

Chapter 6:

Interventions to improve women's health

Chapters 1 to 5 of this report have analysed the many determinants of women's health and illustrated the immense benefits that are associated with its improvements. This chapter looks at how the dream of an African continent inhabited by healthy, prosperous and independent women can be realized by implementing proven interventions designed to improve their health and social status.

Mobilizing political will and commitment

It is clear from the evidence gathered that addressing the issue of women's health requires interventions¹ across multiple sectors. Because governments are best placed to coordinate the various initiatives needed to bring about large scale change, it is essential to mobilize political will and commitment from the very outset, i.e., to establish the prerequisites for the success of the interventions. In this regard, government ministries should be encouraged to talk to one another not only to support health care systems that are more responsive to women's health needs, but also to create the enabling socioeconomic conditions for women's development. The benefits of this multisectoral approach have already been proven in sub-Saharan Africa, notably in regard to control of the HIV epidemic. There is evidence that if those seeking reform can broaden their consultation and build alliances across different sectors, a substantial increase in resources allocated to investments in women's health is possible.² In Cameroon, for example, the involvement of the Ministry of Finance in the development of the reproductive health commodity security strategic plan helped raise awareness of the need to make provision for contraceptives in the national budget.³



↳ **...in order to address the budgetary challenges facing women's health care programmes in the Region, governments should reassess national budget priorities...** ↵

Furthermore, politicians are the ones who pass the legislation that has the potential to change the lives of girls and women. They also play a role in determining the level of budget commitment needed to improve women's health services. As noted throughout this report, in order to address the budgetary challenges facing women's health care programmes in the Region, governments should reassess national budget priorities.⁴ Persuading them to do so is one of the biggest challenges faced by the advocates of change in the Region. Governments that resist the implementation of necessary interventions often cite low domestic resource mobilization and low per capita incomes as their chief obstacles. However, there is abundant evidence that the wealth status of a country is not the single most important determinant of the allocation of funds for women's health.⁵ Moreover, the provision of, at least, safe motherhood care packages is well within the budgetary reach of many African governments.

Political commitment and will, often driven by grassroots movements, have brought about positive change in health care provision in many parts of the developing world, notably in South Korea and Thailand, and there are already encouraging stories within the African Region that show that a similar change is possible in the Region. In Uganda, for example, public acceptance by leaders that HIV/AIDS was a matter of concern led to cooperative efforts between the government and civil society to combat the epidemic. As a result, HIV prevalence in the country has decreased considerably.⁶

Dramatic reductions of mortality achieved in low-resource settings – evidence from Sri Lanka

In 1950, the maternal mortality ratio (MMR) in Sri Lanka was very high, at more than 500 deaths per 100 000 live births. In the same period, gross national product (GNP) per capita was only US\$270. Despite being constrained by its limited resources, Sri Lanka managed to reduce the MMR to below 100 by the mid-1970s – far lower than many countries with similar or higher income levels. Today Sri Lanka's MMR is about 50.

A recent evaluation of Sri Lanka's experience identified several critical success factors headed by political will to invest in maternal health. Services were free to those who could not pay, and the decision was taken to expand access to underserved areas with a focus on the most appropriate interventions. Emergency obstetric care was developed. More skilled birth attendants were made available to help mothers in labour. This was achieved by training a large number of midwives and by promoting the service and improving its quality. Pregnant women were encouraged to consider that they had a right to a skilled birth attendant. Progressive and sequenced investment was an important part of the programme's success. This focused initially on recruiting more midwives and strengthening their capacity. Investments were then made in the primary health care system, and finally in hospitals.⁷

The “Badienou Gokh” Initiative for promoting maternal, newborn and child health – an example from Senegal

The Government of Senegal, through the Department of Health and development partners, has firmly committed itself to achieving MDGs 4, 5 and 6, which are related to improving maternal, newborn and child health as well as disease control. In this context, the then President of Senegal, Mr Abdoulaye Wade, initiated a community programme for promoting maternal, newborn and child health, known as the “Badienou Gokh” Initiative. (Badienou Gokhs are usually older women who mentor younger women about health care needs.) The programme uses a community approach within the broader perspective of the multisectoral setting to accelerate the reduction of maternal and newborn mortality and morbidity in Senegal. The Initiative aims to stimulate demand for health care through a system of sponsorship for women during pregnancy, childbirth and the postpartum period, and for children aged up to five years, with the support and involvement of suburban or village assistants, godmothers or Badienou Gokhs. The Initiative was launched officially in Kolda on 19 January 2009.

