

Policy directions to improve women's health beyond reproduction

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Papers in this issue of the *Bulletin*^{1–16} cover various aspects of women's health that are not limited to the reproductive years. Taken together, they highlight persistent failures to address women's critical health needs. Huge diversity in health service provision prevails as countries move through their health transition. In general, however, health systems, especially in low- and middle-income countries, are not responsive to women's needs and perspectives throughout the life course, even though women remain the greatest users of health care. Many women do not have access to the health services that they need beyond those that focus on a narrow range of objectives linked to reproductive health and infectious disease control.

The list of neglected women's health issues is long. Countries are not adapting quickly enough to the epidemiologic changes resulting from evolving lifestyles and the rapid ageing of the population: specifically, the inexorable shift of the main causes of death and disease away from infectious diseases and towards noncommunicable diseases. Although this shift is observed in both men and women, women are particularly affected because, since they tend to live longer than men, they outnumber men in the older age groups. In 2012, the ratio of 60-year-old women to men in the world was 100:84. The proportion of women in the population rises with advancing age, so that at the age of 80 years, the ratio of women to men becomes 100:61.¹⁷ Furthermore, women face specific gender-related social disadvantages, particularly in terms of access to education, paid employment and economic resources, that influence their risk of disease and death. Women tend to report poorer health than men¹⁸ but access to care, especially for chronic conditions, remains distressingly low for both women and men in many low- and middle-income countries.¹⁹ Services for the prevention, detection and treatment

of common causes of death among women, such as cervical cancer and breast cancer, are seldom available except to a privileged few. This is leading to substantial and widening inequities, both between and within countries, in the mortality associated with these cancers, as shown in analyses by Luciani et al. and Tsu et al. in this issue.^{7,11}

Several measures are required at the policy level to break down the barriers to improving women's health. These policy directions need extensive discussion and require consultations within each country. We focus here on the three main objectives that should underpin policy directions: achieving universal health coverage (UHC), realizing human rights and strengthening health governance.

Universal health coverage

UHC aims to ensure that all people can use the health services they need without the risk of financial hardship.²⁰ The selection of the services to be included under a UHC scheme should be guided by two criteria: addressing people's health needs throughout the life course and redressing health inequities associated with gender, ageing and other social factors. Such criteria would guarantee due attention to women's health needs beyond reproduction, including the development of preventive and curative services for noncommunicable diseases that are on the rise among women. This would involve a major shift in the configuration of health services – away from fragmented, disease-specific, acute care services and towards client-responsive chronic care, with increased emphasis on linking up services and ensuring a continuum of care.

Any approach to extending health coverage must also seek to ensure protection against financial risk. Those who are economically or socially disadvantaged face multiple threats to their health and have the poorest access to the services they need. Access to afford-

able health care remains an important concern for women, since they are more likely than men to be poor and to work in sectors in which employee health benefits are few or non-existent. Older women face the worst problems. They are widowed or live alone more often than older men and are particularly vulnerable to poverty and social exclusion. Little progress will be possible unless efforts are made to lift financial barriers to health care and to ensure social protection for women throughout the life course.

In many settings, high user fees are waived in the case of priority maternal and child health services and of programmes for the detection, care and treatment of major infectious diseases, such as human immunodeficiency virus (HIV) infection and tuberculosis. Several countries are now taking steps towards universal health coverage for a broader range of health problems. Such steps include the avoidance of direct payments at the point of care and the establishment of mechanisms for prepayment and of pooling schemes designed to avert catastrophic health expenditures. A gender-based approach to UHC, as advocated by Rodin in this issue,¹⁶ implies vigilance to extend provisions to people who might be excluded because of widespread inequalities, including those associated with gender and economic status. For example, social health insurance schemes should include people with low decision-making power and few financial resources – usually women and children. This would benefit women in the informal sector or who work in the home and are not covered under employer plans. The content of benefit packages must be progressively expanded to encompass more priority health services for people of all ages, such as long-term and palliative care.

