1.1 Women's health and well-being

STATUS UPDATE

Survive

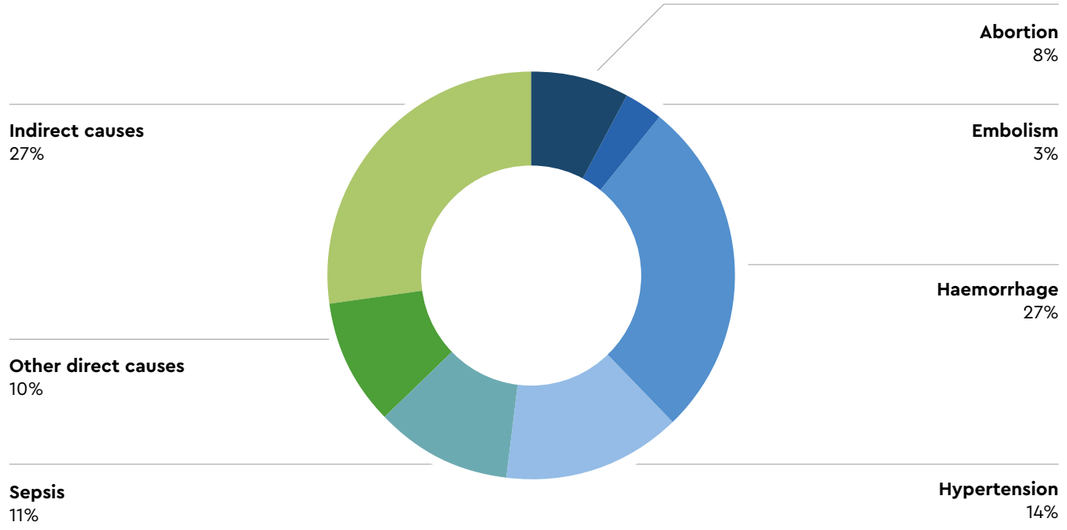
Women's chances of surviving childbirth improved significantly during the MDG era. After 1990, the global maternal mortality ratio (MMR: maternal deaths per 100 000 live births) fell by about 44%, with progress accelerating after 2000.[13,14] However, global progress fell far short of the 75% reduction target set by MDG 5a.[15] The death toll remains high – in 2015, an estimated 303 000 women died from preventable causes during pregnancy and childbirth, with a global MMR of 216 deaths per 100 000 live births. Ninety-nine per cent of all maternal deaths still occur in low- and middle-income countries, with more than 50% in sub-Saharan Africa and almost one third in South Asia.[16,17] The SDG target is a **global** ratio of less than 70 deaths per 100 000 live births by 2030.[18]

The most frequent causes of maternal death are postpartum haemorrhage, hypertensive disorders, infection and complications from childbirth and abortion (Figure 3). Although abortion is safe when performed in accordance with recommended guidelines, many women undergo unsafe procedures. Nearly 7 million women in developing countries are treated for complications from unsafe abortions annually.[19]

Other women die from the interaction between pregnancy and pre-existing health conditions that could have been addressed and managed during pregnancy, for example communicable diseases such as HIV/AIDS, tuberculosis and malaria, and noncommunicable diseases such as cardiovascular diseases. Millions more suffer complications from pregnancy that continue after childbirth. The list of such morbidities is long and diverse, and includes infection, obstetric fistula and depression.[20]

Additionally, in 2015, there were an estimated 2.6 million stillbirths: 18.4 for every 1000 births. The Every Newborn Action Plan target is 12 or fewer stillbirths per 1000 births in every country by 2030.[21] Half of the stillbirths occurred during labour and birth, mostly from preventable conditions, and mostly in low- and middle-income countries.[22] There are huge inequities. At the present rate of change, it will be 160 years before a pregnant woman in Africa has the same chance of carrying her pregnancy through to a live birth as a woman in a high-income country.[23] Stillbirth rate is one of the 16 key indicators to be monitored for the EWEC *Global Strategy*. However, being absent from the MDGs and still missing from the SDGs, stillbirth has received relatively little attention.

Figure 3. Estimates for main causes of maternal deaths



Source: Say L, Chou D, Gemmill A, Tunçalp Ö, Moller AB, Daniels JD, et al. Global causes of maternal death: a WHO systematic analysis. Lancet Glob Health 2014;2:e323–e333.

