

Chapter 1:

Rethinking women's health

Good health is the outcome of many factors. In many African cultures the concept of health relates to achieving a harmonious balance between the body and the mind and, importantly, between the individual and the community. Social determinants of health are thus an implicit part of the concept of balance. Among the Wolofs of West Africa, for example, the concept of “*Jamm*” connotes good health and absolute peace in a person, the family and the community.² Good health and disease are perceived in both individual and communal terms, on the assumption that what is good for the community is good for the individual and vice versa.

It is this complex and composite nature of health that demands new thinking about women's health in the African Region and a multisectoral approach to the development of policy and interventions designed to improve women's health status. The core proposition of this report is that what is good for the health of African women – at all stages of life – is good for the Region as a whole. In a sense this is obvious: a woman's health determines the health of the children she will bear. Investing in her health is therefore an investment in the future. Unfortunately, the perceived role of women in African societies has, for a long time, been limited to childbearing. Consequently, women's contribution to socioeconomic development is often overlooked.

Women in Africa bear a disproportionately large share of the global burden of disease and death, particularly in maternal morbidity and mortality. Africa as a whole accounts for more than half of all cases of maternal deaths worldwide and African women have a one in 42 lifetime risk of dying during childbirth compared with one in 2900 in Europe.³ With regard to HIV/AIDS the picture is equally bleak. African women account for 89% of the global burden of Disability-Adjusted Life Years (DALYs) attributed to HIV/AIDS.⁴

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Rethinking policy

For policy makers to create the enabling conditions for women at all levels of society to benefit from better health care they must establish health systems that are responsive to women's needs; provide education that puts girls on an equal footing with boys; offer quality maternal care; eliminate gender-based discrimination; abolish harmful traditional practices such as female genital mutilation; and reconsider modern methods of childbearing that are practiced at health facilities at the expense of women's convenience or privacy.

However, to make the greatest improvement in women's health, policy makers must also strive to improve the social status of women, notably through the empowerment that comes with education and unhindered participation in all professional spheres.⁵ At the same time, while reaching upwards as it were, it is crucial that governments commit to supporting the most vulnerable of African

women, e.g., by guaranteeing them adequate nutrition, water and sanitation, and giving them access to quality health care that is free at the point of use.

It will take more than rethinking to make the needed changes and, at some point, some committed action will be necessary. To initiate large-scale investments in women's health, political *will* and political *commitment* are needed: the political will to initiate and coordinate the required investments and the political commitment to sustain them. The cultural heritage of African women, a heritage characterized by great resilience and resourcefulness built over centuries of care-giving under challenging circumstances, should help inspire that political will and that commitment and be a source of inspiration and strength to all.

Rethinking health systems financing

Many factors account for the staggering statistics of ill health among women in the African Region, but the failure of health systems in the majority of the countries to provide accessible care of adequate quality is a major factor. This is due partly to low funding and partly to system design. Per capita spending on health in 21 African countries in 2008 is estimated to have been well below the minimum of US\$44 per



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capita recommended by the Taskforce on Innovative International Financing for Health Systems⁶ in order to provide essential services including access to interventions proven to reduce mortality among mothers, newborns and children below five years of age.⁷ African leaders demonstrated their awareness of this in 2001 when they adopted the Abuja Declaration pledging to allocate at least 15% of their annual budgets to the health sector.⁸ Sadly, over ten years after, only Botswana, Burkina Faso, Democratic Republic of Congo, Liberia, Rwanda, Tanzania and Zambia are keeping this commitment, while 13 African countries are actually allocating less of their total national budgets to health now than they did prior to 2001.⁹ Since 2003, average general government health spending as a percentage of total government expenditure of African countries has been around 10%, i.e. two thirds of what governments had pledged.

The impact on women of underfunding, especially of health systems, will be discussed in subsequent chapters, suffice it to note that unless health systems of African countries are adequately funded on a sustainable basis, they cannot meet the needs of the people that use them. This is particularly true of maternal health services where the need for increased investment is considerable. The lack of resources for providing quality skilled care for women during pregnancy, childbirth and the postpartum period is one of the main reasons for the high maternal and child mortalities in the Region.¹⁰⁻¹²

Rethinking direct payment for health services

The impact of inadequate funding on women's health is compounded by reliance on payment of user fees for services, also called out-of-pocket (OOP) payment

for health care. This poses a problem for both sexes and its particular impact on women will be discussed in subsequent chapters. It acts as a barrier to access and a financial disincentive to care-seeking, prompting many women to postpone needed preventive and curative care. User charges can also put people in severe financial difficulties if there is no alternative access to treatment without direct payments. The findings of a survey of 89 countries published in 2007 showed that financial catastrophe – which WHO defines as forced payment of more than 40% of household income to obtain medical care after basic needs have been met – occurs in all countries and at all income levels, but that 90% occurs in low-income countries many of which are in Africa.¹³ When user fees were introduced in Rwanda in 1996, the utilization of health services halved.¹⁴ More research is needed in this area as there are no sex disaggregated data on OOP expenditure. However, OOP is known to account for nearly three fifths of total health expenditure in Africa and a study has shown that a reduction in OOP payment and user fees contributes to increased utilization of health care especially by women and children.¹⁵

The alternative to direct OOP payment is some form of prepayment and pooling of resources as set out in World Health Assembly Resolution WHA58.33 urging Member States “to ensure that health financing systems include a method of prepayment of financial contributions for health care, with a view to sharing risks among the population and avoiding catastrophic health care expenditure and impoverishment of individuals as a result of care seeking.”

