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AGEING AND GENDER

INTRODUCTION

The long-term pattern of demographic changes: declining fertility and mortality rates have resulted in the unprecedented, high rates of population ageing. It is predicted that by the year 2050, 20% of the worldwide population will be 60 years old and older, and the majority of them will be women [5]. The increasing number of elderly people has prompted a considerable interest in their health and well-being conditions. The International Year of Older Persons, declared by the WHO in 1999, was a landmark in the evolution of the research programmes on ageing and policy agenda of public health. Interdisciplinary and inter-sectorial initiatives were fostered, particularly those directed at recognizing the importance of gender differences. Clearly, the findings of numerous studies have revealed some of the constraints imposed by gender stereotyping on each sex. Inequalities between women and men show that women are more likely to receive fewer benefits than men from their access to the mainstream of economic and social life. The solution to this problem lies in improving access of women to resources that might enhance their well-being. A range of health and social policy initiatives has been implemented and achieved a considerable success in creating practical improvements in women's lives. At present women live longer than men, fertility rates have fallen by one third, maternal mortality rates have been halved and female literacy has increased from 54% of the male rate to 74% [5].

Considering the complex pattern of social and cultural attributes that define what is thought of as masculine and feminine in a given time and place, the objective of this paper is to review a gender picture of the health and well-being of the elderly.

THE CONCEPT OF GENDER

In biological common-sense terms, sex is defined as genetic/physiological or biological characteristics of a person which indicate whether an individual is female or male. The basis upon which individuals are allocated to a particular sex is related to anatomical, morphological and hormonal differences in the reproductive system. However, these traits represent only a part of the complex set of criteria by which we learn to distinguish femaleness from maleness. Equally important are the socially defined characteristics that different cultures assign to those individuals defined as female and male, i.e. gender. The core issue of gender refers to the social construction of norms, roles and responsibilities, values and freedoms for each sex. The concept of gender is applied to unequal relationships between men and women, or between the masculine and feminine spheres, with regard to distribution of resources, responsibilities and power. Integration of the gender perspective in health analysis implies linking sexual divisions of labour and power in a given population with epidemiological profiles and characteristics of accessibility, financing and management of the health system for that population [3].

THE GENDER GAP IN LONGEVITY

Women outlive men in all but the poorest and most unequal countries. In certain poor countries, a high maternal mortality rate, discrimination against women in nutrition and access to healthcare, and killing of girl babies cause that women's life expectancy is about the same as, or even lower than men's. In Bangladesh, for example, men outlive women, while in India and Pakistan the two sexes have almost equal life expectancy. However, even if women on average live longer than men, many years of their lives may be spent

in the shadow of disability or illness. The gender gap in longevity becomes smaller when we compare the healthy life expectancy (Figure 1). Healthy life expectancy (HALE) measures the equivalent number of years in full health that a newborn child can expect to live, based on the current mortality rates and prevalence distribution of health states in the population [7].

in longevity among young and middle-aged men and women [4]. Male prebirth advantage quickly disappears as an excess birth rate relative to girls becomes an excess death rate across all ages. Thus, the female survival advantage is most pronounced later in life. The nature of this advantage is described as multi-factorial. Primarily, estrogen provides protection against cardio-vascular

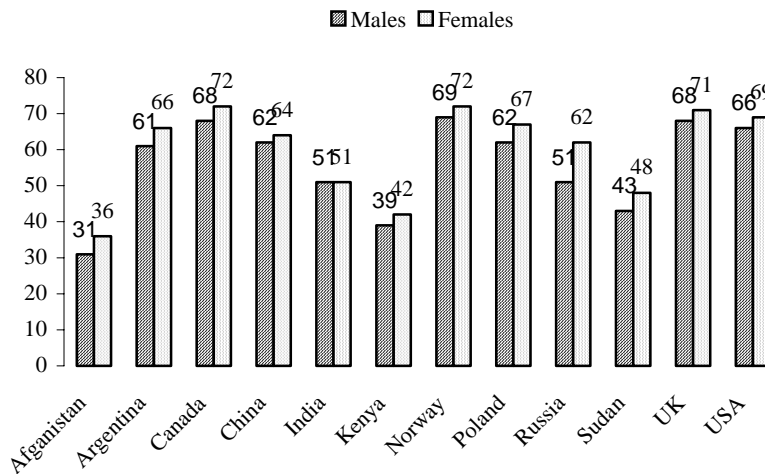


Figure 1. Healthy life expectancy (HALE) at birth in 2001 in selected countries. Source: WHO, 2003, Annex, Table 4

A consequence of differential life expectancy is that older women in the world outnumber older men. This is especially visible in the groups of 75-year-old and older people, as shown in Figure 2.

disease until menopause delaying the onset of disease amongst women relative to men. Of secondary importance are factors such as workplace stress, smoking and drinking patterns, which are thought to differentially disadvantage men [1].

