

Women and health: 20 years of the Beijing Declaration and Platform for Action

Report by the Secretariat

1. An earlier version of this report was noted by the Executive Board at its 136th session.¹ In response to comments, paragraphs 4–9 below have been expanded with further data.
2. The Beijing Declaration and Platform for Action, the outcomes of the Fourth World Conference on Women (Beijing, 4–15 September 1995), set out 12 areas of action for the global realization of gender equality and women's empowerment, one of which was women and health.
3. This report describes the challenges to, and emerging priorities for, improving women's health in the context of the review of the Beijing Declaration and Platform for Action (Beijing+20) and the elaboration of the post-2015 sustainable development goals and the updated Global Strategy for Women's, Children's and Adolescents' Health, for which a comprehensive approach to women and health is vital.
4. Over the past 20 years, governments have taken steps towards implementing the commitments made in Beijing. Overall progress has been made in reducing maternal mortality and, to a greater extent, infant mortality and morbidity rates, objectives that were among the targets of the Millennium Development Goals. Globally the maternal mortality ratio almost halved between 1990 and 2013, with accelerated progress since 2005, a reduction that reflects in particular the increased attention paid by the global community to improving the health of women and children in the context of the United Nations Secretary-General's Global Strategy for Women's and Children's Health launched in 2010. The number of women dying from maternal causes dropped from an estimated 380 per 100 000 live births in 1990 to 210 maternal deaths per 100 000 live births in 2013.
5. Globally, between 1990 and 2013, life expectancy for men and women combined has increased by seven years: from 64 to 71 years. Women, in comparison to men, are nearly half as likely to die from harmful use of alcohol and less likely to have ever used tobacco and related products. They are less likely to die from road traffic injuries, suicide or interpersonal violence.
6. Women's use of health services, especially those for sexual and reproductive health, has increased in some countries, in particular in the areas of family planning, cervical cancer screening, antenatal care and deliveries in health facilities. Skilled health workers attended 69% of births in 2012, a figure significantly higher than 57% and 58% in 1990 and 2000, respectively, and access to antenatal care improved from 37% in 1990 to 52% in 2012 for women in regions classified as developing for the

¹ See document EB136/18 and the summary record of the Executive Board at its 136th session, eleventh meeting, section I.

Millennium Development Goals.¹ Between 1990 and 2015, the use of modern contraceptive methods has increased from 48% to nearly 58% and the number of births to adolescents declined worldwide. In southern Asia, these improvements were also seen in the context of declines in the numbers of married adolescents. School enrolment rates for girls around the world and higher political participation of women – two determinants of women's health – have risen in many parts of the world.

THE UNFINISHED AGENDA

7. Despite 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. The gender differences in health remain a key issue to track.

8. In 2013, female life expectancy still lags behind in the African Region (at 60 years) and the South-East Asia and Eastern Mediterranean regions (at 70 years), compared to 78–80 years in the other WHO regions.² In 2012, 48% of the 6.2 million deaths from communicable, maternal, perinatal and nutritional conditions and the same percentage of 18.1 million deaths due to noncommunicable diseases were in women. However, compared to men, women die disproportionately of certain conditions, accounting for more than half the deaths due to nutritional deficiencies and diabetes and other endocrine disorders. Women account for half all deaths due to cardiovascular diseases and more than half of such deaths in the African, European and Western Pacific regions. In the African Region, more than half the deaths due to malignant neoplasms occur in women.

9. Evidence shows the slow and uneven progress in core areas of the Beijing Platform for Action specifically related to women and health, such as nutrition, sexual and reproductive health, HIV and other sexually transmitted infections, and violence against women. Health service coverage commitments expressed in various international agreements including the International Conference on Population and Development (1994) and within the Millennium Development Goals remain to be met. Despite progress, latest estimates suggest that globally less than 75% of births are attended by a skilled attendant, the unmet need for family planning is greater than 10%, and prevalence of contraceptive use is below 65%. Differences exist across countries: nearly all births in high-income countries are attended by a skilled provider compared to about half in low-income settings; the unmet need for contraception is twice as high among low-income countries compared with high-income countries; and the prevalence of contraceptive use is 41% in low-income countries but 69% in high-income countries. Availability of high-quality data in order to understand the reasons for uneven progress remains a challenge. In only a small proportion of maternal deaths is the cause well documented for the purposes of informing policy and programmes; the available data show the growing contribution of indirect causes of maternal death, which represent the conditions that complicate pregnancy and childbirth including the effect of noncommunicable diseases. The corollary is expansion of health service coverage needs for women of reproductive age beyond the core areas of the Beijing Platform. More work needs to be done, as the data in the following paragraphs illustrate.

