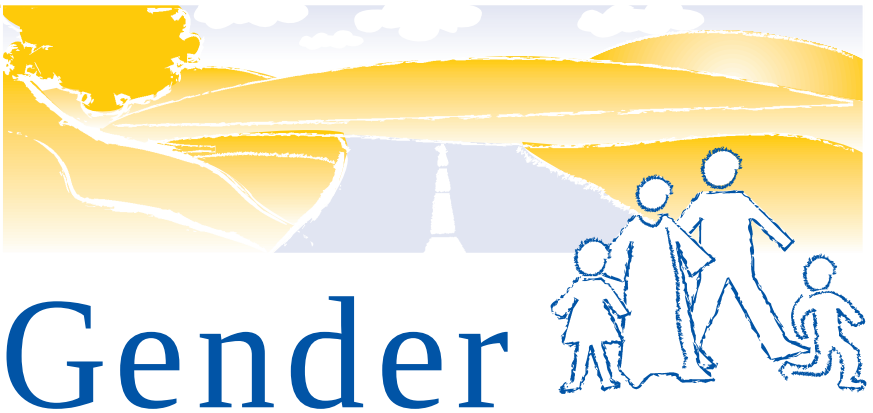

Health and Gender

Gender and Ageing

in the Eastern Mediterranean Region

Most older people will eventually need more care than they did earlier in their lives. The ways in which societies manage or fail to provide this care can have major implications for older people's quality of life. Analysing the differential needs of male and female elderly populations will improve the positive quality of their life outcomes.

Background

In the Eastern Mediterranean Region, declining fertility rates and improvements in life expectancy translate into greater population segments of older people. Currently, 5.8% of the population in the Region is over the age of 60. By 2025 that number will increase to 8.7%, and by 2050, to approximately 15% of the total population. In Lebanon, the percentage of the population over the age of 65 is expected to reach 10.2% by 2025, while currently it is 7.1% [1].

The changing population structure has implications for the elderly as the proportion of youth decreases in the Region and as the family structure becomes more nuclear based, there will be fewer young people to support the elderly in the future. Women will make up the greater number of the elderly population, due to their higher life expectancy and morbidity patterns. However, women are likely to experience more years of disability than men, even when taking their higher life expectancy into account.

In most countries of the Region, life expectancy at birth for females is higher than for males, ranging from 1 year in Afghanistan and Djibouti to 4 years in Tunisia and Bahrain; only in Pakistan is life expectancy higher for males, although the difference is only 4 months. The current ageing index of the Eastern Mediterranean Region (the ratio of people aged 60 or over to children aged < 15) is approximately 13.9 per 100, but that ratio is expected to reach 26.9 by 2025. In 2000, the average sex ratio of the population of the Region for ages 60 and over per 100 women was 86 males per 100 females. There were more men than women (ratio over 100) in nine countries: Bahrain 117, Jordan 103, Kuwait 202, Libyan Arab Jamahiriya 118.6, Oman 107, Pakistan 100.3, Qatar 245, Saudi Arabia 115 and United Arab Emirates (UAE) 246 (Table 1). There remain sex ratios of 100+ for the population aged above 80 in the Region in five countries (Table 2) [2].

Social and physical conditions across the life cycle

The conditions that currently account for the bulk of earlier mortality and increased morbidity among older people stem from experiences and behaviour at younger ages. Smoking, alcohol abuse, infectious diseases, undernutrition and over nutrition, poverty, lack of access to education, dangerous working conditions, violence, poor health care and injuries early in life and throughout the course of life can lead to poor health in later years

Yount found excess mortality of girls in the Middle East in the 1970s and 1980s [3]. In Egypt, the more highly educated a woman, the better the life survival chances for her children are, although women were found to be twice as likely to be illiterate than men [3]. The absence or lack of emphasis of physical education for female schoolchildren in the Region also impacts on health outcomes for these children when they become elderly. A study of the elderly disabled in Egypt, found that for females living a lifetime in rural areas and currently living in a fair-to-poor residence increased the chances of disablement, while being illiterate did not.Literacy for rural women did not necessarily increase their

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opportunities within society. In contrast with older males, literacy guarantees access to a better economic status, and thus can affect the extent of disability in older age. Another factor in the disability of older women concerns the childbearing habits of older generations in which women began childbearing earlier and had a greater number of births. Older rural women were also more likely than urban they face greater reproductive risks [4].