The Badienou Gokhs are chosen by the community within networks of organized groups of women, based on criteria selected under the supervision of a local committee.

Badienou Gokhs are women with proven leadership skills who commit themselves to assisting pregnant and breastfeeding women in seeking reproductive health care and health care for newborns and children under five years, with the involvement of the entire community particularly mothers-in-law, grandmothers and men.

The specific objectives of this Initiative are:

- i) To promote maternal, newborn and child health through strengthening the capacities of individuals, families and communities;*
- ii) To improve the extent of use of maternal and child health services by women during pregnancy, childbirth and the postpartum period, and by children aged up to five years;*
- iii) To give impetus to the involvement of men (spouses, partners, fathers) and mothers-in-law and/or grandmothers (or similar) in reproductive health care seeking by women during pregnancy, childbirth and the postpartum period, and health care seeking for children aged up to five years;*
- iv) To establish a partnership with the community, local councils, the private sector and partners in order to promote maternal, newborn and child health.*

Preliminary results of the Initiative demonstrate, first, improved use of reproductive health services in the Kolda Health District, with skilled birth attendance increased from 114 in April 2010 to 382 in August 2010, and, second, an increased number of antenatal consultations from 1460 in June 2010 to 1882 in August 2010.

Strong advocacy is needed

By giving leaders evidence of the benefits of supporting women's health investments,⁸ backed by current and accurate data, advocacy can play an important role in encouraging political commitment at the highest level possible. Indeed political leaders, whether parliamentarians or senior government officials themselves, are well placed to advocate for women's health, and to act as spokespersons on women's health issues and rights, and also to present themselves as role models for change. They can bring the matter of poor women's health to the fore at national platforms. By disseminating key messages through the mass media, for example, leaders can help immensely to raise awareness and inform the public about the problem and solutions.

An example of this was initiated in Kenya where a successful mass communications effort to improve the reproductive health of girls and women was achieved using a Kenyan radio soap opera, "Understanding Comes from Discussion". This programme has encouraged greater communication between parents and children on issues related to sexuality.

Advocacy has been proven a powerful tool in Rwanda where use of a sophisticated computer modelling advocacy tool has encouraged the adoption of an effective national family planning programme.

Effective advocacy for family planning – an example from Rwanda

Despite the losses resulting from the genocide in 1994, Rwanda is still the most densely populated country in Africa and unchecked population growth threatens socioeconomic development in the country.⁹ Malnutrition is already a leading cause of death among women and children in the country,¹⁰ and if the population growth





continues to follow the higher end of fertility projections, the country will have almost to triple its food crop supplies by 2035 simply to maintain the per capita food crop consumption that existed in 2004. Rwanda has intensified efforts to address the issue using evidence generated with the RAPID (Resources for Awareness of Population Impacts on Development) – a computer model designed to facilitate the analysis of different scenarios based on a range of data as a basis for policy discussion about the effect of population factors on socioeconomic development.⁹

The RAPID Model was first presented to Parliament and Ministry of Health officials in 2005 and in February 2007 the Minister of Health presented the analysis based on the Model to the President and members of the Cabinet. This in turn led to a presidential-level commitment to family planning and the implementation of a National Family Planning Strategy. One of the notable successes of the family planning programme is an increase in the use of modern contraceptives among married women, which rose from 10% in 2005 to 27% in 2008.²

Supporting women's health and development throughout the life course


Key cost-effective interventions^{11,12} of proven value aimed at improving the physical and socioeconomic circumstances in which young girls and women find themselves are presented in **Table 6.1** which reveals, among other things, the importance of interventions that do not concern health care per se.^{13–15} Apart from immunization, the interventions recommended for the girl child, for example, relate to the supply of adequate nutrition, her empowerment through education, and her protection from physical and psychological harm.

Table 6.1 Cost-effective interventions to improve women's health

Females at various stages of the life course	Key interventions
1) Girl child 	Education; nutrition; protection against harmful traditional practices; protection against gender-based violence, child abuse, trafficking and slavery; immunization
2) Adolescent girl 	Primary and secondary school education; protection against early marriage, exploitation, abuse, sexual violence; establishment of youth centres for girls; adolescent-friendly health care services; encouragement of healthy lifestyles; life-skills and sex education; livelihood skills training; and, if affordable, HPV immunization
3) Adult woman in the reproductive years 	Family planning services; comprehensive abortion care services; pregnancy care including antenatal, delivery and postpartum care, and care for the newborn; screening and treatment for STIs including HIV; maternity leave protection; protection against domestic violence; female empowerment programmes; cancer screening
4) A woman beyond the reproductive years 	Healthy nutrition; cancer prevention services (e.g. cervical and breast cancers); protection against gender-related violence; screening for chronic noncommunicable diseases; mental health support

Sources: Adam T, et al. *BMJ* 2005;331:1107; Kumaranayake LC, et al. *Costs of scaling up priority interventions in low income countries*. Geneva: WHO, 2001; World Bank. *World Bank Development Report 1993: Investing in Health*. New York: Oxford University Press, 1993.