Protection of financial risk is achievable by sharing the financial burden of paying for health, but need not be expensive. Rwanda, with a per capita total health spending of just US\$ 45 (in 2008), provides basic health services under a system of low-cost health insurance schemes which now cover over 90% of its population. These schemes have had a marked positive impact, notably with regard to child mortality.⁹ Unfortunately, with two exceptions, most health financing systems in Africa do not have any mechanism for risk pooling and the level of pro-poor subsidy, which is necessary in every country whatever its economic status, is either low or non-existent. Moreover, the sustainability of the existing risk pooling schemes in Africa has not been adequately investigated.

Rethinking service delivery

One of the challenges facing the African policy maker is how to provide quality, accessible and comprehensive health care to women and girls in both isolated rural communities and rapidly growing urban cities. Women in many rural communities frequently have to travel long distances to access care, whilst those in large cities have to wait for long hours to receive care in crowded facilities.

The Region has weak and dysfunctional health systems that are plagued by lack of funds, a human resource crisis and weak and inadequate infrastructure. The existing hierarchical and pyramidal system further exacerbates the problem for women, particularly those in their reproductive years, as it limits access to emergency obstetric care because it concentrates life saving skills at the top especially in the regional and teaching hospitals.

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African women must engage in the planning and organization of their own health care services.

In order to avoid unintentional bias in identifying the key issues related to women's health it is necessary to adopt the "life cycle approach". This life cycle approach is crucial to understanding women's health at various stages of their lives. It permits the use of age categories to identify women's health problems that are unique at each stage of their life course.¹⁶ According to the Nigerian anthropologist Oyérónké Oyéwùmi, age is the main organizing principle of identities and social relationships in many African societies.¹⁷

The age categories in the WHO report *Women and Health*¹⁸ encompass socially constructed age groups and subgroupings relevant to most African cultures where generic terms designate them, i.e., "girl child", "adolescent girl", "adult woman in the reproductive years" and "woman beyond the reproductive years".

Rethinking social attitudes towards women

Notwithstanding the importance of health system reform in delivering better health outcomes for women in Africa, there is absolute need for a similar effort to rethink and reform the broader sociocultural context in which African women live. Here the barriers to health are less easily discernible but nonetheless real. More often than not these barriers are informed if not determined by gender bias. This can take the form of women's exclusion by law from ownership of land or property, which increases their social, physical and financial vulnerability. Another example of gender bias is entrapment of women in household chores just because "that is the way it has always been": cooking with solid fuels in poorly ventilated homes exposes African women to harmful smoke and is estimated to cause millions of deaths every year.¹⁹

Gender discrimination is also often linked to some traditional practices that can result in direct physical harm. An example is female genital mutilation (FGM). An estimated 92 million girls and women above the age of 10 years in Africa live with the consequences of FGM and each year some three million more are mutilated.^{20,21} Women are also exposed to health risks through early marriages, the practice of wife inheritance, and child slavery.

Policy reform designed to improve women's health in Africa must therefore address the issue of women's place in African society. Interventions to that end must be informed by an awareness of gender relations as they affect health and by an understanding that women, just like men, have a basic right to health.

Rethinking social attitudes towards women must also include a recognition that one of the main resources available to policy makers eager to improve women's health is women themselves. Programmes and policies designed to improve women's health should therefore recognize women's potential to mobilize resources and should take advantage of their capacity to initiate change. In the words of an editorial in the *Lancet*: "Too often, the health community ignores the potential power of women to mobilize for health. Maternal and child health advocates have still not fully learned the lessons of the AIDS movement – namely, that self-organization can deliver not only political success, but also tangible improvements in health outcomes".²²

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Rethinking women's right to health

While the main focus of this report is to examine the link between women's health and women's socioeconomic development, it is important to remember that health is a basic human right, and that women have the same claim to that right as men.

The right to health is enshrined in numerous international and regional human rights treaties including the Universal Declaration of Human Rights of 1948, which states in its Article 25, that everyone has a right "to a standard of living adequate for the health and well-being of himself and his family". The United Nations expanded upon the right to health in Article 12 of the International Covenant on Economic, Social and Cultural Rights of 1966 which states that



the right to health is ensured, in part, by “reducing infant mortality and ensuring the healthy development of the child” and by creating conditions “to ensure access to health care for all”. The UN revisited the issue again in 2000 with General Comment No. 14 which extends the right to health not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.