Compared to other countries, Egypt and Tunisia have large proportions of functionally disabled elderly. In Tunisia, there are large proportions of older widowed females with mobility problems, and in Egypt there are large proportions of functionally frail in the eldest age group [5]. Bahrain, which has the highest gross domestic product (GDP) of the group of 10 countries surveyed, the highest percentage allocated to health care and a life expectancy of 67, has a relatively high percentage in categories V and VI of the disablement transition model, which indicates the most severely disabled [5].

Impact of major diseases on elderly men and women

Cardiovascular diseases

Among men and women aged 60 years and older, mortality rates from cardiovascular diseases are approximately the same. However, as older women outnumber older men, cardiovascular diseases actually kill a greater number of older women each year.

Cancer

Men's mortality rates from cancer are 30%–50% higher than women's, with much (though not all) of this difference accounted for by greater incidences of lung cancer among men. These percentages could decrease as increasing numbers of women take up smoking. Cervical cancer is the deadliest cancer for women in the developing world as screening methods, such as the PAP smear and related treatment services, have not yet become routinely available. In developed countries, however, it is young women who are most likely to receive PAP tests, even though regular screening of older women would result in fewer deaths from cancer.

Musculoskeletal problems

Osteoarthritis, the most prevalent musculoskeletal condition among the elderly, is more common among older women than older men. Osteoporosis, or excessive bone tissue loss, is also more common among women. This appears to be linked to hormonal changes in women at the time of the menopause, but it may also be due in part to the more sedentary lifestyles and poorer nutrition that women, as compared to men, often experience.

Disabling conditions are likely to be caused by heavy physical labour and unsafe work environments. Reducing the number of crippling accidents among people of all ages, particularly young men, who tend more often to engage in risk-taking behaviour, could also reduce disability later in life.

Mental health

The most common mental health problems have a higher recorded prevalence among older women than among older men. However, despite older women's higher recorded rates of depression, older men are more likely than older women to commit suicide.

Incidence rates for dementia do not appear to differ between men and women, but as women on average live longer than men, there are a greater number of older women than older men living with dementia-impaired function.

Sensory impairments

A recent meta-analysis suggests that up to two thirds of the world's 40 million blind people may be women. Women apparently make less use of eye-care services, particularly for cataract surgery than men. Also, their role as primary carers for children means that they are more often exposed to trachoma, an infection which over time leads to blindness.

Incontinence

Urinary incontinence affects both sexes. Prevalence appears to be two to three times higher among older women than among older men, due at least in part to poorly-treated complications as a result of childbearing.

Elderly lifestyles

Quality of life

For most older people in the Region, the pattern is still that of co-residence with children. Families are the main source of support for elders in Tunisia and Egypt, but women may get more involved care from the family as they outlive spouses and have better family networks [6]. A comparison of involvement in family decisions between older men and women in Egypt, which is more patriarchal, and in Tunisia, which is more egalitarian, showed that women participate less in family decisions in Egypt than in Tunisia. In addition, women in Egypt participate less with increasing age and poor health, and men reported more participation than women in all areas, except for participation in decisions about daily preparation of food. Women's participation in society continues to an older age in Tunisia.

A short study of Egyptian men and women living in retirement homes and those living independently or with their families [7], found that elderly females ranked high for anxiety and depression while elderly males living in retirement homes suffered more from anxiety and depression than those living with families. Elderly women, irrespective of residence, smoked less but were less functional than men, and there were a greater number of elderly females without health insurance as compared to men [8]

Women are more vulnerable to poverty in their old age, due in part to the lack of pension and provisions for non-working widows. For instance, in Lebanon, 94% of elderly women have never worked and so national retirement plans based on employment would have little value for them.