Much has already been discussed about the importance of education for a growing girl. The issue is revisited to stress the importance of girls getting good education, notably by removing the financial barriers to schooling. The waiving of school fees for girls has been used with some success in a number of countries in sub-Saharan Africa, notably Malawi where a free lunch programme has been introduced. These simple initiatives have been credited with a 38% increase in the number of girls attending school in Malawi, a decrease in drop out and repetition rates, and an increase in girls' pass rates by 9.5%.^{16,17} Conditional cash transfers may also be of value in this regard. Where funding permits, the construction of new schools

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in otherwise underserved communities has been shown to stimulate school attendance by girls, particularly in Egypt where building schools closer to communities in rural areas is reported to have boosted girls' enrolment by 60%, while enrolment among boys increased by 19%.¹⁸

Policy makers also need to do their utmost to protect girls against the various forms of violence to which they are subjected. Physical and psychological harm caused by violent assault and persecution is a problem experienced by many women in the Region throughout their lives, but it takes particularly pernicious forms in childhood, notably in regard to certain harmful traditional practices such as female genital mutilation which, as already noted in Chapter 2, is estimated to be inflicted on more than two million girls between the ages of 4 and 12, every year.

As noted in Chapter 2, many countries in sub-Saharan Africa have passed laws penalizing the practice. However, laws alone have rarely led to sustainable behavioural change. The World Bank's work in combating FGM suggests that legislation can only be effective when it is complemented by more broad-based efforts including public education programmes and the involvement of professional organizations and women's groups in anti-FGM campaigns, as well as interaction with communities in addressing the cultural reasons for the perpetuation of this practice. Indeed, as already stated, efforts to eliminate genital mutilation of young girls in Africa have been most successful when undertaken in collaboration with the people responsible for it.¹⁹

The main focus of interventions designed to improve the health of the adolescent girl (**Table 6.1**) continues to be on empowerment through education but adds the important dimension of empowerment through association with other girls, especially in the context of all-girl programmes such as the Bright Future (Biruh Tesfa) Programme in Ethiopia.

A "Bright Future" for adolescent girls – the Ethiopian experience

In Ethiopia, the Biruh Tesfa (Bright Future) Programme is designed to help girls between the ages of 10 and 19 by promoting functional literacy, life skills, livelihood skills and HIV prevention education. Trained female mentors recruit girls by going house-to-house to identify eligible out-of-school girls from very disadvantaged backgrounds. Nearly half of the girls have lost at least one parent and 16% have lost both. The mentoring meetings are held in girls' clubs in spaces donated by local councils. So far, more than 10 000 out-of-school girls have participated in Biruh Tesfa groups and one-third of the participants are between 10 and 14 years. In Addis Ababa, nearly half the members are young

adolescents. The project is one of the first of its kind to target child domestic workers comprising 30% of Biruh Tesfa's membership.²⁰

As they grow, girls need guidance with regard to the various lifestyle choices they confront; they need to know the risks some of those choices entail. The interventions known to improve the health of adolescent girls²¹ (and of course the women they will become) include counselling and family life education. Family planning information and services are also of fundamental importance. Sexual activity typically begins in adolescence with its associated risks of sexually transmitted infection, including HIV infection, and unplanned pregnancy. Making young women aware of the importance of condom use offers a number of direct benefits including the postponement of their first pregnancy, the prevention of unintended pregnancies, and the reduction of abortions and STIs including HIV. For married women, an understanding of the contraceptive options available can also offer the possibility of reducing pregnancies or planning them in such a way as to be able to recuperate in between.

Promoting healthy motherhood

The socioeconomic benefits of healthy motherhood have been discussed in Chapter 5. Those benefits are enhanced where families are smaller. The same is true at the macroeconomic level: slowing the growth of the population reduces the strain not only on health resources but also on education, social welfare systems and, of course, natural resources such as arable land and water, and the food those resources produce. Where population growth is unchecked, all of those resources come under pressure.

