Reproductive and sexual health of older women in developing countries

Women and their healthcare providers face unique needs and challenges

More than 20% of the burden of disease among women of reproductive age is connected with sex and reproduction.[1] In the developing world—where a woman's lifetime risk of death from maternal causes is 33 times that of her counterparts in developed countries[2]—many women face risks associated with pregnancy and childbirth, unintended pregnancy, sexually transmitted infections, and HIV/AIDS. An estimated 105 million married women in the developing world face an unmet need for contraception.[3]

Despite the clear need to focus resources on women of reproductive age the global health community also needs to ensure that the health needs of older women, including their reproductive and sexual health needs, are addressed. Well over half of women over age 60 live in developing countries.[4] As they age women face both physical and cultural barriers to optimal health.[5] Studies in developing countries have found that women experience gynaecological problems throughout their reproductive years and beyond, in part due to the limited medical care they receive during labour and delivery, combined with high parity.[6] As they move towards menopause and beyond they are at risk from symptoms associated with hormonal changes, heart disease and stroke, gynaecological malignancies, osteoporosis, and various genitourinary conditions.[7]

Ageing women also suffer from the lifelong effects of sexual bias and low social status, which can be especially burdensome in developing countries. Furthermore, many older women disproportionately bear the emotional and economic burdens associated with their role as family care givers, as they are responsible for looking after ageing parents, older husbands, and orphaned or abandoned grandchildren. The HIV/AIDS pandemic has dramatically heightened these demands.

Healthcare providers in developing countries often have limited information about the physical, psychological, and social problems of ageing. Women themselves may not seek care, often because they accept the physical discomforts associated with gynaecological problems, menopause, and ageing as natural.[8] Older women may not understand their unique health risks or know that screening tests can detect health problems early and that treatments are available for many specific reproductive health concerns. Physical and financial limitations may further limit their access to services.

As women age, for example, their family planning goals shift from spacing births to preventing further childbearing. When choosing a contraceptive method, older women and their healthcare providers need to consider declining fertility, conditions that may contraindicate certain methods, and the potential impact of contraceptives on menopausal symptoms and risks.[9] With increased understanding of these issues, healthcare providers can offer more appropriate care.

As women reach menopause they may need help to manage symptoms. Reported symptoms of menopause vary in nature and frequency across regions. Women's perceptions of menopause also vary. In some cultures women view menopause positively, focusing on freedom from menstruation and the relaxation of social restrictions that comes with old age. In other regions women view menopause as a medical problem that requires intervention.[7]

After menopause, women face new long term health risks, including hormonal changes that contribute to an increased risk of cardiovascular disease and osteoporosis. Changes in hormone levels during and after menopause also may lead to decreased sexual libido, sensitivity, and response; vaginal atrophy; and diminished vaginal lubrication, all of which interfere with sexual pleasure.[10]

Healthcare providers need training that enables them to treat these immediate health problems, reduce risks of long term disease, and improve the quality of life of women as they age. Reproductive health programmes, which already serve women during their childbearing years, are well positioned for caring for women as they approach menopause and beyond. Providers, for example, can help ensure that women have access to appropriate contraceptive methods as they move into their late 30s and 40s. Depending on resources, other appropriate services for older women may include counselling about menopause and its symptoms as well as elements of a healthy lifestyle such as diet and exercise.

Healthcare professionals also need to provide screening and treatment of gynaecological disorders including reproductive and urinary tract infections, uterine prolapse, and fistulas. Screening and treatment of precancerous cervical lesions is a clear need in many developing countries, particularly in sub-Saharan Africa, Latin America, and South Asia.[11] In some regions, screening for breast cancer and treatment also may be feasible. Medical management of women at high risk of fractures and cardiovascular disease should be considered, as should support services for women caring for family members living with HIV and AIDS and orphaned grandchildren.

Programme managers for reproductive health must consider both the extent of the problems and their programmes' ability to address them. Some services, such as counselling, can be inexpensive and relatively easy to integrate into existing programmes (although good counselling requires effective training, monitoring, and appropriate educational materials). Other services require significant training for providers and special supplies and equipment. Routine screening for breast cancer, for example, is not cost effective unless the incidence is high and there are diagnostic and treatment centres to which women can be referred.[12]

To attract older women to clinics, programme managers must address a range of barriers to access.

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Public awareness campaigns can help overcome some of these issues, while also promoting active and healthy lifestyles. Outreach programmes also are a valuable supplement to clinic based services for older women. Community based activities, including support groups and volunteer health promoters, hold special promise since they can maximise the interest and resources of the elderly themselves as well as the wider community.

No matter which interventions are selected, expanding services for older women will place new demands on healthcare providers. Providers should receive pre-service and refresher training to learn how to counsel women and treat common health problems. Equally important, educational programmes should aim to change providers' attitudes so that they value older clients. Following the lead of international agencies and local programmes, the global health community must work to address the health needs of older women, especially in the world's poorest countries.

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Balancing benefits and harms in health care

We need to get better evidence about harms

Should kids be plastered with sunscreen this summer? Is this likely to be more beneficial than harmful? How would we know? For example, sunscreen use has been associated with overexposure to the sun, perhaps because of overconfidence in its abilities.[1 2] Might there also be a potential risk of developing contact allergies, skin irritation, and rare but severe adverse effects? People making a decision about whether or not to use sunscreen need reliable evidence on the balance of benefits and harms. The same is true of all healthcare interventions, and unfortunately reliable evidence on harms is often lacking.

Great progress has been made in obtaining reliable evidence on the beneficial effects of interventions, but developments in the identification, interpretation, and reporting of harmful effects is more challenging. Randomised controlled trials are the best way to evaluate small to moderate effects of healthcare interventions, and much of the evidence for benefits from treatment comes from such studies. However, they are not always suitable to evaluate harms, and this was made clear during a recent meeting jointly organised by the Cochrane Collaboration and BMJ Knowledge in London.

There are various problems with randomised controlled trials in relation to harms and some of these problems affect systematic reviews too. Firstly, trialists may know which benefits to assess but may be unaware of potential harms of the interventions they are testing. Identifying unexpected harms is difficult when the delay between the intervention and the onset of side effects is long or when a cumulative exposure is necessary to trigger the harms. Harms may be measured or grouped differently among trials, making it almost impossible to summarise, aggregate, or interpret the evidence in meaningful ways. The debate about the potentially serious cardiovascular effects of cyclo-oxygenase-2 (COX 2) inhibitors illustrates some of these problems. Serious cardiovascular effects associated with the use of COX 2 inhibitors have been identified recently[3 4] because they were not systematically searched for in previous trials.[5] All this can lead to harmful drugs continuing to be used for many years before a warning is raised.

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Problems exist with detection also. Rare harms may turn out to be more common than anticipated once flagged, but providing effective and balanced information to doctors and the public may be a complex and lengthy process. Even if the information is collected it might not be reported or indexed consistently well.[6]

Adverse effects can also be confused with the symptoms of the condition being treated. People taking analgesics for headache may develop analgesic induced headaches.[7] Until this was discovered people with migraine might have thought their condition was getting worse, increased the amount of analgesics they took to compensate, and found themselves being exposed to even more of a harmful treatment.

Raising the alarm about a potential harm can also do more bad than good if the quality of the evidence or