Women's health priorities and interventions[1]

Abstract

The year 2015 marks a defining moment for the work on women's health, with the 20 years anniversary of the Beijing Declaration and Platform of Action, and end point of the Millennium Development Goals. Much has been achieved over the last two decades. Substantial progress has been made in reaching MDG 5 with a 47% reduction in maternal mortality. This is both a moment of celebration as well as reflection. While there has been substantial progress, much remains to be done. As we transition from the MDGs to the Sustainable Development Goals (SDGs), it is imperative to accelerate the momentum and protect the gains made for women's health.

This requires out of the box thinking and cutting edge research to address the needs and aspirations of millions of women and girls around the world. To create a new paradigm for women's health requires working across a range of issues including, sexual and reproductive health, Non-communicable diseases (NCDs) including cancers and older women. This requires a comprehensive approach which addresses structural determinants of health, inequities in access to health care and enhance accountability. Despite decades of unprecedented medical advances and innovations in health care, quality of care in general, and for women's health in particular, is often weak. Building on and extending the unfinished agenda, this paper elaborates actions needed to improve health and well-being of women and girls around the world.

1. Background and introduction

Over the past decades, governments have taken steps towards improving women's health in line with commitments made in key international summits. Overall progress has been made in reducing maternal mortality[2] especially accelerated with the launch of the United Nations Secretary-General's Global Strategy for Women's and Children's Health in 2010. Use of health care, especially sexual and reproductive health, has increased in some countries.[3] Progress has also been seen on two determinants of women's health namely school enrolment rates for girls and political participation of women.

Despite such progress, societies are still failing women in relation to health, most acutely in poor countries and among the poorest women in all countries. Discrimination on the basis of their sex leads to health disadvantages for women.[4]

This paper elaborates the health problems women face, and priority interventions to address them, as a background for and informing the updating of Global Strategy for women, children, and adolescent's health.

2. Problem

Evidence shows the slow and uneven progress in core areas related to women and health. More work needs to be done, as the following data illustrates.

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[1] M. Temmerman, R. Khosla, L. Laski, Z. Mathews and L. Say

[2] Say L, et al. Global Causes of Maternal Death: A WHO Systematic Analysis. Lancet Global Health, 2014.

[3] UNICEF,WHO, World Bank, United Nations Population Division. The Inter-agency group on child mortality estimation. 2014.

[4] WHO. *Women and health: today's evidence tomorrow's agenda*. WHO, 2009.

2.1. Unfinished agenda for women's health

More than twenty years after the International Conference on Population and Development and the Beijing Declaration and Platform of action, poor sexual and reproductive health outcomes represent one third of the total global burden of disease for women between the ages of 15 and 44 years, with unsafe sex a major risk factor for death and disability among women and girls in low- and middle-income countries.

Although global maternal mortality ratio – the number of maternal deaths per 100,000 live births – has halved between 1990 and 2013, this progress is not sufficient to reach the target of Millennium Development Goal (MDG) 5 of a 75% reduction by 2015.[5] It is estimated that in 2013, 289 000 women died from complications in pregnancy and childbirth and that, in 2008, 22 million unsafe abortions occurred (half all induced abortions in that year), nearly all in low- and middle-income countries.[6] Further, worldwide, 222 million women are estimated to have an unmet need for modern contraception.[7]

In 2013, almost 60 percent of all new HIV infections among young people aged 15-24 years occurred among girls and young women.[8] Tuberculosis is often linked to HIV infection and is among the leading causes of death in low-income countries of women of reproductive age and among adult women aged 20–59 years. Nearly 30% of women are affected by anaemia.

Sexually transmitted infections, of which human papillomavirus infection is the most common, disproportionately affect women and adolescent girls. About 70% of cervical cancer cases worldwide are caused by human papillomavirus.[9] In pregnancy, untreated syphilis is responsible for responsible for about every year for 212,000 stillbirths/early fetal deaths and about 92,000 neonatal deaths.[10]

One in three women aged 15–49 years has experienced physical and/or sexual violence by an intimate partner or non-partner sexual violence, with many short- and long-term consequences for their health.[11]

2.2. Emerging priorities for women's health

An analysis of global burden of diseases[12] shows that there new and emerging priorities for women's health which must be taken into account to ensure a comprehensive approach in the renewed Global Strategy for women, children, and adolescent's and health. Significant shifts in population dynamics, towards more ageing populations along with an unprecedented growth in the world's