Human rights at the core

A human-rights-based approach to improving health systems takes account

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of the role of gender in influencing access to health care and promotes the empowerment of women in making decisions affecting their own health. Over the last few decades countries have made commitments in the area of women's reproductive rights through international human rights instruments. We are beginning to see progress in many countries' approach to women's health. Brazil, Italy, Malawi and Nepal, among others, benefited from an explicit human-rights-based approach in at least some respects, such as a reduction in maternal mortality, improved access to reproductive health services and the development of screening programmes for selected cancers.²¹

The neglect and discrimination faced by older women are matters requiring urgent attention. Older women face the effects of age discrimination plus the cumulative effects of lifelong gender discrimination, such as fewer educational opportunities, lower earning capacity and limited rights to property ownership, all of which contribute to their vulnerability in older age. These issues need to be explicitly incorporated into national laws, policies and programmes designed to meet women's health needs.

There is need for a participatory and inclusive policy development process that meaningfully engages women, including the most vulnerable, as key

actors in transforming health systems to meet the challenges of the coming years. A profound change in ingrained attitudes would be required, so that women, including those who are older, are not viewed as passive recipients of welfare benefits but as active right holders and contributing members of society. Improved data collection systems at the country level would also be needed for monitoring progress and ensuring accountability.

Leadership matters

The paper by Binagwaho et al. in this issue¹³ illustrates the progress that can be made in addressing women's health problems when there is commitment at the country level and the necessary changes to the health system are made. Rwanda has undertaken a major health system reform in recent years to improve the coverage and efficiency of key services. It has become the first country in Africa to develop and implement a national strategic plan for cervical cancer prevention, screening and treatment. Political leadership was critical in developing and launching a strategic plan, securing funding and commodities and building partnerships to address "a triple epidemiological, economic and moral imperative".²² Rwanda serves as an example of how cervical cancer control interventions can be integrated

into existing health programmes. The effort was designed to reach various age groups and has primed the country for the introduction of additional packages of care for other cancers.

Charting the road ahead

The challenges ahead may seem daunting, particularly for health systems in low- and middle-income countries that still have to attend to the control of infectious diseases, including HIV infection, malaria and tuberculosis, while taking decisive measures to improve reproductive and maternal health. Yet women have health needs that remain neglected in areas unrelated to reproduction or communicable diseases. To make progress, health systems urgently need to gear up to the rise in noncommunicable diseases that are sweeping across the world. Technical solutions seeking to make incremental improvements to women's health in terms of specific diseases or particular age groups will not suffice. Bold leadership is needed to make the policy changes required to pursue UHC and set up systems that target women's health problems, together with an uncompromising commitment to gender equality and the right to health throughout the life course. ■

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Corrigendum

In Volume 91, Issue 8, August 2013, on page 612: the city for affiliation “c” should be spelt “Ghent”.

In Volume 91, Issue 8, August 2013, on page 566: the group sizes need to be added for sexual assault in Table 5.

Table 5. Fraction of homicides related to child abuse and neglect or to sexual assault, by sex and age of victim, South Africa 2009

Age (years)	Percentage (95% CI)			P
	All	Males	Females	
Child abuse and neglect	(n = 454) ^a	(n = 174)	(n = 276)	
<5	73.8 (66.4–81.2)	45.4 (39.5–51.5)	54.5 (48.5–60.5)	0.0647
5–9	11.7 (7.0–16.3)	24.8 (9.3–51.4)	75.2 (48.6–90.7)	0.0005
10–14	8.0 (3.9–12.0)	22.4 (6.9–52.8)	77.6 (47.2–93.1)	0.0000
15–17	6.6 (3.6–9.7)	8.3 (1.5–35.6)	91.7 (64.4–98.5)	0.0001
Sexual assault	(n = 102)	(n = 10)	(n = 92)	
<5	17.9 (2.8–33.1)	22.2 (6.3–54.8)	77.8 (45.2–93.7)	0.0832
5–9	30.9 (15.7–46.0)	0.0	100	0.0000
10–14	29.1 (18.3–39.8)	13.7 (2.4–50.8)	86.3 (49.2–97.6)	0.0002
15–17	22.1 (11.0–33.3)	8.0 (1.4–34.9)	92.0 (65.1–98.6)	0.0000

CI, confidence interval.

^a This value includes four cases that were excluded from the subgroup analysis because the sex and cause of death could not be determined owing to the decomposition of the body.

In Volume 91, Issue 4, April 2013, on page 242: the first sentence in the forth paragraph of the third column should read: “According to Dr Olayinka Ogunleye, who works in the hypertension unit at that hospital, it costs around 1000 Nigerian Naira (US\$ 6.36) for a patient to have his or her blood pressure checked, although there are opportunities to get blood pressure checked for free in Nigeria as well.”

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