countries²². For instance, mortality is three to six times higher in Latin American countries such as Brazil, Argentina, and Bolivia, than in Canada or the United States²³.

Cervical cancer is one of the few cancers with a readily detectable and treatable precursor stage.

Pap smear screening is relatively simple and effective, but there are logistical and cost considerations in establishing effective screening and treatment programmes, particularly in developing countries. Screening is rarely accessible to women in rural areas, or ageing women who are at greatest risk; even in developed countries, screening rates are usually higher in younger than in older women. Screening once every five years can result in an 85% reduction in mortality from cervical cancer; screening every 10 years could result in a 64% reduction²⁴. Screening older women even once in their lifetime will prevent more cases of cervical cancer than screening a small proportion of younger women every few years. For these reasons, a stepwise approach to the frequency of screening has been recommended where resources are limited; screening should not be encouraged to a level beyond which it cannot be matched by the diagnostic and therapeutic facilities²⁵. In other words, for screening to be effective, the associated cytology and treatment facilities must be available and of a high standard. Prerequisites for establishing complete population programmes and political commitment to action are the recognition that cervical cancer is a preventable major cause of death.

Where cytology-based screening programmes are not feasible, alternative approaches are being investigated such as using nurses or trained non-medical health workers to visually examine cervixes treated with an acetic acid solution that highlights abnormal tissue.

Breast cancer

In developing countries, breast cancer is similar to cervical cancer in terms of its impact on women. In developed countries breast cancer is numerically more important than cervical cancer.

Worldwide, there are almost 600,000 cases of breast cancer each year, 60% of which occur in developed countries. Breast cancer at present accounts for about 3% to 5% of all deaths from cancer in women in developed countries, but represents a smaller proportion of all cancer deaths in Africa and Asia (1% - 2% of all deaths). In most developed countries incidence is higher in urban areas than in rural areas - but emerging evidence indicates that this trend is reversing.

The risk factors associated with breast cancer are poorly understood although an increased risk is associated with a family pre-disposition, particularly breast cancer pre-menopausally in a mother or sister. Age at menarche, age at first and last pregnancy, and age at menopause are also associated with an increased risk, none of which can be easily modified through public health interventions.

There is little possibility for primary prevention strategies to reduce either incidence or mortality from breast cancer. Early detection is the main strategy for prevention. Approaches to early detection include physical examination of the breasts by trained health workers, breast self-examination, and mammography. More randomized controlled trials are needed as there is no conclusive evidence that lives can be saved through the adoption of programmes other than those using the latter approach. Well-designed trials with a high coverage of the population at risk have shown that through screening mammography, followed by effective treatment, breast cancer mortality can be reduced by 30% in women aged 50 years and over²⁵. There is as yet no clear evidence of benefit from screening programmes for pre-menopausal women²⁶. A number of ethical, clinical and resource issues must however be addressed before screening programmes are implemented on a wide scale, even for older women.

The risk factors for breast cancer suggest that it will increase as development brings changes in fertility and reproductive behaviour in developing countries. Although each individual factor may make only a small contribution to increasing the risk, the cumulative effect in terms of absolute numbers will be formidable. The organization and implementation of mass screening programmes are far beyond the resources of developing countries, and breast self-examination (BSE) remains the main option. However, there is an urgent need to address the many uncertainties associated with BSE to improve its effectiveness as a means of early detection that is appropriate to the specific context of different developing countries²⁷.

3.2.3 Communicable disease in developing countries

Communicable diseases are still a major problem for older women in developing countries. Although in late adulthood they are no longer amongst the most common causes of death, they still account for high levels of morbidity and disability. It is also important to consider that episodes of communicable diseases earlier in life can lead to life long disabilities which ageing will further accentuate. Tuberculosis, trachoma, and infectious and parasitic diseases cause significant disability⁹.

Trachoma is an infectious blinding disease which tends to be particularly severe in women. Pre-school children constitute the main reservoir for the micro-organism (*Chlamydia*) that causes trachoma. Women, being involved in child care, frequently become infected with the disease. Blinding trachoma develops slowly over many years, and thus ageing women face the most severe complications leading to visual loss. The WHO Prevention of Blindness Programme reports that some 150 million people in developing countries suffer from trachoma.

The historical experience of developed countries and contemporary programmes to control tuberculosis in many developing countries show that improvements in basic living conditions and nutrition can virtually eliminate tuberculosis. The re-emergence of tuberculosis in some populations is of great concern. The adoption of essential drug programmes provides cost-effective solutions, especially in refugee situations.

Both men and women are exposed to tropical diseases - malaria, schistosomiasis, lymphatic filariasis and onchocerciasis, African trypanosomiasis and Chagas' disease, leprosy and leishmaniasis. However, few - if any - studies have focused on the consequences of these diseases for older women. The impact of these diseases grows increasingly severe with time as exemplified by skin disease and blindness resulting from onchocerciasis, both of which are exacerbated with ageing. Leprosy, too, has a particularly debilitating effect on older women, many of whom are expelled from their homes and families because of this stigmatising illness. With an effective cure for leprosy available, disability can now be prevented in the younger age groups, but for most older women, it is too late.

Ageing women will be major beneficiaries of many programmes directed at controlling communicable diseases. Yet recognition of their needs is rarely the basis for implementation of such programmes, and even where they are implemented, ageing women may not have access to the services provided.

3.3 Chronic disabling conditions

The most effective means of reducing chronic disability in older women is through preventative strategies initiated in mid-life. Where problems become apparent in people who already are older, secondary prevention can still contribute considerably to reducing the disabling effects of chronic illnesses.

3.3.1 Musculo-skeletal conditions

Reduced mobility has a major impact not only on the physical functioning of ageing women, but also on their capacity to maintain social contact and hence their social and mental well-being. Conditions which affect mobility, such as arthritis, have major implications for quality of life. However, because they do not cause death, their effects have been inadequately addressed in health statistics.

Musculoskeletal conditions reduce mobility across a wide range of activities, and so, in turn, have a major impact on self-care. Investing in strategies to reduce musculoskeletal problems would reap a number of benefits including a general increase in independence and well-being of ageing women and a significant decrease in the cost of care and treatment.

For ageing women, even those who are older, exercise is an important preventive activity against all major musculoskeletal conditions. Yet in developed countries, few older women exercise on a regular basis. Lack of exercise and inappropriate nutrition has led to an increase in the proportion of women who are overweight or obese. For older women who have already developed problems, strategies focused on rehabilitation, mobility, and other social and economic factors are needed. Ageing women need encouragement and confidence to participate in safe exercise and recreation. Positive gains from participation can effectively counter negative attitudes that create barriers to many older women's involvement in physical activity. Women also need information on how to maintain appropriate nutritional intake and activity levels throughout their life.

In contrast, in developing countries, it is the excessive physical demands on women throughout their life

course, including their later years, that most adversely affect physical strength and mobility. Prolonged heavy lifting, pulling and carrying loads lead to damage of the joints, particularly the vertebral column.

In addition, nutritional deficiencies reduce the physical strength of women as they age. Broad development programmes are required to reduce the excessive demands for physical labour made on women throughout their lives.

3.3.2 Osteoporosis

Bone loss is a normal occurrence in both sexes after age 30, but it accelerates in women after the menopause. Osteoporosis refers to *excessive* bone tissue loss. Unfortunately, no measures have yet been established that provide reliable data on patterns of bone loss for more detailed population groups, or to predict bone loss for an individual woman as she ages. The causes of osteoporosis are still inadequately understood. Bone mineral loss is exacerbated by life-long lack of calcium in the diet, smoking and excessive physical activity causing prolonged amenorrhoea during earlier years.

Eighty per cent of those who have a hip fracture are women. The incidence of hip fractures among women in countries such as the United States and the United Kingdom is double that for men²⁸. On the other hand, older women in Asian countries who have lower bone density appear to have fewer fractures than older women in some other countries.