[5]World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA) and The World Bank. Trends in maternal mortality: 1990–2013. WHO, UNICEF, UNFPA and The World Bank estimates.
6 World Health Organization. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008, 6th edition. Geneva; 2011.
[7] Singh S, Darroch JE. Adding it up: costs and benefits of contraceptive services – estimates for 2012. New York: Guttmacher Institute and United Nations Population Fund; 2012.
[8] UNAIDS. Global Report on the AIDS Epidemic. 20 12.
[9] WHO. Global Incidence and Prevalence of Selected Curable Sexually Transmitted Infections. 2012.
[10] WHO, Sexually Transmitted Infections, Factsheet 110, 2013.
[11] World Health Organization, London School of Hygiene and Tropical Medicine, South African Medical Research Council. Global and regional estimates of violence against women. Prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization; 2013.
[12] WHO, Global Health Estimates, 2014.

adolescent population, have led to more complexities in the global burden of diseases and ill health, including an increase in non-communicable diseases. [13]

In 2012, most female premature deaths from noncommunicable diseases (82% or 4.7 million) in the age group 30-70 years occurred in low- and middle-income countries, with higher rates in women aged 15-59 years than in high-income countries.[14] Women are differentially affected by key risk factors for noncommunicable diseases.

Girls and women in some parts of the world are generally less physically active than men with many contributing factors related to income, limited mobility, household hierarchies and roles. In some regions, such as the European and the Americas, more than 50% of women are overweight.[15] Globally, tobacco use accounts for about 9% of all female noncommunicable disease deaths. Maternal smoking is associated with risks in pregnancy including ectopic pregnancy, preterm birth, placental problems, miscarriage and stillbirth.[16] Harmful use of alcohol, illicit drugs and other psychoactive substances by girls and women, including during pregnancy, is increasing in many parts of the world with significant public and individual health implications. In 2012 an estimated 4% of deaths of women were attributable solely to alcohol use.

Women's cancers especially breast and cervical cancer, result in high rates of mortality and morbidity, especially in low- and middle-income countries. Widespread major inequalities in access to early detection and screening lead to large variations in clinical outcomes and survival after treatment. Breast cancer, the leading cause of deaths due to cancer in women (1.7 million new cases and 0.5 million deaths in 2012), is diagnosed in low- and middle-income countries mostly at advanced stages, when palliative care is the only option.[17] With 528 000 estimated new cases in 2012, cervical cancer is the fourth most common cancer affecting women worldwide. In low- and middle-income countries, it is the third leading cause of death due to cancer in women, and in most cases women had limited access to screening and treatment of precancerous lesions, with resultant late-stage identification.[18]

Mental disorders cause about 7% of the global disease burden for both sexes and about one-quarter of disability. Suicide is a leading cause of death for women aged 20-59 years globally.[19] Women are more susceptible to depression and anxiety than men. Patterns of mental health problems differ between men and women as a result of different gender roles and responsibilities, biological differences and variations in social contexts. In lower-income countries women benefit much less from mental health services than men do.[20]

Chronic obstructive pulmonary disease is also a leading cause of disease and death among older women, often resulting from tobacco use. In low-income countries, the primary risk factor for women's health is exposure to indoor air pollution caused by the burning of solid fuels for indoor heating and cooking. Road traffic injuries are among the five leading causes of death for adolescent girls and women of reproductive age in most WHO regions.

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[13] AbouZahr, Carla, "Trends and Projections in Mortality and Morbidity", paper prepared for the ICPD Beyond 2014 Expert Meeting on Women's Health – rights, empowerment and social determinants, Mexico City, 30th September – 2nd October 2013.
[14] WHO, Global Health Estimates, 2014.
[15] Update on the WHO Commission on Ending Childhood Obesity (document EB136/10).
[16] WHO. WGO Global Report on Mortality Attributable to Tobacco. WHO, Geneva, 2012.
[17] WHO. Human papillomavirus and cervical cancer: factsheet N.380. WHO, 2013.
[18] Ibid.
[19] De los Angeles CP, Lewis WW, McBain R , Yasamy MT, Olukoya AA , Morris J. Use of mental health services by women in low and middle income countries, Journal of Public Mental Health 2014 13:4.
[20] Ibid.