Unfortunately progress on this front has been relatively slow in sub-Saharan Africa as evidenced by a recent study revealing that attitudinal resistance to contraception remains significant, while access to contraceptives, though improving, is still extremely limited.²² The lack of progress is by no means uniform in the Region, and East Africa is doing rather better with prospects for a future decline in fertility that have been described as "much more positive".²² Involving men in family planning counselling may increase the use of contraception. In an experimental study, more than 500 married women who were not using any modern method of contraception received counselling. Half of them were counselled alone, while half were counselled with their husbands. After 12 months, contraceptive use increased by 33% among couples in which both wife and husband had been counselled together, compared with a 17% increase among couples where the women were counselled alone.²³



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In many rural areas in Africa, traditional and religious leaders, considered as the custodians of community values and beliefs, are often at the forefront of opposition to sexual and reproductive health programmes and need to be engaged on the

issue if contraceptive use is to increase.²⁴ Where sociocultural factors are barriers to the acceptance of effective interventions there is some evidence that community involvement in the design of such interventions can facilitate their successful implementation.

Family Planning Options Project – an example from Guinea

*The Family Planning Options Project (FAMPOP) in Guinea involved the integration of family planning services into primary health care clinics and actively cultivated the support of Islamic religious leaders through a series of seminars. The leaders not only dismantled barriers to cultural acceptance of family planning, but also used their positions to educate their constituencies about the need for such planning.*²⁵

Supporting health care systems that are more responsive to women's health needs

It is as women enter their reproductive years (Life Course Stage 3 in **Table 6.1**) that their need for adequate and accessible health care becomes acute, notably with regard to interventions proven to reduce maternal morbidity and mortality. As already stated, the provision of maternal health care is within the reach of many countries in the Region, as studies have shown that implementing comprehensive safe motherhood care packages at levels of coverage of around 70–90% can be achieved at a cost of between US\$0.22 and US\$ 1.18 per capita.^{26–28} A broader package involving safe motherhood services, family planning, tetanus toxoid immunization and micronutrient supplementation has also been shown to have a cost-effectiveness ratio lower than that of many other interventions.²⁸



The majority of modern health care services provided in the Region are clinic based, physician oriented and urban centred.

The starting point of any reform designed to better meet the needs of women in the Region is the replacement of the pyramidal health system paradigm with more decentralized models designed to deliver comprehensive primary health care. The majority of modern health care services provided in the Region are clinic based, physician oriented and

urban centred. Among the main barriers to service utilization often cited are the long distances women have to cover to reach health facilities and the cost involved in such travel. Admittedly, building and staffing new clinics require considerable investment, and not every country will be able to undertake this without the support of development partners.

However, even in settings where funding for new clinics is lacking women's access to services can still be improved especially by implementing community-based outreach programmes such as those that have been successful in increasing service utilization in Ghana, Kenya, Mali and Zimbabwe.²⁹⁻³³

Community health planning – the Ghanaian experience

An innovative service delivery model designed to reduce geographical barriers to women's access to health services was implemented in Ghana in 1999. A community health officer or community health nurse was assigned to a community and equipped to provide the community with primary health care services. The community health worker travelled from compound to compound on a motorcycle providing essential services such as health education, immunization, family planning, skilled birth attendance, antenatal and postnatal care, and the treatment of minor ailments.

The health worker was supported by community volunteers who assisted with community mobilization and the maintenance of community registers. The introduction of community health workers into communities was preceded by extensive dialogue between the health system and community representatives, in recognition of the importance of traditional leaders if the community is to accept the workers and be ready to support them. The community health workers programme contributed to a 30% drop in child mortality and a decline in the total fertility rate.

Using technology improves access to health care

Technology also offers ways of reducing the isolation of rural communities notably through the introduction of internet and mobile telephones that can be used to train health care providers through e-learning programmes, recruit clients for reproductive health services such as family planning and antenatal care, reduce delays in follow-up care, and gather information. For example, cell phones were introduced to support obstetric care in the village of Amensie, in South Central Ghana in 2006 as part of the Millennium Villages Project. Prior to the initiative about 20 women in the community died each year during childbirth. The mobile handset producer teamed up with a mobile telecommunications firm, to distribute free handsets to health workers and sold handsets to villagers for US\$10 each. With the improved communication network, community members were able to call for ambulance services and to reach skilled care providers for prompt management of maternal complications, leading to drastic reductions in maternal deaths.³⁴



Legal reform improves women's access to health care

Countries can also better serve the health needs of women by passing legislation guaranteeing their right to essential services such as safe abortion, as did South Africa in 1996 with the implementation of the Choice on Termination of Pregnancy Act. In recognition of the sensitivity of the issue there was broad consultation prior to passing the law which allowed midwives to provide first trimester abortion care. Comparison of mortality estimates from 1994 prior to the passing of the Act to the period after the Act indicates a 91% reduction in deaths from unsafe abortions.³⁵

The importance of skilled care providers in improving maternal health outcomes has already been discussed and their relative scarcity identified as one of the leading reasons for the high maternal mortality in the Region.³⁶ Key legal and regulatory reforms are needed to eliminate the overly restrictive laws and regulations such as those that prevent care givers from providing essential health services for women. Countries can boost health system capacity without any major investments by undertaking task shifting.