The need to view women’s health as a human right is widely recognized. Mary Robinson, former President of Ireland, and former United Nations High Commissioner for Human Rights, argues that improving maternal health and reproductive health rights should be seen as an integral part of broader human rights issues such as the right of access to health care and family planning; the right to adequate nutrition; and the right to be free from discrimination, violence and forced marriages.²³ Investing in women’s health, which includes investment in women’s education and other forms of socioeconomic empowerment, is crucial to ensuring women’s health rights.

Most countries in the African Region are state parties to the right to health enshrined in several core international human rights.^{24–26} Specific to women’s health is the United Nations Convention on the Elimination of All forms of Discrimination Against Women (CEDAW), which specifies State Parties obligations in the prevention of maternal morbidity and mortality, and the provision of appropriate health care services for women. All 46 countries of the African Region are signatories to CEDAW. At the regional level the African Charter on Human and People’s Rights (Banjul Charter),²⁷ together with the Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa,²⁸ recognize the right to health of women and identify different measures to be taken by State Parties in ensuring full implementation of the instruments. At national level the right to health, which includes the health of women, has been enshrined in over 80% of the constitutions of countries in the African Region.

One of the most direct ways to combat gender discrimination in Africa is to empower women through education and participation in social, economic and political affairs. The Commission on Macroeconomics and Health identifies education as a key determinant of women's health. Indeed, the positive effect of education on health is well documented. For example, the interrelationships between girls' education and their health status have been shown in several studies on HIV/AIDS including work by Vandemoortele and Delamonica²⁹ revealing that HIV/AIDS in Zambia spread faster among uneducated girls compared with educated ones. In Zimbabwe studies demonstrate that girls dropping out of school are more likely to be infected by HIV than those who continue.³⁰ In Kenya girls who stay in school have been shown to delay their sexual debut more often than those who drop out. The effect of education is by no means limited to improving health outcomes; education can also lead to socioeconomic empowerment in sociocultural contexts where that empowerment is permitted. Education is thus shown to be a powerful tool not just for improving women's health, but also for socioeconomic development.



For centuries African women have been the mainstay of families and communities, often in the face of extreme adversity. Despite the level of their social status and their large share of the burden of disease and death, they continue to be peacemakers, life-givers, entrepreneurs and providers of care for children – the builders of Africa's future.

Evidently this same power to mobilize for and initiate change applies also to socioeconomic development. For centuries African women have been the mainstay of families and communities, often in the face of extreme adversity. Despite the level of their social status and their large share of the burden of disease and death, they continue to be peacemakers, life-givers, entrepreneurs and providers of care for children – the builders of Africa's future.

Rethinking traditional practices

It is important to recognize that not all traditional practices are harmful to health. Likewise, not all modern practices or mindsets in the fields of medicine and public health are beneficial to women's health. Even when a particular practice is harmful, analysing and questioning it can provide insights into local culture that may serve as a lever for positive social transformation. Moreover, because cultural codes, symbols and traditional values are part of the sociocultural environment in which African women live, understanding them is crucial to identifying approaches to implementation of interventions that are effective and sustainable. In implementing interventions that address women's health problems in the African Region, there is a need to design strategies that are consistent with the cultural contexts in which African women live.

Rethinking the connections between women's health and socioeconomic development

Health is both a cause and a consequence of socioeconomic development.³¹ Stated in blunt utilitarian terms, investing in women's health can enhance development through an increase in economic output. Since women make up an estimated 50.2% of the total population of the African Region it implies that the bulk of the Region's human resources are largely underutilized. The positive feedback loop links investment in health with economic development.

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Economic development provides the resources needed to improve women's health, and improved women's health drives economic development. Better women's health also establishes the foundation for empowerment through education which in turn feeds back into health, drives sociocultural enrichment and opens up the possibility for advancement in all spheres of professional life.

Arguably, investing in women's health is cost-effective because it helps save resources that would otherwise be spent on medical treatment and care for chronically ill women at home or in health institutions. Meanwhile, where payment systems based on prepayment and pooling are introduced, OOP payments for medical care for women and children can be phased out, reducing the incidence of impoverishment and liberating domestic resources for long-term investment in nutrition and education. In this sense, investing in women's health, means investing in the future.

It is estimated that maternal and newborn mortality rates alone cause global productivity losses of US\$ 15 billion annually and are a serious constraint on economic growth in low-income countries. Moreover, according to some estimates, 30–50% of Asia's economic growth between 1965 and 1990 is attributed to reductions in infant and child mortality, lower fertility rates, and improvement in reproductive health.³²

Key considerations and points for action

- a) There is a need to rethink women's health in Africa by adopting a holistic, multidisciplinary approach that links together biomedical, sociocultural and economic factors.
- b) Policy needs to reflect the sociocultural determinants of health as well as funding and health service delivery issues.
- c) Women themselves have the potential to be one of the most important agents of change in health reform.
- d) Women's health is a human right and should therefore be pursued and promoted as such.
- e) The social and economic benefits of investing in women's health, starting with the obvious benefits to children, are considerations of fundamental importance in policy making.
- f) Religious institutions and community leaders have an important role in the implementation of women's rights.
- g) All governmental ministries, not solely the ministries of health, should support the advancement of women's health issues.

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