Globally, women represent a higher proportion of older adults. Traditionally, women have provided most of the unpaid care in the family, looking after both children and older people, often to the detriment of their own participation in the paid workforce. The consequences in older age include a greater risk of poverty, more limited access to good-quality health and social care services, a higher risk of abuse, poor health and reduced access to pensions. Furthermore, several serious medical conditions of older age, including dementia, are more common in women, yet women find it harder to access the treatment they need.

As highlighted in the above paragraphs, despite an overall progress, some countries experienced declines in life expectancy due to a variety of factors. Even more significant are the stark disparities in progress within and across countries in health status and in access to services by income level, group characteristics, residence and experience of conflict or humanitarian disasters.[21]

3. Response: priority interventions for women's health

The following sections of this paper highlight the health systems and structural factors for addressing above persisting and emerging women's health issues and high-impact interventions and investments in this area.

3.1. Strengthening health systems and addressing structural determinants of women's health

Persistent obstacles in health systems to realizing women's health and human rights include a lack of gender responsiveness, such as a lack of sex-disaggregated data and gender analysis, with the result that often health services do not take into account the specific needs and determinants of women's health. Removing these obstacles requires tackling a range of cross-cutting issues, including through targeted innovations that improve quality, coverage, completeness of health services for women.

1. **Structural determinants of women's health**: Sex-based biological factors interact with inequalities based on gender, age, race, ethnicity and class in shaping women's exposure to health risks, experience of ill health, access to health services and health outcomes. Gender inequalities in the allocation of resources, such as income, education, health care and nutrition, are strongly associated with poor health and reduced well-being.

2. Another key focus in addressing the remaining gaps should be the persistent **inequalities** and inequities in the accessibility and quality of health systems across and within countries.[22] In many settings, health systems continue to have limited accessibility, and capacity as measured by indicators such as health-worker density, coverage of critical services, use of health information systems, commodity stock-outs and quality assurance.[23] Within many middle- and high-income countries, pockets of weak and poor health-system coverage or low-quality services abound for certain areas or populations, such as for the poor, older

[21] UNFPA, ICPD Beyond 2014: Report on Expert Consultation on women's Health,, 2014.
[22] United Nations Secretary-General. Summary report on the assessment of the status of implementation of the Programme of Action of the International Conference on Population and Development. E/CN.9/2014/4. New York: United Nations; 2014
[23] Kerber KJ, de Graft-Johnson JE, Bhutta ZA, Okong P, Starrs A, Lawn JE. Continuum of care for maternal, newborn, and child health: from slogan to service delivery. The Lancet 2007; 370(9595): 1358-69; Evans DB, Marten R, Etienne C. Universal health coverage is a development issue. Lancet [Internet]. Elsevier Ltd; 2012 Sep 8 [cited 2014 Jan 13];380(9845):864–5. Available from: http://www.ncbi.nlm.nih.gov/pubmed/22959373; Health Metrics Network, World Health Organization. Country health information systems: a review of the current situation and trends. Geneva, 2011.

persons, adolescents, rural residents and residents of urban slums, and for uninsured or undocumented persons.[24]

Often, many of these inequalities overlap, and some individuals or groups of individuals face a multitude of barriers to reproductive health services, for example, women and girls belonging to an ethnic or religious indigenous group, face multiple and unique obstacles to services, which effects on their health status.[25] The experiences and needs of individuals with multiple disadvantages are rarely integrated into national strategies, further aggravating the vulnerabilities they face.[26]

3. Further, women's health services, particularly sexual and reproductive health services are often not provided at a level of **quality** that meets human rights standards.[27] The persistence of poor sexual and reproductive health outcomes among the poor and other marginalised groups, particularly in Africa and South Asia, underscores the need to strengthen the reach, comprehensiveness and quality of health systems.[28] Despite decades of unprecedented medical advances and innovations in health care, stark inequalities persist in the quality of health systems across and within countries.[29] According to the recent WHO multi-country survey on maternal and newborn health it is necessary to go beyond maximizing coverage of essential interventions to accelerate reductions in maternal mortality and severe morbidity.[30] The survey showed that while the coverage of effective interventions are high (above 80%) many women still die or experience severe morbidity due to haemorrhage and hypertensive and other disorders of pregnancy.[31] The survey results show that accessing to health facilities where certain commodities and equipment are available is not in itself sufficient to achieve a substantial reduction in maternal mortality – rather, overall improvements in the quality of maternal health care and a comprehensive approach to emergency care, are needed.