Enhancing human resources for women's health

Task shifting typically allows mid-level staff (e.g., non-physician clinicians, midwives and community health workers) to perform essential procedures. Non-physician clinicians (NPCs) of differing capacities are active in 25 of the 46 countries of the African Region and in nine of those countries the number of NPCs is at least as large as the number of physicians.³¹ In all the 25 countries, NPCs perform basic diagnosis and provide basic medical treatment. In some countries NPCs have even been trained in more complex procedures such as Caesarean section and anaesthesia. There is some evidence that postoperative outcomes for patients handled by NPCs are comparable to outcomes associated with medical officers; however, more definitive evidence is required to substantiate the benefits of using NPCs in emergency obstetric care.^{37,38} In Tanzania, NPCs provide most of the life-saving emergency obstetric care, and perform around 90% of all Caesarean sections in rural district hospitals.³⁹ NPCs also perform other surgical procedures with a high success rates, suggesting that they have an important role in increasing maternal health care coverage.⁴⁰

One of the greatest challenges faced by health systems in the Region is availability of qualified staff to take up positions in remote areas. In some cases this challenge has been met with support from outside agencies. For example, in South Africa, UK National Health Service and UK staff have been recruited to serve in rural parts of the country.⁴¹

Countries can also make better use of the human resources they already have, notably by linking compensation to performance. This approach has already shown its worth in Ghana where a scheme paying doctors for extra hours of work not only improved the retention of doctors, but actually resulted in a shift of doctors from the private sector to the public sector.⁴² In Uganda, private not-for-profit organizations also lost providers to the public sector when compensation in the public sector was increased.⁴³ Non-financial incentives such as career advancement opportunities, continuing education programmes, housing loans, pension schemes and medical allowances have also proved to be effective, notably in Botswana and Namibia where a set of incentive benefits for nurses such as housing and car loans, and medical allowances have been used.⁴⁴ In Ghana, a similar package included car and housing loans for rural-based professionals.⁴²

Quality of care is important

Improving coverage is only part of the battle. Quality must also improve. Poor quality of care has been identified as a major cause of poor health outcomes for women in the African Region and can be a significant cause of under-utilization of health services.^{45,46} The availability of skilled staff and an adequate supply of medicines are among the key factors associated with quality care, but so too is sensitivity to cultural



factors. It is therefore essential that midwifery practices in the Region be informed by an understanding of the sociocultural contexts, which may include traditions relating to the delivery position, for example.⁴⁷ In addition, health care providers, particularly at primary health facilities, require skills to provide gender-sensitive health services to women and girls. Pre-service training that exposes prospective care providers to gender sensitivity in addressing community health issues has shown its worth in Benin where reproductive health care courses have been integrated into the pre-service curriculum of medical, nursing and midwifery students.⁴

Improving financial access is essential

However good the coverage, and however high the quality of services provided, women will not go for regular screening or for the crucial antenatal consultations if they cannot afford it. As already discussed in Chapter 3, available evidence suggests that user fees and direct payment have led to an overall decline in the utilization of health services. In Kenya and Zimbabwe, for example, studies carried out in the 1990s have revealed that the introduction of user fees resulted in a 30–50% drop in demand for maternal health services.^{48,49} Some countries have tried to minimize the negative impact of user fees on vulnerable groups by introducing systems of fee waivers and exemptions. However, implementing such systems has met with considerable challenges, notably with regard to effective identification of the people eligible for benefits.^{49,50} Where fee payments are discontinued, utilization rates rise. In Niger, for example, utilization of child and maternal health services increased by a factor of 2–4 after user fees were cancelled in 2006.⁵¹ In Uganda, the abolition of user fees in 2001 led to a 50% increase in health services at public hospitals,⁵² while deliveries at health facilities increased by 28%, and utilization of antenatal and postnatal services increased by 25% and 32%, respectively.^{51–54} Cancellation of user fees for deliveries in three regions in Ghana increased the utilization of obstetric care by 11–34%.^{55,56}