10. Poor sexual and reproductive health outcomes represent one third of the total global burden of disease for women between the ages of 15 and 49 years, with unsafe sex a major risk factor for death and disability among women and girls in low- and middle-income countries. In addition, worldwide in 2012, 222 million women are estimated to have an unmet need for modern contraception.

¹ <http://www.un.org/millenniumgoals/2014%20MDG%20report/MDG%202014%20English%20web.pdf>.

² World health statistics 2015. Geneva: World Health Organization; 2015.

11. Although the global maternal mortality ratio has almost halved between 1990 and 2013, this rate of progress is not sufficient to reach the target of Millennium Development Goal 5 of a 75% reduction by 2015. The burden of maternal mortality remains unacceptably high: in 2013, an estimated 289 000 women died from complications during pregnancy and childbirth and, in 2008, an estimated 22 million unsafe abortions occurred (half all induced abortions in that year), nearly all in low- and middle-income countries. Furthermore, nearly 30% of women are affected by anaemia.

12. In 2013, almost 60% of all new HIV infections among young people aged 15–24 years occurred among girls and young women. 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.

13. Sexually transmitted infections, most commonly with human papillomavirus, disproportionately affect women and adolescent girls. About 70% of cervical cancer cases worldwide are caused by the two most common pathogenic types of human papillomavirus. In pregnancy, untreated syphilis is responsible for about 212 000 stillbirths and early fetal deaths and about 92 000 neonatal deaths.

14. One in three women aged 15–49 years has experienced physical and/or sexual violence by an intimate partner or non-partner sexual violence,¹ with many short- and long-term consequences for their health.

15. More than 125 million women and girls have been subjected to female genital mutilation, and one in three girls in developing countries (excluding China) are married before the age of 18 years. Both these harmful practices have negative health consequences for girls, women and their infants.

EMERGING PRIORITIES FOR WOMEN AND HEALTH

16. **Adolescents** account for a large proportion of the population in low- and middle-income countries. Adolescent pregnancy rates are usually high in these countries, which are home to about 95% of the 13 million girls aged between 15 and 19 years who give birth each year and where complications from pregnancy and childbirth are among the leading causes of death among such girls. In 2008, there were an estimated three million unsafe abortions among girls aged 15–19 years. The adverse effects of adolescent childbearing also extend to the health of infants. Perinatal mortality rates are 50% higher among babies born to mothers under 20 years of age than among those born to mothers aged 20–29 years. Adolescent mothers' newborns are also more likely to have low birth weight, which may result in a higher rate of long-term health risks for the infants concerned.²

17. 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, and mortality rates in women aged 15–59 years were higher in those countries than in high-income countries.

18. Women are differentially affected by several risk factors for noncommunicable diseases. In most countries, girls and women are less physically active than men with many contributing factors related to income, limited mobility, access to health care, household hierarchies and roles. In some

¹ See document EB136/12 on global status report on violence and health, noted by the Executive Board at its 136th session (see summary record of the eleventh meeting, section 1).

² See document A68/15 for further information on adolescent health and a description of the proposed development of a framework for accelerated action for adolescent health generally.

WHO regions, such as the European Region and the Region of the Americas, more than 50% of women are overweight.¹

19. Globally, tobacco use accounts for about 9% of all female noncommunicable disease deaths, and the risk of adverse effects of women's smoking on their health increases with poverty. Maternal smoking is associated with risks in pregnancy including ectopic pregnancy, preterm birth, placental problems, miscarriage and stillbirth.

20. 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.

21. Chronic obstructive pulmonary disease is a leading cause of disease and death among older women, often resulting from tobacco use. Globally ambient air pollution results in 173 000 deaths in women from chronic obstructive pulmonary disease and household air pollution results in 453 000 such deaths in women.² In low-income countries, the primary risk factor for women is exposure to indoor air pollution caused by the burning of solid fuels for indoor heating and cooking.

22. Road traffic injuries are among the five leading causes of death for adolescent girls and women of reproductive age in most WHO regions.