Osteoporosis can be a contributing factor in vertebral, ankle, wrist and hip fracture, but alone is not a cause. While hip fracture is the most severe consequence of osteoporosis, rates of fracture among older women increase markedly only in advanced old age. Decreased bone density accounts for only part of the increased risk of hip fracture among older women.

There are gaps in knowledge about the incidence of fractures in many regions, particularly those outside North America and Northern Europe. Only scant data are available from Asia, Latin America, Africa and the Middle East. The life long dietary intake of many older women in developing countries may have been deficient in the components necessary to build and protect bones, and this combined with hard physical labour throughout their lives, is more likely to damage than to protect their musculoskeletal system.

Although preventive strategies are available for osteoporosis, it is facing increasing medicalisation. Because the loss of oestrogen at menopause is associated with reduced bone density, osteoporosis is increasingly being defined as a hormone deficiency disease, a condition experienced only by women post-menopausally. This medicalisation owes much to the activities of commercial interests²⁹. By playing on women's fears of ageing, manufacturers of hormones and (to a lesser degree) calcium supplements have succeeded in redefining osteoporosis as a symptom of menopause. This redefinition has been used to justify the routine use of hormone replacement therapy as a preventive measure despite its limitations in the prevention of osteoporosis at advanced ages^{30,31}.

Many preventive strategies used for older women can also be directed at younger women who still have the opportunity to build and maintain strong bones. Such strategies include encouraging exercise and adequate calcium intake, and smoking cessation programmes. A substantial body of evidence indicates that regular exercise can reduce the risk of hip fractures by about half³². Stopping smoking is also important. A woman who stops smoking before the menopause will reduce her risk of subsequent fracture by about a quarter³⁵. Other strategies particularly relevant for older women include modification of unsafe living environments, reduction in the high use of psychotropic drugs, and educating older women about measures they can take to prevent falls.

3.3.3 Incontinence

While there are common causes of urinary incontinence among women of both developed and developing countries, there are also differences. In developing countries frequent childbirth, poor access to facilities for the repair of birth injuries, circumcision practices, and untreated urinary tract infections can all lead to urinary incontinence. Widespread problems of this kind at younger ages in developing countries carry over to high levels of incontinence among ageing women. While attention to the reproductive health of younger women will be the primary preventive solution for the future, secondary prevention is a major need for women who are ageing with these problems. The onset of incontinence with increasing age is a key predictor of loss of functional independence, and can be one consequence of reduced mobility and other impairments. At its most severe, incontinence can lead to institutionalisation.

In developed countries, causes of urinary incontinence include lack of exercise, immobility, surgical intervention in childbirth and the use of specific drugs such as anti-hypertensives, diuretics, and tranquillisers. When these are the causes, there is considerable scope for primary prevention.

Incontinence can have serious personal and social consequences. It can cause anxiety, loss of self-esteem, avoidance of sexual activity, and depression. Through embarrassment, sufferers may avoid social contact and thus become socially isolated. Many sufferers do not seek help because they are too embarrassed to talk about it. As a way of overcoming this barrier, the health care professionals most usefully involved at this stage are community nurses; self-help groups are also useful.

Another factor that inhibits many ageing women from seeking help is their reluctant but misinformed acceptance that little can be done about incontinence. As bladder control problems are not an inevitable consequence of ageing, an important aspect of any preventive strategy is to provide information to this effect. Incontinence does not affect the majority of ageing women, and a range of self-care strategies are effective in managing or correcting problems that do occur.

Self-care, involving techniques such as bladder training and exercises to strengthen the pelvic muscles, is one of three approaches that can be used to deal with urinary incontinence. The other two are medication and surgery.

Given the reluctance of many women to talk about the problem, incorporation of information about incontinence in programmes, such as those on exercise and nutrition, could prove effective. Access to health workers who are specifically trained to manage urinary incontinence is also required. In developing countries especially, education about prevention of incontinence in later years needs to be included in the training of primary health care workers who deliver other community-based health programmes such as fertility control and maternal health.

3.3.4 Multiple conditions, minor conditions, and sensory impairment

Many ageing women experience a number of chronic conditions, including sensory impairments; these may be minor conditions or occur in conjunction with one of the major conditions already discussed. The effects of any one may not be severe, but their interaction can be significant in terms of reduced functioning, pain and anxiety about future health. Further, the ill-defined nature of many minor, chronic conditions poses problems for diagnosis, treatment and research, all of which tend to be oriented to specific diseases. Their effects are often attributed to the ageing process, and as such are accepted by ageing women as normal.

An analysis of the compounding effects of multiple conditions has shown complex interactions, with disability rising almost exponentially as the number of chronic conditions increased³³. Prevalence and the disability impact of the 13 most common chronic conditions in the US were considered. The pairs of conditions which were most often encountered within the context of increased disability were cerebrovascular disease combined with fractured hip, diabetes or osteoporosis. Older women were found to have highest impairment levels of all groups considered: vision impairment and vision disease ranked among the most common conditions and had a marked effect on disability levels when combined with other conditions.

One of the main vision diseases and the most important cause of blindness among older women is cataracts. Some 90% of people with cataracts live in developing countries and 60% of them are elderly; in such countries unoperated cataract is a greater cause of blindness and visual disability than trachoma. The most common form of cataract is age-related, and while there is no known effective prevention, effective low technology procedures are available for restoring sight. More women than men become blind from cataract, presumably due to a longer life expectancy. In many settings gaining access to surgery is more difficult for women than men and more effective strategies such as mobile eye camps are needed in order to reach older women. Hearing loss and deafness in old age also affect negatively social interaction and mental health.

Reduction of the effects of any one of these conditions equally reduces the impact of multiple conditions. Many of these conditions are amenable to primary or secondary prevention, and early intervention can help to avoid the negative consequences that can arise when several minor conditions go unattended. The kinds of physical and social preventative strategies that apply to the major conditions which threaten the health of ageing women also apply to these conditions.

3.4 Mental Health

More than any other health problem of ageing women, mental health is conditioned by social and cultural factors. The definition of mental illness as well as the conditions that affect mental health are more varied than the diagnosis and causes of physical health problems. There are also strong age and gender biases in perceptions and reporting of mental health. Studies in developed countries consistently show that more older women than older men are diagnosed as having mental health problems. There are divergent explanations for such a finding. It could reflect greater stress and hardship experienced by ageing women, or it could be due to the stereotypes held by the medical profession which influence their expectations and diagnosis.

The association between poverty and psychiatric illness has been well documented, and these determinants are more likely to have adverse effects on ageing women than younger women or men. While there is a common misconception that there are higher overall rates of mental disorders among women than men, the prevalence of specific disorders differs for women and men. Of the two most common mental health problems experienced by older women, depression is amenable to supportive interventions but as there are no preventive measures against dementia, both care of those affected and support for their carers are required. Because of this difference in potential outcomes, and because depression and dementia can be confused, proper diagnosis is essential, yet the passive presentation of depression especially, means it may be neglected in ageing women. Such neglect has particular implications for older women needing care for reasons other than depression which, if not actively addressed, can further reduce independence and compound care requirements.

The discussion that follows focuses on depression and dementia as the major mental health problems of ageing women, but anxiety disorders also need to be recognised as being common among ageing women. These disorders can cause ageing women to limit their activities and reduce their independence. Social and psychological therapies to address these problems can restore the functions that have been adversely effected.

3.4.1 Depression

Depression can arise from the many stresses that women face as they age. Because depression can also be associated with biochemical disorders, there is need for accurate diagnosis and treatment. Although the lifetime prevalence of any psychiatric disorder is higher for men, women are twice as likely to be depressed³⁴. It has been claimed that the higher prevalence of depressive illness among ageing women may be somewhat exaggerated; while mild symptoms may be common, severe illness is not frequent³⁵.

Mild depression is associated with the losses experienced at different times over the later life course, the

most common being widowhood. Widowhood commonly brings a change in living arrangements, and it appears that control over choice is more important than the choice *per se* of living alone or with others.

