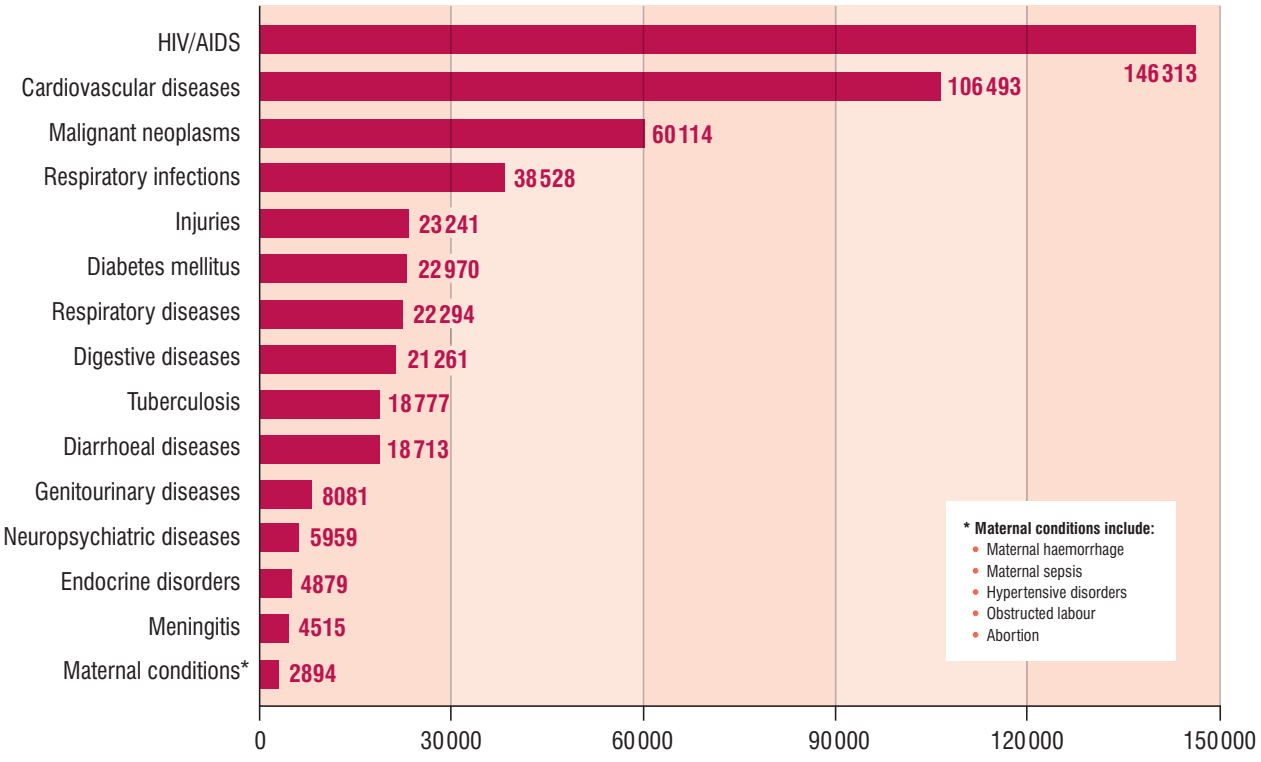
Chapter 4:
The health status of women in the African Region: beyond the reproductive years

Major risk factors for diseases

Just as the childbearing years bring a variety of pressures (biological, sociocultural and economic) to bear on the health of women in the African Region, so do the years that follow. Many of these pressures are a continuance of stresses that have existed since birth. Health problems such as malnutrition, malaria or diarrhoeal diseases precede the onset of sexual activity and continue through the reproductive years and beyond. Then, as the life course continues, African women are faced with new risks and their morbidity and mortality profile begins to alter. HIV/AIDS continues to take the greatest toll on lives in the 45–59 year age group, but as can be seen in **Figure 4.1** noncommunicable diseases (NCDs) start to weigh quite heavily, notably diseases of the heart, cancers and chronic respiratory diseases.

Figure 4.1 Main causes of death among women aged 45–59 in the African Region, 2004



Source: Constructed from World Health Organization, GBD 2004 Summary Tables, Health Statistics and Informatics Department, World Health Organization, Geneva, Switzerland, October 2008.

Some of these health problems are the result of exposure to risks first encountered in youth, including tobacco and alcohol use and a diet with high content of cholesterol, saturated fat and salt, but lacking in fresh fruits and vegetables. Health problems in this age group may also reflect a lack of physical exercise, excessive

physical stress especially in farming, in gathering and carrying food commodities, wood, water and other goods, and in nurturing children. They may also reflect a lifetime of exposure to violence and accidents in farms, the streets, or homes.