However, as noted in Chapter 3, abolition of fee payment presents a number of challenges especially the problem of reimbursing providers for the ensuing loss of fee revenue. Replacing user fees with financing systems based on prepayment and pooling of resources also presents enormous challenges, but Rwanda has already shown what can be achieved in the Region and similar efforts have been made in Ghana. Political leadership is essential to bringing about an effective transition

to prepayment and pooling as indicated by a recent UNICEF study which shows that, with dialogue between political leaders and national technicians, the transition stands a much better chance.⁵⁷

Health insurance schemes – the experience of Rwanda

Mutual health insurance schemes, known as “mutuelles de santé” or simply “mutuelles” were initiated as pilot projects in Rwanda in 1999. The spread of the schemes accelerated sharply in 2000–2005 with the adoption of a national policy on mutuelles and the roll-out of the schemes with the financial and technical support of development partners. The system has been partly financed by external aid from partners such as the Global Fund to fight AIDS, Tuberculosis and Malaria which covers insurance premiums for about 1.5 million vulnerable persons. As of April 2008, every Rwandan is obliged by law to have some form of health insurance. There are several health insurance programmes in the country targeting specific groups of the population.

The “mutuelles” scheme is the biggest in terms of membership, and participation in the scheme is organized on a per household basis, with an annual payment of 1000 Rwandan francs (US\$2) per family member. The growth of the mutual health insurance scheme in Rwanda has been a great success from the point of view of affordability of the programme. Mandatory participation in the “mutuelles” has led to a considerable increase in public health service coverage in Rwanda which is the only country in sub-Saharan Africa in which an impressive 85% of the population participates in some form of mutual health insurance.⁵⁸

Creating the enabling socioeconomic conditions for women’s development

Because some of the major health issues faced by women in Africa are associated with poor living conditions, simply addressing the problems of the health care system will not be enough. As noted throughout this report, women are the main gatherers of wood, fuel and water, in addition to their roles as the principal harvesters and processors of food. All these tasks expose women to health risks and there is ample evidence suggesting that improving infrastructure such as access roads and establishing water sources that are safe and accessible can considerably improve women’s health and economic well-being.



As the main participants in these activities, women themselves have an important part to play in developing policy and designing projects that make the activities less onerous. By co-opting women into the planning process, infrastructure improvement better reflects their needs as was shown recently by a national water programme in Malawi. A national programme to provide pipe-borne water to peri-urban communities in the country failed as a result of poor location of water sites, and wrong use of water points. The absence of women in the planning process was blamed for the poor outcome and women were co-opted into “tap committees”, their representation rising from 20% in the 1980s to over 90% today. Women also began to manage communal water points and took responsibility for their operation and maintenance. As a result overall system performance has improved considerably.^{59,60} Investment in safe water and sanitation can have a huge impact on the health of communities, beginning with a marked reduction in diarrhoeal diseases, without being too expensive. Indeed, according to a recent cost–benefit analysis undertaken by WHO, investing in water and sanitation can bring substantial gains to communities especially to women and girls, each dollar invested yielding a return of between US\$ 3 and US\$ 14.⁶¹

Making simple improvements within the home can bring about a dramatic change in women’s health. Investment in labour-saving household equipment, for example, can enable girls to spend more time on their education or allow women to focus on their children or work in more economically productive activities. In Nigeria cassava processing led to a drastic reduction in the time required to process cassava into gari, thereby increasing household incomes earned from other activities. Such labour-saving devices also reduce the health risks in such work. In East Africa improved wood- or charcoal-burning stoves which can reduce kitchen pollution by up to 50% are being promoted and the newly developed *jiko* stove used in Kenya gives off only 10% of the particulate matter produced by wood fires, reducing the exposure of girls and women to indoor pollution.



Interventions designed to alleviate the burden of domestic tasks carried out by women and girls are only one aspect of a broad commitment to empower them in a way that may actually relieve them of domestic chores or at least decrease their burden. One of the basic tenets of women’s rights movements around the globe is that a woman’s place is not *necessarily* in the home and, as challenging as this idea may be in certain traditional settings, countries ignore it at their own expense – both socially and economically. This report repeatedly stresses the importance of educating young African women. Education should not only be broadly available to all girls but should, wherever possible, lead to opportunities for further education that will open the door to professional advancement. Enabling women to specialize in studies leading to senior positions within the health system is of particular importance.

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Empowerment also comes with social connectedness or association and

countries can do much to encourage the formation of women's social networks including assisting them to raise funds and supporting them with human and other resources necessary for their socioeconomic development. Empowerment through connection is crucial to enabling women in the Region have a voice – particularly the most vulnerable among them such as women with disabilities.