Community-based studies conducted in Brazil have indicated a considerably higher prevalence of depression among poorer older women living with a married child (usually a daughter) not by choice but because lack of economic resources preclude continued independent living. These women were also more likely to indicate a lack of a confidante and to report fewer social contacts outside the household than other women in the study³⁶.

In developed countries medically-diagnosed depression is most often treated with psychotropic drugs such as tranquillisers, sleeping pills and antidepressants; the use of these drugs in elderly women is considerably greater than in elderly men. This medical solution to what is often a social problem can actually cause greater problems than it solves, since drug treatment itself is not without risk, nor does medication address the underlying causes of depression³⁷. Depression can be alleviated through social intervention and other alternatives, and it appears that many women who experience mild forms of depression turn to these forms of support. When the social causes are recognised, approaches based on positive social interactions can be sought. There is a need to formalise more self-help approaches, including support groups, in primary care.

3.4.2 Dementia

The prevalence of dementia rises steeply with age, from less than 3% for the population aged 65 to 70 years to over 25% at age 85 and over. This gradient is remarkably constant in a number of developed countries when comparable case definition has been used³⁷, although social responses to dementia differ widely. Women are more likely to suffer from dementia because of their greater longevity, but there is no clear evidence of greater risk compared to men at equivalent ages. The dementias are major causes of admission to residential care in developed countries, and this likelihood is increased for older women who lack family support. There is as yet no reliable data on dementia prevalence in developing countries and culturally relevant instruments need to be developed in this respect.

Caring for a person with dementia places enormous demands on the carer, frequently for years. Most of those caring for people with dementia are ageing women, either spouses or adult daughters. Gaining recognition and securing support for carers has been one of the main efforts of Alzheimer's Disease International, which is now established in a number of developing as well as developed countries. In addition to offering self-help approaches, such organizations have successfully lobbied governments in countries as diverse as Mexico and Australia. Support for carers is one of seven key components of Australia's National Action Plan for Dementia Care launched in 1992³⁸.

The volume of research into dementia has grown exponentially in recent years, but no causes have yet been identified or treatments established. Most research has been undertaken in developed countries, and while projections of dementia have been based on population projections, no cohort studies have been made to establish whether there is any evidence of changing prevalence in successive cohorts.

3.5 Different problems - common solutions

It is apparent that there are common factors contributing to each of the conditions affecting the health of ageing women. It follows that broad-based strategies which address these common causes will have far more widespread and beneficial outcomes than specific disease-focused strategies. For example, the adverse effects of smoking, poor nutrition and poor physical condition (the latter due either to lack of exercise or the damaging effects of excessively arduous physical labour) have been repeatedly identified as causes of the major health problems reviewed above. Preventive population strategies in these fields would achieve positive outcomes in several problem areas simultaneously. In addition there is an urgent need to provide more information to older women about normal ageing, and about primary health care and self-care approaches to problems that do arise. Information that is accessible and acceptable is the basis of health promotion and prevention strategies and will be best developed by involving older women directly.

Another broad-based strategy is the training of primary health care workers who can respond to older women's health care needs. With basic training, ageing women themselves can also take on many education roles, leading self-help groups and advocating on behalf of ageing women.

Careful consideration should also be given to the risk of over-medicalisation of health problems of ageing women, exposing them to unnecessary, inappropriate, and costly interventions. Preventive strategies can provide a strong counter to this development, including avoidance of an inappropriate use of drugs as noted in several of the problem areas.

Finally there is a need to strengthen and support non-governmental organizations active in the area of women's health, in particular, encouraging close links with existing family health services and maternal and child health programmes.

The major health problems of older women world-wide stem from non-communicable diseases. Primary and secondary prevention strategies offer several advantages in addressing these health problems because they:

- C give women the opportunity to avoid many health problems that might otherwise arise as they age, and to be involved in managing the problems they do experience;
- C provide a low cost, population-wide means of reducing the prevalence of sickness and disability in the future;
- C present an approach to health that ageing women can identify with and participate in, whether at an individual, community, or wider policy level.

The most feasible and valid approach to prevention in both developed and developing countries is through primary health care.

Strategies to address the identified health priorities of ageing women from several perspectives include:

- C** a focus on prevention of major avoidable health problems of ageing women by recognising that:
 - Y** heart disease and stroke are priorities for ageing women as much as for ageing men;
 - Y** smoking is as much an issue for future cohorts of older women as current cohorts, and concerns equally developing and developed countries;
 - Y** cervical and breast cancer are even more important problems for older women than younger women;
 - Y** non-communicable diseases are the major causes of ill-health among ageing women everywhere; and
 - Y** communicable diseases are a continuing threat to the health of ageing women in developing countries.
- C** the encouragement of broad-based preventive programmes that will simultaneously address several priority health areas by:
 - Y** developing disease prevention and health promotion strategies for non-communicable diseases (heart disease and stroke in particular) by supporting nutrition programmes and encouraging better physical fitness as part of healthy ageing. In developing countries this means reducing the adverse effects of hard physical labour, and in developed countries, promoting exercise and making available information on other self-care activities;
 - Y** stressing the health benefits over the life course of not smoking; encouraging anti-smoking programmes targeted at younger women and giving more attention to smoking cessation and other prevention programmes among ageing women. This will require support to halt the spread of the tobacco-related epidemics in developing countries and to introduce comprehensive legislation controlling cigarette smoking;
 - Y** ensuring that population programmes for the early detection of cervical cancer cover post menopausal women, and that breast cancer screening programs are directed to post menopausal women, with no upper age limits imposed.
- C** the use of health promotion to counter the over-medicalisation of health care for ageing women, by providing women with information on normal ageing and self-care approaches to maintaining health;
- C** the training of relevant primary health care workers to enable them to respond to the health care needs

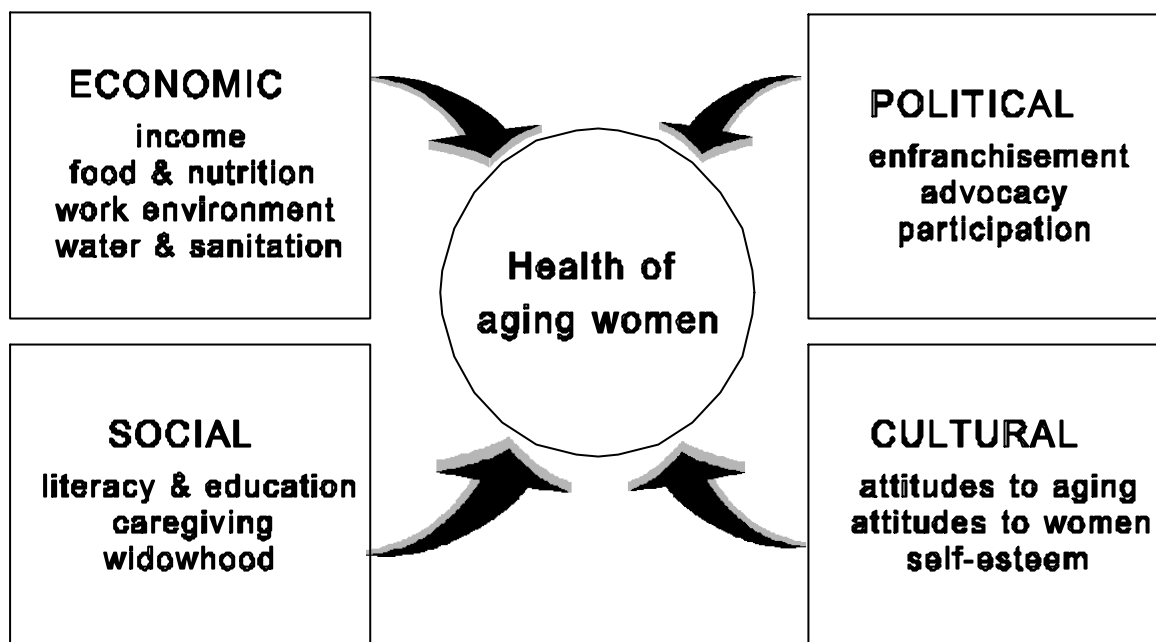
- of ageing women, and to train older women themselves to promote self-care;
- C** the use of the WHO Ageing and Health Programme as a vehicle for consolidating and exchanging information on model initiatives taken so far so that small initiatives become system wide, and the inclusion of experts in the health of older women on relevant committees and working groups;
 - C** the Ageing and Health Programme working with WHO Regional Offices and older women's organizations at national level to identify best practice in local programmes and to develop packages of locally relevant resource materials to advance the strategies proposed by the WHO Global Commission;
 - C** undertaking critical appraisals of existing protocols and guidelines for population screening programmes of relevance to ageing women to ensure they are based on sound epidemiological evidence, and promote cost-effective approaches to prevention.

