

Addressing unmet needs in global women's health

Professor Lesley Regan

President of the Royal College of Obstetricians and Gynaecologists,
Head of Obstetrics and Gynaecology at St Mary's Hospital, Imperial College London.



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Actions required

1. Ensure that all girls and boys complete free, equitable and quality primary and secondary education
2. Mandatory relationship and sex education
3. Contraception available over the counter at pharmacies
4. Access to free and safe medical and surgical abortion care

Introduction

The UN Sustainable Development Goals (SDGs) 2016-2030 represent¹ a set of targets for countries across the world, designed to end poverty, protect the planet and ensure prosperity for all. The SDGs follow and expand on the millennium development goals (MDGs). Two of the 17 SDG goals explicitly recognise the importance of girls and women, and their health, to achieving this ambitious aim, and that the key to the success of one goal involves tackling issues more commonly associated with other goals. SDG 3, 'Ensure healthy lives and promote wellbeing for all at all ages', includes a commitment to 'reduce the global maternal mortality ratio to less than 70 per 100,000 live births', and to 'ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes'. SDG 5, 'Achieve gender equality and empower all women and girls', again underlines the importance of sexual and reproductive health, while also including commitments to 'eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation' and 'eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation'. Unlike its predecessor (MDG3), the goal calls on governments to achieve, rather than just promote, gender equality and the empowerment of all girls.

'Let the 21st century be the century of women.' These were the words of the former UN secretary general, Ban Ki-moon, during his annual report on the post-2015 development agenda. Implementation of all 17 goals would have the potential to change the course of the 21st century, by addressing key challenges such as access to education, poverty, inequality and violence against girls and women. However, underlying all 17 goals is the need to achieve the targets set out in SDG 3 and SDG 5. The health and wealth of any society depends on the health and wealth of its girls and women – only by empowering girls and women, and ensuring they are treated equally in all areas of society, will individuals and nations be able to achieve their full potential.

However, there is still much to do to improve the health care provided to girls and women around the world. While improvements are being made, we need to address the underlying inequity. Every girl and woman should be able to lead a healthy life, no matter where they are born, how wealthy their parents are, or where they went to school. But we know that a woman's life expectancy and ability to lead a healthy life is dictated in large part by the economic circumstances she was born into and the education she receives. The wealthier your parents are, the longer your life expectancy. And the poorer your family is, the more likely you are to die young. That's why we need to take a life course approach to health and focus on prevention rather than treatment. We need to give adolescents the tools early on, enabling them to flourish and make informed choices about their health and life. In the words of Professor Mahmoud Fatallah, founder of the Safer Motherhood Initiative and a world-renowned academic, clinician and activist for women's health, 'Women are not dying of diseases we cannot treat. They are dying because societies have yet to decide that their lives are worth saving'.²

Maternal mortality and morbidity

The MDGs,³ the predecessors to the SDGs, included a commitment to improve maternal health, with a specific target of reducing the maternal mortality ratio (MMR) by 75% between 1990 and 2015. While any decrease in the MMR is to be welcomed, the actual figure of a 45% reduction fell far short of the target.

It must be remembered that for every one maternal death, there are 30 women who have life-changing comorbidities as a result of their pregnancy and birth. Current figures demonstrate the scale of the challenge that faces us. Each year, there are 213 million pregnancies of which 75 million are unplanned. There are over 50 million induced abortions, of which 22 million are unsafe. In 2016, there were 303,000 maternal deaths, of which 25% were adolescent girls.

Figure 1 shows the MMR for each country, demonstrating the far higher rate in low and middle income countries.

Figure 1: Maternal mortality ratios (per 100 000 live births), 2015

SOURCE: World Health Organization (WHO). http://www.who.int/gho/maternal_health/mortality/maternal/en/