Table 1. Sex ratio* 60+ in Eastern Mediterranean countries (per 100 women)

Country	1950	1975	2000	2025	2050
Afghanistan	100.6	99.4	98.2	96.7	94.3
Bahrain	94.4	116.1	117.1	166.6	109.1
Djibouti	82.3	81.6	67.4	42.7	79.0
Egypt	82.7	86.5	81.6	85.9	86.7
Iran, Islamic Republic of	109.0	95.8	93.7	93.2	89.0
Iraq	94.4	89.6	90.6	90.8	90.6
Jordan	116.2	94.8	103.2	97.4	93.2
Kuwait	103.0	102.8	202.6	208.6	113.9
Lebanon	95.5	89.0	84.9	71.1	84.5
Libyan Arab Jamahiriya	152.4	104.0	118.6	95.6	86.1
Morocco	92.1	105.1	81.6	85.0	85.5
Oman	99.0	88.8	107.0	137.1	92.5
Pakistan	134.1	119.1	100.3	99.7	89.8
Palestine	116.2	94.7	75.0	91.7	91.2
Qatar	92.9	143.1	245.4	252.7	128.4
Saudi Arabia	93.5	92.9	115.4	139.8	93.5
Somalia	77.3	84.0	85.9	86.1	88.9
Sudan	91.9	85.9	87.5	90.6	91.9
Syrian Arab Republic	122.0	96.5	90.4	90.5	89.8
Tunisia	76.1	126.2	98.6	87.7	87.1
United Arab Emirates	92.7	137.7	246.7	295.8	150.8
Yemen	88.2	91.5	78.6	71.8	89.8
Eastern Mediterranean Region average	108.4	98.5	86.0	76.8	89.9

Source (Crude): *World population ageing*. New York, Population Division, Department of Economic and Social Affairs, United Nations, 2001 [15]
* The sex ratio is calculated as the number of males per 100 females in a population. The ratio may be calculated for a total population or for a specific age group.

Table 2. Sex ratio 80+ in Eastern Mediterranean countries (per 100 women)

Country	1950	1975	2000	2025	2050
Afghanistan	105.4	97.3	90.8	86.2	78.1
Bahrain	80.0	84.7	101.1	94.8	92.8
Djibouti	64.6	75.4	62.7	47.9	32.6
Egypt	71.3	71.5	69.2	62.9	57.2
Iran, Islamic Republic of	104.6	96.0	83.7	76.1	63.9
Iraq	83.3	75.2	82.1	76.8	74.7
Jordan	116.7	80.1	91.6	81.3	75.7
Kuwait	87.6	93.1	62.8	161.9	116.4
Lebanon	86.5	73.0	70.9	53.4	56.8
Libyan Arab Jamahiriya	191.5	90.0	71.2	77.8	55.5
Morocco	80.0	116.2	85.8	58.8	74.3
Oman	79.8	81.4	79.3	90.1	81.9
Pakistan	139.7	130.6	112.5	94.8	63.1
Palestine	116.7	80.9	76.8	54.5	159.8
Qatar	87.1	101.7	151.9	223.9	72.4
Saudi Arabia	86.6	79.8	81.7	97.6	76.2
Somalia	58.8	62.9	70.4	71.7	80.5
Sudan	85.9	70.4	73.2	78.1	64.8
Syrian Arab Republic	131.4	90.5	82.1	63.0	57.7
Tunisia	56.4	108.1	101.4	65.9	278.5
United Arab Emirates	83.9	83.9	126.6	126.6	196.3
Yemen	80.3	82.7	73.1	54.4	64.5
Eastern Mediterranean Region average	105.9	98.1	89.7	81.2	69.5

Source (Crude): *World population ageing.* New York, Population Division, Department of Economic and Social Affairs, United Nations, 2001 [15].