4 DETERMINANTS OF OLDER WOMEN'S HEALTH

In common with any other population group, the major health problems of ageing women are readily seen to stem from economic, social, cultural and political factors, as well as biological factors. This section will focus on major economic, social, political and cultural determinants of health of specific relevance to ageing women, as depicted in Figure 4.1.

While these factors are common to developed and developing countries, there are substantial variations in the scale and spread of their effects across the population of ageing women. The differentials in health status of women compared to men, and older people compared to younger people are attributable to multiple disadvantages. For many women, the effects of these disadvantages are felt throughout their whole life, and the health status of ageing women reflects the compounding effects of these age and gender differences. Girls' nutrition, for example, will have long-term effects on bone strength, as reproductive health and sexually-transmitted diseases will affect the likelihood of cancers of the reproductive organs.

Figure 4.1
Social determinants of health



While admitting the negative lifelong effects these factors have on the health of some ageing women, it has to be recognised that there are many older women in good health. Positive economic, social, cultural, political and environmental circumstances have contributed to good health for these women, just as negative circumstances have resulted in poor health for others.

The aim of reviewing the economic, social, cultural and political determinants of health of ageing women is to identify correlates of both positive and negative outcomes as a basis for improving and maintaining the health of women as they age. It is also recognised that much of the health of older women reflects the circumstances of their earlier lives, and that particular groups of older women will have special needs. The papers on adolescent health and women's health prepared for the WHO Global Commission on women's health set the scene for the discussion of determinants of healthy ageing for women, and improvements in the health of ageing women can be taken as signifying improvements in the health of women at all stages of their life.

4.1 Economic determinants

4.1.1 Adequate income

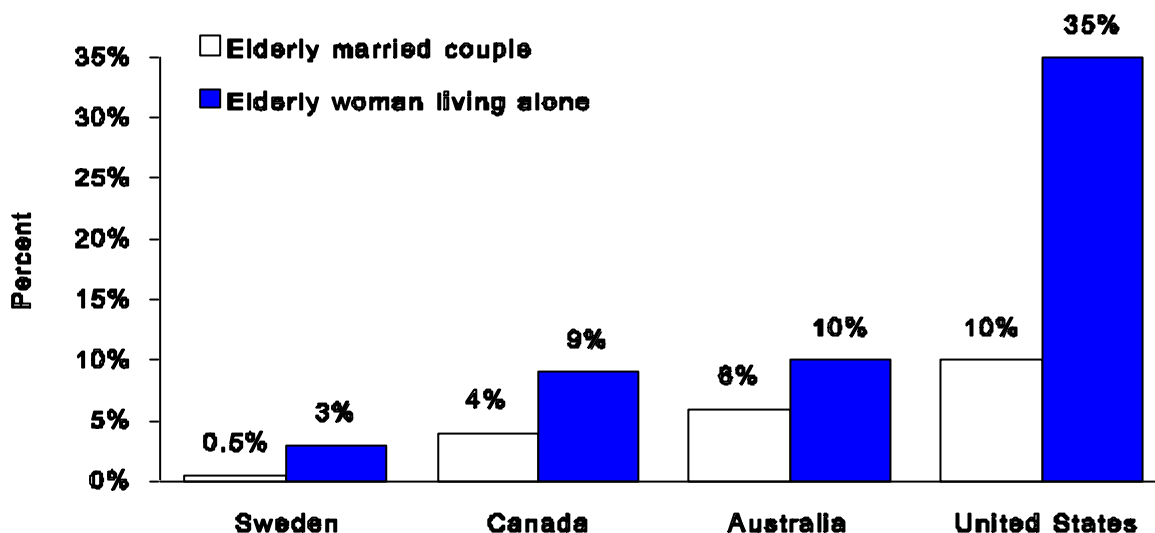
Poverty in old age often reflects poorer economic status earlier in life; many older women exist in conditions of relative if not absolute economic poverty, unable to meet minimal needs in many areas such as nutrition and shelter⁸. Even in developed countries, many older women lack independent economic security; retirement income is almost always lower for women than it is for men.

Social security systems have been, and still are to a large extent, based on three key assumptions: that children are not born out of wedlock; that marriages last forever and that the socially desirable role of a woman is that of housewife and mother, without paid work, and dependent on her husband. The social security systems in the United States and the United Kingdom, for example, while redistributive to women as a group, tend to treat women as dependents of their husbands rather than individuals who make a worthwhile contribution in their own right. Societies have changed. There is a much greater diversity and volatility of marriage arrangements, greater participation by women in the paid work force, and a greater emphasis on individual independence within marriage. Figure 4.2 shows the extent to which the social security systems in different countries are successful in ensuring a fair and adequate retirement income for all women, especially those living alone.

Health care for older people is usually financed in tandem with social security systems. Current transformations and the radical reshaping of some health systems suggest a move away from universal health care provision in favour of various "safety nets" in health and social welfare sectors. The negative impact of reductions in benefits, tighter eligibility criteria, increased charges for health care and reduction in the access to health services will be felt mainly by ageing women.

The insecurity of social security for ageing women is especially evident in Eastern Europe. Notwithstanding high levels of participation in the paid workforce at earlier ages, the level of benefits available on reaching retirement age has generally been low, and recent economic changes have further reduced purchasing power. The loss of men in the Second World War also means that many of these women did not marry and so are not able to call on family support but have to rely on whatever public support is forthcoming.

Figure 4.2
Percentage of elderly (65 years & over) households below 50% of median household income (1987)



While most elderly women in industrialised countries receive some sort of social insurance or occupational benefit, very few elderly women in developing countries receive pensions. Where pension schemes exist in developing countries, they are almost entirely limited to public sector employees, the great majority of whom are men. The prospect of wider systems developing in the future is extremely limited. In the absence of publicly-funded social security schemes, ageing women in developing countries must rely on the family which becomes the main source of security and shelter.

The great majority of ageing women lack the means to pay for even basic health care. Using part of their limited income to meet the cost of health care would exacerbate the deprivations that contribute to their poor health. As shown in Box 4, lack of financial autonomy and reliance on children places older women in rural areas in particular, in a dependent position.

BOX 4: 21.5 million elderly widows in China

China will experience a fast ageing process because of the official one child per family policy established in 1979, which has rapidly lowered the total fertility rate¹². Two thirds of women 65 years and over are widowed (an estimated 21.5 million in 1990); 80% of these widows in villages and 40% in cities depend on the support of their children. Only one woman in 10 aged 60 years and over can read or write; this potentially raises intergenerational conflict when younger age groups have had greater educational possibilities¹².

Increasing urbanisation contributes to deteriorating living conditions for ageing women, both those who have been left behind in rural areas to face increasing responsibility for cultivation of crops, and those who migrate to urban areas only to find traditional roles and reciprocal support no longer available to them. For most of those who remain in rural areas, health services are scarce, while in urban areas, doctors and medically-orientated services make little provision for migrant women from rural areas to share their traditional knowledge and experience. At the same time, the increasing number of younger women living in cities is creating future cohorts of ageing women in urban settings who will have different needs.