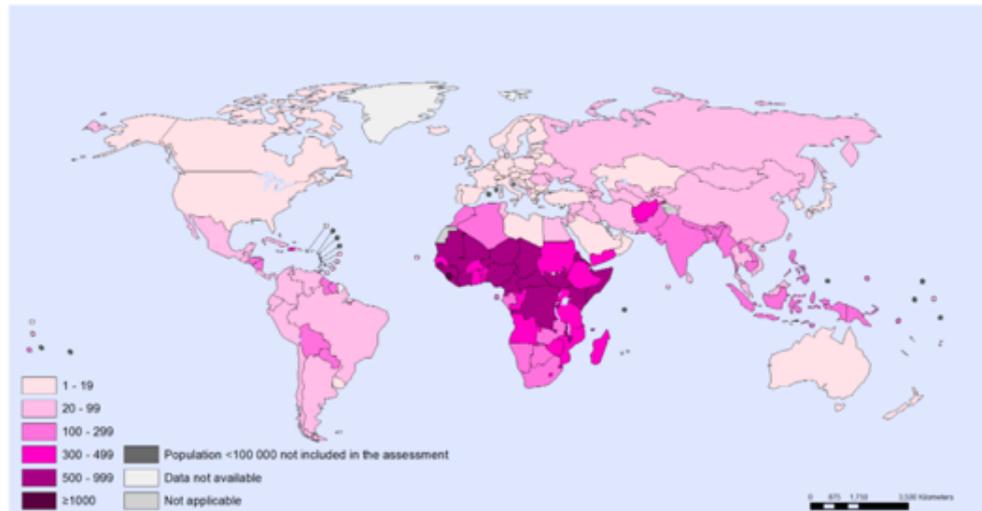


Table 1: Top five global causes of maternal mortality (adapted from WHO 2015 data)

Factor causing maternal death	Maternal deaths (% of total)
Haemorrhage	28%
Sepsis	16%
Unsafe abortion	15%
Pre-eclampsia/eclampsia	13%
Obstructed labour	9%

Table 1 lists the top five global causes of maternal mortality. All five of these factors are easily treatable, with medical treatments or preventive measures routinely being offered to women in high-income countries. However, in low and middle income countries the facilities and resources required to manage an obstructed labour often poses significant barriers for women to access prompt assistance. Nevertheless, it is important to note that this category of obstructed labour accounts for only 9% of the total deaths worldwide. The other 91% of maternal deaths are due to problems for which we have cheap, easily distributed, temperature stable medications and simple interventions to prevent women dying from these complications of pregnancy and delivery.

Historically, global health experts have cited the “Three Delays” model when describing the multiple factors that lead to delays in these girls and women receiving care resulting in such high rates of maternal mortality. The three delays being:

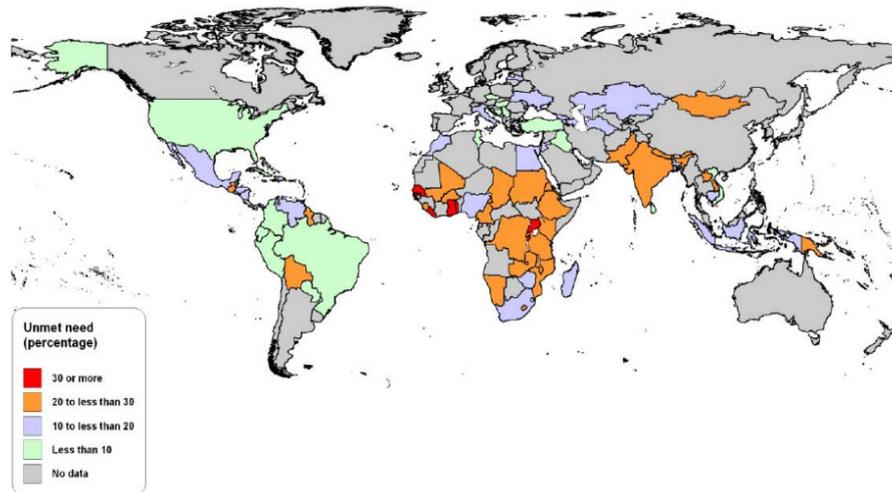
- Women or their families may delay the decision to seek care. This can be attributed to a lack of understanding of complications; a cultural acceptance of maternal death; the low status of women; and socio-economic barriers to seeking care.
- Once a decision to seek care has been made, there may be a delay in the woman reaching a healthcare facility where care can be provided. This may be due to geography (mountainous areas, islands and rivers, for example, can make it difficult to travel), and/or to poorly organised or poorly resourced transport networks. A lack of escalation pathways may also prevent women at high risk from obtaining an appropriate level of care.
- Women may then experience a delay in receiving care. This may be due to a lack of supplies or personnel, or to a lack of finances. It may also be due to poorly trained staff, or a punitive attitude towards women among healthcare staff.

However, if we are to make a sustainable improvement to maternal mortality, I think we need to recognise that the five factors that appear in table 1 are all complications that occur at the time of delivery and that the preventative measures and emergency interventions are effectively firefighting interventions. If we really want to address the problem then we need to shift our focus upstream and empower girls and women with the education and tools they need to take control of their reproductive health. In short, we need to introduce health policies and interventions that allow girls and women to be in control of if, when and how many times they become pregnant during their lives.

Family planning

Across the world, there are 214 million women with no access to family planning.⁴ The unmet need is greatest where the MMR is highest (compare Figures 1 and 2). The statistics for adolescents show the scale of the impact of a lack of family planning on this demographic. Worldwide, pregnancy and childbirth is the number one killer of girls and young women aged 15–19 years, with 50,000 deaths per year. The figures for their children are also stark: one million babies born to adolescent girls die in their first year of life.⁵

Figure 2: Unmet need for family planning. Source: World Contraceptive Patterns 2013 (United Nations, 2013), available from www.unpopulation.org.

