

Achieving gender transformative Universal Health Coverage fit for an ageing world



Key messages

- Women aged 50 and over account for over a quarter (26 per cent) of the world's female population, yet they are almost entirely invisible in debates on gender equality globally – including those related to gender and health.¹
- Gender inequality impacts on the health and wellbeing of women and girls across the life-course and can result in compounded disadvantage in later life.
- Women live longer than men but spend more of their lives in ill health or with a disability. At the same time women of all ages – including older women – are the main providers of health and care globally. This unequal distribution of care at all ages is a root cause of gender inequality across the life-course.
- Despite these facts, older women's needs and rights are poorly addressed within global health agendas and within progress towards universal health coverage (UHC).
- Progress towards UHC can contribute to a more gender equal world. But this will only happen if governments invest in gender transformative approaches to UHC that meet the needs and uphold the rights of women and girls of all ages, including older women.

Universal health coverage (UHC) is defined as everyone, everywhere enjoying access to the health services they need without suffering financial hardship. Progress towards UHC is essential for promoting healthy ageing, delivering social and economic development, and building resilient and equitable societies that respond effectively in times of crisis – including pandemics, climate crisis or other threats to global health security. UHC also has a key role to play in achieving a more gender equal world.

The commitment of governments to achieve UHC within the Sustainable Development Goals aligns directly with their duty to respect, protect and fulfil people’s right to the highest attainable standard of physical and mental health. The Political Declaration on UHC agreed in 2019 also explicitly committed governments to scale up efforts to promote healthy ageing and to mainstream a gender perspective into UHC, with a view to achieving gender equality and the empowerment of women through health policies and health systems delivery.

By 2030, 1.4 billion people will be aged 60 or over – the majority of whom will be female. Yet health and care systems worldwide remain unprepared for population ageing and associated increases in rates of non-communicable diseases (NCDs) and disability. Millions of older people globally are unable to access the health and care services they need, while critical opportunities for promoting healthy ageing and harnessing UHC’s potential to transform gender relations across the life-course are being missed.

An older world is a more female world

Women aged 50 and over account for over a quarter (26 per cent) of the world’s female population, yet they are almost entirely invisible in debates on gender equality globally.¹ Ageing populations also mean more female populations, both in terms of total numbers and the proportion of women compared to men. Although men outnumber women until the age of 50, women outnumber men at older ages due to their longer life expectancies. By 2030, 54 per cent of the world’s 1.4 billion older people will be female, and 60 per cent of people aged 80 and over.

Women live longer than men but spend more of their lives in ill health or with a disability

Partly as a result of their longer life expectancy, women spend a greater proportion of their lives in ill health or with a disability (see table 1).

Location	Life expectancy at birth (years)			Healthy life expectancy (HALE) at birth (years)			Gap between HALE and LE (years)		
	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female
(WHO) Global	73.31	70.85	75.87	63.7	62.5	64.9	9.61	8.35	10.97
Africa	64.49	62.37	66.65	56	55	57.1	8.49	7.37	9.55
Americas	77.16	74.49	79.84	66.2	64.8	67.5	10.96	9.69	12.34
South-East Asia	71.44	69.88	73.1	61.5	61.1	61.9	9.94	8.78	11.20
Europe	78.24	75.09	81.29	68.3	66.6	70	9.94	8.49	11.29
Eastern Mediterranean	69.74	68.31	71.31	60.4	60.2	60.7	9.34	8.11	10.61
Western Pacific	77.66	74.76	80.83	68.6	67	70.2	9.06	7.76	10.63

Source: World health Organisation (WHO), Global Health Observatory: Life expectancy and healthy life expectancy (2019)

Gender inequality impacts on the health and wellbeing of women and girls across the life-course

Our health and wellbeing are shaped by the conditions and environments in which we are born, grow, work, live and age, and the wider set of forces and systems shaping our daily lives. These are known as the 'social determinants of health'. Gender is a key determinant of health. Power imbalances and gender inequalities experienced by women and girls cross their life-course have a profound impact on their health and wellbeing at all ages and can lead to accumulated and compounded disadvantages in later life. Older women often experience 'gendered ageism' – that is, the intersectionality of age and gender discrimination and bias. Gendered ageism can also intersect with discrimination based on other grounds, including health status, disability, race, socioeconomic or migration status. Many women therefore face deepened inequalities, greater exclusion, and heightened risk of gender-based violence in older age. This has a profound impact on their health and wellbeing, and their enjoyment of their fundamental human rights.