International labour and social security organizations have longstanding interests in retirement incomes, and are taking an increasing interest in issues of gender equity. The ways in which social services such as health care and housing relate to employment opportunities and working conditions are also being addressed. It is through liaison with these agencies that issues of health of ageing women can be taken up in an intersectoral framework.

4.1.2 Adequate basic resources: food and nutrition

In developing countries, the nutritional deficiency of the general population is even more pronounced in ageing women. Famine, war and migration disrupt food distribution for everyone. But even under normal circumstances, poor nutrition is exacerbated by such problems as bad teeth, food of low nutritious quality, and chronic digestive disturbances including parasitic infections. The health of ageing women in these countries reflects the cumulative effects of these problems. For example, years of child bearing and sacrificing her own nutrition for that of her family often leads to chronic anaemia.

The nutritional problems of poor rural women have common roots in many countries and regions. In a variety of different settings the same themes emerge: in poor households and communities, women work harder than men but eat less, and men contribute less to family prosperity, health and well being although they earn more. The high cost to women of a heavy workload, combined with insufficient nutrition, is reflected in poor health and lack of well-being in old age. Particular manifestations are injuries to necks and backs from carrying heavy loads (Box 5).

BOX 5: Hard labour

In the remote Himalayan villages 600 kilometres north of New Delhi, women walk an average of 10 kilometres three days out of four, for an average of seven hours at a time. They bring back about 25 kilos of wood with each load. All women, young and old and even pregnant, participate in this activity. When the men in one small village wanted to sell off the nearby community forest to the government to turn it into a farm for seed potatoes, the women protested. If the forest had been cut down, the women would have had to spend several more hours every day to fetch the family's daily requirement of food and fuel³⁹.

Behind most food security policies lies the assumption that once a household obtains sufficient food, all its individual members will be adequately nourished. However, improving a household's access to food does not guarantee that the older women in the family will receive sufficient food. Some development initiatives ignore women, some fail to recognise their particular problems, and some even worsen their situation.

In developed countries malnutrition is usually restricted to the poor and underprivileged and is often manifested as over-nutrition through diets rich in carbohydrates and fat. Some nutritional problems in ageing women are a consequence of lifelong habits and others are imposed by poverty, often compounded by social circumstances such as living alone.

Finally, in situations of conflict, older women may be at even greater risk of not receiving adequate food, as reported in a recent survey in Bosnia Herzegovina⁴⁰.

4.1.3 Adequate living environments: water, sanitation and shelter

Another determinant of health is an adequate living environment, especially access to safe water and sanitation. In rural areas of developing countries less than two-thirds of the population have access to safe water; less than half have access to sanitation. For example, only 10-15% of people in rural areas of the Lao People's Democratic Republic have access to a safe, sustainable water supply and as few as 1-2% have access to properly constructed latrines. Overall figures of this kind can emphasize the plight of many ageing women who have been left in small villages when younger people move to urban areas.

Lack of safe drinking water affects women more than men in terms of their health. Because of the gender-based division of labour (particularly domestic chores), women are more frequently in contact with polluted water and therefore at greater risk of infection from this source. Regular carrying of heavy loads may aggravate musculo-skeletal problems, prolapse of the uterus and acute malnutrition. In Indonesia, for example, the most frequently reported physical disability affecting ageing women is caused by fetching water.

While educating women about safe water management practices has a part to play, its effectiveness will be limited unless there are also changes in heavy agricultural responsibilities and the risk of infection from contaminated water in the fields. The provision of piped water is one such change that alleviates other problems. Other environmental hazards that threaten the health of older women include lifelong exposure to agricultural pesticides and indoor air pollution from smoky kitchens.

4.2 Social determinants

Three social determinants have significant effects on the health of ageing women. The first, education and literacy, is part of earlier life experience. The second and third are major and widely-experienced events that occur in the later life course: the likelihood of caring for a disabled spouse or relative; and widowhood. These experiences can be regarded as normal insofar as there are social and cultural norms that govern roles and expectations. These events can have both positive and negative impacts on health, and the individual experiences of older women vary widely even within the same society. Other events that may occur in later life, such as violence and abuse, can be seen as abnormal and can only have negative effects on the health of ageing women. Fear of these events as well as actual experience can add to their vulnerability. The diversity of experience of ageing women, and their general disadvantage compared to ageing men with regard to literacy and widowhood, are seen in Table 4.1.

The current cohort of older women includes women born in the 1890s and those born in the 1930s. This very wide age range presents considerable contrasts not only in education and occupational opportunities, but also in social experiences and major life events. The next century's ageing women were born post-World War II. Their expectations about their future life will be different from current cohorts of older women. The health status of current cohorts of older women reflects social conditions many years ago, whereas the health of future ageing cohorts will reflect recent, current and future social and economic conditions. It is not easy to predict the future health effects of these factors.

4.2.1 Literacy and education

Education is one of the more readily modifiable social determinants of health. The relationship between education and health is well established, with higher educational levels being associated with good health. People with greater education consistently show less disability and better chances of recovery after illness.

Levels of literacy and education among current cohorts of ageing women are low in many developing countries. Improvements in education of girls will result in better educated future cohorts. Achieving basic literacy for ageing women is a prerequisite to promoting their participation in increasingly literate societies. Just as education of younger women has been a central factor in improving maternal and child health, so increased literacy for older women can be expected to bring health improvements for them.

If attention is not given to literacy, older women will be even further marginalised. In developed countries, the high level of involvement of older women in continuing education indicates their desire to "catch up" on missed opportunities. The current shifts in work force participation of young and mid-aged women, together with their improved education and work experience, will create a potentially large group of ageing women in the future who will wish to be involved not only in the work force but in other aspects of public life, in both the formal and informal sectors.

Table 4.1: Illiteracy and widowhood among ageing women and men (60+ years)⁴⁴

Country	% illiterate		% widowed	
	Women	Men	Women	Men
<i>Sub-Saharan Africa</i>				
Mozambique	99	86	55	19
Burkina Faso	99	94	50	8
South Africa	37	4	48	10
<i>India</i>	92	65	64	19
<i>China</i>	95	61	58	27
<i>Other Asia and Islands</i>				
Bangladesh	96	70	66	8
Philippines	51	42	41	15
Thailand	70	34	53	17
Korea	71	32	64	13
<i>Middle Eastern Crescent</i>				
Egypt	95	77	60	12
Turkey	85	50	50	15
<i>Latin America</i>				
Brazil	56	44	47	12
Mexico	45	33	38	12
Argentina	14	11	44	13
<i>Former Socialist Economies of Europe</i>				
Romania	u	u	50	16
Poland	5	3	52	14
Hungary	3	1	52	16
<i>Established Market Economies</i>				
United States	7	9	26	6
Spain	22	9	42	14
Australia	u	u	43	12
France	u	u	45	13
Japan	u	u	49	12

Note: u = literacy reported as universal

4.2.2 Ageing women as caregivers

WHO has recognised the importance of informal caregiving in both developed and developing countries. Since in industrialised countries the age range above 60 spans more than a generation, it contains a great variety of life styles and living arrangements. A striking feature is the proportion of older women who are carers. Support within the family largely rests on the spouse; ageing women are more likely to care for their older husbands than the reverse. When a spouse is unavailable, it is largely women (usually adult daughters and daughters-in-law) who fill this role; many of these women are themselves aged 50 years and over, caring for parents (usually mothers) who are in their late 70s or 80s. Ageing women also act as caregivers for disabled adult children and for younger children; a case in point here is AIDS, where grandmothers are increasingly assuming the role of caregiver as shown in Box 6. "Family care" generally means care provided by women. Conversely, in developed countries, it is the relative absence of family support for older women that underlies their greater use of residential care.

Providing assistance for caregivers is appropriate, and regular relief from caregiving responsibilities is essential. Caregiving women need options. While there are many positive aspects to the caring role, a growing literature has documented the adverse emotional and physical effects of caring for a disabled older adult over extended periods. Severely disabled people now live for many years, even decades. The value placed on the role of wife or daughter as the primary caregiver is such that providing them with support may be more appropriate than relieving them of caregiving. The social value placed on caregiving is a potent force shaping the nature of assistance provided, and public recognition of this value is fundamental to the provision of public funds to support carers.