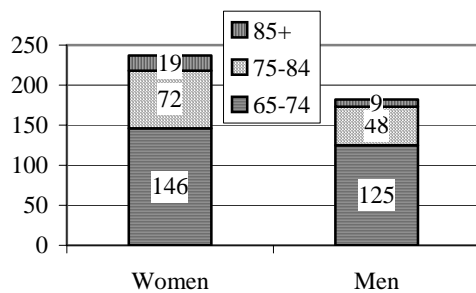


Figure 2. Number of women and men 65 years old and older worldwide, by age group in 2000, in millions. Source: WHO, 2002, Annex, Table 2

It has been suggested that sex differences in survival probability of the elderly outweigh differentials

THE GENDER PATTERN OF MORBIDITY AND MORTALITY

The basic diseases which constitute serious problems to older men and women are the same. There include cardiovascular disease (CVD), cancers, hypertension, stroke, diabetes, chronic obstructive pulmonary diseases, musculoskeletal problems such as arthritis and osteoporosis, mental health – mostly depression and dementia – sensory impairment, incontinence, and – especially in poorer parts of the world – infectious diseases and their sequelae. However, rates, trends, and specific types of these diseases differ between women and men. Table 1 displays the overall worldwide picture of prevalence of diseases, which are main killers of women and men [8].

Table 1. Death by sex and selected causes in WHO regions estimated for 2004. Source: WHO 2004, Annex, Table 2

Population	Males		Females	
6 224 985 000	3 131 052 000		3 093 933 000	
Total Deaths	n (000)	% total	n (000)	% total
	29 891	100	27 138	100
Cause	n (000)	% total	n (000)	% total
Infectious and parasitic diseases	5 795	19.4	5 109	18.8
Tuberculosis	1 030	3.4	536	2.0
HIV/AIDS	1 447	4.8	1 330	4.9
Trachea/bronchus/lung cancers	890	3.0	353	1.3
Colon/rectum cancer	323	1.1	300	1.1
Liver cancer	427	1.4	191	0.7
Breast cancer			474	1.7
Ovary cancer			135	0.5
Prostate cancer	269	0.9		
Diabetes mellitus	441	1.5	547	2.0
Alcohol use disorder	77	0.3	13	0.04
Alzheimer and other dementias	147	0.5	250	0.9
Sense organ disorders	2	0.007	2	0.007
Cardiovascular diseases	8 120	27.2	8 613	31.7
Hypertensive heart disease	419	1.4	492	1.8
Cerebrovascular disease	2 550	8.5	2 959	10.9
Unintentional injuries	2 307	7.7	1 244	4.6
Road traffic accidents	869	2.9	323	1.2

Cardiovascular diseases (CVD) are the worldwide leading cause of death of both sexes. Among men and women who are 60 years and older, death rates from CVD are approximately the same and, since older women outnumber older men, CVD actually kills a greater number of older women each year.

Overall, the men's mortality rates from cancer are some 30-50% higher than women's. Much of this difference is driven by the higher incidence of lung cancer among men. The major killers of men in the developed world are lung, stomach and liver cancers with colon and prostate cancers. Breast and lung cancers are the main killers of women. Colon cancer is significant in the developed world, while stomach, liver, and especially cervical cancers, are the major killers of women in developing countries.

Osteoporosis, or excessive bone tissue loss, is more common in women. This appears to be linked with hormonal changes in women at the time of menopause, but it may be due in part to the more sedentary lifestyles and poorer nutrition that women experience more often than men.

Most common mental health problems have a higher recorded prevalence in older women than in older men. Alzheimer's disease can occur at any age; however, its incidence increases exponentially with age and doubles every five years for those between 65 and 85 years, i.e. up to 20% of males and females aged 85 years or more. Considering that women outlive men, a part of

difference in prevalence of neurodegenerative diseases could be a gender artifact. It should also be emphasized that fewer men with mental ill health come forward to ask doctors for help.

While there is currently no evidence that deafness affects one sex more than the other, a recent meta-analysis suggests that up to two-thirds of the world's 40 million blind people may be women. This is again, partly due to the fact that women, overall, live longer than men, but much of the difference appears to be gender-related. Women as primary care takers of children are more often exposed to trachoma, an infection which over time leads to blindness. Women, compared to men, apparently less often take advantage of eye-care services, particularly for cataract repair surgery due to their lower status in the family, restrictions on their public mobility, and their lack of control of economic resources.

Urinary incontinence affects both sexes. Prevalence appears to be two to three times higher among older women than older men. It is supposed that a part of this difference may be explained by poorly treated sequelae of childbearing.

Unintentional injuries and road traffic accidents affect men twice often than women. This fact is also gender-related as men compared to women are likely to be more mobile.