Unequal distribution of care at all ages is a root cause of gender inequality

At the same time as facing greater need for care and support due to spending a higher proportion of their lives in ill health or with a disability, women of all ages remain the main providers of health and care globally.² As many as 70 per cent of the global health and care workforce is female.³ Women and girls of all ages – including older women – are also the main providers of informal care. Women are estimated to do at least two and a half times more unpaid household and care work than men, including care for older people.⁴ In East and Southern Africa, older women, particularly grandmothers, have played a critical role in the HIV and AIDS epidemic, caring for orphaned and vulnerable children, and in caring for those living with HIV/AIDS.⁵

The level of unpaid care women and girls provide has been further increased during the COVID-19 pandemic with people stuck at home and with key services and external support disrupted. This has had a profound impact on caregivers, including in terms of income and physical and mental health and wellbeing.

What older women say about their right to health and health services

Older women we work with tell us they face multiple barriers to enjoying their right to health and care services that meet their needs.

Few services meet older women's needs

Today, at least half the world's population lack access to essential health services.⁶ As one of the groups with the highest level of need for health and care services, older women are disproportionately affected by this gap. Even where services are available, they often don't respond to older women's needs (see Box 1: Responding to women's right to health and sexual and reproductive health and rights at all ages).

"There are no support services available to older people in my community. Only family members provide assistance with daily activities. But this does not happen for all." 71-year-old woman, Nepal

"Our healthcare here is limited to first aid, not many medicines are distributed." 68-year-old woman, Philippines

"When you come as a sick person you are told there are no medicines." 68-year-old woman, Kenya

Responding to women's right to health and SRHR at all ages

Health services often focus on younger age groups and fail to respond to the needs and rights of older women, including those related to sexual and reproductive health and rights (SRHR).

Older women are nearly always excluded from sexual and reproductive health programmes due to ageist assumptions about their sexuality and discrimination.⁷ Yet older women face unique SRH needs that must be addressed. These include those related to their menopause and post-menopause, their sexuality and sexual health, as well as the long-term impacts of childbirth.^{8,9}

For example, women who have had a larger number of children in earlier life can experience pelvic floor disorders, incontinence and pelvic organ prolapse, which have a significant impact on quality of life and may lead to social isolation and mental health issues that are overlooked by health professionals.¹⁰ Women with low economic status are also more likely to begin menopause at earlier ages than wealthier women,¹¹ increasing risk of osteoporosis, genital tract infections and cardiovascular disease.¹²

Older women also often struggle to access appropriate advice or care related to their sexual health, contributing to the growing burden of sexually transmitted infections (STIs) and HIV and AIDS in this group.¹³ This is especially concerning in East and Southern Africa, where, despite progress, HIV continues to have a significant and complex impact on older people, both as people living and ageing with HIV/AIDS and as caregivers for orphaned and vulnerable children, or providing care for people with HIV/AIDS.¹⁴

Gender-based violence can occur across the life course and may be exacerbated in older age, with the intersection of ageism and sexism resulting in older women being subject to new and distinct forms of violence and abuse. Yet older women remain invisible in datasets on gender-based violence and are routinely excluded from policy and programmes to prevent and address violence against women and girls.¹⁵



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High costs and physical barriers make services inaccessible

Inequalities experienced by women across the life-course mean they are most likely to face multidimensional poverty in later life than men,¹⁶ impacting on their ability to afford the direct and indirect costs involved in accessing health services.

“The mere thought of sickness terrifies me because we do not have any social safety net, healthcare coverage, or protection. Who would care for our fate, especially ours as older people, now that our children have left? The government is nowhere to be found.” 60-year-old woman, Lebanon

Older women also face additional barriers to accessing healthcare, including long distances to facilities and a lack of accessible, age friendly services.

“[The health clinic] is too far for me to walk to. It takes a day to get there on foot and I don’t have enough money to go by bus.” 89-year-old woman, Mozambique

“When we visit a health facility, we queue, younger people cannot even cede their space for you to sit. You queue and queue and sometimes you have high blood pressure, and you collapse.” 68-year-old woman, Kenya

The workforce is often unable to respond to older women’s needs

In many settings, the health and care workforce lacks the training and skills needed to respond to older women’s needs – including their need for sexual and reproductive health services (see Box 1).

“There are those that are trained, and there are those who just came to work but they lack enough experience to treat. Patients like me, the youth and the children should be treated separately. They instead put everyone together whether it’s a girl, a boy or an older person. Therefore, there is no differentiating what they do.” 68-year-old woman, Kenya

“I don’t like to visit the hospital because I don’t feel respected as a woman, and I don’t get to choose the sex of the physician.” 69-year-old woman, Jordan

Discrimination on the basis of age and gender violates older women’s rights

Gendered ageism and intersecting discrimination that older women experience when accessing services violates their right to health and care on an equal basis with others.