BOX 6: AIDS: the grandmothers' burden in an African community; a statement from HelpAge International

"The continuing burden of AIDS may well fall most heavily upon the grandmothers in certain developing countries. This assertion is probably contrary to most received knowledge on AIDS. In a family situation where both parents and some of the children are dying of AIDS, the surviving responsible person is likely to be the grandmother who is likely to be the most active, fit and competent person to manage the family affairs In a society where there are no adequate medical, hospice or counselling facilities, the grandmother is required over a long terminal period to nurse patients suffering from a disease which is unfamiliar, or even still unknown within the local culture. It is a disease which is dangerous to the uninitiated grandmother-nurse herself. It is a disease for which local traditional remedies have no application and no effect. It is a disease for which the grandmother may have no access to prognosis or advice on palliative treatment and preventive action.

In addition to the nursing responsibility, the grandmother will have the domestic care and the preventive health responsibilities for the surviving infants. More than that, it is likely that the family sources of income and the family's ability to produce or procure food supplies will have been cut off. The grandmother will have to become the wage earner or food producer."⁴¹

The entry of more women into the paid work force in developed countries has often been seen to be eroding the availability of family caregivers. The scale of this trend is limited by the low degree of participation of women over 50 in the paid work force, although younger working women caring for elderly relatives are a small but special minority of carers. The rapidly industrialising countries of Asia are currently undergoing major transformations in women's work force participation. The impact on intergenerational relationships, and the extent to which benefits of development are shared across generations, are not yet apparent. Rather than overstating the impact of increased work force participation on the availability of carers, it is more important that a range of options be developed to enable women to choose the balance of work and caring responsibilities that best meets their particular circumstances.

4.2.3 Widowhood

Ageing women everywhere are far more likely to be widowed than older men, but some countries have greater numbers of widowed women than others. The marked differences in the proportion of men and women over age 60 who are widowed in developing countries is due as much to high remarriage rates of men as to women's better life expectancy, which is the main factor in developed countries.

Although social norms that sanction men remarrying, or marrying younger women make widowhood far less likely for men, most women can expect widowhood to be part of their normal adult life. However few older women are prepared for this role. Social norms of widowhood generally mean restrictions of independence, as widowhood triggers a series of adjustments including changes in living arrangements and financial security as well in personal relationships affecting companionship and intimacy. The great majority of older women in developed countries cope with these adjustments without any ill effects on their health, but for a small minority there are significant consequences for mental health.

The vast majority of ageing women in developing countries live in extended family households, as much by necessity as by choice. In addition to urbanisation which can leave widows isolated in rural areas, growing mega-cities are giving rise to ever expanding urban slums, where often there is a lack of support from the extended family. Even when the widow has access to family support and the opportunity to contribute to the household in practical ways, this situation can result in dependency on the younger family members. In some countries, as shown in Box 7, widowhood practices pose a real threat to the health and well-being of these widows.

The situation of widows in developed countries presents a different picture of economic resources and dependency. While it is a degree of independence that enables widows to live alone, living alone may also make them more vulnerable to isolation, a vulnerability that is compounded if health declines.

BOX 7: Widowhood practices in Nigeria

In Nigeria, family law permits certain widowhood practices which discriminate against women, particularly women married according to customary rather than statutory law. Some of the negative practices derive from the belief that "*the beauty of a woman is her husband*". At his death, she is seen as unclean and impure, and the customs she must observe in the weeks following her husband's death can undermine her health. If she has no adult male children, she may be ejected from her husband's house as both it and his land will have been inherited by his oldest brother. In most cases, the husband's kin do not provide the widow with any economic support, particularly if she will not accept the status of additional wife to one of her husband's brothers.

In a study in Imo State, Nigeria, interviews and discussions were held with traditional rulers, leaders of women's organizations and widows. Five factors impacting on the health and economic status of widows were identified: long period of incarceration during mourning, obligatory poor standard of hygiene, deprivation of the husband's property and maltreatment by his relatives, enforced persistent wailing, and the practice of demanding that a widow sit in the same room with her husband's body until burial¹².

Independent relationships with adult children and younger generations provide great support to widows, but dependence on children can cause a conflict of cultural and intergenerational values. As values change, ageing women are in an increasingly vulnerable social position. "*To be old, used to be the best part of life*". This statement from a Kenyan woman refers to a time when older women were respected for their great age and wisdom and played important roles in society as judges, teachers, and community leaders. Ageing women in many such cultures no longer automatically have a central role in the community and the spread of western education and values has diminished the respect previously given to the traditional knowledge possessed by older people.

4.3 Political determinants

Women have traditionally been dependent on men as decision-makers to address their needs, including health needs. This subservience has resulted in a lack of attention to their needs which differ from those of men. The entry of women into political life has the potential to reverse this historic neglect.

4.3.1 Participation and protection of citizenship

The growing participation of women in political life is seen in their enfranchisement and mobilisation for action, including action on health.

Women have only recently had access to political power and progress has been uneven over time and between countries. New Zealand was the first country to grant women the franchise (in 1893), yet the first woman was not elected to Parliament until 40 years later and it took 100 years before a woman was elected leader of a political party. Women in many countries, including France, Japan, Italy and Hungary, did not gain the vote until after the Second World War. In South Africa, many older women voted for their first time in their lives in 1994. Women are still not fully enfranchised in some developing countries.

The greater participation of women in the public life of many nations is partly the result of the political mobilisation of women through the international women's movement of the last 25 years; 1995 is the end of the United Nations designated second International Decade for Women.

*"The pioneers of the second wave of feminism are advancing into middle age or beyond. In fact the whole postwar baby-boom generation is moving into midlife, which means that this will be an age group to reckon with in every sense of the word."*⁴³

The rights and protection usually afforded by citizenship are threatened in situations of political conflict, when the role of the State and legal system break down. They are lost altogether to refugees. Women are more likely to be the victims of these circumstances. The loss of life in conflict also robs many older women of the support of their spouses and children that they could normally have expected in old age. The impacts of war on older people that have been reported in former Yugoslavia⁴⁴ are experienced in many other parts of the world.

4.3.2 Health advocacy

There are already signs that a politicised cohort of older women is emerging, and that health is one of the major causes behind the political mobilisation of ageing women. Increasing numbers of ageing women hold positions in which they can voice their interests in the decision-making process. There will be more advocates for ageing women's health and needs in the future.

An example of advocacy for ageing women is the Boston Women's Healthbook Collective which published the first self-help health manual for women in 1971. This became a landmark in efforts to disseminate and reinterpret issues that medical knowledge had rarefied. The manual had a resounding impact and the Collective became a key promoter of the women's self-help movement in many diverse countries including Puerto Rico and Mexico⁴⁵. Members of the Collective, themselves in mid-life, supported the publication of a book for older women *Ourselves, Growing Older*⁴⁷. This book, which sold more than 100,000 copies in seven years, was written by women aged from 40 to over 90. Those who carried out this project are also involved in initiatives to educate ageing women and their health care providers about a variety of health issues, for example, urinary incontinence.

In both developed and developing countries, positive examples of health advocacy can be found in non-government organizations and informal groups, many of which are highly developed and provide strong leadership. Empowering and mobilising women around the issues of health and ageing is a central strategy for action. The collective nature of such action itself provides a significant opportunity for participation. It also helps women to know the value of anti-discrimination legislation as a tool for equality. Even where such legislation exists, however, there is a need to ensure that principles are put into practice and that *de jure* rights are not simply taken as meaning that *de facto* rights operate.

4.4 Cultural determinants

How women experience ageing and their health status as they age will be profoundly influenced by the cultural context in which this occurs. Attitudes of others towards older women, attitudes of ageing women towards themselves and attitudes towards menopause and ageing in women all influence expectations of health in later years. Fostering positive attitudes to ageing women is critical to maintaining positive public policies.