   Quality of care must therefore go side by side with the increase of service coverage, since the latter alone does not guarantee the health results.[32] Strengthening health networks and

[24] United Nations Secretary-General. Summary report on the assessment of the status of implementation of the Programme of Action of the International Conference on Population and Development. E/CN.9/2014/4. New York: United Nations; 2014; Say L, Raine R. A systematic review of inequalities in the use of maternal health care in developing countries: examining the scale of the problem and the importance of context. *Bull World Health Organ* 2007; 85: 812-9.
[25] European Union Agency for Fundamental Rights. *Inequalities and Multiple Discrimination in Access to Quality of Healthcare*.Vienna. 2013.
[26] Committee on Economic, Social and Cultural Rights. General comment no 16. The Equal Right of Men and Women to the Enjoyment of All Economic, Social and Cultural Rights (Art. 3 of the Covenant). New York: United Nations Economic and Social Council; 2003 (http://www.refworld.org/docid/43f3067ae.html, accessed 20 March 2014); World Health Organization multi-country survey on maternal and newborn health 2010–2012 (http://www.who.int/reproductivehealth/topics/maternal_perinatal/nearmiss/en/, accessed 17 March 2015).
[27] Germain A. Meeting Human Rights Norms for the Quality of Sexual and Reproductive Health Information and Services: Discussion Paper. *ICPD beyond 2014. International conference on human rights.* 2013
[28] Independent Expert Review Group (iERG). Every woman every child: strengthening equity and dignity through health. *The second report of the independent Expert Review Group (iERG) in information and accountability for women's and childrens health.* 2013:1-18
[29] World Health Organization. Quality of care. A process for making strategic choices in health systems. *WHO Press.* 2006;ISBN 978 92 4 156324 6.
[30] Souza JP, Gulmezoglu AM, Vogel J, Carroli G, Lumbiganon P, Qureshi Z, and others. *Moving beyond essential interventions for reduction of maternal mortality (the WHO Multi-country Survey on Maternal and Newborn Health): a cross-sectional study.* Lancet, 2013. 381: p. 1747-55.
[31] Souza JP, Gulmezoglu AM, Vogel J, Carroli G, Lumbiganon P, Qureshi Z, and others. *Moving beyond essential interventions for reduction of maternal mortality (the WHO Multi-country Survey on Maternal and Newborn Health): a cross-sectional study.* Lancet, 2013. 381: p. 1747-55.
[32] Germain A. Meeting Human Rights Norms for the Quality of Sexual and Reproductive Health Information and Services: Discussion Paper. *ICPD beyond 2014. International conference on human rights.* 2013.

referral systems is still an unfinished agenda in many countries. Upgrading of first- and – second level facilities with appropriate infrastructure and equipment, and providing adequate numbers of skilled and motivated human workforce, with ongoing training and mentoring, is necessary to increase coverage and facilitate access.

Quality of care is a multi-dimensional concept that is impacted by stakeholder priorities and context.[33] Attributes of quality of care include access to care, effectiveness of care, safety, equitability, acceptability and efficiency. [34] Innovations that include digital mobile tools, facilitate health systems to ensure quality of care, reduce barriers to access, improve efficiencies, and derive information that can ensure system accountability to clients including registration of births and deaths.

4. Lastly, the advancement of women's health agenda requires ensuring effective **monitoring and accountability**. The Commission on Information and Accountability for Women's and Children's Health emphasized multiple dimensions of accountability, by adopting a framework built on three pillars: monitoring, review and action (including redress).[35] The independent Expert Review Group, established to monitor and assess progress in implementation of recommendations made by the Commission, has stated that accountability needs to be based on certain core principles: clarity about stakeholder responsibility for action; accurate measurement; independent verification; impartial, transparent, and participatory review; and clear recommendations for future action.[36]

   Accountability is also intrinsic to ensuring that individuals' agency and choice are respected, protected and fulfilled. Agency and choice are fundamental to enabling individuals to have a voice and to hold governments and all relevant stakeholders to account.