Overweight and obesity that are major risk factors for a range of chronic NCDs including diabetes, high blood pressure and heart disease, affect women disproportionately in the Region as indicated by a recent STEPS Survey undertaken in Malawi. The survey revealed that 28% of women are overweight compared to just over 16% of men.[1] A STEPS Survey in Sierra Leone showed similar results, reporting obesity in 10.8% of women.[2] In South Africa overweight and obesity are now major components of the malnutrition epidemic and one in every three women is considered obese.[3,4]

Like other public health issues in the Region, the obesity epidemic needs to be understood in the broad sociocultural context. In some settings obesity and overweight are admired as a beauty desirable in women, making it hard for women to adopt healthy lifestyles.[5] Obesity may also result from forced feeding of pregnant women in some traditional settings. Furthermore, the obesity epidemic may reflect a transition in the Region, both economically and socially. This transition is affecting the way women live. One of the key drivers of the NCDs epidemic in sub-Saharan Africa is the growth of its cities. In the Region as a whole the annual average urban population growth rate is 4.5%[6] and, as in other parts of the world, this rapid urbanization is largely to blame for the increasing levels of obesity.

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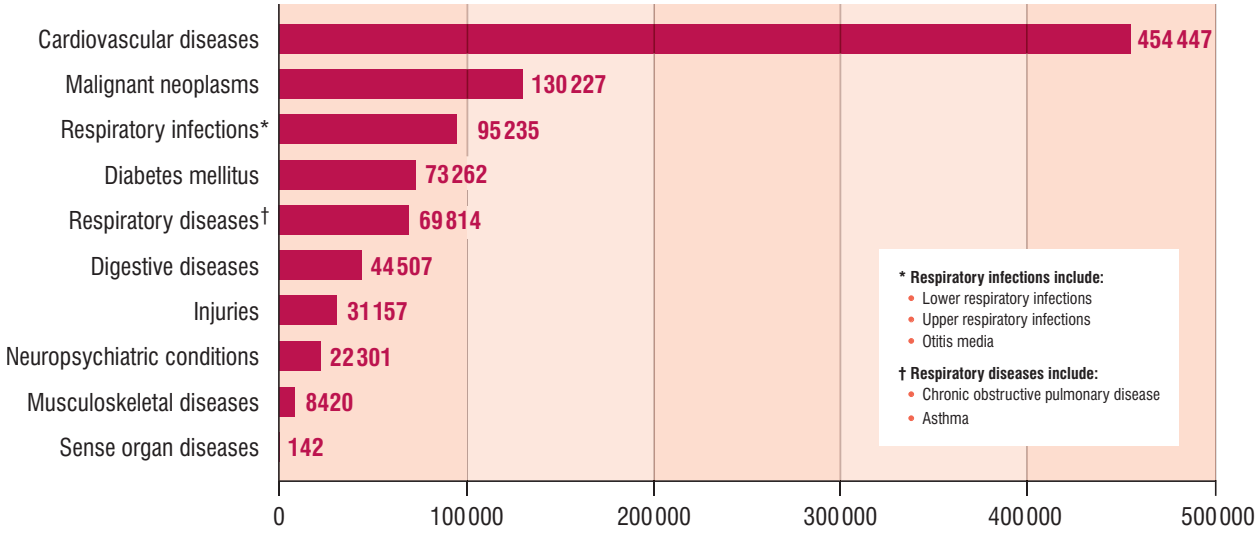
NCDs are high among women above 60 years

Urban population growth is also associated with diabetes and cardiovascular diseases[7] which killed over 106 000 women in the 45–59 age group in the Region in 2004, making it the second biggest killer after HIV/AIDS. Heart disease continues to take its toll on African women in their late years and accounted for more than 450 000 of deaths in 2004 (**Figure 4.2**). Far from being a disease of affluence, cardiovascular disease kills twice as many women aged 60 and above in low- and middle-income countries compared with high-income countries.[8] The same applies to NCDs generally. Contrary to the conventional wisdom that NCDs are a problem of the rich world, they are in fact a matter of growing concern in low-income countries where they are also the second leading cause of death of women.[5] NCD prevalence rates are generally not recorded by health systems in the Region, but selected studies suggest that they are high and increasing. According to WHO, if nothing is done to address the issue of NCDs, they will account for at least 50% of mortality in the African Region by 2020.[9]

Cancers are another significant cause of disease and death as African women age, accounting for more than 60 000 deaths annually in the 45–59 age group and well over 120 000 in the 60-plus group.