4.4.1 *Attitudes towards older*

The status accorded to older women varies tremendously in different cultures. In pre-industrial societies, status was sometimes high with opportunities to gain prestige and authority with age; such opportunities to gain empowerment with age have usually diminished with modernisation and development⁴⁶. Nevertheless, recent work of the European Commission reports positive attitudes to older people in a number of northern European countries where older people have achieved independent and active roles in post-industrial society. In southern European countries however, there was recognition that while the traditional status of the elderly has been lost, no new positive roles have yet emerged⁴⁷.

Women experience discrimination on the basis of age earlier than men. Age discrimination compounds the disadvantages of gender discrimination. Women are considered old at an earlier age than men. Further, they are perceived as weak, dependent, vulnerable, and lacking in femininity and sexuality. Such negative images contribute to rendering older women invisible and negate their significant diversity and resourcefulness. Such low status of ageing women is not inevitable.

As shown in Box 9, in many societies positive roles are available for women as they grow older, which may involve the accumulation of status and authority. These roles include mother-in-law, grandmother, keeper of the lineage, leader in religion and ritual, master craftswoman, councillor and political leader. Many older women also enjoy greater freedom in movement and personal behaviour⁵¹.

BOX 9: Maori women: honour with age

Maori, the indigenous people of New Zealand, offer different definitions as to when a Maori woman becomes a *kuia* (the term to denote respect accorded to an older woman). Being a grandmother is seen as one qualification, yet many Maori women reach this status before their 40th birthday. Another definition (probably the most widely accepted) concerns that stage in her life cycle when a woman passes menopause and is no longer of childbearing years. A third perspective of being a *kuia* is the role itself. The title is given in association with acceptance of any mantle of leadership.

*"The honour is usually received humbly and not without some reluctance, not only because it is a public admission of being old, but because of the responsibility that the role carries: a keeper of tribal lore, arbiter of disputes, source of wisdom and the link with the past all rolled into one. She is the personification of the tribe"*⁴⁸

Even today, in rapidly changing times, the role of the *kuia* has been maintained as a profound expression of traditional Maori values and customary practice⁴⁹.

4.4.2 Attitudes of older women towards themselves: self

The relationships between ageing, health and self esteem are multi-faceted. Self esteem reflects a sense of self worth and being valued by others. Just as self esteem can contribute to both mental and physical health, which in turn enhance self esteem, lack of self esteem can affect health adversely, particularly mental health. Traumatic events earlier in a woman's life are especially likely to have a negative effect on the establishment of her identity and self confidence, with long lasting effects. In extreme cases, these events can include sexual violence and bodily mutilation, but many other lesser events can also lower self esteem.

In some developed countries, ageing women face a difficult choice of either ceding to fashionable trends by trying to remain forever young, or accepting the stereotyped and circumscribed roles assigned to older women. Yet the roles of grandmother, carer or widow can bring new value and meaning to the lives of older women as their relationships with family and close associates are restructured. Where widowhood and other changes in extended family relationships involve losses, contact with peers is likely to be especially important in giving ageing women a valued role in their immediate social group. In establishing new social norms for the transitions of later life, peer support can reduce social isolation and depression, and the over-medicalisation that otherwise frequently accompanies these events in developed countries.

In developing countries where the breakdown of extended family relationships has eroded the status once accorded to older women in traditional society, peer support is likely to play an increasingly important part of the lives of ageing women. The balance of creating new roles and maintaining traditional roles in rapidly changing societies is a major task that ageing women themselves are best placed to undertake. Initiatives that will strengthen the capacity of these women to advocate and act on their own behalf become the major means of overcoming the barriers posed by low self esteem and lack of personal resources, including illiteracy.

In all countries, fostering positive attitudes to their own ageing among older women and enhancing their self esteem are keys to them controlling their lives and maintaining social participation. The benefits to mental and physical health that flow from this in turn enable continuing personal development and involvement in the wider society. The popular media in all societies have a major part to play in presenting the achievements and appearance of ageing women in ways that are positive and accurate rather than sustaining negative and unrealistic stereotypes.

Finally, older women are frequently the guardians of religious and spiritual culture, and these values become more important to many women as they age. Respect for older members of society is often part of these values, and older women can play a significant role in preserving these mores and transmitting them to other generations.

4.5 Better lives - better health

The multi-dimensional determinants of health of older women mean that any strategies to improve and maintain health must be equally broad based. Multisectoral action is required not only to address the disadvantaged status of many ageing women, but also to recognise and support their continuing contribution, taking into account changing social situations in both developed and developing countries.

Several strategies can be proposed to address underlying determinants of the health of ageing women. These strategies concern policy development to improve the well-being of ageing women and advocacy to foster their participation in decision-making and self-help activities, including support for carers.

Strategies proposed to these ends are:

- C** the adoption of a life course perspective on health, which recognises that the most powerful determinants of the health of ageing women (living conditions and social roles) are the same as determine health at earlier stages of the life course;
- C** availability of affordable primary health care, to ensure that ageing women are not denied access to health care because of their inability to pay. Given the very low incomes of ageing women in many parts of the world, strategies must focus on the provision of health care either free or at low direct cost to the consumer;
- C** extension of basic literacy programmes to ageing women so that they may reap the same health benefits from education as younger women and enhance their capacity for continued participation in increasingly literate societies;
- C** recognition of the role of ageing women as caregivers and the provision of support for caregivers as part of community-based primary health care services;
- C** promotion of positive models of healthy older women participating in all avenues of society;

- and self-help groups which enable elderly women to use their collective resources and strengthen older women's networks;
- C establishment of consultative mechanisms at national and local level to give older women a voice in the development of policy and programmes for the health of ageing women and opportunities to advocate on behalf of all older women; and
 - C non-discrimination against older women's access to health care on the grounds of age or sex, through enfranchisement and the development of legislation that protects their rights.

5 A FRAMEWORK AND STRATEGIES FOR ACTION

5C A Framework for Action

5.1C *Role of the WHO Global Commission on Women's Health*

The WHO Global Commission on Women's Health is ideally placed to reinforce the Organization's advocacy for the adoption and implementation of effective strategies to ensure that ageing women's health issues are firmly placed on national and international agendas. This report to the Global Commission might be used as the basis for such advocacy by providing guidance and motivation to Member States and other international agencies. One means to this end is the widespread dissemination of this report.

In addition, the Global Commission on Women's Health, by its very mandate, has an important role within WHO to accelerate the recognition of ageing women in the work of all WHO programmes. The Ageing and Health Programme is a vehicle to this end, and the WHO Fourth International Conference on Health Promotion in 1997 and the International Year of the Older Persons in 1999 provide key points for advancing strategies and reporting progress in the short to medium term.

5.1C *Health for all ageing women*

The framework for improving health for all ageing women is the same as that for improving the health of all members of society. This framework incorporates the principles of the Ottawa Charter and focuses on strategies that address the determinants of health at a population level rather than the consequences of ill health at an individual level.

The Ottawa Charter called for goal-setting and development of action strategies to achieve WHO's goal of Health For All, with particular reference to equity, health promotion, reorientation of health services to strengthen primary health care, community action and participation, healthy public policy, intersectoral cooperation to develop supportive environments, and international cooperation. The initiatives launched by the Ottawa Charter have been furthered through a number of international conferences on health promotion. The fourth such conference is to take place in Delhi in 1997, with the theme Moving Health

Promotion into the 21st Century. Women's health and ageing have been identified as two priority health promotion issues to be addressed.

Based on projected outcomes of current demographic trends, strategies are proposed through which Member States and organizations can take action appropriate to the needs of ageing women. In implementing these strategies it must be remembered that the diversity of the health status of ageing women means it is not practicable to target narrow groups defined by age alone. Rather, a life course perspective is needed which looks to the cumulative health benefits that will accrue to ageing women through the improvement of women's health at all ages. The improvement in the health of older women will itself be an indicator of the extent to which this strategy has been successful.