“When you go to the hospital, they say, ‘This one is too old, we are wasting medicine, it’s better she dies.’ And if a younger woman goes, they know that she still has more years to live.” 70-year-old woman, Kenya

“I know that we are not respected because we are considered as just consumers without being productive.” 75-year-old woman, Rwanda

“Older women are not recognised... as human beings. They are treated like second-class citizens. Nobody is bothered about them.” Older woman, 62, Uganda

Failures to uphold older women's right to participation, autonomy, independence and dignity

Older women often report that health and care professionals, family and friends exclude them from decision-making about their health and care, and fail to support their participation, choice and autonomy.

"There are [opportunities for consultation], but the older person's actions do not lead to complaints or suggestions. We just wait. Sleeping with one eye open." 68-year-old woman, Philippines

"I have to tell them I feel this and this, and my children assume that it is old age. [They say], 'Mother is not in pain.'" Older woman, Kenya

Older women won't count unless counted

Older women are often excluded from official statistics at local, national, regional and global levels. Even if they are counted, data is often not disaggregated to capture the diversity among older women.

Current measures of UHC, including the 'access' indicator (3.8.1) in the SDG indicator framework, do not include indicators such as physical access to health facilities, or staff skills, knowledge and attitudes – factors that are critical to understanding the barriers faced by older women. The indicator includes measures of a number of essential health services of relevance to older people's health needs, including for hypertension and diabetes. However, this indicator relies on age limited data sources, including the WHO STEPS NCD Risk Factor Survey (STEPS), which usually only includes people up to the age of 64, and the Demographic and Health Surveys (DHS), which usually exclude women over the age of 50 and men over the age of 55.

Similarly, despite NCDs having a disproportionate impact on people in older age, including contributing to 89 per cent of all years lived with a disability (YLDs) for women aged 55 and over,¹⁷ SDG 3.4 focuses on the ageist target of reducing 'premature mortality' by one third by 2030, defined as death between the ages of 30 and 70.

Even where data is collected on older age

groups, it is rarely adequately disaggregated. Systems often fail to collect, analyse, report and use sufficiently disaggregated data – including by sex, age and disability – for capturing the diversity of older people and understanding inequalities in access and outcomes to inform system and service design.



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Investing in UHC for a more gender equal world



UHC can contribute to a more gender equal world. But this is only possible if governments invest in gender transformative approaches that meet the needs and uphold the rights of women and girls of all ages – including older women.

We are calling for actors at all levels to:

1. Champion a rights-based approach to UHC that respects, protects and fulfils the rights of women and girls of all ages

A rights-based approach must be embedded in the design, delivery, monitoring and evaluation of health and care systems, upholding principles of Participation, Accountability and Transparency, Non-discrimination and Equality, Empowerment, and Legality for women and girls of all ages, at all levels. This approach must be underpinned by the adoption, enforcement and implementation of comprehensive laws that prohibit all forms of discrimination on the basis of age, gender, and other social identities, and create obligations to advance equality for older women, including through governments adopting a new UN convention on the rights of older people.