Women working in the informal sector, a sector in which they are highly represented, will have no old age insurance or benefits to support them in their old age [8]. In the Eastern Mediterranean Region, women generally marry men older than themselves and are less likely to remarry on the death of a spouse, hence there are many more widowed women than widowed men. In fact, elderly females are more likely to be widowed or divorced at a rate of 54% versus 12.8% for men. Women living alone outnumber males living alone; the rate for women is 15.2% and for men 0.9% [8]. In Egypt, widowhood was associated with a relative increase in women's participation in society and family issues while men's participation remained unchanged after widowhood. The effect of widowhood had less significance for men and women in Tunisia in respect of changes in their participation in society [9].

If healthy life expectancy, that is, expected years of life in full health, is examined in place of overall life expectancy, women's advantage over men often diminishes (Table 1). A further consequence of differential life expectancy is that there are simply a greater number of older women in the world than older men, especially among the 'oldest old',those 80 years of age and older (Table 2).A study of osteoporitic fractures among the Lebanese population aged 50 and over found that the risk of fractures was higher for women at 13%, than for men at 8.6% [10]. Estimates of disability-adjusted life expectancy at birth are lower for women in both Egypt and Tunisia [6]. Given that disability rates increase with age, there are a substantially greater number of older women than older men living with disabilities.

Health care-seeking behaviour

Women are more likely to seek health care. Gender differences may be due to socialization, greater acceptance of the "sick role" or as a result of the greater use of specialist care by men. But for the elderly, the use of health care is complex and varies geographically. Data from a WHO collaborative study on social and health aspects of ageing, completed in 1990, revealed more frequent visits to doctors by womenin Tunisia than in Egypt which may be due to greater freedom of movement in Tunisia [11]. The same study showed women in general using more prescription medicines than men.

A 1990 study of population samples aged 60 and over in Tunisia and Egypt found that women sought less health care than men in relation to serious illness, which may be a reflection of less frequent receipt of care earlier in life [11]. However, in the case of less serious illnesses, women more frequently resorted to care and tended to over-report illness [6].

Disproportionate impact of crises

Crises, such as war, forced migration, famine and the HIV/AIDS epidemic, tend both to disrupt the fabric of society in general, and to either kill or dislocate adults at their most productive ages. These situations can adversely impact older people in at least two ways: (1) by removing younger workers and wage earners, the basis of support on which many older people must rely in the absence of public social insurance schemes; and (2) by leaving in their wake orphaned, sick and disabled people who must be cared for.

Women working in the informal sector, a sector in which they are highly represented,

A health and nutrition assessment undertaken in five camps in Darfur by HelpAge International found that older people were largely excluded from relief efforts. Half of the elderly population was living alone and most of these people were widows without extended family support. Thirty per cent (30%) of those interviewed were caring for orphaned children but were not receiving supplementary food aid [12]. A study completed in Lebanon showed that in the south, the elderly were left behind as the younger generations went to Beirut to find work as a result of economic pressures from the war, and that nearly one quarter of elderly females lived alone [8]. A study by Abdulrazzak [13] highlights the need to provide services for the growing elderly population of Lebanon, especially as the civil war prevented the development of policies and regulations for the care of the elderly, the ramifications of which are still being felt today. Current societal arrangements tend to make women less powerful than men and less able to advocate for their own health.

Need for more research

The complex interrelationship of gender, access to and quality of care, and types of illness are still little understood. Research must be initiated in the Region to better understand these interrelationships and to shape health care deliveryaccordingly. More longitudinal studies on ageing and health should be conducted to account for the fact that ill health and mortality in old age often stem from events and occurrences much earlier in life.

Studies are also needed to quantify the extent of home care of the elderly in the Region and which measures can be taken for the health sector to support effective home care. Research is also needed on the availability of gender-sensitive services for the elderly. A research-based lifetime health care guide would be beneficial to the life course approach. Research is also needed on the sex-specific problems of ageing, such as obesity for women or the impact of high fertility on bone density.

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