Good-quality care during pregnancy and childbirth is essential to prevent maternal mortality and stillbirths. Globally in 2016, an estimated 78% of women were attended by a skilled health worker during childbirth[24] and only 58% of pregnant women had four or more antenatal care visits.[25] Based on data from 79 countries, only 52% of women globally received postpartum care in 2016.[26] Many more lives could be saved, and illness and disability prevented, by improving the quality of antenatal care, care at the time of childbirth, and postnatal care for mothers and newborns, and by improving coverage of and tackling inequities in access to and quality of health services, including basic infrastructure.

Thrive

Statistics on mortality and disease burden are a vital source of information. However, they often fail to give a complete picture of women's progress, beyond survival, to enjoyment of health and well-being. While some health factors threaten women's lives, others profoundly affect their physical and mental health and overall well-being. Examples are the estimated 200 million girls and women alive today who have undergone female genital mutilation,[27] the 15 million girls who marry before age 18 each year,[28] and the nearly one in three women subjected to physical or sexual violence by an intimate partner.[29]

15

MILLION GIRLS
MARRY BEFORE THE AGE OF 18 EACH YEAR

The data show that, in many places, women are taking control of these and other areas of their health. Increasingly they are claiming their sexual and reproductive health and rights, for example by using modern contraceptive methods for family planning. Usage rose from 48% to 58% between 1990 and 2015 among married or in-union women aged 15–49. While contraceptive prevalence has improved globally, this figure has plateaued and needs to be scaled up to achieve universal access.[30] Increased contraceptive use prevents unintended pregnancy, which in turn reduces the rate of induced abortion. Globally, there were 35 abortions per 1000 women aged 15–44 each year from 2010 to 2014, down slightly from 40 per 1000 in 1990–1994. The decline has been uneven, with the abortion rate having declined markedly – by 41% – in developed countries since 1990, but remaining roughly the same in developing countries.[31] Current evidence suggests abortion rates do not differ in countries where abortion is highly restricted and those where abortion is broadly legal.[32]

Despite progress, data from 45 countries show that only one in two women aged 15–49 years (married or in union) makes her own decisions regarding sexual relations, contraceptive use and health care.[33]

Cervical cancer is another consideration for women's sexual health. An estimated one million-plus women worldwide, the majority (more than 80%) in low- and middle-income countries, are currently living with cervical cancer, many with no access to services for prevention, curative treatment or palliative care. The human papilloma virus, which is transmitted sexually, is one of the main causes of cervical cancer. A safe and effective vaccine exists, which when provided to girls between 9 and 13 years old protects against this virus, and technologies to screen and treat women living with cervical cancer are becoming more available but still serve only a minority of affected women. This highlights the importance of taking a life-course approach to health.[34]

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Transform

Socioeconomic factors are important determinants of women's health. Conversely, women's health and empowerment, including through their political, sociocultural and economic participation, can effect transformative socioeconomic improvements. For example, higher levels of education for girls and women's political participation are both associated with better health for women and children, which in turn contributes significantly to socioeconomic development.[35] With respect to political participation, although the number of countries with a female head of state increased from 8 in 2005 to 17 in January 2017, women's representation in politics overall is stagnating.[36]

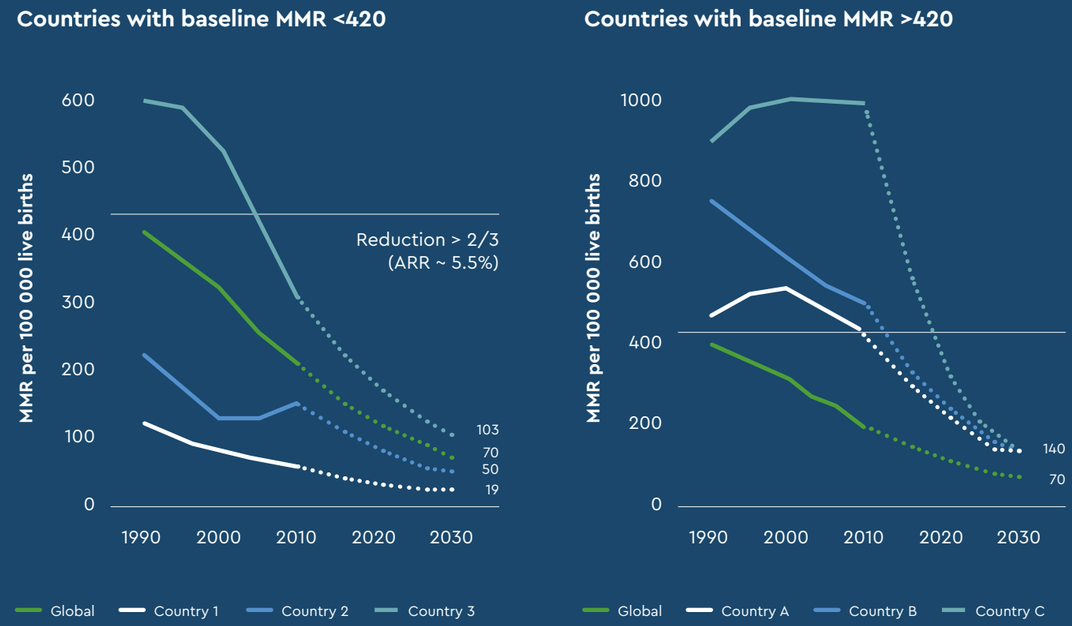
Inequities in access to adequate health services and rights are also significant determinants of women's health and well-being. These inequities may be shaped by social norms on gender inequality, and/or by laws that limit women's autonomy over their health and their participation in society, the labour force and politics. Another barrier in some countries is the lack of supportive legislation for specific subgroups, such as migrants and indigenous women, who are often underserved and marginalized. Access to clean energies in the home will also decrease the burden of disease and death.