The particular sociocultural determinants driving the high prevalence of cervical cancer were discussed in the preceding chapter, but are revisited here as an example of the unique challenge sub-Saharan Africa faces in regard to the rapid increase in NCD prevalence against the backdrop of high morbidity and mortality

Figure 4.2 Causes of death among women aged 60 and above in the African Region, 2004



Source: Constructed from the World Health Organization, GBD 2004 Summary Tables, Health Statistics and Informatics Department, World Health Organization, Geneva, Switzerland, October 2008.

from communicable diseases. In old age in most countries worldwide, death and disability begin to be driven by NCDs, but in the African Region communicable diseases remain the chief cause of female deaths up to the age of 60 years.[10] Sometimes, this double jeopardy gives rise to interactions between communicable and noncommunicable diseases, adding to the burden of female morbidity and mortality. Human papillomavirus and cervical cancer are one example[11] and schistosomiasis is another.

Gender norms and disease

Because many African cultures tend to restrict women to domestic tasks including care-giving, women, more than men, are at a higher risk of suffering from a number of specific diseases. For example, as the main providers and processors of food, women and girls are often present as solid fuels burn in poorly ventilated houses, making them inhale large quantities of particulates and carbon monoxide.[12] Sub-Saharan Africa is one of the two regions with the highest domestic fuel-related disease burdens.[13]

Because many African cultures tend to restrict women to domestic tasks including care-giving, women, more than men, are at a higher risk of suffering from a number of specific diseases.

Women are at a higher risk of poor health relative to men partly because they have limited access to treatment but also because of social roles that predispose them to diseases.[14,15] For example, women are at greater risk of suffering from trachoma, the leading cause of blindness in Africa. The prevalence of trachoma infection in women in the African Region is about 2–3 times higher than in men. Because of their role in fetching water women are more exposed to schistosomiasis infections than men. Schistosomiasis is primarily associated with frequent and prolonged exposure to water infested with snails as can be found in lakes, swamps and slow moving waters. In one study, the proportion of bladder cancer attributable to

schistosomiasis was estimated at 28%. In areas where schistosomiasis is endemic, women are 1.5 times more likely to contract bladder cancer than men.[16]

There were an estimated 313 000 deaths from cancers of the breast, the uterus, and the ovary in 2004, a number partly reflecting exposure to tobacco smoke and indoor pollution (also causing chronic obstructive pulmonary diseases) as well as limited access to screening, late diagnosis and inadequate access to effective treatment.[17]

The economic and social cost of NCDs are discussed in greater detail in Chapter 5, suffice it to note meanwhile that NCDs are expensive to treat and are thus a considerable burden on health systems already struggling to cope with the epidemic of communicable diseases. Moreover, because the treatment of NCDs does nothing to reduce their incidence, they present policy makers with the prospect of yearly increases in expenditure with little to show for it in terms of improved outcomes. At the social level NCDs are also potentially devastating, notably for elderly women who play such an important role in many African societies, especially as care givers for HIV/AIDS orphans.

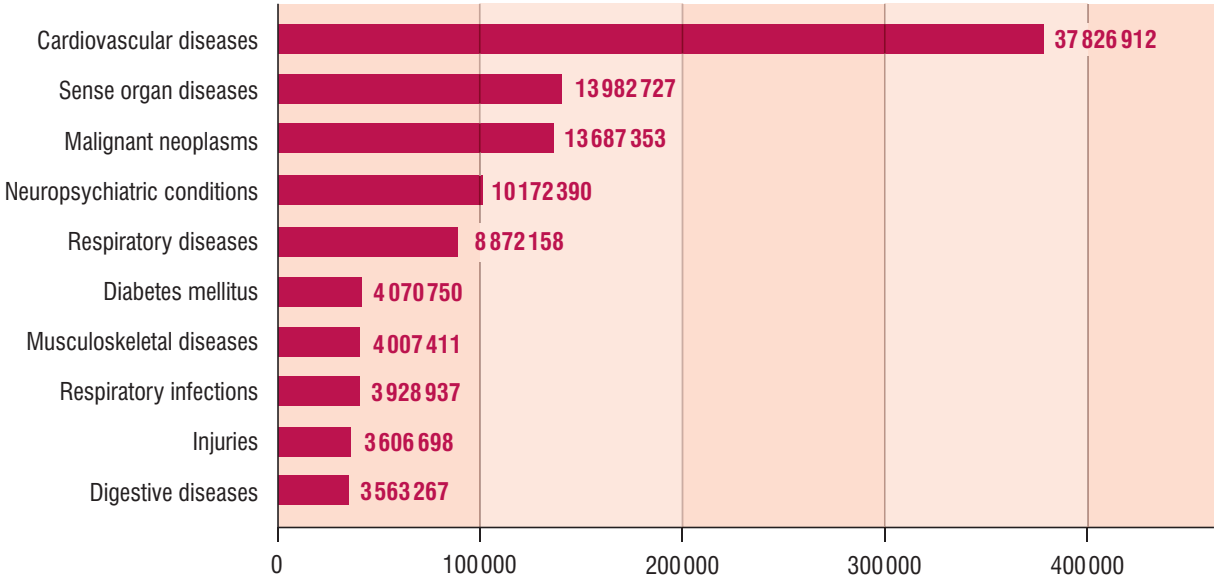
Fortunately, because many NCDs can be prevented through changes in lifestyle, governments have various tools at their disposal to fight this epidemic. Advocacy and well thought out policy reform, backed up by effective legislation can largely contribute to positive change. However, women should be empowered through health education in their early years so that they at least have the information required to lead a healthy life. Finally, it is important for policy makers to make an appropriate balance between public health and commercial interests, notably with regard to tobacco and alcohol.