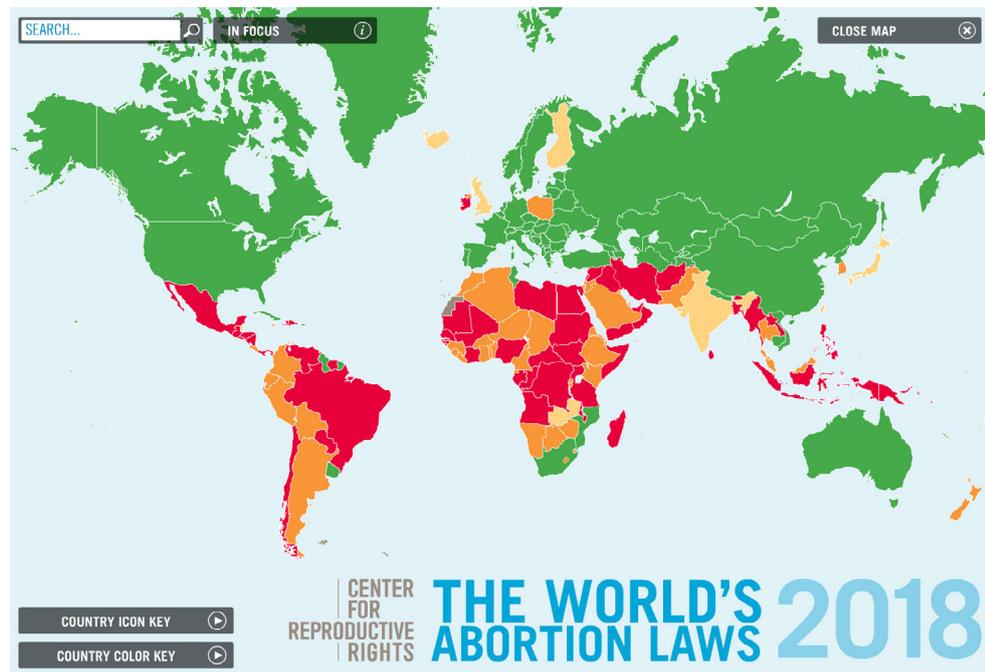


Access to family planning has a positive impact on both the woman and her child. For example, birth spacing of 18-24 months prevents maternal deaths and dramatically improves infant survival.⁶ Providing all women with the choice of using effective contraception would reduce the number of unplanned pregnancies by 70% and reduce the unsafe abortion rate by 74%. In turn, this would result in a two-thirds reduction in maternal deaths and a three-quarters reduction in neonatal deaths. Access to family planning also has wider benefits for society, by allowing women to plan for the future, complete their education and find employment. In addition, the health economics argument strongly supports provision of family planning services: every £1 spent on family planning saves £4 which would otherwise be spent on treating complications of pregnancy or birth.⁷

Abortion

Access to abortion is another key issue in global women's healthcare. Figure 3 depicts the level of legal restriction placed on women's access to abortion services across the globe. Generally speaking, in areas with little or no legal restriction on access to abortion, the procedure is safe. Where the law is restrictive, demand remains the same, with women seeking illegal and/or unregulated abortions which are often unsafe.

Worldwide, 25% of pregnancies end in abortion.⁸ In 2011, rates of unsafe abortion were four times higher in countries with restrictive laws (26.7/1000 women) compared with countries with liberal policies (6.1/1000 women).⁹ Restrictive policies do not reduce abortion rates. In 2010-14, rates were estimated at 34 (29-46) per 1000 in countries where abortion is legal on request but 37 (35-51) per 1000 women in countries with no legal grounds for abortion.¹⁰ Each year between 4.7% – 13.2% of maternal deaths can be attributed to unsafe abortion.¹¹ Although the official figures are undoubtedly an underestimate, this equates to eight deaths an hour from unsafe abortion. Adolescents are, again, disproportionately affected, with one in four unsafe abortions sought by this demographic.¹²

Figure 3: Abortion laws worldwide, 2018.Source: <http://worldabortionlaw-as.com/map/>

It is clear that improving both access to health care and the quality of health care across the globe could bring real improvements to women's health. However, looking at the underlying issues surrounding maternal mortality and morbidity and women's access to family planning and abortion services, it is also clear that in order to effect change more quickly, and ensure any change is sustainable, cultural and economic factors also need to be addressed. This would need to include both a top-down and a bottom-up approach – ensuring there is the political will to invest in women's health care, but also addressing the factors that have an adverse impact on the status of women and girls in society. This will require us to move upstream and focus on preventing problems occurring rather than trying to salvage situations after they have deteriorated.