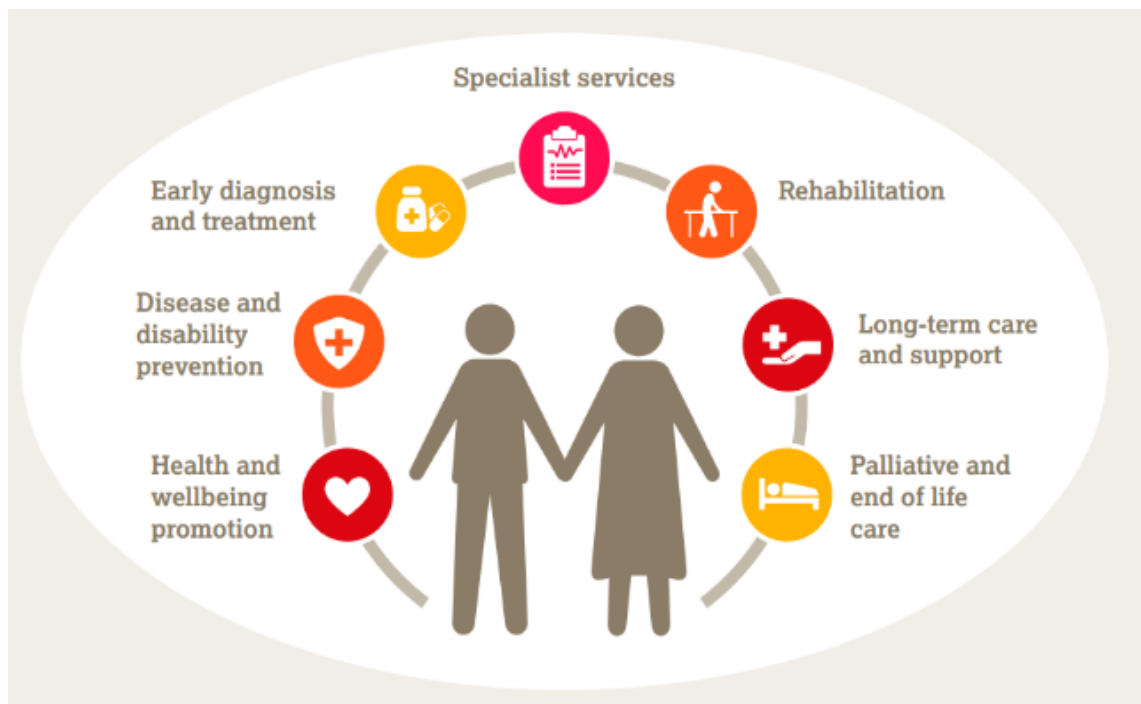
2. Invest in age-, gender- and disability-responsive systems that promote healthy ageing through primary and community-based services reaching the furthest behind first

This must include adopting gender transformative, disability-inclusive and life-course approaches within all health system building blocks, including:

- Services

- Workforce
- Access to medicines, vaccines and assistive technologies
- Information and data systems
- Financing
- Governance and leadership

It means responding to the unique needs of older women across the full continuum of care (see image 1), including long-term care and support in UHC essential service packages, recognising the transformative role this can play in recognising, reducing, redistributing and rewarding the unpaid care work carried out by women and girls of all ages. And it means counting older women, ensuring the collection, analysis, reporting and use of data disaggregated by age, sex and disability alongside other characteristics, to inform equity-based decision making.



3. Address the barriers older people of all genders face to enjoying their right to health and care

This means ensuring health and long-term care and support services, goods and facilities are available, accessible, affordable, acceptable and of good quality to meet the needs of all older people and address the unique barriers they face to enjoying their right to health and care.

4. Ignite intergenerational power to advance gender equality and health for all at all ages

Women and girls of all ages stand to gain the most from the development of comprehensive, integrated, community-based and gender transformative models of UHC. By uniting across generations, we can more effectively promote systems that respect, protect and fulfil the fundamental human rights of all women and girls and achieve gender equality across the life-course.

How HelpAge and partners are driving progress

HelpAge and our network members are part of the solution. We are a global network of over 170 partners working in 91 countries to promote the dignity, wellbeing and voice of older people. Working with partners, we promote approaches that seek to transform gender relations across the life-course from grassroot to global levels. Recognising and addressing gender disparities is essential for fostering inclusivity, meeting the needs and rights of all older people, and ensuring that our approach promotes equal opportunities and outcomes.

One example is HelpAge network member, Gramin Vikas Vigyan Samiti (GRAVIS). GRAVIS is a leading Non-Governmental Organization working in the rural areas of Rajasthan,



Uttarakhand, and the Bundelkhand region of Uttar Pradesh States of India. GRAVIS focuses on improving the quality of life of desert communities, taking a holistic development strategy to understand and respond to the changing needs of people – including women and girls of all ages.

GRAVIS programmes include pre-natal and post-natal care, training camps on girl child nutrition and family planning seminars, as well as interventions focus on promoting the health and wellbeing of older women. In rural India, high levels of care and support needs among older people and limited support available contribute to older people facing multiple challenges in meeting their most basic needs. This is particularly the case for older women and widows. GRAVIS aims at improving their lives by focusing on income security, raising awareness on healthcare and nutrition, providing primary medical care, and linking older women with age friendly, easily accessible and affordable health programmes. They also support older women to engage in community-based groups, including Village Older People's Associations, intergenerational learning groups and Self-Help Groups (SHGs). SHGs promote women's leadership development, vocational trainings, awareness on women's rights, education, microfinance, and sexual and reproductive health and rights of women of all ages.

Since it started its work in 1983, GRAVIS' interventions have supported over 75,000 families and reached more than 1.6 million people, including 800,000 women and girls.

Endnotes

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HelpAge International is a global network of organisations promoting the right of all older people to lead dignified, healthy and secure lives.

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