   As we move towards a new paradigm on international development and the renewed Global Strategy, we must take cognizance of the lessons from International Conference on Population and Development, Beijing Declaration and Platform of Action and MDGs. Promotion and protection of the international development agenda requires placing women's health, particularly sexual and reproductive health and human rights at its center.

Summary of **health systems interventions** for women's health is highlighted in Table 1

Table 1

Women's health	**Health systems interventions**
	1. Universal health coverage for key health interventions for women 2. Structural determinants of health (please see the paper on determinants) 3. Inequities in access a. Steps to enhance coverage

[33] Bruce J. Fundamental elements of the quality of care: a simple framework. *Studies in family planning.* Mar-Apr 1990;21(2):61-91.

[34] Independent Expert Review Group (iERG). Every woman every child: strengthening equity and dignity through health. *The second report of the independent Expert Review Group (iERG) in information and accountability for women's and childrens health.* 2013:1-18; Germain A. Meeting Human Rights Norms for the Quality of Sexual and Reproductive Health Information and Services: Discussion Paper. *ICPD beyond 2014. International conference on human rights.* 2013

[35] World Health Organization, Commission on Information and Accountability for Women's and Children's Health. *Keeping promises, measuring results. Geneva: World Health Organization*. 2011 (http://www.everywomaneverychild.org/images/content/files/accountability_commission/final_report/Final_EN_Web.pdf , accessed 17 march 2015).

[36] WHO, Commission on Information and Accountability for Women's and Children's Health. Keeping promises, measuring results. Geneva: World Health Organization; 2011 (http://www.everywomaneverychild.org/images/content/files/accountability_commission/final_report/Final_EN_Web.pdf , accessed 17 March2015).

	b. Remove barriers to access 4. Quality of care including supplies a. Quality assurance of service delivery, update of evidence based norms, standards, policies b. Adequate supplies for key women health problems 5. Health workforce: a. Development and distribution of health work force for women's health problems including midwives b. Pre-service and in-service training c. Provision of incentives to enhance quality, retention, etc. 6. Monitoring and accountability a. Investing in strengthening the overall governance of the health system to ensure better accountability for results b. Strengthening management capacity at national and sub-national levels 7. Adoption and institutionalization of innovations that enhance quality, coverage, efficiency, and/or completeness of health interventions to women (please see the paper on Innovations) a. Client-specific innovations that improve access and reduce barriers, including the use of digital technologies Health system innovations that improve performance, drive measurement and accountability, including digital innovations for vital events.

3.2. Priority interventions for women's health

Concerted efforts are required to address these differentials. Based on the existing evidence and reviews conducted,[37] the following range of priority interventions are proposed. A synthesis of these are also included in **Table 2**.

Providing health information and Comprehensive Sexuality Education (CSE)

Evidence based health information and sexuality education is a key intervention for promotion and protection of women's health. Since the ICPD, intergovernmental and other agreements, as well as research evidence, have increasingly indicated that CSE is essential for everyone to be healthy and empowered. Such education should be available to all adolescents and youths, in and out of school. CSE provides thorough, scientifically accurate, non-judgmental information and assists people to develop skills for decision-making, critical thinking, communication and negotiation of interpersonal relationships. Quality CSE programmes address human rights, integrate gender perspectives, and address respectful relationships, human sexuality, sexual and reproductive health. Effective CSE programmes seek to roll out nationwide curricula and teacher training materials based on interactive methodologies, select and supervise teachers and facilitators, as well as work with parents, school principals and program managers, among others, at community level. Special programs are needed for adolescent girls.

Contraceptive information and services for all who need

Contraception information and services are vital means for women to maintain health and their availability is necessary for women and girls to enjoy their human rights. Effective policies at the national and local levels and services should ensure the availability of a mix of accessible, acceptable and high quality modern contraceptive methods, including emergency contraception, to meet women's needs across the life course, free from bias, discrimination, unnecessary medical eligibility

[37] World Bank. Global Financing Facility in Support of EWEC, 2014; WHO, Global Investment Framework for Women and Children's Health; and WHO and PMNCH, Essential Interventions, Commodities and Guidelines for RMNCH, 2010.

criteria. Family planning financing should be strengthened through costed implementation plans, health finance facilities, and national budgets. Providers should be trained and supervised to meet human rights standards for quality care. Communications initiatives, messages and materials on family planning, including use of contraception, should be tailored to each audience and implemented at scale with the aim of facilitating free and informed decision-making and fostering supportive social norms. In addition to the quantity of methods delivered, quality issues should be tracked.