5.1C WHO programmes and regional developments

The reactivation and reorientation of the WHO Ageing and Health Programme presents a major opportunity to sharpen the focus on issues affecting the health of ageing women, and to further the strategies proposed here. The Programme acts as a catalyst at three levels: within all WHO programmes, through WHO Regional Offices, and through inter-agency initiatives, involving government and non-government agencies.

The network of WHO Regional Offices serves to transfer general strategies to specific regional, national and local settings. The Regional Offices have a particularly critical part to play in identifying programmes that offer models of good practice for promoting health of ageing women. Given that resources and expertise are especially limited in developing countries, it is essential that duplication of effort be minimised. Most initiatives for improving the health of ageing women will occur within existing structures and programmes, and Regional Offices are well placed to facilitate exchange of information and sharing of practical experience. The great diversity of the latter offers a foundation for further initiatives with an increased focus on ageing women.

By combining a review of past developments with information on models of good practice, simple but effective guidelines for enhancing the focus on health of ageing women in future planning and programmes can be developed. Input from agencies concerned with women's health can be sought in developing these materials, which can in turn be made widely available to other agencies. The Regional strategy on health care of the elderly⁵⁰ and the manual for primary health care workers prepared by the WHO Regional Office for the Eastern Mediterranean provide models of the kind

of guidelines that can be developed for ageing and health promotion, with specific strategies focused on the special needs of ageing women. Another example of widely-applicable material is the training manual on quality health care for the elderly produced by the Western Pacific Regional Office⁵¹.

Ensuring that experts in women's health and ageing from all Regions are involved in WHO activities related to ageing and health will be an important means of advancing the strategies proposed in this report, both within the Organization and in interaction with other international, national and non-governmental agencies.

5C Strategies for action

The action strategies proposed are in accord with the key components of the WHO Ageing and Health Programme, and the work of the Programme will in turn support their adoption and implementation by Member States and other organizations.

5.2C Policy

Policy strategies are fundamental in expressing a commitment to improving the health of ageing women and addressing the underlying determinants of health. The policy strategies proposed are that:

- C Member States undertake a review of national health goals and targets to ensure that health of ageing women is fully addressed. Such reviews are best undertaken by adopting a life course perspective which recognises that the most powerful determinants of the health of ageing women are the same factors associated with living conditions and social roles that determine health at earlier ages;
- C Member States develop intersectoral policy initiatives aimed at reducing the differences in life expectancy between the more and less privileged older women in each country. Such initiatives will eventually contribute to reduce life expectancy differences between older women in developed and developing countries;
- C Affordable primary health care be made available to ensure that older women are not denied access to health care because of their inability to pay. Given the very low incomes of older women in many parts of the world, strategies must focus on the provision of health care either free or at low direct cost to those who cannot afford full payment.

5.2.2 Programme development

Population-based health promotion strategies are the only feasible means of addressing the underlying common causes of the major health problems that adversely affect the health of ageing women. Small scale programmes have been established addressing these problems in some countries, and the coverage of such approaches needs to be widened. Programme development will best be advanced through strategies that:

- C Focus attention on major preventable health problems of ageing women by recognising that:
 - Y heart disease and stroke are as much priorities for ageing women as for ageing men;
 - Y smoking is equally an issue for current and future cohorts of older women in developing countries as well as developed countries;

- Y older women are at greater risk of cervical cancer and breast cancer than younger women;
 - Y non-communicable diseases are the major cause of health problems for ageing women in all countries;
 - Y communicable diseases continue to affect negatively the health of ageing women in developing countries; such diseases, often experienced early in life, may lead to life-long disabilities further aggravated by the ageing process.
- C Develop broad-based preventive approaches that simultaneously address several priority health areas by:
- Y developing programmes to promote prevention of non-communicable diseases (heart disease and stroke in particular) such as nutrition programmes and encouragement of improved physical fitness. In developed countries this means promoting appropriate exercise, while in developing countries it means reducing the adverse effects of hard physical labour;
 - Y stressing among younger women the benefits to health over the life course of not smoking and giving more attention to ageing women in smoking cessation programmes. Global efforts to halt the spread of the tobacco-related epidemics in developing countries and to introduce comprehensive legislation controlling the sale of tobacco products are important endeavours in this respect;
 - Y ensuring that population programmes for the early detection of cervical cancer include post-menopausal women, and that breast cancer screening programmes are directed to all post-menopausal women (without any upper age limit).

- C Extend basic literacy to ageing women so they can benefit from health and other education programmes and enhance their capacity for continued participation in increasingly literate societies;
- C Recognise the role of ageing women as caregivers and provide support for caregivers as part of community-based primary health care services.

5.2.3 *Advocacy*

In order to advance the health of ageing women, older women need to be empowered to participate in the development and implementation of policies and programmes. Ways to equip them for this participation include:

- C Presentation in the popular media of positive models of healthy older women participating fully in society;
- C Providing women with information on normal ageing and self-care in order to counter the trend to over-medicalize health care of ageing women;
- C Establishment of consultative mechanisms at national and local level to give older women a voice in the development of policy and programmes related to their health, and to create opportunities for them to advocate on behalf of other older women;
- C Promotion of self-help groups that enable elderly women to use their collective resources and strengthen older women's networks;
- C Ensuring that older women are not discriminated against in access to health care on the grounds of age or sex, through enfranchisement and the development of legislation that protects their rights;
- C Including representatives with expertise in health of ageing women on different WHO expert Committees - such as that of the Ageing and Health Programme.

5.2.4 *Information*

Information is required at several levels: for ageing women themselves, for policy makers, and for those who plan and develop health care and services for older people. This can be provided in a number of ways, e.g.:

- C Dissemination of information on normal ageing (including facts about the menopause and incontinence, nutrition, mental health and physical activity) showing the diversity of experience of healthy ageing;

- C The WHO Ageing and Health Programme provides the framework for consolidating and exchanging information on model initiatives taken so far, encouraging the involvement of older women's organizations and other NGOs to develop packages of locally relevant resource materials in agreement with the Global Commission's recommendation;
- C Adoption of age and sex specific life expectancies in conjunction with life expectancies at birth as basic indicators for monitoring changes in the later life course.

5.2.5 Training and Research

The reorientation of health services to focus on primary care can be advanced through strategies that train relevant groups of primary health care workers to enable them to respond to the health care needs of ageing women, and training of older women themselves to promote self care.

WHO can play a leading role in shaping the direction of research that will contribute to improving the health of ageing women. Suggested research strategies that can be pursued through the Ageing and Health Programme include:

- 1 Promotion of the involvement of older women in indicating research that addresses their concerns;
- 2 Development of appropriate and relevant indicators of older women's health, involving both the critical analysis of the current global measures of health status from the perspective of older women, and taking account of the way in which ageing women perceive their quality of life and value their health; and
- 3 Critical appraisal of existing protocols and guidelines for population screening programmes of relevance to the health of women to ensure they are realistic and based on sound epidemiological evidence, thereby promoting cost-effective approaches to prevention.

5.3 Global Framework - Local Action

In addition to the above strategies which are closely linked to the Ageing and Health Programme, the Global Commission on Women's Health is itself in a unique position to take action to promote international cooperation to advance the health of ageing women. Other WHO programmes such as Human Resources for Health (HRH), Strengthening of Health Services (SHS), Epidemiological Surveillance and Health Situation and Trend Assessment (HST), Intensified Cooperation with Countries (ICO), Noncommunicable Diseases (NCD), and Mental Health (MNH) should be involved in promoting these strategies. Such action could be very influential in strengthening political commitment to improving the health of older women. To ensure that the work of the Global Commission has a lasting impact, it is proposed that:

- C** This report be widely disseminated at the Fourth World Conference on Women, to member states, international organizations and non-governmental organizations, particularly women's organizations, to raise awareness and recognition of older women's perspectives in all health policy and programmes; and
- C** That a task force of the Global Commission on Women's Health be reconvened in 1999, the International Year of the Older Persons, to report on the progress that has been made in advancing the health of older women.

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