The only way in which this will be achieved is by educating girls and women and empowering them to take control of their own health, and indeed their own lives. Sir Michael Marmot, Director of the Institute of Health Equity at University College London and former chair of the World Health Organization's Commission on Social Determinants of Health, is clear that health inequalities stem from social inequalities. This stems from analysis of the factors that underpin the causes of health inequalities. For example, unhealthy behaviours and biological risk factors are caused by the circumstances in which people are born, grow, live, work and age. Bluntly, the poor are more likely to be unhealthy, and there is a significant social gradient in health. The solution to this issue is education: those with the best chances of health and life expectancy are those who have had a secondary education.

This is particularly true of education for girls and women, given the impact it has not just on the individual but also on their family and wider society. Education has a positive impact on child survival, on fertility control and family spacing and on the woman's own health, all of which has a positive impact on the development of the country in which the woman lives. In the words of Sir Marmot himself, 'If I had to choose a single recommendation to improve health it would be education. And in a global context – the education of women. Education is central to women's empowerment'.¹³

As the health of women is so intrinsically linked to education, then so too is it intrinsically linked to the value society places on women. Taking maternal mortality as an example, we can see it as an indicator of the extent to which society values women and prioritises their

reproductive health, and a measure of inequities that intersect across gender, ethnicity, race, socioeconomic background and geography of residence. The social determinants of this indicator and these measures include the status of girls in society, their level of empowerment and their ability to make healthy choices – all of which are reflected in the lack of educational opportunities for girls in many countries worldwide.

There must therefore be global agreement that investing in education for girls and women is a priority, as part of a broader commitment to ending discrimination based on gender. This must be accompanied by commitments to eliminate gender-based violence and eradicate child, early and forced marriage. Healthcare policy must likewise treat women's health and healthcare equitably, ensuring universal access to sexual and reproductive healthcare and ensuring all women have access to high-quality care during pregnancy and birth. Until this equity is achieved, healthcare professionals must continue to work with the women for whom they provide care to advocate for investment in women's health.

The SDGs provide a unique opportunity for countries across the world to join forces to achieve gender equality by 2030. We must do whatever we can to seize this opportunity, not least because it coincides with a demographic opportunity: the biggest cohort of adolescents in history. If we do not do all we can to ensure the girls and young women of this generation have access to education, we will have missed the chance to make a great stride forward towards a healthier global population for years to come.

References

- 1 <http://www.un.org/sustainabledevelopment/sustainable-development-goals/>
- 2 <https://www.un.org/sg/en/content/sg/statement/2013-09-23/secretary-generals-remarks-high-level-forum-accelerating-mdg-5>
- 3 http://www.who.int/topics/millennium_development_goals/en/
- 4 <http://www.who.int/mediacentre/factsheets/fs351/en/>
- 5 Save the Children (2004) *State of the World's Mothers: Children having Children*
- 6 WHO (2007) *Report of a WHO Technical Consultation on Birth Spacing*
- 7 UNSG (2010) *Every Woman, Every Child*, <http://everywomaneverychild.org>
- 8 Sedgh G, Bearak J, Singh S, Bankole A, Popinchalk A, Ganatra B, Rossier C, Gerdtts C, Tunçalp Ö, Johnson BR Jr, Johnston HB, Alkema L. Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. *Lancet* 2016;388:258-67.
- 9 United Nations, Department of Economic and Social Affairs, Population Division *Abortion policies and reproductive health around the world* (United Nations publication, Sales No. E.14.XIII.11), 2014. <http://www.un.org/en/development/desa/population/publications/pdf/policy/AbortionPoliciesReproductiveHealth.pdf> (Accessed 15 October 2017)
- 10 Sedgh G, Bearak J, Singh S, Bankole A, Popinchalk A, Ganatra B, Rossier C, Gerdtts C, Tunçalp Ö, Johnson BR Jr, Johnston HB, Alkema L. Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. *Lancet* 2016;388:258-67.
- 11 Say L, Chou D, Gemmill A, Tunçalp Ö, Moller AB, Daniels J, Gülmezoglu AM, Temmerman M, Alkema L. Global causes of maternal death: a WHO systematic analysis. *Lancet Glob Health*. 2014 Jun;2(6):e323-33.
- 12 Darroch J, Woog V, Bankole A, Ashford LS. *Adding it up: Costs and benefits of meeting the contraceptive needs of adolescents*. New York: Guttmacher Institute; 2016
- 13 Marmot M. *The Health Gap: The Challenge of an Unequal World*. London: Bloomsbury; 2015.

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British Medical Association, BMA House,
Tavistock Square, London WC1H 9JP
bma.org.uk

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