COUNTRIES WITH A FEMALE HEAD OF STATE INCREASED FROM ***8 IN 2005 TO 17 IN JANUARY 2017***

Accelerate action to reduce maternal mortality

SDG 3.1 includes a target to reduce the global MMR to 70 per 100 000 live births; no country should have an MMR greater than 140. The Ending Preventable Maternal Mortality initiative has developed strategies, including projections, to help countries chart their required progress towards the 2030 targets (Figure 4).[37]

Figure 4. Recommended MMR reduction rates in different countries



MMR: maternal mortality ratio

ARR: annual rate of reduction

Notes:

- For countries with MMR less than 420 in 2010 (the majority of countries worldwide): reduce the MMR by at least two thirds from the 2010 baseline by 2030. For all countries with baseline MMR greater than 420 in 2010: the rate of decline should be steeper so that in 2030, no country has an MMR greater than 140. For example, in the graph on the right, Country C needs about a 12% annual rate of reduction to get to an MMR of 140, which is 2.5 times faster than the progress required in the MDG era.
- For all countries with low baseline MMR in 2010: achieve equity in MMR for vulnerable populations at the subnational level.

Source: Strategies towards ending preventable maternal mortality. Geneva: World Health Organization; 2015.

Improve quality, equity and dignity of care during pregnancy and childbirth

Efforts to improve equity of coverage and to reach those most in need of health care and health-enhancing services must continue. In addition, a focus on improving the quality of these services is required. This includes respecting the rights and dignity of those seeking care, as well as a strong focus on multisectoral action (e.g. to ensure access to water, sanitation and hygiene and electricity). Supporting this approach are new antenatal care guidelines,[38] standards for improving quality of maternal and newborn care in health facilities,[39] and processes for audit and review of maternal, stillbirth, perinatal and newborn deaths.[40,41] The Quality of Care Network,[42] supported by WHO, UNICEF and UNFPA and led by nine countries, is leading the way on institutionalizing quality of care within health systems, with the aim of reducing maternal and newborn mortality in participating health-care facilities by 50% in 5 years.

Implement recommendations on stillbirths

The Lancet Ending Preventable Stillbirth series in 2016 recommended five priority actions: intentional leadership; increased voice, especially of women affected; implementation of integrated interventions; indicators to monitor progress; and research on knowledge gaps.[43]

Realize sexual and reproductive health and rights

In order for women and girls to realize their sexual and reproductive health and rights, they need access to comprehensive sexual reproductive health and rights (SRHR) education and services, including modern contraceptive methods, safe abortion (where legal), treatment and prevention of infertility, and prevention of sexual violence. Available data suggest that restrictions by marital status, requirement for third-party authorization and age are the most common legal barriers preventing access to sexual and reproductive health services,[44] and therefore access to justice mechanisms is crucial. The recently released report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents calls for all States to strengthen legal recognition of human rights "to health and through health", including sexual and reproductive health and rights, in their national constitution and other legal instruments. States should implement legal, policy and other measures to monitor and address harmful social, gender and cultural norms and to remove structural and legal barriers that undermine sexual and reproductive health and rights.[45]