Effects of the gender and socioeconomic status lurk in these figures. For example, there is a tendency to think of CVD as a "male" problem. This is misleading

however, as almost everywhere in the world CVD is the main killer of older people of both sexes. The fact that smoking has traditionally been a male activity has led to alarmingly high lung cancer mortality among men. Female lung cancer deaths are, however, on the rise as cigarette advertisers have successfully linked smoking to women's status and emancipation. In some developed countries, male lung cancer deaths are on the decline, while women's are still rising. Cervical cancer, on the other hand, remains the deadliest cancer in women in the developing world because effective means of screening and related treatment services have not yet become routinely available for women.

The conditions that currently account for the bulk of mortality and morbidity among older people stem from experiences and lifestyle at younger ages. However, the interaction between biological and social vulnerability cannot be denied. Mood swings, related to hormonal changes as a part of the menstrual cycle, may be a good example of genetic and biological factors accountable for higher prevalence of depressive and anxiety disorders among women. On the other hand, smoking, alcohol abuse, infectious diseases, malnutrition or diets heavy in cholesterol, saturated fat and salt and low in fresh fruits and vegetables, dangerous work conditions, violence, poor health care, and injuries are also significant health risk factors. Experience of any of these early in life and throughout the course of life can lead to poor health in later years. Since the gender pattern in a given society affects the degree to which women and men are exposed to these various risk factors, it has an effect on their health in later years as well.

Current societal arrangements affect the gender pattern in health as well. Overall, cultural pressures are reinforced by gender inequalities in income and wealth. There is a general agreement that employment is beneficial for men's health and survival. However, as aforementioned, men suffer from many more occupational accidents and more fatal injuries than women. For many women, their economic and social security is dependent on the support of a male partner, as women's incomes are almost always lower than men's. In consequence, there are many more women than men among the world's poor. Another example of gender inequalities are social insurance schemes that usually implicitly exclude the many women who work at home or in the informal sector as girls often receives less schooling than boys, especially in the developing countries. The women's ability to move about in public is limited by these constraints.

Societies often tolerate violence against the partner. All acts of violence are gendered, irrespective of whether the victim is female or male. However, in general, those who commit the violence are males.

Crises such as war, forced migration, famine, and the HIV/AIDS epidemic tend to disrupt the society and either kill or dislocate adults at their most productive ages. Consequences of these disasters severely affect older people, and especially older women. Although they are not themselves killed or infected, there are older women who come to harm of the wage earners loss. In the absence of younger adults, the older women take primarily responsibility for the care of needy children and others in homes and communities.

Finally, falls are also an important cause of morbidity and mortality among the elderly. Since women on the average live longer than men and are more likely to spend their lives in less permissive environments for their health, older women may be especially at risk for falls.

Differences in exposure to risk factors combined with biological, psychological and social differences between women and men may produce a gender-specific pattern of health problems. The gender approach makes it possible to identify the ways in which gender stereotyping may damage both women and men.

PROSPECTS FOR FUTURE

The groundwork for active ageing is likely to be shaped by life experience and as such is laid much earlier in life. Therefore, the main risk factors for ill health have to be improved in young adulthood, for example, by reducing smoking and alcohol abuse, improving nutrition, promoting physical exercise. The public health policy has to ensure prevention and proper treatment of medical problems to maintain good health across the entire life span. Women and men should be provided with equal access to economic resources and education in the course of their lives.

The availability of medical care and health services for individuals and populations will help older people to live with sensory and physical impairments and allow them to develop interpersonal connections.

Life quality has to be a priority. The focus on the overall life expectancy can obscure the fact that a longer life is not necessarily a blessing if it is burdened with disability, disease, dependency or abuse.

REFERENCES

- [1] Bobak M., Relative and absolute gender gap in all cause mortality in Europe and the contribution of smoking, *European Journal of Epidemiology*, 2003, 18 (1): 15-18.
- [2] Gender, Health, and Development in the Americas, Basic Indicators 2005, www.paho.org/genderandhealth.

- [3] Gómez E.E., Género y Salud: retos para acción, *Revista Panamericana de la Salud Publica*, 2002, 2 (5/6): 454-461.
- [4] Guralnik J.M., Balfour J.C., Volpatp S., The ratio of older women to men: historical perspectives and cross national comparisons, *Aging* (Milano), 2000, 12 (2): 65-76.
- [5] Pan American Health Organization. Area of Health Analysis and Information Systems (AIS), Health Situation in the Americas: Basic Indicators 2004, Washington, DC 2004.
- [6] United Nations. World Population Division. World Population Prospects: The 2002 Revision Population Database, <http://esa.un.org/unpp/>, accessed January 2005.
- [7] World Health Organization, The World Health Report 2003, Annex, Table 4.
- [8] World Health Organization, The World Health Report 2004, Annex, Table 2.