Strengthening maternal healthcare

The effectiveness of maternity care in tackling maternal deaths is firmly established. As maternal mortality continues to decrease sharply in many countries, in order to make more progress and to avoid leaving others behind, priority attention is needed to ensure quality of maternal health care, educate, deploy, retain and improve the quality of the cadres of primary health care workers, such as midwives and nurses, through quality education, effective regulation and an enabling work environment that includes effective referral. As midwives can provide 87% of the essential Interventions for reproductive, maternal, newborn and child health, their impact reaches the full continuum of care for all women of reproductive age and their families.[38] Health care workers should be empowered and provided with the necessary medicines and equipment and must be supported by a functioning health system which includes emergency obstetric and newborn care and strong capacity at the secondary level to address complications of childbirth, with effective referral from the community[39] and the primary levels[40]. Further strengthening of health services delivery systems is also required taking into account task shifting and innovative approaches such as mhealth and ehealth.

In addition to the burden of death, serious and often life-long morbidities such as obstetric fistula, uterine prolapse, incontinence, severe anaemia and mental illness affect many women's lives. While interventions to prevent and treat such conditions are available, services are not always adequately prepared or equipped to provide them, and increased attention to preventing and treating maternal morbidities is urgently needed.

Providing safe abortion and post-abortion care

Unsafe abortion, one of leading causes of maternal death and injuries, is entirely preventable because technologies and safe procedures are well known, low cost and should be widely available. WHO's technical and policy guidelines for access to safe abortion[41,] should be implemented. Laws restricting access to safe abortion do not reduce or end recourse to abortion. Although access to post-abortion care (PAC) for treatment of the complications of unsafe abortion has increased, including through non-governmental organizations (NGOs) and the private sector, women in many countries still do not have access to this life-saving care or are mistreated when they seek it.

Preventing and treating Sexually transmitted infections (STI) and HIV for women

In order to effectively end the AIDS epidemic by 2030 and reduce the burden of other STIs, governments and the international community should fully implement effective prevention interventions; ensure access of young and marginalized people, including young women and girls in all their diversities and higher-risk populations, to information and services on the risks and symptoms of STIs and HIV and to acquire the skills and means to protect themselves; provide universal access to antiretroviral drugs; invest in development of inexpensive technologies for STI diagnosis, treatment and vaccines; and strengthen STI surveillance, including of microbial resistance.

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[38] Van Lerberghe W, Matthews Z, Achadi E, et al., " Country experience with strengthening of health systems and deployment of midwives in countries with high maternal mortality", Lancet 2014; 384: 1215-1225.

[39] WHO, "Working with individuals, families and communities to improve maternal and newborn health", WHO publication, Geneva, 2010.

[40] Murray, S F, Pearson, S C, "Maternity referral systems in developing countries: Current knowledge and future research needs", Social Science and Medicine, Vol. 62, No. 9, 05.2006, p. 2205 - 2215.

[41] WHO, "Safe abortion: technical and policy guidance for health systems", WHO Publications, 2nd ed., 2012.

Preventing and responding to gender-based and sexual violence

The primary intervention is to challenge social norms and gender inequalities that perpetuate violence, especially against women and girls, as well as violence on the basis of gender identity and/or sexual orientation. This can be done through multi-sector primary prevention programs and strategies. Laws, policies, protocols and guidelines are needed for all sectors, emphasizing that violence against women and girls is a violation of human rights, imposes enormous health burdens on individuals, families and society, and will not be tolerated. Health system has a significant role in dealing with the consequences of violence against women and girls. Health services needed to address these include post-rape care such as emergency contraception, safe abortion, and STI and HIV prophylaxis, in line with WHO clinical and policy guidelines.