Empowerment of women with disabilities – a Ugandan example

Groups like the National Union of Women with Disabilities (NUWODU) in Uganda can bring women and girls with disabilities together and help defend, protect and promote their rights. NUWODU not only enables disabled women and girls to gain access to education; it also recruits disabled girls allowing them to acquire employment-relevant experience. NUWODU also trains disabled women in leadership skills and confidence building, and gives financial support to groups of women to start income-generating activities.⁶²

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By coming together as social networks, comprised of women in rural areas, those living in poor suburbs, or those belonging to marginalized groups, women can make themselves heard and should be encouraged by policy makers to do so. Policy makers should also take women's opinions into consideration when drawing up policy and implementing projects and programmes, and should listen to their appraisal and evaluation of these.

The cycle or circle of empowerment described in Chapter 5 is only complete if women can enjoy the fruits of their labour. In the formal sector this means passing and enforcing legislation guaranteeing equal pay for equal work and, in the informal sector, changing attitudes within households that often put the proceeds from the sale of goods at market, for example, into the man's pocket. Such change will not come about by itself; it will require the engagement of national governments making full use of information campaigns delivered through the mass media.

A key aspect of economic empowerment is to allow women to own property. Many countries in the Region have adopted national constitutions that guarantee gender equality before the law, but in some traditional settings women are still not allowed to own property. To ensure that constitutional guarantees are met, countries are making efforts to address gender inequalities by amending existing laws. For example in 1999, Rwanda passed a law giving females inheritance rights equal to those of males, thereby overruling traditional inheritance norms.⁶³ Similarly, Mozambique passed the 1997 Land Law that recognizes the equal rights men and women should have to land, as well as the 2004 Family Law that supports women's land rights. In Botswana, Mozambique, South Africa, Namibia and Uganda, women's rights to land ownership are being protected by ensuring women's participation in local land committees responsible for land reform and land allocation. In Zimbabwe and Zambia, land quotas to be allocated to women have been set at 30% and 20%, respectively.⁶⁴

Focusing on the most vulnerable is key

Policy focusing on the empowerment of women must not overlook the most vulnerable because in the African Region such women often struggle to earn a living

and their ability to pay for health care is limited. Progress is being made by some countries in the Region to assist vulnerable groups and social protection systems are gradually being redesigned to cover women with disabilities. This is notably true of Namibia and South Africa, where special social grant systems exist for women living with disability.⁶⁵

Even so, much more needs to be done and community-based organizations have an important role to play in advocating and fighting for the rights of disabled girls and women. The experience of National Union of Women with Disabilities (NUWODU) in Uganda featured above tells a success story of how this can be achieved.⁶²

There are other factors associated with vulnerability of African women, such as old age, natural disasters and conflicts. In Chapter 4 it was noted that the vast majority of women in sub-Saharan Africa work in some type of informal occupation not covered by any form of pension scheme. This leaves them particularly vulnerable in their late years. For the many women who survive their spouse, destitution is a real threat. The vulnerable elderly women must rely on the support of others and where that support is not forthcoming must rely on the state. Policy makers are urged to establish social protection schemes to shield vulnerable women from events that adversely affect their livelihoods.







Addressing the urgent need for data on women's health

Unfortunately, at present, the African Region lacks data collection and analysis systems that would enable adequate monitoring and evaluation of the progress made in improving the health and social status of women. Because women's health needs change as they progress through the different stages of the life course, there is an urgent need for age and sex disaggregated data to monitor their health status. Demographic and health surveys have proven useful sources of information on reproductive health indicators since they are disaggregated by age and sex,⁶⁶ but unfortunately they do not contain enough information about cancers and other morbidities affecting elderly women. The Demographic and Health Surveys (DHS) represent a benchmark for best practices in collecting information that can be used to design interventions to improve women's health in Africa and are already providing some useful insights into women's health status in the Region.^{67,68}

Because women carry the burden of reproductive health conditions, monitoring the progress of outcomes and evaluating the quality of care provided to them is especially important. A list of indicators has now been published by WHO and these are suitable for monitoring progress in reproductive health.⁶⁹ For emergency obstetric and newborn care, the United Nations agencies have published guidelines for both outcome and process indicators that are applied at national level (Table 6.2).⁷⁰ However, due to the difficulties

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Table 6.2 Useful indicators for monitoring the key interventions