23. Women's cancers 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. With 528 000 estimated new cases and 270 000 deaths 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.

24. Mental disorders cause about 7% of the global disease burden for both sexes and about 25% of disability. Suicide is the second leading cause of death for women aged 20–59 years globally. 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.

25. 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

¹ See document A68/10 on Update on the WHO Commission on Ending Childhood Obesity.

² Data on household air pollution:

http://www.who.int/phe/health_topics/outdoorair/databases/HAP_BoD_results_March2014.pdf?ua=1; and ambient air pollution http://www.who.int/phe/health_topics/outdoorair/databases/AAP_BoD_results_March2014.pdf?ua=1

conditions of older age, including dementia, are more common in women, yet women find it harder to access the treatment they need.

HEALTH SYSTEMS RESPONSE

26. Persistent obstacles in health systems to realizing the aims of the Beijing Declaration and Platform for Action 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 needs tackling the following cross-cutting issues.

27. **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, economic, social and political participation, health care and nutrition, are strongly associated with poor health and reduced well-being.

28. **Inequities in access to health care.** Women continue to have inequitable access to good-quality health care services in many countries. Pockets of low health system coverage exist and services in rural areas and urban slums are often of low quality. Indigenous women, women living with disabilities and those with other vulnerabilities similarly lack good services. Poor health service coverage is exacerbated by gender-related barriers to access to prevention, treatment and care. For example, cardiovascular disease has similar risk factors in men and women yet is the most common cause of death in older women. Gender bias (of providers and in health care research) often means that women are diagnosed late, receive fewer diagnostic tests for cardiovascular disease and receive inadequate treatment.¹

29. Women's inability to obtain necessary health services (including health promotion and disease prevention) also reflects weaknesses in health systems that cannot be rectified solely by targeting interventions at women. The paucity of motivated health workers with the right skills and in the right place constrains the availability and quality of services in many countries. Service delivery is often also compromised by lack of access to good-quality medicines and medical products, health financing systems that require cash prepayment, and information systems that do not provide timely or accurate information. Tackling these problems in an integrated way across all diseases and programmes will significantly improve women's health and well-being.

30. **Quality of care.** 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 poor. A recent WHO study on maternal and newborn health showed that lowering maternal mortality substantially will need a comprehensive approach to emergency care and overall improvements in the quality of maternal health care.²

31. **Monitoring and accountability.** Ensuring these functions underlies the promotion and protection of women's health and human rights. The Commission on Information and Accountability

¹ WHO. A global brief on hypertension. Geneva: World Health Organization; 2013.

² World Health Organization multi-country survey on maternal and newborn health 2010–2012. See http://www.who.int/reproductivehealth/topics/maternal_perinatal/nearmiss/en/ and links therein (accessed 2 December 2014).

for Women's and Children's Health, established to ensure that the results of implementing the United Nations Secretary-General's Global Strategy for Women's and Children's Health are measured, recommended 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. Accountability will also be part of the monitoring framework for the updated Global Strategy on Women's, Children's and Adolescents' health.

32. As the target date approaches for the Millennium Development Goals, a new vision is emerging among stakeholders for advancing the health and development of women, children and adolescents through a new global strategy.¹ Building on and extending the unfinished development goal agenda, this strategy would elaborate actions needed to end preventable maternal, newborn, child and adolescent mortality and for promoting health and well-being of women, children and adolescents. It would emphasize investment in universal access to integrated sexual and reproductive health and human rights, and establish shared goals with health-enhancing sectors, including (but not limited to) education, nutrition, and water and sanitation. It would aim to achieve convergence between high- and low-income countries within a generation, so that women, children and adolescents in low-income countries are not at a higher risk of dying from preventable causes than those in high-income countries, and to ensure that women's health was considered as part of a broad agenda, including the health of children and adolescents. It would also pay special attention to redressing within-country inequities and the situation in fragile states.

ACTION BY THE HEALTH ASSEMBLY

33. The Health Assembly is invited to note this report and give further guidance on WHO's leadership in meeting the challenges and emerging priorities in relation to women's health within a broader strategy for women's and children's health.

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¹ As expressed most recently at the Every Woman Every Child Stakeholder Consultation on Accountability for women's and children's health: setting the foundation for post-2015 (Geneva, 6 and 7 November 2014).