Addressing non communicable diseases

As the evidence highlights women are increasingly facing a disproportionate burden of NCDs. This requires interventions to promote healthy behaviours and addressing risk factors for non-communicable diseases. A woman's health status also relates to the health and vulnerability of her children. Being born to a malnourished mother increases an infant's risk of under-nutrition, low birthweight, and increased vulnerability to NCDs in adulthood. Women's health is therefore critically important to the health of future generations. This requires governments to take steps to address economic, socio-cultural health systems and geographical barriers. Interventions include integration of prevention and control of NCDs into existing health systems initiatives; protection of women and girls from aggressive marketing of tobacco products; gender responsive health systems; inter-sectoral collaboration to identify and promote actions outside health systems; greater involvement of women and girls in identifying problems and solutions and implementing policies in the fight against NCDs; research institutions to integrate sex and gender in design, analysis and interpretation of studies on NCDs and innovative partnerships to improve access to affordable, quality, gender sensitive essential medicines to treat NCDs.[42]

Addressing women's cancers

There is a recognised need to address "changing reproductive health needs over the life cycle," including prevention, diagnosis and treatment of reproductive system cancers. In the decades since the ICPD, important technological breakthroughs have been made that could, with the right investments, assist all countries, especially low- and middle- income countries to expand prevention, diagnosis and treatment particularly for cervical cancer. The HPV vaccine makes widespread primary prevention, and also screening and treatment of precancerous lesions potentially feasible in countries with weak health systems. Advances for breast cancer are primarily in treatment, and identification, which can be used for risk screening, and need to be further available for all. Important new work is being done in low-income countries and needs to be strengthened to inform women, and to train community and primary health care workers to support women, to seek diagnosis and care early enough to treat curable cases, and to improve the management of greatly overburdened treatment facilities.

Adequate Nutrition

Nearly 30 percent women are affected by anaemia. Anaemia, most commonly iron-deficiency anaemia, increases the risk of haemorrhage and sepsis during childbirth. It causes cognitive and physical deficits in young children and reduces productivity in adults. Women and girls are most vulnerable to anaemia due to insufficient iron in their diets, menstrual blood loss and periods of

[42] NCDs Alliance, NCDs: A priority for women's health and development, 2011, available at http://www.who.int/pmnch/topics/maternal/2011_women_ncd_report.pdf.pdf

rapid growth. This requires cross-sectoral collaboration to ensure provision of adequate nutrition to women and girls.

Mental Health

Gender is a critical determinant of mental health and mental illness. The morbidity associated with mental illness has received substantially more attention than the gender specific determinants and mechanisms that promote and protect mental health and foster resilience to stress and adversity. Gender differences occur particularly in the rates of common mental disorders - depression, anxiety and somatic complaints. These disorders, in which women predominate, affect approximately 1 in 3 people in the community and constitute a serious public health problem. To address gender disparities in mental health requires action at many levels. In particular, national mental health policies must be developed that are based on an explicit analysis of gender disparities in risk and outcome. This further requires investments in gender sensitive treatment approaches and services to be developed at the national level.[43]

Table 2. Summary of priority health interventions and health system enablers for women's health

	Health Interventions
Women's health	1. Health information and comprehensive sexuality education 2. Sexual and reproductive health services including family planning[44] 3. Prevention of unsafe abortion, provision of safe abortion and post-abortion care 4. Management of pregnancy complications 5. Pregnancy care 6. Counselling and birth preparedness 7. Skilled care at birth, comprehensive emergency obstetric and newborn care 8. Home birth with skilled care and clean practice 9. Gender based violence and harmful traditional practices prevention 10. HPV vaccine 11. Testing and treatment for HIV, STIs and TB according to need 12. Promotion of healthy behaviours for preventing non-communicable diseases (e.g. tobacco, alcohol, obesity) 13. Cervical and breast cancer screening 14. Adequate nutrition 15. Mental health

4. Conclusion

Despite progress, persisting and emerging problems challenge women's health. Responding to these require a comprehensive approach including implementation of effective interventions both at clinical and health systems level. Additionally, social, economic and political determinants that result in unequal access to care should be addressed to ensure ending preventable deaths among women and improve their health towards achieving convergence between high- and low-income countries within a generation.

[43] WHO, Gender disparities in mental health, 2009, available at http://www.who.int/mental_health/media/en/242.pdf?ua=1

[44] The Mexico meeting one women's health proposed a set priority interventions for women's health. These include interventions related to: integration of services; contraceptive information and services; maternity care; access to safe and legal abortion; STIs and HIV; cervical and breast cancer; comprehensive sexuality education and violence against women.