Life cycle	Key interventions	Useful indicators
Girl child 	Nutrition Immunization Girl child education Protection against harmful traditional practices Protection against gender based violence, child abuse, trafficking and slavery	Stunting among girls Female child immunization coverage Female school gross enrolment rates % of girls/women reporting that they have undergone FGM Incidence of child sexual abuse and defilement Incidence of girl child trafficking
Adolescent girl 	Primary and secondary education Protection against early marriage, exploitation and abuse including sexual violence Youth centres Adolescent friendly health care services Adolescent sexuality and lifestyles, life-skills and sex education Livelihood skills training HPV immunization	Female secondary school gross enrolment rates Age at sexual debut Age at first birth Prevalence of casual sexual encounters without protection amongst adolescents Prevalence of condom use Prevalence of STI/HIV Coverage of HPV immunization
Adult woman in the reproductive years 	Family planning service Comprehensive abortion care services Pregnancy care (basic and comprehensive package: antenatal, labour/delivery and postpartum care, newborn care) Screening and treatment for STI including HIV Maternity leave protection Protection against domestic violence Female empowerment programmes Cancer screening	Total fertility rate Contraceptive prevalence rate Unmet need for family planning % of gynaecological admissions that are for abortion-related complications Case fatality rate for postabortion complications STI case detection, treatment and cure rates HIV prevalence rates Maternal mortality ratio % of deliveries with skilled attendant % of low birth weight babies % of pregnant women receiving antenatal care at least once % of pregnant women who are anaemic Number and distribution of basic and comprehensive essential obstetric care facilities/500,000 population Incidence of rape Violent death rate among women Screening coverage for breast and cervical cancer
A woman beyond the reproductive years 	Healthy nutrition Cancer prevention services (e.g. cervical, breast) Protection against gender related violence Screening for chronic non-communicable diseases Mental health support	Screening coverage for breast and cervical cancer Incidence of breast and cervical cancer

HPV; human papillomavirus; STI, sexually transmitted infection; HIV, human immunodeficiency virus; FGM, female genital mutilation

encountered in collecting data in Africa, these indicators may not be available or reliable enough for much-needed programme reform or initiatives. With regard to maternal mortality, accurate national level information is available for only a handful of African countries and it will be difficult for many to know whether MDG 5 has been achieved or not.⁷¹

Interventions that can improve information management systems for women's health include shifting from manual to electronic data collection and conducting multipurpose national household surveys on a regular basis. However, the strengths and weaknesses of the commonly collected forms of data need to be noted. Quantitative data can be used to describe and portray only certain dimensions of the women's health problems. As is clear from the application of the RAPID model in Rwanda, availability of quantitative information can spur actions to improve women's health. However, certain elements of health problems from which women suffer cannot be elucidated by using quantitative evidence alone. For example, no amount of quantitative evidence can reveal the depth of suffering that women endure when they give birth under desperate and degrading conditions. Failure to bring such suffering to the attention of policy makers is arguably one of the reasons why life-saving and cost-effective facilities and technologies are not provided or are inaccessible to the vast majority of African women. WHO should support Member Countries in the design and implementation of systems for collection and analysis of quantitative and qualitative data, and to facilitate the use of the evidence generated to improve women's health.

Interventions that can improve information management systems for women's health include shifting from manual to electronic data collection and conducting multipurpose national household surveys on a regular basis.



Key considerations and points for action

- a) To improve women's health and social status, there is a need to shift from interventions that are rooted in the health system to society-wide programmes and initiatives.
- b) Government is best placed to coordinate the various initiatives needed to bring about change, hence the need to mobilize political will and commitment for that purpose.
- c) Cost-effective health care interventions exist to improve women's health throughout their life course and many countries of the Region are capable of funding them.
- d) Acceptable and quality health care can be achieved by making health systems friendly to women and sensitive to their cultural contexts.
- e) Use of new ICT technologies can improve access to quality care and enhance efficiency in health care delivery.
- f) Eliminating gender-based discrimination and promoting positive social attitudes towards women is a key aspect of women's empowerment. It is therefore essential that policy makers work to bridge the gender gap in education and employment through legislative reform and public information campaigns.
- g) Mechanisms and institutions to make women's voices heard should be established and women should be encouraged to identify and express their concerns, a process that can partly be supported by creating all-women social groups and networks.
- h) Certain vulnerable groups, notably women with disabilities and the elderly, require social security, including free access to comprehensive health care. Governments that embrace prepayment and pooling of resources as the basis for the provision of universal health care coverage stand the best chance of meeting their obligations to these groups.
- i) Monitoring and evaluation systems should be strengthened to track progress made in improving the health and social status of women.

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