Understandably, no amount of healthy living can postpone indefinitely the onset of senescent change and its attendant vulnerability. In old age women (and indeed men) are exposed to a range of health issues – vision or hearing may be impaired; mental acuity may diminish – posing a threat to well-being in the final years of life (**Figure 4.3**).

These problems often arise when many elderly women face financial hardships if they are unable to work and have no formal old age benefits. In sub-Saharan Africa the vast majority of women are in an informal type of occupation that is not covered by any form of pension scheme.

This problem affects both men and women since sub-Saharan Africa has less than 19% of elderly people benefiting from a contributory pension.[18] Consequently women (and men) live their final years depending largely on family members and the community. As already stated, in traditional African societies elderly women often play important roles and can count

Figure 4.3 Main causes of DALYs in the African Region, women aged 60 years and above, 2004



Source: Constructed from the World Health Organization, GBD 2004 Summary Tables, Health Statistics and Informatics Department, World Health Organization, Geneva, Switzerland, October 2008.

on the support of their children or their extended family. However, with increasing urbanization in the Region, migration of young people to cities, and the emergence of nuclear family structures, elderly women often find themselves isolated. Because women tend to marry older men, whom they generally outlive, many find themselves living as widows without any support in their late years.[18]

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Where elderly people are cared for in non-institutional settings, that care is provided by female family members who then bear an additional burden hampering their socioeconomic empowerment and posing a threat to their health including increased risk of depression.[19] Caring for the elderly at home can also be a substantial financial burden. In this regard, a study in Uganda showed that households with members over 65 years of age are more likely to face catastrophic health expenditure than households with no elderly members.[20]

Clearly these are complex and painful issues faced in many countries worldwide, even in wealthy countries with fully developed pension schemes. However, it is clear that systems providing universal coverage through prepayment and pooling whether from general taxation or forms of social health insurance have a better chance of supporting vulnerable subgroups within their populations, including elderly women.

In the African Region, elderly people have always been seen as a resource, a repository of wisdom and experience. In many African contexts elderly women are accorded certain privileges in their community or may have some distinct roles that promote social cohesion. As already noted, they are often responsible for decisions that affect health, such as granting young women and girls permission to seek health care. They are also the custodians of practices and traditions governing the

feeding of infants, in addition to being the providers of postpartum care. Their other roles include caring for babies and children within the home. The development of modern African societies, especially if that development involves urbanization, threatens this resource.

Part of the solution to this problem in the sub-Saharan context may lie in investing in household and community support services that can relieve domestic caregivers of some of the burden, but the reality is that an increasing number of elderly African women will probably spend their last years in institutions.[21] Policy makers must therefore take responsibility for designing and building institutions in which the most vulnerable can live their final years in dignity and with the respect of their carers.

Key considerations and points for action

a) Many of the NCDs faced by African women as they age are the consequence of habits established in their earlier years, including smoking and the consumption of foods that have a high content of cholesterol, saturated fat and salt, especially in urban areas. Policy makers can thus make a significant impact on the health of elderly women by focusing on the lifestyle choices they make in the early years.
b) Access to adequate care, particularly screening and treatment programmes for diabetes, cancer, hypertension and heart disease would also have a significant impact on the Region's burgeoning NCD epidemic.
c) Women are exposed to certain risk factors for poor health because of the social roles they have to play.
d) The economic and social transitions taking place in many parts of the Region pose a particular problem for women as they age; a multisectoral response to this issue is required, and should be founded on some form of universal health care provision if the most vulnerable members of society are not to face exclusion from the health system.
e) No amount of healthy living can completely stave off senescent change. Governments should plan for the support of the elderly and recognize the burden placed on young women in their domestic care-giving roles. These plans should also acknowledge that the roles occupied by elderly women in African societies are being challenged by 'modernization' and urbanization on the continent.
f) An increasing number of women are likely to spend their lives in their late years in institutions. Policy makers should ensure that these institutions respect the rights of the individuals entrusted to their care to enable them to live with dignity and respect.

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